

**The Influence of Masculinity on White and South Asian Men's
Help-Seeking Behaviour for Chest Pain**

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**The candidate confirms that the work submitted is his own and that appropriate credit has been given
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The thesis is dedicated to the memory of my Father, Maurice Galdas.

Abstract

Coronary heart disease is the leading cause of premature death for men in the UK. The mortality rate is almost twice as high for South Asian men living in the UK compared to the rest of the population. There is established evidence that prompt diagnosis and treatment of heart disease significantly reduces morbidity and mortality. However, there is a growing body of literature to suggest that 'masculinity' may lead men to be reluctant to seek medical help when experiencing symptoms of ill health. It is not known whether there are differences or similarities between white and South Asian men relating to the influence of masculinity on their help-seeking behaviour for chest pain.

This thesis aims to address this gap in the literature by exploring how masculinities influence white and South Asian men's decision to seek or delay-seeking medical help for acute chest pain. A modified grounded theory methodology employing in-depth interviews was used in two studies that investigated the help-seeking experiences of white and South Asian men who had been admitted with acute cardiac chest pain to two hospitals in the North East of England. Thirty-six men were interviewed for the first study; twenty men were interviewed for the second study.

The two studies revealed that both white and South Asian men of Indian and Pakistani origin engaged in a complex process of help-seeking decision-making when experiencing acute chest pain symptoms. The main findings of the thesis highlight white and South Asian men's differing perceptions and behaviours associated with the core concept of this process defined as 'acting like a man'. The core concept illustrated that the salient feature of men's help-seeking decision-making process related to how they perceived they should 'act as a man' whilst experiencing chest pain. For the majority of South Asian men of Indian and Pakistani origin, the concept corresponded to culturally distinct representations of masculinity that were principally signified by a belief that chest pain was a symptom worthy of concern, and a

willingness to discuss their symptoms with others and seek help from their GP. By contrast, for the majority of white men, the core concept corresponded to hegemonic representations of masculinity that were principally signified by a belief that chest pain alone was a symptom unworthy of concern, a perceived need to display a high tolerance for pain, and a fear of being seen to be acting 'soft' by others if they sought medical help.

The thesis argues that a 'gender-sensitive' approach to healthcare practice and policy should recognise the way ethnicity shapes how men represent their masculinity in the context of seeking help, and that current prevailing theories of masculinity that consider first generation Indian and Pakistani men's representations of masculinity as 'marginalised' in this context are overly simplistic and ethnocentric.

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Abbreviations

- CHD - Coronary Heart Disease
- ECG - Electrocardiogram
- MI - Myocardial Infarction
- UK - United Kingdom
- US - United States
- GP - General Practitioner
- DoH - Department of Health (United Kingdom)
- MHF - Men’s Health Forum (United Kingdom)
- RGSC - Registrar General’s Social Class (Social Class based on Occupation)
- NHS - National Health Service
- NSF - National Service Framework

Chapter 1

INTRODUCTION

1.0 Background to the Thesis

This thesis explores the influence of masculinity on white and South Asian men's decision to seek or delay-seeking medical help for chest pain symptoms. The motivation for the focus of this investigation was primarily borne out of my professional experience as a coronary care nurse. Throughout my clinical career, I regularly encountered male patients who had suffered an acute cardiac event but had failed to act on their chest pain symptoms promptly. When caring for these patients and listening to their stories, I became struck by the number of men who had considered severe chest pain symptoms to be due to indigestion, were unaware of their risk of developing heart disease, and had therefore been reluctant to call an ambulance. It was clear to me from the men's accounts that these delays in help seeking were having a real and significant impact on their condition. Many men developed severe heart failure because of the delay in receiving prompt treatment for their heart attack and, consequently, had a dramatically shorter life expectancy and little chance of resuming their 'normal' lives after their event.

A review of the literature reveals mounting recognition of men's reluctance to seek health care in support of the anecdotal evidence presented above. For instance, in March 2000, the then Public Health Minister for the UK, Yvette Cooper, stated that:

'Men are less likely [than women] to visit a doctor when they are ill and are less likely to report on the symptoms of disease or illness' (Department of Health 2000b)

The subsequent minister for public health, Hazel Blears, further noted that *'traditional male attitudes'* can have an adverse impact on men's health, in particular, *'being independent'*, *'not asking for help'*, and *'being self-contained'* (HDA 2002). The President of the Men's Health Forum has described illness and the NHS as a *'No man's land'* (Banks 2001), and a scoping

study of key individuals and organisations that have a role in the care of men in the UK has also revealed a reluctance to access health services as the principal issue facing men's health (White 2001). This recent political and professional interest has placed help-seeking behaviour at the forefront of the UK men's health agenda.

As I argue in the following chapter of the thesis (Chapter 2 – 'Literature Review'), there is a growing body of research evidence to support the suggestions in the professional literature that men's masculinity plays a pivotal role in their reluctance to seek medical help. Studies on samples of healthy men, and those investigating men with prostate and testicular cancer, are increasingly finding that some men's desire to 'live up' to idealised forms of masculinity leads to a reluctance to seek help promptly for symptoms of ill health.

Despite an increasing professional and academic interest in men's help-seeking behaviour, to date only one study (White 2000) has explored how masculinity impacts on men's experiences of chest pain. Coronary heart disease (CHD) remains the leading cause of premature death for men in the UK. South Asian men living in the UK have a 46% higher mortality rate from CHD compared to the rest of the population (British Heart Foundation 2005). Clinical trials have shown significant reductions in mortality and morbidity in patients who are treated within one hour of the onset of symptoms of myocardial infarction (GISSI 1986; UKHAS Collaborative Group 1998; Norris 1998). However, the influence of masculinity on men's decision to seek or delay-seeking medical help for chest pain is not yet fully understood, and it is not known whether there are differences or similarities between white and South Asian men's behaviour in this regard.

In this thesis, I aim to build on current empirical evidence – and address the problem I encountered in my own clinical practice – by furthering the understanding of how masculinity influences the decision to seek or delay-seeking medical help among white and South Asian men who experience acute chest pain.

1.1 Overview of the Thesis

The thesis contains eight chapters. The next chapter, **Chapter 2** ('Literature Review'), presents a critical review of the research literature relating to the topic of investigation that has been briefly outlined earlier. At the beginning of the chapter, I briefly outline the context of the thesis by considering the significance of coronary heart disease in the UK and discussing the development and current context of men's health. The literature on masculinities and help seeking are then reviewed, drawing attention to the key issues, limitations and gaps in the current body of knowledge. The chapter concludes with the research question and study objectives that were borne out of the gaps identified in the knowledge.

Chapter 3 ('Methodology') provides an account of the research methodology used to address the research question and study objectives. I justify the use of Strauss and Corbin's (1990; 1998) grounded theory methodology, and why it was modified to incorporate aspects of Charmaz's (2000) approach to constructivist analysis, based predominantly on ontological and epistemological principles tied to the research question. Later in the chapter, I explain the rationale for the use of interviews as a method of data collection, discuss the strategies for ensuring rigour in qualitative research, and examine the key issues and methodological concerns of interviewing white and South Asian men about their attitudes, beliefs and representations of masculinity.

In **Chapter 4** ('Study One – Research Methods') I then discuss how the modified grounded theory methodology was applied in the first of the two studies that are presented in the thesis.

The study sample, recruitment procedures and ethical considerations are described in detail. Throughout this chapter, I make each stage of the research process explicit so as to allow the reader of the thesis to follow the 'decision trail' and judge the rigour of the study's findings. To achieve this end, a reflexive account of the process of interviewing is provided, in addition to a detailed description of the key stages of the study's analytical process. These accounts illustrate how the data from interviews with thirty-six participants led to the development of a substantive grounded theory of men's help-seeking decision-making process when experiencing chest pain symptoms.

Chapter 5 ('Study One – Findings and Discussion') presents an in-depth account and discussion of this substantive grounded theory. The theory comprises two core concepts and five distinct themes associated with men's help-seeking decision-making process. Attention is drawn to the differences and similarities between white and South Asian men's accounts, and these findings are contextualised alongside existing research to illustrate where the study fits in with, and contributes to, the current body of empirical evidence. In the discussions within this chapter I propose that the differences identified between white and South Asian participants signifies the men's differing cultural attitudes to seeking help for pain and their distinct representations of masculinity in the context of help seeking. The chapter concludes with a discussion of the limitations of the study, and the rationale and objectives for the second study which aimed to explore the research question in greater depth.

In **Chapter 6** ('Study Two – Research Methods') I discuss how the modified grounded theory methodology outlined in Chapter 3 was applied in this second study. As in Chapter 4, this chapter makes clear each stage of the research process, providing a 'decision trail' of how the data gained from interviews with twenty men led to the conception of three themes, linked to a core concept defined as 'acting like a man', that developed and refined the theory conceived in the first study.

Chapter 7 ('Study Two – Findings and Discussion') provides an in-depth account and discussion of the findings from the second study. Each of the three themes that emerged from the analysis of men's accounts is discussed consecutively. Attention is drawn to how the core concept, 'acting like a man', underpinned each theme, the differences and similarities between white and first generation South Asian men of Indian and Pakistani origin, and how these findings fit in with and build on the theory conceived in the first study. In the discussions within this chapter I draw attention to the accounts of two 'deviant cases' and propose that acculturation – or 'Westernisation' – can have a considerable impact on South Asian men's representations of masculinity in the context of help seeking. I also develop the proposals made in Chapter 5, arguing that interpreting Indian and Pakistani men's representations of masculinity as 'marginalised' in the context of help seeking is an overly simplistic, ethnocentric perspective.

Finally, **Chapter 8** presents a summary and conclusion of the two studies. The key findings from the two studies are integrated to form an explanatory theory – grounded in the data – of the influence of masculinity on white, Indian and Pakistani men's decision to seek or delay-seeking medical help for chest pain symptoms. The implications of these findings on healthcare policy and practice are then considered. In this section, I argue that the current prevailing 'gender-sensitive' perspective should be furthered by incorporating a culturally-sensitive approach to healthcare planning and delivery that acknowledges the way ethnicity shapes how men represent their masculinity in the context of seeking help. Recommendations for future research are made on the basis of the study findings, before the chapter closes with some brief concluding remarks.

Chapter 2

LITERATURE REVIEW

This chapter presents a critical review of the gender/masculinity, health behaviour and help seeking theory and research literature. The chapter is not intended to be a systematic review, but rather, a methodological and thematic critique of the literature that was available at the outset of the project and summarised in the *Journal of Advanced Nursing* publication (Galdas et al 2005; see appendix 8). The literature review provides the rationale for the research question addressed in this thesis. Accordingly, although the review has been updated so as to incorporate salient literature that was published during the course of the research study, some of the broader literature on social and cultural psychology is addressed later in the thesis (in the findings and discussion chapters 5 and 7) as these themes did not arise until the need to contextualise the findings of the studies. The original literature search strategy is presented in appendix 1.

The chapter begins by outlining the context and significance of the topic of investigation – coronary heart disease and men’s health. Section 2.1 presents a review of key empirical evidence and health policy that illustrates the problem of coronary heart disease in the UK, with particular attention drawn to inequalities in the health of South Asian populations in the UK. A discussion of the development and current context of men’s health is then presented in section 2.2. The three main approaches to conceptualising masculinity, and the key theoretical perspectives of masculinity and men’s health, are reviewed and critically analysed in sections 2.3 to 2.5.

The subsequent sections of the chapter present a methodological and thematic review and critique of the current research evidence on gender, health behaviour and help seeking. The review is divided into four themes: Men, Health and Masculinity; Gender and Help-Seeking

Behaviour; Men and Help-Seeking Behaviour; and Coronary Heart Disease and Help-Seeking Behaviour. Each of the four themes is followed by a summary that highlights the key messages and limitations of the current body of evidence.

The chapter concludes with a summary and conclusion of the overall literature review. The key messages, limitations and gaps in the existing literature on gender, health behaviour and help seeking are discussed. Particular attention is drawn to the limitations of studies exploring men's help-seeking behaviour and masculinity. Finally, the research question and study objectives that are addressed in this thesis – borne out of the gaps identified in the literature – are presented in section 2.11. The following chapter (Chapter 3 – 'Methodology') provides a detailed account of the methodological approach used to address this research question.

2.1 The Significance of Coronary Heart Disease in the UK

Coronary heart disease (CHD) is the leading cause of death world wide; the World Health Organisation estimates that globally, 3.8 million men and 3.4 million women die from the condition each year (Mackay and Mensah 2004). In the UK, almost 2.7 million people have CHD, and although the mortality rate in the UK is falling it remains among the highest in the world – over 117,000 deaths a year, most of which are caused by acute myocardial infarction (AMI) (British Heart Foundation 2005). This is in comparison to 34,000 deaths a year from lung cancer, 16,000 deaths from colorectal cancer and 13,000 deaths from breast cancer (British Heart Foundation 2005).

Although CHD is the major cause of premature death in the UK, there are significant gender, regional and socio-economic differences in its incidence and prevalence. For instance, CHD causes 22% of premature deaths in men in comparison to 12% of deaths in women. There is also a UK 'North-South divide' in CHD mortality – deaths from CHD are highest in Scotland and the North of England, and lowest in the South of England. The premature death rate from CHD is almost 70% higher for men living in Scotland than for men living in the South-West

of England. The premature death rate is also 58% higher for manual workers than for non-manual workers, and it has been estimated that around 5,000 lives are lost each year in men aged 20-64 years due to these social class differences in CHD death rates (British Heart Foundation 2005).

There are also significant ethnic inequalities in the incidence of coronary heart disease in the UK. South Asians living in the UK (Indians, Bangladeshis, Pakistanis and Sri Lankans) have a higher premature death rate from CHD than the rest of the population; 46% higher in South Asian men and 51% higher in South Asian women in relation to the UK population as a whole (British Heart Foundation 2005). Migration has previously been proposed as an important factor in determining the increased risk of CHD in South Asians (Bhatnagar et al 1995). However, as other migrating populations in the UK (for example, Afro-Caribbean people) do not have an increased risk of CHD compared with the indigenous population (British Heart Foundation 2005), it has become widely recognised that there are specific CHD risk factors that apply to South Asians (Khunti and Samani 2004). Several genetic, cultural and socio-economic explanations have been suggested in the research and theoretical literature.

Insulin resistance has been the foremost genetic explanation for the high rates of CHD among South Asians worldwide (Bhopal et al 1999). The use of ghee and other cooking oils (Nath and Murthy 1988; Ahmed 1999), non-vegetarian diets (Pais et al 1996) and sub-clinical hypothyroidism (Fowler 1985) have also all been proposed as factors responsible for the observed inequalities in CHD incidence for migrating South Asians. In the UK, several culturally linked CHD risk factors – such as smoking, a high fat diet and low rates of physical exercise – have been shown to be more common among South Asians compared to the white population (Bhopal 2000; Rankin and Bhopal 2001).

In the studies cited above, South Asians have largely been considered to be a genetically and culturally distinct, homogeneous group. However, there is a significant body of literature asserting that South Asian people do not share a uniformly greater risk of CHD. A number of studies have highlighted the heterogeneity of CHD risk factors and CHD incidence among South Asian populations in the UK. Nazroo (1997) has showed that the prevalence of self reported CHD is markedly higher in Bangladeshis and Pakistanis compared to the Indian population. Indeed, in terms of cultural factors, although the use of ghee in cooking and a lack of physical exercise have been implicated as CHD risk factors for South Asians, ghee is not used by all of the ethnic groups that comprise 'South Asians' (Nazroo 1997) and there is evidence to suggest that some South Asians groups *do* understand the importance of exercise (Beishon and Nazroo 1997) and diet (Farooqi et al 2000). Bhopal et al (2002) have also found that risk of coronary heart disease is not uniform among South Asians and, in particular, that there are important differences between Indians, Pakistanis and Bangladeshis for many risk factors. Principally, poverty and higher levels of smoking and obesity have been identified as being more prevalent among Pakistani and Bangladeshi groups in comparison to Indian groups (Bhopal et al 2002).

The relatively disadvantaged socio-economic position of some South Asian populations – rather than ethnic or cultural factors – has therefore been proposed by some authors as an explanation for the observed heterogeneity of CHD risk and incidence in South Asian communities (for example, Nazroo 1998b; Bhopal 2000). The claim has been supported by a growing body of empirical evidence demonstrating links between a higher prevalence of self reported heart disease and CHD risk factors among economically disadvantaged South Asian groups (Pakistanis and Bangladeshis), compared to more socio-economically advantaged South Asians (Indians) who have been found to have the same CHD incidence and risk factors as the majority white population (Nazroo 1997; 2001; Bhopal et al 2002). However, it is clear from the number of hypotheses explaining inequalities in CHD between and among

South Asian communities that the differences are unlikely to be demonstrably genetic, economic, or cultural; all these factors are likely to be implicated.

Notwithstanding inequalities between groups, such a high rate of CHD morbidity and mortality across the entire adult population has major economic consequences for the UK. British Heart Foundation statistics estimate that CHD costs the UK economy around £7900 million a year (Liu et al 2002; British Heart Foundation 2005), which represents a cost higher than that of any other single disease for which comparable analysis has been carried out (Petersen et al 2003).

Accordingly, reducing coronary heart disease has become a public health priority for the UK government. In the public health white paper, '*Saving Lives: Our Healthier Nation*' (Department of Health 1999), the government set a target of reducing the death rate from heart disease and stroke and related cardiovascular disease in people under 75 by at least 40% by 2010. In 2000, a blueprint health policy aimed at tackling inequalities in CHD and improving CHD health and care – the National Service Framework (NSF) for Coronary Heart Disease (Department of Health 2000) – was published. The framework set out a programme to modernise the prevention, diagnosis and treatment of CHD, placing responsibility on a wide range of agencies across the National Health Service (NHS) for both primary and secondary prevention strategies. Since the introduction of the NSF there have been marked improvements in the treatment of CHD in the National Health Service. For example, there has been a significant increase in the number of people receiving thrombolysis and prescriptions for the prevention of cardiovascular disease; more than 1.8 million people, over 3% of the population, now receive statins (lipid lowering drugs); NHS Stop Smoking Services are in place across the UK; and primary prevention strategies aimed at increasing exercise and promoting healthy eating have recently been implemented across the UK in conjunction with the '*Choosing Health*' public health White paper (Department of Health 2004b). Reducing ethnic inequalities in CHD has also been made a priority by the UK government (Department

of Health 2003; 2004c). The need for specific CHD interventions for South Asian populations has been highlighted through evidence of an underutilisation of thrombolysis (Lear 1994) and under-provision of treatment for both stable CHD (Barakat et al 2003) and acute MI (Lear 1994) for South Asian groups despite data to suggest their increased risk and susceptibility to CHD. As such, the National Service Framework for CHD set out strategies to tackle established risk factors and address inequalities in access to, and provision of, services in South Asian communities (Department of Health 2000; 2004; 2004c).

Although recent improvements in the treatment and prevention of CHD have been made in light of recent government health policy, CHD still remains the leading cause of premature death in the UK (British Heart Foundation 2005). What is more, inequalities in CHD mortality and morbidity between South Asian communities and the rest of the population continue to increase (British Heart Foundation 2005). Clearly, reducing CHD morbidity and mortality is of central importance to improving the health of all men and women in the UK and, in particular, the health of South Asian communities. Research into how primary and secondary CHD prevention interventions can be made effective is, therefore, likely to result in considerable health and economic benefits for the UK.

2.2 The Current Context of Men's Health

The notion of 'men's health' has gained increasing prominence in the public domain, health policy and mainstream academic literature. However, until relatively recently there has been considerable ambiguity surrounding what 'men's health' actually is, or what constitutes a 'men's health issue'. Differences between men's and women's rates of death and disease in developed countries have long been recognised and documented in the literature (Verbrugge 1976; Waldron 1976; Verbrugge 1985; Annandale and Hunt 1990). Many general texts addressing men's health have begun by highlighting a series of conditions, risk factors and causes of death which men are statistically more likely to suffer from, such as suicide, heart disease, alcohol abuse, drug misuse and accidents, as well as testicular and prostate cancer

(O'Dowd and Jewell 1998; Harrison and Dignan 1999; Luck et al 2000). Much of the statistical data on men's illness/disease incidence in this literature has been presented in relation to women (Lloyd and Forrest 2001). Some 'headline' figures often quoted include:

- Men are twice as likely as women both to develop, and to die from, the ten most common cancers affecting both sexes.
- Men are significantly more likely than women to be overweight or obese, and suffer from the consequences of being overweight or obese such as coronary heart disease and metabolic syndromes.
- Three times as many men than women die from suicide.
(Department of Health 1998)

From this perspective, men's health problems can largely be seen to be constructed in contrast to women's health. Women's health is generally understood in the public domain as a sex-based aggregate of reproductive pathologies and statistical indicators related to women's mortality, morbidity, disability and lifestyle practices (Doyal 2001). Correspondingly, men's health is seen to be constituted by men's diseases of the reproductive organs, such as impotence and prostate and testicular cancer, and by the *margins of difference* between men's and women's rates of death and disease (Schofield et al 2000). Two general perspectives can be distinguished in the literature as to how these margins of difference between men's and women's health have been conceptualised; the biogenic perspective and the psychosocial perspective.

The biogenic view attributes health differences between the sexes to biological (i.e. genetic and hormonal) factors (Kaplan and Marks 1995). For example, women's greater longevity has been explained as being due to the health advantages that accrue from their differing physiological systems; for instance, those that are concerned with pregnancy and childbirth (Bird and Rieker 1999). These advantages include a stronger and somewhat different immune system that allows women to have higher levels of passive immunity during pregnancy and to pass on a substantial level of protective antibodies to infants during breast-feeding (Grossman et al 1991; Hegde 1991). Doyal (2000) has argued that women's greater longevity is due, at

least in part, to the fact that men are innately the weaker sex; reflected by the higher numbers of male deaths both in utero and around the time of birth (Hart 1988; Waldron 1983).

In arguing that the biological male is, on most measures, weaker than the female, Kraemer (2000) also draws on the results of various studies concluding that perinatal brain damage (Lavoie et al 1998), cerebral palsy (Singer et al 1968), congenital deformities of the genitalia and limbs, premature birth and stillbirth are all commoner in boys (Taylor 1985). Kraemer (2000) also notes that developmental disorders such as hyperactivity (Taylor 1994), autism and related disorders, clumsiness, stammering, and Tourette's syndrome also occur three to four times more often in boys than girls. Further commonly cited examples of biological sex differences in adulthood include suggestions that women have a consistently lower neuro-endocrine and cardiovascular reactivity to stressors than men (Manuk and Polefrone 1987) and men are thought to have a lifelong sensitivity to certain prostaglandin metabolites that puts them at higher risk of vascular damage and coronary disease than women (Ramsey and Ramwell 1984).

Although biological factors such as genetics, prenatal hormone exposure and natural hormone exposure in adults have been widely acknowledged to contribute to differences in men's and women's health, the explanatory power of biological (sex) differences *alone* in predicting differences in men's and women's mortality and morbidity has been argued to be comparatively small (Verbrugge 1985; 1988; Courtenay et al 2002). Furthermore, the biogenic view has been criticised as proceeding from reductionist assumptions that ignore a wide range of social processes that create, maintain, or exacerbate underlying biological health differences (Waldron 1983; Bird and Rieker 1999; Sabo 2000).

The psychosocial view attributes sex differentials in large part to gender; that is, the cultural and social meanings, norms and expectations attached to being a man or woman (Harrison et al 1989; Kilmartin 1994; Kaplan and Marks 1995). The possibility that poor health behaviour

on the part of men might account for the disparity between men's and women's health was raised as early as the mid-1970s (Waldron 1976; Harrison 1978). However, it was not until the 1992 Annual Report of the Chief Medical Officer for England and Wales (Calman 1992) that the social aspects of men's health-related behaviour were first recognised in a political context in the UK. The report detailed the epidemiological evidence on men's health inequalities for the first time and encouraged the government, public and health professions to look more specifically at the behaviours and attitudes of men towards their health from a *gendered* perspective – the social dimensions of their health and health behaviour – as opposed to focussing on sex (biological) differences.

At this time, the UK government was in the process of shifting the focus of the NHS from treating sickness towards promoting health by emphasising the individual's capacity to change behaviour (Department of Health 1992); an emphasis illustrated in the conclusion of the report that the primary difference between men's and women's health was due to variations in exposure to risk factors (Calman 1992). The report noted:

'Gender differences in mortality and morbidity exist: but what are they caused by and what can be done about them? There is increasing evidence that many of the patterns observed stem from differences in health related behaviour, which may be influenced by the knowledge, attitudes, and beliefs of men' (Calman 1992, p.105).

Reflective of this, health professionals began to place focus on attempting to change behavioural risk factors in men through seeking to understand the basis of male lifestyles from a gendered perspective. For instance, Fareed (1994) noted in a nursing context;

'Much ill-health among men is a consequence of their lifestyle, and these are issues that nurses can address in their role as health educators. There is a need to help men recognise that stereotypical gender role behaviour....can pose a risk to health and should be changed' (p.26)

In the past decade, situating men's health in a sex/gender differences context has since been criticised for suggesting that women's health is the gold standard against which men's health should be measured; that it leads to competition for resources between men's and women's health projects; and that it can create competition between men and women about which sex is the bigger 'victim' (Men's Health Forum 2002). Accordingly, since the late 1990s the

following definition of a men's health issue, formulated in Australia, has become commonly used in men's health discourse:

'A men's health issue is a disease or condition unique to men, more prevalent in men, more serious among men, for which risk factors are different for men or for which different interventions are required for men' (Fletcher 1997)

Significantly, the definition recognises that men's health is not in contrast to women's health or solely about sex (biological) based problems such as prostate and testicular cancer, but rather acknowledges that men (and women) have specific health concerns that require specific interventions based on their gender (Men's Health Forum 2004). Indeed, although rates of prostate and testicular cancer are rising and represent a significant health problem for men in the UK, as identified earlier, the single largest cause of death of men in the UK is coronary heart disease (Department of Health 1999) – a problem that is not 'male-specific' but is increasingly recognised as having gender-specific risk factors that require gender-specific interventions (Men's Health Forum 2004). (The evidence on gender-specific risk factors associated with CHD is reviewed in section 2.9 of this chapter).

In the 1998 UK Department of Health publication *Independent Inquiry into Inequalities in Health* (Department of Health 1998), Sir Donald Acheson focussed the attention on gender as a key determinant of health from a political and public health perspective. The report recognised that across the whole adult life, mortality rates are higher for men than women for all the major causes of death; differences which did not appear to be predicated on inevitable differences in biology. Although not addressing men's health *per se*, Acheson's report (Department of Health 1998) drew attention to the need to see men's health within the context of the government's inequalities framework. Since the Chief Medical Officer's report of 1992 (Calman 1992), much was written about 'men' as a homogeneous group; statements such as '*men's tendency to...*' and '*targeting men*' were liberally used in men's health literature (Kilmartin 1994). However, the two previous major research studies investigating inequalities in health in the UK implicated *socioeconomic* disadvantage as accounting for major disparities in health in the UK population (Black et al 1980; Whitehead 1992). Indeed, it has

been argued that once socioeconomic inequalities are considered, gender differences in health are substantially altered and in some instances reduced to non-significance (Copper 2002; Read and Gorman 2006). Acheson's report similarly drew attention to the fact that, although gender differences in health existed in the UK, socio-economic and ethnic factors contributed to significant inequalities in health *between* men that were often greater than the disparities between men and women. For instance:

- Indian, Bangladeshi and Irish men have higher rates of ischaemic heart disease (angina and heart attack) and Black Caribbean, Bangladeshi and Indian men have higher rates of stroke (all compared with the general population);
- Men from all the ethnic minority groups have higher rates of diabetes;
- Bangladeshi men are nearly twice as likely to smoke as men from the general population;
- Men in higher managerial jobs live, on average, three and half years longer than men in manual work;
- Routine and manual workers are twice as likely to smoke as workers in higher managerial and higher professional positions.

(Department of Health 1998; Office for National Statistics 1998)

Theories of men's health have since moved away from a *gender-centric* approach that highlights differences between men and women, toward a *gender-sensitive* approach that does not see gender as a 'stand alone' inequality. This is the approach the UK Men's Health Forum (MHF) has taken in its policy programme for Men's Health, *Getting it Sorted*, published in spring 2004 (Men's Health Forum 2004). The document criticises Fletcher's (1997) earlier-cited definition of a men's health issue for ignoring the importance of the wider political and social determinants of health, such as socio-economic status, environmental factors and culturally-determined behaviours (Men's Health Forum 2004) – factors which underpin much of the UK government's health improvement strategy (Department of Health 1999; 1999b). As such, the MHF proposed a new definition of a 'male health issue' (as opposed to 'men's health issue' so as to include boys as well as men):

'A male health issue is one arising from physiological, psychological, cultural, or environmental factors that have a specific impact on boys or men and/or where particular interventions are required for boys or men in order to achieve improvements in health and well-being at either the individual or the population level' (Men's Health Forum 2004; p.5)

Despite the impact of gender being recognised in the Acheson report (Department of Health 1998), male-specific strategies have been largely absent from subsequent national and local health policies in the UK. This is in spite of a government wide commitment to 'gender mainstreaming' in all aspects of policy – a strategy that promotes the integration of gender concerns into the formulation, monitoring and analysis of policies, programmes and projects with the objective that women and men achieve the highest health status (World Health Organisation 2001; Department of Trade and Industry 2003). Baker (2004) has argued that the omission of male-specific policy is directly linked to the relatively low importance attached to gender as a determinant of health or as an inequalities issue. Baker's (2004) argument is supported by the fact that the 2003 UK government white paper, *Tackling Health Inequalities: A Programme for Action* (Department of Health 2003) mentions gender only once in the entire document. Furthermore, although the National Service Framework for Coronary Heart Disease (Department of Health 2000) accepts that there are gender differences in CHD incidence, there are no clear guidelines as to how these are to be addressed, which has prompted criticisms that the policy is written in 'gender-neutral language' (White and Lockyer 2001).

Although gender has been given low importance as a key determinant on the patterning of health in UK public health policy, male gender – or 'masculinity' – has gained increasing recognition in the research literature as being central to the state of men's health and the ways in which improvements to men's health can be made (White 2002). Before reviewing this literature, it is first necessary to review and clarify what is meant by the concept of 'masculinity' and how it has been theorised to interplay with aspects of men's health.

2.3 What is Masculinity?

Researchers and theorists have varied in the way they have conceptualised masculinity and masculine identity. A review of the theoretical literature reveals three principal approaches that have been taken:

- Psychoanalytical;
- Social Psychology;
- Social Constructivist.

One of the earliest set of approaches to understanding masculinity derives from psychoanalysis. The psychoanalytical approach is diverse, but Freud's and Jung's work is usually considered as the starting point of modern thought about masculinity (Connell 1995). Orthodox Freudianism emphasised 'castration anxiety' and 'penis envy' relating to men's infant psychological origins, and the relationship and conflict with parents – the 'Oedipus complex' – which implied that paternal relations were crucial in adult masculinity (Freud 1953). Jung worked on the premise of bi-polarity, where masculinity and femininity were seen as exclusive domains. He focussed on the balance between a masculine 'persona' and a feminine 'anima' and the influence of 'archetypes' – an inherited pattern of thought or symbolic imagery – on men's identity (Jung 1982). Similar to Jung's emphasis on 'archetypes', masculinity has also been represented as a 'deep centre', an essence of man. In this conceptualisation, masculinity is that which is assumed to lie behind mere culture (Hearn 1996). The mythopoetic work of Bly (1990) is one of the most well known to have taken this approach as an indicator of a deep hidden masculinity within all men.

A significant body of literature has furthered psychoanalytical perspectives in addressing the association of masculinity and femininity with psychological adjustments and 'appropriate' sex role behaviours. This approach assumes that 'healthy' or 'normal' development entails sex-role identification with one's own biological sex (Robinson and Green 1981). The approach is epitomised by social psychologists' work on 'the male sex role' (for example,

Goldberg 1976; Nathanson 1977; Harrison 1978; Pleck 1981; Verbrugge 1985). According to Pleck (1981), the sex role paradigm claims that:

'The individual is pre-programmed to learn a traditional sex role as part of normal psychological development; thus culturally defined sex roles do not arbitrarily restrict individuals potential – on the contrary, they are necessary external structures without which individuals could not develop normally' (p.4).

According to the sex role perspective, being a man or a woman therefore means enacting a general pre-programmed set of expectations tied to ones sex. Brannon (1976), for instance, identified the following four major components of the 'male role':

1. No Sissy Stuff: the need to be different from women
2. The Big Wheel: the need to be superior to others
3. The Sturdy Oak: the need to be dependent and self reliant
4. Give 'Em Hell: the need to be more powerful than others, through violence if necessary

Consistent with the principles of the sex role paradigm, a number of inventories have been developed that purport to measure individuals' sense of themselves on masculinity and femininity scales as a function of their endorsement of stereotypical masculine and feminine characteristics. Prominent examples include the Bem Sex Role Inventory (BSRI) (Bem 1974), the Personal Attributes Questionnaire (PAQ) (Spence et al 1974), the Extended Personal Attributes Questionnaire (EPAQ) (Spence et al 1979), and the Masculine Gender Role Stress Scale (MGRS) (Eisler and Skidmore 1987).

Critical debates within sociology and gender theory have since challenged psychoanalytical and social psychologists' ways of thinking about masculinity. In particular, feminist social theorists in the 60s and 70s argued that while sex differences may be natural, gender differences – which refer to the distinction between 'masculine' and 'feminine' – had their source in 'culture' and were essentially social constructions (de Beauvoir 1972; Oakley 1972). Subsequently, theoretical understandings of masculinity have predominantly been developed from social constructivist perspectives by feminist and pro-feminist theorists such as Bob Connell, Jeff Hearn, Michael Kimmel, Michael Messner, Andrew Tolson and Will Courtenay. Psychoanalytical and sex role approaches have been criticised in this body of

literature for assuming that gender represents two fixed, static and mutually exclusive role containers (Tolson 1977; Kimmel 1986; Brittan 1989) and therefore foster a notion of a singular female or male personality (Brod 1987; Mac an Ghail 1994; Connell 1995; Petersen 1998; Courtenay 2000). For example, critics of Brannon's (1976) role theory have argued that the four major components identified are only likely to be relevant in a minority of men, thereby excluding the majority from the definition of masculinity (Messerschmidt 1993; Connell 1995; Courtenay 2000). Similarly, 'trait' measures such as the BSRI (Bem 1974) have been suggested to be fraught with conceptual and methodological problems because of the fixed view of society adopted and their cultural specificity (Eichler 1980).

2.4 Masculinity as a Social Construction

From social constructivist perspectives, masculinity is not seen as a set of fixed traits or static categories, but rather, as a set of socially constructed relationships – configurations of practice or 'representations'– which are produced and reproduced through men's actions and interactions (Courtenay 2000). Gender (masculinity and femininity) is therefore something that is seen to be 'done' or 'accomplished' in specific contexts in everyday life (Connell 1995). Kimmel and Messner (1995) explain:

'The social construction of masculinity is not a biological imperative but a socially constructed event ... men are not born; they are made. And men make themselves, actively constructing their masculinities within a social and historical context ... Our sex may be male, but our identity is developed through a complex process of interaction with the culture in which we both learn the gender scripts appropriate to our culture, and attempt to modify these scripts to make them more palatable' (p.xx)

Kimmel and Messner's (1995) definition makes clear that, from a constructivist perspective, men are assumed to think and act the way they do because of ideals of masculinity adopted from culture. Masculinity is therefore seen as both a generalisable cultural phenomenon as well as a variety of culturally specific representations of gender and possible gender identities (Hearn 1996). Social constructivist perspectives thus recognise that there are likely to be *multiple masculinities* (Carrigan et al 1985).

The concept of multiple masculinities refers to the notion that various masculinities are defined in relation to other men, other masculinities, women, femininities and other differences such as age, ethnicity, appearance, socio-economic position and religion (Hearn and Collinson 1994). Masculinity is a relational, evolving collection of meanings created in culture, constructed in relationships with others, meaning different things at different times to different people (Kimmel 1994; Connell 1995). In multicultural societies such as the UK there are therefore likely to be multiple definitions, dynamics and norms of masculinity that are continually being constructed and reconstructed (Connell 2000).

However, the multiple and constructionist nature of masculinities in the social constructivist paradigm does not prevent the dominance of particular representations of masculinity. Masculinity theorists, such as Connell (1995), have argued that there are social relations between the different masculinities and the different representations are not given equal value in (Western) culture. Especially, there are relations of hierarchy, for some masculinities are dominant while others are subordinated or marginalised (Connell 2000). Connell (1987) used the term 'gender order' to refer to these patterns of power relations between definitions of masculinity. The gender order is seen to contain two structural aspects: a hierarchical system in which men dominate women, and a system of intermale dominance in which a minority of males dominates the masses (Sabo and Gordon 1995).

Within the gender order, 'hegemonic masculinity' – the culturally dominant (or culturally authoritative) form of masculine behaviour in any given place or time – is seen as the form by which other masculinities become measured and represented as subordinated to, or marginalised from. The relationship between hegemony, marginalisation and subordination provides a framework which can be used to examine men's differing representations of masculinity: different masculinities are produced, and continually reproduced, in respect of this hierarchy. To illustrate, Kimmel (1996) has argued that, although the United States/Western societies may be multicultural and economically diverse, dominant historical

discourses produce 'manhood' [hegemonic masculinity] constituted as white, heterosexual and middle-class. Accordingly, in Western cultures a white, heterosexual, economically privileged male has been seen as 'normality' (Phillips 2005). Connell (1995; 1998) argues that this hegemonic ideal of masculinity is produced in Western popular culture and men are variously positioned in subordinate or marginalised relations to this norm.

Hegemonic masculinity is therefore seen to be the masculinity that sets the standards for all other men, against which other men are measured and, more often than not, found wanting (Kimmel 1994). Masculinities are produced in the wake of this ideal in excluded and oppressed groups – such as gay men and men from ethnic minorities – and are positioned as being 'marginalised' (given less value) in Western culture (Mac an Ghail 1994; Connell 2000; Phillips 2005). Again, hegemonic and marginalised masculinities are not seen as fixed character types, but *representations* of masculinity (what men actually do in their interactions).

Hegemonic masculinity, then, refers to the dominant, culturally exalted representation of 'real' manhood. However, similar to the limitations of 'male role' theories, this prescriptive definition of hegemonic masculinity can be seen to be restrictive – the majority of men are likely to be excluded from the definition of 'real' manhood. Connell (1995) addresses this limitation by emphasising that hegemonic masculinity may in fact only be rigorously practiced in its entirety by a minority of men, but many align themselves with aspects of the hegemonic pattern in differing contexts. Connell (1995) refers to this variability as *complicit* masculinity, whereby men neither challenge hegemonic masculinity nor conform to it all of the time. As a consequence of the resultant cultural dominance of hegemonic masculinity, the majority of men are argued to benefit from 'the patriarchal dividend' – the social advantages (such as economic and political) men in general gain from the overall subordination of women and lower status men (Connell 1995).

Thus, the concept of hegemonic masculinity means that, in any given social context, there are culturally dominant behaviours that are considered to represent how a 'real' man is seen to act. For instance, Lee and Owens (2002) suggest hegemonic masculine representations (in Western culture) are predominantly related to toughness, unemotionality, physical competence, competitiveness and aggression. Marginalised masculinities – deviations from this culturally exalted representation of being a 'real' man – are signified as being weak and inadequate (Phillips 2005). Kimmel and Kaufman (1994) argue that the fear of being viewed as a 'sissy' – that is, seen to be weak and inadequate as a man – dominates cultural definitions of manhood. This fear of being marginalised, and men's subsequent desire to 'live up' to hegemonic ideals of masculinity, have been suggested to impinge on men in real and often problematic ways; most notably, with regard to their health (Connell 1995; Messner 1997; Connell 2000; Courtenay 2000; Broom 2004).

2.5 Theoretical Perspectives of Masculinity and Men's Health

Researchers have previously examined how a variety of activities have been used as resources for constructing masculinity/gender; for example, language (Crawford 1995), work (Connell 1995; Price et al 1998), sport (Messner and Sabo 1994; Connell 1995; Robertson 2003b), and crime (Messerschmidt 1993). Similarly, from constructivist perspectives, health behaviours and actions have been theorised as being used by men as representations of masculinity. In this regard, health actions are social acts and can be seen as a form of practice which constructs 'the person' in the same way that other social and cultural activities do – the 'doing' of health is therefore the 'doing' of masculinity/gender (Saltonstall 1993; Courtenay 2000a). The 'doing' of health associated with any form of masculinity is seen to differ depending on whether a man is performing a hegemonic, subordinate or marginalised form (Courtenay 2000). However, attention in the theoretical literature addressing masculinities and men's health from a constructivist perspective has almost exclusively focussed on the health risks associated with the enactment of hegemonic forms (Sabo and Gordon 1995; Courtenay 2000; 2000a; Lee and Owens 2002; White 2002).

In Western culture, hegemonic definitions of masculinity prescribe certain behaviours as appropriate for men and others as completely inappropriate. Powerful social sanctions come into play against individuals who transgress social expectations for these gender-appropriate behaviours which have been theorised to counteract the recognised health risks associated with some health behaviours (Lee and Owens 2002). For example, Courtenay (2000a) argues that a man who 'does' gender as socially prescribed would be relatively unconcerned about his health and well-being in general and would place little value on health knowledge. He would see himself as stronger, both physically and emotionally, than most women; would take risks, think of himself as independent, not needing to be nurtured by others, and would be unlikely to ask for help.

It has been suggested that men may use behaviours that have a negative impact on health to demonstrate hegemonic ideals that they are 'real' men and reinforce cultural beliefs that men are more powerful and less vulnerable than women and lower status (subordinated or marginalised) men (Sabo and Gordon 1995; Pyke 1996; Schofield et al 2000; Courtenay 2000). For example, it has been proposed they might be emotionally inexpressive, get involved in risky behaviours such as physical sports, display violent and aggressive behaviours, eat a diet high in meat and low in vegetables, and deny pain, vulnerability and the need for medical help for physical and emotional problems (Sabo and Gordon 1995; Pyke 1996; Schofield et al 2000; Courtenay 2000).

Men who do not adhere to these hegemonic patterns of behaviour and who adopt healthy behaviours, such as getting annual health checks, seeking medical help, or eating healthy foods, are still seen to be representing a form of masculinity but it is not the dominant (hegemonic) form and therefore positioned as being marginalised or subordinated (Courtenay 2000a). Although, as noted, little attention has been placed on the health implications associated with these 'other' representations of masculinity in the literature, a number of authors have suggested that when men are marginalised as a result of their ethnicity,

sexuality, or economic status – and therefore denied access to the social power and resources for constructing hegemonic masculinity – they may seek other resources for validating their masculinity that also have a negative impact on their health (Hearn and Collinson 1994; Mac an Ghail 1994; Cheng 1999; Phillips 2005). For example, toughness, violence, and disregarding health behaviours have been suggested as being used by some Black African American men as a signifier of ‘true’ masculinity (Franklin 1984; Majors and Billson 1992; Rich and Stone 1996; Courtenay 2000a). Similarly, it has been suggested that gay men may engage in unsafe sexual behaviour as a means of validating their masculinity (Levine 1998) or as a protest against hegemonic masculinity (Connell 1995).

A significant body of theoretical literature has also addressed the influence of masculinity on men’s health from a gender-role perspective. Theoretical explanations have predominantly focussed on the hazardous influences of the ‘male role’ – the gendered attitudes and behaviours about what it means to be a man learnt from cultural values, norms and ideologies. This perspective is most notably exhibited in the research literature by investigations of ‘gender role conflict’ – a psychological state where gender roles have negative consequences or impact on a person or others. Harrison et al (1989) explain this as follows,

‘...the greater mortality rate of men is at least partially a consequence of the demands of the male role and emphasizes the ways in which male-role expectations have a deleterious effect on men’s lives, and possibly contribute to men’s higher mortality rate’ (p.271)

Male-role expectations, or gender role conflict, have been suggested to have a number of deleterious effects on men’s health. For example, taking a ‘give ‘em hell’ approach to life – the need to be more powerful than others, through violence if necessary (Brannon 1976) – has been theorised to lead to high risk behaviours (Sabo and Gordon 1995). Similarly, in relation to help seeking, admitting a need for medical help or recognising and labelling an emotional problem has been suggested to conflict with the messages men receive about the importance of self reliance, physical toughness and emotional control (Pleck 1981; Addis and Mahalik 2003). However, because an inherent assumption of gender role perspectives of men’s health

are that men are passive victims of a socially prescribed homogeneous role, they do not adequately explain why some men do not exhibit these prescriptive traits and adopt healthy behaviours, such as choosing to seek medical help. As such, the male role paradigm can be considered to overlook the complexities of how social, economic and cultural factors may interplay with men's constructions and representations of masculinity. The following section (2.6) of this chapter draws attention to this limitation in reviewing the empirical studies that have taken a male role perspective in the analysis of men's health and masculinity.

2.6 Research on Men, Health and Masculinity

A dominant trend in the men's health literature has been the use of epidemiological data to illustrate problematic men's health issues. For example, surveys from a range of countries demonstrate that high levels of men engage in unhealthy behaviours such as excessive alcohol intake, smoking, and drug misuse (Department of Health 1998; 1998b; Harnett et al 2000); suffer a greater number of fatal accidents than women (Avery and Jackson 1993); and have substantial sexual ill health (Nicoll et al 1999). Although some of the literature presenting such epidemiological evidence has explained the patterns in the data as being a testament to men's endorsement of hegemonic masculinity, the male role, or 'traditional' masculinity (for example, Courtenay 2000; Lloyd and Forrest 2001; Meryn and Steiner 2002; Lee and Owens 2002), reliance on epidemiological data reveals little about men's actual experiences of health and illness and, therefore, what the underlying social processes associated with men's poor health outcomes may be.

A large body of literature has examined men's adherence to the 'male gender role' and found that this leads to poor health practices and contributes to some physical and mental disorders that are disproportionately experienced by men (Kilmartin 1994). For example, several US-based research projects – predominantly large quantitative surveys on samples of university students – have identified the negative impact of aspects of masculinity (associated with the

‘male role’) and the positive effects of femininity in a number of conditions and health behaviours (Courtenay 2003).

Korzenny (1988) and Kimmel and Levine (1989) argued that traditional feminine characteristics are implicated in health promoting behaviours with respect to the adoption of safer sexual practices, whereas traditional masculine characteristics represent barriers to preventive action. Kaplan and Marks (1995) also found feminine characteristics to be associated with positive health behaviour and implicated masculine characteristics to be associated with negative health behaviour. Kaplan and Marks (1995) examined the relationship between gender role orientation and appraisals of health risks on a random sample of 201 US college students. The participants were asked to complete the Bem Sex Role Inventory (BSRI; Bem 1974) and were also presented with questionnaires containing sets of scenarios that depicted health-threatening events such as exposure to chemicals and symptoms of coughing, chest congestion and depression. Participants were asked to rate the extent to which the different scenarios posed a threat to their health. The researchers found ‘highly feminine’ men exhibited the highest health concern ratings compared to other sub-groups and concluded that feminine socialisation among males appears to heighten the perception of health risk and mitigate the destructive influence of masculinity (Kaplan and Marks 1995).

Several other US-based studies have similarly found that men who adopt ‘traditional’ attitudes about masculinity, compared to men who have less ‘traditional’ attitudes, are more likely to suffer from depression and anxiety and engage in a number of unhealthy and risky behaviours such as smoking, alcohol and drug abuse, a poor diet and unsafe sexual practices (Lemle and Mishkind 1989; Good et al 1989; Good and Mintz 1990; Eisler and Blalock 1991; Pleck et al 1994; Eisler 1995). Courtenay (1998) has reported comparable findings of traditional beliefs about manhood leading to increased risk-taking in his study of young men in the US.

Along the same lines of enquiry, Eisler et al (1988) found that high scores on the masculine gender role stress (MGRS) scale were related to an increase in poor health habits (alcohol and tobacco usage). Similarly, Pleck et al (1993) surveyed 1880 young men in the United States about their beliefs about masculinity and found 'traditional' masculine expectations such as '*a man always deserves the respect of his wife and children*' and '*I don't think a husband should have to do housework*' were associated with being suspended from school, drinking and use of drugs, being picked up by the police, number of heterosexual partners in the last year, and coercive sex. Emslie et al (2002) have reported similar results in a cross sectional survey in the UK. Emslie et al (2002) distributed self-completion questionnaires and the BSRI to 2139 full time employees in a bank and 1611 university staff. Analysis revealed both men and women with high masculinity scores were statistically significantly more likely to smoke more and drink more heavily.

Sharpe and Arnold's (1998) investigation is one of the few studies in this body of literature to have used qualitative methods. Sharpe and Arnold (1998) used in-depth interviews and focus groups to investigate the health beliefs and attitudes of men aged 25 to 35 years with a variety of occupations from eight different workplaces settings. Although the main methodology was qualitative, a pre-selection questionnaire containing demographic and health related questions and attitude statements was also distributed to men within the eight workplaces. The researchers argued that their findings reinforced theories that 'traditional' masculinity has a damaging influence on men's health. A typical interview response from a study participant to support this suggestion was cited as:

'My view is, being one of the lads means that you drink a lot and you smoke a lot, so you can't be that healthy which is a problem because being one of the lads can be quite fun sometimes' (Sharpe and Arnold 1998; p.3)

Questionnaire responses from the study also revealed that male peer pressure to live out a 'traditional masculine role' appeared to lead to negative health behaviours associated with smoking, drinking and eating behaviours in many participants. This theme was supported by the study's qualitative data. For instance, one participant described feeling unable to choose

salad when his friends were eating steak and chips. Similarly, many subjects noted that they found it hard to have a drink with male friends and not have something alcoholic as it tended to provoke the question '*Is there something wrong with you?*'.

Helgeson (1991; 1995) interviewed 70 men (and 20 women as a comparison) who had been admitted to hospital with an acute myocardial infarction. In addition to interviewing the participants, Helgeson (1991; 1995) had participants complete the personal attributes questionnaire (PAQ; Spence et al 1974) with the aim of investigating a link between severity of heart disease and masculinity/aspects of the male gender role. Helgeson (1991; 1995) highlighted an overlap between type A behaviour and 'trait masculinity' (possession of masculine traits as defined by the PAQ) and, furthermore, established statistically significant correlations between aspects of 'trait masculinity' and severity of MI, post MI chest pain and non-compliance with cardiac rehabilitation advice and medical regimes. However, Helgeson (1995) also suggested that some aspects of masculinity have a positive effect on adjustment to illness. She suggested that exercise, self-confidence, independence, and being focussed and task-orientated are all characteristics of masculinity that may help with the recovery and adjustment process (Helgeson 1995).

In support of Helgeson's (1995) suggestion, and in contrast to the predominant theme evident in the literature, several studies have found that adherence to the male gender role has a *positive* impact on men's health. For example, in a UK based study, Annandale and Hunt (1990) used a similar survey methodology to that of Kaplan and Marks (1995) to investigate the relative impact of gender role orientation (according to the BSRI) upon aspects of mental and physical health such as diastolic blood pressure, self-assessed health and GP visits. In contrast to the findings of Kaplan and Marks (1995), Annandale and Hunt (1990) found that highly masculine men and women reported *better* mental and general health than subjects who rated themselves as less masculine on the BSRI. Nezu and Nezu (1987) have also found that amongst men and women,

'high masculine subjects [scored on the BSRI], compared to low masculine persons, reported significantly lower scores on self reported measures of depression, state anxiety, and trait anxiety' (p.205).

Likewise, Stoppard and Paisley (1987) found that high masculinity was associated with lower levels of depression, even when controlling for life stress. Taylor and Hall (1982) also concluded on the basis of a meta-analysis of similar studies using the BSRI that:

'individuals of healthy psychological functioning typically showed relatively large and consistently positive masculinity effects and less consistently positive and almost always smaller femininity effects' (p.359)

Gordon's (1995) study adds to the body of evidence asserting the positive effect of masculinity on men's mental health. Gordon (1995) used face-to-face semi-structured interviews to collect data on twenty men's experiences of having testicular cancer. Questions in the interview guide were organised into four general categories: medical aspects; social relationships; self-concept; and a general overview of the experience. Thematic analysis of the twenty face-to-face interviews revealed that a 'traditional' masculine identity appeared to have both positive and negative impacts on men. For example, men who drew upon aspects of the traditional masculine role to interpret their cancer (for example, taking a 'give 'em hell' approach) enabled them to feel more self-confident and more masculine, leading to an attitude to 'fight it' (the cancer). However, these men also found difficulty in coping with a less desirable body image. Gordon (1995) also found some men adopted a non-traditional male role strategy to cope with their cancer. This was signified by men who became more emotionally expressive, more relationship orientated, and more concerned about the well-being of others. Men who employed elements of this strategy did not report feeling less masculine, but rather appeared to redefine their masculinity to incorporate these characteristics (Gordon 1995).

Summary: Research on Men, Health and Masculinity

Summing up the harmful effects of 'male role expectations', Harrison et al (1989) have noted,

'that it is not so much biological gender that is potentially hazardous to men's health, but rather specific behaviours that are traditionally associated with the male sex role' (p.307)

However, a review of the research literature illustrates that the implications of adhering to the male role on a man's health appears to be more ambiguous than Harrison et al (1989) suggest. Studies present contradictory evidence which indicate that adhering to the male role may be linked to high risk behaviours that are detrimental to men's *physical* health, but conversely, have a positive effect on men's *mental* health. Kaplan and Marks (1995) explain this contradiction by arguing that an underreporting of symptoms that leads to findings indicating that masculinity is associated with positive health measures may be a result of response bias stemming from the male role expectation of not admitting to sickness. Although this is a possibility, studies exploring the influence of the masculine gender role on health that rely on standardised instruments such as the BSRI or the PAQ can be seen to have more fundamental methodological limitations. Using such instruments to measure masculinity, men are asked to rate their personality characteristics on a scale in answer to questions such as '*How desirable is it for a man to be assertive/yielding?*' without any observation of men's corresponding or actual behaviour (Hearn 1994). As Moynihan (1998) has pointed out, cultural assumptions and expectations inherent in the measures pre-empt static responses that serve to perpetuate the myth of what it means to be masculine and how a man behaves. What is more, these inherent limitations have been compounded by the majority of the cited 'male role studies' being limited to the examination of white males in a university environment (convenience samples).

Qualitative studies, such as Gordon's (1995) and Sharpe and Arnold's (1998), offer a greater insight into men's gendered experiences of health and illness as they do not assume masculinity to be a set of pre-determined, static variables. This is illustrated by the participants in Gordon's (1995) study who appeared to redefine their masculinity as a strategy

to cope with having testicular cancer – an insight that would not be possible using standardised measures such as the BSRI. However, by situating their analyses in the male gender role paradigm, studies such as Gordon's (1995) have notable conceptual limitations. As discussed, gender role perspectives assume that men (and women) are passive victims of a socially prescribed homogeneous role. Because masculinity is treated as a stable, internal, trait-like construct; male role perspectives of masculinity do not adequately explain why some men in Gordon's (1995) study did not appear to exhibit these prescriptive traits. As noted, conceptualising masculinity in the male role paradigm limits the potential for explaining how the complexities of social, economic and cultural factors influence men's representations of masculinity.

As discussed in section 2.3 ('What is Masculinity?'), critics of gender role perspectives have developed theoretical understandings of masculinity from a constructivist perspective whereby men are assumed to think and act in the ways they do, not because of their role identities or psychological traits, but because of concepts of masculinity that they adopt from their culture (Courtenay 2000). Constructivist perspectives see gender as actively created in social interactions – masculinity is 'done' – and the way in which masculinity is 'done' is seen to be informed by social structures such as class, ethnicity and sexual orientation. Thus, from a constructivist perspective, aspects of the male gender role are not seen as the *singular* male role or personality, but rather, the representation of one form of masculinity – albeit the dominant, culturally exalted form: hegemonic masculinity. There is an emerging literature that is emphasising that men who try to live according to stereotypical or hegemonic masculine ideals which demand they exhibit characteristics like being tough, unemotional, aggressive and independent are resistant to acknowledge their health problems or seek medical help for them. This literature, together with the broader empirical evidence on gender and help-seeking behaviour, is now reviewed.

2.7 Gender and Help-Seeking Behaviour

There is a significant body of research in the United States that suggests that men are less likely than women to seek help from health professionals for problems as diverse as depression, substance abuse, physical disabilities and stressful life events (Weissman and Klerman 1977; Padesky and Hammen 1981; Thom 1986; Husaini et al; 1994; McKay et al 1996). UK based empirical evidence from the last decade also supports the suggestion that men are less likely to use health services and seek help from health professionals in comparison to their female counterparts. For instance, men visited their general practitioner 67 million times in 1990, while women visited 143 million times in the same period (OPCS 1991). Although the total number of visits by women will be inflated by family planning, childbirth and child related health issues, the magnitude of the difference nevertheless highlights the fact that men appear to use primary care services (as a point of referral) less frequently than women (OPCS 1991). Cook et al (1990) found that, across all social classes, 10% of men aged 45-65 did not consult their GP over a three year period, and a further 44% consulted on average twice a year or less. Similar findings have been noted in an NHS survey of younger men which found 69% of men aged 18-24 had visited their surgery in the preceding 12 months compared with 90% of women of the same age group (NHS Executive 1998). Moreover, the same survey showed that only 58% of men in excellent health attended their surgery, compared with 74% of healthy women, suggesting men are also poor attendees for preventative medicine.

There is also evidence that men not only consult less often than women, but their reasons for seeking medical help also differs. Möller-Leimkühler (2002) found that although minor emotional symptoms increase the probability of consulting a general practitioner (GP), physical symptoms were the determining factor for men seeking help. Corney (1990) demonstrated that, in contrast to women, men are less likely to report psychosocial problems and distress as an additional reason for consulting. Lewis and O'Brien (1987) note that men are also unlikely to be the first to seek help when there are marital, child-care, or other

relationship problems. An Australian study that investigated help-seeking behaviours for emotional problems in a sample of 715 adolescents provides further evidence to suggest that men are reluctant to seek help for emotional problems (Rickwood and Braithwaite 1994). After controlling for psychological symptoms, gender was found to have a direct correlation with help seeking patterns: male adolescents experiencing high levels of distress did not ask for help through their social networks or from professionals (Rickwood and Braithwaite 1994).

In contrast to these findings, an equally substantial body of research has found that gender is *not* a determining factor in help-seeking behaviour. For instance, Emslie et al (1999a) found small gender differences in malaise and physical symptoms between male and female university employees, but found that the effects of working conditions were far more important in predicting these variables. The researchers thus concluded that observed differences are explained not by gender, but by the behaviours and attitudes associated with particular career and lifestyle choices. Similar results were found in a subsequent survey of bank employees (Emslie et al 1999b).

Further evidence refuting the theory of gender differences in help-seeking behaviour can be noted in the work of Feeney et al (1998) and Macintyre (1993). Feeney et al (1998) conducted large-scale survey research with British civil servants. The study revealed that although women were more likely than men to take time off work for illness, the effects were small and social class was the defining characteristic predicting illness (Feeney et al 1998). Macintyre (1993) collected data from 1700 volunteers who were inoculated with a cold virus (or placebo) in the Medical Research Council's Common Cold Unit in Salisbury, England. Volunteers in the study were visited by a medically qualified clinical observer who assessed the presence and severity of symptoms and signs using a standardised numerical scoring system. Scores for each recorded symptom or sign (e.g. sore throat, fever, swollen glands)

were added to produce a total overall score for each volunteer at the end of the trial. The findings illustrated that men and women in the study were equally likely to report symptoms.

Similar results were found in Macintyre's later work in a survey of the general population of Scotland (Macintyre et al 1999). The enquiry found no evidence for the proposition that men were less willing than women to report symptoms or to seek health care, or that men were reluctant to report symptoms that were 'trivial' or emotional in nature (Macintyre et al 1999). A similar study by the same research group (Wyke et al 1998) found that men were less likely than women to report a range of some 33 symptoms of illness (27% of men compared to 34% of women) but paradoxically, those who did report symptoms were just as likely to have seen a doctor about them. A study of illness behaviour among people with cancer of the colon or rectum (Marshall and Funch 1986) adds to the weight of evidence supporting the claim that women are no more likely than men to recognise and respond to symptoms of ill health. Furthermore, two early reviews of the literature (Waldron 1976; Lewis et al 1977) also reported no consistent gender differences in response to symptoms, especially those suggesting serious disease.

A further theme in the gender and help-seeking literature concerns several studies that assert women *over-report* symptoms. For example, Corney (1990) administered four validated health and social instruments to 178 women and 80 men with the aim of exploring the variables associated with GP consultation and help-seeking behaviour for minor illnesses (such as frequent headaches, backache, swollen ankles), chronic conditions (such as stroke, epilepsy, diabetes), mental health problems, and social difficulties (such as housing, finance and employment). Results of the study revealed that women were more likely than men to have visited health agencies such as doctors, nurses, social workers, psychiatrists or psychotherapists and physiotherapists, whereas men were more likely to have used accident and emergency services (Corney 1990). Corney (1990) argued that the results of the study suggested women found it easier to divulge personal information than the men, and found it

easier to confide in others about their social or psychosocial problems. Similar results have been found in an extensive US based study by Green and Pope (1999). Green and Pope (1999) examined data from a household interview survey carried out in 1970-1971, linking this to 22 years of health services utilisation records to explore the effects of gender, self-reported health status, mental and physical symptom levels, health knowledge, illness behaviours and health concerns. After controlling for these factors, female gender remained an independent predictor of higher utilisation over the 22 year period studied.

Summary: Gender Comparative Help-Seeking Studies

The review of gender comparative research literature reveals conflicting evidence relating to whether gender/sex has been found to be a significant or determining factor in help-seeking behaviours. Notwithstanding the contradictory nature of this evidence, the gender difference literature also suffers from several methodological flaws. In particular, the questions asked in the surveys are often gender-biased (the interviewers employed and the respondents questioned are predominantly female), and the inconsistent conceptualisation of 'health', 'illness' and behavioural indices are also sources of potential bias (Nathanson 1978; Briscoe 1984; Clarke 1983; Gijsbers van Wijk et al 1992).

Perhaps more importantly, gender comparative studies are not designed to generate findings from which to understand *men's* help-seeking behaviour. The fact that men and women differ in the frequency of a set of behaviours reveals little about the psychological, sociological or cultural processes responsible for any observed differences (Mechanic 1978). Indeed, when studies document gender differences, the authors often speculate about possible mediators of help-seeking behaviour, but rarely can the data address directly the hypothesised pathways (Addis and Mahalik 2003). As such, in order to understand the help-seeking behaviours of men it is necessary to focus investigation on *men's* experiences of seeking help, not merely on the differences between men and women. What is more, gender difference studies are also ill equipped to account for differences *between* men.

As discussed in section 2.2 of this chapter ('The Current Context of Men's Health'), current approaches to understanding men's health issues, as reflected by the earlier cited definition developed by the Men's Health Forum (2004), take a gender-sensitive view that acknowledges psychological, biological, social, economic and cultural factors as contributing to differences in the health and health behaviours between men. It is precisely this inter and intra-individual variability among men that needs to be understood in order to develop effective men's health interventions (Addis and Mahalik 2003).

2.8 Men and Help-Seeking Behaviour

Several US-based studies have examined the relationship between 'masculinity ideology' or gender role conflict and men's negative attitudes toward help seeking (Robertson and Fitzgerald 1992; Wisch et al 1995; Mendoza and Cummings 2001; McCarthy and Holliday 2004). For example, in a study of 401 undergraduate men in the US, Good et al (1989) tested the theory that adherence to the traditional male gender role and negative attitudes to help seeking were related. Subjects were asked to complete stereotypical male role and gender role conflict measures associated with factors such as success/power/competition, 'restrictive emotionality' and 'restrictive affectionate'. The findings indicated that traditional attitudes about the male role were significantly linked to negative attitudes toward seeking professional help. Subjects who were found to have 'restrictive emotionality' were also found to have significantly decreased past help-seeking behaviour and decreased likelihood of future help-seeking behaviour.

A UK-based study by Sharpe and Arnold (1998), discussed earlier in the review, has also identified a widespread negative attitude to help seeking in a sample of healthy men. The majority of subjects in the study (men from eight differing work places in the UK) were found to have ignored symptoms of ill health and avoided seeking help from health services in the past. Results of the questionnaire revealed that a majority of men agreed that '*minor illness*

can be fought off if you don't give in to it' (64%); *'I often ignore symptoms hoping they will go away'* (52%); and *'I have to be really ill before I go and see the doctor'* (75%).

As discussed earlier in the chapter, studies employing instruments designed to assess masculinity-related constructs have considerable methodological and conceptual limitations. In particular, the studies offer little insight into men's actual experiences of help seeking and actual perceptions and/or representations of masculinity. For instance, Sharpe and Arnold's (1998) study provides no explanation of why 48% of men in their study did not agree with the statement *'I often ignore symptoms hoping they will go away'* or how these men may have represented their masculinity in the context of help seeking. As noted, qualitative studies are better suited to eliciting detailed understandings of men's perceptions of health, illness, help seeking and masculinity.

The most prominent theme in the qualitative literature on men's help seeking and masculinity concerns investigations of the experiences of men with prostate cancer. In a descriptive longitudinal study that aimed to describe the experiences associated with diagnosis and treatment among white men with prostate cancer, Gray et al (2000b) implicated hegemonic masculinity as having a detrimental effect on how the men managed the impact of prostate cancer on their life. The researchers argued that men's adherence to hegemonic masculinity prevented them from expressing emotion and seeking emotional support, which in turn impacted on their relationships, the ability to manage their feelings, the ability to make sense of their illness, and the ability to lessen the impact the cancer had on their everyday lives (Gray et al 2000b). Broom (2004) interviewed 33 Australian men with prostate cancer and also found that, because of many men's desire to adhere to hegemonic forms of masculinity, the nature and effect of investigative, diagnostic and treatment procedures for prostate cancer – specifically, incontinence, loss of potency and trans-rectal examination – led many to choose to forgo these treatments as they prioritised aspects of their lifestyle (associated with hegemonic masculinity) over a cure. Comparable findings have been reported in studies by

Lavery and Clarke (1999), Oliffe (2005), George and Fleming (2004) and Boehmer and Clark (2001).

Broom's (2004) findings have also been mirrored in a study on Canadian men by Evans et al (2005). Evans et al's (2005) investigation is also one of the few studies in the men's health literature that has examined how masculinity influences the experience of having prostate cancer among men from a minority ethnic group. Using a participatory action research approach, Evans et al (2005) collected data from 57 men using focus groups in five African-Canadian communities in Nova Scotia, Canada. Akin to the themes identified by Broom (2004) in a sample of white Australian men, the African-Canadian men in Evans et al's (2005) study identified masculinity as a critical factor in their avoidance of cancer screening, especially digital rectal examinations (DREs), and placed great emphasis on sexuality and sexual performance as a measure of their 'manhood'. The researchers argued, therefore, that,

'...because historically, Black men have not been rewarded for being manly, courageous, or assertive – a situation that has stripped Black men of their masculinity...avenues for demonstrating masculinity are narrowed for Black men such that sexual virility and sexual performance may be the primary ways that African Nova Scotian men can affirm their identity as a man...Black men's practices of avoiding DREs may consequently be understood as practices to protect and defend an already compromised masculinity' (p.268)

In support of this proposition, one participant noted that, as a Black man, *'you're not allowed to be a man'* (Evans et al 2005; p.265). Several participants in the study also perceived that prostate cancer was less devastating for older men because sexual performance and sexual virility had less meaning in relation to older men's masculinity. However, these findings may point toward commonalities between men of a similar age as opposed to variation between men of differing race/ethnicity. Although Evans et al (2005) did not compare the experiences of their participants with a sample of white men, the findings of studies on white participants by Lavery and Clarke (1999), Oliffe (2005), George and Fleming (2004), Boehmer and Clark (2001) and Broom (2004) would suggest that sexual performance, sexual virility and the avoidance of DREs are key aspects of constructing/preserving *young* men's masculinity,

regardless of their ethnicity. Similar themes have been reported in a UK-based study on white men with prostate cancer by Chapple and Ziebland (2002) that further support this claim.

