EXPLORING MEN'S HEALTH
IN THE CONTEXT OF THEIR DAILY LIVES

EXPLORING MEN'S HEALTH IN THE CONTEXT OF THEIR DAILY LIVES

By

LIDIA MARTINUS, B.A.

A Thesis

Submitted to the School of Graduate Studies

in Partial Fulfilment of the Requirements

for the Degree

Master of Arts

McMaster University

MASTER OF ARTS (1998)
(Sociology)

McMaster University
Hamilton, Ontario

TITLE: **Exploring Men's Health in the Context of their Daily Lives**

AUTHOR: **Lidia Martinus, B.A. (McMaster University)**

SUPERVISOR: **Dr. Vivienne Walters, Professor**

NUMBER OF PAGES: **x, 105**

ABSTRACT

This thesis presents a literature review and data from individual interviews conducted with a total of 20 men in Southern Ontario and the Lower Mainland of British Columbia. The objective of this qualitative study was to identify what these men consider to be their main health problems, and what they consider to be the main health problems of Canadian men in general. In addition, this study explored the ways in which the men understand health and the particular health problems they experienced.

Several general trends emerged in the data. Respondents described health in both physical and mental terms. They associated physical health predominantly with lifestyle in the form of adequate activity/exercise, diet, and balance of activities. Mental health was associated with state of mind. Insofar as respondents worried about their health, they were concerned about developing physical health problems such as prostate and testicular cancer. However, the day-to-day problems that they actually experienced were low level mental health problems such as stress and tiredness.

Data analysis revealed a broader underlying theme of control. In particular, respondents' explanations of health reflected their ability to control the onset of many health problems by living a healthy lifestyle. Yet, social structural influences, specifically work and gender roles, did not always afford

these men control over health-related problems such as stress. Respondents explained the health of Canadian men in terms of lifestyle (reflecting control over health), and by unknown etiology (reflecting lack of control over diseases such as cancer). Review of the research findings identifies gaps in research and offers suggestions for further studies.

ACKNOWLEDGEMENTS

The process of completing a thesis affects the totality of a student's life. It was my good fortune to have many people assist me in the research and writing stages of this process.

First, I would like to thank my thesis supervisor, Dr. Vivienne Walters, who guided me, not only in the writing of this thesis, but throughout my years studying sociology. Dr. Walters is a true role model as a sociologist, scholar, and professional. Her support, guidance, and encouragement made the process of completing this research pleasantly memorable and her hard work and kindness will not be forgotten. I would also like to thank my committee members, Dr. Roy Cain and Dr. Charlene Miall, for their advice, support, and overall helpfulness during the writing of this thesis. Special acknowledgement and thanks are extended to Dr. Dorothy Pawluch who often provided me with valuable advice in the early stages of this research.

This thesis would not have been possible without the twenty men who willingly participated in the study and openly shared their experiences with me. Several people put forth unrelenting recruiting efforts to help me find potential respondents and so special thanks are extended to Linda (Seka) Martinus-Naccarato, Lorelei Organ, Julie and Herman Robers, James (Jerry) Natis, and Mary-Jo Monk.

Finally, the completion of this thesis is largely the result of the love and support I received from my family. It is from the bottom of my heart that I give my family thanks. To my niece and nephew, Elise and Alexander, I thank you for the many hugs and kisses you sent over the phone that helped Auntie through the more challenging times of finishing this written work. I would also like to thank my brother-in-law, Pat, for his input and support, and also for tolerating my many visits during breaks from my research. To my dad, John, I could not have completed this work without your patience and support. You consistently tried to make things easier for me in any way you knew how. To my sister, Linda, I extend my deepest gratitude for providing me with all the "things" I needed, when I needed them. You gave me support when I was down, a break when I was tired, and, most of all, love throughout the entire process of my research. I'm lucky to have you as my seka. Finally, to my mom, Louise, I say thank you for the tireless effort and encouragement that you provided in order to help me through the writing of this thesis. You provided me with love and support the entire time, and have taught me everything I know about perseverance (and editing!). Your accomplishments have been a source of guidance, strength, and encouragement not only in the writing of this thesis, but in the daily events that affect my life. Thank you for being the remarkable person that you are.