Chapple and Ziebland (2002) used in-depth interviews to investigate the way in which prostate cancer and its treatment affected men's bodies, their roles, and sense of masculinity among 52 (white) men with prostate cancer in the UK. The main findings of the study were that many men were hesitant about seeking help for their problems because they believed it was not 'macho' to seek advice about health problems, that 'boys don't cry', and it was not 'masculine' to display signs of weakness (Chapple and Ziebland 2002). Similarly, African-Canadian men in Evans et al's (2005) study were reluctant to share their cancer experience with others because, as one participant in the study pointed out, *'I don't want people to know I am a weakling'* (p.265). Men's reluctance to display 'un-masculine' signs of weakness has also been identified as having a detrimental impact on health in a study of the identity dilemmas of white men with chronic illness by Charmaz (1995). For example, one participant with diabetes in Charmaz's (1995) study was unable to manoeuvre his wheelchair with a cafeteria tray and would therefore skip lunch and risk a coma rather than ask for help and risk undermining his masculine identity.

A comparable theme relating to men's reluctance to seek or admit the need for help is prominent in the literature on the experiences of men with testicular cancer. For example, an investigation by Moynihan (1998) found that men who had been cured of testicular cancer and had been treated one to five years before being interviewed for the study had often experienced anxiety or depression or both, yet no man had sought medical help. Moynihan (1998) suggested that this pattern of behaviour clearly demonstrated an enactment of a stereotypical masculine identity in the face of illness. For instance, one subject had described *'being like a shutter pulled down, stark and unflinching'* and others were noted to have *'wept in private away from their families, and often in their cars where they felt enclosed and safe'* (Moynihan 1998 p.1074).

Several studies have also reported that men delay seeking help *prior* to diagnosis/receiving treatment for testicular cancer. Sanden et al (2000) interviewed 21 men with testicular cancer and found that they did not see seeking medical help as an obvious solution to their health problems. The data revealed that men had experienced significant delays between discovering a testicular lump and seeking treatment because of a 'wait and see' attitude. Akin to the findings of Sharpe and Arnold (1998), Sanden et al (2000) noted participants had delayed seeking help as they had frequently regarded physical problems initially as something that would cure themselves, and seeking expert advice was regarded as strange behaviour for men in general. Interestingly, Sanden et al (2000) made no attempt to link their findings to the masculinity literature, concluding instead that the men's problematic help-seeking behaviour was a result of their lack of preventative health knowledge.

By contrast, Gascoigne and Whitear (1999) have conducted similar qualitative research on six men who had been diagnosed with testicular cancer and situated their analysis within a gendered theoretical framework. The main themes from the interviews illustrated that participants had delayed seeking help due to feelings of embarrassment, a reluctance to appear foolish, and an attempt to 'normalise' symptoms. For example, regarding his experience of testicular cancer, one subject stated,

'You try to blank it out, you don't want to know. It was actually that the lump was getting bigger and bigger....it was getting to a stage that it was prominent' (p.66)

Gascoigne and Whitear (1999) thus suggested that *'powerful internalised gender notions of masculinity and masculine identity'* (p.67) were evident in their subjects' responses. The results of Gascoigne and Whitear's (1999) small study have been mirrored in a grounded theory study of 10 men with testicular cancer by Mason and Strauss (2004). Issues of masculinity were found to be associated with the central theme in the study which related to how men faced and handled the uncertainty caused by their symptoms. The main theme of the study was manifested by a *'wait and see'* approach and a continuing hope that symptoms *'would just go away'* (Mason and Strauss 2004; p.99).

In a larger qualitative interview study, Chapple et al (2004) endeavoured to explore patients' perspectives on why treatment delays occurred for men with symptoms of testicular cancer in the UK. The researchers asked 45 men with testicular cancer to tell their story from when they first suspected they had a problem. As identified in a number of previous studies, Chapple et al (2004) found that many of the participants had delayed seeking treatment, the reasons for which appeared to be bound up with men's masculine self-image; for example, fear of appearing weak, fear of being seen to be a hypochondriac, and fear of loss of masculinity. However, Chapple et al (2004) also identified interpretation of symptoms (whether seen to be important or not), occupation, and conflicting responsibilities (holidays, busy lifestyles) as salient factors among men who had delayed seeking treatment. The findings add significantly to the body of knowledge, illustrating the potential complexity of the help-seeking process; in particular, that the influences on men's help-seeking behaviour are not likely to be confined to their desire to 'live up' to stereotypical/hegemonic forms of masculinity.

Akin to Chapple et al's (2004) finding that men's 'masculine self-image' leads to delays in seeking medical treatment, Tudiver and Talbot (1999) have identified that, from the data gathered from four focus groups with 18 GPs, men's reluctance to access health services was perceived as being predominantly a result of barriers that related to 'men's traditional social role' which corresponded to a sense of immunity and immortality, a difficulty in relinquishing control, and a belief that seeking help is unacceptable for a man.

In support of Tudiver and Talbot's (1999) study on GP's perceptions, two further studies employing focus groups to investigate the help-seeking attitudes of samples of healthy men have indicated a widely held endorsement among participants of the view that men should be reluctant to seek help. Richardson and Rabiee (2001) used a semi-structured focus group interview method with small groups of healthy young men aged 15 to 19 years. The researchers found that:

'...participants consistently equated health to physical fitness and help-seeking behaviour was dictated by 'social norms'. These demanded that a problem should be both physically and sufficiently severe to justify needing help. GP's were not a popular choice for confiding because of discomfort associated with communication issues, unfamiliarity and feelings of vulnerability.' (p.3)

However, although Richardson and Rabiee (2001) concluded that the responses from their subjects exhibited the 'social norms' expected of men, they do not clarify what is meant by 'social norms' by linking the findings to theories of masculinity. A similar study by O'Brien et al (2005) has addressed this oversight. The study on 50 men aged 15 to 72 years in Scotland found that there was a widespread reluctance to seek help among the study participants, attributed by the authors to the men's *'hegemonic stance on masculinity'* (O'Brien et al 2005; p.515) that they should be strong and stoical in the face of ill health. Interestingly, O'Brien et al (2005) also found that seeking help was a behaviour *embraced* by some men when it was perceived as a means of preserving, or restoring another, more valued, representation of masculinity such as working as a fire-fighter or maintaining sexual performance or function.

Using a narrative qualitative methodology that utilised both focus groups and in-depth individual interviews, Robertson (2003) has investigated how men's attitudes towards preventative health care and service delivery are determined by masculinity. Robertson's (2003) study is unique in the body of men's health literature because gay and disabled men were included in the study sample. Robertson (2003) aimed to explore how these aspects of identity interplayed with men's health practices and masculinity. The main findings of the study highlighted how men thought of their health as part of everyday life, as opposed to as an abstract concept, and often engaged in a 'don't care/should care' dichotomy concerning the management of their health. The 'don't care about health' aspect of men's identity was interpreted as corresponding to their adherence to a hegemonic form of masculinity – for instance, caring about health was 'feminised' by many subjects. However, a number of men also reported that they felt they 'should care' because 'good citizenship' was perceived to require caring for one's health. A notable finding of the study was that gay representations of

masculinity permitted, and sometimes obliged, gay men to take a 'should care' approach to their health and well-being. Likewise, disabled men were noted to be able to use their impairment as a legitimate reason for caring about their health, although care was often taken in the narratives of disabled men to reinsert a commitment to hegemonic masculine values through expressing notions of living dangerously, but not going 'too far' (Robertson 2003).

2.9 Coronary Heart Disease and Help-Seeking Behaviour

Nearly all deaths from CHD are because of myocardial infarction (MI), of which chest pain is the foremost symptom (Jowett and Thompson 1996; British Heart Foundation 2006). The most important modifiable determinant of mortality from MI is speed of accessing appropriate medical assistance (UK Heart Study Collaborative Group 1998). Opportunities for reducing fatality from acute MI therefore lie mainly outside the hospital – survival from cardiac arrest may be trebled by improvements in ambulance and patient response (Norris 1998). Effective interventions that reduce delay in seeking help when patients experience chest pain suspected to be of cardiac origin are thus likely to have a significant influence in minimising CHD mortality (for example, GISSI - Avoidable Delay Study Group 1995). Accordingly, a significant body of literature has addressed the help-seeking experiences, and reasons for help-seeking delay, of patients who have suffered acute cardiac events.

Although several qualitative studies of patients' experiences of seeking help for CHD in the 1970s and 1980s were almost exclusively conducted with male participants, the studies did not address men's gendered experiences (were 'gender blind') as they tended to generalise from 'male' experience to 'human' experience (Emslie 2005). For example, Cowie (1976) was among the first to have described the cardiac 'careers' of twenty-seven men who had suffered a heart attack, from their first perception of symptoms through to their decision to call for medical assistance and their experiences in hospital. Cowie (1976) found that a heart attack had often not immediately been recognisable to the participants in the study, who had frequently 'normalised' symptoms by attributing them to indigestion or exertion. The study's

subjects had commonly only sought help when pain was so severe that non-serious complaints could be ruled out.

Many of the themes identified in Cowie's (1976) study have been mirrored in several subsequent studies on men's and women's experience of CHD (Finlayson and McEwan 1977; Ruston et al 1998; Horne et al 2000; Pattenden et al 2002). For example, in a study of 88 men and women who had experienced their first MI, Horne et al (2000) also found that a mismatch between symptoms experienced and those expected was the most significant cause of help-seeking delay. Two similar qualitative studies employing face-to-face semi-structured interviews by Ruston et al (1998) and Pattenden et al (2002) that investigated the decision-making processes in men and women with symptoms of myocardial infarction have also reported related findings. Ruston et al (1998) interviewed 43 patients who had suffered a heart attack and concluded that illness and help-seeking behaviour had several stages involving warning, interpretation, preliminary action, re-evaluation and final action. Delays in seeking help were primarily found to be influenced by a patient's perceived risk of having a heart attack, their knowledge of CHD symptoms, and the severity of symptoms experienced. Ruston et al (1998) also found demographic (gender, socio-economic status, age) differences between help seeking 'delayers' and 'non-delayers'. 'Non-delayers', defined as participants who had delayed seeking help for less than four hours, were more likely to be male, have a manual occupation, and be under 65 years old. However, the authors do not go on to suggest what the underlying processes associated with the observed demographic differences may be.

Pattenden et al (2002) reported comparable results to that of Ruston et al (1998) in a study of 22 men's and women's experiences of a heart attack in two district hospitals in the North of the UK. Six main themes associated with the decision to seek help were identified: appraisal of symptoms, perceived risk, previous experience of heart disease, fear and embarrassment of being wrong in ascribing their symptoms to a heart attack, fear of wasting or misusing NHS resources, and presence of another person during an event. In contrast to the findings of

Ruston et al (1998), Pattenden et al (2002) concluded that delay in seeking help was not primarily influenced by knowledge of symptoms, but by a complex process of decision-making influenced by the six identified themes. However, like previous studies, Pattenden et al (2002) do not make any attempt to suggest how gender (or indeed other demographic factors such as socio-economic status, age or ethnicity) may impact upon this complex process of decision-making.

The trend for these studies to overlook the influence of socio-economic factors on help-seeking behaviour is a significant limitation in the light of a review of the US literature that has revealed the deleterious effects of low socio-economic status on delay in seeking treatment for heart attack symptoms (Dracup et al 1995). This theme in the US help-seeking research literature has been supported by the findings of two qualitative studies by Richards et al (2002) and Tod et al (2001) on participants (men and women) from socio-economically deprived areas in the UK.

Richards et al (2002) explored socio-economic variations in response to chest pain symptoms in a sample of men and women from Glasgow, Scotland. The researchers compared interview responses from 30 subjects (15 men and 15 women) from a deprived area of Glasgow to 30 respondents from an affluent area. The main findings of the study were that participants from the deprived area reported a greater perceived vulnerability to heart disease stemming from a greater exposure to heart disease in family members and a greater identification with high risk groups and stereotypes of cardiac patients. However, this greater feeling of vulnerability was not associated with an increased presentation with chest pain to a GP. Interestingly, the deprived group also reported a greater exposure to general ill health which appeared to lead them to confuse their chest pain with other conditions and 'normalise' their chest pain more readily than those from the affluent group (Richards et al 2002).

Tod et al (2001) interviewed 14 patients with stable angina in an economically deprived area of South Yorkshire, England. The researchers found that the culture associated with the study area's industrial past – corresponding to coping, independence, and attributing symptoms to industrially related lung disease – led many participants to delay seeking help for their chest pain symptoms. Tod et al (2001) also found that some of the reasons for delay were similar to the themes identified in previous studies; for example, little awareness of the symptoms of heart disease and a low perceived risk of having heart disease.

In addition to the emerging body of knowledge suggesting socio-economic status has an impact on help-seeking perceptions, ethnic differences in help-seeking patterns for angina symptoms have also been reported. Chaturvedi et al (1997) found differences in attitudes to help seeking between European and South Asian men and women in the UK. The researchers compared the attitudes to help seeking among 903 randomly selected subjects (553 European, 124 Hindu, and 235 participants of Sikh origin) from GP practices in London, UK. The study used questionnaires to investigate how participants would respond to a fictional scenario of experiencing chest pain. No difference between the ethnic groups in the proportion identifying the pain as cardiac were found, but Hindus and Sikhs reported a significantly greater likelihood to seek immediate care for angina symptoms compared to European participants.

A similar study has been conducted by Adamson et al (2003). However, Adamson et al's (2003) study examined the influence of socio-economic status and gender, as well as ethnicity, on individuals' perceptions of the need and urgency for seeking health care. A random sample was selected from two GP practices in the UK and sent questionnaires which included two fictional vignettes; one describing a character experiencing chest pain and the other a character discovering a lump in the armpit. The questionnaire survey indicated that Black respondents, respondents from lower socio-economic groups and women were at least *as likely* to report an intention to seek health care immediately in response to the clinical

vignettes as white respondents, those from higher socio-economic groups and men. However, akin to the limitations of the gender comparative literature, the results of the studies by Chaturvedi et al (1997) and Adamson et al (2003) do not provide any insight into the possible underlying gender, cultural or social processes associated with the help-seeking patterns identified in their samples because questionnaires were used to gain data on hypothetical behaviour (from a fictional vignette)

Taking a different perspective to the majority of previous studies on CHD and help seeking, Clark (2001) drew on notions of the body and the self to interpret patient's treatment decision-making during the early stages of a heart attack. The qualitative study examined pre-hospital decision-making retrospectively in 14 men and women admitted with MI in a Scottish hospital. Clark (2001) found that decision-making was interpreted as a five-stage pattern: experiencing symptoms as familiar sensations, the failing body, responding to breakdown, increasing crisis and the decision to call for help. Throughout these phases, Clark (2001) suggested that participants in the study had drawn on aspects of the interpretation of their body, self and society in order to understand and react to what was happening to them – for example, believing that their bodily changes signified minor illness and that they were at low risk of CHD. Interestingly, Clark (2001) did not attempt to address whether male and female participants interpreted their bodily changes differently; a noteworthy oversight given the body of literature indicating significant gender differences in this respect (Connell 1995; Nettleton and Watson 1998; Williams and Bendelow 1998).

A reluctance to seek help for chest pain has also been found in a study of patients in the hospital setting. Mackintosh (1994) studied 55 patients admitted to a coronary care unit (CCU) over a three-month period. Similar to several of the themes identified in previous studies on pre-hospital delay, Mackintosh's (1994) findings revealed that patients frequently did not report their chest pain on a CCU due to feelings that the symptoms were not important enough, that the symptoms did not last very long and they waited for it to go away, that they

expected to feel pain and therefore felt it was not worth reporting, and had misunderstandings about who the pain should be reported to.

Although, as noted, much of the qualitative literature has overlooked gender as a factor in the help-seeking process associated with symptoms of heart disease, there is a growing body of knowledge reporting gender differences associated with the incidence, presentation, referral, recovery, and rehabilitation of coronary heart disease (Thompson and Bowman 1997; Radley et al 1998; Milner et al 1999; Peterson et al 2000; Martin et al 2004; Chen et al 2005). For example, Foster and Mallik (1998) found that, in a study of 12 men and 12 women admitted to a CCU, men had been more likely than women to believe that they might be having a heart attack. Women in the study were also found to be more likely than men to have delayed before seeking help because they believed CHD to be a 'man's disease' (Foster and Mallik 1998). This theme has also been reported in a study by Ruston and Clayton (2002) that explored female participants' assessment of the risk of CHD. Women in this study attributed risky lifestyle behaviours to men and only deemed themselves to be at risk of CHD if they adopted 'a man's way of life'. Several similar qualitative studies have also explored women's experiences of seeking help for heart disease. Thomas (1994), LaCharity (1999), Lockyer (2000) and Schoenberg et al (2003) have all investigated women's experiences of having CHD and reported comparable themes that were associated with delays in help seeking, such as being unaware of their risk of CHD, and fearing being seen by their GP to be a worrier or ignorant.

Despite a growing literature on women's experiences of seeking help for symptoms of heart disease, few studies have investigated men's perceptions and experiences of heart disease from a *male*-gendered perspective. The qualitative investigation by White (2000) is notable in the literature as the only study that has explored men's interpretation of chest pain and considered the impact of masculinity on their experiences. White (2000) used grounded theory methods to explore how 25 men admitted to a coronary care unit with acute chest pain

interpreted their symptoms. He used participant observation (working as a nurse) to observe the men and followed this up with in-depth interviews with 10 of the participants after discharge.

Similar to the themes identified by Cowie (1976) and a number of subsequent studies, White (2000) found that men had often delayed seeking help due to a complex period of 'making sense' in which they had 'normalised' their pain, trying to reduce it down to an explainable occurrence. Akin to the findings of studies on women by Foster and Mallik (1998) and Ruston and Clayton (2002), the majority of men in White's (2000) study had also not believed themselves to be at risk of CHD and had therefore not initially interpreted their bodily symptoms as being of cardiac origin. Notably, in contrast to the findings of previous 'gender blind' investigations, White (2000) recognised that part of this 'making sense' process for a number of men had been related to a reluctance to seek help for their symptoms, or to discuss them with their wives, because of a fear of being seen to be a 'wimp'. White (2000) thus found that,

'the delay in seeking hospital care seems to lie in the men's apparent uncertainty over their symptoms and their reluctance to seek help' (p.144)

Relating these findings with the literature on masculinity and Foucault's (1975/1991) notion of the body and self-surveillance, White (2000) proposed a link between masculinity and men's interpretation of their chest pain for the first time. White argued that men are continually undergoing self-surveillance to assess their performance against their impressions of society's expectations of them; a performance which is threatened by the possibility of ill health and leads to the use of denial as a psychological defence and, therefore, a reluctance to acknowledge their chest pain;

'It seems that man is not prepared to deal with his body when it makes the transition from being healthy to being ill. He is expected to be fit, productive and able to carry out the roles expected of him. There is a feeling of invincibility that is deep seated and, when this is threatened, men have to rationalise their position and negotiate, both within themselves and with their wives and families, about what to do.' (White and Johnson 2000; p540)

Summary: Men and Help-Seeking Behaviour

A review of the literature reveals a small but growing body of knowledge – based predominantly on studies of the experiences of men with prostate and testicular cancer – implicating ‘masculinity’ as a factor in men’s help-seeking delays. Despite this emerging literature, limited attention has been given to men’s gendered experiences of seeking help for illnesses other than those in relation to prostate and testicular cancer. There is emerging evidence pointing toward gendered differences in the experience of coronary heart disease. However, to date, the research has largely been limited to ‘gender blind’ studies or investigations of samples of women. Only one study has focused on men’s gendered/masculine experiences of chest pain, and no study has set out with the explicit intention of examining how masculinity influences the help-seeking decision-making process of men who experience symptoms of heart disease.

Notwithstanding the limited amount of evidence, a review of the masculinity and help-seeking literature also raises a number of methodological issues. A notable limitation of existing studies has been the tendency for researchers to investigate men as a homogeneous group. As discussed in section 2.3 of this chapter (‘What is Masculinity?’), there has been a move away from theoretical understandings of masculinity as a homogeneous concept – as reflected by male role theories – toward constructivist perspectives of masculinity that assert various definitions of masculinity are likely to be defined and lived out by men of differing culture, socio-economic status, age, sexuality and religion (Connell 1995; Hearn 1996).

From constructivist perspectives, the health-related beliefs and behaviours that men adopt are thought to vary depending on whether a man is performing a hegemonic, subordinate or marginalised form of masculinity. Marginalised men, such as gay men and men from minority ethnic groups, are thought to ‘do health’ differently to men who adhere to a hegemonic pattern of masculinity (Courtenay 2000).

Although many researchers have purported to adopt a constructivist theoretical standpoint, it has not been reflected in the methodological approaches taken. Few studies addressing men's help-seeking behaviour have obtained a heterogeneous sample of men – in terms of culture, socio-economic status, age, sexuality and religion – and investigated how these differences may result in men 'doing' gender, health and help seeking differently. This is a significant oversight given that recent understandings of men's health are placing increasing emphasis on the difference and diversity in the health of men (Men's Health Forum 2004).

The majority of researchers that have studied men, help seeking and masculinity have therefore implied an overly simplistic view in their discussions that 'stereotypical/hegemonic masculinity' influences '*men*' in a detrimental way. For example, White's (2000) argument that '*man* has a deep seated feeling of invincibility and perceives an expectation to be fit and productive' overlooks the fact that not *all* 'men' may feel and act this way. Although White's (2000) study sample contained men of differing occupations and some men of South Asian ethnicity, the study did not address if or how socio-economic and ethnic factors shaped men's representations of masculinity in the context of seeking help for chest pain.

The limitation is further highlighted by the findings of Robertson's (2003) recent study, which included a sample of gay and disabled men. Robertson's (2003) investigation demonstrated that not all men will perceive the need to 'live up' to and enact stereotypical/hegemonic masculine ideals – such as denying and delaying the need for medical help – when making decisions about their health. Furthermore, the findings of 'gender blind' studies by Tod et al (2001), Pattenden et al (2002), Chaturvedi et al (1997) and Richards et al (2002) also highlight the need to consider that socioeconomic and ethnic factors may interplay with representations of masculinity and contribute to differences in men's help-seeking behaviour for chest pain symptoms.

2.10 Literature Review Summary and Conclusion

The current context of men's health places recognition on the wider political and social determinants of health that contribute to significant inequalities between men and to the overall state of men's health. This approach has been reflected in the recent definition of a 'male health issue' proposed by the Men's Health Forum (MHF). The MHF definition will be adopted for addressing CHD as a men's health issue in the two studies that are presented in this thesis.

'A male health issue is one arising from physiological, psychological, cultural, or environmental factors that have a specific impact on boys or men and/or where particular interventions are required for boys or men in order to achieve improvements in health and well-being at either the individual or the population level' (Men's Health Forum 2004; p.5)

Crucially, the definition acknowledges men's gender as a key determinant of their cardiac health whilst recognising the impact of social and political factors, thereby placing emphasis on the inequalities between groups of men in relation to CHD incidence.

Despite recent emphasis on physiological, psychological, cultural and socio-economic factors as contributors to the state of men's health, male gender – or masculinity – remains central to the discussion on men's health and health behaviours and the ways in which they can be improved. A review of the theoretical literature illustrated how prevailing ways of thinking about masculinity have moved away from restrictive perspectives of masculinity as a homogeneous concept – as reflected by psychoanalytical and social psychology theories – toward understandings of masculinity as a social construction.

Social constructivist perspectives of masculinity view masculinity as a set of socially constructed relationships which are continually produced and reproduced through men's actions and interactions. The perspectives thus recognise that there are likely to be multiple masculinities; that is, various forms of masculinity are defined and lived out by men of differing age, culture, ethnicity, appearance, socio-economic status and sexuality. Hegemonic masculinity refers to the culturally dominant form of masculinity in any given time or place,

and is the form of masculinity by which other masculinities are seen as measured and represented as marginalised or subordinated from.

From constructivist perspectives, health actions are seen as social acts which construct the person in the same way as other social and cultural activities – the ‘doing’ of health is seen as the ‘doing’ of masculinity. It has been suggested that men may use behaviours that have a negative impact on their health – such as denying the need for help and engaging in risky behaviours – to demonstrate hegemonic ideals that they are ‘real’ men. Men who do not adhere to these hegemonic patterns of behaviour and adopt healthy behaviours, such as eating healthily or seeking medical help, are still seen to be constructing a form of masculinity but it is not the dominant, hegemonic form. Thus, the ‘doing’ of health associated with any form of masculinity has been theorised to differ depending on whether a man is performing a hegemonic, subordinate or marginalised form.

There is significant theme in the literature that has addressed the deleterious effects of aspects of the male role on men’s health. However, a considerable limitation of male role theories is that they do not adequately deal with the diversity and difference between men. Because masculinity is treated as a stable, internal trait-like construct; male role perspectives do not account for why some men may adopt healthy behaviours, such as seeking medical help for their problems, and others may adopt unhealthy behaviours, such as denying the need for help. From a constructivist perspective, the concept of hegemonic masculinity does not down play the differences between and among men in terms of ethnicity and class, but is rather seen to emphasise the complex interplay of unities and differences between men. Social constructivist perspectives of masculinity are therefore the most appropriate for understanding the current context of men’s health in the UK, as reflected by the earlier cited MHF definition, that acknowledge social, economic and cultural factors as contributing to differences in men’s health and health behaviour. As such, a constructivist perspective will be adopted as the framework for interpreting men’s masculinities in this thesis.

A review of studies that have investigated men's health and masculinity quantitatively, and compared patterns and attitudes to help-seeking behaviour between genders, raised a number of methodological limitations. However, recent political and professional interest has placed help-seeking behaviour at the forefront of the UK men's health agenda. This has corresponded to an increasing interest in research in this area of men's health. The principal theme in this body of literature relates to qualitative investigations of the experiences of men with prostate and testicular cancer. A common theme evident in the findings of the studies emphasises that men who try to live according to stereotypical or hegemonic masculine ideals appear to be reluctant to seek medical help for their symptoms. However, little attention has been placed on the influence of masculinities on men's help-seeking behaviour for conditions other than cancer.

The emerging evidence that men may be reluctant to seek medical help due to a desire to adhere to and enact stereotypical/hegemonic forms of masculinity has particular significance for men who suffer from CHD. There is established evidence that prompt diagnosis and treatment of heart disease significantly reduces mortality and morbidity. Effective interventions that reduce delays in help seeking when men experience chest pain of cardiac origin are therefore likely to have a considerable impact on minimising mortality from CHD.

However, the influence of masculinity on men's decision to seek or delay-seeking medical help for chest pain is not yet fully understood. To date, only one study has explored how masculinity influences men's experiences of chest pain, highlighting a pressing need for further investigation and development of this area. Furthermore, it is not known whether there are differences or similarities between white and South Asian men in this regard. No study has yet considered whether South Asian men attempt to 'live up' to and enact stereotypical/hegemonic representations of masculinity, or whether they have distinct gendered experiences of illness and help seeking.

The significant inequalities in the prevalence and treatment of heart disease between South Asian populations and the majority white UK population highlight the urgent need to address this gap in the literature. South Asian men have an increased risk and susceptibility to CHD and receive less treatment for both stable heart disease and acute MI compared to the general UK population; inequalities which continue to increase. Paradoxically, however, there is some evidence to suggest Hindus and Sikhs may be more likely to seek immediate care for angina symptoms than Europeans; although there is no indication in the current literature as to what the possible underlying gendered, cultural or social processes associated with these observed ethnic differences may be.

Significant socio-economic inequalities in CHD prevalence also exist in the UK – manual workers have a 58% higher death rate compared to non-manual workers. This evidence, coupled with findings from several ‘gender-blind’ studies suggesting the deleterious effects of low socio-economic status on help-seeking behaviour, also illustrate the need for exploration into the help-seeking experiences of men from diverse socio-economic groups who experience chest pain.

2.11 Research Question and Study Objectives

The gaps identified in the research evidence reviewed in this chapter provided the rationale for the research question addressed in this thesis:

How do masculinities influence white and South Asian men's decision to seek or delay-seeking medical help for acute chest pain?

In order to answer the research question, three study objectives were developed:

- 1 Explore the process of help-seeking decision-making in men who have recently experienced acute chest pain
- 2 Examine the influence of masculinity on the decision to seek or delay-seeking medical help in white men of differing *age* and *socio-economic status* who have recently experienced acute chest pain
- 3 Investigate the influence of masculinity on the decision to seek or delay-seeking medical help in South Asian (Indian, Pakistani, and Bangladeshi) men who have recently experienced acute chest pain

Chapter 3

METHODOLOGY

3.0 Introduction

As outlined in the summary and conclusion of the preceding chapter, the critical review of the literature revealed gaps in the research evidence that underpinned the rationale for the research question of this thesis. This chapter provides an account of the research methodology used to address this research question.

The beginning of the chapter, sections 3.1 and 3.2, discusses the justification for the use of a qualitative research paradigm, and specifically grounded theory as the methodology of choice, based predominantly on ontological and epistemological principles tied to the research question. Sections 3.3 to 3.5 then provide a detailed discussion of the approaches, procedures and limitations of grounded theory methodology; explaining how and why Strauss and Corbin's (1990; 1998) method was adopted and modified to incorporate a constructivist approach to analysis advocated by Charmaz (1990; 2000). Section 3.6 then discusses the issue of generalisability in qualitative research, outlining the extent to which the findings of the studies presented in this thesis aimed to be generalised.

The rationale for the use of interviews as a method of data collection is then addressed in section 3.7, before attention is paid to the methodological concerns associated with interviewing white and South Asian men about their masculinity in sections 3.8 and 3.9. The chapter concludes with an account of the strategies used to ensure the rigour of the studies, with reference to the criteria of credibility and dependability, in section 3.10. A brief summary of the key messages discussed in the chapter is then presented.

3.1 The Research Paradigm: Why take a Qualitative Approach?

Qualitative research methods involve the systematic collection, organisation and interpretation of data derived from discourse or observation. In qualitative research the data has primacy; theory is not predetermined but derived from the data inductively, providing a rounded, in-depth account of the phenomena under study (Holloway and Wheeler 1996). By contrast, the process for investigation in quantitative research is deductive, involving the systematic breaking down of complex information or situations into their simpler components (Cormack 1996). As such, qualitative rather than quantitative methods are recognised as the best means for discovering and understanding what lies behind a phenomenon about which little is yet known (Miles and Huberman 1994; Strauss and Corbin 1990).

It was implicit in the research question that, as little was known about the topic under investigation, a qualitative (inductive) rather than a quantitative (deductive) methodology would be most appropriate. The literature review highlighted that a qualitative approach is particularly suited to eliciting men's detailed understandings and perceptions of illness and masculinity. For instance, studies by Gascoigne and Whitear (1999), Chapple and Ziebland (2002) and White (2000) are notable examples of research that have effectively employed qualitative approaches exploring how men's representations of masculinity are associated with the experience of having testicular cancer, prostate cancer and chest pain respectively.

The epistemological assumptions of qualitative methodology were also considered to be appropriate to the research question. Epistemology is concerned with the beliefs and assumptions about the nature of knowledge and how that knowledge can be made known (Blaikie 1993). Qualitative research is grounded in an epistemological position which is broadly interpretivist. The interpretive approach has its roots in philosophy and the human sciences and centres on the interpretation and creation of meaning by human beings; it is concerned with how the social world is interpreted, understood, experienced or produced. The approach stems from constructivist ontology – the assumptions made about the form and

nature of reality – that assumes social reality is produced and reproduced in social relationships and interactions (Guba and Lincoln 1994).

By contrast, quantitative research is largely grounded in an epistemological position which is positivist. Positivist epistemology is based on the supposition that the social world can be investigated in the same way as the natural world – that it is one system comprised of variables which can be separated and explored independently. Positivism stems from a natural science approach in which theories and hypotheses are generated and tested with the aim of establishing causal relationships or links between events. Accordingly, quantitative studies typically seek to measure or categorise behaviour or attitudes, whereas qualitative research typically involves the study of things in their natural settings, attempting to make sense of or interpret social phenomena in terms of the meanings people bring to them (Denzin and Lincoln 2000). Qualitative research is, therefore, most appropriately used when the research question is about processes rather than outcomes (Murphy et al 1998).

Thus, as the focus of the research question in this thesis was to explore men's experiences of the *process* of help seeking when experiencing chest pain, and the differing *meanings* of masculinity that influenced men's experiences, the interpretivist epistemology of qualitative enquiry, rather than the positivist epistemology of a quantitative approach, was deemed to fit most closely with the research question.

3.2 The Methodology: Why Grounded Theory?

Woods (2003) has argued that the grounded theory method has often been misconceived, misrepresented or misused in nursing research:

'it is evident that many published studies purporting to adopt this [grounded theory] approach do so, almost in a piecemeal fashion, often falling short of demonstrating the development of any substantive grounded theory at all' (p.4)

In order to overcome these pitfalls, it is crucial that there is a logic based on ontological and epistemological principles, tied to the research question, which underpin the choice of a study's methodology (Mason 1996). The rationale for the choice of a grounded theory methodology in this thesis was, therefore, principally based on the links between symbolic interactionism and the constructivist epistemological assumptions about masculinities – discussed in detail earlier in Chapter 2, section 2.4 ('Masculinity as a Social Construction') – that underpinned the research question.

Four main strategies of qualitative enquiry have been commonly used by researchers in respect of health related research: ethnography, phenomenology, grounded theory and ethnomethodology/discourse analysis (Leininger 1985; Morse and Field 1995; Cormack 1996; Hollway and Wheeler 1996; Mason 1996; Grbich 1999; Denzin and Lincoln 2000). Each approach has developed from epistemological underpinnings within the social science disciplines. For instance, in anthropology the concept of culture underlines ethnographic approaches, and from applied philosophy, phenomenology developed (Morse and Field 1995). Grounded theory is an interpretive qualitative approach that originates from sociology. The epistemological assumptions of grounded theory are derived from a branch of interpretivism – symbolic interactionism – which places emphasis on eliciting and understanding the way meaning is derived in social situations (Stern 1994; Schwandt 2000).

According to the social constructivist assumptions about masculinity that underpinned the research question, gender is seen to be a socially constructed phenomenon: masculinities are considered to be produced and reproduced through men's actions and interactions with others

(Courtenay 2000). Similarly, symbolic interactionism places emphasis on understanding behaviour as part of an individual's social role and relationship with others. For instance, Mead (1934), the main proponent of symbolic interactionism, saw the self as being a social rather than a psychological phenomenon. According to Mead (1934), individuals are seen to model their roles on the important people in their lives and learn to act according to others' expectations, thereby shaping their behaviour. Eventually the individual is able to play a number of social roles simultaneously and can organise the roles taken from the community. Mead compares this to a team game, where members of a team anticipate the behaviour of other players and can therefore play their own role (Holloway and Wheeler 1996).

The model of the person in symbolic interactionism is therefore active and creative rather than passive – individuals are seen to plan, project, create actions, revise them, and share the attitudes and responses to particular situations with members of their group (Mead 1934). Likewise, prevailing constructivist perspectives of masculinity argue that men think and act the way they do because of ideals of masculinity adopted from culture (Connell 1995; Kimmel and Messner 1995; Courtenay 2000).

Symbolic interactionist theories also assert that the way in which people base their justifications for conduct can only be understood in context (Mead 1934). Grounded theory investigations therefore stress the importance of understanding the context in which people function; a characteristic that further emphasised the suitability of adopting a grounded theory approach in this thesis: social constructivist perspectives of masculinity also emphasise that the way in which a man will mark oneself as a man is likely to be situationally different and dependent on what is at stake in a particular context (Connell 1995). Potential help seeking situations are contexts in which various representations of masculinity are likely to be constructed (Addis and Mahalik 2003). The epistemological assumptions of grounded theory were, therefore, considered appropriate to foster the exploration of how men represent their masculinity in the context of seeking help for chest pain.

The symbolic interactionist epistemological assumptions of grounded theory also make the approach well suited to generating knowledge from which to inform healthcare practice and policy. As discussed in Chapter 1 ('Introduction'), the stimulation for this thesis was primarily borne out of a desire to address a problem identified during the course of the researcher's nursing practice. As the focus of grounded theory is on behaviour and its constituted meanings as expressed through social interactions, the method is particularly appropriate for facilitating an interpretive understanding of the social processes associated with healthcare provision (Benoliel 1996). The findings of grounded theory studies can therefore be used to advance patient care by making the gap between theory and healthcare practice apparent (Sheldon 1998). The extent to which the findings of grounded theory studies can be generalised is discussed in greater depth in section 3.6 of this chapter.

3.3 Approaches to Grounded Theory

Grounded theory was first used in the 1960s by the sociologists Barney Glaser and Anselm Strauss who worked together on research about health professionals' interaction with dying patients. They defined grounded theory as a theory that will:

'...fit the situation being researched and work when put into use. By fit we mean that the categories must be readily (not forcibly) applicable to and indicated by the data under study; by work we mean that they must be meaningfully relevant and be able to explain the behaviour under study' (Glaser and Strauss 1967; p.3)

The work of Glaser and Strauss generated two books which have become exemplars for grounded theory (Glaser and Strauss 1965; 1968). However, the core ideas of the original grounded theory have since diverged resulting in the formation of two predominant approaches to the method.

Many examples of the two approaches have been used within nursing research as investigators have 'tinkered' with the method (Stern 1994). McCann and Clark (2003b) suggest that, essentially, the two main approaches differ in their ontology. Glaser's (1978; 1992) approach to grounded theory has been viewed as being guided by a positivist ontology

which maintains that a 'reality' exists but can only be incompletely measured by research as a result of the inability of the researcher and researched to fully comprehend the situation and the complex constitution of the phenomenon under investigation (known as a *critical realist* position) (Guba and Lincoln 1994; Benoliel 1996; Annells 1997; McCann and Clark 2003b). The product of grounded theory in this mode is seen as the first step in a hierarchical research agenda aimed at eventually adding to the accumulation of verified (positivist) knowledge (Annells 1997).

In contrast, the literature tends to view Strauss and Corbin's (1990; 1998) method as drawing more on an interpretivist-constructivist ontology which attests that multiple realities shaped by ethnic, cultural, gender, social and political values are produced and reproduced by members of society, and that this reality cannot be *known* but can be *interpreted* (known as a *relativist* position) (Benoliel 1996; Annells 1997; McCann and Clark 2003; Ponterotto 2005). The product of grounded theory in this mode is therefore seen as *one* interpretation of reality (Strauss and Corbin 1990; 1998a; Annells 1997).

However, it is methodology, rather than ontology, that has been cited as the main source of divergence (Heath and Cowley 2004). Glaser (1978; 1992) is generally seen to have remained faithful to classic grounded theory (Holloway and Wheeler 1996; McCann and Clark 2003;), with Strauss and Corbin (1990; 1998) producing a reformulation of the classic mode by developing the analytic techniques and providing guidance to novice researchers. Glaser (1992) argues that a grounded theory methodological approach should be creative and not formulaic. For instance, he suggests the grounded theory researcher should not impose a research question, but should start with a research interest and a question in mind so that they can see their participants' perspectives in the absence of any preconceptions. The grounded theorist, according to Glaser (1992), should begin:

'with the abstract wonderment of what is going on that is an issue and how it is handled' (p. 22)

For this reason, Glaser (1992) believes that any literature review prior to data collection contaminates the data gained in a grounded theory because it might direct the researcher to irrelevant or preconceived ideas.

In contrast to Glaser's (1992) approach, Strauss and Corbin (1990; 1998) convey a more linear, structured approach to the methodology. They outline a three step approach to data analysis and advocate conducting a partial literature review as it can provide a point of verification for new data, can be used as a secondary source of data, and can stimulate questions to be asked in the grounded theory study. Strauss and Corbin (1990; 1998) also argue that all researchers come to the research situation with background information in the 'technical literature' and it is important to use it. In Glaser's (1992) view, the structured approach to analysis advocated by Strauss and Corbin (1990) places an overemphasis on extracting detail from the data. In view of these deviations from the classic method, Glaser (1992) has accused Strauss and Corbin's (1990) method as 'forcing the data' resulting in a 'full conceptual description' and not a grounded theory.

Charmaz (2000) has also produced a notable critique of Strauss and Corbin's (1990) methodology. Akin to Glaser's (1992) criticisms, Charmaz (2000) argues that the rigid nature of the analytical process in the Strauss and Corbin (1990) method is didactic and prescriptive rather than emergent and interactive, sticks close to the depiction of the overt data and, as a result, does not allow for the understanding of underlying assumptions because data is 'taken-for-granted'. Especially, Charmaz (2000) has suggested that Strauss and Corbin's (1990) method of analysis – and in particular the process of 'axial coding' and the 'paradigm model' (see section 3.4 of this chapter – 'The Procedures of Grounded Theory') turn the grounded theory method into a set of immutable rules that result in a focus being on objectivist analysis (the search for *occurrences* in data) as opposed to a focus on constructivist analysis (the search for *meaning* in data).

Charmaz (2000) thus advocates a constructivist approach to grounded theory analysis that:

'recognises that categories, concepts and theoretical level of analysis emerge from the researcher's interactions within the field and questions about the data...each is a rendering, one interpretation among multiple interpretations' (p.523)

To facilitate constructivism in grounded theory analysis, Charmaz (2000) proposes that, rather than obtaining data on 'acts and facts' on situations and structures by using systematic guidelines, the researcher should engage in a creative process of coding whereby an understanding of respondents' beliefs, meanings and ideologies are sought. Glaser (2002) has since challenged Charmaz's (2000) view, reiterating his positivist stance in arguing that conceptual reality *does* exist and that 'constructivist grounded theory' is a misnomer and merely an effort to avoid the work of confronting researcher bias.

Annells (1997) suggests that the divergence in the approaches should not be interpreted as a case of one being superior to the others, but rather an indication that grounded theory is maturing and branching. Nevertheless, the divergence is confusing for the novice researcher seeking to undertake a grounded theory study. Heath and Cowley (2004) advocate the novice researcher to adhere to the common principles of the grounded theory method and discover which approach helps them best achieve the balance between interpretation and data that produces a grounded theory. To this end, Strauss and Corbin's (1990; 1998) method was adopted and modified to incorporate aspects of Charmaz's (2000) approach to constructivist analysis in this thesis for two reasons. First, as discussed earlier in this chapter, the constructivist-interpretivist ontology of Strauss and Corbin's (1990; 1998) method was considered to have clearer links with the constructivist assumptions inherent in the research question than the positivist ontology of Glaser's (1992) approach. As noted, the ontological assumptions of Strauss and Corbin's (1990; 1998) method attest that multiple realities shaped by ethnic, cultural, gender, social and political values are produced and reproduced by individuals in society: an assumption that is in agreement with the assumptions held in this thesis that men are likely to construct differing forms of masculinity that are shaped by ethnic, social and contextual factors.

Second, as the researcher was new to grounded theory, Strauss and Corbin's (1990; 1998) structured approach to the method was preferred to Glaser's (1992) and Charmaz's (2000) more flexible approaches. Although based on differing ontological assumptions, the methods described by Glaser (1978; 1992) and Charmaz (2000) both place importance on a vague and loose creative process which was considered to have the potential of limiting the aspects of good science – rigour, clarity and a systematic approach (Murphy et al 1998) – particularly as the researcher was carrying out grounded theory for the first time. Indeed, it is this 'looseness' and lack of verification that have been the basis for the main criticisms of the grounded theory approach since its conception (Stern 1994). Adopting the Strauss and Corbin (1990; 1998) approach was considered to minimise the potential for a lack of transparency in undertaking the method by providing a structured framework for data collection and analysis.

However, in support of Charmaz's (2000) argument, it was also recognised that rigidly adhering to Strauss and Corbin's (1990; 1998) analytic procedures – in particular, the use of the 'paradigm model' in axial coding – can result in a focus being on the search for occurrences in the data (objectivist) as opposed to the search for meaning in the data (constructivist). This was considered to be potentially problematic since the searching for underlying meaning in the data, specifically, men's tacit representations of masculinity in the context of help seeking, was central to exploring the research question.

Strauss and Corbin (1998) have emphasised that their method can be modified, noting that the procedures are '*designed not to be followed dogmatically but rather to be used creatively and flexibly by researchers as they deem appropriate*' (p.13). Therefore, in this thesis, combining aspects of Charmaz's (2000) approach to axial coding with Strauss and Corbin's (1990; 1998) grounded theory framework was considered to be a pragmatic way of facilitating a constructivist analysis whilst maintaining a structure that would enhance the rigour of the study by allowing the analytical process to be made transparent (see section 3.10 – 'Rigour').

The next section of this Chapter ('The Procedures of Grounded Theory') now discusses the procedures of Strauss and Corbin's (1990; 1998) methodology in detail, and how the process of axial coding was modified to incorporate aspects of Charmaz's (2000) approach to constructivist analysis.

3.4 The Procedures of Grounded Theory

Grounded theory methodology incorporates a systematic process of data collection and analytic procedures from which theory is inductively derived. Strauss and Corbin (1990) define a grounded theory as:

'...one that is inductively derived from the phenomenon it represents...it is discovered developed, and provisionally verified through systematic data collection and analysis of data pertaining to that phenomenon...one begins with an area of study and what is relevant to that area is allowed to emerge.' (p.23)

Theory evolves through a continuous interplay between analysis and data collection (Strauss and Corbin 1998a). There are six key characteristics associated with this process that are common to all grounded theory methods (McCann and Clark 2003):

- Theoretical sensitivity;
- Theoretical sampling;
- Constant comparative analysis;
- Coding and categorising the data;
- Theoretical memos and diagrams;
- Literature as a source of data.

Theoretical Sensitivity

Theoretical sensitivity corresponds to an ability to recognise what is important in data and give it meaning. It refers to the attributes of having insight, the ability both to understand and give meaning to data, and to differentiate the relevant from the irrelevant in a conceptual rather than concrete manner (Strauss and Corbin 1990; 1998a). Theoretical sensitivity has two sources; the technical literature, and professional and personal experience (Strauss and Corbin 1990). In this thesis, theoretical sensitivity was gained through both these sources.

To illustrate, in addition to providing the rationale for the research question and study objectives, a critical review of the pertinent research and theoretical literature (presented in Chapter 2) also sensitised the researcher to 'what was going on' in the phenomenon of study (Strauss and Corbin 1990). For instance, a knowledge of the masculinity literature facilitated an understanding of 'what was going on' in men's accounts of their help-seeking experience and allowed this to be labelled during analysis.

The researcher's professional experience as a coronary care nurse also provided an understanding of the field of investigation that could be taken into the research situation in order to understand what Strauss and Corbin (1990) refer to as '*events and actions seen and heard*' (p.42). For instance, the researchers' understanding of the pathophysiology of heart disease and the National Health Service in the UK facilitated an understanding of participants' accounts of their chest pain symptoms and their interactions with health services.

Theoretical Sampling

Theoretical sensitivity is central to being able to identify concepts that have *theoretical relevance*. Theoretical relevance refers to concepts that are deemed to be significant because they are repeatedly present, or notably absent, when comparing incident after incident (Strauss and Corbin 1990; 1998). Theoretical sampling involves the sampling of events or participants on the basis of concepts that have proven theoretical relevance to the evolving theory. For example, if the researcher begins to realise that a certain factor, such as a participant's socio-economic status, is important to the emerging theory, the sampling strategy may be altered accordingly to accommodate this emergent finding.

Participants are continually selected until nothing new emerges from the data about the concepts being explored, the categories have conceptual density, and all variations between categories and links between them have been explicated; this is known as *theoretical saturation* (Strauss and Corbin 1990; 1998). If an emergent concept requires verifying or

requires further detail to achieve conceptual density, *discriminate sampling* can also take place to gain additional data on the concept(s) from relevant participants/interviewees.

In contrast to the procedure described by Strauss and Corbin (1990; 1998), theoretical sampling in the two studies presented in this thesis commenced after an initial *purposeful* sample was obtained. This process of ‘delayed theorising’ is supported by Coyne (1997), Cutcliffe (2000), and Denzin and Lincoln (2000), who argue that it allows relevant data and analytic directions to emerge without being forced. The sampling procedures of each study are described in detail in the research methods chapters (4 and 6). Sections 4.10 and 6.6 in these two chapters also illustrate how a theoretical sampling strategy informed the studies’ analytical processes.

Constant Comparative Analysis

Theoretical sampling is integrally linked with the constant comparative method of data analysis which lies at the heart of the grounded theory method. Constant comparative analysis entails the contrasting of data first against itself, then against original data, and then against theoretical and conceptual claims (Strauss and Corbin 1990). The method allows the discovery of relationships between incidents and their properties, leading to the generation of categories and concepts that are ‘grounded’ in the data. For example, interview transcripts may be juxtaposed to search for similarities in specific incidents or processes, or a single transcript may be searched to verify a tentative proposition that has emerged from the data (see ‘Coding and Categorising the Data’ below). There are four stages in the constant comparative method (Glaser and Strauss 1967):

- Comparing incidents applicable to each concept;
- Integrating concepts and their properties;
- Delimiting (setting the limits of) the theory;
- Writing the theory.

The final grounded theory consists of plausible relationships proposed among concepts and sets of concepts, and the process of constant comparison continues until theory that is

conceptually dense, that is, with many conceptual relationships, is attained (Strauss and Corbin 1998a).

Two levels of grounded theory can be generated using this method: formal and substantive. Formal theories are more general than substantive theories and deal with a conceptual area of enquiry, such as illness experience (McCann and Clark 2003). Substantive theories concentrate on specific social processes and are developed for narrower empirical areas of study in one particular substantive area (Blaikie 1993; Strauss and Corbin 1998a). The analytical process sections 4.10 and 6.6, in Chapters 4 and 6, respectively, give an account of how a constant comparison method of analysis resulted in the conception of two substantive grounded theories relating to the influence of masculinity on men's help-seeking behaviour for chest pain.

Coding and Categorising the Data

Coding initiates the process of theory development (Charmaz 2000) and represents the operations by which data are broken down, conceptualised, and put back together in new ways (Strauss and Corbin 1990). The analytical process described by Strauss and Corbin (1990; 1998) comprises three major types of coding: open coding, axial coding and selective coding. Open coding is the process of breaking down, examining, comparing, conceptualising and categorising the data – the result is labelled as a code. Axial coding is described as a set of procedures whereby data are put back together in new ways after open coding by making connections between codes and raising them to a conceptual level – the result is labelled as a category or concept (or advanced code). Selective coding involves the selection of the *core concept* – the central phenomenon around which all the other categories/concepts are integrated – and systematically relating the core to other concepts and validating those relationships.

Strauss and Corbin (1990; 1998) specify a coding framework named the 'paradigm model' to enable data to be coded systematically and categories to be related during the process of axial coding. The model aims to provide an understanding of social interaction process by enabling categories to be integrated into the aspects of the model: causal conditions, phenomenon, context, intervening conditions, action/interactional strategies, and consequences (Strauss and Corbin 1990). Coding, theorising and data collection interact and occur simultaneously; for example, coding may result in an emergent theory that informs the theoretical sampling strategy.

Strauss and Corbin (1990) stress that the lines between each type of coding are artificial, noting that in a single 'coding session' the researcher may move between one form of coding to another, especially between open and axial coding. However, as discussed in the preceding section of this chapter, forcing codes into the pre-structured paradigm model – as advocated by Strauss and Corbin (1990) – was considered to be a formulaic procedure that over-emphasised the *labelling* of data and overlooked the search for *meaning* in the data. For example, labelling data as 'intervening conditions' or 'action/interactional strategies' was considered to overlook the search for the *implied* meanings that may be present in participants' accounts (in particular, men's tacit representations of masculinity).

As noted, in order to address this limitation the axial coding procedures were modified in this study to incorporate aspects of a constructivist approach to analysis suggested by Charmaz (1990; 2000). Accordingly, rather than using the Strauss and Corbin (1990) paradigm model, axial coding in the two studies involved a less formulaic process incorporating two analytic procedures: continued questioning and constant comparison. In brief, continued questioning involved the searching for views and values, as well as for acts and facts, through the continual raising of questions about codes such as 'how?', 'why?' and 'under what conditions?' (Charmaz 1990; 2000). Constant comparison principally involved a process of 'inductive and deductive thinking', whereby a phenomenon/occurrence associated with an

open code was searched for across the data set to see if it occurred explicitly, or had been implied in the behaviour of other participants (Charmaz 2000). Using this process, connections between codes were made, raised to a greater conceptual (or interpretive) level, and labelled as 'advanced codes'. The analytical process sections 4.10 and 6.6, presented in Chapters 4 and 6, respectively, illustrate in detail how this analytical procedure was implemented.

Theoretical memos and diagrams

Both Glaser (1992) and Strauss and Corbin (1990) place great importance on the use of memos and diagrams in the process of generating grounded theory. Memos are written records of analysis related to the formulation of theory and can take several forms: code notes, theoretical notes, or operational notes (Strauss and Corbin 1990). Memos can be used to guide theoretical sampling and enable the analyst to keep an ongoing record of the analytic process. They provide 'density' for the research by guiding the researcher:

'away from the data to abstract thinking, then in returning to the data to ground these abstractions in reality' (Strauss and Corbin 1990; p.199)

Diagrams are visual relationships between concepts and can be used to aid the formulation of theory by showing process (Strauss and Corbin 1990).

Both memos and diagrams are necessary tools for integrating the grounded theory as they aid the synthesising of emergent categories by creating theoretical links between them. As noted earlier, the end product of a grounded theory analysis takes the form of a set of relationships proposed among concepts and sets of concepts – researcher memos and diagrams that suggest possible linkages and models that describe the data are essential for producing the theory (Strauss and Corbin 1990). In this thesis, memos were principally documented as code notes – short statements that represent descriptions, thoughts and intuitions about the conceptual origin (underlying meaning) of codes that emerged during the process of open, axial and

selective coding (Strauss and Corbin 1990). Integrative diagrams were also used as ‘visual memos’ to try out and show conceptual linkages borne out of the researcher’s memos.

Memos and integrative diagrams, in addition to reflexive accounts, were documented in an analytical diary by the researcher throughout the research process. Sections 4.10 and 6.6 of Chapters 4 and 6 (‘Research Methods’) illustrate how memos and integrative diagrams guided theory development during the process of analysis.

Literature as a source of data

As noted earlier in this chapter, the use of literature is one of the main sources of debate between Glaser and Strauss and their respective approaches to grounded theory. Strauss and Corbin (1990) outline five ways in which literature can be used in grounded theory research:

- To stimulate theoretical sensitivity;
- As a secondary source of data;
- To stimulate questions (for example, questions to ask participants, questions to ask of the data during analysis);
- To direct theoretical sampling;
- As supplementary validation (for example, reference literature to validate accuracy of findings/concepts, or point out how findings differ from others and relate to existing theories).

The literature was used in three ways in this thesis. First, a primary literature review was conducted (Chapter 2) to provide background information on the phenomenon of investigation, identify the gaps in the empirical literature to justify the need and direction of the study, and provide theoretical sensitivity. Second, the literature was used to inform the initial interview guide for the first study (see Table 2: Interview guide used for purposive sample (first five participants); page 105). Finally, the findings of the two studies, Chapters 5 and 7, are presented alongside relevant literature to validate the final theories, provide context of where the study fits in with the existing body of knowledge, and to point out how the theories that were developed differ from existing theories.

3.5 Limitations of Grounded Theory

As noted at the beginning of this chapter, the grounded theory approach has frequently been seen to have been misconceived, misrepresented or misused in nursing research (Woods 2003). However, it has been argued that such weaknesses in *using* the method have become equated with weaknesses *inherent* in the method (Charmaz 2000).

The weaknesses inherent in the method are principally associated with the ontological and epistemological assumptions of symbolic interactionism. Critics of the grounded theory method have drawn attention to an ontological paradox inherent in symbolic interactionism that, if meaning is conferred on the social world by the interaction of individuals, there cannot be *a* reality of basic social processes to be investigated. However, this paradox can be resolved if it is accepted that there can be multiple non-contradictory descriptive and explanatory claims about any phenomenon (Hammersley 1989). Charmaz (2000) and Strauss and Corbin (1998a) have both taken this stance in explaining the constructivist ‘reality’ of the product of grounded theory (although, as discussed earlier, Glaser (1992) has challenged this view). Strauss and Corbin (1998a) note:

‘Theories are interpretations made from given perspectives as adopted or researched by researchers’ (p.171; emphasis added)

Therefore, rather than treating the findings of grounded theory as reproducing reality, it is important to acknowledge that they are in fact the *researchers interpretations* of reality which are time, place, person and context bound. The implication of this is twofold. Firstly, the researcher needs to make explicit the personal and theoretical assumptions that contributed to these interpretations by demonstrating reflexivity (Horsburgh 2003). This has particular significance when interviewing men about masculinity and is discussed in detail in sections 3.8 and 3.9 later in this chapter.

Secondly, like all interpretive qualitative research, the findings of grounded theory are not empirically generalisable; that is, the findings cannot be said to be representative of the wider

population from which the sample was drawn. Rather, the substantive theories produced by grounded theory methods aim to have transferability and *theoretically generalisability*. The issue of generalisability in qualitative research, and the extent to which the findings of the studies presented in this thesis aim to be generalised, is discussed in the following section (3.6) of this chapter.

The majority of limitations relating to the grounded theory approach, however, centre on the *use* of the method rather than on epistemological concerns. The criticism most frequently made of published grounded theory studies, particularly in the field of nursing research, is the ‘muddling of methods’ or ‘method slurring’ (Baker et al 1992; Stern 1994; Wilson and Hutchison 1996; Smith and Biley 1997). Method slurring refers to research that compromises the integrity of the grounded theory approach and instead generates, for example, a typology, long verbatim biographical narratives, or an outcome associated with any number of other qualitative approaches (Wilson and Hutchison 1996).

Other major criticisms relating to the use of the methodology prevalent in the literature, such as generational erosion (Stern 1994), premature closure, and being overly generic (Wilson and Hutchinson 1996), can be seen to take a similar line of criticism of researchers that ‘tinker with’ the method and undermine the central tenets of the grounded theory approach by breaking with the creativity and philosophy inherent in the methodology. For instance, several studies purporting to use grounded theory methods have been criticised for being too descriptive or not situation specific because they have not progressed to the additional analysis and conceptual depth required of a substantive grounded theory. For example, Becker (1993) notes that grounded theory approaches can often result in mere description of the phenomenon, where researchers produce good stories including categories and types but often neglect the underlying social processes and abstract concepts.

However, as Stern (1994) has acknowledged, the evolution of a methodology and the ‘tinkering with’ the method need not be problematic *per se*. Rather, the methodological criticisms associated with ‘method slurring’ can be considered to be problems with methodological *rigour* as opposed to a problem inherent with modifying the grounded theory method in order to meet the objectives of a study. As such, these problems can be overcome if the researcher endeavours to adopt a systematic and self-conscious approach to research design, data collection, interpretation and communication. This is a view shared by Baker et al (1992), Cutcliffe (1997; 2000) and Mason (1996), who argue that studies that ensure rigour should ‘stand up’ better to critique by enabling the reader to examine whether or not the chosen methodology was appropriate to the nature of the research study. Section 3.10 (‘Rigour’) of this chapter discusses the strategies that were employed to overcome these potential pitfalls in the two studies presented in this thesis.

3.6 Generalisability

One of the key issues and criticisms of qualitative research relates to the extent to which its findings can be generalised beyond the particular setting in which they were generated (Murphy et al 1998). As noted earlier, the epistemological assumptions of qualitative research mean that the findings cannot be said to be representative (empirically generalisable) of the wider population from which the sample has been drawn. As such, the issue of generalisability in qualitative research often relates to the *transferability* of findings; that is, the extent to which the findings can be used to understand the phenomenon when it occurs in a similar context (Lincoln and Guba 1985; Horsburgh 2003). In order to determine the extent to which the findings of qualitative research can be transferred, a ‘thick description’ of the study context is required. ‘Thick description’ involves the provision of sufficient descriptive detail about the study settings, analysis, events and situations, as well as verbatim narratives of participants’ accounts, so as to allow an informed judgement about whether the study context is sufficiently similar to give confidence that the findings will hold in a comparable context (Holloway and Wheeler 1996; Murphy et al 1998).

However, as described earlier, grounded theory methods involve the *building of theory* through the discovery of relationships between categories and concepts that are ‘grounded’ in the data, and the identification of the salient concept(s) relating to the phenomenon being studied (Strauss and Corbin 1998). Therefore, in addition to making generalisations on the basis of commonalities in the study context, grounded theory methodology also allows generalisations to be made on the basis of the identification of a general concept(s) concerning the phenomenon/problem in question; a *theoretical generalisation* (Sharp 1998) or *theoretical inference* (Hammersley 1992). It is the knowledge related to the comparability of the phenomenon/problem studied, as opposed to the comparability of the demographic variables of the sample, which is generalised (Morse 1999). Strauss and Corbin (1998) refer to this as the explanatory power, or ‘predictive ability’, of grounded theory: the ability to explain what might happen in given situations that are related to the phenomenon under investigation.

The breadth of theoretical sampling is crucial in determining the extent to which theoretical generalisations can be made from the data gathered. As noted earlier, in grounded theory, participants are selected on the basis of their theoretical relevance, i.e. their ability to provide information (and consequent theory development) about the area under investigation. It is this selecting that ensures the theory is comprehensive, complete, saturated and, therefore, applicable to similar phenomena/problems (Morse 1999). Accordingly, the more systematic and widespread the theoretical sampling, the more conditions and variations will be discovered and built into the final substantive grounded theory and, therefore, the greater its explanatory power (Strauss and Corbin 1998). As such, ‘thick description’ of the study context is also fundamental in grounded theory in order to make clear the conditions/limits that apply to the theoretical propositions that are made.

By using the grounded theory methods described in this chapter, and providing a ‘thick description’ of the study context in the subsequent research methods chapters (4 and 6) and

findings chapters (5 and 7), the findings presented in this thesis aim to go beyond transferability (i.e. whether the experiences of the study participants are typical of those in similar contexts), toward the generation (where appropriate) of theoretical propositions, the validity of which may be subsequently tested in other contexts that are related with the phenomenon in question (i.e. theoretical propositions about the influence of masculinity on men seeking help for chest pain). Chapter 8 ('Summary and Conclusions') discusses the implications of the study findings on healthcare practice and policy.

3.7 Data Collection: Why use In-Depth Interviews?

Interviews are one of the most common methods of data collection used in qualitative research. However, as with the choice of a study's methodology, it is crucial that there is a logic based on ontological and epistemological principles, tied to the research question, which underpin the choice of data collection (Mason 1996).

Interviews allow access to the way in which respondents themselves define the experiences and practices which are the object of the research, allowing a means of uncovering the interviewee's framework of meaning (Britten 1995). Therefore, the interview offers a way of gaining an understanding of how respondents understand their world and how they create and share meanings about their lives (Rubin and Rubin 1995). The intention of the interview is not merely to describe the way in which respondents understand their world, but also to treat any differences between the participants' understandings and those of the researcher as legitimate, cultural differences, rather than seeing them in terms of an unfortunate departure from the norms and interests of the researcher (Murphy et al 1998). It was this emphasis on understanding how different respondents create and share different *meanings* about their worlds – in particular, the meaning of masculinity to men of differing ethnicity in the context of help seeking – which underpinned the constructivist assumptions of the research question in this thesis and provided the principal rationale for the use of in-depth interviews as a method of data collection.

Observational methods of data collection are also commonly used in grounded theory research. Collecting data using observational methods aims to understand the symbolic world of the participants under study; that is, the way participants interpret and act on interaction, actions and behaviours (Mason 1996). A considerable advantage of this approach is that it is able to produce descriptions and explanations appropriate to the way in which people actually behave. By contrast, interview responses can be seen to provide idealised accounts of attitudes and behaviours which, because they are rationalisations, have an uncertain relation to actual situations (Silverman 1985). However, the nature of the phenomenon under investigation in this thesis, specifically, that the focus was on participants' experience of chest pain that was impossible to access until *after the event*, meant that using observational techniques was unfeasible. This also precluded the use of other methods of data collection commonly used in grounded theory such as documents, diaries and biographies. The limitations of using interviews as the sole method of data collection are addressed in the following section (3.8) of this chapter.

Qualitative interviewing encompasses a variety of ways of questioning, and the incisiveness of the analysis relies heavily on developing an effective interview approach (Charmaz 1990). The development, implementation and limitations of the interview approaches used in the two studies presented in this thesis are discussed in detail in Chapters 4 and 6 ('Research Methods').

3.8 Interviewing Men about their Masculinity

As discussed earlier, according to the interactionist-constructivist assumptions of grounded theory the experiences of people are viewed as context-bound; that is, they cannot be free from time or location. Interview accounts are therefore viewed as interpretations of the world shaped by the contexts in which they occur, which includes the values and interests of the researcher (Hammersley and Atkinson 1995). As such, the context which frames participants' descriptions of their experiences in an interview needs to be made clear as part of the process

of grounded theory research. This requires reflexivity on the part of the researcher. Reflexivity means sensitivity and acknowledgement to the ways in which the values, assumptions and influence of the researcher are part of the research process in this respect, and how this may have shaped the collected data (Mays and Pope 2000).

The need for reflexivity in this thesis had an additional dimension relating to the epistemological limitations of interviewing men about their masculinity. It has been recognised that the participant's and researcher's gender affects the dynamic and information shared in a qualitative interview: participants assess and gauge the interviewer's orientations and opinions and develop their responses within a gendered context (Williams and Heikes 1993; White and Johnson 1998; Schwalbe and Wolkomir 2001; Hutchinson et al 2002; Oliffe and Mroz 2005). This phenomenon takes on greater significance when, as in the two studies presented in this thesis, the aim of the interview is to gain responses on gendered (masculine) notions of health-related behaviour.

As noted earlier, the way in which a man will mark himself as a man is likely to be situationally different and dependent on what is at stake in a particular context (Connell 1995). The interview is a context which is both an opportunity for signifying masculinity and a peculiar type of encounter in which masculinity is threatened (Schwalbe and Wolkomir 2001). This draws attention to a significant limitation of using interviews as the sole method of data collection in the studies presented in this thesis. Specifically, men's interview responses may be the product of a masculine performance tailored to the researcher and interview interaction and bear little relation to their interactions and masculine representations in an actual help-seeking context. For example, the interview can be an opportunity for men to portray themselves as powerful, in control, autonomous and rational. This may result in men taking a distant, inexpressive, stoical manner during an interview, or responding to questions in such a way that gives the interviewer the desired impression of being in control (White and Johnson 1998; Oliffe and Mroz 2005).

By contrast, the interview can also be a threat to masculinity if the interviewer controls the interaction, asks the questions, and the man gives up control to a certain extent. This may be demonstrated by a defensive or aggressive reaction to questioning, or a refusal to participate in a study (White and Johnson 1998; Schwalbe and Wolkomir 2001). Rather than filtering this out of the data, reflexivity on the part of the researcher is necessary to address the concern. Accordingly, reflexive accounts are presented in Chapters 4 and 6 ('Research Methods') in order to illustrate how participants' masculine performances tailored to the researcher and the interview situation were recognised and addressed during an interaction, and how these performances were considered to have influenced the findings of the two studies.

3.9 Interviewing South Asian Men

The exploration of the influence of masculinity associated with the help-seeking process among men of South Asian ethnicity also gave rise to additional methodological concerns in this thesis. Specifically, whether a researcher (a white British man) can legitimately conduct interpretive interviews with participants of a different (Indian, Pakistani and Bangladeshi) ethnicity/culture (Adamson and Donovan 2002).

Rubin and Rubin (1995) suggest that to learn about culture, an interviewer does not have to be an 'insider' (of the same ethnicity/culture) as they can become accepted as someone who can be taught. However, it has also been suggested that cultural differences between researchers and participants may render the researcher unable to generate 'meaningful' data because they cannot access the shared understandings and cultural knowledge of the participants (Archer 2002). Indeed, studies looking at the effects of race/ethnicity on interview response have demonstrated that the ethnic backgrounds of the participants in an interview can significantly affect the types of response proffered by the respondent (Davis 1997; Scott 1998; Sin 2004).

Cultural differences between researchers and participants have also been argued to have implications for the interpretation of data that is collected. Conventional concerns relating to

data interpretation by white researchers focus on the role of ethnocentrism – a view of things in which the researcher's own cultural/ethnic group is the centre of everything, and all others are scaled and rated with reference to it (Stanfield 1998). For example, Archer (2002) argues that research concerning 'race' and ethnic identity has been traditionally dominated by white, middle class researchers (as in this thesis), and this has resulted in the production of theories that normalise particular white, middle class, male knowledge/truths.

However, the existence of cultural/ethnic differences between interviewer and interviewee does not necessarily mean that resultant interview accounts are inherently less 'accurate' or 'truthful' than if the interviewer and interviewee were both of South Asian origin. Firstly, to do so would assume that the experience of participants from the same ethnicity is uniform and does not vary by social class, religion, country or age. Indeed, some middle class South Asian men may have experiences closer to a middle class white British researcher than those of lower class South Asians (Sin 2004).

Secondly, as already discussed, the 'realities' produced by constructivist grounded theory are interpretations made from given perspectives as adopted or researched by researchers (Strauss and Corbin 1998a). As such, neither the account from an ethnically-different nor that from an ethnically-matched interviewer-interviewee can be considered to be the single 'truth'. An individual can have different understandings of the same phenomenon and these different meanings emerge under different circumstances (Sin 2004). Therefore, if the researcher recognises and is aware of the effect their own personal and cultural assumptions may have on the collection and interpretation of the data, this methodological limitation can be addressed (Adamson and Donovan 2002). The reflexive accounts presented in Chapters 4 and 6 ('Research Methods') illustrate how the researcher's personal and cultural assumptions were considered to have influenced the interview process and data collected from interactions with South Asian participants.

3.10 Rigour

An integral element of producing 'good evidence' to inform nursing and healthcare knowledge is to ensure the rigour of the research on which it is based (Maggs-Rapport 2001).

There is much debate in the literature relating to the difficulty of establishing criteria for evaluating the rigour of qualitative research. For quantitative research, objectivity is one of the most important criteria by which the research is judged. It contains two parts: validity, which refers to the truthfulness of findings, or the extent to which research measures what it is supposed to measure; and reliability, which refers to the stability and reproducibility of research findings (Cormack 1996).

However, these criteria are widely recognised as being inappropriate to apply to qualitative studies because they are based on positivistic assumptions (Murphy et al 1998). As such, the criteria have frequently been redefined in order to fit the realities of qualitative research and the interpretive perspective. For example, Lincoln and Guba (1985) translated internal validity into credibility; external validity to transferability; reliability to dependability; and objectivity into confirmability. Beck (1993) proposed credibility, auditability and fittingness as three main standards of rigour common to qualitative methods.

In addition to the development of general criteria for qualitative research, criteria to assess specific qualitative approaches have also been developed. With regard to grounded theory, Glaser (1992) has stated four criteria for evaluating a study: Fit, Work, Relevance and Modifiability. Strauss and Corbin (1990; 1998) do not identify specific criteria, instead deferring to the concepts of validity, reliability and credibility as advocated by other qualitative researchers. However, they do identify seven criteria for evaluating the research process and eight criteria for evaluating the empirical grounding of a study.

The numerous standards that have been proposed in the literature have been argued to illustrate that the evolution of qualitative enquiry has resulted in a loss of common

terminology about the issue of rigour (Whittemore et al 2001). Long and Johnson (2000) have suggested that, essentially, the various terminologies have the same meaning.

However, in reviewing the various criteria (Lincoln and Guba 1985; Hammersley 1992; Long and Johnson 2000; Mays and Pope 2000; Whittemore et al 2001; Chiovitti and Piran 2003), it is apparent that the concept of *credibility* is most commonly seen to parallel the concept of validity in qualitative research, in that it relates to the trustworthiness of findings: how faithful to ‘reality’ the description of the phenomenon is (Lincoln and Guba 1985; Beck 1993; Holloway and Wheeler 1996). A constructivist qualitative study is thus deemed credible if it reveals accurate descriptions of individuals’ experiences (Hammersley 1992). Similarly, the concept of *dependability* (or auditability) is most commonly seen to parallel the concept of reliability in qualitative research, in that it is concerned with the stability of data and the collection methods (Lincoln and Guba 1985; Hammersley 1992; Beck 1993; Robson 1993). Therefore, the concepts of credibility and dependability are adopted as the criteria for establishing rigour in this thesis.

Numerous strategies for fulfilling the criteria of credibility and dependability are proposed in the literature. The most common of these are, for credibility: reflexivity, *in vivo* coding, member checking, and an attention to deviant cases. For dependability, the most common means are peer debriefing and a clear exposition of the decision trail (Lincoln and Guba 1985; Hammersley 1992; Long and Johnson 2000; Mays and Pope 2000; Whittemore et al 2001; Horsburgh 2003; Chiovitti and Piran 2003). Each of these strategies is now discussed in relation to how they were used to establish the rigour of the two studies that are presented in this thesis.

Reflexivity

In order to ensure the rigour and credibility of qualitative research, reflexivity should be considered at every stage of the research process (Hand 2003). As noted, throughout the research process the researcher recorded reflexive accounts in an analytical diary. The reflexive discussions presented in Chapters 4 and 6 ('Research Methods') are borne out of the reflections made in this diary and aim to make clear how the researcher's personal and theoretical assumptions were considered to have influenced the studies' research process. The accounts aim to enable the reader to judge the credibility of the findings by illustrating the extent to which they reflect the personal qualities of the researcher (Hall and Callery 2001). The structure of this thesis also reflects an attempt to take an overall reflexive approach by making the whole research process transparent and open, thereby providing a clear 'trail' of decision-making at every stage of the research (Munhall 1997).

Peer Debriefing

Peer debriefing concerns the exploration of the researchers' analysis and conclusions with a colleague or other peer as a strategy for testing the dependability of the analysis (Robson 1993). In particular, peer debriefing, or 'inter-rater reliability' (Mays and Pope 1995), is aimed at stimulating consideration and exploration of additional perspectives and explanations in an attempt to prevent 'premature closure' of the search for meaning and patterns in the data (Long and Johnson 2000). Holloway and Wheeler (1996) suggest that supervisors have a key role to ensure the rigour of research students' analysis using this strategy. Peer debriefing can be pursued in a number of forms: a discussion of emerging findings with knowledgeable colleagues, presenting and defending methods and findings at national research conferences, or presenting findings to interested groups.

All three of these forms of peer debriefing were pursued throughout the research process. In particular, a process of peer-debriefing involving two research supervisors exploring the researcher's analysis was used. The strategy was predominantly employed after the axial

coding phase of analysis in order to draw attention to areas in the data that required further exploration and prevent premature closure. The analytical process sections in Chapters 4 and 6 ('Research Methods') describe the process of peer debriefing and illustrate how it influenced the evolution of data analysis in the two studies.

In Vivo Coding

In accordance with grounded theory methods, using participants' own language at all levels of coding – *in vivo* coding – adds to the credibility of the findings as it makes the theory 'grounded' in the actual data (and therefore the participants' 'reality') (Strauss and Corbin 1990). For example, if a participant recounted during an interview that they did not seek medical help for their chest pain symptoms because they felt fit and well, an *in vivo* code for this incident could be '*fit and well*' (see Table 6: List of open codes and researcher memos (code notes) – Study One; page 123). *In vivo* coding was used throughout open, axial and selective coding in the two studies.

Member Checking

Guba and Lincoln (1989) argue that member checking is the most important technique for increasing the credibility of qualitative research. Member checking (or 'respondent validation') involves returning data and/or findings to the participants in order to obtain their validation of its accuracy (Mays and Pope 2000). Member checking techniques primarily entail the returning of the overall research findings to each study participant, or alternatively, carrying out the 'validation' as part of an interview interaction, whereby the interviewer asks questions designed to ensure an individual participant's perception is clearly identified and clarified (Horsburgh 2003). The former technique of returning the research findings as a whole to each individual participant was considered to have significant limitations in this study. Especially, as the study findings would be a grounded theory developed from a synthesis of the perspectives of a number of participants, it was considered to be inappropriate to expect each individual respondent to have the ability to 'validate' the theory as a whole

(Morse 1998). In addition, given the constructivist nature of the grounded theory methods used, individual participants may have been unconscious of (and unable to 'validate') some of their tacit representations of masculinity which formed part of the study data and, furthermore, may (consciously or unconsciously) have denied less attractive aspects of their behaviour (Hammersley and Atkinson 1995; Mason 1996; Long and Johnson 2000). Therefore, in the two studies presented in this thesis, the technique for member checking involved the researcher continuously attempting to clarify participants' responses during an interview interaction in order to obtain their 'validation' of its accuracy (Horsburgh 2003). The reflexive accounts presented in Chapters 4 and 6 ('Research Methods') illustrate this process.

Attention to Deviant Cases

Sandelowski (1986) identified holistic bias, making the data look more patterned than they are, as a threat to the validity (sic) of qualitative research. In order to overcome this, an attention to deviant cases is required to enhance the rigour and credibility of the findings (Mays and Pope 1995). An attention to deviant, or negative, cases involves searching for elements in the data that contradict, or seem to contradict, the emerging explanation of the phenomena under study. Strauss and Corbin (1990) note:

'...all of these instances qualify our original questions and statements of relationship. They don't necessarily negate our questions or statements, or disprove them; rather they add variation and depth of understanding.' (p.108-109; emphasis in original)

When such cases are identified, propositions and theory can be modified accordingly, or reasons found why the data may not be applicable in a particular instance (Holloway and Wheeler 1996). Again, the research methods chapters (4 and 6) present detailed accounts of the studies' analytical processes that illustrate how deviant cases influenced the final substantive grounded theories. Excerpts from the accounts given by 'deviant cases' are also presented and discussed in the findings chapters (5 and 7).

Exposition of the Decision Trail

Dependability refers the extent to which the appropriateness of decisions that were made throughout the research study can be demonstrated (Lincoln and Guba 1985, Guba and Lincoln 1989). An important aspect of establishing the dependability and credibility of the findings of a qualitative study lies in giving an adequate account of the circumstances of their production (Murphy et al 1998). Therefore, the presenting of a clear exposition of the methods of data collection and analysis (Mays and Pope 2000), or a decision trail (Long and Johnson 2000), is required so that another researcher is able to follow the methods and conclusions of the original researcher (Chiovitti and Piran 2003). The concept can therefore be seen to be similar to retest reliability in quantitative research (Mays and Pope 1995).

In this thesis, the research methods Chapters 4 and 6, in particular, the analytical process sections 4.10 and 6.6 within these chapters, make the interpretive process by which the findings were derived from the data collected explicit, enabling the reader of the thesis to ‘audit’ the findings and conclusions of the research.

3.11 Chapter Summary

This chapter has provided a detailed account of the methodology used to address the research question and study objectives in this thesis. The rationale for the decision to adopt Strauss and Corbin's (1990; 1998) grounded theory approach, modified to incorporate aspects of Charmaz's (2000) approach to constructivist analysis, has been made explicit with reference to appropriate methodological literature. The extent to which the findings of grounded theory can be generalised has also been discussed. The rationale for the choice of interviews as a method of data collection has been made clear, and the epistemological limitations of interviewing white and South Asian men about their masculinity have been addressed. The rigour of the studies has also been given consideration with reference to the criteria of credibility and dependability. The next chapter ('Study One – Research Methods') now provides a detailed account of how the methodology discussed in this chapter was applied in the first of the two studies that are presented in this thesis.

Chapter 4

STUDY ONE – RESEARCH METHODS

4.0 Introduction

This chapter provides an in-depth account of how the modified grounded theory methodology discussed in the preceding chapter was applied in the first of the two studies that are presented in this thesis. The structure and content of this chapter aims to make each stage of the research process explicit, providing a clear ‘audit trail’ that will enable the reader of the thesis to judge the rigour of the study’s findings.

The chapter begins by outlining the study setting and recruitment procedures in section 4.1. Sections 4.2 and 4.3 then present a discussion of the rationale underpinning how the study participants’ ethnicity and socio-economic status was defined. The ethical considerations of the study are then discussed in section 4.4 with reference to three principal areas widely recognised as necessary to ensure all qualitative research is carried out ethically: ensuring consent; reducing the risk of harm; and ensuring confidentiality. Sections 4.5 to 4.7 provide an account of how the study’s interview structure and approach was developed using a pilot study before the main study sample and sampling strategy is described in detail in section 4.8.

Section 4.9 of the chapter presents a reflexive account of the process of interviewing men about masculinity which makes explicit the extent to which the study’s findings reflect the personal and theoretical assumptions of the researcher. The reflexive account provides an overview of the key issues and challenges faced during research process, with reference to pertinent methodological literature that was used to in order to address these challenges.

Finally, the chapter concludes by presenting a detailed account of the key stages of the study’s analytical process in section 4.10. The account provides a clear exposition of the study’s

analytical ‘decision trail’, illustrating how the analysis of thirty-six interview accounts evolved from the initial formation of 28 descriptive ‘open codes’ to become a substantive grounded theory of men’s help-seeking decision-making process.

4.1 Study Setting and Recruitment Procedures

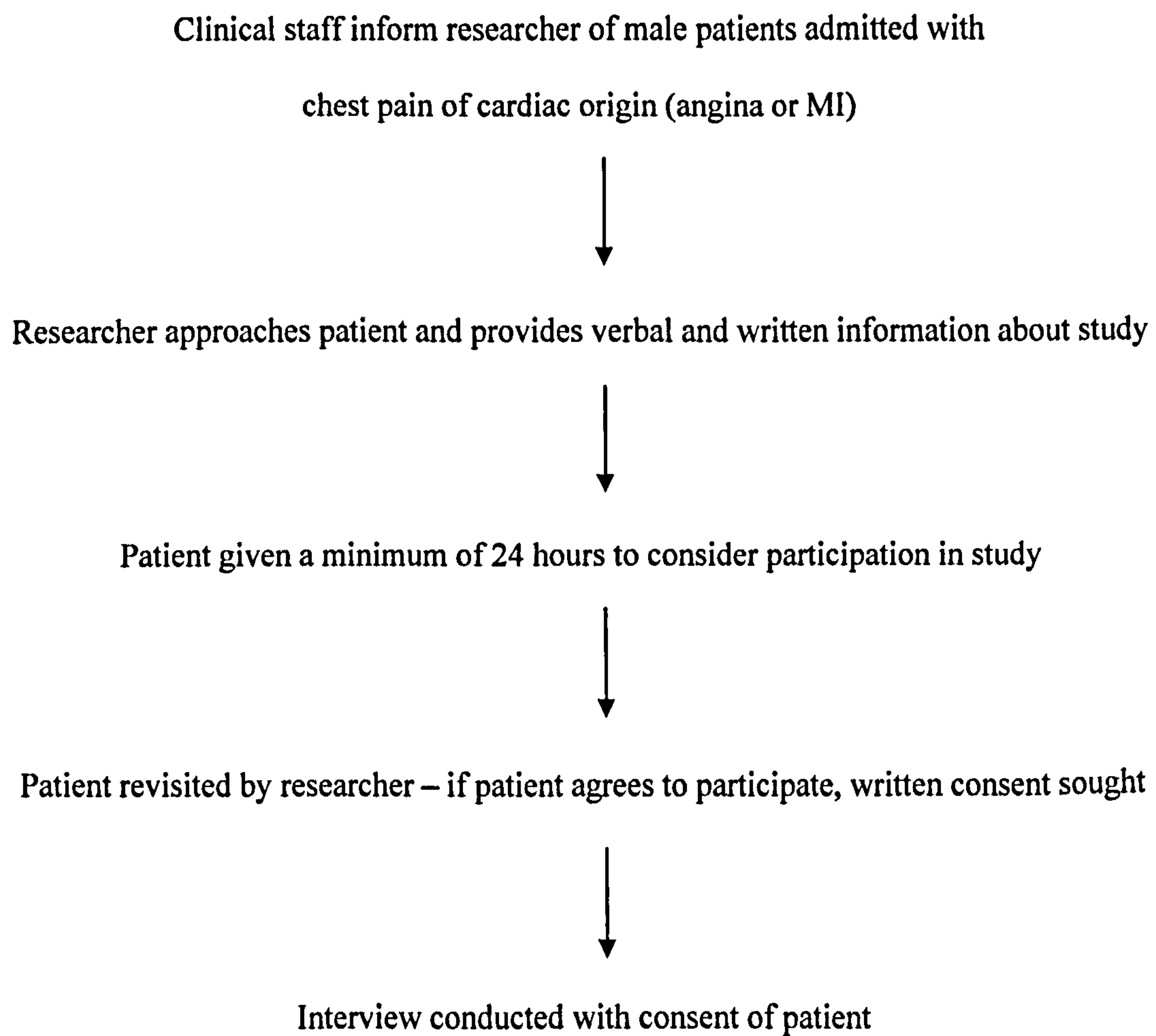
The setting for the study was two large acute teaching hospitals in the North East of England. Eight clinical areas within the two hospitals were identified as sites where participants meeting the study sample criteria, white and South Asian men who had been admitted with acute chest pain, could be identified, recruited and interviewed (section 4.8 of this chapter discusses the study’s sampling strategy and inclusion criteria). The eight clinical areas consisted of four thirty bedded medical cardiology wards, two eight bedded coronary care units and two twenty two bedded clinical decision units (CDUs). CDU is an adjunct area to the accident and emergency department where many patients are admitted with mild/moderate chest pain, usually without electro-cardiogram (ECG) changes, and await the results of cardiac enzyme blood tests to determine a cardiac/non-cardiac diagnosis. Many of these patients have either ‘self-referred’ to hospital or have consulted their GP who has then referred them to hospital. The cardiology wards and coronary care units principally admit patients with severe cardiac related symptoms, usually via ambulance/999 emergency, often with a definite diagnosis of angina or myocardial infarction with acute ECG changes.

Fifteen medical consultants and seventeen nurse managers from the eight clinical areas were sent written information about the study and their permission was sought to undertake the study, specifically, for the researcher to recruit and interview patients under their care (see appendix 7). Within one month of being sent the information all consultants and nurse managers had replied giving permission for the researcher to access the eight study site areas. As the researcher was not a hospital staff member, an honorary contract was obtained prior to the commencement of the data collection to allow the researcher to approach patients and to

comply with local and national Research Governance guidelines and the Data Protection Act (HMSO 1998).

Staff working in the eight clinical areas were subsequently visited to allow the researcher to explain the purpose of the study and the process of recruitment. This was achieved by discussing the study with staff during informal meetings, for example, after nurse handovers. Posters with information about the study were also distributed in communal areas such as nurses' stations and coffee rooms (see appendix 7). As the recruitment procedures relied on clinicians working in the settings to identify patients who were eligible to participate in the study, this process of building relations with the clinical team was essential preliminary work prior to the commencement of data collection. The participant recruitment procedure consisted of three stages, illustrated by figure 1. No data were collected from those patients who chose not to be involved in the study (see section 4.4 – 'Ethical Considerations').

Figure 1: Study Recruitment Procedure



4.2 Study Participants – Who are men of ‘South Asian’ and ‘White’ ethnicity?

Contemporary European and American research on ethnicity and health has used a variety of racial and ethnic nomenclature to describe study populations. There has been a longstanding and ongoing debate in this literature about what is accurate or appropriate terminology for different racial and ethnic groups (for example, Bradby 1995; Bhopal 1997; Adamson and Donovan 2002). Despite the continuing debate, there remains no consensus or published guidelines on the appropriate terms for use in the scientific study of health and race/ethnicity (Bhopal 2000). As such, the general conventions used in UK ethnicity research (Smaje 1994; 1995; Office for National Statistics 2001; Bradby 2003) and UK government CHD health policy (Department of Health 2004; 2004c) are used to characterise and identify participants in this thesis. This approach was primarily adopted so as to situate the findings of the studies within the context of the existing literature on race/ethnicity, men’s health and the UK government’s health policy framework.

The term ‘race’ is generally accepted in the sociological and epidemiological literature as referring to biological and genetic distinctions whereby human populations are divided into sub-species (Bradby 1995; Bhopal and Donaldson 1998). Since race/ethnic group categories are widely considered to be socially constructed, the term ‘race’ has largely become abandoned in the UK literature in favour of ‘ethnicity’ on the grounds that ‘race’ perpetuates the misconception that racialised differences are discrete, scientifically recognised and potentially biologically constituted (Bhopal and Donaldson 1998; Bradby 2003). Ethnicity was also considered to be a more appropriate terminology and means of characterising the participants in this thesis given the social and cultural aspects of gender and help-seeking behaviour (rather than biological factors) that were implicit in the research question.

To illustrate, in this thesis the term ‘ethnicity’ is taken to mean a socially constructed category based on the group a person belongs to as a result of a mix of cultural factors including patterns of social interactions, language, diet, religion and ancestry (Nazroo 1998b; Bhopal

and Donaldson 1998; Bhopal 2000; Bradby 2003). Similarly, the assumptions about masculinity that underpinned the research question emphasise that the relations between men and masculinities on the basis of ethnicity, specifically, relations of hegemony and marginalisation, are socially constructed (Connell 1995; 2000). Participants' ethnicity was determined by their ancestry (family origins); a strategy used by the majority of published research on health and ethnicity in the UK (Nazroo 1998b).

White, rather than Caucasian or European, is the term currently in practice to describe people with UK ancestral origins (Bhopal 2000). The term Caucasian categorises people on the ill-defined basis of a common origin in the distant past in the Caucasus region of Central Europe. Most populations originating from India, Pakistan and Bangladesh, for example, are Caucasian. Therefore, the term has little value in health and ethnicity research (Bhopal and Donaldson 1998). Thus, participants who stated they were of UK ancestral origin were considered, and are referred to, as being of 'white' ethnicity in this thesis.

Although who is categorised as 'Asian' has been contested in health research (Aspinall 2003), the term 'South Asian' is conventionally used in UK studies on ethnicity as meaning those resident in Britain with an ancestry in the Indian subcontinent (Bradby 2003). Participants recognised as being of 'South Asian' ethnicity in this thesis are therefore men who stated their ancestry was in the Indian subcontinent; effectively, India, Pakistan or Bangladesh. This is also the approach to operationalising 'South Asian ethnicity' the UK government has taken in health policy aimed at tackling ethnic inequalities in heart disease; evident in the 2004 document *Heart Disease and South Asians: Delivering the National Service Framework* (Department of Health 2004c).

The operationalising of the term 'South Asian ethnicity' recognises the significant commonalities in world views, cultural views and behavioural patterns held by populations in the Indian subcontinent, particularly when they have shared the experience of immigration

(Bhattacharya 2004). However, ethnic classification systems that employ such broad categories have been criticised for assuming or exaggerating homogeneity (Aspinall 2003). South Asian populations are recognised as having significant cultural, economic, political and religious diversity as well as similarity (Modood et al 1997). Indeed, as has been discussed in Chapter 2 ('Literature Review'), important economic and behavioural differences associated with CHD risk between Indians, Pakistanis and Bangladeshis in the UK have been reported previously (Nazroo 1997; 1998b; Bhopal et al 1999). In order to recognise and explore South Asian ethnic diversity in this study, Indian, Pakistani and Bangladeshi participants were recruited, and data on religion, specific country of origin and occupation was collected from all South Asian participants. The study sample and sampling strategy is described in section 4.8 of this chapter.

4.3 Study Participants – Classifying Socio-economic Status

One of the key contexts relevant to the relationship between health and ethnicity is socio-economic position. As with ethnicity, the social constructivist assumptions about masculinity that underpinned the research question emphasise that the relations between masculinities on the basis of 'class' are primarily based on occupational status and the socially constructed power relations between men (Hearn and Collinson 1994; Connell 1995; 2000). The Registrar General's Social Class (RGSC) classification, an ordered scale based on occupation, has been the principal classification of socio-economic status used in UK research.

Table 1: Registrar General's Social Class (Social Class based on Occupation)

I	Professionals
II	Managerial and Technical
IIIN	Skilled Non-Manual
IIIM	Skilled Manual
IV	Partly Skilled Manual
V	Unskilled Manual

In previous census surveys, the RGSC has been noted to portray a 'person's standing within the community' and 'level of occupational skill' (Donkin et al 2002). However, after nearly a century of use in official statistics and many research studies, the RGSC was replaced as the official measure of social position in the UK by the National Statistics Socio-economic Classification (NS-SEC) in the 2001 Census (Office for National Statistics 2001). The RGSC was criticised for a lack of a clear theoretical rationale and for its failure to deal adequately with women's occupations and individuals not currently in employment (Donkin et al 2002). NS-SEC differentiates occupations in terms of their dominant form of employment regulation, including source of income, economic security and prospects of advancement and typical work situation (Donkin et al 2002).

Although the NS-SEC has been widely used and validated in health research (Craig and Forbes 2005), participants' description of their occupation and resultant position on the RGSC is used as a measure of socio-economic status in this thesis. The relationship between health and social class measured according to the RGSC is well established: the majority of studies in the UK have used the RGSC to show the existence of social inequality in CHD outcomes (Chandola 1998); and studies have shown that the NS-SEC and the RGSC are both strongly associated with self-assessed health despite their differing theoretical bases (Craig and Forbes 2005). Therefore, although the RGSC is a proxy measurement of socio-economic status, for the purpose of the studies presented in this thesis, it was considered to be a pragmatic way of facilitating the exploration of the interplay between class, masculinities and help seeking.

4.4 Ethical Considerations

There is a continuing debate in the research literature about the appropriateness of applying ethical codes that originated in bio-medicine to qualitative research. Beauchamp and Childress (1994) outline four ethical principles around which these discussions centre:

- The principle of autonomy or self-determination;
- The principle of non-maleficence (to do no harm);
- The principle of beneficence (to do good);
- The principle of justice (to be treat people equally).

A review of the literature that has attempted to operationalise these common ethical principles to qualitative research reveals three principal areas which have been widely recognised as being necessary to ensure all qualitative research is carried out ethically. They are: ensuring consent, reducing the risk of harm and ensuring confidentiality (Babbie 1992; Murphy et al 1998; Tschudin 2003; Royal College of Nursing 2004).

Ensuring consent

Informed consent is an explicit agreement given by research participants, without threat or inducement, based on information which any reasonable person would want to receive before consenting to participate (Sieber 1992). For research studies within the healthcare setting, patients who are able to consider what participation will involve also have the right to decide whether or not to take part (Royal College of Nursing 2004). In order to ensure informed consent in this study, potential participants (patients) were approached by the researcher and given verbal and written information about the aim and scope of the study. The information included the types of questions likely to be asked during an interview, the use to which the results would be put and the processes for maintaining confidentiality. Participants were then given a minimum of twenty four hours to consider their participation in the study and given time to ask questions of the researcher before signing a written consent form and taking part in an interview (see appendix 7 for patient consent form and information sheet).

By its very nature, unexpected themes arise during interviews in a qualitative study that may not have been anticipated at the time consent was gained. Participants in this study were therefore informed prior to an interview that they could choose not to answer any question if they wished, and could discontinue the interview at any time without giving a reason why. This ensured that informed consent was an ongoing process throughout the interview as opposed to a one off event (Richards and Schwartz 2002).

It has also been recognised that it can be difficult to ensure *true* voluntary participation in the hospital environment, particularly when the researcher is a healthcare professional, as patients may feel subject to external pressures such as a sense of duty or because they depend on the good will of their carers (Richards and Schwartz 2002). For this reason, it was reinforced to potential participants prior to the gaining of written consent, both verbally and on the written information sheet, that the decision whether or not to take part in the study had no influence on the care they would receive while in hospital and that the researcher was employed by the University and was not part of the healthcare team.

Reducing the Risk of Harm

Causing anxiety and distress to participants has been recognised by social scientists as the major potential cause of harm when conducting a qualitative study using interviews (Hammerlsey and Atkinson 1995; Morse 2001). In this study, discussing the experience of chest pain had the potential for provoking feelings of anxiety about issues associated with having a serious or potentially life-threatening disease. To minimise this risk, potential participants were provided with comprehensive information about the nature and scope of the study so they could make an informed choice about whether or not to take part.

Furthermore, as the participants in the study had experienced an acute cardiac event, interviews were not conducted until forty-eight hours after admission. This was to allow participants' conditions to stabilise and minimise the effect any potential distress taking part

in an interview would have. Patients who remained critically ill or clinically unstable after this period were not eligible for inclusion in the study. The final decision on the suitability of a patient to be interviewed, based on their clinical condition, was made by the nurse or doctor in charge of the clinical area.

A fundamental requirement of reducing the risk of harm in qualitative research is also to ensure that the study is scientifically sound; that is, properly designed, carried out by researchers of sufficient levels of expertise and likely to produce results that lead to some tangible benefit (Richards and Schwartz 2002). Studies conducted in the healthcare setting should, therefore, seek the approval of an appropriate ethics committee to determine that it meets agreed standards, is expected to result in worthwhile findings and ensure that hospital patients are not inconvenienced or harmed for no justifiable end (Royal College of Nursing 2004). The study was approved by East Leeds Research Ethics Committee on 11th June 2003 (Project No 03/136) (see appendix 7).

Ensuring Confidentiality

Confidentiality refers to the safeguarding of participants' dignity and privacy and involves ensuring that personal information given as part of the study is kept confidential (Royal College of Nursing 2004). In order to safeguard confidentiality, all the data gathered from participants was handled in accordance with the Data Protection Act (HMSO 1998). As such, participants were not asked to give their name during interview and are identified by pseudonyms throughout the thesis. All participants were given the option of being interviewed either in a private room within the clinical setting, usually a relative's room or empty day room, or at their bedside with the curtains drawn. Interviews were recorded on audiotape and the tapes and transcripts kept in a locked cupboard to which only the researcher had access. The tapes are to be destroyed on completion of the project. In accordance with local and national Research Governance and ethics guidelines, transcripts will be destroyed fifteen years after the end of the study.

4.5 Interview Structure and Approach

The structure of a qualitative interview can range from a structured standardised interview to an unstructured non-standardised interview. In the standard schedule (or structured) interview, wording and order of the questions is the same for all respondents (Murphy et al 1998). The underlying assumption of the standardised interview is that, by standardising the stimulus (interview questions), variations in the responses to questions are seen as being a true measure rather than an artefact of the method (Mason 1996). Facts can therefore be isolated from the context of the interview. In qualitative research, the standard schedule approach to interviewing has considerable epistemological shortcomings.

As discussed in Chapter 3 ('Methodology'), qualitative research is grounded in an epistemological position which is broadly interpretivist and, as such, concerned with how the social world is interpreted, understood, experienced or produced. By contrast, the standardised interview approach is based on a positivist assumption that interviews are concerned with the eliciting of *facts* from respondents which can be isolated independently (Oakely 1981; Silverman 1985; Murphy et al 1998). The positivist assumptions of standard schedule interviews were therefore deemed to make the approach unsuitable for collecting data in this qualitative study.

The depth (or semi-structured/non-schedule standardised) interview also uses an interview guide consisting of a set of questions but, in contrast to the standardised interview, provides flexibility for the sequencing and phrasing of questions to be altered depending on the process of the interview and the answers of each participant (Britten 1995). The non-standardised (or unstructured) interview starts with a general question in the broad area of study and a general list of topics to be covered in the interview (an *aide-memoir*) instead of a set of predetermined questions.

Depth and non-standardised approaches to interviewing are based on the ontological position that suggests that people's knowledge, views, understandings, interpretations, experiences and interactions are meaningful properties of the social reality which a study's research questions are designed to explore (Mason 1996). As it was precisely these properties the research question in this thesis was designed to explore, depth and non-standardised interviews were considered to be appropriate ways of collecting the study data. Furthermore, depth and non-standardised interviews also allow issues to be raised during an interview that had not been anticipated by the researcher (Collins 1998; Murphy et al 1998), a characteristic that is central to the grounded theory method. As the interviews were to be conducted by an inexperienced interviewer, a depth (semi-structured) interview approach was used because it provides flexibility to explore the topic area, whilst maintaining a structure to the interview process that minimises the gathering of information of little relevance to the research question that can occur when inexperienced interviewers use a non-standardised format (Holloway and Wheeler 1996).

The depth qualitative interview can take either a cultural or topical style of questioning (Rubin and Rubin 1995). Cultural questions focus on norms, values, understandings and taken-for-granted rules of behaviour of a group or society. Topical questions are more narrowly focussed on a particular event or process and are concerned with what happened and why (Rubin and Rubin 1995). Both cultural and topical experiences were implicit in the research question in this thesis: investigating men's experience of chest pain and their help-seeking process (topical) in addition to exploring the influence of masculinity associated with this process (cultural). The initial interview guide (Table 2; page 105) therefore incorporated both topical and cultural lines of questioning

To illustrate, the first part of the interview guide contained directive questions, focussed on the events leading up to the participant's admission to hospital with chest pain, and aimed to elicit *topical* information such as what happened during a participant's experience of chest

pain and what actions they took. The second part of the interview guide contained more broad questions, focussed on views, common behaviours and premises about seeking medical help ‘as a man’, and aimed to elicit *cultural* information on the perceptions and influence of masculinity associated with a man’s help-seeking experience. In practice, the two styles of questioning were mixed throughout the course of an interview. For example, a directed topical question such as ‘*Why did you call for help at that particular time?*’ often led to a focussed cultural question associated with the participant’s answer such as ‘*is this how you would normally behave when you are ill?*’ (See sections 4.7 and 4.9 of this chapter for reflexive accounts of the interview and data collection process).

As outlined in Chapter 3 (‘Methodology’), the overall approach to interviewing – what to ask, who to ask and why, was an iterative process informed by a theoretical sampling strategy: concepts that emerged during interviews as having ‘theoretical relevance’ to the developing theory were incorporated into the interview guide. A purposeful sample of five participants was obtained prior to the commencement of theoretical sampling (‘delayed theorising’) in order to allow theoretically relevant data and analytic directions to emerge. As advocated by Strauss and Corbin (1990; 1998), the theoretical concepts that were the focus of the questions in the initial interview guide were derived from the theoretical sensitivity gained from a review of the literature and from the researcher’s professional experience as a cardiology nurse. The initial interview guide, presented in Table 2, illustrates how both topical and cultural questions were incorporated into the interview approach. Prompts and probes, additional questions designed to search for elaboration, meaning and reasons associated with a concept, are in parentheses. The process of theoretical sampling is illustrated in section 4.10 (‘The Analytical Process’) later in this chapter.

Table 2: Interview guide used for purposive sample (first five participants) – Study One

- Demographic questions: ancestry; age/DoB; occupation; religion; married/single/divorced.
- To start, tell me about what has happened to you that has brought you into hospital? (What symptoms did you have? What were you doing at the time?);
- Tell me how you felt at this time? (For example, did you ignore it? Did it not bother you? Did it worry you? What did you think it was?);
- What did you think the pain was? Why did you think it was.... Heart/indigestion/muscle pain?
- What did you do about it? Why? (Did you tell anyone? Did you carry on as normal? Did you take any painkillers?);
- How long did you wait before you asked/called for medical help? Why?
- Why did you call for help at that particular time? Or why did you delay calling for help?; (did the pain become unbearable? Did your wife make you? Could you not work anymore?)
- What type of medical help did you get? Why did you call (an ambulance? Your GP? Your wife?).
- From what you have said, it seems like you were reluctant to ask for, or call for help – why do you think that is?
- Why did you not tell anyone about the pain you had? (did you not want to worry them? Did you not want to appear like you were moaning?)
- What influence does your wife/partner have on you when you are ill? (does she make you go to the doctor? Do you not tell her? Does she nag you?)
- Thinking back to when you had chest pain this time, would you say this is typical of how you have behaved in the past when you have been ill?
- How do you think a man should behave when they are ill? (For example - Should they ignore it? Carry on as normal? Get help as soon as possible?);
- Is being seen to be ‘acting like a man’ by other people important to you when you are ill? Why?;
- Tell me about what you think influences someone and the way they act when they feel ill? For example, do you think different types of people behave differently?
- What do you think about men who are always going to see their doctor? (Do you respect them? Think they are weak? Feel sorry for them?).
- Is there anything else you would like to say about how you felt and how you acted when you had chest pain recently?

4.6 Pilot Study

The framing, pacing and managing of an interview affects the type and quality of data obtained and the incisiveness of the analysis. In particular, the success of qualitative interviewing depends greatly on the ability of the interviewer to listen, be self-confident, adaptable and able to follow up insights and track down new themes (Rubin and Rubin 1995). Because the researcher in this study was a novice interviewer, conducting a pilot study was considered to be a crucial step in the research process so that an effective interview approach/style could be developed prior to data collection for the main study. The pilot study was also used to identify any practical problems with the application of the research methods, and verify the suitability of the questions in the initial interview guide. The specific objectives were:

- To identify any problems with the recruitment process (i.e. access to clinical areas, help from clinical staff, consent procedures);
- To identify any problems with the sampling strategy (e.g. were enough participants, i.e. men admitted with cardiac chest pain, available in the chosen study settings?);
- Develop an effective interview approach/manner (e.g. are the questions relevant to the topic being investigated? In what way should the interview questions be posed?).

Six of the eight identified clinical areas (two cardiology wards, two coronary care units, and two CDU's) were used as the settings for the pilot study. The researcher visited the six areas every day (Monday-Friday) over a three week period. In discussions with clinical staff, ten patients admitted with chest pain were identified by the researcher as potential participants. Seven consented to participate in the study when re-visited twenty four hours after the initial approach. No problems were identified with the study's recruitment procedures and sampling strategy. Table 3, below, presents the demographic data of the pilot study participants.

Table 3: Demographic Characteristics of Sample – Pilot Study

Participant	B	T	J	D	M	B	A
Age	43	55	69	73	47	64	80
Ethnicity	White	South Asian (Pakistani/ Muslim)	White	White	White	White	White
Occupation (RGSC position)	Prison Officer (II)	Furniture Maker (IIIM)	Factory Maintenance (retired) (IV)	Police Officer (retired) (II)	Gardener (IV)	Union Worker (IIN)	Market Trader (retired) (V)

(RGSC Position Key: I – Professionals / II - Managerial and Technical / IIN - Skilled Non-Manual / IIIM -Skilled Manual / IV - Partly Skilled Manual / V - Unskilled Manual)

4.7 Reflexive Account: Pilot Study – developing an effective interview approach

As noted in Chapter 3, section 3.10 (‘Rigour’), interview accounts in constructivist grounded theory are, in effect, the researcher’s interpretations of the world shaped by the contexts in which they occur. Therefore, to ensure the credibility of a constructivist grounded theory study, reflexivity in the way of exploration and identification of the interview context as part of the research process is required. The following is the researcher’s reflexive account of how the study’s interview approach was developed using a pilot study. In addition to the reflexive discussions presented in sections 4.9 and 6.5 of the thesis, this discussion makes explicit the context and framing in which the participants’ descriptions of their experiences occurred.

My inexperience as an interviewer became patently obvious to me in the first three interviews I conducted. As a qualified nurse I had a great deal of experience of talking to male patients about their cardiac illness and their feelings associated with seeking medical help for their chest pain; experience that had motivated me to undertake this study. However, it soon

became apparent that talking to men about their experiences in an interview situation was a very different context to the one with which I was familiar.

As I was approaching the interviews with men as an inexperienced researcher, not as a nurse, I was extremely nervous and self-doubting and stuck to the questions in the interview guide word-for-word in my first three interviews. As a result, these early interviews did not resemble the flexible style of interaction of a depth interview I was trying to achieve; they were more reminiscent of a standardised scheduled interview. Perhaps unsurprisingly, the first three interviews also generated very little useful data. I allowed little time for participants to elaborate on their experience and did not have the confidence to follow up participants' responses with prompts or cues in an attempt to track down or clarify themes in more depth. Men's responses to my directive questioning style were often stilted and sometimes one-worded. It is possible that this was because the men had not clearly formulated the reasons underpinning their behaviour in their minds in a way which could be clearly articulated in response to my directed questions. I was uncomfortable with silences during an interview and my fast paced structured style gave little time for thought or rumination.

In the next four pilot interviews I became more confident and altered my approach, adopting the style I would have taken as a nurse getting a medical or social history from a patient. I began with the same questions on the interview guide, but my conversational style of questioning created an atmosphere in which participants were more willing to speak openly and at greater length about their experiences. The approach was also more responsive to the dynamics of each interaction and I found I was doing more listening and less questioning.

I began to use the interview guide more as an *aide-memoir* to make sure I covered all the relevant topics during the course of an interview, and placed more emphasis on the use of prompts and probes such as '*how did that happen?*' and '*why do you think you did that?*'; relying less on the actual wording of the questions on the guide. For instance, if a participant

stated that they had thought their chest pain had been indigestion, I attempted to track down their underlying thought processes by encouraging them to clarify *why* they had thought it was indigestion. This approach also allowed me to follow up participants' responses along the lines that were relevant to their particular experience. For example, one participant ('B') stated that he had experienced chest pain whilst at work. I followed up his response by exploring if he had told his colleagues about his pain and why he had thought his pain was indigestion despite not having eaten recently. Crucially for a grounded theory study, this approach allowed the interviews to be 'guided by the data' – as illustrated by the above example, the conversational style allowed new themes to emerge and be pursued. This was, therefore, the approach I took when interviewing the participants in the main study sample (a reflexive account of the interviews conducted with the participants for the main sample is in section 4.9 of this chapter).

In addition to facilitating the development of an effective interview approach, carrying out the pilot study also revealed that obtaining data relevant to the research question from men who had a long established history of heart disease was problematic. Two participants in the pilot sample – 'J' and 'D' – had both had several previous admissions with angina and myocardial infarction. 'J' had also recently had a coronary artery bypass graft. Both interviews with these participants indicated that the experiences of participants with a history of CHD would be less likely to provide insight into the influence of masculinity on the process of deciding whether to seek or delay-seeking medical help for chest pain. For example, 'J' explained that he had sought help immediately because his pain was like his '*normal angina*'. 'D' similarly recalled that he had sought help because his chest pain had not been relieved after taking glycerine tri-nitrate (GTN) spray. The participants with the greater theoretical relevance to the research question emerged as those who had been admitted with a *new* onset of chest pain, had no past medical history of CHD and, therefore, no previous experiences of seeking help for chest pain. As such, men with a history of CHD were excluded from the main study sample (see Table 4, page 110, for Participant Inclusion Criteria). The implications of excluding

participants with a history of CHD on the theoretical generalisability of the study findings are acknowledged in Chapter 8 ('Summary and Conclusions').

4.8 Study Sample

Over a seven month period, the eight clinical areas were visited by the researcher up to five times a week to recruit and interview participants for the main study sample. All participants approached had been admitted to the areas with a *new* onset of acute chest pain diagnosed as being of cardiac origin (angina or MI), and had no medical history of CHD. The clinical manifestations of cardiac related chest pain are diverse and can vary from individual to individual. Some individuals suffering from angina or MI may experience the 'classic' symptom of central chest pain, whilst other individuals may experience atypical symptoms such as recurrent 'twinges', general discomfort, sharpness, burning or heaviness and tightness in the chest (Jowett and Thompson 1996). There is evidence to suggest that, among patients with angina and confirmed MI, South Asians are more likely to present with atypical chest pain than the white population (Neill 1993; Lear et al 1994; Bhopal 2000; Barakat et al 2003). Therefore, men who were admitted with atypical chest pain (diagnosed as being of cardiac origin – angina or MI) were also included in the sample. The inclusion criteria for the study sample are presented in Table 4. Patients who met the study inclusion criteria were identified in discussions with clinical staff (doctors and senior nurses) in each respective study setting (see Study Recruitment Procedure; Figure 1; page 94).

Table 4: Participant Inclusion Criteria – Study One

<ul style="list-style-type: none">• Male over 18 years old• Admitted to clinical area 48 hours prior to interview with new onset of chest pain diagnosed as being of cardiac origin – Angina or Myocardial Infarction• No past medical history of CHD• Clinically stable• Of white or South Asian (Indian, Pakistani, Bangladeshi) ethnicity• Able to speak English and participate in a depth interview

An initial purposive sample of five participants, consisting of four men of white ethnicity and one man of South Asian (Pakistani) ethnicity who met the inclusion criteria, was recruited during the first two months of data collection. As outlined in Chapter 3 ('Methodology'), following the initial analysis (open coding) of the data from the purposive sample, a theoretical sampling strategy, whereby data collection, analysis and sampling occur concurrently, was used. Subsequent recruitment decisions were therefore based on the inclusion criteria and the concepts that emerged during the analytical process. Section 4.10 of this chapter ('The Analytical Process') illustrates how the analytical process informed the theoretical sampling strategy.

After four months of data collection it became apparent that many South Asian patients did not speak English sufficiently fluently to take part in a depth interview. Financial constraints meant it was not possible to employ interpreters or interviewers who spoke South Asian languages to overcome this problem. Consequently, the recruitment of a sufficient number of South Asian participants to achieve theoretical saturation became problematic. Difficulty in recruiting South Asian participants for UK-based research studies has been recognised previously as being due to investigator bias, inappropriate recruitment strategies and cost issues such as those for language translators (Mason et al 2003).

In addition to language barriers, discussions with clinical staff in each of the study settings also suggested that the study was employing an inappropriate strategy to recruit South Asian patients. Only a small number of South Asian men were being admitted to the study settings, and opportunities to recruit some of these patients were missed because they were being discharged in-between routine visits by the researcher. The recruitment procedures were subsequently modified to target South Asian patients specifically in response to this problem. The targeted strategy involved informing staff in the eight study settings through the distribution of additional posters and handouts that the researcher needed to see *all* South Asian men that were admitted with chest pain (see appendix 7 for poster). Routine visits to

the settings to identify and recruit patients were also increased to include evenings and weekends so that any South Asian patient who was admitted would not be 'missed'. The modified strategy resulted in the completion of four further interviews with South Asian men.

Theoretical saturation was considered to have been reached when thirty-six interviews had been completed and analysed. Overall, forty-five patients were invited to participate in the study during the seven month period of data collection; nine declined. All of the thirty-six patients that consented to participate in the study chose to be interviewed at their hospital bedside. Interviews were audio-recorded and later fully transcribed verbatim. The length of the interviews varied between five and ninety minutes (average thirty-one minutes). Of the thirty-six interviews, twenty were transcribed by the researcher with the remainder transcribed by secretarial support staff. The sixteen interviews transcribed by secretarial staff were verified for accuracy by the researcher, and amended where necessary, by cross checking audio tapes with the text transcriptions.

Table 5 presents the demographic characteristics of the study sample (see appendix 2 for short summaries of men's experiences of chest pain and seeking help). The ages of the participants ranged from 30 to 79 years (average of 57 years). Delay in seeking help (from onset of chest pain to call for medical help, as recalled by the participant during interview) ranged from less than one hour to over one week. Participants' position on the RGSC scale varied from II to V (unemployed participants who did not state they had a previous occupation were classed as V – unskilled manual). Of the thirty-six participants, eight were of South Asian ethnicity and twenty eight of white ethnicity. All but one of the South Asian participants (Faisal) had been born in the Indian subcontinent: five men stated they had been born in India, two in Pakistan and one in the UK. The South Asian participants also varied by religion: three men stated their religion was Sikh, three stated Islam (Muslim), and two men identified themselves as Hindu [data on white participants' religious affiliation was not collected]. The ethnic mix of the study sample was broadly reflective of the ethnic mix of the population in which the study

settings were situated. The 2001 census recorded the ethnicity of the population in the city in which the study was set as 89.16% white, 2.11% as Pakistani, 1.72% Indian, and 0.35% Bangladeshi (Office for National Statistics 2001).

Table 5: Demographic Characteristics of Sample – Study One

Participant	Age	Occupation (RGSC position)	Ethnicity	Approx Help Seeking Delay (hrs)
Ahmed	30	Baker (IIIM)	Pakistani (Muslim)	1
Barry	55	Baker (IIIM)	White	24
Andrew	70	Engineer (Manual) (Retired) (IIIM)	White	12
Max	54	Market Porter (V)	White	48
Gareth	54	Orthotist (II)	White	12
Lee	57	Security Officer (V)	White	1
Craig	37	Retail Manager (II)	White	10
Dave	79	Managing Director (II) (Retired)	White	2
Paul	69	Taxi Driver (IV)	White	72
Tom	37	School Teacher (II)	White	24
Christopher	55	Painter/Decorator (IIIM)	White	48
Jack	41	Driver (IV)	White	48
Harry	68	Manager (II)	White	48
Robert	35	Engineer (Manual) (IIIM)	White	12
George	57	IT Manager (II)	White	12
Donald	56	Wood Machinist (IV)	White	72
Alan	53	Retail Manager (II)	White	168
Robin	57	University Lecturer (II)	White	7
Michael	76	Painter/Decorator (IIIM)	White	72
Gary	73	Housing Manager (II)	White	168
Ian	73	Personnel Manager (Retired) (II)	White	1
Steve	60	Joiner (IIIM)	White	1
Eric	68	Heavy Goods Driver (IV)	White	168
Richard	77	Engineer (Manual) (IIIM)	White	1
Anthony	75	Bricklayer (Retired) (IV)	White	168
Henry	48	Hospital Theatre Porter (V)	White	1
Geoff	43	Long Distance Lorry Driver (IV)	White	8
Gordon	66	Bus Driver (IV)	White	1
Les	56	Factory Engineer (IIIM)	White	12
Gurnam	60	Retired (Long Term Sick) (V)	Indian (Sikh)	1
Faarooq	64	Retired (TV engineer) (IIIM)	Pakistani (Muslim)	12
Mahesh	39	Taxi Driver (IV)	Indian (Sikh)	8
Jasdeep	57	Unemployed (V)	Indian (Sikh)	48
Danvir	54	Asda Check-Out (V)	Indian (Hindu)	12
Faisal	38	IT Business Director (II)	Bangladeshi (Muslim)	24
Gurdeep	71	Retired (Engineer) (IIIM)	Indian (Hindu)	2

(RGSC Position Key: I – Professionals / II - Managerial and Technical / IIIN - Skilled Non-Manual / IIIM -Skilled Manual / IV - Partly Skilled Manual / V - Unskilled Manual)

4.9 Reflexive Account: Interviewing White and South Asian Men about Masculinity

As discussed in Chapter 3 ('Methodology'), in order to ensure the rigour and credibility of qualitative research, reflexivity is required to demonstrate how the researcher's personal and theoretical assumptions were considered to have influenced the research process. In order to achieve reflexivity in this study I kept an 'analytical diary' in which I recorded my reflections of the research process, as well as my emerging ideas and tentative propositions about the data. Much of the content of the analytical diary is presented in the 'analytical process' discussion in the next section (4.10) of this chapter. The reflexive discussion presented here gives an overview of some of the key issues and challenges I faced during the process of interviewing which I recorded in the diary. I have combined these reflections with some of the pertinent methodological literature I referred to during the data collection process in order to address the challenges. In addition to making the analytical process of the study explicit, this discussion aims to enable the reader of the thesis to judge the credibility of the study's findings by illustrating the extent to which they reflect my own personal and theoretical assumptions.

Reflecting on my experience of interviewing men for the pilot study, I was conscious that being able to establish a 'guided conversation' during an interview would be crucial to the success of the data collection process in the main study. However, I was also aware that, in attempting to establish a 'guided conversation' with men, they were likely to assess and gauge my own (hegemonic) masculine representations (as a young, healthy, white, middle class man) and develop their responses within a gendered context. As noted earlier, the interview is a context which can be both an opportunity for signifying masculinity and an encounter in which masculinity is threatened (White and Johnson 1998; Schwalbe and Wolkomir 2001)

In order to overcome this problem and facilitate an environment which is conducive to men talking freely, Oliffe and Mroz (2005) and Schwalbe and Wolkomir (2001) advocate projecting a courteous, non-competitive, organised masculine self in order to emphasise the

participants' centrality and downplay the role of the interviewer. As such, I always arrived on time for an interview, dressed smartly but informally in shirt and trousers, and tried to project a professional manner but also one that indicated to the men that I did not have a governing role in the interaction. As Oakley (1981) has also argued, the goal of finding out about people through interviewing is best achieved when the relationship between interviewer and interviewee is non-hierarchical.

Perhaps unsurprisingly, the nature of my interactions with participants in the study was varied. The hospital bedside was initially a problematic setting in which to successfully conduct an in-depth interview. For example, in the early stages of the data collection process, nurses who were unfamiliar with my role would regularly interrupt interviews to do routine observations. A number of men also expressed that they were anxious about missing a visit by their doctor because I was interviewing them. This frequently undermined the success of an interview as participants became pre-occupied with the environment in which it was taking place. The relationships I had built with clinical staff within the study settings were crucial in overcoming these problems, particularly when reassuring participants that the interview would not be detrimental to the care they received and that they would not miss a visit by the medical staff.

In addition to the problems I encountered with the hospital setting, I also made several observations in my diary about early interviews that did not provide the in-depth data I was seeking. Some men were reluctant to say anything about how they felt during their experience and would recount only factual information about their event. As I had adopted a social constructivist perspective of grounded theory, I was keen to go beyond men's superficial explanations of their experiences and explore and uncover the underlying processes and feelings that were associated with their process of seeking help. However, it soon became apparent that the way in which I was attempting to elicit this information was having a detrimental affect on some of my interactions. For instance, in addition to being inexpressive,

a number of men also appeared to respond to my questioning about why they had delayed seeking medical help in a defensive manner. My experience of these interviews was comparable to what Collins (1998) has recognised as a ‘smash and grab’ approach, and what Oakley (1981) has referred to as the ‘*proper textbook interview*’ (p.38), whereby interviewers interrogate their interviewee in an attempt to ‘extract’ useful information. I made the following observation in my analytical diary:

‘...it appeared as though [the participant] felt I was trying to get to the bottom of the reason for his ‘inappropriate’ help-seeking behaviour – why he had delayed seeking help despite having severe chest pain which was obviously cardiac. He once responded to my questioning in an assertive tone that ‘*I aren’t a doctor so how should I know what to do?*’. This surprised me somewhat and I quickly moved on to another topic. I think that on this occasion I did not fully appreciate how I was being perceived as a researcher (not as a nurse) and did not take enough time to build a relationship at the beginning of the interview. Some men may think I am interrogating them and making a judgement about their behaviour, or quizzing them about their knowledge, and I do not think I have fully considered how this may impact on what men will disclose.’

Schwalbe and Wolkomir (2001) suggest that men who are aggressive or defensive during an interview may be trying to establish control in what they perceive to be a threat to their hegemonic masculine identity. On reflection, it became clear that my style and line of questioning about help-seeking delays may have been calling for answers that put the men’s sense of control, rationality and autonomy (and therefore their hegemonic masculine identity) into doubt. In subsequent interviews, I therefore tried to overcome men’s defensive manner by attempting to establish trust at the beginning of an interaction by asking general questions; for example, seeking a chronology of the events associated with their experience. Once a relationship had been developed I proceeded to more potentially sensitive questions about the reasons they had delayed seeking help; reassuring the men that I was interested in their experiences and beliefs and, therefore, there were no right or wrong answers. However, I was not always successful – two interviews did not last more than ten minutes because the men were only willing to talk about the factual information relating to their experience.

Despite these challenges, in general, the majority of men I interviewed were willing to talk in detail about their experience. However, men's enthusiasm to discuss their experience in an interview presented me with a number of additional challenges. When analysing the ensuing transcripts I often found that my lack of experience as an interviewer had led me to miss an opportunity to recognise and track down a theme that was clearly evident in a participant's account. Many of these missed opportunities were pursued in the second study that is presented in this thesis (Chapters 6 and 7). However, I have also attempted to highlight missed opportunities as areas requiring future research in the discussion of the study findings in Chapter 5.

On several occasions, many white participants' willingness to talk at length about their experience also led me to sense that some responses were designed to give *me* the impression that they were, for example, not a 'wimp' or that they had a high threshold for pain. This was particularly noticeable when I pursued explicit questions about acting '*as a man*' in the first five interviews I conducted (see Table 2: Interview guide used for purposive sample (first five participants) – Study One; page 105). These aspects of an interview have been recognised by Collins (1998) as 'impression management': where the interviewee becomes concerned with the presentation of self to the interviewer. As discussed already in this account, and earlier in Chapter 3, section 3.8 ('Interviewing Men about their Masculinity'), this phenomenon can be particularly problematic when the interviewer is interested in gender, since this increases the salience of the participant's identity as a man (Schwalbe and Wolokmir 2001). I made the following observation in my analytical diary:

'Before I do an interview I am very aware that some men might produce a masculine 'performance'. However, I am not sure whether this awareness is leading me to be overly sceptical as to the extent to which their accounts are representative of their *actual* experience and feelings. The fact I have noticed that many white men are keen to express to me that they did not want to appear soft or weak when they had chest pain might also be reflective of my own assumptions about masculinity and *my* masculine identity as well as those of the men I interview. I would probably be concerned that a younger man who was interviewing me might think of me as a wimp.'

The masking of weakness and vulnerability is a key signifier of hegemonic masculinity (Connell 1995) and the interview can be used by some men to signify the self as having desires and capacities that warrant membership to the dominant (hegemonic) group (Schwalbe and Wolkomir 2001). In order to limit the effect of such 'masculine impression management', Oliffe and Mroz (2005) have reported that asking participants to 'tell their story', rather than questioning them directly about gender-specific issues, can be a successful strategy to employ during an interview. Similarly, I found the most candid and insightful data came from general discussions I had with men, as opposed to specific questions about '*acting like a man*'. For example, questions such as '*tell me about what happened when you got your chest pain*' commonly led to an in-depth account of how the men had felt, and the masculine meanings and interpretations they gave to their experience. As a result, in subsequent interviews, I altered the nature of my interactions so as to place less emphasis on gender-specific questions about '*acting like a man*'.

In general, the nature of the interviews I conducted with South Asian participants were considerably different to those I conducted with white participants. As many other qualitative researchers have observed, interviews with ethnically-matched interviewers-interviewees, and those where interviewer and interviewee are from different ethnic backgrounds, can have dramatically different dynamics (Song and Parker 1995; Adamson and Donovan 2002; Gunaratnam 2003). In this study, the interviews I conducted with men of South Asian ethnicity were often shorter and less free-flowing than those I conducted with white men. As reflected by the study's findings, in contrast to the majority of white participants, the Indian, Pakistani and Bangladeshi men also did not appear to be concerned with the presentation of Western hegemonic masculine ideals (i.e. being a man who is strong and not a 'wimp') during an interview. Indeed, it was often difficult to initiate a 'guided conversation' with many of the South Asian participants, and I initially considered this as being due to language barriers – English was a second language for most of the South Asian participants. Sin (2004) has similarly recognised that interviewing ethnic minorities in English may not be conducive to

the establishment of rapport and communication. A comparable issue relevant to this study is illustrated by an observation I made in my analytical diary:

‘I am becoming aware that I am much more comfortable when I am interviewing white men in comparison to when I am interviewing the South Asian men and that this is having an impact on the quality of data I am gathering. When a South Asian man does not speak good English, I find it difficult to build a rapport and the interviews are becoming too structured. My interviews with white men are very conversational, but with South Asian men, I find I am sticking to the interview guide and it is introducing an element of formality and artificiality to the interactions which is resulting in me gathering superficial data.’

I attempted to overcome these communication problems by consciously using more prompts and probes such as *‘why did you think you acted in that way?’* and *‘how were you feeling at that time?’*. I also began to re-phrase questions and circle back to topics that I had already covered. For instance, to ensure a participant had understood the meaning of my questions, and to clarify and expand on the meaning of an earlier response, I would circle back to a topic by saying *‘Earlier you said....’* or *‘What did you mean when you said...?’*. This strategy was also crucial for maintaining the credibility of the study findings in accordance with the ‘member check’ technique discussed in section 3.10 of the preceding chapter (‘Rigour’).

As a consequence of the language difficulties I faced when interviewing South Asian men I also began to reflect further on my interactions with white participants. In doing so, I came to realise that, in addition to language barriers, my difficulty in establishing rapport with South Asian men may also have been a reflection of a lack of shared cultural understanding. To illustrate, it became apparent to me that I had developed an effective rapport with many white participants, and implicitly understood many of their responses (such as *‘acting soft’*, being *‘macho’*), because I had a shared understanding with the men – many aspects of their accounts were consistent with my own cultural understanding of masculinity. As a result, I could respond to white men’s accounts in a natural, informal and conversational manner. By contrast, my lack of shared understanding with aspects of some South Asian men’s accounts led me to rely more heavily on the interview guide, prompts and probes.

As noted in Chapter 3, section 3.9 ('Interviewing South Asian Men'), the existence of cultural/ethnic differences between interviewer and interviewee does not necessarily mean that the resultant interview account is less 'accurate' or 'truthful'. However, it became apparent during data collection that, because of my shared cultural understanding with *white* participants, I had often failed to question the meaning of some men's responses in sufficient detail. McEvoy (2001) has recognised a similar 'taken-for-granted' perspective, whereby a researcher who is familiar with the social world of which they are part fails to question areas of that world that are self evident. Williams and Heikes (1993) have suggested that such a 'taken-for-granted' perspective is particularly common when men interview other men, as interviewers may allow the gendered meaning of responses to go unarticulated in an attempt to develop a common masculine identity with the interviewee and maintain rapport. In order to address this limitation in subsequent interviews I continuously sought to clarify and uncover the implied meanings in white men's responses by using a similar probing and circling back strategy that I employed in interviews with South Asian men. For example, I would circle back to a topic by saying '*Earlier you said you behaved in a 'macho' way. What did you mean by that?*' or '*What did you mean when you said you feared others would see you as acting soft?*'. A further reflexive account of how I attempted to overcome my cultural assumptions about masculinity during the interview process for the second study is presented in Chapter 6.

4.10 The Analytical Process

As discussed in section 3.10 of the preceding chapter ('Rigour'), a salient aspect of establishing the dependability and credibility of the findings of a qualitative study lies in giving an adequate account of the circumstances of their production (Murphy et al 1998; Mays and Pope 2000; Long and Johnson 2000). This section presents a detailed account of the key stages of the study's analytical process, with particular attention on the development and refinement of codes, themes and concepts. The account provides a clear exposition of the analytical 'decision trail' so as to enable the reader of the thesis to judge the rigour of the

study findings presented in the following chapter (Chapter 5: ‘Study One – Findings and Discussion’).

The analytical process was aided by computer assisted qualitative data analysis software (CAQDAS) – *NVivo* (version 2.0). *NVivo* was principally used as a tool for executing the mechanical task of analysis as it was considered to enhance the efficiency in which a large amount of data could be coded. In addition, given the inductive nature of the study’s grounded theory methodology, *NVivo* also allowed ‘key data’ to be located that was relevant to the process of creating interpretive, conceptual and analytical codes and themes in a more pragmatic way than could have been accomplished entirely by hand (Holloway and Wheeler 1996).

As outlined in Chapter 3 (‘Methodology’), the study’s analytical process involved three phases informed by the grounded theory methods of Strauss and Corbin (1990; 1998), incorporating aspects of constructivist analysis advocated by Charmaz (1990; 2000). The first stage of this process involved conceptualising the data through ‘open coding’. The open coding procedure entails the breaking down, examining, comparing, conceptualising and categorising of the data (Strauss and Corbin 1990). Open coding was achieved by employing a line-by-line analytical procedure – examining every line and paragraph of a transcribed interview to label incidents and phenomena described by the participants. Comparisons for similarities and differences in incidents and phenomena between the participants were made using *NVivo*, and similar phenomena were ‘coded’ under the same name.

Line-by-line analysis led to the generation of codes that formed the basis for the theoretical sampling strategy – the emerging codes were incorporated into the interview guide and participants with theoretical relevance to the codes were recruited. For example, work emerged as being an important feature of the help-seeking decision-making of a number of participants (see the codes ‘Hypochondriac’ and ‘Work’ in Table 6, page 123). Accordingly,

the influence of work on men's decision to delay seeking help was incorporated into the interview guide, and participants who were of working age (under 65) were sought for recruitment into the study.

Throughout the analytical process, the writing of memos in an analytical diary played a crucial role in helping to raise data interpretation beyond the descriptive to a conceptual level. Memos are the written records of analysis relating to the formulation of theory (Strauss and Corbin 1990). As noted in Chapter 3, in this study memos were principally documented as code notes – short statements that represented descriptions, thoughts and intuitions about the conceptual origin (underlying meaning) of codes that emerged during the analytical process (Strauss and Corbin 1990). Summarised versions of these memos are presented together with the code names in Tables 6, 7 and 8 of this section.

Consistent with the process of *in vivo* coding (Strauss 1987), the words and phrases used by the participants were frequently used to label the initial codes – the code '*I don't want to know*' is illustrative of how this process was used during open coding. The use of *in vivo* codes allowed the codes to be 'grounded' in the data, minimising the influence of the researcher's pre-conceived ideas, literature, or theories (as discussed in section 3.10 – 'Rigour'). Open coding resulted in the development of 28 codes, listed in Table 6, below. *In vivo* codes are signified by quotation marks (Strauss and Corbin 1990).

Table 6: List of open codes and researcher memos (code notes) – Study One

- **‘A man thing’**

(Overt or implied) references to macho, bravado or typically/exclusively ‘male behaviour’. For example, in comparison to how women behave. ???Based on interview ‘performances’ in reponse to my specific questions.

- **‘Age’**

Informants’ references to their age. Some older men think their age influences/has changed their perceptions, views on health, help seeking, health care etc.

- **‘Body’**

Men’s references to their body. For example, expressions of what they felt were happening to their body, ‘my body was telling me’, etc.

- **‘I don’t want to know’**

Men’s expressions of denial about their health status and not wanting to know if anything serious was wrong.

- **Emotions**

Men’s expressions of their emotions (generally); for example, how they felt during their experience of chest pain, help-seeking, hospitalisation etc.

- **Family**

References to family members’ involvement in the experience of help seeking, chest pain, health service interaction etc.

- **‘I am fit and well’**

Men’s perceptions of themselves as being fit and well (perhaps prior to their event) and leading an active lifestyle, playing sport, walking etc. – therefore believe they can’t have heart disease?? Also, the consequences of having chest pain meaning they won’t be/might not be fit and well anymore.

- **‘Invincible’**

Men’s perceptions of themselves as feeling as though they are/were invincible or immortal i.e. never being ill; never thinking they could be ill. Similar to fit and well

- **‘Hypochondriacs’**

Expressions (often negative and derogatory) about other men (??often work colleagues) who are always going off sick or always going to the doctor, in their view, unnecessarily. Tacit hegemonic masculinity?

- **‘Wimps’**

Men’s perceptions of themselves and other people as ‘wimps’ or ‘softies’ because they go to the doctor/complain when they are ill, when they should just put up with it???

- **'I made a mistake'**

Men looking back on their experience and thinking what may have caused their health problem and how they could have done things differently. Often associated with feelings of regret and a resolution to do things differently in the future, for example, 'from now on I am going to do more exercise' etc.

- **Ignorance of symptoms**

Participants expressing they are ignorant regarding the symptoms of cardiac problems/angina etc.

- **Knowledge of symptoms**

Men's knowledge of the symptoms of heart disease; gained through, for example, education, health promotion material, the media etc.