I share the success of this thesis with all those mentioned above. Any defects I accept as my own.

To Mom, Dad, and Linda
with profound respect, love, and gratitude.

Thank you for giving me my "wings".

TABLE OF CONTENTS

LIST OF TABLES

INTRODUCTION

While research on women's subjective experiences with health has been increasing in recent years, similar research on men's health is limited. To date, health research on men is still largely reported in terms of morbidity and mortality statistics or quantitative measures of variables thought to affect men's health. Of the qualitative studies that have been conducted, much of the focus has been on men's experiences with life-threatening or life-altering illness. Sociologically, masculinity and men's roles have dominated discussions on men. However, to date, there is little evidence that research has begun to examine men's daily experiences with health problems and concerns from men's own perspectives. As a result, we have a limited understanding of men's subjective experiences with health on a day-to-day basis.

The goal of this study is to document the health problems and worries of a small sample of men as well as what they considered to be the health problems of Canadian men in general. In addition, this study explores these men's understanding of the health problems that they experienced. By identifying trends that surround the respondents' experiences with health and their understanding of their own health problems, it is hoped that further studies will utilize these research findings to expand the body of work that is currently available on men's health. In this way, men's health may be discussed less from

the perspective of the researcher as expert and more from the perspective of the men themselves as experts on their own health. Similar research on women by Walters (1992, 1993, 1994) has pointed to the day-to-day factors that influence women's health and her work provides the conceptual framework for the research reported here.

The first chapter introduces this study and begins with a discussion of the current literature that is available on men's health. The status of men's health from the perspective of morbidity and mortality statistics is presented first. Given that statistics cannot provide explanations for the causes of ill-health and disease, three models are presented that discuss the determinants of health. Specifically, Chapter One presents the biomedical, the environmental/social-structural, and the lifestyle models of disease causation. Also presented is research on masculinity and men's roles and their relationship to men's health. The chapter concludes with an outline of the aims of this study.

The second chapter outlines the methodology used in data collection. The usefulness of qualitative methodology in general as well as the benefit of using a qualitative approach in this study are discussed. Chapter Two also includes a discussion of the lay perspective as an effective method of understanding men's perceptions of their health outside of broad theoretical paradigms. The research methodology used in this study is presented and the interview schedule is reviewed. In addition, the methods used in sample collection and the demographics of the sample are presented. Data collection

(using individual interviews) and data analysis (using inductive methodology) are also discussed. Methodological considerations are reviewed as factors that may have affected the research process.

Presentation of the research findings begins in Chapter Three. In order to provide a reference point with which to understand the respondents' concepts of ill-health, their concepts of health are reviewed first. Findings revealed that the respondents viewed health in both physical and mental terms. Physical health was associated with various lifestyle components such as activity/exercise, diet, and maintaining a balanced lifestyle. Mental health, on the other hand, was linked to the control men felt over their state of mind. The chapter then presents the respondents' perceptions of their own health. The majority of the men considered themselves to be healthy which they attributed to having good physical health. The minority of men who did not feel that they were healthy cited mental factors as the cause for their poor health. Finally, the respondents' concerns and experiences with health-related problems are then presented. Summary tables are incorporated into the discussion and indicate that men's primary health concerns (that is, health problems that these men worry about developing) are related to disease, specifically prostate and testicular cancer. Men's actual experiences with health problems (that is, problems that these men actually encountered), however, reveal that men suffer most often from low level mental health problems such as stress and tiredness.

Chapter Four addresses the respondents' explanations of ill-health in relation to the findings of Chapter Three. Lifestyle is a significant part of men's explanations of their experiences with ill-health. In particular, men in the study cited an improper diet, lack of exercise, and insufficient rest as lifestyle components that affected their health. Social structural factors were also a part of their explanations of ill-health particularly in the form of work and men's gender roles. However, a broader theme of control emerged in the data and this is discussed in relation to men's explanations of their own health. Respondents explained the health of Canadian men in similar terms. Lifestyle was seen as the largest factor affecting Canadian men since it afforded men in general a great degree of control over their health. However, respondents also indicated that some diseases, such as various forms of cancer, are out of the direct control of individuals since specific disease etiology is unknown.