- **'Loss of control'**

Men expressing the feeling that they were not in control during their experience of ill health, or their desire to be in control ;associated with denial.

- **Pain and events leading up**

Men's descriptions of what happened/what they were doing when they first got their chest pain, their experience and perceptions at this time, and associated context e.g. severity, presentation, duration

- **Normalisation**

Men normalising the chest pain (i.e. not thinking it is anything serious); for example, muscle strain, nothing to worry about, just my age etc.

- **'Indigestion'**

Men thinking the pain they were experiencing was due to indigestion.

- **'Wife'**

Informants referring to their wives and how they interacted with them during their experience of having chest pain. Often the reason they decided to seek help?

- **Perceptions of health services**

Perceptions of dealing with and utilising health services (both positive and negative), often associated with past and present experience of themselves or family/friends. For example 'you come to hospital to die'

- **Past medical history**

Informants' references to past, current or long term illness that may or may not be associated with their current event; for example, diabetes, asthma, high blood pressure.

- **'Putting it off'**

Delay in seeking help when men get chest pain because they 'put it off' for various reasons; for example, 'it went away', 'I ignored it', 'I waited to see if it went off by itself'.

- **'Scared'**

Men's overt expressions of feeling fear or panic when confronted with their chest pain or the need to seek medical help

- **Seeking help**

General expressions of when, how and why men sought medical help for their chest pain e.g. 999, GP etc.

- **'Something is not right'**

Men making the decision in their mind that the pain and the symptoms they have been experiencing were 'not right' or 'I knew what it was' sometimes leading to immediate seeking of help or a resolution that it 'needs to be sorted out'.

- **'Things are going to change'**

Men's feelings and expression about how their experience of chest pain/angina/heart attack will change their life (often negative); for example, change in job, change in diet etc.

- **'Usually'**

Men's expressions of how they normally behave (?when they are well)

- **Work**

Participants describing how being at work affected their decision to delay seeking help: e.g. wanting to finish shift, perceptions of work colleagues.

- **'What's wrong with me?'**

Men describing the thought processes about they had when they were experiencing the chest pain i.e. trying to work out what was happening to them.

Following open coding, the analytical process progressed to a second phase of 'axial coding'. Axial coding involves reassembling data that has been fractured during open coding by making connections between codes and forming a more precise and complete explanation about phenomena (Strauss and Corbin 1998). As summarised in Chapter 3 ('Methodology'), as opposed to using the paradigm model proposed by Strauss and Corbin (1990), the method of axial coding in this study was modified to incorporate aspects of constructivist analysis advocated by Charmaz (1990; 2000). Two analytic processes were associated with this modified approach: continued questioning and constant comparison.

A central feature of Charmaz's (1990; 2000) approach to constructivist analysis relates to continued questioning. This involves the search for tacit meaning in participants' accounts through the continual 'asking of questions' about codes such as 'how?', 'why?' and 'under what conditions?'. Thus, in accordance with Charmaz's (1990; 2000) approach, axial coding

in the study initially involved ‘asking questions’ about each open code in an attempt to *‘find out how each develops, changes and gives rise to consequences’* (Charmaz 1990; p.1165). For example, in an attempt to establish a greater explanation and understanding of the meaning of the ‘putting it off’ open code, the following questions were ‘asked about the data’:

1. What did ‘putting it off’ mean to men?
2. Did ‘putting it off’ mean different things to white and South Asian men?
3. When did men decide to ‘put it off’?
4. What were the consequences of ‘putting it off’?
5. How did the men handle their chest pain when ‘putting it off’?
6. Was ‘putting it off’ a common strategy for both white and South Asian men?

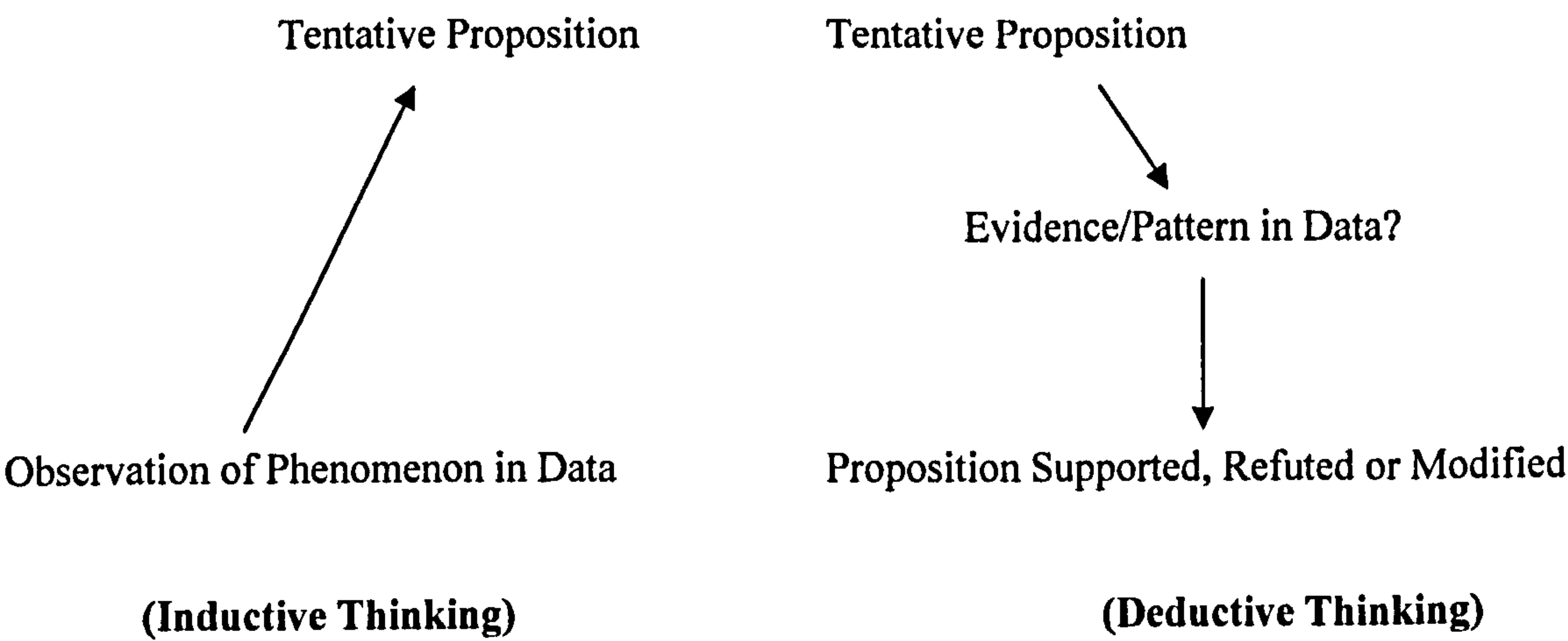
Following the initial ‘asking of questions’ about the 28 open codes, axial coding then incorporated a constant comparative analysis. Constant comparison involves the contrasting of data first against itself, then against original data, and then against theoretical and conceptual propositions (Strauss and Corbin 1990). Strauss and Corbin (1990) advocate the use of inductive and deductive thinking to facilitate constant comparative analysis:

‘...propose statements of relationships or suggest possible properties and their dimensions when working with the data, then actually attempt to verify what we have deduced against the data as we compare incident with incident’ (p.111)

A similar process was used in this study, whereby tentative theoretical/conceptual propositions relating to an open code or an individual participant’s account were made. The entire data set was subsequently searched to establish if the phenomena/concept occurred explicitly in other accounts, or had been implied in the behaviour of other participants (Charmaz 2000). The tentative proposition could then be supported, refuted or modified accordingly, and relationships between codes could be established. For example, a tentative proposal was made during axial coding that an incident of chest pain was often followed by men attempting to ‘normalise’ their pain as indigestion. Consequently, all the accounts were re-examined to search for evidence and incidents (explicit or implicit) related to the concept

of ‘normalisation’ to support, refute or modify this proposal – to verify deductively what had been proposed inductively. Figure 2, below, illustrates this process.

Figure 2: The Process of Inductive and Deductive Thinking



As a result of continued questioning and repeated inductive and deductive thinking, the open codes were conceptually linked, subsumed and developed into ‘advanced codes’. For example, ‘Indigestion, ‘I am fit and well’, ‘Invincible’ and ‘What’s wrong with me?’ were developed to become the advanced codes ‘*Genuine Normalisation*’ and ‘*False Normalisation*’. Similarly, ‘A man thing’, ‘Hypochondriacs’, ‘Wimps’; and ‘Loss of Control’, were developed to become the advanced code ‘*get on with it/put up with it*’. The advanced codes were based on phenomena derived directly from the data and therefore had greater conceptual depth than the initial open codes; that is, they provided a greater interpretive understanding of ‘what was going on’ in the data (Strauss and Corbin 1990) (see Tables 7 and 8, pp130-131, for a list of the Advanced Codes).

In addition to searching for evidence of relationships and conceptual linkages between the open codes, instances that *did not* fit the emerging theory were also actively sought: a search for evidence of differences and variation. At this stage of the analytical process, several negative or ‘deviant’ incidents became apparent. For instance, it emerged that a number of

participants who had previous knowledge of the symptoms of heart disease as a result of medical training, experience, or a relative's past medical history, had a differing perception of their help-seeking experience compared to the majority of participants. Examination of their accounts revealed that knowledge of heart disease symptoms appeared to transcend the 'barriers' to seeking help and result in shorter delays in help seeking. These participants were labelled as 'deviant cases'. Excerpts from the deviant cases' accounts are presented in the discussion of the findings (Chapter 5) to add density and variation to the final theory.

Integrative diagrams played a salient role in the development and direction of analysis throughout the axial coding phase. The diagrams symbolize visual representations of analytic thinking that are used to test conceptual linkages (Strauss and Corbin 1990) and were used to assist in the formation of inductive proposals about relationships between advanced codes, in addition to providing an overview of how all the codes might link together as a whole. The integrative diagram conceived at this phase of analysis (see appendix 3) illustrates that axial coding resulted in a deductive proposal that the advanced codes were linked to two *core concepts* relating to the 'barriers' to seeking help and the 'triggers' to seeking help. The core concept is the central phenomenon or main theme that has the analytical power to:

'pull other categories [the advanced codes] together to form an explanatory whole'
(Strauss and Corbin 1998; p.146; comment in parentheses added.)

At this stage of the analysis, emphasis was placed on verifying/refuting the relationships between the advanced codes and the two core concepts through the search, comparison and 'asking of questions' of the data set.

Comparisons of the accounts given by men of white and South Asian ethnicity, and men of differing socio-economic status and age, also took place at the axial coding phase of the analytical process. For example, data/incidents related to codes such as *'get on with it/put up with it'* and *'wife'* were searched for across the accounts given by South Asian participants. This analysis revealed that data pertaining to the *'get on with it/put up with it'* code appeared

to be absent among South Asian men's accounts, but widespread in the majority of white men's accounts. By contrast, data/incidents pertaining to the code of '*wife*' were present in both white and South Asian men's accounts.

Discriminate sampling of two further South Asian participants also occurred at this stage of the study in order to gather additional data that was required to support or refute inductive proposals. For instance, additional data was required to verify/refute the proposal that South Asian men would often 'wait and see' if their pain would go away before deciding to seek help. The proposal was supported by the data gained from the two additional interviews and was therefore developed into an advanced code (see table 7). This method of comparison, whereby incidents/data to support or refute inductive proposals were searched for in both South Asian and white men's accounts, was a process used throughout axial coding and resulted in an emerging picture of the conceptual similarities and differences between white and South Asian men.

Following the completion and analysis of the two further interviews with South Asian men, the relationship between the advanced codes and two core concepts were considered to be well established and validated. No new or relevant data appeared to be emerging on the advanced codes in the final interviews. As such, theoretical saturation was deemed to have been reached at this stage and data collection was ceased. The axial coding phase of the analytical process concluded with the conception of seventeen 'advanced codes' (concepts) which were related to two core concepts – '*the barriers to seeking help*' and '*the triggers to seeking help*'. They are presented in table 7 and table 8, below.

Table 7: Advanced Codes: The Barriers to Seeking Help – Study One

<p><u>‘Genuine’ Normalisation</u></p> <p>Refers to men <i>genuinely</i> thinking their chest pain was not serious in nature or was a normal variant such as indigestion etc.; i.e. no associated denial. Related to unawareness of symptoms/lack of knowledge because of a stereotypical view of the symptoms of CHD; often occurs in the early stages of onset of pain.</p> <p><u>Get on with it/Put up with it</u></p> <p>Men putting up with chest pain and not taking any action. Reflected in sayings such as ‘It was just a dull ache I could cope with’; ‘I got on with it; and ‘live with it’. Frequently associated with sub-codes to rationalise why they put up with the pain e.g. fear; soft; fit and healthy etc. Absent in South Asian men’s accounts.</p> <p><u>‘It’s nothing’ - ‘False’ Normalisation</u></p> <p>Refers to men ‘telling themselves’ that the pain they are experiencing is nothing serious / is normal e.g. indigestion/wind/muscle strain. Also, if pain goes away, not thinking about it any more (i.e. must have been nothing).</p> <p><u>‘Wait and See’</u></p> <p>Refers to men thinking about their pain and waiting to see what happens (before they decide to do something about it). For example, see if it goes away, see if it gets worse etc.</p> <p><u>‘Soft’</u></p> <p>Refers to men putting up with the pain because they want to be seen to be able to ‘stand pain’ and don’t want to be seen as acting ‘soft’ or like a ‘wimp’ by complaining or doing something about it. Absent in Asian men.</p> <p><u>‘Work’</u></p> <p>Refers to the men’s perceptions of how work influenced their reaction to their chest pain. (There are socioeconomic differences in the influence of work). For instance, not seeking help because of wanting to maintain a reputation as a hard worker (who is rarely off work – all socio-economic groups), not damaging promotion chances (higher SE groups) or economic reasons (lower SE groups and self-employed i.e. time off work equals no pay). Asian men appear to react to work differently – go home when experience chest pain symptoms.</p> <p><u>‘Hypochondriac’</u></p> <p>Not seeking help due to fear of being branded a complainer or hypochondriac, or seeing the doctor over something ‘trivial’; includes ‘making a fuss’.</p> <p><u>‘Acting like a man’</u></p> <p>Men noting the difference between how men and women react to illness and help seeking. For instance, not wanting to be seen to be ‘acting like a woman’.</p> <p><u>‘I’m fit and healthy’</u></p> <p>Refers to men feeling that because they have never been ill before, or have thought themselves to have always been fit / have a strong fit body that there was no need to seek help (assumption: fit people don’t get heart problems). Includes feelings of being ‘invincible’/ ‘immortal’ and examples of why; e.g. I never even get a cold; I lead an active lifestyle; play sport etc.</p> <p><u>Failure</u></p> <p>Refers to men’s feelings that chest pain/heart problems or requiring medical help means you are NOT fit/invincible and therefore they are ‘failing’; ‘not up to scratch’. Absent in Asian men,</p> <p><u>Fear</u></p> <p>Refers to fear resulting in not wanting to know what’s wrong and thus delaying/putting off seeking help (‘I don’t want to know’; ‘scared to admit it to myself’). For example, fear of death, fear of finding out ‘the worst’ (e.g. cancer/serious diagnosis).</p>

Table 8: Advanced Codes: The Triggers to Seeking Help – Study One

<p>Factors that contribute to men resulting in thinking that ‘something is not right’ leading them to seek medical. The codes are not mutually exclusive; there is often a cumulative effect that triggers the thought that ‘something is not right’ and thus help-seeking behaviour.</p> <p><u>‘Too much pain’</u></p> <p>Refers to men saying the pain was too severe to put up with or getting worse (hence they sought help). Prevalent in South Asian men.</p> <p><u>Activities of Daily Living</u></p> <p>Pain becomes so severe that it affects men’s activities of daily so they then feel they then must seek help. For example, walking only a few yards brings on pain, unable to work because of the pain etc.</p> <p><u>‘It hasn’t gone away’</u></p> <p>Refers to men feeling that if the chest pain was normal ‘it would have gone away by now’ or wouldn’t be happening so frequently. Time span varies. Prevalent in Asian men.</p> <p><u>Self treatment failure</u></p> <p>Refers to men feeling they need to seek help because their pain has not been relieved by pain killers/indigestion remedies; resting in bed/bath etc.</p> <p><u>Multiple Symptoms - ‘Sweaty and Clammy’</u></p> <p>Refers to the onset of additional symptoms (as well as chest pain) that lead men to believe that their condition was serious and therefore they needed to seek help; For example, clamminess; sweating; looking pale; radiation of pain to jaw/arms. ???Mild/Moderate chest pain alone is therefore rarely enough to trigger help seeking. Prevalent in white men.</p> <p><u>Wife</u></p> <p>Refers to the influence of men’s wives (or partners) as a trigger to seek help. For example, ‘my wife made me to go’ or ‘my wife phoned the doctor’.</p>
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Following the conception of the ‘advanced codes’, analysis progressed to a third and final phase, selective coding. Strauss and Corbin (1990) describe selective coding as being concerned with the integrating and refining of the ‘categories’ (in this study, the advanced codes), selecting of the core concept and substantiation of the proposed theory and ‘storyline’.

As noted, *two* distinct core concepts had emerged from the axial coding process: *‘the barriers to seeking help’* and *‘the triggers to seeking help’*. The selective coding process was therefore adapted to focus on the substantiation of *both* these concepts as the core. This process was conducted in accordance with both Strauss and Corbin’s (1998) and Glaser’s (1992) proposals that, when more than one core concept emerges, each should be theoretically developed *in turn*; the other concept should be demoted until such a time as the researcher chooses to

switch core focus. As such, '*the barriers to seeking help*' and '*the triggers to seeking help*' were developed and refined in turn using the process of selective sampling.

Selective sampling involved systematically relating and validating the proposed relationships between the two core concepts and the seventeen advanced codes. For instance, the data pertaining to an advanced code – for example, '*genuine normalisation*' – was examined with the aim of validating (or refuting) its conceptual meaning and relationship to the core concept of '*the barriers to seeking help*'.

Peer debriefing also occurred at the selective coding stage of analysis, whereby the researcher's interpretations were discussed with two research supervisors (as outlined in Chapter 3, section 3.10 – 'Rigour'). This process involved each research supervisor examining the advanced codes (and memos) and three randomly selected transcripts that had been coded by the study researcher. The research supervisors studied the interpretation of the data with the aim of preventing premature closure by drawing attention to areas in the data that needed to be explored more fully. The process of selective coding and peer debriefing resulted in the identification of several advanced codes that appeared to be conceptually linked (associated with a common theme) and were therefore deemed to have been prematurely closed. Analysis was therefore 'taken back' to the axial coding stage to enable the advanced codes to be re-examined.

Re-examination involved selecting each advanced code in turn and engaging in further axial coding of the data associated with the concept. To illustrate, the re-examination of the data and incidents associated with '*Genuine normalisation*' and '*I'm fit and healthy*' led to a deductive proposal that these advanced codes both related to men attempting to explain their chest pain in a period of '*self diagnosis*' that was influenced by their perceptions of their health, recent events and perceived risk of getting heart disease. The proposal was verified by searching and identifying similar (implicit or explicit) incidents in the entire data set. As a

result, the advanced codes *'Genuine normalisation'* and *'I'm fit and healthy'* became subsumed under the theme *'Self Diagnosis'*. Table 9 illustrates how, by using a similar process of axial and selective coding, the seventeen advanced codes were subsumed under five distinct themes.

Table 9: Evolution of Advanced Codes to the Final Five Themes – Study One

Previous Advanced Code	(concepts linked / subsumed)	Theme
Genuine normalisation 'I'm fit and healthy'	—————→	Self Diagnosis
Get on with it/Put up with it 'Wait and See' 'Soft' 'Work' 'Hypochondriac' 'Acting like a Man' 'Failure'	—————→	Wait and See
False normalisation Fear	—————→	Fear
'Too Much Pain' Activities of Daily Living 'It hasn't gone away' Self treatment failure Multiple symptoms	—————→	Change in Symptom Perceptions
Wife	—————→	Men's Partners

During the process of peer debriefing it also became apparent that, although the relationship between the advanced codes and the core concepts *'the barriers to seeking help'* and *'the triggers to seeking help'* had been substantiated during axial coding, 'barriers' and 'triggers' were descriptive terms that did not encapsulate the common conceptual content of men's accounts. As such, analysis was 'taken back' to the axial coding stage in an attempt to redefine and identify the core concepts.

The process of redefining the core concepts involved the re-examination of several participants' transcripts. Particular attention was focussed on examining the accounts given by participants of differing ethnicity and occupational status, and participants who were considered to have delayed for a period under 12 hours and those who had delayed for an extended period of over 12 hours. [The 12 hour cut-off-point was based on established evidence recommending the administration of thrombolytic agents within 12 hours of the onset of myocardial infarction (ISIS-2 1988)]. The coded transcripts of participants such as Robin (7 hours delay) and Dave (2 hours delay) were juxtaposed against coded data from accounts such as Michael (72 hours delay) and Tom (24 hours delay) to explore, identify and label the 'common conceptual thread' of their accounts. Differences in men's experiences that may have resulted in differing delay times were also searched for.

The analysis revealed that, regardless of the time help seeking had been delayed, the core feature pervading the '*self diagnosis*', '*wait and see*' and '*fear*' themes evident in men's accounts related to the men trying to *make sense* of how they felt about their pain, what was causing it and what to do about it. Thus, the term '*making sense of chest pain*' was considered to conceptualise 'what was going on' in the data more accurately than '*barriers*', and the first core concept was modified accordingly.

Similarly, men's decision to seek medical help represented by the '*change in symptom perceptions*' and '*men's partners*' themes, previously linked to the core concept '*the triggers to seek help*', was identified as corresponding to men coming to the realisation that they *did* need help because '*something is not right*'; a phrase used by ten participants in the study. Thus, the second core concept was also modified accordingly.

The final part of the analytical process involved the writing and re-writing of drafts for the findings section. Writing enabled the theory and 'storyline' to be viewed as a whole. It was at this final stage that the relationships between the core concepts and the five themes were re-

validated against raw data. The writing-up process therefore involved selecting and re-examining interview transcripts to confirm that the concepts and themes that had been developed accurately reflected ‘what was going on’ in men’s accounts. During the final process of writing drafts, an integrative diagram (see appendix 4) was conceived to aid in the refinement of the substantive grounded theory. The diagram provides an illustration of the relationships among the major themes and core concepts that became apparent during the analytical process. The diagram depicts the five themes that emerged as the major features of men’s accounts of their help-seeking process, and illustrates that men initially ‘making sense of chest pain’ and then subsequently realising that ‘something is not right’ was the common ‘conceptual thread’ that pervaded their accounts.

4.11 Chapter Summary

This chapter has provided an in-depth account of the research methods of the first of two studies presented in this thesis. The study setting, sample, recruitment procedures and ethical considerations have been described in detail. The chapter has discussed how the study’s interview strategy was developed using a pilot study, and a reflexive account of the process of interviewing men about masculinity has been presented with reference to appropriate methodological literature. Finally, a clear exposition of the study’s analytical process has been presented, illustrating the ‘decision trail’ that culminated in the two core concepts and five themes that represents the final substantive grounded theory. Each stage of the research process has been made explicit so as to provide a clear ‘audit trail’ that enables the credibility of the study’s findings to be judged.

The next chapter (‘Study One – Findings and Discussion’) now presents the detailed ‘storyline’ and discussion of the study’s findings that were borne out of the application of the research methods described in this chapter.

Chapter 5

STUDY ONE – FINDINGS AND DISCUSSION

5.0 Introduction

This chapter presents the findings of the first of two studies in this thesis that aimed to explore the following research question:

How do masculinities influence white and South Asian men's decision to seek or delay-seeking medical help for acute chest pain?

The study objectives were to:

- Explore the process of help-seeking decision-making in men who have recently experienced acute chest pain
- Examine the influence of masculinity on the decision to seek or delay-seeking medical help in white men of differing *age* and *socio-economic status* who have recently experienced acute chest pain
- Investigate the influence of masculinity on the decision to seek or delay-seeking medical help in South Asian (Indian, Pakistani, and Bangladeshi) men who have recently experienced acute chest pain

As outlined in the preceding chapter, the analytical process concluded in the conception of a substantive grounded theory of men's help-seeking decision-making process that comprised two core concepts and five themes. Throughout the discussion of these findings in this chapter, direct quotations taken from the accounts given by the study participants are presented in indented italics in order to illustrate how the theory is grounded in the data.

The chapter begins by discussing the first core concept associated with men's help-seeking decision-making process – 'making sense of chest pain' – in section 4.1. The three key themes that were identified as being associated with the process of 'making sense of chest pain' are discussed consecutively in sections 5.2, 5.3 and 5.4, with particular attention drawn to the similarities and differences between white and South Asian men associated with each respective theme.

A summary of the ‘making sense of chest pain’ concept is then presented in section 5.5. In this section, the findings are contextualised alongside existing research and relevant literature in order to illustrate where this study fits in with, and contributes to, the current body of empirical knowledge in this area. Sections 5.7 to 5.9 then present an in-depth discussion of the ‘making sense of chest pain’ core concept in which it is proposed that the perceptions and behaviours relating to this period of men’s help-seeking decision-making process signifies white and South Asian men’s distinctly different representations of masculinity in the context of seeking help.

Section 5.10 then addresses the second core concept associated with men’s help-seeking decision-making process – ‘something is not right’. The two key themes associated with the concept are discussed in sections 5.11 and 5.12, and attention is once again drawn to the similarities and differences between white and South Asian men. Section 5.13 addresses the differences and similarities between participants who delayed seeking help for less than twelve hours with those who delayed for over twelve hours. The ‘something is not right’ concept is then summarised and contextualised alongside existing research findings in section 5.14.

The final part of the chapter presents a discussion, building on the propositions made on the basis of the ‘making sense of chest pain’ concept, that the decision to seek or delay-seeking medical help signifies white and South Asian men’s differing cultural attitudes to seeking help for pain and their distinct representations of masculinity. A summary is then presented in which the key findings of the study are discussed with reference to the original research question and study objectives. Finally, the chapter concludes with a discussion of the study limitations, and the rationale for a second study that aimed to explore the research question in greater depth.

5.1 Core Concept I: Making Sense of Chest Pain

Analysis of men's accounts of their help-seeking decision-making revealed commonalities associated with a period in which they had attempted to understand the meaning of their chest pain symptoms. It became apparent that a common 'conceptual thread' that pervaded both white and South Asian participants' accounts of this period of their experience corresponded to men's attempts to *make sense* of their chest pain symptoms. Accordingly, 'making sense of chest pain' was recognised as being the first core concept associated with men's help-seeking decision-making process.

The 'making sense of chest pain' core concept corresponds to men's engagement in an 'internal dialogue' of rumination and rationalisation in which they attempted to make sense of what was causing their pain, how they felt about it and what to do about it. Three distinct themes were identified as being associated with this complex process of decision-making: self diagnosis; wait and see; and fear.

Although 'making sense of chest pain' was recognised as being a concept that pervaded the majority of participants' accounts, a number of differences between white and South Asian men's experiences of 'making sense' also became apparent. The three themes that emerged as the distinct features of the core concept are now discussed in detail, and particular attention is drawn to the similarities and differences between white and South Asian men in relation to these themes.

5.2 Self Diagnosis - '*it's indigestion*'

When asked to recount their specific thoughts and feelings at the onset of their episode of chest pain and during the immediate period afterwards, the majority of white and South Asian men explained that they had not initially considered their symptoms to be serious. Over three quarters of the participants stated that their foremost thoughts during the early stages of their chest pain were that they were experiencing indigestion. A number of men similarly recalled

that they had initially attributed their pain to a muscle strain, wind, or a comparable non-serious complaint; often relating this self diagnosis to a recent, new, or unusual experience in a period of rationalisation. For instance, several men recalled that they had ‘told themselves’ that they must have eaten something they did not normally eat, had eaten too quickly, or had physically over-worked. Self treatment with pain killers or indigestion remedies featured commonly in men’s accounts of this time in their experience. Furthermore, both white and South Asian men’s accounts of self diagnosis were described as having been undisclosed: men’s thoughts about their pain were seldom shared with other people such as partners, friends or work colleagues.

For two white participants (Michael and Ian), age was an additional factor that contributed to their rationalisation that their chest pain was not serious. For example, Michael indicated that his ‘internal dialogue’ had primarily been associated with thinking that ‘*I’m just getting older*’. However, younger white men and men of South Asian ethnicity did not allude to their age as being a significant factor in their help-seeking decision-making. Indeed, the data indicated that participants’ age was not a significant factor affecting the overall help-seeking decision-making process – men of all ages, from 30 through to 79 years, gave similar accounts of how they had made sense of their pain.

Researcher: So you’d been getting pains for quite a while then now?

Participant: Yeah, but not thinking of it, you know, don’t...eh...I thought it was just I’m getting older, getting all these aches and pains, you now, but eh, apparently it’s been a bit more than I thought.

(Michael; white male aged 76 years old; delayed 72 hours)

You know...as I get a bit older, you do get aches and pains that you don’t use to get and you put that down to “it’s just me age” don’t you? So you carry on a little bit.

(Ian; white male aged 73 years; delayed 1 hour)

Analysis of the eight accounts given by South Asian men revealed that, at the onset of their chest pain, they had engaged in a similar initial decision-making process to the majority of white participants. All eight South Asian participants described how they had initially gone through a process of self diagnosis in an attempt to make sense of their chest pain. Akin to the

process identified among the white participants, the data indicated that the majority of South Asian men had initially attributed their chest pain to indigestion or a similar non-serious complaint.

The accounts given by Mahesh and Robin, quoted below, illustrate the similarities between men of white and South Asian ethnicity relating to the self diagnosis theme. Mahesh, a 39 year old man of Indian origin, described how he initially thought his pain was heartburn as he had eaten some fried Pakoras on an empty stomach. He recalled that he had tried to '*sleep it off*' which led to his initial delay in seeking help. Similarly, Robin, a 57 year old white male, recalled that he had taken bicarb of soda because he thought his chest pain was indigestion as he had not eaten anything before playing squash.

The data clearly indicated that self diagnosis of chest pain as a non-serious illness was the primary reason that had led to *initial* delays in help seeking for the majority of both white and South Asian participants. Over 95% of men recalled that they had not initially thought their pain signified a serious illness. Hence, seeking medical help had rarely been considered at the onset of chest pain symptoms.

Just walking home, just walking home from work! Pain in me right arm and me left arm, like you know a trapped nerve? Took a Gaviscon and that when I got home, paracetamol, and went to bed.

(Robert; white male aged 35 years; delayed 12 hours)

I had a hot chocolate before I went to play squash and a drink of pop on the way back, but... I hadn't eaten so I thought it may be indigestion, so I had some bicarb of soda.

(Robin; white male aged 57 years; delayed 7 hours)

Participant: I'd just finished work, I started getting a real bad burning sensation in my chest. I tried to sleep it off, but it wouldn't go away, it kept coming and going, coming and going, so I told my wife about it that I might have to call an ambulance and go to hospital, or catch a taxi and go down.

Researcher: Right, so when you first got it then, you tried to sleep it off did you?

Participant: Yes I just thought it was, what do you call it, heartburn. Because my wife made some of these Indian fried Pakoras, they're called, and I had eaten them on an empty stomach with a cup of tea and I thought that's what triggered it off.

(Mahesh; 39 year old Indian man; Delayed 8 hours)

‘Heart attacks like things you’ve seen on television’

A concept that emerged as being commonly associated with the self diagnosis theme was men’s knowledge of heart disease and the symptoms of an acute cardiac event. Several white participants recounted a ‘text book’ perception of a heart attack; a view that appeared to have been constructed by how the men had seen the condition portrayed in the media. These men’s accounts indicated that they had perceived heart problems to be an abrupt, dramatic and incapacitating event associated with extreme pain in the left arm and centre of the chest, or similarly, preceded with a reduced exercise tolerance. As a result, the men had not initially associated their own experience with an acute cardiac event because their symptoms (such as heaviness or tightness in the chest) did not match their perceptions of this condition. The responses from George and Alan, quoted below, illustrate this theme.

You know, you always think of erm, heart attacks like things you’ve seen on television a bit like childbirth...Branches between the teeth, buckets of water and towels and things like that. With heart attacks it’s always someone clutching their left arm really severe. I did not have that.

(George; 57 year old white male; delayed 12 hours)

I wouldn’t say it [chest pain] was that bad you know, you see and hear of people with heart attacks and they can be in excruciating, you know really bad pain, but this wasn’t that bad.

(Alan; 53 year old white male; delayed over one week)

Similarly, few South Asian men recalled that they had initially attributed their chest pain to the heart. However, differences between white and South Asian men in relation to their knowledge of heart disease symptoms were apparent. The majority of South Asian participants did not recall ‘text book’ perceptions of heart disease borne out of media representations of the condition. Rather, the South Asian men’s accounts of self diagnosis revealed a stark ignorance of heart disease and its symptoms. For example, Faarooq delayed for 12 hours before finally realising his pain was not going away and sought help for it. He recalled his surprise on admission to hospital that the doctors were investigating his heart. Similarly, a 54 year old participant of Indian origin (Danvir) was candid about his ignorance of heart disease prior to his admission to hospital, explaining *‘I thought angina was your balls’*.

I mean I never read about it but when I came here [hospital] there is so many things it does tell you. Some of the books, though your doctors, the books, the pamphlets are not there.... I mean I never knew what angina is, to me I thought angina was your balls...But by reading this you learn so much and these books are not out [there].
(Danvir; 54 year old Indian man; delayed 12 hours)

Researcher: Did it not cross your mind that it [your symptoms] might be serious at all?

Participant: No, because I've never had any problems before. And it was the first time, when I came to the hospital, the doctor told me that they'd check me for a, you know this, the heart, there might be a problem, and I was a bit surprised to hear that.
(Faarooq; 64 year old Pakistani man; delayed 12 hours)

In contrast to the majority of participants, seven white men recalled that they *had* experienced an immediate onset of 'text book' cardiac symptoms involving severe central chest pain. Despite these men's accounts of more severe 'text book' chest pain, they illustrated that self diagnosis of a non-serious illness – such as indigestion – was still a common initial response to their symptoms. For example, Craig recalled that he had experienced central chest pain radiating to his left arm, but nevertheless initially self diagnosed indigestion.

For both white and South Asian men, it became apparent that it was only when their pain became persistent, severe, or they began to experience additional symptoms, that the majority began to attribute their symptoms to their heart and realise that 'something is not right' (see Core Concept II: 'Something is not Right', later in this chapter).

I woke up about half past two-ish in the morning. Had a pain and, centre, centre left if you like. Erm, like an intermittent pain in my left arm. Thought it was indigestion originally. So I went downstairs, took a couple of indigestion tablets and toddled off back to bed.
(Craig; White Male aged 37 years; delayed seeking help for 10 hours)

'If you're a fit bloke, I'm a good grafter, I work hard'

A prominent feature of the self diagnosis theme emerged as being men's appraisal and perceptions of their health and physical condition. A pattern clearly apparent in both white and South Asian participants' accounts related to the frequency with which the men had recounted that, during their process of making sense, they had appraised their health status and considered themselves to be *'fit and well'* or *'physically fit'* prior to their event.

For white men of all socio-economic groups, working hard or having a physically active job (for example, a manual trade) were frequently cited as the reason why they perceived themselves to be *'fit'* and healthy. It was clear in the data that this belief had affirmed men's self diagnosis of indigestion and, accordingly, the decision that they did not require medical help. Paul is a case in point. When asked why he initially attributed his symptoms to indigestion, he was unequivocal in the self-appraisal of his health status because he was a *'good grafter'*.

Well, I had never had heart trouble. You know what I mean? I mean, if you're a fit bloke, I'm a good grafter, I work hard, you know, and my hobby, I am a joiner, and when I do these things, you never think of anything like that when you are fit. Because you get something in your mind, oh, you know...That's it. Once you're active that's it, you think it isn't gonna happen to me.
(Paul; 69 year old white male; delayed 72 hours)

A comparable theme was also apparent in several of the accounts given by South Asian participants. Four South Asian men described that, at some stage in their process of making sense, they had considered themselves to be healthy because they were physically fit. Akin to the perceptions of many white men, it was clear in the accounts provided that their perceptions of themselves as *'fit and well'* had also led them to consider that their self diagnosis (of a non-serious illness) was accurate.

However, in contrast to the majority of white men, it was also apparent that South Asian men were more likely to allude to their *general* physical fitness – no South Asian participant referred to their health or fitness in relation to having a physically demanding job or working

hard. Danvir, a 54 year old man of Indian origin, illustrated this theme when recalling why he had not attributed his pain to his heart. His account also illustrates his lack of awareness of heart disease and its symptoms that was pervasive in the accounts provided by South Asian men.

Because if you are physically fit you don't know. You don't think, how can you think, it's just a real thing in life experiences, it happens. Probably if I would have read something like this what it does, probably you get the idea that all is doing this by doing this, or let me get it checked out. It's a knowledge in daily life, people don't have knowledge.

(Danvir; 54 year old Indian man; delayed 12 hours)

The accounts given by three white men also emerged as not fitting the pattern identified in the majority of participants accounts in which men initially attributed their chest pain symptoms to indigestion or a similar non-serious complaint. In contrast, these three participants, identified as 'deviant cases', had indicated that they had *immediately* suspected their chest pain to be heart related and had sought medical help promptly as a result.

Analysis of the accounts given by these participants revealed that they did not appear to have experienced significantly different symptoms to the majority of participants in the study; for example, more severe, or 'text book', chest pain. Rather, it became evident that the three men possessed knowledge or experience of heart disease or heart related health originating from a family history of heart disease, health-related training (for example, a first aid course), or work experience within a health related field (for example, working in a hospital). For instance, in addition to having a long established family history of heart disease, one participant identified as a 'deviant case' (Lee) had been trained in first aid and was therefore aware of the symptoms of myocardial infarction. He experienced the onset of chest pain at work and recalled that he immediately associated his symptoms with a heart problem. Accordingly, he went straight to the casualty department of a local hospital. Comparable accounts of prompt attribution of chest pain to the heart were given by a hospital porter and a participant whose father had recently died of a heart attack.

One participant's account also indicated that an awareness of the symptoms relating to heart disease acquired *during* his experience had prompted him to seek medical help. Escalating pain and growing doubt over his self diagnosis prompted Donald to discuss his symptoms with his son-in-law who had medical knowledge. Prior to this discussion he had delayed seeking medical help for almost three days, believing for much of this time that his pain was indigestion. Knowledge of the symptoms of angina gained from the discussion with his relative led him to attribute his symptoms to the heart and to decide that he required immediate medical attention.

Researcher: So what made you think that it wasn't right then? What was it in your mind?

Participant: Well, I have done several courses, first aid courses, whilst in the army, and erm... things just clicked and fell into place, and I knew there was something, something that shouldn't be there, do you know what I mean?

Researcher: So what did you think it was? Did you have any idea?

*Participant: Ticker. I thought straight away, ticker.
(Lee; white male aged 57 years; delayed less than 1 hour)*

*It was eh like a crushing pain across eh...went down both arms. I had em...I'd done first aid at work so I had an idea of what were happening and I got wife up and she just phoned for ambulance
(Gordon; white male aged 66 years; delayed less than 1 hour)*

*He [son-in-law] told me about what it could've been [angina]. I told him what I felt like; he said "you go and see your doctor" and I did do... In my head it came together, he's telling me this and I'd better go and see him [the doctor], do you know what I mean?
(Donald; white male aged 56 years; delayed 72 hours)*

5.3 Wait and See – 'I should feel there's something really wrong'

As discussed, men's self diagnosis and rationalising about the cause of their chest pain was not a one off event that occurred at the onset of their symptoms. Rather, the data indicated it was an ongoing process of rumination and rationalisation throughout men's experience of chest pain. A common theme associated with this ongoing process of rumination emerged as being a decision to 'wait and see' how pain developed before coming to a final self diagnosis. The majority of participants in the study indicated that they had, at some point in their experience, taken a decision to 'wait and see' if their pain would go away/respond to pain

killers/get worse tomorrow/after work/after the weekend, before determining *for certain* that it was not serious. It was evident in the accounts provided that, for both white and South Asian men, the period of 'waiting to see' had been the primary cause of their help-seeking delay. However, distinct differences between white and South Asian men relating to the rationale underpinning this behaviour were also evident.

It was apparent that the majority of white men in the study had feared being seen to be acting 'soft' by others – having a low threshold for pain/being unable to cope with pain – should they seek medical help and learn that their symptoms were *not* serious. As such, it was evident in the data that the men's rationale for 'waiting to see' had been to determine, *without doubt*, the cause and severity of their chest pain symptoms. Accordingly, the majority of white men had 'put up' with their chest pain and 'waited to see' in order clearly determine in their mind whether or not their chest pain was sufficiently serious to warrant medical attention.

Over three quarters of the white participants had experienced the onset of their chest pain at work. In these men's accounts, the fear of being seen to be acting 'soft' was clearly evident. Four white men were explicit about the reason they had 'put up' with their pain at work: 'waiting to see' because of a fear of being seen to be 'soft' by work colleagues, or getting a reputation of being a '*hypochondriac*' or '*swinging the lead*' at work. Four other white participants made derogatory comments about colleagues they considered to have taken sick leave for illnesses they deemed to be insufficient to warrant medical attention. One participant, Eric, also made a derogatory comment about a patient in the adjacent hospital bed that he perceived to be acting '*soft*'.

As such, the data clearly indicated that seeking medical help, or taking time off work, unless you were *seriously* ill was behaviour perceived by the majority of white men as synonymous with having a low threshold for pain or acting '*soft*'. Until they had been certain that their

pain represented a serious illness, the majority had therefore considered their symptoms to be *just pain* and ‘put up’ with it. Eric’s account, quoted below, starkly illustrates this theme. He noted that he ‘*should feel there’s something really wrong*’ before he seeks medical help.

It’s just that culture that you’ve been brought up in. Like with everyone in the pub “Ah you soft git”, you know what I mean, going to the doctors.
(Henry; white male aged 48 years; delayed 1 hour)

Researcher: Why did you not go to the doctors then?

Participant: I think it’s a bit macho, you know, I can take this business and, you know, ‘I can stand pain’.
(Richard; white male aged 77 years; delayed 1 hour)

Researcher: Why did you not get some help, like, you know, going to the doctor?

Participant: You don’t want to be seen as a woman, do you?
(George; white male aged 57 years; delayed 12 hours)

Researcher: So, why did you delay getting help?

Participant: Shrug ‘em off [pains]...I don’t know. I think there are some that go to the doctor for every toothache and all sorts.

Researcher: Yeah? What do you think to that?

Participant: Load of tossers, got one next door [in adjacent hospital bed]...It depends on what’s wrong with you. You know, how serious it is. Some people go for trifling things, I should really feel there’s something really wrong.
(Eric; white male aged 68 years; delayed for 168 hours)

‘Waiting to see’ was also a pattern of behaviour that was apparent in the accounts provided by the majority of South Asian men. However, although it was evident that this aspect of South Asian men’s experience was the main reason given for the cause of their delay in seeking help, the rationale for this behaviour emerged as being distinctly different to that identified in the accounts given by white men.

In the majority of cases, the South Asian men appeared to have ‘waited to see’ for markedly shorter periods of time in comparison to the white men. The South Asian men’s accounts revealed that most had ‘waited to see’ for a number of hours, and some men only a matter of minutes, before they had decided to seek medical help. No South Asian participant had delayed seeking medical help for more than forty-eight hours. By contrast, eleven white

participants had 'put up' with their chest pain for forty-eight hours or more whilst they were 'waiting to see'.

Analysis of South Asian men's accounts of 'waiting to see' revealed that an absence of the perceived need to 'put up' with pain appeared to have resulted in their shorter delay times. 'Putting up' with pain was behaviour unique to white participants in the study. Moreover, no South Asian participant had recalled any concern of being perceived to be acting 'soft' or like a hypochondriac because they sought help for their chest pain.

In contrast to the majority of white men, the data suggested that South Asian men's rationale for 'waiting to see' was to ascertain whether or not their pain would go away by itself, not behaviour associated with the fear of being seen to be acting 'soft' or the need to be seen by others as able to endure pain. When pain had been deemed as being persistent, the South Asian participants had seldom delayed seeking help for a prolonged period of time. In illustration, when explaining why he eventually decided to visit his doctor, Faisal recalled that he had 'waited to see' if pain killers would relieve his pain. However, when he realised the pain was not going away, he had decided to wait no longer. Notably, contrary to the pattern identified in white men's accounts, he did not indicate that he had 'put up' with his chest pain or had had any concern of being perceived to be acting 'soft' by others.

Participant: So it was like a central sort of tightness, so that was beginning to worry me a little bit, but thinking it might just be heart burn, because it did come on after I'd eaten in the evening. I took some antacids to try and relieve it, it didn't seem to work. The only painkillers I had were just paracetamol at home, so I did take some of those during the afternoon and in the evening, hoping that might relieve this, but they didn't.

Researcher: So why did you go to your doctor then?

*Participant: All of those things, and nothing getting any better
(Faisal; 38 year old Bangladeshi man; delayed 24 hours)*

Participant: Well suddenly I had a pain, little bit of pain. The pain going slowly, slowly and then up and up. Then call the doctor. Doctor came down to see, he said you, maybe you get a heart attack or heart something. So he sent me to hospital.

Researcher: How long did you wait before you called the doctor?

Participant: Couple of hours....Pain coming slowly, then going bigger and bigger and bigger.

Researcher: What made you call the doctor then, what was it?

*Participant: Call the doctor. Never happened before, the pain... Too much worry.
(Gurdeep; 71 year old Indian male; Delayed 2 hours)*

As discussed, the fear of being perceived to be acting 'soft' by others was apparent in the accounts given by white men of all ages and socio-economic groups. However, subtle differences between white men of differing socio-economic status pertaining to their period of 'waiting to see' were also apparent.

Several men from lower socio-economic groups (those with a manual or unskilled occupation) and those who were self employed recalled their concerns about the financial implications of taking time off work. In addition to not wanting to appear 'soft', it was apparent that these men had also decided to 'wait and see' because seeking medical help would have required taking time off work and losing money. The men had 'put up' with their pain and continued to work due to financial pressure. For example, one participant with a manual occupation (Max) recalled that he had thought his pain was probably indigestion but, despite an escalation in its severity, he had gone to work because he needed to make money 'to live'.

Participant: But er... Sunday night, when I got up to go to work, I was in that much bleeding pain... and they just....

Researcher: But you went to work anyway?

Participant: Oh yeah, yeah, yeah.

Researcher: Was work important to you?

Participant: Well yeah, yeah, you know what I mean, cos, you can't in my business, well, where I work, you can't afford to stay away more than two days.

Researcher: Why's that?

*Participant: Because the wages are that low, you need the money to live, you know what I mean? And erm, when I got there, it happened. Straight away [collapse]. Got onto the ambulance, and they brought me here.
(Max; 54 year old white male; Food Market Porter)*

If you're desperate for money at home and you've got family to look after, the roof over your head comes first.

(Steve; 60 year old white male; retired joiner)

I'm self employed, you know, I can't afford to take time off work... If I don't work, I don't get paid. I don't pay the bills

(Gareth; 54 year old white male; Orthotist)

Attending work, or continuing to work, despite having chest pain was also behaviour identified in the accounts given by men from higher socio-economic groups. However, in contrast to the financial pressure cited by men from lower socio-economic groups, it emerged that a number of men from higher socio-economic groups (professional occupations) had been reluctant to seek help and take time off work because they considered it would damage their work-place reputation of being reliable and dedicated. One participant was unequivocal in his view that taking sick leave jeopardises promotion opportunities. The following excerpts are reflective of this theme.

...it's the, you know, eh, first in last out syndrome. You know my office would be the last light in the building to be turned off... You're trying to impress people. You're trying to em... you're trying to impress your bosses that you're worthy the promotion you're after. That sort of thing. That's what it's all about... A lot of senior management, even today, would turn round and say "well, there's two people up for this particular job, there's X who's got heart trouble or there's Y who never has a day off sick", who would you give it to?

(George; 57 year old white male; Senior IT Manager)

Because I have got a thing, like I won't have days off, I have got... you know, I know somebody's relying on me for, then I will go to work, and work, instead of having the day off.

(Tom; 37 year old white male; Teacher)

Once more, South Asian men's perceptions of work, and their perceptions of their work colleagues, emerged as being distinctly different to those recalled by white participants. Four of the eight South Asian participants were either retired or unemployed (see Table 5: Demographic Characteristics of Sample – Study One; page 113). However, of the four South Asian men who were in employment, only one (Danvir) referred to work as being an issue associated with his experience of chest pain. Consistent with the theme identified among the majority of South Asian men's accounts of 'waiting to see', he expressed no perceived need to continue to work despite his pain and, furthermore, expressed no concerns that he would be

perceived as acting 'soft' or like a hypochondriac by his colleagues if he took sick leave. Accordingly, he recalled that at the onset of his symptoms he immediately decided to go home.

*I do nightshift and I was at work. I got this funny feeling which I had not experienced...Half 12 I get my break but somehow I couldn't get to half 12, by 12 o'clock I decided to go home. Obviously they didn't say we'd take you home and I didn't know how, what actually, it was new thing to me, so I went to get car keys out from there and got in my car and I sat for a while and I was funny a little bit again. I thought I am I going to go home
(Danvir; 54 year old Indian man; Supermarket Worker)*

Interestingly, it was clear in the accounts provided by the three participants identified as 'deviant cases' (white men who had a prior knowledge/experience of heart disease) that, like the majority of white participants, they also feared being seen to have a low threshold for pain by others should they seek medical help for symptoms that were *not* serious. For example, Lee recalled that he would usually self diagnose illness rather than visit the doctor, and was critical of a work colleague he perceived to be 'swinging the lead' for an 'illegitimate' illness.

However, in contrast to the majority of white participants, it was evident in the accounts provided by the three 'deviant cases' that their knowledge of the symptoms of myocardial infarction had resulted in the men not perceiving a need to 'wait and see'. The men had been confident about the cause – and legitimacy – of their chest pain symptoms. For instance, Gordon was explicit in his account that the reason he had sought help promptly for his chest pain was not because he could not tolerate the pain, but rather, because he *knew* his condition was serious.

Participant: Yeah, because... there is some people who swing the lead, right...A lad at work. At the moment he's been off two weeks, and all he said was he was, dermatology, dermatitis or something like that... two weeks. Two weeks! Is that swinging the lead or what? In my eyes that's swinging the lead.

Researcher: What about you?

Participant: Nah...I can diagnose myself. If I think I can do. I'd rather do that than go to the doctor.

Researcher: And....

Participant: And just leave it. But this, I knew there was something there, so that was why I came straight up [to the hospital].

(Lee; white male aged 57 years; delayed less than 1 hour)

Participant: Well, oh I can stand pain, you know, but I mean em...I wouldn't have called it prickling, you know, it didn't throw me to the floor or owt like that. It was just a pain what I could've walked with. If they had said walk to the ambulance, I could have done it, but it were there and it were tight.

Researcher: So what was it that made you call the ambulance then?

Participant: Well I thought I were having an heart attack!

Researcher: And why did you think that?

Participant: Well, 'cause I'd seen it happen before in...I used to go to social services when I was eh...driving for them and taking them to day centres and I've seen two or three people go with them like you know, so...

(Gordon; white male aged 66 years; delayed less than 1 hour)

5.4 Fear – ‘If I go to the doctor, I'll find out the worst’

Fear emerged as being an additional theme that was a distinct feature of the ‘making sense of chest pain’ process for several men in the study. Nine participants of both white and South Asian ethnicity recalled explicit feelings of fear during their experience; fear that commonly appeared to stem from the potential seriousness their symptoms may have represented. For instance, three men talked about not wanting to be told ‘the worst’. ‘The worst’ referred to having a disease such as cancer or a heart attack that was perceived as being fatal.

Fear was a prominent theme in the accounts of two white participants (Gary and Geoff) in particular. For these men, in addition to not wanting to appear to be ‘soft’ or like a ‘hypochondriac’, waiting to see had served a further purpose – seeking help would have signified an acceptance that their pain was potentially serious, confirming their ‘worst’ fears. In order to cope with this fear, the two men recalled that they had endeavoured to put it out of their mind; denying the potential severity of their symptoms and ‘telling themselves’ their pain was a normal and non-serious pain that did not require treatment. For example, Geoff

recalled having tried to '*blank it out*'. Similarly, Gary cited his major reason for not seeking help was the fear of being told he had lung cancer.

By contrast, the fear of 'the worst' had a paradoxical effect for one South Asian participant. Ahmed recalled that on realising that his chest pain was persistent, he immediately became fearful that he might die. In contrast to the participants who coped with their fear by putting it out of their mind; Ahmed addressed his fear by seeking medical help without delay.

I think its sort of an in-built thing in your, in your head that you think, "oh, if I go to the doctor, I'll find out the worst".

(Gary; white male aged 73 years; delayed 168 hours)

You know, if it goes away you think, "aah, just a bit of indigestion", but you know, I think you're scared to know. You don't want to know the worst. I think you don't want to know. You really don't. So you think well, "nah, can't have been", you know, so just try and blank it out I think.

(Geoff; white male aged 43 years; delayed 8 hours)

I thought it was something serious, like you know, am I gonna die or something like that...I felt really scared, you know. So, they brought me here, gave me some injections, she said, oh you've had a heart attack, and that really shocked me.

(Ahmed; 30 year old Pakistani Man; delayed less than 1 hour)

5.5 Summary: Making Sense of Chest Pain

This section presents a summary of the study findings relating to the ‘making sense of chest pain’ core concept. The summary is presented alongside existing literature to illustrate where this study fits in with, and contributes to, the current empirical evidence. The following section (5.6) presents a discussion of these findings with reference to the masculinity theoretical literature. The study findings relating to the second core concept, ‘something is not right’, are then addressed.

Men’s Self Diagnosis

Several aspects of the ‘making sense of chest pain’ core concept identified in this study have been recognised in a number of previous help-seeking studies. There is a substantial body of empirical evidence to support the ‘self diagnosis’ theme, corresponding to participants attributing their chest pain to non-cardiac causes, such as indigestion, that suggests that it is not a *gender-specific* feature of help-seeking decision-making. Cowie (1976), Dempsey et al (1995), Gardner and Chapple (1998), Horne et al (2000), Tod et al (2001) and Clark (2001) have all found that patients with acute cardiac conditions (male and female) initially attributed their symptoms to causes such as old age, tiredness, or heartburn rather than coronary heart disease.

Dracup and Moser (1997) and Pattenden et al (2002) have similarly found that patients with acute cardiac conditions have problems recognising the severity of their symptoms and attempt to ‘normalise’ their chest pain, self medicate, and/or rest in order to overcome their early discomfort. Ruston et al (1998) also found that a crucial factor influencing time between onset of symptoms and the calling for professional help related to whether patients recognised their symptoms as cardiac in origin. Participants in Ruston et al’s (1998) study engaged in a similar period of self diagnosis to that identified among men in the study presented in this thesis; often self treating and interpreting their pain as ‘common and non-threatening’.

The self diagnosis theme identified in this study is also consistent with the findings of White's (2000) investigation of men who had been admitted to a coronary care unit with chest pain. White (2000) similarly found that men frequently put their chest pain down to an explainable occurrence such as stress, indigestion, or getting old:

'The symptoms men experienced... had to be made sense of and acted upon. The nature of the pain, discomfort, or unusual sensations such as heavy arms was a source of great concern to the men. However, some were seen to have great difficulty in associating these feelings with problems of cardiac origin. The majority of the men had a delay in help seeking whilst they decided what action, if any, to take' (White 2000; p167).

However, as discussed in Chapter 2 ('Literature Review'), previous studies have largely overlooked whether there are differences or similarities between men of differing ethnicity in relation to their help-seeking decision-making process for chest pain. The findings of the study presented in this thesis further existing knowledge having identified a comparable process of self diagnosis in a sample of both white and South Asian men. It was clear in the data that both white and South Asian men's *initial* help-seeking delays in this study were a result of their attributing their chest pain symptoms to indigestion or a similar non-serious complaint.

Men's Perceptions of their Health

A theme that contributed to the self diagnosis process emerged as being men's perception of themselves as healthy because they felt physically 'fit' prior to their event. This finding mirrors White's (2000) finding that men's perceptions of themselves as being at low risk of getting heart disease contributes to delays in associating their symptoms with the heart. The finding also has commonalities with previous research on lay perceptions about CHD that have identified beliefs about coronary 'candidates' as being, fat, inactive, overweight and having a fatty diet (Davison et al 1991; Clark 2001).

The South Asian participants' perceptions of being 'physically fit' and healthy are also consistent with the findings of Howlett et al (1992) and Webster et al (2002), who have

previously identified that the concept of health is often defined by South Asian patients as an ability to 'do things'. Likewise, many South Asian men in this study had considered themselves to be healthy because they were 'active'; a belief that had affirmed their initial (inaccurate) self diagnosis of indigestion.

However, in contrast to previous findings, men from *all* socio-economic groups in this study recalled a perception of being fit and healthy that appeared to have contributed to their self diagnosis. This is contrary to the findings of Richards et al (2002), who reported that men and women from a deprived area in Glasgow, UK, had a greater perceived vulnerability to heart disease, and a greater identification with high risk groups and stereotypes of cardiac patients, in comparison to those from an affluent area.

In the study presented in this thesis, it was also evident that both white and South Asian men's perceptions and awareness of heart disease symptoms was a significant factor that contributed to their self diagnosis/attribution of their chest pain. The symptoms many white participants experienced were not like the 'text book' abrupt, excruciating symptoms they perceived as a heart attack: a perception that appeared to be borne out of media representations of the condition. This theme has also been well documented in the literature and would appear to further suggest that the 'self diagnosis' theme is not gender-specific *per se*.

For example, Oliveria et al (1999) have found that men and women with malignant melanoma had often delayed seeking help because they were not aware of the changes in their skin or because they were not knowledgeable about the signs and symptoms of melanoma. Previous studies on (predominantly white) men and women with heart disease (Johnson and Morse 1990; Ruston et al 1998; Wiles 1998; Horne et al 2000; White 2000; Pattenden et al 2002; Zuzelo 2002) and those in the general population (Emslie et al 2001) have similarly found that patients had an image of a 'typical' heart attack involving dramatic, crushing pain and sudden collapse. The phenomenon has been recognised and labelled as a 'Hollywood Heart

Attack' in a US based focus group study on help-seeking delay for heart attack symptoms (Finnegan et al 2000).

However, in contrast to these findings, the accounts given by the majority of South Asian participants in this study pointed toward a more stark lack of knowledge of coronary heart disease and its symptoms. This finding would appear to bear out the patterns identified in a quantitative study by Rankin and Bhopal (2001), which reported that among 334 men and women of South Asian origin living in the UK, 34% of men did not know what was meant by the term 'heart disease', and 19% reported they still did not know the meaning of heart disease even after being read a British Heart Foundation definition of CHD.

A small number of qualitative studies have also suggested that South Asian men and women perceive stress to be an important cause of heart disease (Farooqi et al 2000) and that South Asians may have misconceptions about heart disease that have been obtained from a variety of sources, such as television and magazines (Beishon and Nazroo 1997). Contrary to these findings, stress was not referred to by any South Asian participant in this study as a factor they considered to have influenced their experience of chest pain or heart problems, and no participant alluded to perceptions of heart disease obtained from television or magazines.

Barakat et al (2003) have previously found that, in a quantitative study of white and South Asian patients who suffered acute myocardial infarction (AMI), similar proportions of patients from the two ethnic groups interpreted their symptoms as being suggestive of AMI. Overall, the 'self diagnosis' theme identified in the study presented in this thesis suggests that, paradoxically, both white and South Asian men (of Pakistani, Indian and Bangladeshi origin) are equally likely to initially interpret their chest pain symptoms as being suggestive of *indigestion* (or similar).

These findings would appear to suggest opportunities for health promotion initiatives and educational interventions that aim to raise the awareness of CHD and its symptoms among both white and South Asian communities. However, several U.S. based studies have reported that increasing knowledge does not necessarily have the effect of changing behaviour and prompting help seeking (Ho et al 1989; Meischke et al 1997; Luepker et al 2000). In one UK based study, six men with knowledge of testicular cancer were noted to be no more likely to seek help earlier than men who did not have knowledge of the condition (Sanden et al 2000). The accounts of three participants identified as 'deviant cases' in the study presented in this thesis contrast with these findings. It was clear in the accounts provided by the deviant cases that their knowledge of heart disease and its symptoms, gained from a family history of heart disease or medical training/experience, had led them to promptly attribute their symptoms as being heart related. This, in turn, had led the men to seek medical help considerably quicker than the other participants in the study. (The implications of the study's findings on healthcare practice and policy are discussed in detail in Chapter 8 – 'Summary and Discussion').

Waiting to See

A theme that was central to the 'making sense of chest pain' core concept related to men making a decision to 'wait and see'. In the accounts provided by both white and South Asian men, the rationale for 'waiting to see' appeared to be to confirm whether or not symptoms were going away, were serious and, therefore, whether or not they warranted medical attention. It was clear in the data that 'waiting to see' was the foremost cause of men's help-seeking delay. Sanden et al (2000) have identified a similar trend among white men who had discovered a testicular lump. They noted,

'The delay between discovery (of a testicular lump) and treatment can be attributed mainly to the men's "wait-and-see" attitude...Physical problems were initially seen as something that would cure themselves' (Sanden et al 2000; p.306)

McKinley et al (2004) also reported that among 595 MI patients from the US, UK and East Asia, 'waiting to see if symptoms would go away' was predictive of longer time to presentation (to hospital) in the entire sample. However, in this study, the rationale for the

majority of white men's 'waiting to see' behaviour emerged as being more complex than merely 'waiting to see if it would cure itself', as reported by Sanden et al (2000) and McKinley et al (2004).

The majority of white participants indicated that they had 'put up' with their pain to avoid being seen to be acting 'soft', having a low threshold for pain, or being seen to be acting like a hypochondriac by others. This finding is consistent with research on men with prostate cancer (Chapple and Ziebland 2002); testicular cancer (Chapple et al 2004); and chest pain (White 2000). For example, Chapple and Ziebland (2002) noted in their study of men with prostate cancer,

'During the interviews some men suggested that it was not 'macho' to seek help for health problems. Other explanations... included the notion that 'boys don't cry' and the belief that it was not masculine to admit to weakness' (Chapple and Ziebland 2002; p.826)

Studies on men with symptoms of testicular cancer (Tudiver and Talbot 1999; Gascoigne and Whitear 1999; Sanden et al 2000) emotional problems and depression (Blazina and Watkins 1996; Davies et al 2000; Möller-Leimküler 2002) have also found that men were reluctant to discuss these health concerns with others due to feelings of embarrassment. However, there was no evidence in this study to support suggestions that men delay seeking help for their chest pain because of a fear of 'bothering' the doctor or calling the emergency services unnecessarily because of a false alarm (Pattenden et al 2002).

The 'wait and see' theme identified among white participants in this study also adds support to the findings of White's (2000) study. White (2000) found that, although men began to have 'niggles and doubts' about their chest pain symptoms, they appeared to want to retain control for as long as possible to see if their symptoms would go away, often denying the potential severity of their symptoms as a 'psychological defence'. A number of men in White's (2000) study were also reluctant to discuss their problems with others because of a fear that they would appear to be a 'wimp' or 'unmanly'.

However, the findings of this study draw attention to distinct differences between white and South Asian men in relation to the 'wait and see' theme. No South Asian participant indicated that they had felt the need to 'put up' with their pain. Furthermore, there was an absence of responses associated with being perceived to be acting 'soft' or like a hypochondriac in the accounts given by all the South Asian participants. Contrary to the findings of previous studies on men's help-seeking behaviour, the data in this study indicated that the primary reason South Asian men had 'waited to see' was merely to ascertain whether their pain would go away by itself. The data did not suggest that South Asian men feared being seen to be acting 'soft' or unmanly.

It was also evident that, because they had not 'put up' with their pain, the South Asian participants had 'waited to see' for considerably shorter periods in comparison to the majority of white participants. Thus, although it was apparent that white and South Asian participants were both as likely to initially attribute their pain to *indigestion*, the data indicated that South Asian men may have been less inclined than white men to 'wait and see' for long periods whilst experiencing their pain. This finding would appear to support previous quantitative studies that have reported South Asians are as likely to seek help for chest pain (Smaje and Le Grand 1997; Kelaher et al 2003) or *more* likely to seek help for chest pain symptoms (Chatuverdi et al 1997) in comparison to the white/European population.

Experiencing Pain Whilst at Work

The fear of being seen to be acting 'soft' was particularly evident in the accounts of white men who had experienced their pain whilst at work. These men expressed fears that seeking help for their chest pain, or taking time off work because of their symptoms, would be perceived by their work colleagues as acting like a hypochondriac or acting 'soft'. Johnson and Morse (1990) have also found that patients who were absent from work because they had suffered a heart problem were fearful that others would regard them as physically weak, impotent, or incapable. Moynihan (1998) has similarly reported that men who had suffered

testicular cancer became anxious when the subject of work was raised and they hid the fact they were ill from their work colleagues.

Bellaby (1990) studied sickness and absence in a pottery factory and noted that it was unusual for older men to 'give in to sickness' and take time off work. Bellaby (1990) suggested older manual workers with family responsibilities had a particular need to demonstrate their continual capacity for manual labour and saw others as 'skiving off'. These findings are consistent with the accounts provided by a number of participants in the study presented in this thesis who were explicit about sick leave being synonymous with 'swinging the lead'. In addition, it was apparent in this study that men from higher socio-economic groups were also concerned with the impact having time off work would have on their reputation as hard working and reliable, and their subsequent opportunities for promotion. By contrast, men in lower socio-economic groups (manual occupations), and those who were self employed, were more likely to recall having been concerned with taking time off work (to seek help/take sick leave) because they would not have got paid for their time away.

In contrast, the accounts given by the South Asian men in this study indicated that they were *not* concerned with their status as a reliable or hard worker during their experience of chest pain. No South Asian participant reported being concerned that their work colleagues would consider them to be a hypochondriac or 'soft' for taking time off work because of their pain.

Fear

Fear was an additional theme that emerged as being central to a number of men's accounts of 'making sense of chest pain'. Several men recounted their fear of being told that their symptoms were due to a serious health condition, often expressed as a fear of 'the worst'. The accounts of two white participants indicated that this fear significantly contributed to a reluctance to seek help. Previous help-seeking studies have similarly found fear to be related

to delay in both men and women (Smith and Andersen 1985; Mor et al 1990; Gascoigne et al 1999).

However, two previous studies investigating help seeking for cancer symptoms have also suggested that fear is associated with *immediate* help-seeking behaviour (Hackett et al 1973; Lauver and Chang 1991). The influence of fear on help-seeking behaviour was similarly ambiguous in this study; one South Asian participant indicated that he had addressed his fear by seeking medical help immediately.

5.6 Discussion: Making Sense of Chest Pain and Masculinity

Self diagnosis was a theme that pervaded the ‘making sense’ process in the accounts provided by participants of both white and South Asian ethnicity. The theme can be interpreted, in part, as being a reflection of men’s lack of knowledge about heart disease and the symptoms of an acute cardiac event. The help-seeking decision-making process cannot begin in earnest until a problem has actually been identified. The ‘self diagnosis’ theme can be seen to illustrate the importance of having knowledge of coronary heart disease if chest pain symptoms are to be interpreted as serious. The majority of men in this study believed that their chest pain was unlikely to be serious because they were fit, active and healthy prior to their event. Several white participants also assumed that an acute cardiac event could not happen without prior warning – such as experiencing a reduced exercise tolerance – and many South Asian men were completely unaware of *any* of the symptoms of heart disease.

As noted in the preceding summary, many of the characteristics of the ‘self diagnosis’ theme identified in this study have been identified in several previous help-seeking studies on mixed gender samples, and would appear to suggest that this aspect of the help-seeking decision-making process is not gender-specific *per se*. However, in this study, men’s self diagnosis and rationalising about the cause of their chest pain was not a one off event that occurred at the onset of their symptoms. Rather, the data indicated it was an ongoing process of rumination

and rationalisation that involved a decision to ‘wait and see’ how pain developed before a conclusion about the seriousness of the symptoms was reached. The perceptions and patterns of behaviour associated with the ‘wait and see’ theme have resonance with the masculinity theoretical and research literature.

5.7 Masculinity and Men’s Bodies

The literature on conceptions of health and the sociology of the body supports the idea of the gendered body (Scott and Morgan 1993). A number of studies have examined how men experience their bodies and construct their masculinity in a variety of contexts (Connell 1995; Nettleton and Watson 1998; Watson 2000). Connell (1995) places importance on the notion of the body ‘doing’ versus ‘being’ in the context of constructing one’s masculinity; noting that *‘gender is social practice that constantly refers to bodies and what bodies do’* (p73). Messener (1992) has also identified the ‘instrumental’ male in which the body becomes the focus of the self and is viewed as a ‘machine’ or a ‘tool’. This approach has been recently adopted in a men’s health guidebook that likens men’s bodies to a car that needs to be ‘seen by a mechanic’ (Banks 2002).

White (2000) took a similar approach to understand the ‘making sense’ concept among men who had experienced an acute cardiac event. White (2000) applied Foucault’s (1975/1991) notion of ‘gaze’ and ‘surveillance’, set in the context of the ‘masculine stereotype’, and hypothesised that men go through a self-justification process in which they make sense of what is happening to them and their bodies. White argued that the ‘well man’, the ‘productive man’, is seen to be meeting the expectations that society has placed on him, and men continually undertake ‘self-surveillance’ of their body to assess their performance against these societal masculine expectations (White and Johnson 2000). White therefore argued that delays in seeking help may occur for men during the ‘making sense’ period because their position as a ‘productive man’ is threatened by the possibility of ill health and they have to rationalise and negotiate what to do (White and Johnson 2000). Although the data from the

study presented in this thesis does not support theorising about ‘self surveillance’ of the body, the ‘wait and see’ theme can be seen to further the empirical basis of theorising about the ‘productive man’ and the embodiment of the perception of men as ‘breadwinners’.

5.8 Hegemonic Masculinity and the ‘Breadwinner’ Identity

A central tenet of hegemonic masculinity (the dominant, culturally exalted representation of masculinity) in Western societies is the assumption that a ‘real’ man will have a full-time permanent job which supports his family financially – a ‘breadwinner’ identity (Price et al 1998; Connell 2000). For example, Tolson (1977) has noted that:

‘In Western, industrialised, capitalist societies, definitions of masculinity are bound up with definitions of work. Whether it is in terms of physical strength or mechanical expertise, or in terms of ambition and competitiveness, the qualities needed to be a successful worker are closely related to those of the successful man’ (pp.12-13)

Several participants with professional occupations in this study recalled a reluctance to take time off work to seek medical help because of concerns about damaging their reputation (being reliable and dedicated) and their subsequent chances of promotion. The men were concerned about the identity they would project to others should they take sick leave, and had therefore decided to ‘put up’ with their pain and ‘wait and see’. Similar to White’s (2000) theorising on the ‘well man/productive man’, the men’s refusal to take sick leave from work can be seen as behaviour taken as a means of preserving and enacting a hegemonic masculine identity that embodies the perception of men as ‘breadwinners’ (Connell 1995; Petersen 1998; Courtenay 2000; 2000a). This characteristic of hegemonic masculine behaviour, distinctive to the accounts provided by men from higher socio-economic groups, is also consistent with assertions that hegemonic masculinity in Western society is embodied by white, educated, European/American men of upper/middle-class economic status (Kimmel 1994; Sabo and Gordon 1995; Connell 1995; Courtenay 2000).

However, whilst some of the findings related to the *white* participants’ experiences in this study appear to echo previous empirical work, evidence from the accounts given by men of

differing socio-economic status, and men of South Asian ethnicity, furthers this knowledge. In particular, the accounts given by a number of white men with manual occupations in this study point toward subtle differences between men of differing socio-economic status in relation to their representation of a 'breadwinner' masculine identity. Donaldson (1991) and Messerschmidt (1993) have suggested that men will construct their masculinity differently depending upon their position in social structures and, therefore, upon their access to power and resources. It was apparent in this study that, in contrast to men with professional occupations, men with manual occupations recounted concerns about the financial implications of taking time off work as opposed to their reputation and chances of promotion.

These observed differences can be seen to signify men's use of differing access to power and resources (associated with occupation) to construct their masculinity. Men from professional occupations can be seen to have used high status, ambition and competitiveness at work (being dedicated, getting promotion) to construct a hegemonic 'breadwinner' masculine identity. By contrast, men with manual occupations, who did not have access to the 'resource' of having a high status occupation, can be seen to have focussed on their capacity to continue to work and support their family financially despite having pain (reflected by their effort – *'I'm a good grafter'*) to construct a hegemonic masculine identity.

In further contrast, the study's findings also point toward a distinctly different pattern of masculine behaviour among the South Asian participants. Current empirical evidence on men's construction of their masculine identity is largely limited to understandings of the experiences of white/Euro-American men. Contrary to the 'breadwinner' theme evident in this body of literature, no South Asian participant in this study expressed perceptions relating to the need to be seen to be a hard worker, or the need to continue working when they began to experience their chest pain symptoms/illness. The theme was illustrated by Danvir, who recounted that he immediately left work at the onset of his symptoms.

This finding draws attention to the possibility that, although work appears to be a central tenet of constructing masculinity in '*Western, industrialised, capitalist societies*' (Tolson 1977; p.12), it may *not* be a central aspect (or be a less important aspect) associated with the construction of South Asian men's masculine identity. The data did not suggest that being seen to enact or maintain a masculine identity as a 'breadwinner' was a significant feature of South Asian men's help-seeking decision-making process, or that their masculine position in society as a 'productive male' was threatened by the prospect of illness. [The influence of work on South Asian men's construction of masculinity was not explored in detail in this study – this is an area that requires future research].

The account provided by Danvir, coupled with the absence of responses relating to the importance of being seen to be a 'hard/productive worker' in the accounts of the other South Asian participants, suggests that the South Asian men in this study *did not* adhere to a hegemonic representation of masculinity that was apparent in many white men's accounts. Support for this tentative proposition can be noted in the further differences identified between white and South Asian men pertaining to their period of 'waiting to see'.

5.9 Hegemonic and Marginalised Masculinities

The way one chooses to mark oneself as a man within a particular context can be seen to influence whether a person seeks help (Mansfield et al 2003). In the context of health and illness, hegemonic forms of masculinity in Western culture position men as 'naturally' strong, resistant to disease, unresponsive to pain and physical distress, and unconcerned with minor symptoms (Petersen 1998). With regard to seeking help, men may therefore deny pain and distress and minimise the problem as a way of enacting hegemonic masculinity (Kaufman 1994). For example, Bendelow (1993) has noted that 'male socialisation' actively discourages men from expressing pain, whether physical or emotional. Courtenay (2000) has argued that men will often face risk and physical discomfort rather than be associated with what are perceived as emasculating traits associated with illness such as vulnerability, dependence and

weakness. This hegemonic pattern of behaviour was clearly apparent in the accounts provided by the majority of white participants in this study: 'putting up' with chest pain and not wanting to appear 'soft' by others was the central feature that pervaded the majority of white participants' period of 'waiting to see'.

Being seen to be able to endure pain, and have a high threshold for pain, appeared to be fundamental to white men's identity and the identity they projected to others when experiencing chest pain. Henry and George gave accounts that were illustrative of the perceptions many white men recounted. The men expressed fears of appearing '*soft*' to their friends in the pub, or '*being seen to be like a woman*', respectively, if they discussed their pain or a need to seek medical help. Henry's account can be seen to be consistent with a hegemonic representation of masculinity that was signified by his belief that he should not show his friends that he was experiencing pain. George can also be seen to have adhered to a hegemonic representation of masculinity that is illustrated by his 'feminisation' of the behaviour of seeking medical help for pain. His response of not wanting to '*be seen to be like a woman*' is consistent with a hegemonic representation of masculinity taken to signify to others that he was stronger than women and, therefore, a 'real' man (Mansfield et al 2003).

Notably, although subtle differences between men of different socio-economic groups with regard to constructing a 'breadwinner' masculine identity have been proposed, hegemonic representations of masculinity, principally signified by 'putting up' with pain and not wanting to be seen as acting 'soft', were identified in the accounts of white participants of *all* socio-economic groups. This would suggest that socio-economic status is *not* a significant factor in determining white men's representation of hegemonic masculinity in the context of help seeking.

However, South Asian men's accounts of 'waiting to see' provide further indication in the data that *ethnicity* may be a determining factor in men's representations of masculinity in the

context of help seeking. As discussed in detail in section 2.5 of Chapter 2 ('Theoretical Perspectives of Masculinity and Men's Health'), current prevailing constructivist perspectives of masculinity assert that the health-related beliefs and behaviours men adopt vary depending on whether a man is performing a hegemonic, subordinate, or marginalised form of masculinity (Courtenay 2000). Previous findings have indicated that men from minority ethnic groups may use signifiers of hegemonic masculinity in an attempt to protect and defend their compromised masculine identity. For example, denying the need for health care ('African-Canadian Men' – Evans et al 2005) or engaging in high risk behaviours such as violence ('Black men' – Franklin 1984; Majors and Billson 1992; Hearn and Collinson 1994; Mac an Ghail 1994; Rich and Stone 1996; Cheng 1999).

However, the South Asian men's accounts of 'waiting to see' in this study would appear to run counter to these findings. The accounts provided by South Asian men revealed an absence of responses consistent with Western cultural hegemonic representations of masculinity signified by a perceived need to continue to work while in pain, 'put up' with pain, or attempting to demonstrate a high threshold for pain to others. These absences in the data suggest that South Asian men's help-seeking behaviour may signify a marginalised representation of masculinity. That is, South Asian men's behaviour 'as a man' is marginalised/devalued (in Western culture) because it is not consistent with the pattern of behaviour that is culturally exalted as representing 'real' manhood in the UK (Connell 1995; Courtenay 2000). The second core concept identified in the study – *'something is not right'* – provides further evidence to support and develop this tentative proposition.

5.10 Core Concept II: ‘Something is not right’

The period of time men had spent delaying seeking help and ‘waiting to see’ varied considerably; some men had delayed seeking help for minutes, and others for hours or even days (see Table 5: Demographic Characteristics of Sample – Study One; page 113). Despite the wide variation in delay times, a common feature evident in the majority of men’s accounts related to a moment when they realised that ‘something is not right’ and that medical help was required. ‘Something is not right’ was thus recognised as being the second core concept that pervaded men’s help-seeking decision-making process.

Two themes corresponding to the distinct features of the ‘something is not right’ concept were identified: ‘a change in symptom perceptions’ and ‘men’s partners’. As was apparent in the ‘making sense of chest pain’ core concept, although the ‘something is not right’ concept was recognised as pervading the majority of participants’ accounts, a number of differences between white and South Asian men were evident. The two themes are now discussed in detail, and particular attention is drawn to the similarities and differences between white and South Asian men’s process of realising that ‘something is not right’.

5.11 A Change in Symptom Perceptions – *‘anything less would have gone away’*

As discussed, the accounts provided by the majority of both white and South Asian men indicated that they had taken a decision to delay seeking medical help whilst they ‘waited to see’ whether or not their pain was sufficiently serious to warrant medical attention. Analysis of men’s accounts of their period of ‘waiting to see’ revealed a common moment, experienced by the majority of participants of both white and South Asian ethnicity, whereby they had altered their perception of their symptoms, realised that ‘something is not right’, and therefore decided to *stop* ‘waiting to see’.

For a number of white participants, it was apparent that when their pain had escalated and become sufficiently severe and persistent to have affected their activities of daily living (for

example, walking, working, doing leisure activities) it was at this time they had realised 'something is not right'. The accounts given by these men suggested that severe, *debilitating* pain was consistent with what they perceived to be a symptom/condition that legitimately required medical help. A number of white participants recalled having an immediate onset of severe pain or a rapid escalation in the severity of their pain. These men's accounts similarly indicated that, at this point in their experience, they had felt they had *no choice* but to seek help because 'something was not right'.

By contrast, three white participants recalled that they had persisted in delaying seeking help despite having severe chest pain. In contrast to the other participants who had described severe pain, it emerged that the three men who had persisted with 'putting up' with their pain had described it as being transient. The men's transient severe pain had not been sufficiently persistent to disrupt their activities of daily living for long periods; for example, they recalled that they had continued to work or do leisure activities. As such, it was not until the pain became persistent and began to restrict their activity that these men realised that 'something is not right' and that they required medical help. These findings indicated that severity of pain was not the foremost factor that led to the men's realisation that 'something is not right'. Rather, the disruptive influence of the pain on their activities of daily living appeared to be of greater significance.

Researcher: So what made you think, I've got to get some help?

Participant: You know, the accident I had with me foot, I had fork lift truck involved with back end, with all weight on it. And this pain in me chest got to a point where it was worse than what that were! I couldn't do owt then!
(Les; white male aged 56 years; delayed for 12 hours)

Researcher: So what, what made you think it was...what made you call the doctor and the ambulance on that occasion?

Participant: Well it got that bad and this pain were getting worse and I couldn't, I couldn't get up!
(Richard; white male aged 77 years; delayed 1 hour)

A theme that emerged early in the analysis of South Asian men's accounts was the frequency with which many had explicitly recalled being anxious about their chest pain during their experience. Further analysis revealed that all eight South Asian participants had indicated that their chest pain had been the primary reason that had led them to realise that 'something is not right'.

However, in contrast to the theme identified among many white participants, many South Asian participants' experiences indicated that it was not an escalation in their pain, or the pain becoming severe and debilitating, that had prompted their realisation that 'something is not right'. Rather, the fact that chest pain had not abated appeared to have been sufficient to alter many South Asian men's thoughts that their pain was not serious. The South Asian participants had seldom 'waited to see' for long periods before their self diagnosis of their pain as indigestion/not serious had been discounted. For example, Faisal and Ahmed recalled initiating the call for help because it became apparent to them that their pain was '*not going*'.

Researcher: Why did you call the ambulance?

Participant: It [the pain] did not go away after taking some Gaviscon, which was persistent through that.'
(Faisal; 38 year old Bangladeshi Male; delayed 24 hours)

I just knew there and then that it was something serious, you know, because anything less would have gone away.
(Ahmed; 30 year old Pakistani Male; delayed 1 hour)

Well, as I said, about three o'clock, when I came back from University, and I asked the wife to make a cup of tea, and she made a big cup of tea, and I thought it'd be just a bit of pain again, but I did not think much about it, but it started getting worse and it didn't go away. I told the wife and she rung my doctor, and she brought me to hospital straight away.
(Faarooq; 56 Year old Pakistani Male; delayed 12 hours)

In contrast to the theme identified among the South Asian participants, the onset of physical symptoms, such as clamminess, breathlessness, loss of skin colour or nausea, emerged as being the symptoms that had most frequently prompted a realisation that 'something is not right' among the majority of white men. Fourteen white participants recalled that when they began to experience these additional physical symptoms, in addition to their chest pain, it was

at this time they had realised ‘something is not right’ and subsequently decided they needed medical help.

The accounts given by these men further illustrated that a central aspect of many white men’s help-seeking decision-making process had been the perceived need to ‘put up’ with chest pain. For example, George recalled that at the onset of his clamminess and nausea he realised ‘*he couldn’t do it*’; inferring that when he was experiencing pain alone he felt he *could* handle it himself – illustrated by the fact he had ‘put up’ with his pain for twelve hours.

I had never had indigestion that bad before. And, I don’t know, I went all clammy and white, and just thought something’s not right, be it I am having a heart attack or something, maybe I have had an ulcer that’s burst, or something like that. Just felt that I need to get it checked out pretty sharpish.

(Tom; white male aged 37 years; delayed for 24 hours)

...once I had started feeling clammy, then I knew there was something. Pain could be indigestion, it could be a multitude of things, it could be a muscle spasm, but...It could be, it could be lots of things, but when you start feeling really clammy and nauseous and you know...That triggers in your mind and says “get some help. You can’t do it, get some help”.

(George; white male aged 57 years; delayed 12 hours)

Men’s recollections of how the onset of additional physical symptoms had prompted them to realise that ‘something is not right’ further signified that chest pain had been perceived by many white men as a symptom that could be attributed to a number of non-serious causes. Once again, the data indicated that the men’s uncertainty about the cause and seriousness of their chest pain underpinned their perceived need to ‘put up’ with it and ‘wait and see’ until a time they were certain it was sufficiently serious to warrant medical attention. As George explained, ‘*pain could be indigestion, it could be a multitude of things, it could be a muscle spasm*’.

By contrast, it was also clear in the accounts provided that, in comparison to experiencing chest pain alone, the onset of clamminess, breathlessness, or nausea, were consistently perceived by white men as symptoms that could *not* be ‘put up’ with. Akin to how many South Asian men had perceived their persistent chest pain, it became evident that the onset of

additional physical symptoms had altered many white men's thoughts that their condition was not serious. Furthermore, the onset of additional physical symptoms also appeared to transcend men's fear that they would be perceived to be acting 'soft' for seeking help. Notably, no white man recalled that they had feared to be seen to be acting 'soft' by others for seeking help as a result of their physical symptoms. For instance, Les delayed seeking help for 48 hours when he was experiencing just chest pain, noting that he could *'put up with it'*. However, at the onset of sweating and clamminess he felt he could not *'play about with it'* anymore.

"I can put up with pain" and well yeah, you can put up with pain, I mean I can put up with pain myself, but, I think when it's something out of normal...you know you're sweating and you're clammy and what not, it isn't something to play about with'
(Les; white male aged 56 years; delayed for 48 hours)

5.12 Men's Partners – *'it was my wife who phoned the doctor'*

Subsequent to realising that 'something is not right', a common theme evident in both white and South Asian men's accounts related to the role their partners had played in calling for medical help. When realising that 'something is not right', the majority of men had decided to share these thoughts, feelings and worries with their partner. Discussions men had had with their partners that contributed to the initiation of medical help seeking were identified in twenty-five men's accounts. As noted, prior to this discussion, making sense of chest pain had been an 'internal dialogue' for the majority of men. Thoughts and rumination about their condition had rarely been discussed with anyone else.

Although partners played a crucial role in the calling for help, the majority of men's partners had not *made* the decision to call for medical help on their behalf. Rather, the data indicated that most men had already decided *themselves* that they needed medical help at the time they disclosed their symptoms to their partner. It was apparent that the actual act of calling for medical help was problematic for the men, and it was this that required the intervention or help of their partner.

Illustrative of this theme, only five out of the thirty-six men in the study had called for medical help independently; the other participants' partners had called for an ambulance on their behalf or taken them to see a doctor. For example, Les told of how he had delayed seeking help for 48 hours, 'putting up' with his pain and 'waiting to see'. At the onset of additional physical symptoms (sweating and clamminess) he realised that 'something is not right' and disclosed this to his wife who subsequently called for medical help. The theme was also prevalent among the South Asian participants. For example, Ahmed, a 30 year old man of Pakistani origin, had decided he needed to seek help but *'got his wife to call an ambulance'*.

Yeah. Eh... well I got... I went to bed about half past eleven Friday night and... you know from almost ... supposed to be off it for a few week but I put it down to a, you know, a bit of a flu type thing you know and then about three o'clock then Saturday morning I just woke up with terrible indigestion and went downstairs and took some of wife's heartburn medicine and had that down about ten minutes and just brought it back up and... I managed to get back upstairs and woke wife up and says "you're going to have to get me some help 'cause its not heartburn, it's-", 'cause by that time I'd started sweating and were all clammy.

(Les; white male aged 56 years; delayed 48 hours)

So I got my wife to call an ambulance. Ambulance came, they took me outside, laid me on stretcher, about thirty to forty minutes, gave me a tablet, some injections, and they brought me here.

(Ahmed; 30 year old Pakistani Muslim Male; Delayed less than 1 hour)

Although the majority of participants disclosed their symptoms to their partners when realising themselves that *'something is not right'*, the fear of being perceived to be 'soft' led to a number of white men to keep their symptoms hidden from everyone *throughout* their experience. However, in these cases, men's partners still played a crucial role. When seeing their partner's distress, they initiated the call for help without discussion. Andrew is a case in point. He had kept his pain hidden from everyone for twelve hours, despite being *'in agony'*. However, his wife took it upon herself to call for an ambulance after seeing the obvious distress he was in. His account provides a stark illustration of the perceived need to 'put up' with pain and a reluctance to seek medical help.

She [wife] did [phoned the ambulance] but she was worried about me. I was really going through agony at the time. I'm pleased she did because when I realised what she was doing I just left her to it because I did need help.

(Andrew; white male aged 70 years; delayed 12 hours)

Five men in the study were either not married or divorced, although three of these were co-habiting with a partner. The three co-habiting participants gave accounts comparable to the married participants in relation to this aspect of the help-seeking process. However, for one participant who lived alone (Anthony), his help-seeking decision-making process remained internalised – he did not discuss his symptoms with anyone and nobody called for medical help on his behalf. Max, who was also single, did not discuss his symptoms with anyone until his pain became extremely severe. He eventually did disclose his symptoms to a work colleague but subsequently collapsed. Interestingly, these two single participants had prolonged help-seeking delays; over two days in the case of Max and over one week in the case of Anthony.

When I got to work I says to my mate, by, I've got a bleeding pain...And that was it, booomph, I was out.
(Max; white male aged 54 years; delayed for 48 hours)

5.13 'Something is not right' – the time taken to reach the decision

As noted, the time taken to realise that '*something is not right*' varied markedly between the study's participants (see Table 5: Demographic Characteristics of Sample – Study One; page 113). Although the study's sample size was not sufficient to allow an in-depth comparison between participants who had sought help promptly with those who had delayed seeking help for a prolonged period, it was apparent in the data that the majority of men's experiences shared conceptual similarities. To illustrate, regardless of their help-seeking delay, the majority of men's stories indicated that they had engaged in a process of 'making sense of chest pain' involving 'self diagnosis', 'fear', and 'waiting to see', before they eventually realised that '*something is not right*'. The following excerpts illustrate the differences and similarities between George, who had delayed seeking help for 12 hours, and Steve, who had delayed seeking help for less than 1 hour. They are quoted at length to illustrate the men's complex process of decision-making involving the two core concepts; 'making sense of chest pain' and '*something is not right*'. Both participants clearly describe themes associated with the first core concept – self diagnosing and then 'waiting to see'. Steve's account indicated

that he had a comparatively early onset of additional physical symptoms (sweating) and an escalation in his pain which had made him realise that 'something is not right'. As a result, he had 'waited to see' for less than an hour. George recounted a similar period of self diagnosis of his chest pain but, in contrast to Steve, he chose to go to work and 'wait and see' because he felt he could tolerate the pain. His onset of additional physical symptoms occurred later in his experience and, as a result, he had delayed seeking help for over 12 hours until he realised that 'something is not right'.

I had eaten a biscuit... thought it was indigestion in me stomach. Right at the centre and I tried to sort of belch to bring it away and I thought "you've eaten that too quick" and I was in the toilet for a while. The next thing I knew I started sweating on my forehead, my head, and em, I came out of there, I walked into the lounge, back into the bedroom. Me wife were at that time still asleep em, I'm coming out of there, I went back into the lounge again and this is "Sorry love I don't feel too good" and by this time the pain was building up...it was, it was quite strong and my wife said "oh I'll ring the doctor", so I said "Just give it a few minutes. If it that biscuit what's stuck" I said "it might just clear it". It didn't. I went back to the toilet, I tried to put my fingers down my throat to be sick to bring, bring it up. Brought a little bit up but it was still there. I went back into the room, I was cold, and I sat there in the chair and me wife says "I'm going to ring the doctor" and I said "Okay", so I'll get checked out.

(Steve; white male aged 60 years; delayed 1 hour)

Right I got up at, I get up at eh twenty to seven every morning and went through the usual routine, you know shower, breakfast. Em, out of the house for about five past seven and after breakfast, getting into the car, it felt a bit tight in my chest, nothing disastrous. It wasn't you know burning pain; you know something that was going to cause me any trouble I thought. But as I was starting to drive to Sheffield where I work, em, it became more persistent. Again, you know, whether its, you know, I've got a high pain tolerance I don't know, but it did not feel anything disastrous...but I got to work, did a couple of e-mails, sorted a couple of things out and I thought, the rest of the work I've got today I can do at home and I thought I don't feel that great, I'll go work at home and it was still there, I thought it might have been erm, indigestion, primarily because we'd had pasta the night before...Spaghetti - sometimes you swallow it all and it sticks, but it hadn't gone away, it hadn't reacted to Rennie's and I just felt clammy and I thought well, it must be something and I went to the doctors straight away into surgery and she started going through the procedures you know for a heart attack.

(George; white male aged 57 years; delayed 12 hours)

5.14 Summary: ‘Something is not right’

This section presents a summary of the study findings relating to the ‘something is not right’ core concept. The summary is presented alongside existing literature to illustrate where the findings fit in with, and contribute to, the current empirical evidence. The following section (5.15) presents a discussion of these findings with reference to the masculinity theoretical literature that develops the analysis presented earlier in this chapter (Section 5.9 –‘Hegemonic and Marginalised Masculinities’).

Men’s Partners

The second core concept associated with men’s help-seeking decision-making process corresponded to the moment men realised that ‘something is not right’, decided not to ‘wait and see’ any longer, and to seek medical help. The role of men’s partners was a key theme of the core concept. This finding mirrors those of several previous studies, most notably that of Umberson (1992), that have reported that wives and partners play a crucial role in managing (white) men’s health and prompting them to seek medical help (Norcross et al 1996; Sharpe and Arnold 1998; Tudiver and Talbot 1999; Gascoigne and Whitear 1999; White 2000; Seymour-Smith et al 2002; Brink et al 2002; Zuzelo 2002). For instance, Sharpe and Arnold (1998) found that most (white) men in their study observed that their partners,

‘often noticed if they were not well and encouraged, instructed, ‘nagged’ or ‘dragged’ them to the doctors’ (p.4)

The findings of the study presented in this thesis further this body of evidence having indicated that wives and partners play a comparable role in the help-seeking process of men of South Asian ethnicity. However, in contrast to previous findings, it was also apparent in this study that the majority both white and South Asian participants did not have to be ‘nagged’ or ‘dragged’ to the doctors. Rather, the actual act of calling for medical help appeared to be problematic for the men, and it was this that required the intervention of their wives or partners.

A Change in Symptom Perceptions

Several previous qualitative studies addressing the help-seeking decision-making of men with chest pain and testicular cancer have reported that, akin to the ‘change in symptom perceptions’ theme identified in this study, symptom changes have been seen as a sign for men to reappraise their symptoms and take action (Tudiver and Talbot 1999; Sanden et al 2000; White 2000; Mason and Strauss 2004).

It was clearly apparent in the data from this study that, for a number of white participants, severe chest pain alone had not been sufficient to prompt them to disclose their symptoms to their partner or seek medical help. Chest pain had to be constant and sufficiently severe to disrupt men’s activities of daily living in order to prompt a realisation that ‘something is not right’. This theme was also evident in the accounts given by three other white participants who had ‘put up’ with transient severe pain until it became sufficiently persistent to disrupt their life. These findings are consistent with those of a study conducted by Zola (1973) on ‘the pathways to the doctor’. Akin to the accounts provided by many white men in this study, Zola (1973) found that people explained their decision to visit the doctor in terms of a breakdown in their attempts to accommodate their symptoms; that is, to continue as normal – patients sought help when their symptoms interfered with their lives. The findings from the study presented in this thesis would therefore appear to support evidence that help-seeking delay (among many white men at least) is not related to the severity of chest pain associated with the acute cardiac event (Hofgren et al 1988; Schmidt and Borsch 1990); the disruptive influence of symptoms appears to be more important.

The study findings also illustrated that, for several *white* men, additional physical symptoms, such as clamminess, breathlessness and loss of skin colour, had been the principal trigger that prompted them to realise that ‘something is not right’ and to seek medical help. This finding is also well supported in the literature. For example, Mason and Strauss (2004) have found that, among ten men with symptoms of testicular cancer, the majority explained that their

decision to seek medical help had been a result of a progression of their symptoms that interfered with their normal functioning. White (2000) has also found that, among men admitted to a coronary care unit, either an escalation in their chest pain or another sudden change in symptoms had caused them to re-appraise their health status and seek help.

However, the accounts given by the South Asian participants in this study point toward a distinctly different process of help-seeking decision-making to those apparent in the existing empirical evidence. The South Asian participants experienced a comparable 'something is not right' moment to the white participants – deciding that they required medical help after altering their perception of their symptoms. However, contrary to the findings of several previous studies on white men's help-seeking behaviour, the South Asian men in this study did not have to experience a sudden change in their symptoms, experience pain sufficiently severe to interrupt their activities of daily living, or experience an escalation in their pain, in order to realise that 'something is not right'. By contrast, the fact that chest pain was not abating appeared to have been sufficient for South Asian men to discount their self diagnosis and seek medical help. The data suggested that *persistent* chest pain, as opposed to *severity* of chest pain, had been the trigger to rule out non-serious complaints for the South Asian participants. Again, this finding would appear to support the broad patterns evident in several quantitative studies that have asserted South Asians in the UK would be almost twice as likely as white Europeans (sic) to seek medical help if they experienced chest pain symptoms (Smaje and Le Grand 1997; Chaturvedi et al 1997; Barakat et al 2003; Kelaher et al 2003).

5.15 Discussion: ‘Something is not right’: South Asian men’s *culturally specific* marginalised representation of masculinity

Similar to the interpretation of men’s behaviour associated with the ‘making sense of chest pain’ core concept, men’s behaviour associated with the ‘something is not right’ core concept can also be explained, in part, as being a reflection of their lack of knowledge of the symptoms of heart disease and an acute cardiac event. It was apparent in the accounts provided that physical symptoms, such as clamminess and breathlessness, or persistent and severe chest pain, were more easily ‘made sense of’ as being attributable to a serious illness in comparison to chest pain alone. However, the data also suggested that white and South Asian men differed in their perceptions of, and behavioural responses to, their chest pain symptoms.

Cultural differences in pain interpretation are well recognised in the social psychology literature (Radley 1994; Kazarian and Evans 1998). For instance, in a prominent study on Italian, Jewish and ‘Old American’ men’s reactions to pain, Zborowski (1952) found distinct differences between the different ethno-cultural groups; Italians appeared to complain about the pain itself, Jewish patients typically expressed worries about the implications of the pain on their health, and ‘Old Americans’ did not complain about their pain or display their feelings.

Zborowski (1952) interpreted these various pain behaviours in terms of men’s different cultural attitudes as to what is acceptable as a way of complaining and seeking help. Similarly, in this study, the observed differences between white and South Asian men associated with the ‘something is not right’ core concept can be seen to signify cultural differences in pain interpretation and, furthermore, the men’s culturally different representations of masculinity in the context of help seeking.

To illustrate, as discussed in section 5.9 of this chapter (‘Hegemonic and Marginalised Masculinities’), many white men’s accounts of their ‘waiting to see’ period can be seen to

signify a hegemonic representation of masculinity which embodies the view of men as strong, resistant to disease and unresponsive to pain and physical distress. It was evident in the accounts provided that being seen to be able to tolerate pain was central to the identity many white men projected to others during their experience of chest pain. In Western society, hegemonic definitions of masculinity prescribe certain behaviours as *appropriate* for men and others as completely *inappropriate* (Lee and Owens 2002). Many white men's accounts of 'waiting to see' clearly illustrated that seeking help for chest pain *alone* was considered to be an 'inappropriate behaviour' for a man. The majority of white men 'put up' with pain as they feared being seen to be acting 'soft' if they sought help, and many made derogatory comments about others they perceived to be 'soft' for behaving in this way.

By contrast, the 'something is not right' concept revealed that at the onset of physical symptoms (such as clamminess and breathlessness) no white man alluded to a fear of being seen to be acting 'soft'. The majority of white men had quickly discounted their perceived need to 'put up' with their pain, realising almost immediately that they required medical help. This finding suggests that, in contrast to seeking help for pain alone, seeking help for *physical symptoms* was perceived to be an 'appropriate behaviour' for a man.

The stark transformation in help-seeking perceptions that was evident in many white men's accounts at the onset of their physical symptoms appears to support Robertson's (2003c) suggestion that men may need,

'...a means of legitimising their visit [to a doctor] so that they can maintain face, or keep their male identity in tact' (p.113)

Adopting Robertson's (2003c) proposition, it can be argued that the presence of physical symptoms served as a means of legitimising men's help-seeking behaviour and allowed them to keep their hegemonic masculine identity 'in tact'. Breathlessness, clamminess, or a loss of skin colour meant others could *see* that the reason they were seeking help was not because they were 'soft' and could not tolerate pain, but rather, because of symptoms that clearly

signified that they were *legitimately* ill. Seeking help for these symptoms did not challenge the men's (hegemonic) masculinity because it did not bring into question their threshold for pain.

This finding supports O'Brien et al's (2005) argument that men who adhere to a hegemonic representation of masculinity only contemplate seeking help following endurance, stoicism and visible injury. The additional physical symptoms experienced by numerous white men in the study presented in this thesis can be seen to be akin to the 'visible injury' noted by O'Brien et al (2005).

The accounts provided by the participants who did not realise 'something is not right' or seek help until their pain began to affect their activities of daily living add support to this proposition. For these men, being debilitated by their pain can be interpreted as being the *visible injury* that signified a 'legitimate' illness which did not threaten their hegemonic masculine identity. The men can be seen to have demonstrated their hegemonic masculinity to others, and themselves, by tolerating pain to the point of being physically debilitated. Likewise, although the participants identified as 'deviant cases' endorsed a hegemonic masculine pattern of behaviour – signified by their perceptions of seeking help only for a *serious* illness – their knowledge of the symptoms of MI appeared to legitimise their help-seeking behaviour. The three 'deviant cases' stressed that the reason they had sought help was *not* because they could not tolerate their pain or because they were 'swinging the lead', but because of symptoms they *knew* clearly signified a legitimate illness.

However, the data suggested that chest pain *alone* appeared to be sufficient to prompt the South Asian participants to realise that 'something is not right'; even when they had not been debilitated. This finding would appear to indicate that, contrary to the perceptions of the majority of white participants, seeking help for pain alone was not perceived to be an emasculating trait by South Asian men. The accounts provided by South Asian men indicated

that they did *not* perceive a need to 'legitimise' their help-seeking behaviour in order to keep their masculine identity 'in tact'.

Different behaviours to pain have been recognised as being a result of different cultural attitudes; attitudes which shape ideas of what is bearable in terms of pain (Radley 1994). The implication in the data from the study presented in this thesis that South Asian men sought help for chest pain alone – without fear of being seen to be acting 'soft' by others – suggests that the cultural meaning of experiencing chest pain *as a man* differed distinctly between the white and South Asian men. Specifically, the 'something is not right' concept indicated that, *when in pain*, the white and South Asian participants had culturally distinct perceptions of how to act, what behaviour was perceived as acceptable, and what behaviour was perceived as acceptable to others.

This finding, coupled with the 'non-hegemonic' features of South Asian men's accounts associated with the 'making sense of chest pain' core concept, provides further evidence to support the tentative proposition presented earlier in this chapter that the South Asian participants' help-seeking behaviour signified a *culturally specific*, marginalised representation of masculinity.

5.16 Chapter Summary

This chapter has provided an account, and detailed discussion, of the findings from the first study that is presented in this thesis. The study aimed to address the following research question and study objectives, as outlined in the summary of Chapter 2 ('Literature Review'; page 57):

Research Question:

- **How do masculinities influence white and South Asian men's decision to seek or delay-seeking medical help for acute chest pain?**

Study Objectives:

- 1 Explore the process of help-seeking decision-making in men who have recently experienced acute chest pain
- 2 Examine the influence of masculinity on the decision to seek or delay-seeking medical help in white men of differing *age* and *socio-economic status* who have recently experienced acute chest pain
- 3 Investigate the influence of masculinity on the decision to seek or delay-seeking medical help in South Asian (Indian, Pakistani, and Bangladeshi) men who have recently experienced acute chest pain

Objective #1: The study revealed that the participants' process of help-seeking decision-making for chest pain symptoms was principally associated with the core concepts of 'making sense of chest pain' and realising that 'something is not right'. Five themes that corresponded to the distinct features of these concepts were identified. Men of all ages, socio-economic status and ethnicity recounted commonalities in their process of help-seeking decision-making involving these two core concepts and five themes.

Objective #2: The themes identified in the accounts provided by *white* men in this study echoed many of the findings of previous studies, strengthening the empirical basis of theorising about the detrimental effect of hegemonic masculinity on men's help-seeking behaviour. Subtle differences between men of differing socio-economic status with regard to the construction of a hegemonic masculine identity were identified. However, an adherence to

a hegemonic representation of masculinity, signified by a perceived need to ‘put up’ with chest pain, was apparent in the majority of white men’s accounts regardless of their age or socio-economic status.

Objective #3: Although many of the themes identified in this study mirrored those identified in previous empirical work, the accounts provided by South Asian men revealed distinct help-seeking perceptions and behaviours that appeared to run counter to those identified in a number of previous studies. The data gave rise to a tentative proposition that South Asian men’s accounts of seeking help signified a culturally specific, marginalised representation of masculinity.

5.17 Study Limitations

As discussed in Chapter 3 (‘Methodology’), a recognised limitation of the guiding principles of grounded theory analysis used in this study, as advocated by Strauss and Corbin (1990; 1998), is the overemphasis on the search for *occurrences* in the data and the overlooking of underlying *meaning* in the data (Charmaz 1990; 2000). As noted, Glaser (1992) has argued that this can result in the description of concepts – a ‘full conceptual description’ – and not a substantive grounded theory that offers an explanation of the social processes associated with the phenomenon under investigation. Although the findings presented in this chapter were not considered to constitute a ‘conceptual description’, the underlying *meanings* of the grounded theory concepts were deemed to require further development. Especially, although the study described the themes and core concepts associated with white and South Asian men’s help-seeking decision-making process for chest pain symptoms, the findings were considered to fall short of a comprehensive substantive grounded theory of the *influence of masculinity* associated with these themes and concepts.

Furthermore, the study also brought to light a number of new areas that required further investigation. In particular, the data gave rise to a number of tentative propositions relating to

the distinct differences between white and South Asian men's decision-making and representations of masculinity during the period of 'waiting to see'. However, the testing of propositions about South Asian men's representations of masculinity during the 'wait and see' period were principally based on the juxtaposing of white and South Asian men's accounts that revealed an *absence* of data corresponding to hegemonic representations of masculinity. As such, the analysis of the accounts provided by South Asian men was considered to be ethnocentric – South Asian men's representations of masculinity were interpreted with reference to those of white participants. Although South Asian men's 'non-hegemonic' accounts of seeking help pointed toward their culturally distinct representations of masculinity, the data were not in sufficient depth to elucidate the underlying meaning, perceptions and patterns of behaviour associated with these masculine representations.

Moreover, although the data pointed towards commonalities between the South Asian participants in relation to their help-seeking decision-making process, the accounts provided by the men were not in sufficient depth to facilitate an in-depth exploration of the similarities and differences between Indian, Pakistani and Bangladeshi men, and between Muslim, Sikh and Hindu men. As noted earlier, South Asian populations in the UK have been recognised as having significant behavioural and cultural diversity (Modood et al 1997) particularly in the context of experiencing CHD (Nazroo 1997; 1998b; Bhopal et al 1999). Therefore, an additional grounded theory study was considered necessary in order to investigate the influence of masculinity on white and South Asian men's help-seeking decision-making process in greater depth and address the unanswered questions.

5.18 Study Two: Objectives

In order to explore the research question in greater depth, the following three additional objectives, borne out of the unanswered questions and emergent themes from the first study, were developed for the second study:

- 1 Examine the differences and similarities between white and South Asian men's decision-making process relating to the period of 'waiting to see';
- 2 Explore the differences and similarities between white and South Asian men's representations of masculinity in the context of seeking medical help for acute chest pain symptoms;
- 3 Investigate the differences and similarities relating to the influence of masculinity on the decision to seek or delay-seeking medical help for acute chest pain among South Asian men of differing ancestry and religion.

The next chapter (Chapter 6: 'Study Two – Research Methods') now presents a detailed account of how the methodology outlined in Chapter 3 ('Methodology') was applied to explore these objectives in the second study.

Chapter 6

STUDY TWO – RESEARCH METHODS

This chapter provides a detailed account of how the methodology outlined in Chapter 3 ('Methodology') was applied in the second study presented in this thesis. As in Chapter 4 ('Study One – Research Methods'), the structure and content of this chapter aims to make each stage of the research process explicit, providing a clear 'audit trail' that will enable the reader of the thesis to judge the credibility of the study findings.

The chapter begins by discussing the study settings, recruitment procedures, ethical considerations and interview approach in sections 6.1 to 6.3. The study sample is then described in detail in section 6.4 before a reflexive account of the interview process is presented in section 6.5. The reflexive account provides an overview of the key issues and challenges faced during the research process, drawing particular attention to the limitations of the interview approach in the first study and how they were addressed in this study.

The chapter concludes by presenting a summary of the key stages of the study's analytical process in section 6.6. The account provides a clear exposition of the study's analytical 'decision trail', illustrating how the analysis of twenty interviews evolved to become a substantive grounded theory of the influence of masculinity on white, Indian and Pakistani men's decision to seek or delay-seeking help for chest pain.

6.1 Study Setting and Recruitment Procedures

The eight clinical areas situated in two large acute teaching hospitals in the North East of England that were used as the study sites in the first study (described in Chapter 4, section 4.1) were also used in the second study. The fifteen medical consultants and seventeen nurse managers in the eight clinical areas were provided with written details of the intention to conduct a second study, and their permission was sought to continue to recruit and interview patients within their clinical areas (see appendix 7). All responded positively within three weeks of the correspondence.

The procedures for recruiting participants that were employed in the first study (Figure 1: Study Recruitment Procedure; page 94) were also used for the second study. However, new posters and handouts were developed and distributed in the eight sites to raise awareness among the staff of the intention to conduct a second study (see appendix 7).

6.2 Ethical Considerations

The study was conducted in accordance with the three key ethical principles described in Chapter 4, section 4.4 (page 99). A notice of substantial amendment to the original study (ref 03/136), outlining the rationale for the proposed additional interviews using a modified interview guide, was submitted to East Leeds Research Ethics Committee. Substantial amendment to the original study was approved by the ethics committee on 18th October 2004 (see appendix 7).

6.3 Interview Structure and Approach

The wealth of data gathered for the first study demonstrated that a conversational depth (semi-structured) interview strategy which incorporated cultural and topical styles of questioning (see section 4.5 – ‘Interview Structure and Approach’) would be an effective approach to employ in undertaking the interviews in the second study. However, as noted in the summary of the preceding chapter, the interview strategy used in the first study was also recognised as

having a number of limitations. Section 6.5 of this chapter ('Reflexive Account: Interviewing Men about Masculinity') discusses how these limitations were addressed in the second study.

An interview guide was developed for use in the interviews with an initial purposive sample of five participants (presented in Table 10). The concepts around which the interview questions were developed were derived from the theoretical sensitivity gained from the findings, and unanswered questions, from the first study. Subsequent to the analysis (open coding) of the first five interviews, the content of the interview guide evolved in accordance with a theoretical sampling strategy.

Table 10: Interview guide used for purposive sample (first five participants) – Study Two

<ul style="list-style-type: none"> • Demographic questions: ancestry (Country of Origin); age/DoB; occupation; religion; married/single/divorced. • ‘Tell me about what you thought was causing your chest pain? (Why did you think that? Did you ever think it was caused by your heart? What made you think it was/wasn’t your heart? What made you change your mind?) • ‘Tell me what you know about the symptoms of a heart disease? (What did you think they were before you came in?)’ • ‘Tell me about your initial thoughts and reactions to having chest pain.’ (Did you worry? Put it out of your mind? Ask for help or information?) • ‘What do think would be the difference in how you would feel and react to having chest pain and say, having shortness of breath?’ • ‘How do you think you might react differently to these symptoms? (For example, one worry you more than the other? Would you wait and see for a longer time with breathlessness? Why?)’ • ‘Imagine you had moderate pain that you felt you could ‘live with’, how do you think you would react to that? (What would make you go see a doctor? Why wouldn’t you go straight away? How long would you wait and see for?’ • In comparison to women, do you think people in general expect men to behave in a certain way when they are ill?’ (Do you think that there is a ‘normal’ way to react? Why?) • Would you say these beliefs about how men should behave when ill are similar or different to your own? What about within your family (father, brother) and local community? • Do these beliefs change depending on the type of illness (e.g. a cold compared with having chest pain)? • ‘What about when you had the chest pain recently, do you think your family/relatives expect you to behave in a certain way when you have that?’ Would this be the same or different with your male friends or your work colleagues? • ‘When you had the chest pain, why did/didn’t you seek help straight away? Were you concerned about how it would affect how others saw you? What did you think would be the consequences?’ • ‘I have spoken to a lot of men who have said they were worried that other people would see them as a softy/wimp/(hypochondriac) if they went to the doctors for their pain. What do you think about that? Do you feel like that? • Have you come across these terms “softy”, “wimp”-what do they mean to you? • Some men do believe that going to the doctor is a sign of weakness (being a softy/wimp) what do you think about about that? Do you agree/feel that way?’ Would your friends/family feel the same way?. • ‘What do you think about men who regularly see their doctor?’ (Do you respect them? Think they are weak? Feel sorry for them? • ‘In general, how do you feel about going to see the doctor? (Do you feel that it is an o.k. thing to do, or something to do as a last resort? Why?)’ • ‘Why did you choose to call 999/the GP/NHS direct?’ (Were you more familiar with that service?)

6.4 Study Sample

Each of the eight clinical areas was visited by the researcher up to seven times a week over a seven month period to recruit and interview participants. As in the first study, all participants had been admitted to the clinical areas with a *new* onset of chest pain diagnosed as being of cardiac origin (angina or MI), and had no past medical history of CHD. The participant inclusion criteria are presented in Table 11. Patients who met the study inclusion criteria were identified in discussions with clinical staff (doctors and senior nurses) in each respective study setting (see recruitment procedure; Figure 1; page 94).

Table 11: Participant Inclusion Criteria – Study Two

<ul style="list-style-type: none">• Male over 18 years old• Admitted to clinical area 48 hours prior to interview with new onset of chest pain diagnosed as being of cardiac origin – Angina or MI• No past medical history of CHD• Clinically stable• Of white or South Asian (Indian, Pakistani, Bangladeshi) ethnicity• Able to speak English and participate in a depth interview
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A purposive sample of five men, consisting of two Pakistani, one Indian, and two British white men, was initially recruited. As noted, following the initial analysis (open coding) of the data from the purposive sample, a theoretical sampling strategy, whereby data collection, analysis and sampling occur concurrently, was used. Subsequent recruitment decisions were therefore based on the inclusion criteria and the concepts that emerged during the analytical process. Section 6.6 of this chapter ('Analytical Process') illustrates how the analytical process informed the theoretical sampling strategy

Theoretical saturation was considered to have been reached when twenty interviews had been conducted and analysed. Overall, twenty eight patients had been invited to participate in the study during the seven month period of data collection; eight declined. All twenty participants who consented to participate in the study chose to be interviewed at their hospital bedside. All

interviews were audiotape recorded and later fully transcribed verbatim. The length of the interviews varied between fifteen and one hundred minutes (average thirty five minutes). Of the twenty interviews, seven were transcribed by the researcher with the remainder transcribed by secretarial support staff. The thirteen interviews transcribed by support staff were verified for accuracy by the researcher, and modified accordingly, by cross checking audio tapes with the text transcriptions. The demographic characteristics of the sample are presented in Table 12 (see appendix 2 for short summaries of men's experiences of chest pain and seeking help).

The age of the participants ranged from 41 to 84 years (average 56 years). Delay in seeking help (from initial onset of pain to the call for medical help, as recalled by the participant during interview) varied from less than one hour to four days. Participants' position on the RGSC scale varied from I (professional occupation) to V (unskilled manual occupation). Of the twenty participants, twelve defined themselves as being of either Indian or Pakistani ethnicity, and eight men stated they were of white (British) ethnicity. All twelve of the South Asian participants had been born in the Indian subcontinent: eight were born in Pakistan; three were born in India. Eleven of the twelve South Asian participants had been educated and brought up in the Indian subcontinent and had immigrated to the UK within the last 20 years. One participant had been educated and brought up in the UK (Rashid).

Eight men in the South Asian sample stated they were Muslim; two men stated they were Sikh and one man stated he was a Hindu [data on white participants' religious affiliation was not collected]. The study's South Asian participants' country of origin and religion was broadly reflective of the demographics of the population of the city in which the study was set. The 2001 census survey recorded the South Asian population of the city in which the study was set as 2.99% Muslim, 1.06% as Sikh, and 0.58% as Hindu (Office for National Statistics 2001).

Table 12: Demographic Characteristics of Sample – Study Two

Participant	Age	Occupation (RGSC position)	Ethnicity	Approx Delay (hrs)
Abdul	54	IT Worker (IIN)	Pakistani (Muslim)	4
Faarooq	48	Warehouse Worker (V)	Pakistani (Muslim)	4
Mansur	62	Printer (Retired) (IIM)	Pakistani (Muslim)	1
Harry	54	Civil Servant (II)	White	16
David	42	Security (V)	White	1
Dinesh	56	Security (V)	Indian (Sikh)	2
Mitchell	54	Taxi Driver (IV)	White	8
Eddie	68	Weaver (IIM)	White	2
Frank	49	Police Officer (II)	White	3
Rashid	46	Film Director (II)	Pakistani (Muslim)	6
Matthew	47	Probation Officer (II)	White	36
Amit	53	Self Employed Business Owner (II)	Indian (Hindu)	1
John	55	Postman (IV)	White	96
Jamaal	41	Retailer (II)	Pakistani (Muslim)	1
Mahesh	74	Architect (Retired) (II)	Indian (Sikh)	96
Abdur	84	GP (Retired) (I)	Pakistani (Muslim)	1
Trevor	57	IT Worker (IIN)	White	36
Imraan	72	Printer (Retired) (IIM)	Pakistani (Muslim)	4
Shahid	52	Civil Engineer (IIM)	Pakistani (Muslim)	6
Mohammad	48	Banking (II)	Pakistani (Muslim)	8

(RGSC Position Key: I – Professionals / II - Managerial and Technical / IIN - Skilled Non-Manual / IIM -Skilled Manual / IV - Partly Skilled Manual / V - Unskilled Manual)

6.5 Reflexive Account: Interviewing White and South Asian Men about Masculinity

As discussed in Chapter 4 (‘Study One – Research Methods’), throughout the study I kept an analytical diary in which I recorded my reflections of the data collection process as well as my emerging theoretical ideas and tentative propositions. The reflexive discussion presented here provides an overview of some of the key issues and challenges I faced when interviewing men for the second study which I recorded in the diary. As in the reflexive discussion presented in Chapter 4, I have combined these reflections with some of the pertinent methodological literature I referred to in order to address the challenges.

Reflecting on my experience of the research process for the first study drew my attention to a number of weaknesses I needed to address in the second study. I became aware that my inexperience of qualitative interviewing had led me to take some men’s responses ‘for

granted' and, as a result, I had occasionally missed opportunities to recognise and explore the underlying *meaning* of responses and emerging themes. Furthermore, I recognised that, when analysing the ensuing transcripts, I had stuck too rigidly to the Strauss and Corbin (1990) three-step analytical process and not, as advocated by Charmaz (1990; 2000), questioned 'why?' enough. As outlined in the following section of this chapter ('Analytical Process'), I attempted to address this limitation by making axial coding in the second study a more creative, less structured, process (Charmaz 1990; 2000).

In order to minimise the 'taken-for-granted' effect during the interview process and explore men's tacit representations of masculinity in greater depth, I continuously sought to place emphasis on clarifying the meaning of participants' responses by using a probing and circling back interview strategy (discussed in detail in Chapter 4; page 119). However, recognising and accounting for white men's masculine 'performances' during an interview once again posed a challenge throughout the process of data collection. Schwalbe and Wolkmir (2001) have warned that the desire to signify a hegemonic masculine self may lead men to exaggerate rationality, autonomy and control when giving accounts of their experiences, which may result in a distorted and oversimplified picture of men's lives. In this study, I similarly became aware that many white men's desire to exaggerate rationality, autonomy and control, coupled with my probing and exploration of their perceptions of 'acting like a man', may have resulted in the participants over emphasising the extent to which they had 'put up' with their pain and dismissed the need for help during their experience. I documented the following reflexive account after I had completed interviews with three white participants:

'As I have taken some of white men's responses at face value in my previous interviews, I have consciously been attempting to clarify men's accounts of how they felt during their experience and their interpretations of their behaviour. In comparison to the men I interviewed in the first study, what appear to be endorsements of hegemonic masculine behaviours/patterns are coming through much stronger in the interviews I have done so far. I am concerned that men are overemphasising the importance of 'putting up' with pain during their help seeking process because this is what I am asking specifically/probing for'

Schwalbe and Wolkmir (2001) recommend that, in order to counter men's exaggerations and attempt to elicit revealing accounts, direct questions that might lead to accounts of the hyper-rational should be avoided at the beginning of an interview; initial questions should focus on context and process to lower the threat to the masculine self. I therefore began to focus my initial questioning on the context of a participant's experience and how they felt during that time before probing for information about personal opinions and interpretations. For example, I would begin by asking a contextual question such as '*What was it that made you call an ambulance at that time? What were you feeling?*' followed by a direct question (if related to their earlier response) such as '*Do you think that as a man experiencing pain you are expected to 'put up' with it for a certain amount of time?*'. Despite my attempts to recognise and limit men's exaggeration of their hegemonic masculine values as part of an interview 'performance', the effects of this may still feature in the study's findings.

Prior to the start of data collection for the second study, I was also aware that I had taken an ethnocentric focus in several previous interviews in the first study: considering the accounts of white men as the 'norm' and therefore focussing on what was 'missing' from the responses of South Asian men. I attempted to address this in the second study by making my questioning as open and minimally directive as possible so as to allow participants to recount in their own words what it meant to be an Indian or Pakistani man seeking help for chest pain. However, as in the first study, language difficulties and a lack of shared cultural understanding were barriers to establishing rapport with Indian and Pakistani participants. Again, I had to rely heavily on prompts and probes to uncover and attempt to clarify the meanings and interpretations men gave to their help-seeking experiences 'as a man'. In particular, I encountered specific problems when pursuing questions about Indian and Pakistani men's religious and cultural beliefs and practices. Rhodes (1994) suggests that researchers can successfully learn about participants' culturally specific experiences by emphasising their position as 'students'. I had endeavoured to adopt this strategy by

explaining to the South Asian men at the outset of an interview that I was interested in learning about Muslim/Sikh/Hindu practices of which I had very little knowledge.

However, it became apparent that many participants were reticent to discuss their religious and cultural beliefs with me in any depth. Two men avoided answering my questions on their religious beliefs by remaining completely silent. During these interviews, my feelings were comparable to what Adamson and Donovan (2002) recognised when interviewing Black people about their culturally specific experiences. The researchers reflected that they (as white people) had often felt ill at ease when researching ethnic minorities because they did not have a shared cultural understanding. I recorded similar reflections in my diary:

‘I often feel anxious when I am pursuing questions about culture and religion with South Asian men – particularly when I am talking to Muslim men about Islam. I am very conscious of how I might be perceived by them – a young white man with a shaved head – and frequently find myself worrying that the men might think I am being racially prejudiced because I am focussing on their religion, particularly because of some of the recent negative media coverage about Islam.’

‘I have wondered whether some men are not elaborating on culturally specific issues such as their religious beliefs because they have a defensive attitude in the light of recent publicity about Islamism (though nobody has mentioned this) and my appearance as a white, middle class male. When I asked one man if the Koran teaches Muslims to react to symptoms of ill health in a certain way he did not answer and I chose not to pursue it. I think that, as I am hyper-conscious of exploring issues of religion sensitively because I am aware of the racial stereotyping of Muslims that is currently present in the UK media, I am often ‘backing off’ and moving on to other topics instead of using more questioning. I am certain that a Muslim interviewer would gather different and possibly more in-depth data than I am doing.’

Despite these problems, several interviews with South Asian men were free-flowing interactions. The accounts of these ‘key informants’, most notably Rashid (who had been educated in the UK) and Abdur (a retired GP), were crucial in shaping my ideas and confirming/refuting tentative propositions. For example, in accordance with Charmaz’s (2000) approach to constructivist analysis, the concepts and themes that had been made explicit by ‘key informants’ facilitated the search for similar themes that were *implicit* in the behaviour of other Indian and Pakistani participants (Charmaz 2000). [See the following section on analytical process for an illustration of this procedure].

However, it is important to recognise that the emphasis I came to place on culture and religion in relation to Indian and Pakistani men's help-seeking behaviour could still reflect my ethnocentric assumptions. Bradby (1995) has recognised that the study of individuals who have migrated to a country that does not share their religion, family patterns or languages, often results in the ethnicity and culture of these individuals being referred to more than the majority. The effects of this may feature in my interpretation of the accounts given by the Indian and Pakistani participants in this study.

Trying to avoid ethnocentric interpretations of men's masculinity (interpreting white men's masculinity as 'the norm' and South Asian men's as 'the other') was consistently problematic throughout the study because of the current prevailing constructivist perspectives of masculinity that I had adopted as my interpretive framework. As discussed in Chapter 2, section 2.3 ('Masculinity as a Social Construction'), according to prevailing constructivist perspectives, masculinities are seen as relational: white men's (hegemonic) masculinity is positioned as the defining, 'norm' gender performance in Western societies. Other masculinities, including those of ethnic minorities, are seen to be measured against, and represented as marginalised/subordinated by, this hegemony.

When this difficulty was raised during a peer debriefing session with my research supervisors I came to recognise that the questions I had been using associated with being seen to be '*acting like a softy/wimp*' were problematic. Several Indian and Pakistani men had replied to my questioning on this topic with comments such as '*I don't live like that*'. Reflecting on the responses to these questions during the debriefing session, I realised that my questioning had assumed that Indian and Pakistani participants were interpreting the meaning of the concept of '*acting soft/like a wimp*' the same as white participants because its meaning *to me* was implicit. As I had done on occasion with participants in the first study, I had failed to clarify and explore what '*acting soft/like a wimp*' meant to the Indian and Pakistani men in sufficient depth. This became a significant limitation as 'acting like a man' in the context of help

seeking had emerged as the study's core concept. As such, I conducted three further interviews with Pakistani men in order to substantiate the core concept by clarifying the men's understanding and meaning of '*acting soft/like a wimp*'. The next section of this chapter illustrates how my attempt to overcome ethnocentric assumptions shaped the study's analysis and core concept.

6.6 The Analytical Process

As discussed in Chapter 3 ('Methodology'), in order to establish the dependability and credibility of the findings of a qualitative study a detailed account of the key stages of the analytical process is required. The account presented here provides a clear description of the analytical 'decision trail' of the study, with particular attention on the development and refinement of codes, themes and concepts. The account aims to enable the reader of the thesis to judge the rigour of the study findings presented in the following chapter (Chapter 7: 'Study Two – Findings and Discussion').

As in the first study, analysis was conducted with the aid of *NVivo* (version 2.0) software. The analytical process involved three phases informed by the methods of Strauss and Corbin (1990; 1998) and Charmaz (1990; 2000) – open coding, axial coding and selective coding. The first phase of the analytical process, open coding, involved a line-by-line analysis in order to break down the substantive data set and conceptualise and label 'what was going on in the data'. Open coding resulted in the conception of 25 codes. The codes are presented alongside a summarised version of researcher memos, code notes, which were documented in an analytical diary and represent the initial thoughts, intuitions and descriptions of the codes' conceptual origins (Strauss and Corbin 1990). *In vivo* codes (codes borne out of the actual words used by participants) are signified by quotation marks (Strauss and Corbin 1990). They are presented in Table 13, below.

Table 13 – List of open codes and researcher memos (code notes) – Study Two

<ul style="list-style-type: none">• Asian Specific Help Seeking Experience General account/overview of help seeking experience given by a South Asian man• Asian Male Identity Asian man referring to perceptions of being a man/what is expected of a man/response to questioning about acting 'soft' etc. - ?they do not fear being soft or do not see their behaviour as 'soft'• 'Body' Overt or implied references to the body – for example, having a fit or healthy body• 'Culture' Overt or implied references to cultural beliefs – for example, tradition, diet, etc. – This appears to be implied in many accounts – i.e. this is the way I do things and I don't know why???• 'Religion' Reference to religion/religious beliefs• 'Different from Women' Reference to the difference between how participant would feel a woman would react, or if their behaviour/identity is perceived to be different from a woman• 'Don't Panic' Men telling themselves to be calm and not panic during their experience of chest pain – common in Asian men?• 'Education' Reference to education being important in help seeking decisions – 'it's all about how much you know' – common in Asian men?• 'Family' Reference to the role of the family during chest pain experience – 'I told the family about it'• Fear* Feelings of fear during chest pain and need to 'put it out of the mind'/block it out or delay help seeing for fear of the worst• First Generation Attitude South Asian men's behaviour originating from Indian subcontinent (home country)- i.e. related to 'culture'• GP Reference to the GP e.g. visit to the GP, attitude of the GP, why men went to see the GP• Healthcare perceptions Perceptions of healthcare services – for example, previous experiences, perceptions of when to visit, where to visit etc.• Integrating cultures Accounts of adoption of British culture – e.g. diet, attitudes. – often implied• Knowledge* Reference to knowledge of heart disease and its symptoms• Making Sense* Men making sense of their pain
<p>[* As in first study]</p>

- **Macho/Masculinity***

Overt or implied reference to male behaviour/typically male/macho etc.

- **Pain Perceptions**

Accounts of how participants felt about their pain – e.g. put up with it/worry, no problems, seek help immediately

- **Physical Symptoms***

Accounts of the onset of physical symptoms such as sweating, nausea.

- **Past Medical History***

Reference to a previous medical problem/encounter with health service

- **When to seek help**

General accounts of the when and why the decision to seek medical help was made

- **Tightness**

Men describing they had a tightness (or not a pain as such)

- **'Too much Pain'**

Asian men describing they had too much pain/couldn't stand it – related to 'pain perceptions'

- **Wait and See***

Men waiting to see

- **Wife***

Reference to wife/partner

Following the completion of open coding, the analytical process progressed to a second phase, axial coding. As described in detail in Chapter 4 ('Study One – Research Methods'), the method of axial coding in this study was modified to incorporate aspects of constructivist analysis advocated by Charmaz (1990; 2000). Two analytic processes were associated with this modified approach: continued questioning and constant comparison.

As discussed earlier, although the themes and core concepts associated with white and South Asian men's help-seeking decision-making process emerged during the first study, the underlying *meanings* and influence of masculinity associated with these themes and concepts were considered to require further development. In order to facilitate the search for meaning in the data, and limit the 'taken-for-granted' perspective, axial coding in the second study involved a more conscious application of Charmaz's (2000) approach to constructivist analysis. For example, the recognition of the ethnocentric perspective that resulted in the identification of an *absence* of hegemonic responses among South Asian participants led to the focus of axial coding being on finding out what was 'going on' in accounts provided by

South Asian men (not merely finding what was ‘missing’ in the accounts in comparison to white men). To facilitate this process, the data that had been imported into *NVivo* was divided into two sub-sets, based on participants’ ethnicity, to enable the accounts to be analysed independently.

Continual questioning about the data in these subsets guided theory development throughout axial coding. As discussed, in order to facilitate a constructivist analysis, Charmaz (2000) recommends asking questions such as ‘What are the properties of an open code?’, ‘Under what conditions and what circumstances does it happen?’ and, ‘Where is it leading to and what does it mean?’. A number of the key questions that were ‘asked about the data’ provided by the Indian and Pakistani participants are presented below:

- What does ‘waiting to see’ mean to Indian and Pakistani men?
- Is going to the doctor a ‘natural’ response to pain for Indian and Pakistani men?
- When and why do Indian and Pakistani men decide to *stop* ‘waiting to see’?
- What are the differences between white, Indian and Pakistani men relating to this period?
- Do Indian and Pakistani men view their pain as a ‘legitimate’ illness and are therefore less reticent to seek help?
- Under what circumstances do Indian and Pakistani men consider chest pain an ‘illness’?
- What is perceived to be a ‘legitimate’ reason to seek medical help for Indian and Pakistani men?
- What role do family members play in Indian and Pakistani men’s help-seeking decision-making?
- How do Indian and Pakistani men view the illness behaviour of their wives and other women? Is there a difference?
- Are the help-seeking behaviours in Indian and Pakistani participants the same as those prevalent in the Indian subcontinent?
- What role does religion play in men’s help-seeking perceptions and masculine identity? Are there any differences between South Asian men of differing religion/cultural origin?

As in the first study, axial coding in the second study incorporated a constant comparative method of analysis that involved a process of inductive and deductive thinking (see Figure 2: The Process of Inductive and Deductive Thinking; page 127). This entailed making tentative theoretical/conceptual propositions relating to an open code or an individual participant's account, then searching the entire data set to establish if the phenomena/concept occurred explicitly, or had been implied in the behaviour of, other participants (Charmaz 2000). The tentative proposition could then be supported, refuted or modified accordingly. Relationships between codes were then established and developed into 'advanced codes'. This process also further informed the theoretical sampling strategy.

To illustrate, during axial coding, conceptual similarities between a Sikh participant and several Muslim participants were proposed relating to the role of the family in men's help-seeking decision-making process. A tentative proposition was made that the family supported both Muslim *and* Sikh men's decision to seek medical help. An additional Sikh participant was recruited, and the data from his interview was examined for incidents (implied or explicit) relating to the proposed concept of '*Extended Family Decision-making*' that would verify, refute, or modify the tentative proposal. The data from the additional interview supported the tentative proposal and an advanced code was therefore conceived (see Table 15, page 206, for list of advanced codes).

In addition to the asking of questions about the data, integrative diagrams (visual representations of analytic thinking that are used to try out the conceptual linkages) and *text searches* using *NVivo* software were also used to facilitate the process of inductive and deductive thinking during axial coding. Text searching involved selecting a word (or phrase) relevant to a tentative proposition, searching for the word/phrase across the data set, and subsequently examining the passage and context in which it had been used by a participant. This allowed comparable incidents to be identified that would allow emergent theories to be verified, refuted or modified.

For example, a tentative proposition was made during axial coding that consulting the GP was a feature of most South Asian men’s help-seeking process. Therefore, the words ‘doctor’ and ‘GP’ were searched for across the data set in an attempt to uncover incidents that would verify, refute or modify this proposal (see Table 14, below, for a list of key search terms). It subsequently emerged that South Asian men appeared to perceive their GP consultations as a means of ‘making sense’ of their symptoms. As such, three additional participants were recruited to gather additional data required to explore the emerging theory relating to men’s use of the GP (theoretical sampling). The data from these interviews – and in particular the interview of Abdur (a retired GP who was serendipitously recruited) – confirmed the tentative proposition that South Asian men perceived their GP as a resource for ‘making sense’ of their symptoms, as opposed to consulting them solely to seek treatment. Hence, the advanced code ‘*Making Sense by Consulting the GP*’ was conceived. After the completion of these three interviews, theoretical saturation was deemed to have been reached and data collection was consequently ceased.

Table 14: Text search terms used during axial coding – Study Two

<ul style="list-style-type: none"> • ‘<i>Individual</i>’/‘<i>individually</i>’ (related to the deductive proposal that Asian men perceived their behaviour and identity as a distinctly individual phenomenon) • ‘<i>Panic</i>’/‘<i>panicking</i>’ (borne out of references of reacting to pain by ‘not panicking’) • ‘<i>GP</i>’/‘<i>doctor</i>’ (borne out of the deductive proposal of the significance of GP perceptions in men’s accounts) • ‘<i>Education</i>’ (borne out of a number of Asian men’s reference to education being important in help-seeking decision-making) • ‘<i>Work</i>’ (to search for the influence of work and socio-economic differences in help-seeking perceptions between participants) • ‘<i>Family</i>’ (borne out of researcher memo that family play a salient role in help-seeking decision-making in Asian men) • ‘<i>Pain</i>’ (borne out of study one inference that white and South Asian men have distinctly different perceptions of their pain which trigger/delay help seeking) • ‘<i>Wife</i>’ (further investigation of the influence of wives in the help seeking process) • ‘<i>God</i>’ (borne out of deductive proposal that religion plays important role in South Asian men’s help-seeking and illness perceptions) • ‘<i>Religion</i>’ (as above) • ‘<i>Soft</i>’ (borne out of search for reactions to questioning on how men perceived their behaviour ‘as a man’)
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Using text searches to search for common incidents, the data from all the South Asian participants were compared to identify the differences and similarities between Indian and Pakistani men at this stage of the analytical process. Despite a limited amount of data from Sikh and Hindu men to make an in-depth comparison of men of differing religious affiliation, it nevertheless became clear at this stage that there were similarities between the Indian and Pakistani participants pertaining to several aspects of their help seeking experience, regardless of their religion, age, occupation, or country of origin. Furthermore, it also became apparent during axial coding that many aspects of the accounts provided by white men appeared to fit the conceptual model that had been conceived on the basis of the findings from the first study.

Text searching was also used to search for incidents that *did not* support the emergent concepts. For instance, text searching revealed that a number of aspects in the account given by one South Asian participant (Rashid) were significantly different to the similarities that had been identified among the majority of South Asian participants. The account of the ‘deviant case’ (Rashid) led to the influence of acculturation being incorporated into the theory at this stage. Rashid’s account is presented in the following chapter.

The integrative diagram developed at this stage of analysis (see appendix 5) illustrates the relationships between the concepts that were proposed at this time. As the diagram indicates, the axial coding process resulted in open codes such as ‘Family’ ‘Religion’ and ‘Culture’ being subsumed (as they were conceptually linked) under the advanced code of ‘*Extended Family Decision-making*’. The ‘Wife’, ‘Wait and See’ and ‘Soft’ open codes were also subsumed under the ‘*Keep it to Yourself*’ concept. Similarly, ‘Don’t Panic’ and ‘Too Much Pain’, and ‘Pain Perceptions’ and ‘When to seek help’, evolved to become the advanced codes of ‘*Appraisal of Pain*’ and ‘*Threshold for Pain*’ respectively. Axial coding resulted in the conception of eight ‘advanced codes’ – based on phenomena derived directly from the data – that provided a greater interpretive understanding of ‘what was going on’ in the data than the previous 25 open codes (Strauss and Corbin 1990). They are listed in Table 15.

Table 15: Advanced Codes and Researcher Memos (code notes) – Study Two

Appraisal of Pain

Asian men viewing their pain as worthy of discussion with others (usually family members) and worthy of seeking of medical help (usually GP). However, chest pain has to be deemed by man as being something ‘new’ (never experienced before) and persistent, so delays in help seeking still occur whilst ‘making sense’ but there is no fear of being perceived to be acting soft or weak for seeing the doctor. Seeking help for pain is legitimate for an Asian man??

Threshold for pain

Perceptions of many white men who perceive their pain as unworthy of concern and help seeking until a particular threshold had been reached.

Extended Family Decision-making

Asian men discussing their symptoms with family and friends who subsequently all mutually decide that the man needed to see a doctor. The family ‘push’ the man to seek help in a joint process. Further evidence of seeking help being OK for an Asian man ???religion involved

Keep it to yourself

White men’s recounts of hiding their symptoms from others, in particular, their wives –Associated with the fear of being seen to be soft etc. if they discussed their problems.

Making Sense with the GP

Accounts given by Asian men relating to their experience with their GP and distinct perceptions of the reason they visited the GP (as opposed to visiting A&E or other health service).

GP’s appear to be a comfortable, natural place to visit when suspecting ill health for Asian men. Religious beliefs appear to implicitly encourage this course of action

Avoiding the GP

White men’s accounts of how long it has been since they saw their GP, why they avoid the GP etc.

South Asian Men’s Perceptions of ‘acting like a man’

Recounts of a rejection of the need to put up with pain or fear of being seen to be acting soft if medical help is sought or expression of being in pain shown (similar between Indian and Pakistani men - dramatically different to white men’s behaviour) - ??borne out of South Asian culture/religion. Help seeking for pain seen as an appropriate behaviour *for a man* – male identity not threatened by help-seeking behaviour – other aspects important?

White Men’s Perceptions of ‘acting like a man’

Perceptions of the need to ‘put up with’/endure pain - not wanting to be seen to be acting soft, or like a wimp etc. – Hegemonic masculine representations. Help seeking for chest pain not consistent with how the men perceived they should behave ‘as a man’.

After the formation of the advanced codes, analysis progressed to the selective coding phase. Selective coding entailed selecting the core concept, integrating and refining the advanced codes, and substantiating the final grounded theory and 'storyline'. The process of selecting the core concept involved the identification of a central phenomenon or main theme in the data that had the analytical power to pull the advanced codes together to form an explanatory whole, and could also account for variation amongst the advanced codes (Strauss and Corbin 1998). Accordingly, the advanced codes were re-examined in an attempt to identify the common concept underpinning the phenomena. For example, the data that had been coded under the advanced code '*appraisal of pain*' was compared with the data from '*making sense with the GP*' with the aim of exploring and identifying a common 'conceptual thread'.

At this stage of analysis it was proposed that participants' perceptions of '*acting like a man*' was the common 'conceptual thread' that pervaded the advanced codes. To illustrate, six advanced codes – men's appraisal of their pain, threshold for their pain, decision to consult the family, keep it to themselves, or consult/avoid the GP – were all concepts that were considered to be underpinned by the participants' perceptions of how, *as a man*, they felt they should behave whilst experiencing chest pain and seeking help. The two advanced codes, '*Asian men's perceptions of 'acting like a man''*' and '*White men's perceptions of 'acting like a man''*' were therefore subsumed into the (provisional) core concept of '*acting like a man*' at this stage.

Subsequent to the selective coding procedure, the researcher's analysis was discussed with two research supervisors as part of the peer debriefing process. The two researchers examined the interpretation of the data – the advanced codes, memos and provisional core concept – in order to draw attention to areas that needed to be further substantiated or developed. During the process of peer debriefing it became apparent that there were limitations associated with the core concept. In particular (as alluded to in the reflexive account that preceded this section), it became evident that the researcher's questioning associated with the concepts of

'acting soft' and *'like a wimp'* had been assumed to have been interpreted the same way, and have the same meaning, to Indian, Pakistani and white participants. Additional data was required to overcome these conceptual weaknesses and substantiate the core concept. Further data collection was therefore undertaken.

Three additional interviews with Pakistani Muslim men were conducted with a revised interview schedule that incorporated a number of additional questions that aimed to gather pertinent data associated with the core concept (see Table 16 for additional questions used in these interviews). The data from the three additional participants, Imraan, Shahid and Mohammad, were compared with the rest of the data set to refine and substantiate the *'acting like a man'* concept and confirm that it was the central phenomenon pervading the advanced codes. Thus, *'acting like a man'* was verified as the core concept at this stage of the analysis. The findings from the analysis of these three additional interviews are presented in section 7.9 ('Pakistani Muslim men's perceptions of 'acting like a man' in the context of help seeking') of the following chapter.

Table 16: Additional questions used in interviews to verify core concept – Study Two

<ul style="list-style-type: none">• A lot of white English men have said to me they won't go to the doctors because they think they would be seen to look 'soft' or like a wimp. What does being 'soft' or acting 'like a wimp' mean to you?• Do you think Pakistani/Indian/Bangladeshi men fear being seen to be acting 'soft' or acting 'like a wimp' if they go to the doctors for pain?• Some white English men in this study have told me they think they behave in a 'macho' type way – what does 'macho' mean to you?• Do you think that <i>you</i> act 'macho' when you're ill?• When you see another man, what makes you think he's not a 'soft man' or a 'weak man', I respect him?• When you see a man and you respect him, what is it about what they do that makes you think that?• Do you think that, as a man, other people – like your wife and friends – expect you to react in a certain way to pain or illness? For example, do you think they expect you to act strong and be brave?• How do you think a man who is not 'soft' or 'weak' would react to symptoms like chest pain?
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Once the core concept had been identified and verified, selective coding focussed on searching the entire data set with the aim of integrating the advanced codes and developing them into the final themes. This process involved re-examining the data associated with each advanced code – ‘asking questions’ about the coded data – with the aim of developing and validating the underlying meaning and process associated with each code.

For example, the advanced codes *‘Extended Family Decision-making’* and *‘Keep it to Yourself’* were re-examined by asking questions about the data such as, what are the properties of the code? Under what conditions and what circumstances does it happen? As a result of this analysis, it became apparent that the common theme of the two advanced codes related to men’s decisions about whether or not to *disclose* their pain to others. To illustrate, in most South Asian men’s accounts of *‘Extended Family Decision-making’*, it was evident that they had taken an early decision to ‘disclose’ their pain to family and friends who had subsequently endorsed their decision that their chest pain was ‘worthy of concern’. By

contrast, it emerged that the aspects of white men’s accounts associated with the ‘*Keep it to Yourself*’ code were evidently related to their decision *not to* ‘disclose’ their pain to others until they considered it to be serious. Thus, the advanced codes ‘*Extended Family Decision-making*’ and ‘*Keep it to Yourself*’ evolved to become the final theme of ‘*Disclosure*’. Table 17 illustrates how, by using this process, six advanced codes became subsumed under three themes that corresponded to the distinct features of men’s help-seeking decision-making process.

Table 17: Evolution of Advanced Codes to the Final Three Themes – Study Two

Previous Advanced Code	(concepts linked / subsumed)	Theme
Appraisal of Pain Threshold for Pain	—————→	Is Pain Worthy of Concern?
Extended Family Decision Making ‘Keep it to Yourself’	—————→	Disclosure
Making Sense with the GP Avoiding the GP	—————→	Shall I Consult the GP?

The final part of the analytical process involved writing and re-writing drafts for the findings chapter of the thesis. At this final stage, the three themes and core concept were again re-validated against key data in order to confirm that they accurately reflected ‘what was going on’ in men’s accounts, and an integrative diagram was conceived (see appendix 6) to aid in the refinement of the substantive grounded theory.

The integrative diagram depicts the relationships among the major themes and concepts, and provides an illustration of how the core concept and three themes developed in the second study (highlighted by grey shading) were considered to fit in with and build on the themes and concepts developed in the first study (see appendix 4).

The diagram illustrates that the core concept, 'acting like a man', represents the salient concept underpinning men's help-seeking decision-making process, and is linked to the themes the data from the second study indicated were influenced by how men perceived they should act '*as a man*' in the context of experiencing chest pain and seeking medical help. The next chapter now presents the substantive grounded theory developed from the second study. The chapter presented a detailed discussion of the three themes developed in the study, drawing attention to how the themes fit in with and build on the findings from the first study, and the differences between white and South Asian men's help-seeking process in relation to the 'acting like a man' core concept.

6.7 Chapter Summary

This chapter has provided an in-depth account of the research methods of the second study presented in this thesis. The study setting, sample, recruitment procedures and ethical considerations have been discussed. The chapter has presented a reflexive account of the process of interviewing men about masculinity, illustrating how the limitations of the first study were recognised and addressed, with reference made to appropriate methodological literature. Finally, a clear description of the study's analytical process has been presented, illustrating the 'decision trail' that culminated in the conception of three themes conceptually linked to a core concept. Each stage of the research process has been made explicit so as to provide a clear 'audit trail' that enables the credibility of the study's findings to be judged.

Chapter 7

STUDY TWO – FINDINGS AND DISCUSSION

7.0 Introduction

This chapter presents the findings of the second study in this thesis that aimed to explore the following research question and study objectives:

How do masculinities influence white and South Asian men's decision to seek or delay-seeking medical help for acute chest pain?

- 1 Examine the differences and similarities between white and South Asian men's decision-making process relating to the period of 'waiting to see';
- 2 Explore the differences and similarities between white and South Asian men's representations of masculinity in the context of seeking medical help for acute chest pain symptoms;
- 3 Investigate the differences and similarities relating to the influence of masculinity on the decision to seek or delay-seeking medical help for acute chest pain among South Asian men of differing ancestry and religion.

Analysis of interviews conducted with twenty men culminated in the conception the following three themes, conceptually linked to a core concept defined as 'acting like a man', that corresponded to the distinct features of the help-seeking decision-making process evident in men's accounts:

- Is Pain Worthy of Concern?
- Disclosure
- Shall I Consult the GP?

Each of the three themes are discussed consecutively in this chapter, drawing attention to how the core concept of 'acting like a man' underpinned each theme, the differences and similarities between white and South Asian men of Indian and Pakistani origin, and how the findings fit in with and build on the theory conceived in the first study. As in Chapter 5 ('Study One – Findings and Discussion'), throughout the discussion of these findings, direct quotations taken from the accounts provided by the study participants are presented in indented italics in order to illustrate how the theory is grounded in the data.

The chapter begins with a discussion of the first theme, 'Is Pain Worthy of Concern?', in section 7.1. Section 7.2 then presents an analysis of these findings, building on the tentative proposals made on the basis of the findings from the first study that white and South Asian men have culturally specific representations of masculinity in the context of help seeking. The following section 7.3 presents a discussion and interpretation of the account of a participant identified as a 'deviant case' in which it is proposed that acculturation may lead some South Asian men to adhere to hegemonic representations of masculinity in the context of help seeking.

Section 7.4 then considers the findings of the second theme identified in the study, 'Disclosure'. This is followed by a discussion and analysis of these findings in section 7.5 in which it is proposed that the 'Disclosure' theme signifies Indian and Pakistani men's maintenance of South Asian cultural health related practices. Section 7.6 addresses the third and final theme, 'Shall I Consult the GP?'. Section 7.7 presents an analysis and discussion in which it is argued that Indian and Pakistani men consider consulting their GP as a distinct stage of the 'making sense' process. The subsequent section 7.8 presents a detailed interpretation of the account provided by an Indian participant which pointed towards the mixing of British and South Asian cultures in the context of seeking help.

Following the discussion of the three themes, section 7.9 of the chapter discusses the findings of three interviews with Pakistani Muslim participants that were conducted with the aim of clarifying and substantiating the 'acting like a man' core concept. The chapter concludes (sections 7.10 and 7.11) with a final discussion that highlights the limitations of current prevailing constructivist perspectives of masculinity, and proposes that interpreting Indian and Pakistani men's representations of masculinity in the context of help seeking as being 'marginalised' is an overly simplistic, ethnocentric perspective. A summary of the key study findings and limitations are then presented in sections 7.12 and 7.13.

7.1 Is Pain Worthy of Concern? – *‘I was concerned about the pains that I was getting’*

The accounts provided by the twenty participants in the second study indicated that, at the onset of chest pain symptoms, all men had attempted to ‘make sense’ of their symptoms in a process that involved a period of internal rumination and rationalisation that was not disclosed to other people such as wives, family members or work colleagues. As in the first study, the majority of men recalled that they had initially self diagnosed a non-serious illness, such as indigestion, and then made a decision to ‘wait and see’ in order to determine whether or not their chest pain was serious and warranted medical attention.

However, the more detailed accounts provided by the white, Pakistani and Indian participants in the second study also revealed a number of distinct thought processes and perceptions, linked with the period of ‘waiting to see’, in which men discerned whether or not their pain was ‘worthy of concern’. Among all white, Indian and Pakistani participants, it was apparent that their perceptions of *‘acting like a man’* in the context of experiencing chest pain and seeking medical help was the core concept that underpinned this period of decision-making and, furthermore, accounted for the differences between white and South Asian men’s rationale for ‘waiting to see’.

The majority of Indian and Pakistani men in the second study indicated that they had initially delayed seeking medical help at the onset of their chest pain and ‘waited to see’. However, akin to the trend identified among South Asian participants in the first study (section 5.11 – ‘A Change in Symptom Perceptions’), it was also evident that the men’s thoughts that their chest pain was a non-serious symptom had been quickly discounted early in their experience. Two principal features emerged as being associated with South Asian men’s decision-making during their ‘waiting to see’ period; first, the men attempting to determine if their pain was persistent and whether they had experienced it before (was it ‘new’?), and second, making the decision that if the pain was new and persistent, it was therefore of unknown cause and worthy of concern.

Significantly, the data revealed that the majority of Indian and Pakistani men had not had to attribute their pain to a heart condition in order to decide that it was worthy of concern and warranted medical attention. Rather, the men's accounts indicated that if they had regarded their chest pain as a persistent, 'new' symptom (because they had never experienced pain like it before) they had spent little time 'waiting to see'.

Thus, it was clearly apparent in the accounts provided that both Indian and Pakistani men did not have a low threshold for pain *per se*, but rather, a low threshold for 'waiting to see'. In support of the tentative proposition made on the basis of the findings from the first study, the data from the second study indicated that it was concern about what was causing persistent pain, as opposed to the pain becoming intolerable, that had prompted Indian and Pakistani men to change their perception of their symptoms, realise that 'something is not right', and *stop* 'waiting to see'. This low threshold for 'waiting to see' appeared to be the principal reason why the majority of South Asian participants had delayed seeking medical help for less than eight hours.

Further similarities in the perceptions associated with this period of the help-seeking process were evident in the responses given by both Indian and Pakistani men when asked if they felt similar to how many white men felt with regard to the need to 'put up' with their pain, or if they feared being seen to be acting 'soft' if they sought help for their pain. The accounts given by eleven of the twelve South Asian men confirmed the inferences from the first study that 'putting up' with pain, or a fear of being seen to be acting 'soft', were clearly *not* associated with their perceptions of help seeking. Seeking help for chest pain was behaviour consistent with the majority of Indian and Pakistani men's perceptions of '*acting like a man*'.

Faarooq, quoted below, gave an account that was illustrative of this theme. In explaining how he had made sense of his chest pain symptoms, he described the difference between pains with which he would and would not visit the doctor. He explained that pains such as

headaches could be self treated because you knew what they were, but if you did not 'understand' the pain and it is 'not going' you should seek help without any fear or concern of how other people might perceive this behaviour.

Researcher: What was going through your mind [when you were getting the symptoms]?

Participant: I'd better get it checked out...I went to get it checked up because I was concerned about the pains that I was getting

Researcher: Some men that I've interviewed they don't like going to the doctors because they think it's like soft, they don't want to be seen as being soft or a hypochondriac. Did you feel like that?

*Participant: Not really no, I just wanted to get it checked up and see if there was anything that I could get it sorted out with....I book an appointment whenever I'm getting pains or if I'm feeling not normal, I will book an appointment straight away rather than just leaving it and thinking it will get better.
(Abdul; 54 year old Pakistani Muslim Male)*

Participant: Better if you go straight to the doctor. There's different kind of pain, if you bad pain you should go to the doctor.

Researcher: Bad pain you should go straight to the doctor? Do you ever worry about how other people might see you if you go to the doctors with the pain?

Participant: No problem, you can go to doctors with pain but sometimes you have pain but after you are all right but you don't understand this pain is which kind. If the pain is too much you must go to doctor... Sometimes you feel headache like that and you can take sometimes paracetamol or some other thing and you are okay.

Researcher: How did you know it was going wrong then?

*Participant: Because the pain is not going.
(Faarooq; 48 year old Pakistani Muslim Male)*

Researcher: Some men that I speak to they don't like going to doctors because they think it's acting 'soft', and they feel like they need to be seen to be strong and things, do you understand?

Participant: Yes

Researcher: Do you think you are like that?

*Participant: In this case, no. Only flu or anything else but in this case it was special because this was a pain in my chest and I thought it was serious...When the pain is pain it's not a person feeling. Feeling this pain, when the pain is serious then you must see doctor.
(Imraan; 72 year old Pakistani Muslim Male)*

The accounts provided by the Indian and Pakistani men illustrated that once a decision had been made that their pain was worthy of concern and that ‘something is not right’, the majority had few inhibitions about subsequently seeking help from their GP. Seeking medical help had been a ‘natural’ response for most Indian and Pakistani participants when they had determined that they were experiencing symptoms of an unknown cause. The accounts given by Dinesh and Mohammad clearly illustrate this perception. When questioned whether he would put off seeking help for his pain because of a fear of being perceived to be acting ‘soft’, Dinesh expressed a belief that if you are ‘*not feeling well*’ you should see the doctor. Similarly, Mohammad noted that he would visit his doctor for ‘*something new*’ (section 7.6 of this chapter discusses men’s perceptions of consulting the GP).

Researcher: Some men that I’ve spoken to, they tend to put off going to see the doctor, would you normally do that or would you ...?

Participant: No, if anything serious like there are some days you don’t feel too good.

Researcher: Because some people talk about this macho type attitude in men to put up with pain, can you identify with that at all or do you think? Do you see what I mean? Like, they don’t want to appear soft and things if they go to the doctor.

Participant: No, no, no, I don’t live like that, I mean if you are not feeling well you got to go to doctor.
(Dinesh; 56 year old Indian Sikh Male)

Researcher: If you had pain, you had a sudden pain and you didn’t know what was causing it, would you go see the doctor about that or would you wait and see and not go to the doctor?

Participant: No, I will go to doctor. Only if that pain I had never had it before and it was very new and I don’t know and it was causing serious, I would go to doctor definitely rather than pretending no there is no problem, I would definitely. For example, flu is common problem for me and if it happens I normally don’t go to doctor because from childhood this is problem for me, so I know already. I know that whenever it starts it goes and after two or three days, but if it something new I would definitely go to it.
(Mohammad; 48 year old Pakistani Muslim Male)

Similar to the pattern of behaviour that was commonly identified among white participants in the first study, a theme that pervaded white participant’s accounts of ‘waiting to see’ in the second study was the perceived need to ‘put up’ with chest pain so as not to appear to others to be acting ‘soft’. In stark contrast to the perceptions of the majority of Indian and Pakistani men, the white participants indicated that they had perceived their chest pain as something to

be 'put up' with in the first instance, regardless of whether or not they considered it to be a 'new' symptom. It was evident in the accounts provided that the white participants considered that perceiving pain as worthy of concern signified to others that they could not tolerate it and that they had a low threshold for pain. Thus, seeking medical help for chest pain *alone* was not behaviour consistent with their perception of *'acting like a man'*.

Reflective of these perceptions, several white participants made explicit reference to their previous experiences of pain and how they had coped by 'putting up' with it. Three white men stated that they had felt that their chest pain could be coped with in the same way. The theme is evident in the accounts provided by Mitchell and Eddie. The two men made reference to their past experience of pain when explaining why they did not seek immediate help for their chest pain symptoms, describing their previous *'enjoyment'* of pain, and having a good *'threshold for pain'*, respectively. In support of the findings from the first study, it was clear in the men's accounts that they had not changed their perception of their symptoms and considered them to be worthy of concern until they began to experience physical symptoms (breathlessness, sweating, clamminess, or loss of skin colour) in addition to their chest pain. The account given by Frank is a further case in point. After 'putting up' with severe chest pain for over three hours, it finally got to the stage where it disrupted his ability to work and he therefore decided that he had *'had enough'* and called an ambulance. However, he remained preoccupied with demonstrating to the ambulance staff that he was not a *'softy'* and that he had *'gone to work'* with his pain.

Researcher: So do you think there's something particular about just getting pain, do you know what I mean?

*Participant: Yes, I mean sometimes if you, I mean I've had pain before with working with, I've worked in the building game and I've been a plasterer's labourer, yes you do get pain but at the end of the day I mean I know I've been working like. I get them pains, it wasn't pain as pain, I used to enjoy it, love it... I mean I've had severe pain before and it's gone and I've thought nowt of it.
(Mitchell; 54 year old white male)*

*I get pains and I can take them alright. I've a right good threshold for pain...the actual pain itself I can stand that alright.
(Eddie; 68 year old white male)*

Researcher: So what was it that made you call an ambulance then eventually? What were you feeling?

Participant: Well I realised that the pain, I mean in the past what had happened with the pain, as I say I'd had mild sort of bouts of it and I'd been able to sort of ease the pain. I mean I'd even gone to work and sort of like taken a little bit of time out just to sort of stand there, prop myself up against the counter or whatever and just relax myself..., it got to a point where I couldn't get shut of it. I couldn't ease it off, there was no respite to it so it just continued and continued and every so long it would build up to another degree of intense pain. To be quite honest with you I'd just had enough, I couldn't concentrate and I was pissed off with it and I wanted to get shut of it and so what do I do?

<Later in the Interview>

Researcher: Do you think that as a man experiencing pain you are expected to put up with it for a certain amount of time?

Participant: I must admit that when I came in, in fact to the ambulance men I said "Look, I kept on going to work" I remember this. I kept on saying stuff like "Look I'm not a softy" and I thought "What am I saying that for because it's stupid". My wife kept saying "You're not a softy" and probably I had some inbuilt thing like you know, they will be saying "Oh it's just a little pin prick" that sort of thing... I suppose yes I did, that's probably why I said.

Researcher: So you were saying to them that you weren't a softy?

*Participant: No what I was trying to say, I was trying to convey to them that I'm not a softy, I don't get upset at the slightest thing. If it's a pain it's a pain. But this pain, I was trying to emphasise the fact that this pain is the worst pain I have ever experienced in my life and this is how strong it is, because they keep asking you on a scale of one to ten and I'm saying "Alright, we won't go for the full ten, we will go for 9.5" you know, I said "That's how bad it is to me". I don't know, you just try to sort of say to people "I'm not a softy but look this is how the pain is".
(Frank; 49 year old white male)*

The stark difference between white and South Asian men's perceptions and responses to their chest pain were illustrated further in the account provided by Rashid; a Pakistani Muslim man identified as a 'deviant case'. Although born in Pakistan, he had – in contrast to the other Indian and Pakistani participants in the study – grown up and been educated in the UK. During his interview, he recounted his perceptions of the difference between what he expressed as his 'Asian mentality' and 'English mentality' with regard to help-seeking perceptions.

Consistent with the patterns identified in the majority of Indian and Pakistani men's accounts in the study, Rashid described his '*Asian mentality*' as corresponding to being health conscious, seeking help promptly for problems and discussing his health problems with his family. By contrast, he perceived his adopted '*English mentality*' as corresponding to stubbornness, not telling others about health problems and not wanting to appear weak to his family and his wife by showing them he was ill. Consistent with the accounts given by many white participants in the first study, he also stressed the importance of his perceived self identity as a 'leader', a worker and not wanting to appear weak to work colleagues; perceptions he recognised as contributing to his decision to delay seeking help during his experience of chest pain. However, when questioned how he considered his family members would react to illness, he recognised a distinctly different 'Asian' attitude of '*running to the doctors*'.

Further commonalities with the perceptions and behavioural patterns identified among white participants were recounted later in his interview. For instance, in further support of the 'physical symptoms' phenomenon identified among many white men, Rashid did not consider his chest pain *alone* to be worthy of concern but, by contrast, felt he should '*get it checked*' once his breathing became erratic. Interestingly, he also recalled how, in a period of rationalisation, he legitimised his decision to get help by recalling a number of football managers who had also recently sought help for chest pain symptoms.

Participant: I think, if I talk about myself I take the good from both cultures and societies. Okay I am independent, I don't need the family... That's like an English attitude...but I've got the Asian thing in me as well. Make sure that you do bring the kids to see me so they can see I'm okay but I don't want them coming until I can talk to them. That's that stubbornness again...not to tell anybody and that's not Asian, that's English...Men have this private "Oh I can deal with this myself. I'm a business man, I can deal with this myself" ...

Researcher: How do you think your dad would have reacted to this?

Participant: Oh he used to, because he had a heart attack and he was seen in London, he just didn't take no chances. He was down there [the doctors] all the time and he, oh yes, he had the apple every day and he was giving us apple and he was buying the tonics and he was dealing with it and I suppose that helped him last a bit longer than he did. He had a regime that he was like implementing onto the family. I probably am

not as vigorous in that way. I suppose that's the Englishness in me ...I know other members of my family, they would run to the doctors. My mum..she's still got the Asian mentality. I haven't.

<Later in the Interview>

*Participant: I'd read about people, sort of [football] managers going into hospital like Houllier and Souness and some of the others and in fact just recently when Leeds thrashed that team 6 -1, one of the managers, QPR's manager went into hospital for something else and I thought...that was the reason that prompted us to sort of call the ambulance. You know, best get it checked.
(Rashid; 46 year old Pakistani Muslim male)*

7.2 Discussion: Is Pain Worthy of Concern? – culturally specific representations of masculinity

The twelve South Asian participants originated from either India or Pakistan. As discussed in Chapter 4, section 4.2 ('Who are men of 'South Asian' and 'White' ethnicity?'), these countries have been recognised as having significant cultural, economic, political and religious diversity (Modood et al 1997), as well as considerable similarity in terms of world views, cultural views and behavioural patterns, especially when sharing the experience of immigration (Mohan et al 2003; Bhattacharya 2004). The findings from the second study in this thesis draw particular attention to distinct commonalities between South Asian (Indian and Pakistani) men in relation to their perceptions of chest pain and representations of masculinity in the context of help seeking. What is more, the findings further illustrate that the commonalities identified among Indian and Pakistani men are distinctly different to the experiences and behavioural patterns of white men.

There is a body of empirical evidence in which ethnic differences in the experience of pain have been reported, although the majority of these studies have investigated differences between white and African-American people of both genders in the US (for example, Neill 1993; Callister 2003; Edwards et al 2001). A prominent theme evident in the small number of pain studies that have investigated South Asian participants is that white/European men and women have a higher tolerance for pain than South Asians (Stretzler and Wade 1981; Zatzick and Dimsdale 1990; Houghton et al 1992; Ng et al 1996). However, these studies have

predominantly focussed on documenting differences between groups and have ignored the underlying mechanisms that may account for these differences. Furthermore, the studies have largely considered 'South Asians' as a homogeneous ethnic group.

For instance, the studies above have primarily focussed on the post-operative analgesia requirements of hospital in-patients and, therefore, the observed results could equally have been attributed to healthcare professionals' ethnocentric perceptions of the analgesia requirements of ethnic minorities, or cultural and psychological factors such as differences in pain perception. Indeed, there is a considerable body of theoretical literature that asserts pain perception and the behaviours associated with pain are primarily influenced by socio-cultural factors (Bates 1987; Berry 1998; Montes-Sadoval 2000; Nayak et al 2000; Callister 2003). In support of this literature, the findings of this study indicate that white and South Asian men's differing perceptions of chest pain, and their subsequent help-seeking behaviours, may signify culturally distinct representations of masculinity.

As discussed in detail in the first study, behaviour associated with delaying seeking help and 'putting up' with chest pain can be seen to signify an adherence to a hegemonic representation of masculinity (based on Euro/American definitions of 'real' manhood) which position men as 'naturally' strong, resistant to disease, unresponsive to pain and physical distress and unconcerned with minor symptoms (Petersen 1998). Similar to the theme identified among white men in the first study, an adherence to this hegemonic pattern was evident in the accounts provided by the white participants in the second study: men had delayed seeking help and 'put up' with their chest pain so as not to appear 'soft' to others or be seen as having a low threshold for pain.

However, the accounts provided by the majority of Indian and Pakistani participants in the second study revealed contrasting interpretations and perceptions of chest pain to those identified in white men's accounts. It was apparent that most Indian and Pakistani men had

consistently perceived their chest pain symptoms as worthy of concern, appeared to be less inclined to 'wait and see', and had no fear of being seen to be acting 'soft' or like a 'wimp' for not 'putting up' with their pain.

These findings would appear to indicate that the South Asian men of Indian and Pakistani origin were more likely than white men to interpret and recognise the symptom of chest pain as a potential 'illness'. This finding is supported by a large body of cultural psychology evidence that asserts that the recognition of a condition as an 'illness' is a subjective experience that varies between cultures (Bishop 1994; Berry 1998; Kazarian and Evans 1998). For example, Radley (1994) noted that people's beliefs about health and illness, and specifically the meanings they give to symptoms, owes much to their cultural beliefs.

Contextualising the findings of the second study from the social psychology perspective, the observed differences between South Asian and white men's accounts of help seeking further the argument put forward in the first study (Section 5.15: 'Something is not right': South Asian men's *culturally specific* marginalised representation of masculinity) that the men gave different cultural meanings to their chest pain symptoms. In addition to indicating cultural differences relating to the interpretation of chest pain, the data also illustrated distinctly different perceptions of what white and South Asian men considered to be gender-appropriate behaviour; that is, how they perceived they should behave 'as a man' in response to chest pain.

The 'worthy of concern' theme illustrated that the majority of Indian and Pakistani men perceived acknowledging being in pain to others as an appropriate, acceptable and legitimate behaviour *for a man* – behaviour that was in stark contrast to most white men's accounts of seeking help for pain. This finding provides further evidence to support the tentative proposition put forward on the basis of the findings from the first study that most South Asian

participants' help-seeking behaviour signifies a culturally specific, marginalised representation of masculinity.

Connell's (2000) assertion that marginalised masculinities are symbolically assimilated to [western notions of] femininity and weakness supports the suggestion that South Asian men's culturally specific representations of masculinity in the context of seeking help are *marginalised* in Western culture. A man who expresses being in pain and seeks medical help for pain (perceived to be a legitimate behaviour for most Indian and Pakistani participants) was symbolically assimilated to being a 'wimp' or 'soft' by the white participants who adhered to hegemonic masculine ideals. [No specific data were collected in this study relating to whether white men perceived the behaviour of South Asian men as being 'feminine' or 'soft': this is an area of interest that could be explored in future investigations]

Robertson (2003b) has explored relations between hegemonic and subordinate/marginalised representations of masculinity and provides a useful framework from which to analyse the findings of the study presented in this thesis. Robertson (2003b) found that, in the context of participation in sport, gay men *contested* hegemonic representations of masculinity. He suggested that:

'the deliberate, non-identification and non-participation with teams sports by gay men, whilst highlighting a vehicle for marginalisation, also creates space for a form of...non-complicity with damaging hegemonic masculinities' (Robertson 2003b; p.714)

It could similarly be argued that, for South Asian men, their willingness to express being in pain and seek medical help for it corresponded to a deliberate non-complicity with white men's hegemonic pattern of masculine behaviour. If accepted, this argument would also point towards South Asian men's representations of masculinity being marginalised – their behaviour is seen to be measured against, and marginalised from, dominant (western) hegemonic representations of masculinity.

However, the data from this study does not support the argument that the Indian and Pakistani men's help-seeking behaviour was borne out of a deliberate, non-complicity with – or desire to disassociate themselves from – white men's masculine behaviour, as Robertson (2003b) found among gay men who were marginalised. Furthermore, as in the first study presented in this thesis, the Indian and Pakistani men's accounts in the second study also run counter to previous findings that have suggested some Black men in the UK and North America use signifiers of hegemonic masculinity, such as taking excessive risks with their health, as a resource for validating and defending their compromised masculine identity (Franklin 1984; Majors and Billson 1992; Hearn and Collinson 1994; Mac an Ghaill 1994; Rich and Stone 1996; Cheng 1999; Evans et al 2005).

Although the accounts provided clearly illustrated that most South Asian men did not associate their behaviour as being consistent with white men's representations of hegemonic masculinity in the context of seeking help ('putting up' with pain, fear of being seen to be 'soft', and so forth), the data did not support the proposition that they perceived their behaviour to be *marginalised* from these hegemonic behaviours, or that they were attempting to validate a compromised masculine identity. Rather, the accounts provided by South Asian participants indicated that most perceived their behaviour as a *normal* and *expected* response to chest pain as a man. This finding would suggest that the men acted in a way that was consistent with *South Asian* cultural representations of masculinity (in the context of seeking help).

This may explain why the findings in this study appear to run counter to those of previous studies that have indicated that men from minority ethnic groups attempt to validate or defend a compromised masculine identity. Previous studies have principally investigated men from ethnic minorities who were indigenous to a Western Country; for example, Evans et al's (2005) study on African-Canadian men. For these men, who were born and raised in Western culture, the masculinity embodied by *white* heterosexual men can be considered to have been

the dominant, culturally exalted representation of 'real manhood' throughout their lives. As Evans et al (2005) note, historically, avenues for demonstrating masculinity have therefore been narrowed for Black and ethnic minority men in Western culture. However, by contrast, all but one South Asian participant in the study presented in this thesis had recently immigrated to the UK. Therefore, if, as the data suggested, the Indian and Pakistani men maintained *South Asian* cultural representations of masculinity, it is possible that they did not perceive a need to 'live up' to (compensate for, or validate) dominant *Western* representations of masculinity.

This draws attention to a potential limitation of current prevailing constructivist perspectives of masculinity: namely, whether a Western representation of hegemonic masculinity is the *only* culturally exalted representation of masculinity in a multi-cultural society such as the UK. This subsequently raises the question of whether the Indian and Pakistani participants' maintenance of South Asian cultural representations of masculinity can be measured against, and therefore be seen as *marginalised* from, *Western* cultural representations of hegemonic masculinity. This argument is developed in section 7.11 of this chapter.

7.3 Deviant Case: Assimilation of Hegemonic Masculinity

Acculturation is the extent to which an individual who migrates from the country in which they were born adopts the values, beliefs, culture and lifestyle of their host country (Mavreas et al 1989). Berry (1998) has suggested individuals deal with the issue of how to acculturate using four strategies:

- *Integration* – individuals have an interest in maintaining their original culture while in daily interactions with other groups;
- *Assimilation* – individuals do not wish to maintain their cultural identity and seek daily interaction with other cultures;
- *Separation* – individuals place a value on holding onto their original culture and at the same time wish to avoid interaction with others;

- *Marginalisation* – where there is little possibility or interest in cultural maintenance (often for reasons of enforced cultural loss) and little interest in having relations with others (exclusion or discrimination).

The extent of an individual's acculturation has been recognised as having both positive and negative effects on health and health behaviour. For example, a review of the literature on East Asian immigrant populations in the US has found that acculturation appeared to lead to an increase in the use of health services, but also increased incidence of chronic disease such as coronary heart disease and diabetes (Salant and Lauderdale 2003).

Differing perceptions and responses to pain within ethnic groups have also been documented according to the degree of acculturation to the host society's norms for health and illness (Thomas and Rose 1991). By contrast, studies on the effect of acculturation on South Asians in the UK relating to psychological distress (Cochrane and Stopes-Roe 1981; Furnheim and Sheikh 1993), eating disorders (Mumford et al 1991), and hospital anxiety and distress (Sonuga-Barke and Mistry 2000), have found no significant correlation between acculturation and health. However, there is currently no evidence on the effects of acculturation on the help-seeking behaviour of South Asian communities in the UK. The account of one South Asian participant in the study presented in this thesis, Rashid, suggests that assimilative acculturation may lead to an alignment with hegemonic representations of masculinity (of the host country) that results in a different perception of chest pain symptoms and gender-appropriate help-seeking behaviour.

A degree of assimilation can be seen to be evident in Rashid's account, signified by his reference to his adopted 'English' mentality which corresponded to a perceived need to hide his pain from others due to a fear of being seen to be 'weak'. This aspect of his account can be seen to signify assimilation to the culturally dominant (hegemonic) representation of masculinity in the host country that embodies the perception of men as being unresponsive to pain and physical distress; perceptions that were commonly identified in white participants' accounts.

Further evidence of assimilation to hegemonic masculinity in Rashid's account is evident in his recollection that his decision to eventually seek help was affirmed by the recent help-seeking actions of several English football managers. This behaviour has similarities with the earlier cited proposition, based on the findings from the first study, that men who adhere to a hegemonic representation of masculinity may need a means of legitimising their visit to the doctor in order to keep their masculine identity 'in tact'. Football managers can be seen to be exemplars of hegemonic masculinity (King 1997). Hence, the recent trend of a number of football managers seeking help for heart problems can be seen to have been the legitimisation required for Rashid to perceive his behaviour to be consistent with a hegemonic representation of masculinity to which he had assimilated.

As noted earlier in Chapter 6 ('Research Methods'), in contrast to the other Indian and Pakistani men in the study, Rashid had been educated at a public school in England. This may explain why he appeared to have a high degree of acculturation to the culturally dominant representation of masculinity in the UK, whereas the other South Asian men, who were educated and brought up in either India or Pakistan, appeared to exhibit less acculturation and maintained South Asian cultural representations of masculinity in the context of help seeking.

Interestingly, Rashid's account runs counter to Garner and Shukur's (1994) suggestion that young Muslims educated in the UK are increasingly defining themselves in terms of their religion. The account provided by Rashid is also contrary to the findings of a qualitative study on (British born) male Muslim secondary school children by Archer (2001) that illustrated many males rejected 'whiteness' and British identity by constructing a masculine identity through identification with a 'strong' religion that unifies young Muslims from different backgrounds. However, in contrast to the account provided by Rashid, Garner and Shukur (1994) and Archer's (2001) findings were based on samples of Muslim schoolboys. Nonetheless, the difference between the account provided by Rashid and these previous

studies on Muslim schoolboys is further suggestive of differences in acculturation and masculine identity among South Asian men of differing generations.

Furthermore, the differences between this study and those by Garner and Shukur (1994) and Archer (2001) also point toward factors other than ethnicity *alone* that play a part in South Asian men's construction of their masculine identity. Indeed, the interplay between socio-economic status and construction of masculinity may explain the hegemonic representation of masculinity that is apparent in Rashid's account. Rashid was a film director and was from a high socio-economic group (II). He experienced his pain whilst at work and his perception of himself as a '*business man*' and a '*leader*' were central aspects of his account of the reason he had delayed seeking help. For example, he noted: '*I'm a business man, I can deal with this myself*'.

The value Rashid placed on his occupation in constructing his masculine identity is consistent with a central tenet of constructing hegemonic masculinity in Western industrialised capitalist societies (the host country) that embodies the perception of men primarily as 'breadwinners'. As such, his experience shares commonalities with a theme identified among white men from higher socio-economic groups in the first study (section 5.8 – 'Hegemonic Masculinity and the 'Breadwinner' Identity') who were similarly reluctant to take sick leave from work because of concerns about their work-place reputation. Again, this feature of Rashid's account is in contrast to the accounts given by the majority of South Asian participants in the first study who appeared to place less importance on constructing a 'breadwinner' masculine identity.

However, it could also be argued that the alignment to a hegemonic representation of masculinity evident in Rashid's account was a *compensation* for his perceived subordinate status as a member of an ethnic minority; a phenomenon similar to what Pyke (1996) identified among lower class men who were noted to have,

'ostentatiously pursued drugs, alcohol, and sexual carousing...[to compensate] for their subordinated status in the hierarchy of their everyday work worlds' (p.538)

Connell (1995) and Courtenay (2000) have also recognised this phenomenon, referring to them as *protest* and *hyper* masculinities, respectively. A similar trend has been recognised among Black/Afro-Caribbean men who use sexist and homophobic discourses to create *hypermasculinities* in order to compensate for their subordinate status as members of ethnic minorities (Majors and Bilson 1992; Mac an Ghail 1994; Thomas 1996).

The various potential explanations for the hegemonic representation of masculinity evident in Rashid's account of his help-seeking decision-making process illustrates that, although the findings from this study have drawn attention to ethnicity as an important determinant in the representation of masculinity in the context of help seeking, there is not a *single* representation of South Asian masculinity and a *single* representation of white masculinity – rather, multiple masculine identities are likely to be constructed through the various positioning of the self and others with regard to interconnected social divisions of gender, ethnicity and class.

Masculinities may be simultaneously an *assertion* of a particular social location and a form of *resistance* of one social division to another, as Hearn and Collinson (1994) note:

'...multiple masculinities are important because tensions and schisms can arise between one identity (or aspect of identity) and another...for example, is the individual foremost black, middle-class, or a man?...some [aspects of identity] will be prioritised over others [in differing contexts]' (p.111; comments in parentheses added)

Therefore, it is possible that Rashid's hegemonic representation of masculinity was simultaneously a result of acculturation, an assertion of his high socio-economic status, and a resistance/compensation for his marginalised status as a member of an ethnic minority group.

7.4 Disclosure – ‘*not to tell anybody...that’s not Asian, that’s English*’

Men’s judgment of their chest pain symptoms as being worthy or unworthy of concern was directly linked to their subsequent decision to disclose and discuss their symptoms to other people, or keep the symptoms to themselves and continue to ‘wait and see’. A prominent theme evident in most men’s accounts of help seeking related to the thoughts and perceptions associated with this process of ‘*disclosure*’. Again, it was evident in the data that white, Indian and Pakistani participants’ perceptions of how to ‘act like a man’ in the context of experiencing chest pain and seeking medical help was the core concept underpinning this period of decision-making.

As in the ‘worthy of concern’ theme, commonalities between the Pakistani and Indian participants were identified in relation to the ‘disclosure’ theme which corresponded to the involvement of their family members during their help-seeking decision-making process. Eleven of the twelve South Asian participants recalled that, when they realised their chest pain was ‘new’, persistent and worthy of concern, they had subsequently decided to discuss their symptoms with their wife, family member and/or friend at this time. As a consequence of such discussions, it was apparent that South Asian men’s help-seeking decision-making process became a *mutual process* of decision-making.

Men’s mutual process of decision-making involved them discussing, consulting and attempting to ‘make sense’ of their symptoms in partnership with their family and/or friends. It was apparent in the accounts provided that these discussions had often led to family and/or friends providing support for the decision to seek medical help by *endorsing* the men’s judgment that their pain was worthy of concern.

For example, Faarooq recalled that when he had become concerned about his chest pain he had decided to share his concerns with his brother’s wife. Although her response was not reflective of those identified among the majority of the South Asian participants (as she did

not immediately endorse his fears about his pain and encourage him to seek help), his disclosure of his symptoms are nevertheless illustrative of how family and friends became part of most South Asian participants' help-seeking decision-making process. For Faarooq, a discussion about pain with his sister-in-law appeared to be a 'natural' response to his decision that his pain was worthy of concern. It was clear from South Asian men's accounts of disclosure, and the subsequent involvement of their family and friends in their help-seeking decision-making, that this behaviour was consistent with their perceptions of 'acting like a man' in the context of help seeking. Discussing and disclosing being in pain to others was not perceived by the men, or their families, as being 'unmanly'.

One day I feel chest pain on this side, only one side. I thought my, brother's wife, she tell me no is not worry because if you have heart problem then both sides will feel pain.

(Faarooq; 48 year old Pakistani Muslim male)

Researcher: What about do you think how you are is the same as how your brother or cousin would react to this?

Participant: My brother or cousin what?

Researcher: Do you think that they would be the same, that they would feel the same as you if they got the same chest pains and things?

Participant: Yes because I talked to my brother about, he told me this reaction.

Researcher: Right, so you've seen other people with heart disease and they've told you about it?

Participant: Yes we talk about it.

Researcher: Who do you talk about it with?

Participant: Family and friends.

(Imraan; 72 year old Pakistani Muslim male)

By contrast, the white men's accounts of disclosure emerged as fitting the same pattern of responses to those identified in the first study; disclosing being in pain was not consistent with the men's perceptions of 'acting like a man' in the context of seeking help. Disclosing being in pain was seen as synonymous with complaining about it and, therefore, was incongruent with the men's perceived need to demonstrate a high tolerance for pain. Four

white participants explicitly stated in their interviews that they had intentionally hidden their pain symptoms from their friends, partners and work colleagues for this reason.

For example, Matthew was unequivocal about why he purposefully hid his chest pain symptoms from his partner. He described the effect he perceived such a discussion would have on his partner's view of him, explaining he felt pressured by women to be '*seen as being strong and dependable*'.

*I think females also put pressure on men because there's the old joke about they have a cold and it's like they are on their last legs and that we moan and complain a lot, so we have that in the back of our mind also at the same time, so we don't want to be perceived like that by the people obviously that you want to impress and when you are having a relationship you want to be seen as being strong and dependable. So if females are saying that men complain a lot and if they knew about childbirth and even these different sorts of stories that sort of bolster up men's ideas about being strong and so I'm aware of that too.
(Matthew; 47 year old white male)*

The accounts provided by the white men indicated that, having decided that their pain was *unworthy* of concern; they had subsequently 'put up' with it, kept it to themselves and 'waited to see'. In support of the findings from the first study (section 5.12 – 'Men's Partners'), the majority of white men in the second study indicated that they had only disclosed their pain to someone else (usually their wife) in order to initiate the call for medical help *after* realising that 'something is not right'.

By contrast, it was apparent in the accounts provided by the majority of South Asian men that they had disclosed their pain to their family and friends in order 'make sense' of their symptoms after they had realised that 'something is not right', not merely to initiate the call for help. Moreover, in difference to the findings from the first study, the accounts provided by a number of South Asian men in the second study indicated that they had discussed their symptoms with a wide array of people, not only their wives. Although the majority of South Asian men recalled that they had consulted their wife or children in the first instance, six Indian and Pakistani men indicated that their friends and extended family members (such as brothers-in-law; cousins) had also been involved in their 'making sense' discussion. These

findings provided further evidence that discussing and disclosing pain symptoms with others was consistent with Indian and Pakistani men's perceptions of 'acting like a man'.

The accounts given by Matthew and John make clear the differences between white and South Asian men associated with this aspect of help-seeking behaviour. As previously discussed, Matthew intentionally hid his symptoms from his partner, but noted later in his interview that if he ever does discuss health problems, *'it would be my girlfriend first and foremost'*. Consistent with the trend identified in the first study, Matthew did eventually disclose his symptoms to his partner, but only after delaying for some time and subsequently realising *himself* that he needed some help because 'something is not right'. Similarly, John recalled that he intentionally hid his symptoms from his wife and also recognised similar behaviour in a recent experience involving his next door neighbour.

I'm trying to think that hopefully it will just go away and in the end, when I told her, she [partner] insisted that I come down and I agreed because I was getting concerned myself

<Later in the Interview>

*In the first instance I usually keep it to myself... but eventually you seek another source, which would be in this case it would be my girlfriend first and foremost.
(Matthew; 47 year old white male)*

What she's seen when I came out of that car because I didn't tell her what happened Monday, Tuesday, Wednesday, I never told her about all these pains I'm having. I put it down as indigestion, I never told her, I just got on with it.

<Later in the Interview>

*I've got a next door neighbour there, ...They nearly lost him. He started bleeding, pain, blood and all sorts. I was away for the weekend, I got a phone call from the wife and they'd taken him in hospital, he'd collapsed twice, just retired as well. Anyway they took him in and they found out that he'd trouble with his bowels and that, that he'd kept it to himself. His wife was angry, raging
(John; 55 year old white male)*

The account given by Rashid pertaining to his perceived differences between 'Asian' and 'English' characteristics were consistent with the differences identified between white and South Asian participants in relation to the disclosure theme. He described an Asian trait as being able to discuss and make illness known to children and the family but, by contrast, he

perceived his behaviour to be congruent with English traits which were '*not to tell anybody*'. Accordingly, he did not disclose his symptoms to anyone until his pain became extremely severe and his breathing became erratic.

*I've got the Asian thing in me as well. Make sure that you do bring the kids to see me so they can see I'm okay ...not to tell anybody and that's not Asian, that's English.
(Rashid; 46 year old Pakistani Muslim male)*

*If you are ill yourself, if you are ill and you want to keep it to yourself no-one is going to help you...
(Amit; 53 year old Indian Hindu Male)*

7.5 Discussion: Disclosure – Maintenance of South Asian Cultural Health Related Practices

Relationships within South Asian families living in the Indian subcontinent have been proposed as being more interdependent than their white (European) counterparts, in a 'joint family system' where families are closely knit with grandfathers, fathers, sons, and grandsons sharing the same spirit, tradition and property (Mohan et al 2003); and with up to three generations involved in decision-making (Beishon et al 1998).

However, it has been suggested that the 'extended family' is neither universal nor protective among South Asian families living in the UK (Ahmad 1996a). For example, Stopes-Roe and Cochrane (1990) have argued that strict immigration laws, a growing preference for nuclear households, occupational mobility, and fragmentation of family networks make the assumption of joint family systems among South Asian families in the UK questionable. In support of this argument in relation to health matters, Atkin and Ahmad (2000) and Katbamna et al (2004) have studied parental carers of family members suffering a chronic illness in South Asian families in the UK and found that practical or emotional support from the extended family was negligible. Interestingly, Thomas et al (2000) have found that women who were living in 'joint families' in India who had been diagnosed with tuberculosis reported that no one else in their family was made aware of the disease due to their fear of the consequences (being deserted) if other family members found out. Thomas et al's (2000)

finding suggests that the involvement of family in health matters may differ between type of illness (and stigma attached to it), and between male and female members of the family. However, in contrast to these findings, the mutual process of decision-making identified in the study presented in this thesis did suggest that most Indian and Pakistani participants, who were born in the Indian subcontinent but were living in the UK, maintained aspects of South Asian cultural practices associated with support from the extended family in health matters.

The mutual process of decision-making associated with the disclosure theme demonstrated that the families and friends of the Indian and Pakistani participants played a salient role in their decision to seek medical help. The majority of Indian and Pakistani participants had made their decision to seek medical help for their chest pain after they had discussed it with friends and family members, who subsequently appeared to endorse their symptoms as worthy of concern. This finding is consistent with those of Bhatt and Dickinson (1993) who found, in a study of healthy Asian men and women in the UK, support from the family was ranked highest in a list of factors thought to have a beneficial effect on health, and advice from family members over health matters was ranked as 'important'.

Interestingly, the finding in this study that Indian and Pakistani men's families encouraged them to seek help runs counter to previous studies on (white) women with chest pain that have found seeking help from relatives led to increased delay as they minimised symptoms and provided reassurance (Foster and Mallik 1998; Zuzelo 2002). The involvement of families in the help-seeking decision-making process of South Asian participants in the study presented in this thesis was also in contrast to the accounts provided by white men. Many white men were explicit about having hidden their pain from others, including family members, for significant periods of time so as not to appear to be acting 'soft' or unable to endure pain. This finding supports the trends identified in a study on hypothetical help-seeking behaviour by Chaturvedi et al (1997). Chaturvedi et al (1997) reported that greater proportions of South

Asian men and women compared to white Europeans (sic) conveyed that they would discuss chest pain symptoms (given a fictional vignette) with friends and relatives.

An additional theme in the literature on social support networks in minority ethnic communities is the nature of kinship ties between and within generations, and focuses on issues such as who in the kinship network is likely to be approached for help (Katbamna et al 2004). For instance, Phillipson et al (1998) revealed that social support networks of elderly Indian and Bangladeshi people living in the UK were mainly located within multigenerational households, and children and spouses were the primary source of support for elderly people. In the study presented in this thesis, it was notable that the Indian and Pakistani participants had consulted a wide range of family members and friends for assistance in their help-seeking decision-making. However, consistent with the findings of Phillipson et al (1998), it was also apparent that at the onset of chest pain the participants' spouses and children had been the primary source of support and advice.

Again, in contrast to the Indian and Pakistani men, when eventually disclosing their symptoms it was apparent that most white men had seldom discussed their pain with anyone else but their wife. Similar findings have been reported in a focus group study that looked into the patterns of disclosure among white men with prostate cancer (Gray et al 2000). In Gray et al's (2000) study, most of the men that were studied wanted to avoid talking about their condition with anyone other than their wives. The comparable trend identified in the study presented in this thesis can be seen as a further indication of white participants' representation of hegemonic masculinity in the context of experiencing chest pain. As Courtenay (2000) has proposed, a man who does [hegemonic] masculinity as prescribed would think of himself as independent, not needing to be nurtured by others, and would be unlikely to ask for help from others.

By contrast, as noted earlier, South Asian men's accounts of having disclosed and discussed their chest pain symptoms with friends and family members with little reticence provides further indication that expressing being in pain to others is perceived as gender-appropriate behaviour for an Indian or Pakistani man – behaviour that does not threaten their masculine identity. Contextualising the accounts of the Indian and Pakistani participants with the literature on Hindu, Sikh and Islamic religions adds support to the proposition made earlier in the chapter that, despite living in the UK, most Pakistani and Indian participants maintained *South Asian* cultural representations of masculinity in the context of seeking help for their chest pain.

The twelve South Asian participants were a heterogeneous group in terms of religious affiliation; participants stated they practiced Islam, Sikh or Hindu religion (see Table 12: Demographic Characteristics of Sample – Study Two; page 194). Although religious beliefs were not explicitly recounted by many South Asian men (as discussed in the reflexive account in Chapter 6), their willingness to seek help for their pain and discuss their symptoms with family and friends has resonance with a number of the common principles of Islamic, Sikh and Hindu religions. For example, consistent with the mutual process of decision-making identified among Sikh participants (Dinesh, Mahesh) and Hindu participants (Amit), Sikhism customs encourage the need to make the most of human life through family life and serving the needs of the community (*sewa*) (Gill 2002); and according to Hinduism, the person is seen as intimately integrated within the family and environment (Jootun 2002). Similarly, consistent with aspects of the accounts provided by the majority of Muslim participants in this study, some interpretations of Islam and the Koran have suggested that Muslims view the family as the building block of society and are encouraged to seek medical treatment and care when experiencing ill health (Akhtar 2002; Athar 2005).

Conversely, however, it has also been suggested that religion may have an *adverse* influence on help-seeking behaviour. Al-Hassan and Omran (2005) have suggested that Muslims may

hold a belief that illness is '*God's Will*' and, consequently, may use prayer to help them cope with ill-health which leads to delays in seeking medical help. Similarly, Naqvi (2003) found that, in a focus group study investigating primary care staff's perceptions of South Asian patients with cardiovascular disease in the UK, a number of GPs felt their Muslim patients suffered their condition as part of '*Allah's will*'. A typical response from one GP in this study was cited as,

'In the sense that the actual religious aspects of life is a fairly downbeat affair in Anglo-Saxon white culture, whilst Muslim folk feel their lives are determined outside the 'self' and choice, so they feel that suffering is part of Allah's will. There is a bit of fatalism with suffering' (Naqvi 2003; p.14)

Although the theme of '*Allah's will*' was not specifically explored in the study presented in this thesis, the Muslim participants' general accounts of their help-seeking behaviours and perceptions do not support this suggestion. Indeed, the findings illustrated that, paradoxically, the majority of Muslim participants clearly *rejected* any perceived need to suffer, endure or 'put up' with their pain, and it was [Anglo-Saxon] white men who perceived a need to suffer their pain.

Notably, Naqvi's (2003) findings were based on the opinions of GP's and practice nurses (their ethnic origin was not stated). The contrasting findings of Naqvi's (2003) study with those of the study presented in this thesis draw attention to the possibility that some health professionals in the UK may hold misconceptions about the help-seeking behaviour of Muslim men. The implications of this on healthcare practice and policy are discussed in the next chapter (Chapter 8 – 'Summary and Conclusions').

Mohan et al (2003) have also suggested that tolerance to pain as part of the Hindu-Indian religious belief of *karma* might significantly delay a person from seeking medical attention when suffering chest pain, although this proposition was not based on any empirical evidence. The two main principles of Hinduism, *karma* and *dharma*, have shaped the structure of traditional Indian society – *karma* is a significant and pervasive belief among Indian Hindus

and relates to the idea that every action has effects on present and future lives (Kalman 1990). Thus, pain may be perceived by Hindus as a punishment for their actions in a previous life (*karma*). Again, the account of the Hindu participant (Amit) in this study appears to refute this suggestion. Amit was identified as having an attitude to seeking help for chest pain that was similar to that described by the majority of South Asian men – he rejected any perceived need to endure his chest pain or delay seeking help.

However, as noted in the reflexive discussion presented in the preceding chapter, the influence of religion on South Asian men's help-seeking beliefs and behaviours was not an area that was explored in great depth in this study. The inferences in the data highlight the need for a focussed investigation in order to confirm or refute the tentative propositions made in this discussion.

7.6 Shall I Consult the GP? – *'you don't need an invitation to go to a doctor'*

A theme that emerged early in the analytical process was the frequency with which both Pakistani and Indian participants had referred to the role of their general practitioners (GP's) in their experience of seeking help. As discussed earlier, it was apparent in the majority of Indian and Pakistani men's accounts that seeking medical help had been perceived to be a 'natural', rational response once they had considered their chest pain to be 'new', persistent, and of unknown cause. Consulting the GP emerged as being a central feature of this 'natural' help-seeking response. However, it emerged that white men had distinctly different perceptions of consulting their GP and seeking medical help once they had realised their symptoms were worthy of concern. Once again, it was apparent in the data that the differences between white and South Asian participants' perceptions of consulting the GP was linked to the men's differing perceptions of how to 'act like a man' in the context of experiencing chest pain and seeking medical help.

Analysis of the Indian and Pakistani participants' accounts of their help-seeking experience revealed similarities in the rationale given for their visit to the GP. As opposed to visiting solely to seek treatment, it appeared the majority of South Asian men had gone to their GP to seek advice and clarification, to '*make sense*' of, the cause and severity of their chest pain symptoms. Although many South Asian participants' visit to their GP led to the calling of an ambulance immediately after or during the consultation, the men's responses relating to the reason they had consulted their GP suggested that visiting the doctor had been widely viewed by the Indian and Pakistani men as a precursor to seeking treatment. This is illustrated by the fact that, rather than directly calling for an ambulance or self-referring to a casualty department, all but one of the South Asian participants ('deviant case' Rashid) had consulted their GP during the help-seeking process.

The data indicated that consulting the GP was perceived by South Asian men as a distinct and necessary 'step' in the process of seeking medical help: symptoms were initially 'made sense' of as worthy of concern, then disclosed and endorsed as worthy of concern in a mutual process of decision-making with the extended family, and subsequently taken to the GP to clarify what should be done. This finding also provided further evidence that the men did not have to attribute their pain to a heart condition in order to consider it worthy of concern and subsequently seek medical help. For example, after previously speaking to his brother's wife, when Faarooq recognised his pain was persistent he immediately felt he should consult his GP to 'make sense' of his symptoms, as opposed to solely to receive treatment.

*I feel pain for long time. I thought I should have to go to my GP and he tell me what [the pain is] when I tell him so and so, pain in my chest and my arm.
(Faarooq; 48 year old Pakistani Muslim male)*

Researcher: Were you worried at all that it might be something serious or something to do with your heart, or...?

Participant: Never came into my mind...

Researcher: But you went to see your doctor anyway?

Participant: Yes, to find out what it was. As it was, we don't have any appointments like in the morning so I went straight in and I told them and I had to wait about five or ten minutes.

(Dinesh; 56 year old Indian Sikh male)

Researcher: A lot of men that I've interviewed, when they got chest pain they were reluctant to like see the doctor because they expressed feelings that they deemed to be like soft by other people because the doctor would think he was a hypochondriac. Can you identify with anything like that?

Participant: No, I've always gone to the doctors straight away when I think something is wrong, he will tell me.

Researcher: So what about other men, have you come across this sort of male thing of like putting up with pain and everything.

Participant: Yes

Researcher: What do you think about that?

Participant: Well I, I don't know about that. If I am poorly I go to the doctor, simple as that.

(Jamaal; 41 year old Pakistani Muslim Male)

Researcher: Do you have any problems coming to see the doctor at all? A lot of men that I've spoke to they don't like coming to see the doctor.

Participant: No my family does come and see him and he give me some medicine.

Researcher: Some men that I've spoke to they think that if you go see the doctor you might be seen to be a bit soft.

Participant: No, very co-operative.

(Mahesh; 74 year old Indian Sikh male)

Trust and respect was an additional theme associated with South Asian participants' accounts of consulting the GP, based on their past experience of positive consultations with their doctor. The perception of trust and respect appeared to contribute to the men's lack of reluctance about seeking help and advice from their GP during their experience of chest pain. Furthermore, this perception was apparent whether or not the doctor was of white or South Asian ethnicity. For example, Imraan, quoted below, had known his GP for twenty years.

Researcher: Do you think that going to the doctors makes you look weak or do you think no problem going to the doctors?

Participant: No problem ... I think it's good going to the doctor.

Researcher: Do you know your local doctor?

Participant: Yes, for about twenty years.

Researcher: Is he an Asian doctor?

Participant: No. Before that it was an Asian doctor and then in the health centre now there's a [white] doctor.

(Imraan; 72 year old Pakistani Muslim male)

The account given by Abdur, a retired general practitioner of Pakistani origin, substantiated the theme identified in the Pakistani and Indian participants' accounts in relation to their perceptions of the GP. What is more, his account also supported the wider patterns in the data that suggested South Asian men maintained South Asian cultural help-seeking practices despite living in the UK. In illustration, although he recalled that in his professional experience (as a GP in the UK) he perceived no difference between people of differing culture or gender with respect to their help-seeking behaviours, he nevertheless drew attention to two significant reasons why he perceived Muslim men may not be reluctant to visit their doctor. He indicated that Islamic religion may endorse Muslim men's decision to see the doctor when ill-health is suspected and, in addition, suggested that South Asian men may maintain help-seeking behaviours in the UK that are similar to a tradition in the Indian subcontinent whereby visiting the doctor is undertaken at all costs.

Researcher: So do you think the people, the men in your family, if they get a problem they go see the doctor?

Participant: Yes I will definitely advise them to go to doctor. No point if it's boy, girl, woman, whatever, when in doubt will seek medical attention.

Researcher: They don't delay?

Participant: No, no delay.

Researcher: Do you think most Muslim people, they would react the same?

Participant: Muslim is religion, caste or creed the same, religion doesn't play in the matter here.

Researcher: You don't think it makes any difference at all or what background or anything?

Participant: No, religion doesn't affect the matter. Even the Muslims in their religion they say 'If you are sick, seek a doctor, go to the doctor'....In the Holy book. The Prophet himself, he goes to the doctor, he got the medicine, he treated himself and he had to seek medicine, so every Muslim knows about it. But everybody, Catholics, Roman, everybody there know, if they are ill then they have to go to doctor but some doctors don't agree with the patient, then it is different, man to man different.

<Later in the Interview>

Researcher: Some people born in England, white men, they don't like going to see the doctor sometimes.

Participant: Oh I know that.

Researcher: Do you see what I mean? Do you think that people from a South Asian background do the same?

Participant: No they will go.

Researcher: Do you think they are different [to white men]?

*Participant: They [South Asian men] would sell their property because it's expensive, they will sell everything and they will go to the doctor... in India, Pakistan and Bangladesh, there is vast creed and colour, they believe in doctor as a second god. Whatever the doctor says they believe it. They believe in doctor, their second god. The doctors also believe in the same way.
(Abdur; 84 year old Pakistani Muslim male; retired GP)*

The account given by Amit, a 53 year old man of Indian origin, also provided further evidence of an Indian culture of willingness to visit the doctor. For example, he noted that he understood that *'you don't need an invitation to go to a doctor'*. During his interview, Amit also described his and his family's experience as Indian Hindus living in an English culture, suggesting that *'Indians'* were generally *'better at seeing the doctor'* due to a culture of health education (what he noted as *'Asian programmes'*) and being health conscious that was prevalent in the Indian community.

However, he also recognised that this Indian culture was merged to some extent with a British culture and, furthermore, was being eroded in his children who were British born. In contrast to the other South Asian participants, he also drew comparisons of his positive health behaviour and lifestyle as an Indian Hindu against other South Asian communities of

Pakistanis and Bangladeshis. Despite this suggestion, Amit's account shared the conceptual similarities identified in the accounts of the majority of Indian and Pakistani men in the study.

I think the Indians are more concerned I would say because they are more health conscious than some other people... So I think we Indians we are more, I'm talking about being Indian myself, the Indian people are more health conscious, they do fairly well at the going to doctor... I understand that you don't need an invitation to go to a doctor. If you are ill yourself, if you are ill and you want to keep it to yourself no-one is going to help you. Like I said we Indians, some Muslims, Pakistanis and Bangladeshis, I think Hindus are better looking after themselves, eating wise, drinking wise like English, more health conscious, better educated in some senses, they try to live up with the British culture I am talking about here. They don't just stick to their own religion, I mean now you are in England you do like the Romans does. It's like my family, I am an Indian man and I still have a lot of Indian background but a lot of things what we do it's all English. We speak English in the house as well, all my children are fairly well educated, my brother is also a doctor. We try to take this out and go into other culture and we have our own little, the Asians have their own little holes and whatever. Sometimes we get together and we talk about it, this heart disease and diabetes and how it is with people and why is it so, cut down on your meat product, try and create a balance, if you get pain in your chest what you should do, why do you have this pain. They do talk and more and more education coming in....we have a lot of Asian programmes now and they are giving them completely different information to people. Those people who don't speak proper, you know, I'm talking about my parent's age. Most of them more or less now they are old, they are all passed away, now the new generation is my age in this country so we will be a little bit like our parents but our children are different, they are more like English group. I mean obviously we try to do a little bit of our parents, but our children they are completely changed now.
(Amit; 53 year old Indian Hindu Male)

The accounts provided by the white participants provided further evidence of the differences consistently identified between white and South Asian men in the study. All eight of the white participants alluded to a reluctance to visit their GP; a trend illustrated by the fact that seven out of the eight white participants had sought medical help by calling an ambulance from home. No white participant had contacted a GP at any time during their experience of chest pain.

Again, it was apparent in the accounts provided that visiting the GP was not consistent with their perceptions of 'acting like a man'. Visiting the GP appeared to challenge the men's perceived need to demonstrate an ability to tolerate pain and illness. In contrast to the Indian and Pakistani men, the white men had therefore not considered visiting their GP to make sense of/clarify the cause of their chest pain symptoms; instead choosing to 'put up' with the

pain and make sense of it alone. Five white participants commented explicitly on the amount of time since they had last visited their doctor. Harry is a case in point. He was explicit about his reluctance to visit his doctor in noting that *'I haven't been for 13 years'*. The account provided by Trevor also embodied the perception that was evident in the accounts given by white participants relating to consulting the GP. He noted that visiting the doctor was not something you *'readily look to do... if you can put things off you do tend to do that'*.

Consistent with these perceptions, it was apparent that when most white men had eventually realised that they required medical help (that *'something is not right'*), they perceived their condition to be an emergency which necessitated an ambulance or hospital casualty department, not the GP. This again suggested that seeking medical help was perceived by the white men as being a last resort; a behaviour only undertaken when it was absolutely necessary, namely, a medical emergency.

The account given by John, the only white participant in the study who *did not* call for an ambulance, provided a stark illustration of the need to delay seeking medical help, hide illness from others, and keep masculine identity *'in tact'*. He recounted that he had chosen to drive to hospital himself, rather than phone an ambulance, so that people would not think he was poorly and pity him.

So I thought I'd set off to work. I mean I didn't feel too bad, I wasn't in agony, if I'd have been in agony I wouldn't have gone but there was some pain there ... I mean I do go to the doctors but it's not something I readily look to do, so I think sometimes if you can put things off you do tend to do that.
(Trevor; 57 year old white male)

You see I've never really, I can't say I've actually rung up to see a doctor, you know what I mean. When I was a kid yes, I had a perforated ear, I probably still have, it's probably scarred now but I used to see a doctor on a regular basis when I was at school. I fell down some steps when I was about 2 or 3 years old and perforated an ear and since I left school I've hardly seen a doctor.
(Mitchell; 54 year old white male)

I don't want an ambulance coming up the bloody street and all that. I don't want people to think I'm poorly, you know what I mean... I just don't want pity, people looking.
(John; 55 year old white male)

7.7 Discussion: Consulting the GP

A consistent finding in the research literature is that adult South Asians attend general practices more frequently than the white population in the UK. For instance, Balajaran et al (1989) found that Pakistani men aged 16-44 years were twice as likely to consult a GP in comparison to European (sic) men in the UK; a finding that has been replicated in similar survey studies (Gillam et al 1989; Atri et al 1996; Murray and Williams 1996; Chaturvedi et al 1997). Children and young people from South Asian ethnic groups have also been found to be more likely to consult a GP compared to white children and children of other ethnic groups in the UK (Cooper et al 1998). However, previous studies have failed to establish whether the observed differences are a result of differences in morbidity, or due to differing perceptions to illness and health care between minority ethnic groups and the majority white population in the UK. The findings from this study suggest that men's perceptions of when and why to visit the GP may be a significant factor that contributes to the differences in attendance to GP surgeries between white and South Asian men who experience chest pain.

The data illustrated a common perception among the majority of Indian and Pakistani participants relating to the need to consult their GP for their chest pain; a trend illustrated by the finding that all but one of the South Asian men had consulted their GP during their experience of chest pain. Furthermore, it was apparent that the majority of South Asian participants had consulted their GP to 'make sense' of their symptoms. This pattern of behaviour was in contrast to the white participants who were reluctant to consult their GP and had predominantly sought medical help via the emergency services. These findings are supported by a study by Johnson et al (1983) that suggested white Europeans (sic) are more likely to bypass their GP by visiting emergency clinics, whilst South Asians are more likely to attend such services following referral from their GP.

Furthermore, the South Asian participants' reasons for visiting their GP may explain previous findings that, in comparison to non-Asian patients, GP's in the UK perceive South Asians

take up more time in the surgery, consult for 'trivial' disorders, and make excessive and inappropriate use of health services (Wright 1983; Ahmad et al 1991; Hawthorne 1994). The themes identified in the second study presented in this thesis would suggest that this may be a result of South Asian patients' perception that consulting the GP for even 'trivial' disorders is a legitimate and necessary feature of the 'making sense' period of the help-seeking process.

The data also revealed that a number of South Asian men appeared to know their local GP well, trusted and respected them, and were positive about their previous consultations. What is more, South Asian men's perceptions and experiences of their GP consultations appeared to be similar regardless of whether their GP was of white or South Asian ethnicity. These findings appear to be contrary to previous studies that have reported that South Asians in the UK tend to consult GPs of the same ethnic origin (Beishon and Nazroo 1997), have language and communication problems associated with their consultations (Wright 1983; Farooqi et al 2000; Naqvi 2003), and are dissatisfied with the GP service (Rashid and Jagger 1992; Webster et al 2002). However, men's interactions and access to primary care services were not areas explored in any depth in this study. The inferences evident in the accounts provided by several South Asian participants relating to their use of the GP highlight this as an area that requires further research attention.

Nonetheless, although men's interactions with their GP was not a topic explored in depth in the study, the differences identified between white and South Asian participants relating to their reluctance or willingness to seek help from their GP can be seen as further evidence of the men's culturally different help-seeking practices and, furthermore, the men's culturally distinct representations of masculinity in the context of experiencing chest pain and seeking help.

There is a dearth of evidence on men's patterns of help seeking within the Indian subcontinent, and the small amount of evidence that is available is largely limited to studies

on help seeking for tuberculosis symptoms (Nair et al 2002; Morankar and Weiss 2003; Atre et al 2004). However, the findings of these few studies appear to support the proposition that the help-seeking patterns identified in the majority of South Asian participants' accounts in this study are broadly similar to the behavioural patterns of men living in the Indian subcontinent.

For instance, consistent with the concepts identified in the study relating to a 'mutual process' of decision-making and the use of the GP, Morankar and Weiss (2003) have similarly found that the most common factors influencing choice of healthcare provider among men in rural Maharashtra, India, were positive past experience and persuasion by a family member. Similar findings have also been reported in a study by Grover et al (2003) on men and women from a Northern Indian community and by Nair et al (2002) and Atre et al (2004) on samples of Southern Indian men and women. Interestingly, both Nair et al (2002) and Atre et al (2004) found that men were more likely to seek help than women; a theme that has been echoed in studies of help-seeking behaviour in Pakistan (Shaikh and Hatcher 2005) and Bangladesh (Ahmed et al 2001). These findings would appear to support the accounts provided by Indian and Pakistani participants in this study that indicate seeking medical help is perceived to be gender-appropriate behaviour *for a man* in South Asian cultures and, as such, behaviour that does not threaten their masculine identity.

In contrast to the majority of South Asian participants, no white participant in the study had visited their GP, choosing to 'wait and see' and 'put up' with their symptoms alone until a time when they considered their symptoms represented a serious illness/emergency. Courtenay (2000) has theorised a link between rejecting the need for the doctor and key practices of hegemonic masculinity that are consistent with the responses of the white participants in the study. He suggested that:

'When a man brags ' I haven't been to a doctor in years', he is simultaneously describing a health practice and situating himself in a [hegemonic] masculine arena' (Courtenay 2000; p.1389; comment in parentheses added)

Again, the finding that the majority of the study's South Asian participants were willing to consult their GP is further suggestive of South Asian men's culturally distinct representation of masculinity in the context of help seeking that is distinctly different to Western hegemonic representations of masculinity.

The finding in the study that South Asian men were willing to consult their GP also draws attention to possible ethnocentric interpretations in the UK men's health literature relating to primary care services, and in particular the GP, being 'male unfriendly' (Robertson 1998; Tudiver and Talbot 1999; White 2001; Men's Health Forum 2002; 2004). For instance, Banks (2001) suggests that,

'attending a general practice can be difficult for many men, and they often find it male unfriendly...waiting rooms display all the propaganda of women's and children's health, but there are few if any examples for men' (p.1059)

White (2001) has investigated several key providers of men's health services in the UK and also reported that they perceived that 'men' had a general reluctance to contact a GP, principally because of inappropriate opening times, feelings that the service was primarily for women and children, and an inability to negotiate with female receptionists. The rationale for consulting the GP consistently recounted by the Indian and Pakistani participants in the second study presented in this thesis draws attention to the possibility that these themes may not be reflective of South Asian men's perceptions. Again, the study findings highlight the need for further research into how the delivery of healthcare services, such as the structure and organisation of primary healthcare services, promotes (or restricts) South Asian men's help-seeking behaviour. Chapter 8 ('Summary and Conclusions') presents a number of recommendations for future research based on the findings of the studies presented in this thesis.

7.8 Deviant Case: A Mixing of Indian and British Cultures

Several studies have found that second and third generation young male South Asians suffer from ‘mixed up’ and confused identities because of the culture clash that results from occupying a contradictory location between conflicting ‘majority’ and ‘minority’ cultures and identities (Kitwood and Borrill 1980; Mullard 1985; Archer 2001). Among Iranian immigrant families in Canada, Shahidian (1999) found that men and women selectively mixed and matched ‘traditional norms’ with ‘modern’ options. During his interview, Amit similarly alluded to a mixing of British and Indian cultures when recounting his experience of being an Indian Hindu living in British society. He noted that his and his families’ behaviour was more allied with the British culture, in particular, speaking English in the house, being well educated, and his family’s diet – ‘*you do like the Romans does*’ (sic). However, he also recognised that, despite a lot of what his family does is English, he retained a lot of his Indian background, but this retention of Indian identity was less apparent than in his parents and other South Asian groups who he perceived to ‘*stick to their own religion*’.

The mixing of British and Indian cultures that is evident in Amit’s account can be interpreted as being an ‘integration’ level of acculturation, where there is some degree of cultural integrity maintained but at the same time there is a seeking to participate in the majority culture as an integral part of the larger social network of the host country (Berry 1998). For instance, a prominent feature in his account related to health education and his recognition of the specific health concerns associated with people of South Asian origin (*‘Asian programmes’*) such as diet – ‘*eating wise, drinking wise...try and create a balance*’. This finding is consistent with those of a qualitative study by Beishan and Nazroo (1997) which found that amongst South Asian groups, most subjects were well informed of the factors associated with cardiovascular health. Similarly, Farooqi et al (2000) found that South Asians from all cultural subgroups living in the UK reported an awareness of what constituted a healthy diet (with Indian diet perceived as being unhealthy) and also recognition of the importance of exercise on cardiovascular health.

Although a degree of integration is apparent in Amit's account, his reference to retaining an '*Indian background*', and of other South Asian groups who '*stick to their own religion*', provides further evidence to support the suggestion made throughout this chapter that the Indian and Pakistani men maintained *South Asian* cultural representations of masculinity signified by a willingness to seek medical help and express being in pain. However, his account also draws attention to the possibility that the degree to which these South Asian cultural representations are maintained may differ between first, second or third generation members of the family and the extent to which they are acculturated to British culture (or 'Westernised').

Notably, Amit recognised he was 'more English' than his parents were, but his children, who were British born, were more like '*the English group*' than he was. This response may signify a form of *assimilative* acculturation in his children – where individuals do not wish to maintain their cultural identity and seek daily interaction with other cultures – a phenomenon similar to that identified in the account given by Rashid, discussed earlier in this chapter, who had been educated and brought up in the UK.

The indication in the account provided by Amit that British born South Asians may be decreasing in the extent to which they maintain South Asian culture, and increasing in their acculturation to aspects of British culture, may also explain findings that show increasing acculturation/Westernisation in immigrant populations leading to coronary heart disease incidence 'migrating' to the norm of the host country (Marmot and Syme 1976; Kliever 1992). Berry (1998) proposes that this may be due to individuals acculturating to cultural risk factors such as diet and lifestyle; a theme that is apparent in the account provided by Amit, and to an even greater extent in the account given by Rashid.

The account provided by Amit is also suggestive of differences in the extent of acculturation between men of differing country of origin, culture and socio-economic status. Notably, he

made reference to the fact he perceived Indian Hindus were better at '*looking after themselves*' and were better educated (in health terms) than some Muslims, Pakistanis and Bangladeshis. Although the accounts provided by both Indian and Pakistani men (of Muslim, Hindu and Sikh religion) appeared to fit a similar conceptual model in this study, his reference to the behaviour of other, non-Hindu, South Asian groups draws attention to the possibility that non-Hindu South Asians may acculturate to British culture and lifestyle to a lesser extent than Indian Hindus.

There is a significant body of knowledge that would suggest Amit's perceived differences in prevalence of coronary heart disease risk factors and lifestyle between South Asian ethnic groups are principally due to socio-economic factors (Nazroo 1998; Bhopal 2000). For example, Bhopal et al (1999) found that, compared to Indians, Pakistanis and Bangladeshis in the UK had higher coronary risk factor profiles associated with lifestyle, and these differences were linked to socio-economic differences. For instance, Indians ate more fruit and vegetables and were the most physically active of all the South Asian groups, although paradoxically, had a higher rate of obesity than Bangladeshis. Analysis of the Fourth National Survey in the UK also showed that, whilst South Asians as a group had a greater risk of indicators of CHD, once the group was broken into its constituent parts, this only applied to Pakistanis and Bangladeshis – Indians had the same rates as whites (Nazroo 1997). This evidence is consistent with the inferences made by Amit relating to a greater awareness of healthy behaviour and lifestyle in his family – he ran a successful business and was in a high socio-economic group.

However, the affects of acculturation on the health status and health behaviours of South Asian men discussed here can only be seen as tentative as they were not areas that were investigated in detail in this study. What is more, no Bangladeshi men were recruited for the second study presented in this thesis, and men who did not speak English were excluded from the sample; groups who are likely to have markedly different experiences of acculturation.

This is an area in which future investigation is essential, particularly given the established evidence that South Asian communities in the UK remain disadvantaged, experiencing a higher rate of CHD risk factors in comparison with the white majority population (Bhopal et al 1999; Bhopal 2000).

7.9 Pakistani Muslim men's perceptions of 'acting like a man' in the context of seeking help – *'these are basic, logical things'*

As discussed in the 'Reflexive Discussion' and 'Analytical Process' sections of the preceding chapter ('Chapter 6: Study Two – Research Methods'), three additional Pakistani participants were recruited and interviewed with the aim of substantiating and verifying the 'acting like a man' core concept.

The accounts provided by these three additional Pakistani Muslim men – Imraan, Shahid and Mohammad – substantiated the 'acting like a man' core concept identified as underpinning the help-seeking decision-making process of the majority of South Asian men's accounts in the study. Significantly, all three participants confirmed that they understood the meaning of the (Western) concept of acting 'macho' and not wanting to appear 'weak', but strongly rejected that they would delay seeking medical help due to a fear of being perceived by others to be acting this way. For instance, Shahid, quoted below, recognised what 'macho' behaviour represented among many white men in the UK, but noted that he did not perceive seeking help from a doctor to be acting weak, 'soft', or embarrassing. In his account, he also drew comparisons between his family and '*English families*' which supported the differences between white and South Asian participants relating to the '*disclosure*' theme discussed earlier in this chapter. He noted that, in contrast to English families, his family endorsed symptoms of illness as being worthy of concern and supported the need to seek medical help.

Participant: ...the family will know first [about any illness]. They will push, they will push me. As my wife will and the children 'Oh go, they will take you there'.

Researcher: They just say you need to go to the doctors? Is it embarrassing to discuss?

*Participant: No, no, there's nothing embarrassing there. If the doctor is needed you must go, they will push it. It doesn't seem more in the English families. They go to the doctors but they don't discuss much with the family first.
(Shahid; 52 year old Pakistani Muslim Male)*

Further exploration of the understanding of the concepts of 'acting soft/weak' among the three Pakistani men revealed that the participants did not perceive there to be a 'male culture' which they felt they were expected to 'live up' to when they were ill. The perceptions recounted by all three participants indicated a common belief that men in general should not act in a similar 'man-like' way when ill, but rather, that every man and woman is different depending on their individual circumstance. As such, it was apparent that being seen to be 'acting like a man' at times of ill health was perceived to be a distinctly individual phenomenon by all three men. A prominent theme identified in the men's accounts relating to their perception of women's help-seeking behaviour provided further evidence to support this proposition.

The three men all indicated that they did not perceive women, in general, to be weaker than men and, furthermore, considered that their wives and other women would react in the same way as they had done should they experience similar chest pain symptoms. For instance, Imraan supported the proposition that 'acting like a man' was perceived to be a distinctly individual phenomenon when he noted '*some ladies are stronger and some men are weak*'.

Researcher: Do you think that men and women are different in how they act to illness or being poorly?

Participant: My experience of this is some ladies are stronger and some men are weak, depends on the person.

Researcher: How would your wife behave if she had chest pains, same as you or different do you think?

*Participant: She would feel the same.
(Imraan; 72 year old Pakistani Muslim male)*

Despite the accounts of the three participants indicating that they considered ‘acting like a man’ to be an individual phenomenon, commonalities between what the three men considered ‘not acting weak’ was in respect to their own identity as a Pakistani man were evident. The three men all described that ‘not acting weak’ was equivalent to their perception of being a ‘brave’, ‘respectful’ or a ‘strong’ man. Exploration of what characteristics the men perceived to be associated with being a ‘brave’ or a ‘respected’ man also revealed a number of common traits.

The participants described that being a man who is ‘respected’ was not associated with having a high threshold for pain or being a hard worker – aspects identified as being central to the majority of white participants’ male identities. By contrast, the Pakistani men’s perceptions of being a ‘respected’ man were associated with being polite, respectful and compassionate to other people. The theme is illustrated in a response from Mohammad, who described that ‘*a person who is gentle, who has got good manners*’ is a man who should be respected. The responses from the three Pakistani men also indicated that being a ‘strong man’ was someone who was, first and foremost, concerned with his family. This perception is illustrated in the response given by Imraan who, when asked how you could tell whether a man was brave or strong, expressed that a man should consider his family first but also be considerate of others.

In response to questioning about what ‘acting like a man’ entailed in the context of seeking medical help, an additional theme that emerged from the three interviews related to a man being ‘educated’. Education was implied as being a significant factor by all three participants when they were questioned how they thought a brave/strong man would react to having chest pain symptoms. In illustration, Shahid and Mohammad both strongly rejected the notion that the decision to seek medical help is influenced by how they perceived men were ‘expected to react’ to pain. By contrast, the men felt that seeking medical help was a rational response for a man who was ‘educated’ or ‘wise’. Mohammad, for example, noted that ‘*every wise man knows what he should do*’ when faced with symptoms of ill health.

As such, the accounts provided by Imraan, Shahid and Mohammad supported the common 'conceptual thread' pervading the majority of accounts provided by Indian and Pakistani participants in the second study – namely, seeking medical help was considered to be consistent with their perceptions of 'acting like a man'. For example, Imraan noted that a brave man would react to chest pain symptoms by seeing the doctor but, importantly, he would '*not panic*'. Similarly, the decision to seek help for pain was emphasised by Mohammad as '*a logical decision*'.

Researcher: Do you think a lot of English men, they won't go to the doctors because they think they look soft and like a wimp, do you think Asian men are like that or do you think they are different?

Participant: I think the person is not in good health, every person has their own misery. Everyone is brave man, every weak man, so we don't know, strong or it depends on the person.

Researcher: What do you think makes a... how can you say somebody is brave or strong?

Participant: Very strong the person is that works for others, live for others, live for their own self. Everybody can live for themselves, but they must live for others... Family, first family and then others.

Researcher: So do you think, how would a brave man react to illness like chest pain?

Participant: It would be calm. Myself, when I am worried about...It depends. I see the doctor but not to panic.

(Imraan; 72 year old Pakistani Muslim male)

Researcher: Do you think that as a man, being a man, you have to, people expect you to react in a certain way to pain or illness, for example, be strong or, do you see what I mean?

Participant: I don't know.

Researcher: Do you think that Asian men act macho then or do you think it's mostly English men, white men, do you think there's a difference?

Participant: Health has so many factors, its your style as well, what it's affecting, under what pressure you are, how giddy you are, this kind of thing and your family background as well ... In India there is a big difference in the role of family...There are so many variants that you can't pin point whether the Asian man is like than the white man. No, it depends upon your education....Education because if you are an educated person, naturally you will seek some advice from the doctor. In the Asian men I have seen if they are dying they all go to see their doctors...the family ties, more live together so they have more family. It's different here [in England].

(Shahid; 52 year old Pakistani Muslim male)

Researcher: What makes you think about another man that you think he's a brave man, I respect him? When you see someone and you respect them or you think it's, when you think somebody's a brave man, what is it about them exactly that makes them like that ?

Participant: There are many things, first is that his behaviour towards other people. The way he speaks to other people. Bravery doesn't mean that you, a person would speak very rough and maybe something about the dealing and the manner. One must always be very gentle to other people, family and others in the community...The bravery, a person...who is gentle, who has got good manners, he is respectable, he should be given respect.

<Later in the interview>

Researcher: So what would you do if you were at work and you suddenly got pain and things, would you carry on working or would you go home?

Participant: It depends the type of the pain and where it is actually and it's severeness as well and also the duration of pain....I would tell to my team leader I would take off and go to doctor. Actually it is a logical thing, based on two logics. Every wise man knows what he should do, for example, I am an educated person. I know these are very basic logical things. I should know what I should do in that situation. That is a logical decision.

(Mohammad; 48 year old Pakistani Muslim male)

7.10 Discussion: Indian and Pakistani men's cultural representations of masculinity in the context of seeking help

Very little attention has been paid to the study of masculinities in men of South Asian ethnic origin. Connell (2000) has remarked that there has been almost no application of modern conceptual and empirical masculinity work on 'ethnicity' and its changing construction. Ouzgane (2003) has also noted that:

'at a time when masculinity studies is experiencing a tremendous boom in the West, dominant (heterosexual) masculinity in Islamic cultures has so far remained an under examined category... there are very few studies that render Muslim men as visible gendered subjects' (p.231)

The findings of the second study presented in this thesis go some way to addressing this gap in the current body of evidence. The accounts given by men in this study have consistently indicated that representations of masculinity in the context of help seeking – what 'acting like a man' means when you experience chest pain – was distinctly different between white and South Asian participants. The accounts given by the majority of Indian and Pakistani men indicated that they maintained South Asian cultural representations of masculinity signified

by a willingness to seek medical help and express being in pain to others. The accounts provided by the three additional Pakistani participants – Imraan, Shahid and Mohammad – were consistent with this finding.

The accounts provided by the three participants clearly illustrated that they did not consider their help-seeking behaviour as being consistent with Western representations of hegemonic masculinity that are signified by an ability to tolerate pain and a reticence to seek help due to the fear of being seen to be acting ‘soft’ by others. Consistent with the accounts provided by the majority of Indian and Pakistani men in the study, the accounts provided by the three additional Pakistani participants indicated that seeking medical help was perceived to be a normal and appropriate behaviour for a man who suspected ill-health.

In addition, the accounts provided by the three Pakistani men illustrated that a common element of their perception of ‘acting like a man’ appeared to be how you related to others with kindness, consideration and compassion. These responses suggest that the Pakistani men’s representations of masculinity may be associated with [Western notions of] femininity, and may explain why previous studies have shown South Asian schoolboys have been viewed by white boys as being ‘feminine’ and ‘unmanly’ (Mac an Ghail 1994; Archer 2001). As noted, Western representations define a ‘real man’ as fundamentally, inevitably and unchangeably different from a woman (Lee and Owens 2002).

Contextualising the accounts of the three Pakistani participants’ perceptions of ‘acting like a man’ with the literature on the central principles of Islam suggests that the men’s religious beliefs may be implicit in their representation of masculinity. For example, one of the fundamental principles of Islam – that every human being is a member of the universal family and there is no room for racial prejudice, social injustice, or second-class citizenship (The Islamic Council of Queensland 2005) – has resonance with the importance the three Muslim

participants placed on being kind, gentle and compassionate as features that corresponded to their perceptions of 'acting like a man'.

There are also commonalities with the central tenets of both Hinduism and Sikhism that would suggest that religion may also play a comparable role in the representation of Hindu and Sikh men's masculinity. For instance, Hindus follow the law of *Dharma*, which states that in order to obtain a state of everlasting peace, individuals must perform their duties required by their life; and *Karma*, the idea that every action will have an effect on present and future life; for instance, if someone does good, something good happens to them in return (Mohan et al 2003). Similarly, Sikhism encourages people to make the most of human life to achieve reunion with God through truthful conduct, humility, family life, meditation and prayer, and serving the needs of the community (Gill 2002).

The three Pakistani Muslim men's perceptions of women's help-seeking behaviour – specifically, that they did not perceive women, in general, to be weaker than men when experiencing illness – also have resonance with the literature on Islamism. The Koran has been interpreted as teaching that women and men are equal and deserve to be treated as equal (Akhtar 2002; The Islamic Council of Queensland 2005). Similarly, in most Hindu families, men and women have been noted to share decisions (Jootun 2002); and Sikh theology teaches that all people are equal, irrespective of caste, colour or creed, and thus, men and women should enjoy equal aspects of all Sikh life (Gill 2002). Once more, this literature would appear to indicate that the perceptions of women's help-seeking behaviour identified in the accounts of Muslim participants Imraan, Shahid and Mohammad may be similar among Hindu and Sikh men.

By contrast, studies on help-seeking patterns and behaviours in Pakistan have suggested that (Islamic) religious misinterpretations have led many Muslim men to view women as inferior and resulted in them being prevented from recognising and voicing their concerns about their

health needs (Shaikh and Hatcher 2005). The contrasting attitudes evident in the accounts provided by Imraan, Shahid and Mohammad in this study may further indicate a degree of acculturation (or ‘Westernisation’). However, once again, the affects of acculturation on South Asian men’s perceptions of women and their help-seeking behaviour can only be seen as tentative as they were not areas that were investigated in detail in this study. Further research is necessary in order to support, refute or modify this proposition.

7.11 Discussion: Is Indian and Pakistani men’s masculinity a marginalised representation?

As outlined in Chapter 2 (‘Literature Review’), the current prevailing feminist and pro-feminist constructivist perspectives of masculinity assert that there are likely to be *multiple* masculinities (for example, Kimmel 1994; Connell 1995; 2005; Kimmel and Messner 1995; Courtenay 2000). However, not all these masculinities are afforded the same status in society. Within Western culture, hegemonic masculinity – embodied by white, middle-class, heterosexual Euro/American men – is seen as the masculinity that sets the standards for all other men and against which other men are measured (Kimmel 1994; Connell 1995; Courtenay 2000). All others representations of masculinity – such as those of men from ethnic minorities and gay men – are seen as marginalised from, or subordinated to, this hegemonic form. Kimmel (1994) explains:

‘all masculinities are not equal because definitions of masculinity are not equally valued in society...we equate manhood with being strong, successful, capable, reliable and in control. The very definitions of manhood we have developed in our culture maintain the power that some men have over other men [subordination/marginalisation] and that men have over women’ (pp124-125; comments in parentheses have been added)

As discussed previously, according to this perspective, the cultural representations of masculinity signified by the help-seeking behaviours of the Indian and Pakistani participants in this study would be considered to be ‘marginalised’ representations. Their behaviour *as a man* is not consistent with a hegemonic representation of masculinity (being strong, able to endure pain, not needing help from others) that is exalted in Western culture as signifying

‘real’ manhood. As Kimmel and Kaufman (1994) argue, the fear of being seen to be a ‘sissy’ – weak and inadequate ‘as a man’ – is what dominates Western definitions of manhood.

However, as discussed in section 7.2 of this chapter (‘Is Pain Worthy of Concern?’), the findings from this study challenge these prevailing constructivist perspectives of masculinity. The majority of Indian and Pakistani men appeared to maintain dominant *South Asian* cultural representations of masculinity in the context of seeking help for chest pain. This finding would suggest that positioning the Indian and Pakistani men’s representations of masculinity as ‘marginalised’ relative to *Western* hegemonic representations of masculinity is an overly simplistic and ethnocentric perspective.

The data clearly indicated that the Indian and Pakistani men did not fear being seen to be a ‘sissy’, weak or as acting ‘soft’. Moreover, they did not appear to perceive their behaviour to be less valued than, or marginalised from, the hegemonic masculine representations identified in the accounts of many white men. Rather, the South Asian men considered their actions – seeking help for pain – to be gender-appropriate behaviour for a man. This suggests that, despite living within a Western culture, the majority of Indian and Pakistani men did not consider Western hegemonic representations of masculinity to be – as Kimmel (1994) argues – the masculinity that ‘sets the standards’.

These findings may indicate that Western hegemonic representations of masculinity are only *one of many* ‘cultural reference points’ around which masculinity is organised and adopted in the UK (Wall and Kristjanson 2005). Specifically, a hegemonic pattern of masculine behaviour associated with experiencing chest pain (delaying seeking help, ‘putting up’ with pain, not acting ‘soft’) may be only one of many cultural representations of masculinity which is perceived to be how ‘real’ men behave when experiencing chest pain, and which men attempt to ‘live up’ to.

Therefore, rather than considering hegemonic masculinity to be the *singular* culturally exalted representation of masculinity; it is perhaps more accurately considered to be culturally exalted according to the extent to which a man adopts *Western* culture. This proposition is consistent with the account given by 'deviant case' Rashid, who appeared to have acculturated to Western culture *and* attempted to 'live up' to Western hegemonic masculine ideals.

Thus, although in a wider context in Western (UK) culture, the majority of men of Indian and Pakistani ethnic origin may indeed be marginalised from the privileges of power and social status that are ascribed to a white hegemonic masculine role (Mac an Ghail 1994; Connell 1995); the findings of this study suggest that 'marginalised' is a simplistic interpretation of first generation Indian and Pakistani men's representations of masculinity in the context of help seeking for chest pain. The men's masculinity cannot be said to be marginalised *per se*, because they did not perceive Western hegemonic masculinity to be the culturally exalted representation of masculinity from which they could be marginalised. They are therefore perhaps more accurately considered to be culturally distinct representations of masculinity.

However, it is important to note that although the data from this study has indicated that Indian and Pakistani men's behaviour in seeking help promptly (rather than 'putting up' with pain) to be a culturally distinct rather than marginalised representation of masculinity, it remains possible that these culturally distinct representations of masculinity *do* result in South Asian men's behaviour being devalued by healthcare professionals in the UK. For instance, similar to the phenomenon of the 'unpopular patient' (Stockwell 1984; Johnson and Webb 1995), South Asian men's willingness to seek medical help may result in them being taken less seriously by healthcare professionals, or perceived as inappropriately frequent users of health services. Indeed, evidence suggesting that GPs in the UK perceive their South Asian patients to take up more time in the surgery and as generally consulting for 'trivial' disorders (Wright 1983; Ahmad et al 1991; Hawthorne 1994) may point toward such a phenomenon. However, there is currently little evidence on how the gendered construction of health

services interplays with men's experiences of accessing health care in the UK. The findings discussed in this thesis highlight this as an area that urgently requires further research attention (see Chapter 8, Section 8.4 – 'Recommendations for Future Research').

7.11 Chapter Summary

This chapter has presented a comprehensive account, and detailed discussion, of the findings from the second study presented in this thesis. The study aimed to address the following research question and study objectives:

How do masculinities influence white and South Asian men's decision to seek or delay-seeking medical help for acute chest pain?

- 1 Examine the differences and similarities between white and South Asian men's decision-making process relating to the period of 'waiting to see';
- 2 Explore the differences and similarities between white and South Asian men's representations of masculinity in the context of seeking medical help for acute chest pain symptoms;
- 3 Investigate the differences and similarities relating to the influence of masculinity on the decision to seek or delay-seeking medical help for acute chest pain among South Asian men of differing ancestry and religion.

Objective #1: The 'Is pain worthy of concern?' theme conceived in the second study furthered the findings of the first study by revealing a number of distinct thought processes associated with white, Indian and Pakistani men's period of 'waiting to see'. Two principal features emerged as being associated with Indian and Pakistani men's decision-making process during this period; first, the men determining if chest pain was persistent and 'new', and second, making the decision that if the pain was new, it was therefore worthy of concern and warranted medical attention. As such, it was apparent that the South Asian men of Indian and Pakistani origin did not have a low threshold for pain *per se*, but rather, a low threshold for 'waiting to see' when experiencing persistent chest pain of unknown cause.

By contrast, in support of the findings from the first study, the data indicated that, for the majority of white men, the period of 'waiting to see' was principally associated with 'putting up' with pain so as not to appear to others as having a low pain threshold. It was apparent

that, for the majority of white men, they did not consider their pain to be worthy of concern and stop 'waiting to see' until their pain disrupted their activities of daily living, or they experienced an onset of additional symptoms such as breathlessness or clamminess.

Objective #2: Analysis of the accounts provided by the twenty participants in the second study revealed a common 'conceptual thread' underpinning the three themes 'Is pain worthy of concern?', 'Disclosure' and 'Shall I consult the GP?', that related to the core concept 'acting like a man'. The 'acting like a man' core concept signified the themes of the help-seeking decision-making process which the data indicated were underpinned by how men perceived they should 'act like a man' in the context of experiencing chest pain, and has been argued to correspond to white men's, and Indian and Pakistani men's, distinctly different representations of masculinity in the context of seeking medical help.

The distinct features of white men's accounts of help-seeking relating to the three themes, signified by the men considering chest pain alone as unworthy of concern, keeping symptoms undisclosed from others, and avoiding consulting the GP, have been argued to correspond to hegemonic representations of masculinity. By contrast, Indian and Pakistani men's behaviour and perceptions associated with these three themes, signified by the men's willingness to seek help and consider chest pain alone as worthy of concern, disclose their pain to others, and consult their GP, have been argued to correspond to culturally distinct representations of masculinity. The data indicated that first generation Indian and Pakistani men's culturally distinct representations of masculinity were borne out of, and maintained from, those dominant in South Asian culture. As such, it has been argued that considering these masculine representations as being 'marginalised' from Western representations of masculinity is an overly simplistic and ethnocentric perspective.

Objective #3: In support of the findings from the first study, the accounts provided by the twelve South Asian men in the second study – comprising nine Pakistani Muslim men, two

Indian Sikh men and one Indian Hindu man – revealed commonalities in their representations of masculinity in the context of seeking help for chest pain. However, the data suggested that acculturation may result in differences between South Asian men in relation to the influence of masculinity on their help-seeking behaviour for chest pain. The account provided by one Pakistani Muslim man suggested that assimilative acculturation and/or a high socio-economic status may lead to an alignment with hegemonic representations of masculinity, and the account provided by one Indian Hindu participant pointed towards to an ‘integration’ level of acculturation that was signified by a mixing of Indian and British cultures.

7.12 Limitations

Although the data suggested commonalities between Indian and Pakistani men’s representations of masculinity in the context of seeking medical help (and they have therefore frequently been referred to as ‘South Asian men’), the study sample did not include any men of Bangladeshi ancestry and, as in the first study, men who could not speak sufficiently fluent English to take part in a depth interview were excluded from the study sample. It is possible that these groups of South Asian men have entirely different experiences of help seeking, and construct differing representations of masculinity in this context that are not consistent with the theory presented in this chapter.

Similarly, although hegemonic representations of masculinity were apparent in the accounts provided by the eight white participants in the study, it is important to emphasise that other white men may construct and represent their masculinity differently based on (and not limited to) factors such as sexuality, disability and religion that have not been considered in this thesis.

Finally, as alluded to in the reflexive accounts earlier, despite the strategies employed to ensure the rigour of the study data, the effects of men’s exaggeration of their hegemonic masculine values as part of an interview ‘performance’ may still feature in the study’s

findings. Similarly, ethnocentric bias in the interpretation of the data (by the white, middle-class researcher) may also have led to an overemphasis on culture and religion in relation to Indian and Pakistani men's help-seeking behaviour and masculinity.

The next chapter now summarises the findings of the two studies that have been presented in this thesis, bringing them together to form an explanatory whole. The implications of these findings on healthcare practice and policy are then addressed, before the conclusion of the thesis is presented.

Chapter 8

SUMMARY AND CONCLUSIONS

8.0 Introduction

This chapter presents the summary and conclusions of the findings of the two studies that have been presented in this thesis. The chapter begins by summarising the empirical findings presented in the thesis in section 8.1, integrating the two studies to form an explanatory theory, grounded in the data, of the influence of masculinity on white, Indian and Pakistani men's decision to seek or delay-seeking medical help for chest pain, in order to answer the original research question. Section 8.2 then addresses the limitations of these findings.

The implications of the thesis findings on healthcare policy and practice are then discussed in section 8.3. A discussion is presented relating to how the findings can be used to inform the planning and delivery of future healthcare services that aim to reduce mortality from MI by improving help-seeking response among white and South Asian men of Indian and Pakistani origin who experience chest pain. Reference is made to relevant literature and existing health policy in order to illustrate the need for gender *and* culturally-sensitive healthcare practice and policy.

Recommendations for future research, made on the basis of the findings of the two studies, are presented in section 8.4, drawing particular attention to the need for further investigation into the influence of masculinities on the help-seeking behaviour of second and third generation British-born South Asian men. Concluding remarks are then presented in section 8.5.

8.1 Summary of Thesis Findings

The two studies presented in this thesis aimed to explore the following research question, borne out of gaps identified in the existing body of empirical evidence, as outlined in the summary of Chapter 2 ('Literature Review'):

How do masculinities influence white and South Asian men's decision to seek or delay-seeking medical help for acute chest pain?

Both studies employed a modified grounded theory methodology and used in-depth interviews as the method of data collection. Overall, a total of fifty-six men who had been recently admitted to hospital with acute cardiac chest pain were interviewed: thirty-six men in the first study; twenty men in the second study. Of these fifty-six participants, thirty-six were of white ethnicity and twenty were of South Asian ethnicity (eight men of Indian origin; eleven men of Pakistani origin; and one man of Bangladeshi origin).

The studies revealed that white and South Asian men's decision to seek or delay-seeking medical help initially involved a complex process of rumination and rationalisation in which they attempted to 'make sense' of their chest pain symptoms. At the onset of pain, both white and South Asian men of Indian and Pakistani origin engaged in an 'internal dialogue' of decision-making that involved self diagnosis and, in some participants, a fear of finding out 'the worst'.

It was evident in the accounts provided that the initial period of men's attempt to make sense of their symptoms was primarily underpinned by their knowledge of heart disease, the symptoms of an acute cardiac condition, and their perception of their physical health. These findings reinforce those of previous studies in relation to the importance of symptom interpretation in prompting or delaying help-seeking behaviour. The majority of men did not initially attribute their symptoms to the heart as they were not consistent with their own perceptions (or lack of knowledge) of heart disease. Initial delays in seeking help occurred as the majority of white, Indian and Pakistani men *initially* self diagnosed their pain as being

indigestion (or a similar non-serious condition) or because they feared being diagnosed with a fatal disease. Comparable themes have been identified in several previous help-seeking studies on samples of men and women which would appear to suggest that they are not gender specific *per se*.

However, the main findings presented in the thesis highlight the influence of masculinity on men's subsequent process of help-seeking decision-making. It was apparent in the data that, following their initial self diagnosis, white, Indian and Pakistani men's decision to 'wait and see' before making a final judgment about whether their pain was worthy of concern was the primary cause of help-seeking delay. Furthermore, it became evident that the rationale, perceptions and behaviours associated with this period of 'waiting to see' differed distinctly between white and South Asian men of Indian and Pakistani origin. These initial tentative propositions, made on the basis of the findings from the first study, were developed in the second study and led to a refinement of the substantive grounded theory.

The refined theory demonstrated that, although the initial period of men's help-seeking decision-making process did not appear to be gender specific *per se*, the process of seeking help during and after the 'waiting to see' period was underpinned by the core concept 'acting like a man'. The 'acting like a man' core concept illustrated that men's help-seeking decision-making process was influenced by how they perceived they should 'act as a man' whilst experiencing chest pain, and was signified by white men's, and Indian and Pakistani men's, distinctly different representations of masculinity in the context of seeking help.

For the majority of white participants, the 'acting like a man' core concept corresponded to their perceived need to display a high tolerance for pain and discomfort, and their fear of appearing 'soft' or like a hypochondriac to others if medical help was sought. The majority of white men considered that chest pain *alone* was unworthy of concern or medical attention. These perceptions were signified by men 'putting up' with chest pain, avoiding consulting

their GP, and keeping symptoms hidden from others, such as their wives, family members and work colleagues, whilst they ‘waited to see’.

Seeking help or admitting the need for help – either from their wife or from a healthcare professional – appeared to be seen as a last resort for the majority of white participants. It was not until the onset of additional physical symptoms, such as clamminess, breathlessness or loss of skin colour, or the onset of severe debilitating pain, that the men began to change their perception of their symptoms, realise that ‘something is not right’, and stopped ‘waiting to see’.

The majority of white participants’ perceptions of ‘acting like a man’ in the context of experiencing chest pain and seeking help can be seen as a representation of hegemonic masculinity. In Western culture, hegemonic representations of masculinity embody the perception of men as ‘naturally’ strong, resistant to disease, unresponsive to pain and physical distress, and unconcerned with minor symptoms. Most white men in the studies presented in this thesis had faced risk and physical discomfort rather than be associated with the emasculating behaviour of help seeking that was symbolically assimilated to being a ‘softy’, wimp or hypochondriac.

Variations in how white men of differing socio-economic status constructed a hegemonic masculine identity in the context of experiencing chest pain at work were evident in the first study (‘breadwinner identity’). However, in both studies, hegemonic representations of masculinity were apparent in the accounts provided by the majority of white men regardless of their socio-economic status or age. These findings suggested that age and socio-economic status were not key factors in determining white men’s perceived need to ‘live up’ to hegemonic masculine ideals in the overall context of seeking help for chest pain. However, the study also illustrated that hegemonic representations of masculinity were not limited to white men alone. Assimilative acculturation – ‘Westernisation’ – and/or a high socio-

economic status appeared to lead to an alignment with Western hegemonic representations of masculinity in one Pakistani Muslim man who had been educated in the UK.

However, for the majority of first generation South Asian participants of Indian and Pakistani origin, the core concept of 'acting like a man' corresponded to a distinctly different pattern of help-seeking decision-making to the hegemonic patterns evident in most white men's accounts. For the majority of Indian and Pakistani men, the 'acting like a man' core concept corresponded to their belief that discussing their symptoms with family members and consulting the GP was a 'natural', logical response when experiencing persistent chest pain of unknown cause. The majority of Indian and Pakistani men's accounts clearly illustrated that they had not perceived a need to 'put up' with their chest pain, and had not feared being seen to be acting 'soft', like a wimp, or like a hypochondriac by others when they had sought medical help. In contrast to the white participants, most South Asian men of Indian and Pakistani origin had considered their chest pain alone to be worthy of concern, and had therefore had a low threshold for 'waiting to see' – their self diagnosis of a non-serious illness had been discounted relatively early in their experience. This low threshold for 'waiting to see' appeared to make clear why, in contrast to the white participants, South Asian participants of Indian and Pakistani origin had comparatively shorter help-seeking delays.

The Indian and Pakistani men's perceptions of 'acting like a man' in the context of help seeking can be seen as a culturally distinct representation of masculinity that was borne out of, and maintained from, those dominant in South Asian culture. The majority of Indian and Pakistani men considered seeking medical help for pain and disclosing their symptoms to others to be an entirely gender-appropriate behaviour for a man. Moreover, the men did not appear to perceive their behaviour to be less valued than, or marginalised from, the Western hegemonic masculine representations evident in the accounts of many white men. This data suggested that interpreting Indian and Pakistani men's culturally distinct representations of

masculinity as ‘marginalised’ relative to Western hegemonic representations of masculinity in this context to be a simplistic and ethnocentric perspective.

8.2 Limitations of Thesis Findings

As noted earlier, it is important to emphasise that the distinct representations of masculinity discussed in this thesis do not represent typologies of ‘white masculinity’ and ‘South Asian masculinity’. Men are best understood as a diverse group who will construct *multiple* (and maybe contradictory) representations of masculinity in differing contexts based on, among other factors, their age, sexuality, ethnicity, disability, religion, appearance and socio-economic status. Moreover, men with a past medical history of CHD and those who did not speak sufficiently fluent English to take part in an interview were excluded from both study samples. The second study also did not involve any participants of Bangladeshi ancestry. The grounded theory presented in this thesis is therefore not likely to be theoretically generalisable to these populations.

Overall, seventeen patients declined invitation to take part in the study; nine in the first study, eight in the second study. It has been suggested that men may refuse to participate in qualitative research studies in order to maintain control and autonomy, being ‘strong and silent’, as a signifier of hegemonic masculinity (White and Johnson 1998; Schwalbe and Wolkmir 2001; O’Brien 2005). It is therefore possible that men who strongly adhered to hegemonic representations of masculinity were under-represented in the study. However, as no data were gathered from the seventeen patients who declined to participate, it is also possible that the representations of masculinity discussed in this thesis are not theoretically generalisable to these men.

Finally, as has been discussed throughout the thesis, despite the strategies employed to ensure the rigour of the study data, ethnocentric bias in the analysis of South Asian men’s accounts, and white men’s exaggeration of hegemonic representations of masculinity as part of an

interview ‘performance’ to the researcher, were issues that pervaded the research process and will feature in the study findings to some extent. Linked to this are the broader limitations of using interviews as the sole method of data collection to investigate the topic area. In particular, given the retrospective nature of the research, the reasons men gave for seeking or delaying-seeking medical help may have an uncertain relation to their actual help-seeking situations because they were rationalisations of a past event.

8.3 Implications for Healthcare Policy and Practice

As outlined in Chapter 2 (‘Literature Review’), there is established evidence that the most important modifiable determinant of mortality from MI is speed of accessing appropriate medical assistance (UK Heart Study Collaborative Group 1998). As such, opportunities for reducing mortality from acute MI lie mainly outside the hospital. Survival from cardiac arrest may be trebled by improvements in ambulance and patient response (GISSI - Avoidable Delay Study Group 1995; Norris 1998). The grounded theory presented in this thesis can contribute to informing healthcare policy and practice that aims to reduce mortality from MI by improving help-seeking response among white and South Asian men of Indian and Pakistani origin who experience chest pain.

Implications for Health Policy

Reducing help-seeking delay and promoting public recognition of the symptoms of heart attack are among the ‘guiding principles’ of UK government health policy aimed at improving CHD health and care – the National Service Framework (NSF) for Coronary Heart Disease (Department of Health 2000; pp8-9). The findings presented in this thesis have shown that masculinity plays a crucial role in determining whether men choose to seek or delay-seeking medical help when they experience acute chest pain. This adds support to the broad recommendations made by men’s health researchers and policy makers of the need to move away from ‘gender-neutral’ health policy – such as the NSF for CHD – toward the development of policy that acknowledges men’s gender as an important determinant of their

health behaviour (White and Lockyer 2001; Baker 2004; Men's Health Forum 2004). Although the NSF acknowledges gender differences in CHD, there is no clear recognition of gender-specific issues or how they can be addressed (White and Lockyer 2001).

However, the study findings draw attention to the need for policy makers to *further* the gender-sensitive approach by recognising that ethnicity shapes how men construct and represent their masculinity differently in the context of experiencing chest pain and seeking help. Statements such as '*male friendly*' services (Men's Health Forum 2004; 2005) and '*targeting men*' (Peate 2004) remain prevalent in men's health policy and mainstream healthcare journals. The study findings suggest that there is not likely to be one effective gender-sensitive '*male*' strategy for tackling the problem of help-seeking delay among men who experience chest pain. Men of white and South Asian ethnicity appear to have distinct representations of masculinity that have a differing impact on their help-seeking behaviours. This would suggest that strategies that aim to reduce help-seeking delay need to be developed to specifically target men of differing ethnicity. The extended understanding of how masculinity influences men who seek help for chest pain generated from the studies presented in this thesis can contribute to informing future health policy that aims to develop services that are gender *and* culturally-sensitive to white and South Asian men of Indian and Pakistani origin in the UK.

Implications for Healthcare Practice

Nurses are at the forefront of healthcare provision to men who suffer from, or are at risk of developing, heart disease. Caring within nursing involves a complex process that not only involves the application of practical knowledge, but also an understanding of the socio-political context in which the need for, and nature of, healthcare takes place (Miers 2002; Mohan et al 2003). Gender-sensitivity is a salient feature of this socio-political context, and refers to an understanding of men's and women's distinct experiences of health and illness in their social world (Miers 2002). However, in order for nursing care to be gender-sensitive,

there needs to be an understanding of the complexity and fluidity of gender to avoid universalising assumptions about men and women (Miers 2002). The findings presented in this thesis suggest that, in order to avoid these assumptions and facilitate the provision of care that is truly gender-sensitive; nurses need to be aware of the distinct gendered illness experiences of men of differing ethnicity. The extended understanding of masculinity provided in this thesis may be used by nurses to help them understand the ways in which white and South Asian men of Indian and Pakistani origin interpret their chest pain symptoms and seek help. This knowledge can be used to incorporate gender-sensitivity in the delivery of cardiac care and in the design and delivery of coronary health promotion and behaviour modification strategies (Abdullah 1995).

The study findings also have implications for improving the delivery of culturally-sensitive primary healthcare. Cultural sensitivity refers to an awareness, knowledge and recognition of the cultural diversity of a population's attitudes, perceptions and values (Kim-Godwin et al 2001). In order to provide culturally-sensitive cardiac care, health professionals need to be aware of ethnic and cultural differences that influence the presentation and behaviour of patients with CHD (Khunti and Samani 2003). The UK Department of Health report addressing how the NSF can be delivered to South Asians (Department of Health 2004c) indicates that GPs and primary healthcare professionals may hold a misconception that Muslim patients delay seeking help because of a 'fatalistic' attitude toward chest pain (based on the study by Naqvi (2003), discussed in Chapter 7 of the thesis). The findings of the studies presented in this thesis illustrate that, paradoxically, Indian and Pakistani Muslim men's culturally distinct masculine behaviour corresponds to a willingness to seek help for chest pain and consult their GP. These findings could be used in the delivery of culturally-sensitive primary healthcare services by helping health professionals to understand the influences on Indian and Pakistani men's help-seeking decision-making process when they experience chest pain symptoms.

Linked to this, the study findings also have implications for improving the delivery of effective health promotion strategies, targeted specifically at South Asian men at risk of CHD in the UK, which are culturally and gender-sensitive. The interpretation of symptoms was an important source of help-seeking delay during the period of 'waiting to see' for the majority of Indian and Pakistani men. Moreover, when seeking help, Indian and Pakistani men were more likely to consult their GP than emergency medical services, behaviour that has been identified as leading to delays in receiving effective treatment and an increase in mortality from MI (Hitchcock et al 2003). Health promotion that aims to raise awareness of the importance of prompt *hospital* treatment for symptoms suggestive of MI during this 'wait and see' period may contribute to reducing help-seeking delay and mortality among South Asian men who experience chest pain. The finding that Indian and Pakistani men's 'extended families' play a crucial role in their help-seeking decision-making process could also contribute to informing the planning and delivery of future health promotion initiatives. For instance, the health check 'MoTs' that form a key part of the UK government's White Paper on improving community health and care services (Department of Health 2006) could be used to target South Asian men at risk of CHD, take place in GP surgeries within South Asian communities, and incorporate men's families into the 'MoT' procedure.

However, as discussed, the study findings suggest that a distinctly different strategy would be required to effectively target men (of both white and South Asian ethnicity) who attempt to 'live up' to hegemonic ideals of masculinity. The findings suggest that the planning and delivery of healthcare services and health promotion should also take account of the restrictive aspects of hegemonic masculinity on many men's help-seeking behaviour. This may explain why there is little evidence to support the effectiveness of 'gender-neutral' media/public education on reducing delays in help seeking (Kainth et al 2004).

Developing future healthcare services, such as health check 'MoTs', that are consistent with, and not threatening to, a hegemonic masculine identity may be an effective way to open up

help-seeking pathways for many men. For instance, it may be beneficial to provide a confidential health advice/MoT service outside the traditional health setting so that men can initiate the help-seeking process without perceiving a threat to their masculine identity. Indeed, there is emerging evidence of interventions that have successfully targeted men using this strategy (White and Cash 2005). Using men who embody a hegemonic masculine identity in the delivery of health promotion campaigns, such as football managers, may also be a valuable way to encourage white and South Asian [hegemonic] men to seek help when they experience chest pain. The experience of a number of 'deviant cases' in this thesis indicated that increasing awareness of the symptoms of MI in this way could be an effective method of 'legitimising' help-seeking behaviour.

8.4 Recommendations for Future Research

Although the study findings can contribute to informing healthcare education, planning and delivery, they principally highlight an urgent need for further research into how ethnicity interplays with gender and impacts on men's health behaviour. The theory base of understanding men's health is not yet developed (White and Cash 2005). As noted in the preceding chapter, there has been almost no attention paid to the influence of ethnicity on men's representations of masculinity in the context of health and health behaviour. The findings presented in this thesis represent a starting point for future empirical work into the gendered health and illness experiences of men of differing ethnicity.

As discussed earlier, the distinct representations of masculinity identified in this thesis are not typologies that are theoretically generalisable to *all* white men and *all* South Asian men in the UK. There is therefore a pressing need for further investigation into the influence of masculinities on the help-seeking behaviours of South Asian men resident in the UK. A number of accounts provided by South Asian men suggested diversity in representations of masculinity and help-seeking behaviours dependent on the extent of men's acculturation (or 'Westernisation'). Furthermore, as has been noted, the influence of men's religious beliefs on

help-seeking behaviours was not explored in great detail in the two studies. Additional research is therefore required in order to explore how acculturation, religion and culture shape how South Asian men, and in particular, second and third generation British-born South Asian men, represent their masculinity, and how this impacts upon their health behaviour.

Further research is also required on white men who seek medical help promptly and/or participate in healthy behaviours. The experiences of several 'deviant cases' discussed in this thesis suggested that help seeking can be engaged in without delay, and without threat to a hegemonic masculine identity, if men perceive there is a 'legitimate' reason to do so. Research into what 'legitimises' help seeking among white men who attempt to 'live up' to hegemonic masculine ideals is likely to make a significant contribution to informing the design and delivery of healthcare which is both culturally and gender-sensitive.

The distinct perceptions and patterns of help-seeking behaviour identified among South Asian men in this thesis also highlight a need to explore South Asian men's representations of masculinity in the context of other illnesses; for example, mental illness, prostate cancer or diabetes. It would be interesting to discover whether seeking medical help for the symptoms of these diseases, such as depression, incontinence or impotence, are also seen as gender-appropriate behaviour by Indian/Pakistani/Bangladeshi men, or whether they are perceived to be a threat to masculinity and results in a distinctly different pattern of help-seeking behaviour.

Previous empirical studies on men, masculinities and health have largely focussed on men's behaviour, and there is limited research on the role the gendered construction of health services may play on inhibiting or promoting men's access to healthcare. Institutional structures, such as primary healthcare services, provide both limits and opportunities to display masculinity and can either foster or undermine men's help-seeking behaviours (Courtenay 2000). As noted earlier, it is possible that South Asian men's culturally distinct

representations of masculinity may result in their health behaviour being devalued by health professionals in Western society. The differing cultural representations of masculinity discussed in this thesis highlight a pressing need to explore how these differences impact on men's interplay with health services, and if and how they restrict, inhibit or promote access to health care.

8.5 Conclusions

This thesis has strengthened the empirical basis of existing theorising about the deleterious effect of hegemonic masculinity on men's help-seeking behaviour. However, the thesis has presented new empirical evidence and discussion that asserts that current prevailing perspectives of the influence of masculinities on men's health are overly simplistic. The study findings challenge men's health researchers and policy makers to go beyond a gender-sensitive approach that emphasises the impact of masculinity on 'men's' health, toward a gender *and* culturally-sensitive approach that recognises how ethnicity shapes the way men construct and represent their masculinity in the context of experiencing ill health.

In the study of men's health and masculinity, it has become common to recognise multiple masculinities. However, prevailing feminist and pro-feminist constructivist perspectives that consider Western representations of hegemonic masculinity, as embodied by white Euro/American men, as the *only* exalted representation of masculinity in Western culture should be challenged. Interpreting and positioning all men's representations of masculinity as marginalised or subordinate relative to Western hegemonic representations is simplistic and ethnocentric. Increasing ethnic and cultural diversity in Western society appears to be changing the relations and dynamics between men and masculinities. The concept of marginalisation does not adequately explain the complexity of how many men from South Asian cultural subgroups perceive, construct and represent their masculinity in the context of ill health. Masculinity is a historically mobile construct that is open to transformation

(Connell 1995; 1998). The findings presented in this thesis may signify the occurrence of such a transformation in the UK.

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Contents:

- Literature review search strategy

The following search strategies were used for the cited databases. Only literature written in English was reviewed. The literature search was snowballed using bibliographic references from the reviewed articles.

MEDLINE 1966 - 2004

1. MESH term 'men'
2. MESH term 'health' – trends/history/standards/statistics and numerical data/utilisation
3. Keywords 'men? adj3 health' 'male adj3 health'; 'Men? Inequal*'; 'Gender inequal';
4. MESH term 'men'/px [psychology]
5. Keyword 'masculinit\$'
6. MESH term 'sex factors'
7. MESH term 'disease susceptibility' – classification/psychology/epidemiology/genetics/history
8. Keyword 'help seeking behav\$'
9. MESH term 'Attitude to health' – ethnology/statistics and numerical data
10. MESH term 'Health Maintenance Organisations' – Utilisation
11. MESH term 'Health Services' – Utilisation

CINAHL 1982 – 2004

1. MESH terms 'Men's Health'; 'Gender Identity'; 'Sex Role'; 'disease susceptibility' (familial and genetic/epidemiology/physiology); 'help seeking behaviour'; 'health resource utilisation'; 'attitude to health'; 'attitude to illness';
2. Keywords 'men? adj3 health' 'male adk3 health' 'masculinit\$'; 'sex role'; 'gender role'; 'Men? Inequal*'; 'Gender inequal';

EMBASE 1980-2004

1. Keywords 'men? adj2 health'; 'male adj2 health'; 'masculinit\$' ; 'sex role'; 'gender role'; 'Men? Inequal*'; 'Gender inequal';

2. MESH terms 'masculinity'; 'illness behavior'; 'sex difference'; 'gender'; 'health service utilisation'

PsychINFO 1984-2004

1. MESH terms 'masculinity'; 'illness behaviour'; 'health care seeking behaviour'; 'human sex differences'
2. Keywords 'men? adj3 health' 'male adk3 health' 'masculinit\$'; 'sex role'; 'gender role'; 'Men? Inequal*'; 'Gender unequal';

COCHRANE LIBRARY

1. Keywords 'health service utilisation' (and variations); Experience of Illness (and variations); Help seeking Behaviour (and variations); 'masculinit*'; 'men's health'; 'male health'
2. MESH terms 'gender identity'

HMIC (kings fund database 1979 –2004; DH data 1983 – 2002; HELMIS 1984 –1998)

1. Keywords 'Men? Health'; 'Men? Inequal*'; 'Gender unequal'; 'Male health'

INDMED

1. Keywords 'health service utilisation' (and variations); Experience of Illness (and variations); Help seeking Behaviour (and variations); 'masculinity'; 'men's health'; 'male health'; 'gender'

Contents:

- **Summaries of men's experiences of chest pain and help seeking**

Summaries of Men's Experiences of Chest Pain

Study One

Lee was a 57 year old security officer whose father had died of a myocardial infarction approximately 12 months prior to his interview. Whilst at work, he experienced a sudden onset of severe central chest pain. After resting for 10 minutes, Lee realised he was experiencing similar symptoms to those his father had experienced, and walked to the Accident and Emergency department of a local hospital. **Gordon**, a 66 year old married bus driver, was trained in first aid, and **Henry**, a 48 year old hospital theatre porter, had worked with patients who had suffered myocardial infarction. Gordon experienced central chest pains at home whilst with his wife and immediately attributed them to his heart. Similarly, Henry immediately attributed his central chest pain, which radiated down his left arm, to his heart, and was candid in his interview about the responsibility he felt to his family to get better quickly.

Ahmad, a 30 year old married man of Pakistani origin who worked as a baker, experienced a sudden onset of severe central chest pain whilst spending time with his wife at home. He immediately became fearful he might die and, as a result, asked his wife to call 999 immediately. Like Ahmad, **Barry**, **Gary** and **Geoff** all confessed during their interview that they had been fearful that their symptoms represented a serious, life-threatening condition. However, as the three men all experienced intermittent chest pain, they had attempted to explain their symptoms away as a non-serious condition until it became so severe that they felt they had no choice but to accept they needed medical help.

Anthony, a 75 year old retired bricklayer, and **Max**, a 54 year old market porter, were both single. Anthony recounted experiencing a one week history of worsening central chest pain whilst gardening and walking his dog, but he had told nobody. He eventually called 999 when his chest pain began to start radiating down his left arm. Max experienced a gradual increase in severity of central chest pains over a 2 day period. During his interview, Max told of how he continued to attend work, which involved physically demanding tasks such as lifting and moving heavy objects, because he would not receive any sick pay. He collapsed at work after lifting a box of carrots and his colleagues called an ambulance. Like Max, **Gareth**, a 54 year old self-employed Orthotist who was married with 2 children, continued to attend work due to financial pressures – ‘paying his bills’ – despite experiencing intermittent central chest pain over a 12 hour period.

Jasdeep, Christopher, Jack and Donald all recounted similar stories of their cardiac symptoms. The men all had difficulty describing their symptoms during interview as they did not consider them to be chest 'pain', but rather a general feeling that 'something was not right' in their chest. Despite experiencing some chest 'tightness' overnight, initially, **Steve's** main symptoms were nausea and vomiting. An escalation in the severity of his chest pain prompted him to ask his wife to call an ambulance. **Faarooq**, a 64 year old retired TV engineer, also explained that his pain in his chest was unlike any type of pain he had experienced previously. He made an appointment to see his GP because his symptoms had been persistent for over 12 hours.

Both **Alan**, a 53 year old retail manager, and **George**, a 57 year old IT manager, explained that they had expected symptoms of an acute cardiac event to be much worse than the 'nagging' chest pains they had experienced. Both men had decided to go to work because they were unsure of the significance of their symptoms. George also explained that he had been concerned that taking sick leave would jeopardise his work-place reputation and chances of promotion. An eventual onset of profuse sweating and clamminess prompted both men to get help. **Tom**, a 37 year old married school teacher, had also gone to work and delayed seeking help for 24 hours, despite experiencing severe intermittent chest pain, because he did not want to 'let anybody down'.

Ian, a 73 year old retired personnel manager, initially rationalised his central chest pain to be the 'aches and pains' of getting older, but a sudden increase in the severity of his pain over a one hour period prompted him to ask his wife to call an ambulance. **Michael**, a 76 year old married man with 3 children, still worked as a painter and decorator, and similarly thought his symptoms were a sign of getting older. He recalled that he had not attributed his moderate chest 'heaviness' to a condition requiring medical attention until he began to experience breathlessness and loss of skin colour. During his interview, he was candid about his regret that he had delayed seeking help for over 2 days and had possessed no knowledge of the symptoms of an acute cardiac event. **Danvir**, a 54 year old man of Indian origin, had delayed seeking help for 12 hours and was also frank about his ignorance of the symptoms of angina and regretful that he had not possessed the necessary knowledge to act more promptly on his chest pain symptoms.

Gurdeep, a 71 year old retired engineer, and **Gurnam**, a 60 year old Indian man who was on long term sick leave due to chronic back pain, both became concerned about a gradual increase in the severity of their central chest pain over a 1 hour period. **Dave, Eric, Richard** and **Les** told similar stories of a gradual increasing in the severity of central chest pain, but the

men had put off seeking medical help until their pain had become so severe that they could no longer continue to work or function at home. Whilst experiencing his chest pain at home, **Andrew** confessed to have been 'in agony' but was still reluctant to call an ambulance himself after delaying for 12 hours. His wife called 999 after seeing Andrew's obvious distress.

Overnight, **Craig**, a 37 year old married retail manager, experienced a sudden onset of central chest pain radiating down his left arm. **Robert** was walking home from work and initially experienced pain radiating down both arms. Both men took indigestion remedies and waited 10 and 12 hours, respectively, before asking their wives to call an ambulance. **Harry**, a 68 year old office manager, had suffered with gastro-intestinal problems for much of his life and had put off seeking medical help for his chest tightness for 2 days as he believed it to be indigestion.

Similarly, **Robin**, **Faisal** and **Mahesh** had considered their symptoms to be indigestion because they initially experienced a burning sensation in the chest. Mahesh rationalised his onset of pain as being due to some fried pakoras and a cup of tea, and Robin put his pain down to drinking hot chocolate before playing a game of squash.

Paul, a 69 year old taxi driver, was the only participant in the study to be interviewed with his wife. In his interview, both Paul and his wife were clear that they considered Paul to be fit for his age – citing his hobby as a joiner as an example of his fitness. As a result, neither Paul nor his wife had suspected his central chest pain symptoms to be of cardiac origin until it became extremely severe.

Study 2

Matthew, a 47 year old probation officer, was out walking on holiday with his long-term girlfriend when he began to experience tightness in his chest. He kept the symptoms to himself for almost 2 days; hoping it would go away. He eventually told his partner about his symptoms and she convinced him to seek medical help. Like Matthew, **Abdul**, a 54 year old IT worker of Pakistani origin, and **Mansur**, a 62 year old retired printer of Pakistani origin, also experienced chest tightness. After 4 hours of persistent tightness, Abdul discussed his condition with his son and subsequently decided that he should visit his GP in order to ascertain the cause of his symptoms. Similarly, after discussing his symptoms with his family, Mansur's son drove him to see the family GP.

Eddie, **Harry** and **Mitchell** all explained during their interviews that they had felt they could cope with the central chest pain and heaviness they had experienced. Harry, a 54 year old civil servant, had not visited his GP for over 13 years, and Mitchell, a 54 year old taxi driver, confessed that he had not consulted a doctor since he was at school. All three men had believed themselves to be fit and well prior to their acute cardiac event, had never before considered pain to be symptomatic of a serious or life-threatening illness, and sought medical help only when their pain became incapacitating.

Rashid was a 46 year old film director who had been educated at a grammar school in the UK. He experienced central chest pain whilst at work, but delayed seeking medical help for 6 hours until his breathing became erratic. He eventually informed his work colleagues that he was not feeling well and called an ambulance. **Imraan**, **Faarooq**, and **Jamaal** told similar stories of central chest pain radiating to their arm(s), described as being like nothing they had ever experienced before. Because of the unusual nature of their symptoms, the men all acted on them promptly; calling or visiting their GP within 4 hours of the onset of their pain. By contrast, **Dinesh**, a 56 year old security officer of Indian origin who was married with 3 children, told of feelings of general malaise associated with a mild ache in his chest. During his interview, Dinesh recalled that it had never crossed his mind that his symptoms may be attributable to a cardiac condition, and was shocked to learn of his diagnosis when he was admitted to the coronary care unit.

Frank, a 49 year old police officer, explained that he had experienced severe bouts of central chest pain for 3 days. On the third day, he rated the severity of his chest pain as '9½ out of 10'. He could not continue to work and therefore decided to call 999. **Trevor**, a 57 year old IT worker, also did not initially consider his chest pain to be sufficient to prevent him from attending work because he was not 'in agony'. He waited over a day before he began to

experience additional symptoms – breathlessness and sweating – that made him realise he required medical attention. **David**, a 42 year old security guard, delayed seeking help for less than one hour because he experienced a sudden and extremely severe onset of central chest pain in the middle of the night.

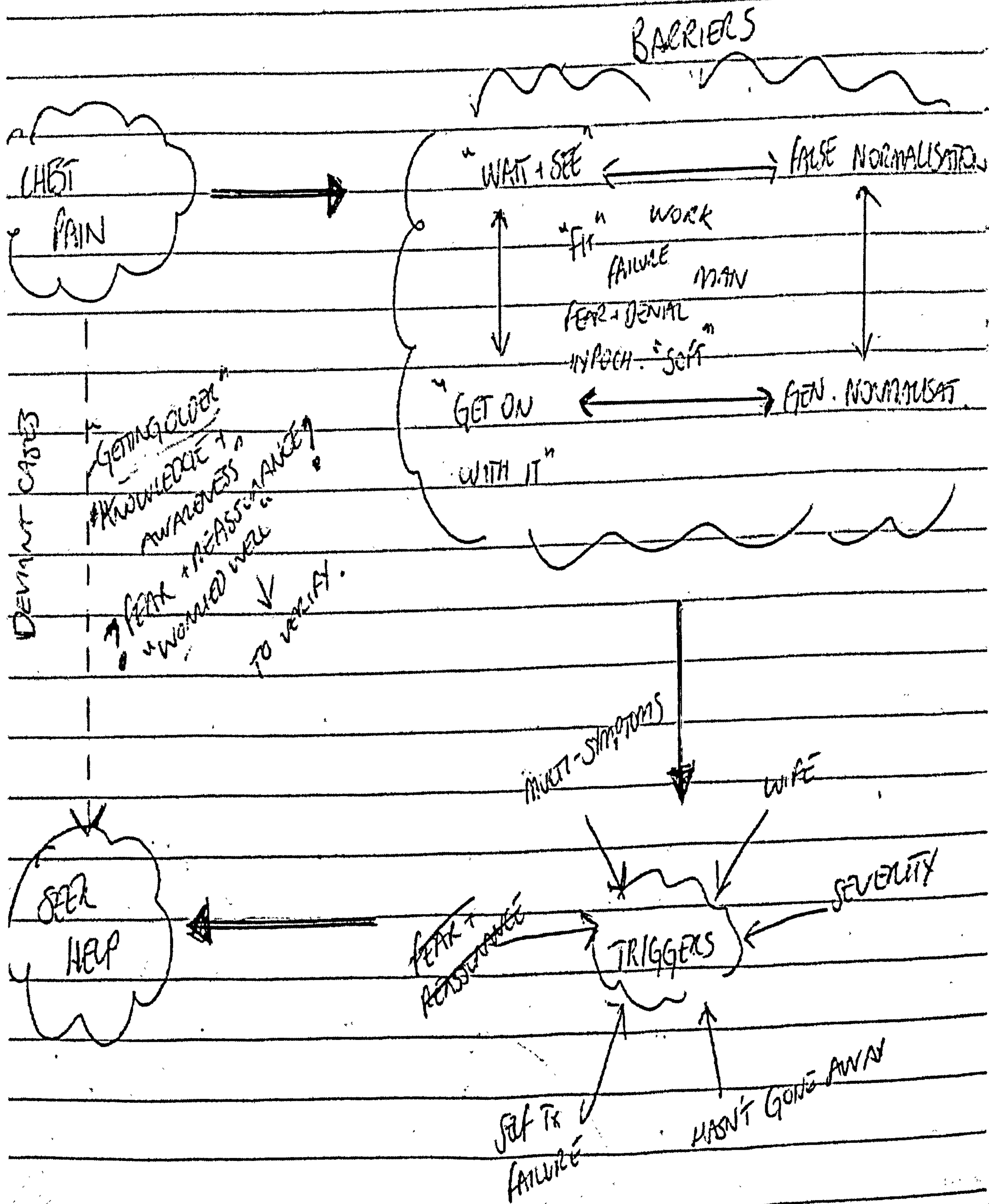
Amit, a 53 year old self-employed business man of Indian origin, was aware of the symptoms of an acute cardiac event and the high risk of heart disease in South Asian populations. He sought help from his GP within one hour of his onset of central chest pain. During his interview, **Mahesh**, a 74 year old retired architect of Indian origin, discussed the good relationship he and his family had with his local GP. Mahesh experienced intermittent pain on the right hand side of his chest for over 3 days and eventually decided to visit his GP because it became clear his symptoms were persistent. **Shahid**, a 52 year old civil engineer, also experienced intermittent pain on the right side of his chest and was encouraged by his sons and daughter to seek medical help. **Mohammad**, a 48 year old Pakistani man who worked for a high-street bank, experienced a gradual increase in the severity of his central chest pain. During his interview, he emphasised that visiting his GP was a ‘logical decision’ once he had realised his pain was persistent.

Abdur was an 84 year old retired GP who had worked in both Pakistan and the UK. Within one hour of the onset of chest tightness, he consulted his GP who immediately referred him to hospital after doing an ECG. **John**, a 55 year old postman with two sons, described his experience of severe intermittent chest pain that had lasted over a 3 day period. Despite his symptoms becoming severe and persistent he remained reluctant to call an ambulance to his house because he did not want his neighbours to view him with pity. As a result, he decided to drive himself to hospital. Before entering the Accident and Emergency department, John recalled that he had had a ‘final cigarette’ because he knew his condition was serious and that he would need to give up smoking.

Contents:

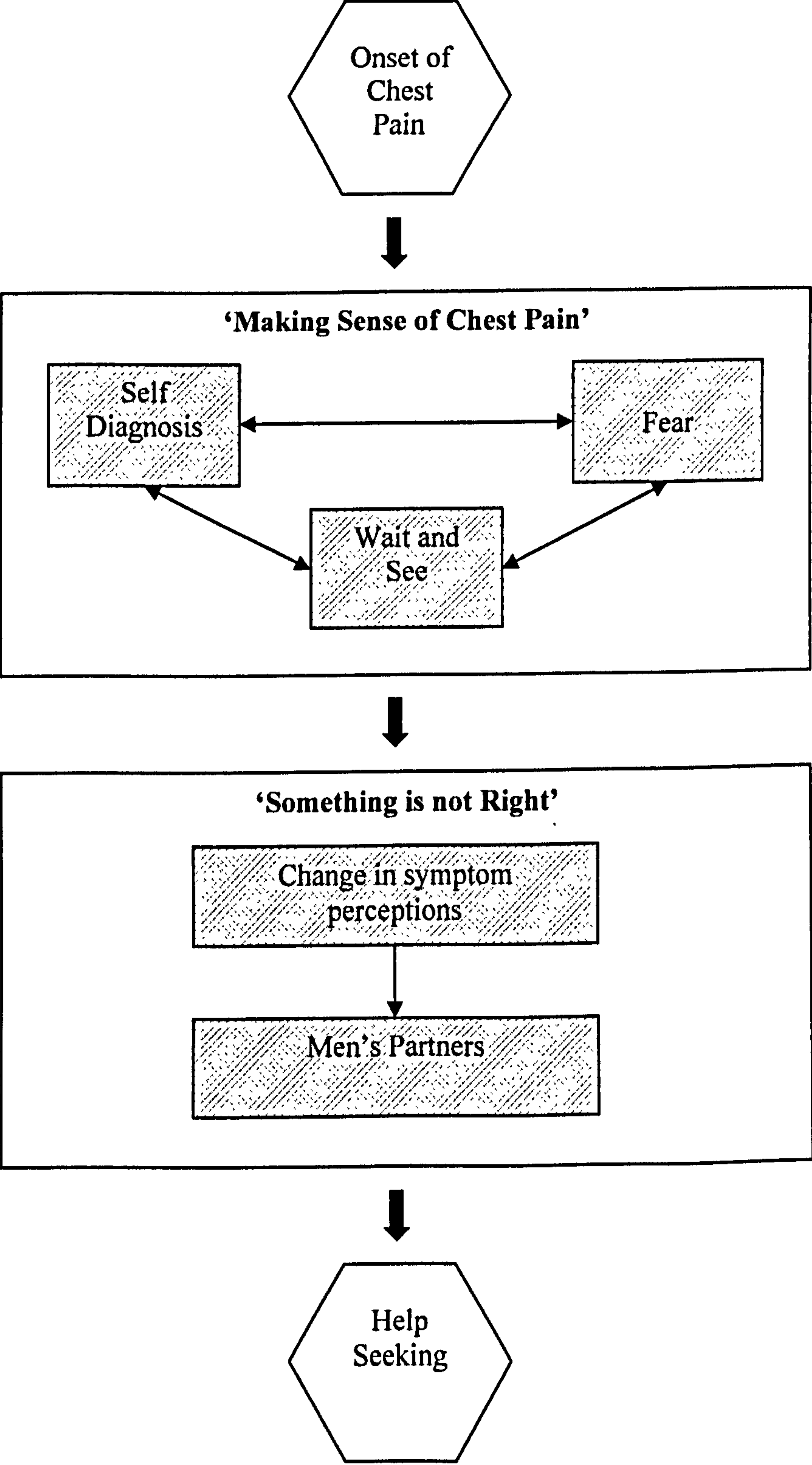
- Integrative diagram (study one)

20/4/06 CONCEPTUAL FRAMEWORK.



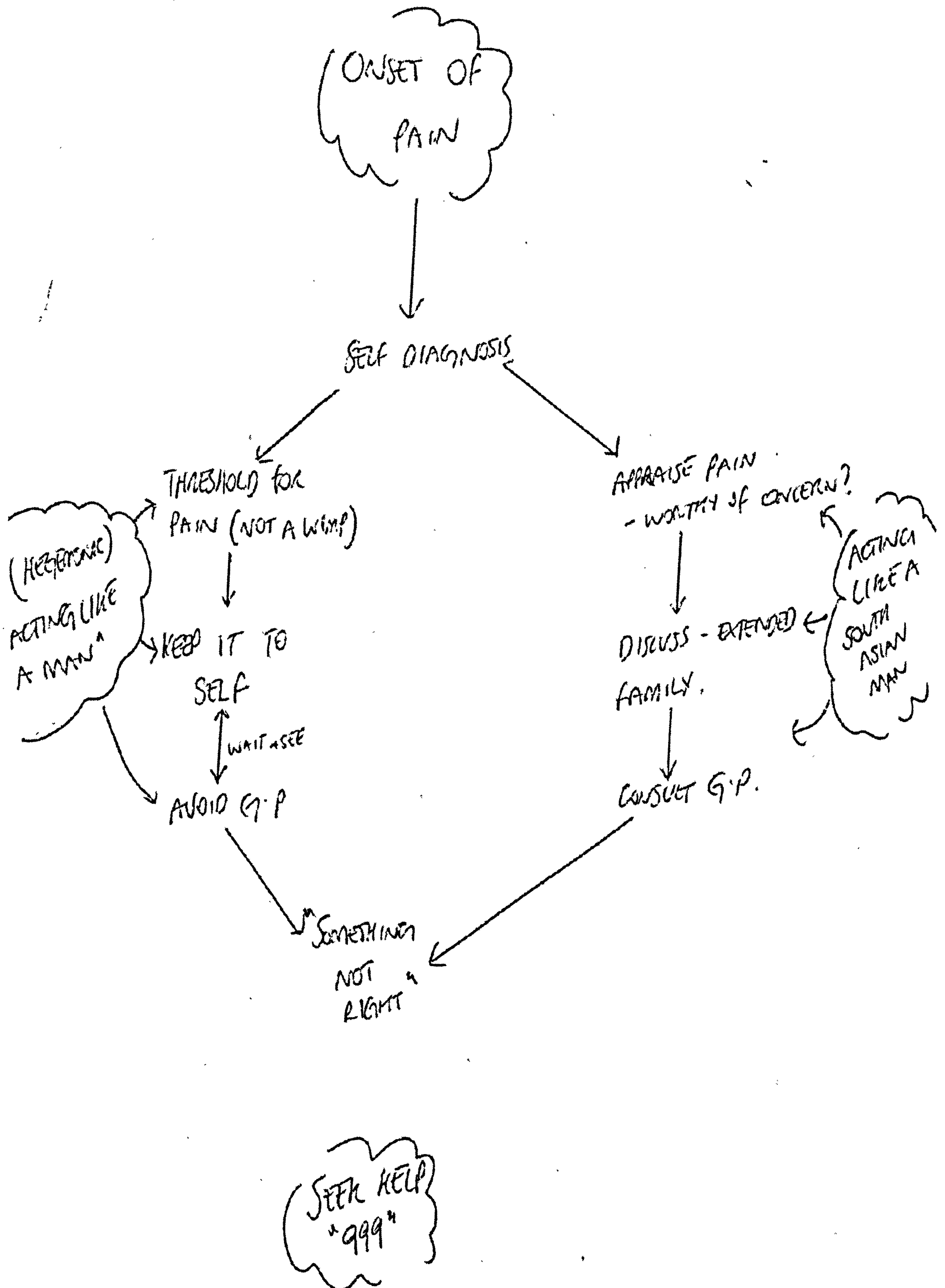
Contents:

- Integrative diagram (study one)



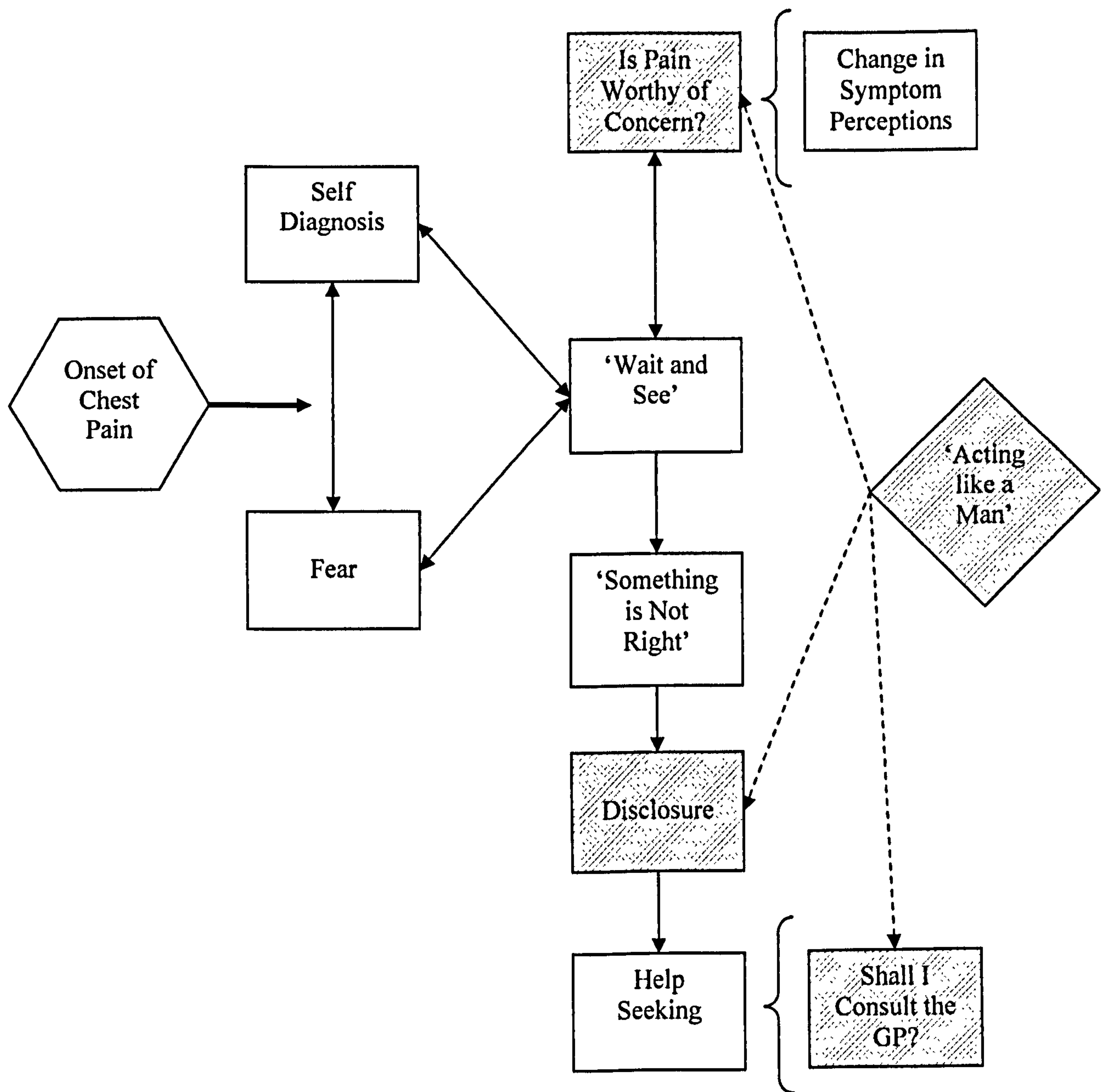
Contents:

- Integrative diagram (study two)



Contents:

- Integrative diagram (study two)



Contents:

- Patient information sheet and patient consent form
- Correspondence to clinicians in study settings (study one & two)
- Research Ethics Committee Approval (study one & two)
- Posters used in study settings (study one & two)



Chest Pain in Men and the Influences on Help Seeking Behaviour

A RESEARCH STUDY

You are being invited to take part in a **RESEARCH** study. Before you decide, it is important that you understand why the research is being done, and what it will involve. Please take the time to read the information in this leaflet. Feel free to discuss it with friends, relatives, or the nurses and doctors looking after you.

A researcher from the School of Healthcare Studies at the University of Leeds, Paul Galdas, will be conducting the research.

If you decide to take part in the research, you may withdraw at any time, without any reason.

Feel free to ask the researcher, Paul Galdas, if there is anything not clear, or if you would like more information.

Thank you for taking the time to read this.

What is the purpose of the study?

The purpose of the study is to investigate men's experiences of recent chest pain and to find out if, how, and why they sought medical help for their condition. The research will collect information on men's opinions of their experience of chest pain, and how, when and why they asked for medical help.

Why have I been chosen?

You have been chosen because you have come to hospital with chest pain. The study requires approximately 60 men who agree to be interviewed. The study will comprise of men from a range of backgrounds and ages who have all recently experienced chest pain.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time and you do not have to give a reason. This study will not affect the standard of care you receive.



What will happen to me if I agree to take part?

The researcher, Paul Galdas, will interview you at your bedside, in a separate room, or at a venue of your choice, providing you are not on bed rest. The interview will last approximately 30-45 minutes and will be tape-recorded with your permission.

What do I have to do?

The interview will consist of a number of questions about a range of issues associated with your experiences of having chest pain, and how, when and why you sought medical help. If you do not wish to answer certain interview questions, or wish to stop the interview at any time, you may do so.

Are there any disadvantages in taking part?

The only requirement of the research is to take part in one interview with the researcher, Paul Galdas.

How might I benefit from taking part?

You will not benefit directly by taking part, but your views and opinions will help us understand more about the reasons why men like yourself ask for medical help, or put off asking for help. This will help to develop better services to be delivered to men in general in the future.

Will my taking part in the research be kept confidential?

All information which is collected about you during the course of the research will be kept **strictly confidential**. Any information you provide will have **your name and address removed** so that you cannot be identified. All interview recorded will be kept locked away so only the researcher has access to them. The tapes will be destroyed at the end of the project.

What will happen to the results of the study?

The results of the study will be written up as a thesis by the researcher as part of a PhD. The results may also be published in a medical journal. **You will not be identified in any report or publication.**

School of Healthcare

Baines Wing
The University of Leeds
PO Box 214
Leeds LS2 9UT



Who do I ask for further information?

Feel free to discuss the study with family, friends, and your doctors and nurses. If you would like more information about the study and taking part, please contact Paul Galdas through information below, or through the nurse in charge of the area you are in.

Thank you for considering taking part in this study.

Paul Galdas
School of Healthcare
University of Leeds
P.M.Galdas@leeds.ac.uk
Tel: 0113 2331373 / 0787 6235694

PATIENT CONSENT FORM FOR RESEARCH STUDY

Title of Project:

Chest Pain in Men and the Influences on Help Seeking Behaviour

Name of Researcher:

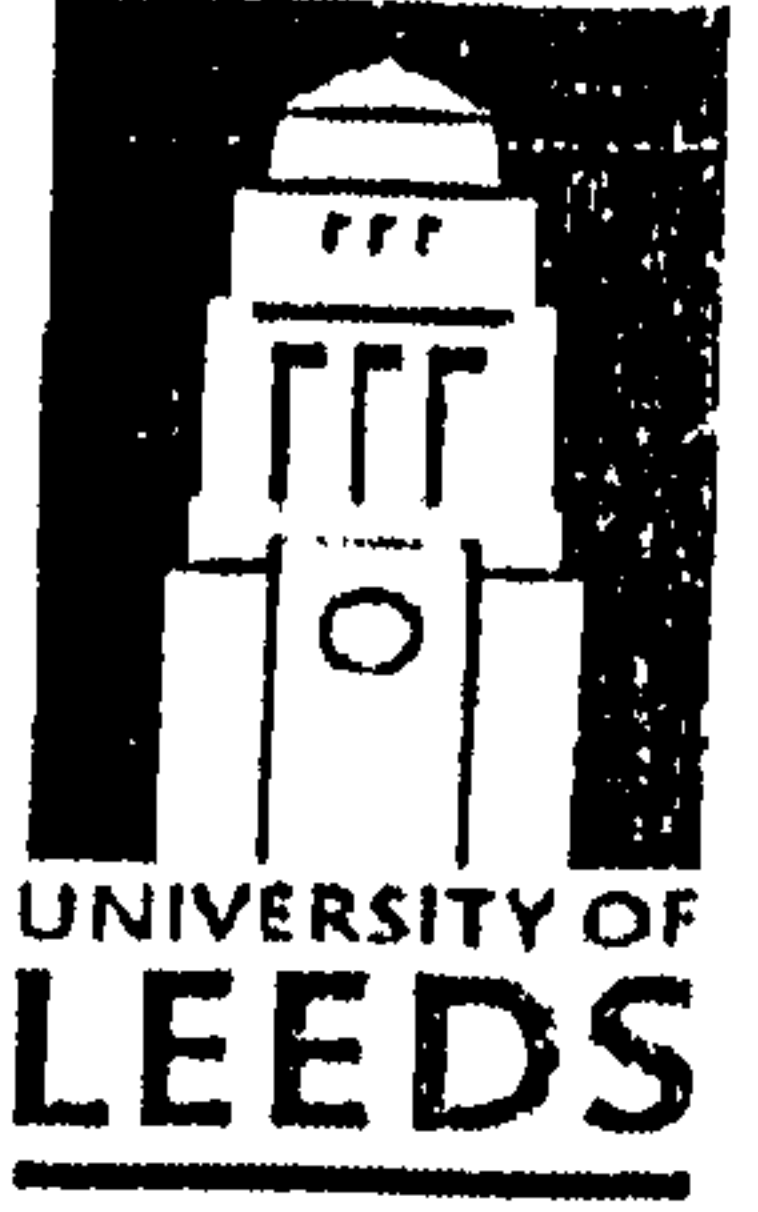
Paul Galdas

Please tick to confirm

- I have read the information sheet for the above study. ☐
- I have had the opportunity to ask questions about the study, and to discuss it with family and friends. ☐
- I understand the purpose of the study. ☐
- I understand, and accept, that if I take place in the study, I may not gain any personal benefit from it. ☐
- I understand that all the information collected in the study will be held in confidence and that, if presented or published, will have my personal details removed. ☐
- I understand that the study researcher will have access to my medical records where it is relevant, and I consent to this access. ☐
- I confirm that I will be taking part in this study of my own free will, and I understand that I may withdraw from it, at any time and for any reason, without my medical or legal rights being affected. ☐

I agree to take part in the above study.

.....
Signed	Date
.....
Person Taking Consent	Date
.....
Researcher (if different from above)	Date



Baines Wing
The University of Leeds
PO Box 214
Leeds LS2 9UT

Friday 5th September

Dear Sister/Ward Manager,

Re: Project No 03/136: Chest Pain in Men and the Influences on Help Seeking Behaviour

I am a nurse researcher at the University of Leeds. In the coming weeks I will be undertaking a research project in your clinical area for which I require your permission. The project should also require minimal assistance from nursing colleagues

The focus of the research is on chest pain and the triggers and barriers to help-seeking in men, an interest that has arisen from my own work as a cardiology nurse in the trust. The overall aim of the study is to investigate the perceptions of help seeking, held by men who have been admitted to hospital for the first time with acute cardiac chest pain. To achieve this aim, I am proposing to interview approximately 60 men who have been admitted with angina or MI to acute cardiology services and Clinical Decision Units (CDU) across the [REDACTED]. Interviews will last approximately 30-45 minutes and take place at the patient's bedside.

I propose to frequently visit each clinical area to discuss with the nursing staff if there are any suitable patients for interview. This process is only likely to last a few minutes. After identifying suitable patients, I will recruit and interview all patients myself and will not ask any nurse or NHS employee to aid in the study in any other way. Clinically unstable patients and those with multiple pathologies will not be sought for interview.

Ethical approval has been obtained and procedures for research governance are in place. I have also gained the permission of the relevant medical consultants to approach and interview patients under their care.

I propose to visit your area in person in the next few weeks to discuss the study with yourself and your colleagues in more detail. If you require any further information, or would like a detailed copy of the research protocol, please do not hesitate to contact me.

May I thank you in advance for your invaluable help in the study. I look forward to seeing you in the very near future.

Yours sincerely,

Paul Galdas BSc (Hons) RN
Tel: 0113 2331373 / 0781 2079082
p.m.galdas@lccds.ac.uk

Baines Wing
The University of Leeds
PO Box 214
Leeds LS2 9UT



Dear Dr,

Re: Project No 03/136 Chest Pain in Men and the Influences on Help Seeking Behaviour

I am writing to seek your permission to approach patients under your care for recruitment into a research project, which I am undertaking as part of a PhD at the University of Leeds. I am seeking to gain a fuller understanding of men's experiences of chest pain; an interest that has been stimulated from my experience as a registered nurse in acute cardiac care at the trust.

The overall aim of the study is to investigate the influences on help seeking behaviour in men who have recently experienced acute cardiac chest pain. I aim to interview approximately 60 men presenting or admitting to [REDACTED] with angina or MI, and have no previous medical history of chest pains or heart disease.

Interviews will last approximately 30-45 minutes and will take place at the patient's bedside or at a location of the patient's choice (if bed-rest is not medically advised). Patients who are medically unstable, have multiple pathologies, and/or are severely ill will not be sought for recruitment into the study.

Ethical approval for the project has been granted by Leeds (east) Research Ethics Committee (Project No 03/136). The procedures for research governance are also in place.

Informed, written consent will be sought from patients prior to interview. I will approach patients to discuss the project and provide them with a written information sheet. Written consent will then be sought from the patient at least 24 hours after this initial approach. I will conduct all the interviews.

If you agree to me approaching your patients please would you return the form enclosed using the enclosed stamped addressed envelope as soon as possible.

If you have any queries regarding the project, or would like a detailed copy of the research protocol, please do not hesitate to contact me. May I thank you in advance for your invaluable help in the study.
Yours sincerely,

Paul Galdas BSc (hons) RN
School of Healthcare Studies
University of Leeds
P.M.Galdas@leeds.ac.uk
Tel: 0113 2331373 / 0781 2079082



Baines Wing
The University of Leeds
PO Box 214
Leeds LS2 9UI

Dear Dr,

Re: Project No 03/136 Chest Pain in Men and the Influences on Help Seeking Behaviour

You may remember I wrote to you sometime ago to seek your permission to approach patients under your care for recruitment into a research project which I am undertaking as part of a PhD at the University of Leeds.

The overall aim of the study is to investigate the influences on help seeking behaviour in men who have recently experienced acute chest pain. To date, I have interviewed 36 men as part of the project. The study has provided new insights into the reasons men delay when they experience acute chest pain. It has also brought to light new lines of enquiry surrounding differences in help-seeking behaviour between men of differing ethnicity. Therefore, I aim to interview a further 30 Caucasian and South Asian men who have been admitted to [REDACTED] with acute chest pain.

Interviews will last approximately 20-50 minutes and will take place at the patient's bedside or at a location of the patient's choice (if bed-rest is not medically advised). Patients who are medically unstable, have multiple pathologies, and/or are severely ill will not be sought for recruitment into the study.

Ethical approval for the project has been granted by Leeds (East) Research Ethics Committee (Project No 03/136). The procedures for research governance are also in place.

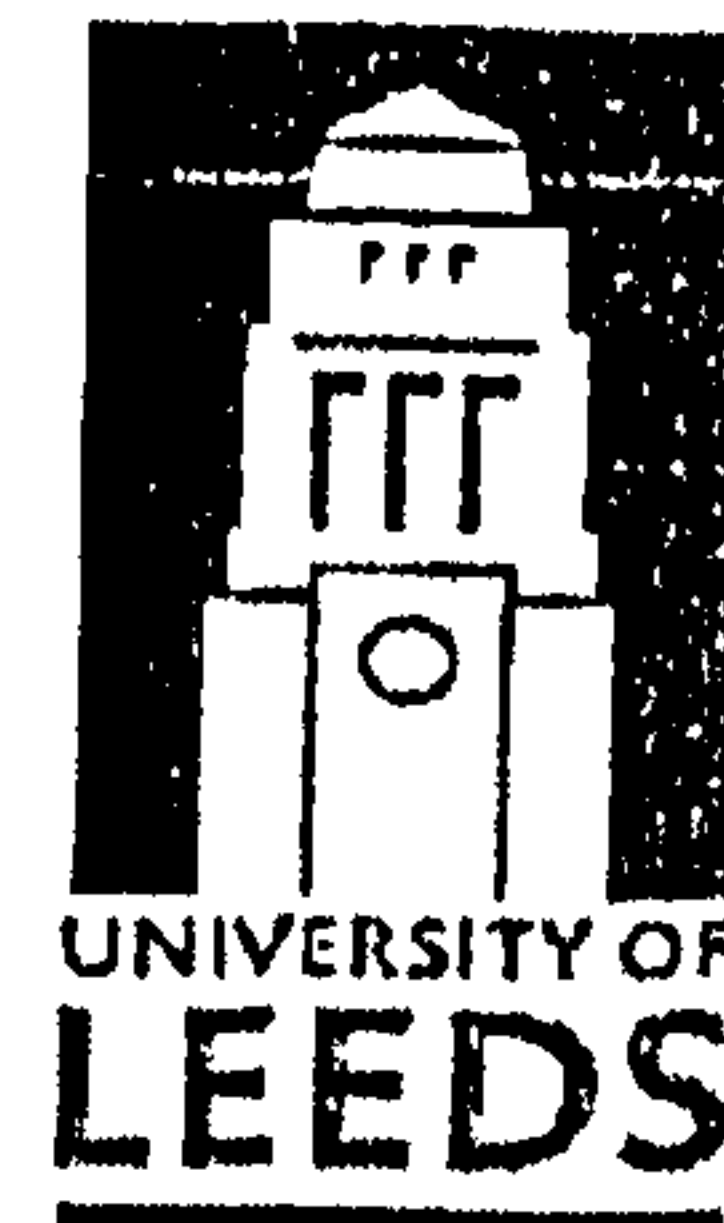
Informed, written consent will be sought from patients prior to interview. This will involve two phases. Initially, a nurse (or allied health professional) will seek verbal consent from eligible patients to be approached by me. On gaining verbal consent, I will then approach patients to discuss the project and provide them with a written information sheet. Written consent will then be sought from the patient at least 24 hours after this initial approach. I will conduct all the interviews.

I aim to begin the further search for patients in November 2004. If you have any problems regarding the interviewing of patients under your care for the project, and would rather I did not approach them, please contact me as soon as possible.

If you have any further queries regarding the project, or would like a detailed copy of the research protocol, please do not hesitate to contact me. May I thank you in advance for your invaluable help in the study.

Yours sincerely,

Paul Galdas BSc (Hons) PG Cert RN
School of Healthcare Studies
University of Leeds
P.M.Galdas@leeds.ac.uk
Tel: 0113 2331373 / 0781 2079082.



Baines Wing
The University of Leeds
PO Box 214
Leeds LS2 9UT

Clinician Form

Title of Project

Chest Pain in Men and the Influences on Help Seeking Behaviour

Name of Researcher

Paul Galdas

- I agree that Paul Galdas (the researcher) may approach patients who meet the inclusion criteria to invite them to participate in the above named study. If patients consent to be in the study I also agree that Paul Galdas may interview patients under my care as part of the above named research project.

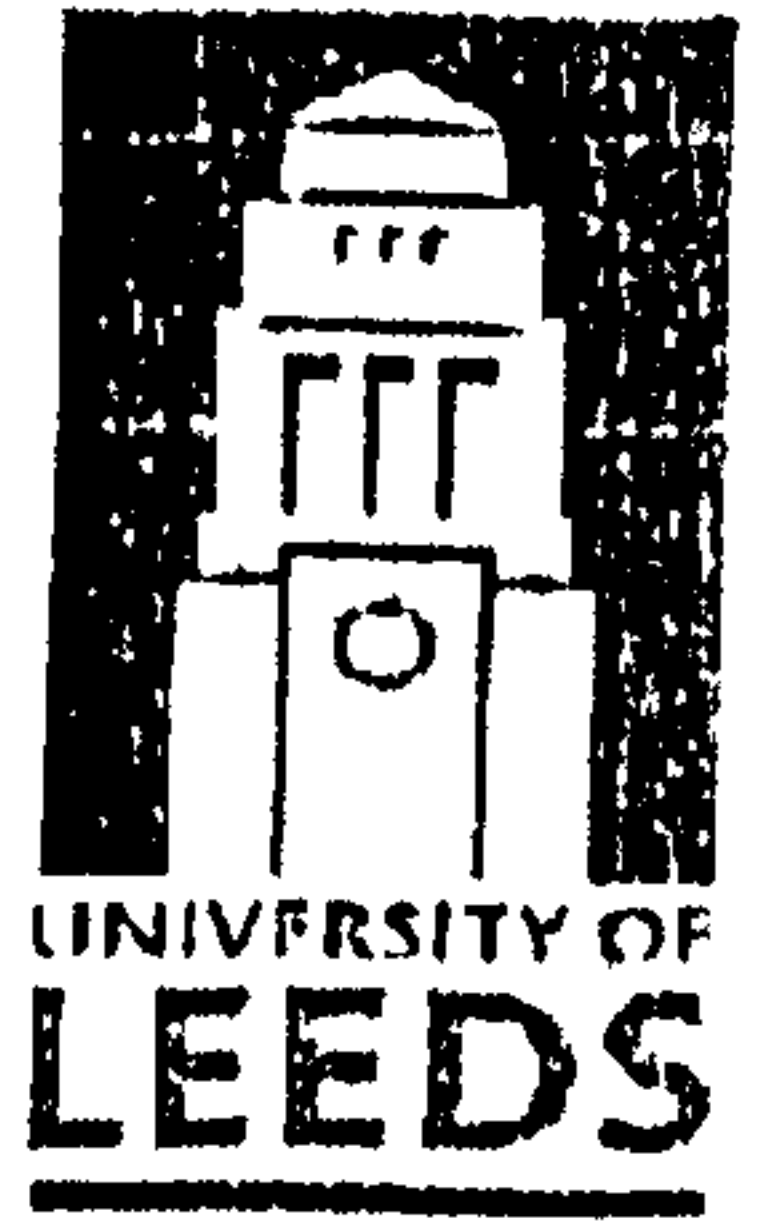
.....
Signed

.....
Print Name

.....
Date

School of Healthcare

Baines Wing
The University of Leeds
PO Box 214
Leeds LS2 9UT



Dear Sister,

Re: Project No 03/136 Chest Pain in Men and the Influences on Help Seeking Behaviour

I am writing to thank you for your recent invaluable help in the conducting of my project. To date, 36 patients have been interviewed as part of the study. As a result, the focus of my project has since changed and moved on to a second phase. In this second phase, I still intend to interview men who have been admitted with chest pain, but I will now be particularly focussing on male patients of South Asian ethnicity.

I will continue to regularly visit your clinical area to liaise with yourself and nursing colleagues to identify suitable patients for interview.

Once again, thank you again for your important help in the successful completion of the first phase of the study. If you have any queries regarding the project, or would like a detailed copy of the research protocol, please do not hesitate to contact me.

I look forward to seeing you again in the very near future.
Yours sincerely,

Paul Galdas BSc (Hons) RN
School of Healthcare Studies
University of Leeds
p.m.galdas@leeds.ac.uk
Tel: 0113 3437186 / 0781 2079082

The Leeds Teaching Hospitals
Local Research Ethics Committee



NHS Trust

e-mail: a.d.prothero@leeds.ac.uk

Mr P M Galdas
PhD Student
School of Healthcare Studies
Baines Wing
Leeds University

Enquiries to: Ann Prothero
(Ethics Secretary)

Direct Line/Ext: 0113 (20) 65652

11 June 2003

Dear Mr Galdas

Project No 03/136: Chest pain in men and the influences on help seeking behaviour

Your study was considered by the Ethics Committee at the meeting on 3 June and I am pleased to confirm that it was approved. We would like you to make a minor correction to the information sheet and add 'answer' to the final sentence in the section headed 'What do I have to do?' Also, please ensure that the information sheet is printed on headed paper.

The Committee would be very interested in receiving a copy of your findings at some future date.

Yours sincerely

Ann Prothero

Dr P R F Dear
Chairman
Leeds (East) Research Ethics Committee

Documents approved:

Ethics application form dated 14.5.03
Research protocol
Patient information sheet
Patient consent form
Appendix 1 – Interview schedule

Chairman Martin Buckley Chief Executive Neil McKay CB

The Leeds Teaching Hospitals Incorporating: Chapel Allerton Hospital Cookridge Hospital Leeds Chest Clinic
Leeds Dental Institute Seacroft Hospital St James's University Hospital The General Infirmary at Leeds
Wharfedale Hospital

WTA068

Leeds (East) Research Ethics Committee

e-mail: a.d.prothero@leeds.ac.uk

Mr P M Galdas
School of Healthcare
Baines Wing
University of Leeds

Enquiries to: Ann Prothero
Ethics Secretary
Direct Line/Ext: 0113 (20) 65652

20 October 2004

Dear Mr Galdas

Full title of study: *Chest pain in men and the influences on help-seeking behaviour*
REC reference number: 03/136
Protocol number:

Amendment number: 1
Amendment date: October 2004.

The above amendment was reviewed by the Sub-Committee of the Research Ethics Committee at the meeting held on 18 October 2004.

Ethical opinion

The members of the Committee present gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

Notice of substantial amendment dated 5 October 2004.
Revised interview schedule, version 2 dated October 2004.
Revised sampling criteria, version 2 dated October 2004.

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Management approval

Before implementing the amendment, you should check with the host organisation whether it affects their approval of the research.

Statement of compliance (from 1 May 2004)

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

REC reference number: 03/136

Please quote this number on all correspondence

Yours sincerely,

Ann Prothero

W Dr P R F Dear
Chairman

[REDACTED]

List of names and professions of members who were present at the meeting:

[REDACTED]
[REDACTED]



RESEARCH PROJECT IN YOUR CLINICAL AREA

Project No 03/136: Chest Pain in Men and the Influences on Help Seeking Behaviour

In the coming weeks I will be undertaking a research project in your clinical area for which I require minimal assistance from nursing staff and colleagues.

The focus of the research is on chest pain and the triggers and barriers to help-seeking in men. The overall aim of the study is to investigate the perceptions of help seeking, held by men who have been admitted to hospital for the first time with acute cardiac chest pain. To achieve this aim, I will be interviewing approximately 60 men over the next 2-3 months who have been admitted with angina or MI to acute cardiology services and Clinical Decision Units (CDU) across the [redacted] sites. Interviews will last approximately 30-45 minutes and take place at the patient's bedside or at a location of the patient's choice (if bed-rest is not medically advised). The interviews will be arranged at convenient times so as not to interfere with your clinical practice.

I will frequently visit your clinical area over the coming months to discuss with the nursing staff if there are any suitable patients for me to interview. This process is only likely to last a few minutes. I will be looking to interview patients who meet the following criteria:

- Male aged 18+
- Admitted with angina or MI and presented with, but not limited to, chest pain
- No past medical history of heart disease

(Clinically unstable patients and those with multiple pathologies will not be sought for interview)

Ethical approval has been obtained and procedures for research governance are in place. Permission from the relevant medical consultants in this area to approach and interview patients under their care has also been granted.

If you have any questions, require any further information, or would like a detailed copy of the research protocol, please do not hesitate to contact me.

May I thank you in advance for your invaluable help in the study. I look forward to seeing you in the very near future.

Paul Galdas BSc (Hons) RN
Tel: 0113 2331373 / 0787 6235694
p.m.galdas@leeds.ac.uk



Baines Wing
The University of Leeds
PO Box 214
Leeds LS2 9UT

'CHEST PAIN IN MEN STUDY'

Project No 03/136: Chest Pain in Men and the Influences on Help Seeking Behaviour

As many of you may (or may not!) know, over the past three months I have been searching for and interviewing men who have been admitted to your clinical area with acute cardiac chest pain.

I have successfully completed a number of interviews, for which I cannot thank you enough for your help in identifying suitable patients.

The focus of my project has consequently developed, and I am now searching solely for **SOUTH ASIAN MEN WHO HAVE BEEN ADMITTED WITH CARDIAC CHEST PAIN** (i.e. Indian, Pakistani, Bangladeshi men).

(Clinically unstable patients and those with multiple pathologies will not be sought for interview)

Ethical approval has been obtained and procedures for research governance are in place. Permission from the relevant medical consultants in this area to approach and interview patients under their care has also been granted.

If you have any questions, require any further information, or would like a detailed copy of the research protocol, please do not hesitate to contact me using the information below.

Paul Galdas BSc (Hons) RN
Tel: 0113 2331373 / 0781 2079082
p.m.galdas@leeds.ac.uk

ATTENTION!
YOUR HELP IS NEEDED...



Project No 03/136: Chest Pain in Men and the Influences on Help Seeking Behaviour

As many of you may (or may not!) know, over the past few months I have been searching for and interviewing men who have been admitted to your clinical area with chest pain.

The project has moved into a second phase, and I am now searching for **WHITE AND SOUTH ASIAN MEN** (i.e. Indian, Pakistani, Bangladeshi men) **WHO HAVE BEEN ADMITTED WITH CHEST PAIN**

I need your help to identify these patients!!

Just to remind you, the underlying cause of the chest pain must be angina or MI, and the patient must have not PMH of heart disease.

I shall frequently **visit** or **telephone** the ward to discuss if any eligible patients have been admitted.

Thanks in anticipation for your help in identifying these patients!

Ethical approval has been obtained and procedures for research governance are in place. Permission from the relevant medical consultants in this area to approach and interview patients under their care has also been granted.

Paul Galdas BSc (Hons) PG cert RN
Tel: 0113 2331373 / 07876235694
p.m.galdas@leeds.ac.uk

Contents:

- Galdas P.M. Cheater F.M. and Marshall P. (2005) Men and health help-seeking behaviour: literature review **Journal of Advanced Nursing** 49(6); pp616-623

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Men and health help-seeking behaviour: literature review

Paul M. Galdas BSc RN CertEd

PhD Student, School of Healthcare, University of Leeds, Leeds, West Yorkshire, UK

Francine Cheater MA PhD RGN

Professor, School of Healthcare, University of Leeds, Leeds, West Yorkshire, UK

Paul Marshall BSc PhD RGN RMN CertEd

Senior Lecturer, School of Healthcare, University of Leeds, Leeds, West Yorkshire, UK

Accepted for publication 26 March 2004

Correspondence:

Paul Galdas,
School of Healthcare Studies,
University of Leeds,
PO Box 214,
Leeds LS2 9UT,
UK.
E-mail: p.m.galdas@leeds.ac.uk

GALDAS P.M., CHEATER F. & MARSHALL P. (2005) *Journal of Advanced Nursing* 49(6), 616–623

Men and health help-seeking behaviour: literature review

Aim. This paper reviews the key research literature regarding men's health-related help seeking behaviour.

Background. There is a growing body of research in the United States to suggest that men are less likely than women to seek help from health professionals for problems as diverse as depression, substance abuse, physical disabilities and stressful life events. Previous research has revealed that the principle health related issue facing men in the UK is their reluctance to seek access to health services.

Method. The investigation of men's health-related help seeking behaviour has great potential for improving both men and women's lives and reducing national health costs through the development of responsive and effective interventions. A search of the literature was conducted using CINAHL, MEDLINE, EMBASE, PsychINFO and the Cochrane Library databases.

Results. Studies comparing men and women are inadequate in explaining the processes involved in men's help seeking behaviour. However, the growing body of gender-specific studies highlights a trend of delayed help seeking when they become ill. A prominent theme among white middle class men implicates 'traditional masculine behaviour' as an explanation for delays in seeking help among men who experience illness. The reasons and processes behind this issue, however, have received limited attention.

Conclusions. Principally, the role of masculine beliefs and the similarities and differences between men of differing background requires further attention, particularly given the health inequalities that exist between men of differing socio-economic status and ethnicity. Further research using heterogeneous samples is required in order to gain a greater understanding of the triggers and barriers associated with the decision making process of help seeking behaviour in men who experience illness.

Keywords: men's health, health service research, gender issues, nursing, literature review

Introduction

Across the developed world, the health of men is in urgent need of attention (Baker 2002). The United Kingdom (UK) is a case in point; men in the UK are more likely to die younger at all age groups; experience cancer, heart disease and human immunodeficiency virus; and visit their doctor less frequently, than their female counterparts [Department of Health (DoH) 2002]. A former UK Chief Medical Officer recognized that a major factor contributing to the poor state of men's health could be risk behaviour associated with traditional 'male lifestyle' (DoH 1993). Reflective of this, health professionals have placed much focus on attempting to change behavioural risk factors in men by seeking to understand the basis of male lifestyles from a gendered perspective. Fareed (1994, p. 26) noted in a nursing context:

Much ill-health among men is a consequence of their lifestyle, and these are issues that nurses can address in their role as health educators. There is a need to help men recognise that stereotypical gender role behaviour...can pose a risk to health and should be changed.

More recently, a scoping study on men's health, in which key individuals and organisations that have a role in the care of men were researched, revealed men's reluctance to access health services as the principle health related issue facing men in the UK (White 2001). In addition, successive UK Public Health Ministers have also noted that 'men are less likely to visit a doctor when they are ill and are less likely to report on the symptoms of disease or illness' (DoH 2000), thus placing help seeking behaviour at the forefront of the men's health agenda.

The study

Aim

The review aimed to provide a critical summary of the available evidence on men's health related help-seeking behaviour and to identify studies that illuminated if, how and why men delay seeking help when they experience ill health.

Method

The search of the literature was conducted using CINAHL, MEDLINE, EMBASE, PsychINFO and Cochrane library databases over the years 1966–2003. The Mesh terms and keywords: men's health, health service utilisation, experience of illness, help seeking behaviour, health service utilisation

and masculinity were used. The search was limited to articles published in English. From the search, 124 relevant studies were identified and critically analysed by the primary author. The studies selected for the review were those that discussed help-seeking behaviour in the context of gender. The themes to emerge from these studies are discussed in this paper.

Findings

Gender and help seeking: what are the differences?

There is a growing body of research in the United States (US) to suggest that men are less likely than women to seek help from health professionals for problems as diverse as depression, substance abuse, physical disabilities, and stressful life events (Weissman & Klerman 1977, Padesky & Hammen 1981, Thom 1986, Husaini *et al.* 1994, McKay *et al.* 1996). To a lesser extent, UK based empirical evidence from the last decade also supports the theory that men are less likely to use health services and seek help from health professionals in comparison with their female counterparts. For instance, men visited their general practitioner 67 million times in 1990, while women visited 143 million times in the same period (OPCS 1991). Although the total number of visits by women will be inflated by family planning, childbirth and child related health issues, these differences are thought to highlight the way women use primary care services (as a point of referral) more frequently than men (OPCS 1991). Cook *et al.* (1990) have also found that, across all social classes, 10% of men aged 45–65 did not consult their GP over a 3-year period, and a further 44% consulted on average twice a year or less. Similar findings have been noted in an National Health Service (NHS) survey of younger men; 69% of men aged 18–24 had visited their surgery in the preceding 12 months compared with 90% of women of the same age group (NHS Executive 1998). Moreover, the same survey showed that only 58% of men in excellent health attended their surgery, compared with 74% of healthy women, suggesting men are also poor attendees for preventative medicine. In addition, there is evidence that men not only consult less often than women, but their method of help seeking behaviour differs. Möller-Leimkühler (2002) found that although minor emotional symptoms increase the probability of consulting a general practitioner, physical symptoms were the determining factor for help seeking by men. Corney (1990) has also found that, in contrast to women, men are less likely to report psychosocial problems and distress as an additional reason for consulting. Lewis and O'Brien (1987) note that men are also unlikely to be the first to seek help when there are marital, child-care, or other

relationship problems. Indeed, the 'absent man' has been noted in a variety of other clinical settings, such as child health clinics, family planning centres and antenatal classes (O'Dowd & Jewell 1998).

In contrast to these findings, however, a significant body of research argues *against* gender as a determining factor in help seeking behaviour. For instance, Emslie *et al.* (1999a) found small gender differences in malaise and physical symptoms between male and female university employees, but found that the effects of occupational grade were far more important in predicting these variables. The researchers thus concluded that observed differences are explained not by gender, but by the behaviours and attitudes associated with particular career and lifestyle choices (Lee & Owens 2002). Similar results were found in a survey of bank employees (Emslie *et al.* 1999b). Further research evidence refuting the theory of the gender differences in help seeking can be found in the work of Feeney *et al.* (1998) and Macintyre (1993). Feeney *et al.* (1998) conducted large-scale survey research with British civil servants which revealed that women were more likely than men to take time off work for illness, but the effects were small and again strongly influenced by occupational grade. Macintyre (1993) collected data from 1700 volunteers who were inoculated with a cold virus (or placebo) in the Medical Research Council's Common Cold Unit in Salisbury, England. Volunteers in the study were visited by a trained clinical observer (medically qualified) who assessed the presence and severity of symptoms and signs using a standardised numerical scoring system. Scores for each recorded symptom or sign (e.g. sore throat, fever, swollen glands) were added to produce a total overall score for each volunteer at the end of the trial. The findings illustrated that men and women in the study were equally likely to report symptoms. Similar results were found in Macintyre's later work in a survey of the general population of Scotland (Macintyre *et al.* 1999). The enquiry found no evidence for the hypothesis that men were less willing than women to report symptoms or to seek health care, or that men were reluctant to report symptoms that were 'trivial' or emotional in nature (Macintyre *et al.* 1999). A similar study by the same group (Wyke *et al.* 1998) found that men were less likely than women to report a range of some 33 symptoms of illness (27% of men compared to 34% of women) but paradoxically, those who did report symptoms were just as likely to have seen a doctor about them. A study of illness behaviour among people with cancer of the colon or rectum (Marshall & Funch 1986) adds to the weight of evidence supporting the notion that women are no more likely than men to recognize and respond to cancer symptoms. Furthermore, two early reviews of the literature (Waldron 1976, Lewis

et al. 1977) also reported no consistent gender differences in response to symptoms, especially those suggesting serious disease.

A further theme can be noted in the literature indicating that women *over-report* symptoms. For example, Corney (1990) sent research participants four validated health and social instruments to investigate symptoms (such as frequent headaches, backache, swollen ankles) in the past 12 months, chronic conditions (such as stroke, epilepsy, diabetes), mental health status and social difficulties (such as housing, finance and employment). Results showed that women were significantly more likely to report symptoms or chronic conditions than men. Corney (1990) further noted that women were more likely (than men) to have visited health agencies such as doctors, nurses, social workers, psychiatrists or psychotherapists and physiotherapists, whereas men were more likely to have used accident and emergency services. Similar conclusions have been drawn in an extensive US based study by Green and Pope (1999). Green and Pope (1999) examined data from a household interview survey carried out in 1970–1971, linking this to 22 years of health services utilization records to explore the effects of gender, self-reported health status, mental and physical symptom levels, health knowledge, illness behaviours and health concerns. After controlling for these factors, female gender remained an independent predictor of higher utilisation over the 22-year period studied.

Gender comparative studies: methodological issues

The review of gender comparative research literature reveals a contradictory picture in which diverse conclusions can be drawn on the influence of gender in help seeking behaviour. However, *gender-comparative* studies are unsuitable to formulate hypotheses regarding *men's* help seeking behaviour. The fact that men and women differ in the frequency of a set of behaviours reveals little about the biological, psychological, or cultural processes responsible for any observed differences (Mechanic 1978). Indeed, when studies document sex differences, the authors often speculate about possible mediators of help-seeking behaviour, but rarely can the data address directly the hypothesized pathways (Addis & Mahalik 2003). As such, in order to understand the concept of help seeking among men, it is necessary to focus investigation on *men*, not merely on the differences between genders. What is more, by design, sex-difference studies are also ill equipped to account for within group variability. Not all men are the same, nor does it make sense to assume that individual men behave similarly in all help-seeking contexts. From a clinical standpoint it is precisely this inter and

intra-individual variability that needs to be understood in order to develop effective interventions (Addis & Mahalik 2003).

Men and help seeking behaviour: a 'No Man's Land?'

Sharpe and Arnold (1998) have conducted one of the few quantitative UK based studies investigating male gender-specific help-seeking behaviour. Sharpe and Arnold (1998) yielded qualitative and quantitative data through the use of focus groups, in-depth interviews and questionnaires on a sample of 760 men from diverse occupations. The findings illustrated that men consistently ignored health symptoms and avoided seeking help from the health services. For example, from the questionnaire men agreed that 'minor illness can be fought off if you don't give in to it' (64%); 'I often ignore symptoms hoping they will go away' (52%); and 'I have to be really ill before I go and see the doctor' (75%). Similar themes have been found in a qualitative semi-structured interview study of 21 men who had discovered a testicular lump (Sanden *et al.* 2000). The findings revealed significant delays in men between discovery (of a testicular lump) and treatment, attributed by the authors to men's 'wait and see' attitude. For the men in the study, seeking help was not an obvious solution. Akin to the findings of Sharpe and Arnold (1998), Sanden *et al.* (2000) noted subjects regarded physical problems initially as something that would cure themselves, like a cold, and seeking expert advice was regarded strange 'for men in general'. Richardson and Rabiee (2001) reported comparable findings in a qualitative study employing a semi-structured interview schedule with small groups of young men aged 15–19 years. Based on the findings of three focus group interviews, the researchers concluded that:

...participants consistently equated health to physical fitness and help-seeking behaviour was dictated by 'social norms'. These demanded that a problem should be both physically and sufficiently severe to justify needing help. GP's were not a popular choice for confiding because of discomfort associated with communication issues, unfamiliarity and feelings of vulnerability. In some cases this was expressed using homophobic comments. (Richardson and Rabiee 2001, p. 3)

Richardson and Rabiee (2001) concluded that the responses from the participants in their study exhibited the 'social norms' expected of men. Gascoigne and Whitear (1999) conducted a similar small qualitative research project on young men who had been diagnosed with testicular cancer. The researchers hypothesized that 'an understanding of the way in which men appraise symptoms of testicular cancer,

and arrive at the decision to seek health care, could be of assistance in developing a strategy aimed at encouraging men to seek early diagnosis' (p. 63). Inductive qualitative methods and semi-structured interviews yielded data suggesting participants in the study were reluctant and delayed seeking help because of feelings of embarrassment, a reluctance to appear foolish and an attempt to normalize symptoms. In illustration, one subject regarding his experience of testicular cancer stated,

You try to blank it out, you don't want to know. It was actually that the lump was getting bigger and bigger...it was getting to a stage that it was prominent (Gascoigne and Whitear 1999, p. 66)

The authors suggest that the subject's responses were 'a reflection of powerful internalised gender notions of masculinity and masculine identity' (p. 67). Chapple *et al.* (2004) have built on the findings of Gascoigne and Whitear (1999) in a qualitative study using narrative interviews to investigate patients' perspectives on why treatment delays occur for those with testicular cancer in the UK. Chapple *et al.* (2004) found that men they interviewed delayed seeking treatment because they did not recognise the symptoms (of testicular cancer), feared appearing weak, hypochondriacal, or lacking in masculinity. The research of Moynihan (1987) and Moynihan *et al.* (1998) identified similar themes, although not directly concerned with help seeking behaviour. Their studies found that a significant minority of men who were cured of cancer and had been treated 1–5 years before interview were experiencing anxiety or depression or both, yet none of the men had sought help. In illustration, one patient described 'being like a shutter pulled down, stark and unflinching...sympathy was not welcome but neither was dismissal or intolerance' (p. 1074). Another man said how he:

wept in private away from their families, and often in their cars where they felt enclosed and safe (Moynihan 1998, p. 1074).

The researchers concluded that it was crucial for the men in the study to be controlled and silent about their emotional life, representing a traditional masculine stereotype.

From a different perspective, Richards *et al.* (2002) investigated the socioeconomic variations in responses to chest pain in participants from a deprived area of Glasgow to participants from an affluent area of Glasgow. The authors found that men from the deprived area tended to normalize their chest pain leading to significant delays in seeking help for their condition. Aside from the theme of men 'normalizing' their chest pain, the findings from this study can be also be seen to emphasize the way in which perceptions of symptoms and illness behaviour are likely to be shaped by social and cultural factors, and not merely by gender alone.

A longitudinal study of 76 men who had suffered heart attacks (Finlayson & McEwan 1977), and a more recent grounded theory study using participant observation of men admitted to a coronary care unit with chest pain (White 2000), furthers the theme of men 'normalizing' their pain, resulting in delayed help seeking. White (2000) provides a comprehensive qualitative account of the phenomenon among men who were admitted to a coronary care unit with chest pain. He found that men in the study frequently delayed seeking help when experiencing chest pain. White's (2000) grounded theory study provides constructive insight into the personal experiences of men who have experienced ill health and how they adapt to the acute medical setting. The author relates subjects interpreting chest pain with the literature on masculinity, hypothesizing that the delay in seeking hospital care may lie in men's apparent reluctance to seek help and thus, men may need help in facing up to the impact which ill health may have on their (masculine) standing in society. A notable feature in the findings was that, although the men had suffered intense pain prior to admission, there had been a series of delays while they tried to rationalise their symptoms. The study concludes that men ignored feelings of ill-health because of masculine feelings of 'invincibility'. Within a similar masculinity paradigm, Helgeson (1987) interviewed 70 men (and 20 women as comparison) who had been admitted to hospital with an acute myocardial infarction in order to test a hypothesized link between type A behaviour, masculinity and coronary heart disease. Helgeson (1987) establishes a strong empirical link between what she termed 'trait masculinity', and severity of and adjustment to coronary heart disease, as well as an increase in mortality linked to 'traditional' masculinity. The study findings suggested:

...that patients who scored higher on negative masculinity and lower on positive femininity also scored higher on a measure of type A personality. A measure of qualitative social support was related to the presence of a positive aspect of femininity, empathy, and the absence of a negative characteristic of masculinity, homophobia. Patients who practised good health care were more often female and more often in empathy. Negative aspects of masculinity were related to longer delays before seeking help. Thus, not only did negative aspects of masculinity appear to be harmful, but positive aspects of femininity appeared to be beneficial. (Helgeson 1987, p. 81)

In addition to the investigations relating to men and help-seeking behaviour, masculinity has emerged as a significant theme in a growing body of social science literature, although the conclusions remain contradictory. For instance, Kaplan and Marks (1995) examined the relationship between 'gender role orientation' and appraisal of imaginary health risks in a sample of 201 US college students. Highly feminine men

exhibited the highest health concern in a number of fictional scenarios. The authors concluded that when males are socialized towards greater femininity this appears to lead to a heightened sense of awareness and concern about health compromising situations; a finding that is consistent with a growing body of psychosocial literature showing beneficial effects of femininity on health and illness outcomes (Korzenny 1988, Kimmel & Levine 1989, Good *et al.* 1994). By contrast, a UK based study by Annandale and Hunt (1990) revealed conflicting results. They investigated the relative impact of gender role on mental and physical health measures such as self-assessed health, GP visits, and blood pressure, and found that highly masculine men (and women) reported significantly better health than their less masculine counterparts, a finding also reported in comparable studies (Nezu & Nezu 1987, Stoppard & Paisley 1987) and meta-analyses of similar studies (Taylor & Hall 1982).

Discussion

The review of key gender-comparative help seeking studies does not fully support the hypothesis that men are less likely than women to seek help when they experience ill health. Although many studies note the relative under use of health services and symptom reporting by men in comparison with women, conversely, many also find an increase in help seeking in men compared with women, or indeed, no significant difference in help-seeking behaviour between genders. The evidence suggests that occupational and socio-economic status, among others, as more important variables than gender alone. Such inconsistency in the research literature is unsurprising given the widespread differences in study design and samples investigated. Indeed, no two studies have utilized the same indicators to measure ill health and help-seeking, nor the same data collection instrument. Moreover, the body of research comparing help-seeking behaviour between genders notably lacks any qualitative methods of enquiry. In addition to the contradictory nature of the findings, the sex-differences approach utilized in these investigations also fall short of providing an explanation for the actual differences between men and women in help-seeking patterns, and furthermore, do not address within group variability. As noted, 'men' are not a homogenous group that can be compared against 'women' (and vice versa). Given this, such empirical data must be seen as inadequate from which to inform policy and from which to draw firm conclusions concerning men's help seeking behaviour and use of health services.

A review of gender-specific research reveals a clearer picture of the potential factors influencing help seeking

behaviour in men, supporting the supposition that males delay seeking help. Notably, there is a mounting research literature pointing towards 'traditional masculinity' and/or 'masculinity beliefs' as a significant variable influencing the help-seeking behaviour and health risk appraisal of men when they become ill. Indeed, theories prevalent among international men's health discourse contend that men are not permitted to be expressive in their illness behaviour (Robertson 1995), or are 'unable' because of the construction of traditional masculinity, or an effort to conform to a socially prescribed male role where weakness and need for help are not believed to be masculine (Forrester 1986, Helgeson 1987, Lloyd 1996, Courtenay 2000, Davies *et al.* 2000, Möller-Leimkühler 2002). Nurses need to be aware that, as a result of this 'male socialization', men may react differently to health care services and health promotion messages, both in comparison with women and between men of differing age, social and ethnic groups.

However, despite such contentions and a significant emerging theme illustrating a trend for men to delay seeking help when experiencing symptoms of ill health, the dearth of studies integrating masculinity and men's perceptions into the investigation of help-seeking behaviour represents a significant gap in the literature. To date, no research has explicitly investigated whether men's perceptions of masculinity influence their decision-making processes with regard to seeking help when they experience ill health. In sum, there is little empirical evidence supporting effective interventions to tackle male reluctance to seek help.

Concepts of masculinity

The emerging research literature that has integrated masculinity into the analysis of men's health issues also shows evidence of restrictive assumptions regarding the concept. It is well established among sociological literature that multiple 'masculinities' are likely to exist among a diverse male population [see Morgan (1992), Connell (1995) and Seidler (1997) for an in-depth discussion]. However, despite researchers acknowledging this theoretical premise, it is in fact not reflected in the approaches taken to investigate the phenomenon empirically. For instance, many of the studies concluding 'masculinity' influences male help-seeking behaviour [for example, Gascoigne and Whitear (1999), Richardson and Rabiee (2001) and Chapple *et al.* (2004)] are based on homogenous samples (mostly white middle class males) that are not able to explore *variations between men*; for instance, in ethnicity and socioeconomic status. As such, it follows that in these studies ensuing conclusions, the construction of masculinity is paradoxically, a restrictive

unitary construct. In illustration, observing a group of Caucasian men displaying 'traditional' masculine behaviours of being tough and self-reliant translating into a failure to utilize health services does not adequately explicate the influence of masculine beliefs among men *per se*. Thus, it follows that the dominant form of masculinity discussed in the literature can be seen as a distinctly 'western' perspective. Therefore, a research approach is needed that recognizes masculine socialization as being dependent on culture, beliefs and environment. Indeed, the need is heightened because of significant class and ethnic divisions in both the extent of illness/mortality and the type of health problems suffered [for example, mortality from heart disease and stroke is three times higher in social class V than class I (Drever & Whitehead 1997); higher rates of diabetes are prevalent in all the ethnic minority groups (DoH 1999)].

In short, heterogeneous samples need to be investigated to establish whether there are masculine commonalities between men, and how these are played out under different social circumstances.

Conclusions

Across the developed world men's health is poor according to a wide range of measures. There is a growing trend in the literature indicating that 'male socialization' may have an adverse effect on men's health with, in particular, a reluctance to seek help when they experience illness. The study of men's help seeking behaviour thus has the potential for bettering both men and women's lives and reducing health care costs. Nurses at the forefront of health service provision are ideally placed to tackle the issue through the development of more responsive and effective interventions and services. The research literature emphasizes that help-seeking is a complex phenomenon in which there are likely to be multiple influencing factors aside from gender; notably, occupation, socioeconomic status and age. A review of existing evidence raises the question for professional agendas of whether the root of delayed help seeking in men are to be found in their own masculine attitudes, behaviour and values. There is a significant opportunity for nurses to play a central role in addressing this issue if their daily clinical practice is informed by an understanding of men's beliefs, values, and reactions to health services and ill-health. However, the current body of knowledge is insufficient to inform policy or clinical practice. Accordingly, further research is required in order to gain a greater understanding of the diverse nature of masculinity among men from differing backgrounds and cultures, and explore its role in men's help seeking behaviour. Current studies represent a fertile foundation for further investigation

What is already known about this topic

- Men have been stereotyped as less likely than women to seek professional help when faced with illness.
- Men's reluctance to access health services is a principle issue associated with improving men's health.

What this paper adds

- There are significant gaps in the research evidence on men's health-related help seeking behaviour.
- The socialization of men and the resulting masculine ideologies may be a significant factor in men's decisions to seek help when faced with illness.
- Further research is urgently required to investigate the determinants of men's help-seeking behaviour, in particular, the influence of masculine beliefs and the variations between men of differing socio-economic status, age and ethnicity.

into the phenomenon, having brought to light prominent themes amid men's health, masculinity, and help seeking behaviour. Further investigation which builds on the literature discussed in this paper can offer policy-makers and practitioners an understanding of if, how and why men delay in seeking help when they experience ill health.

Author contributions

Study conception and design/Drafting and critical revisions of manuscript/Supervision – PG, PM, FC; Data collection and analysis/Admin – PG.

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