The final chapter reflects on the study as a whole and discusses possible avenues of exploration in future research. While men have traditionally been the subjects of scientific health research only a limited amount of information is available on men's experiences with health. Given the little research that has been conducted on men's experiences with health in the context of day-to-day living, I argue that further research is necessary for a more comprehensive understanding of men's health. It is hoped that the findings of this study will expand the current information that is available on men's health and that further research will build on the findings presented in this thesis.

CHAPTER ONE

INTRODUCTION AND LITERATURE REVIEW

While research specific to women's health has been increasing over the years, resulting in a better understanding of women's health problems and experiences, research specific to men's views on health is limited. Certainly men have traditionally been the subjects of scientifically based medical research, but there are many gaps in our understanding of their health. For example, often neglected in men's health studies has been the role of the individual male as an "authority" on his own experiences and concerns with ill-health. Men's health has seldom been examined from the lay perspective.

Current research reflects a variety of data that have been accumulated on the topic of men's health. Health surveys, for example, have been conducted at both the local and national levels of government in order to provide aggregate-level statistics for specific sectors of the population. Also, quantitative as well as qualitative studies have been used to study men's health. Narrower in scope than health surveys, other quantitative studies have also demonstrated the statistical relationship of specific variables (such as unemployment) to the measurable aspects of men's health. Conversely, qualitative research has begun to explore men's health by studying the experiences of men with specific

illnesses and the media seek to communicate information on men's health by providing summaries of research findings in a marketable format.

Data on men's health have identified men's health problems and also sought to explain them, though they have seldom relied on men's definitions and explanations of their health problems. I start this chapter by reviewing the government data on men's health which has documented the main causes of death and the main sources of morbidity among men. With respect to mortality, the data often reflect internationally agreed experts' definitions and the determinations by physicians of causes of death. I follow this with a discussion of the main explanations of health status used by physicians, academics, and policy makers. These include the biomedical model, individualistic cultural/ behavioural explanations that focus on lifestyles, and social structural models that emphasize structural inequalities and other ways in which social structures influence health. In addition, I bring together studies which have argued that concepts of masculinity and men's roles have had an important influence on men's health. In conclusion, I suggest that what is often missing in research is the experience of men themselves and outline the purpose of the current study.

The Main Causes of Mortality and Morbidity Among Men

Men's Health: Statistical Findings

Statistics Canada data for 1995 indicate that the leading cause of death for Canadian men is ischemic heart disease followed distantly by tracheal/

Table 1: Male deaths, main causes, Canada 1995

CAUSE	NUMBER OF DEATHS
Malignant neoplasms	**31, 332**
- esophagus and stomach	2, 099
- intestine and rectum	3, 349
- pancreas	1, 414
- trachea, bronchus and lung	9, 769
- breast	36
- prostate	3, 761
- urinary system	1, 666
- lymphatic tissue and leukemia	2, 875
- other	6, 363
Diabetes mellitus	**2, 728**
Diseases of the nervous system and sense organs	**2, 766**
Diseases of the circulatory system	**40, 091**
- ischemic heart disease	24, 333
- cardiac dysrhythmias and heart failure	3, 430
- cerebrovascular disease	6, 586
- arteries and capillaries	2, 557
- other	3, 185
Respiratory diseases	**10, 210**
- pneumonia and influenza	3, 465
- chronic bronchitis, emphysema, and asthma	1, 159
- other chronic airways obstruction	4, 309
- other	1, 277
Chronic liver disease and cirrhosis	**1, 503**
Congenital anomalies	**597**
Certain perinatal causes	**568**
Accidents and adverse effects	**9, 228**
- motor vehicle accidents	2, 238
- accidental falls	1, 063
- suicide	3, 158
- homicide	330
- other	2, 439
All other causes	**9, 892**

Adapted from: Statistics Canada, 1997, pp. 6-14

bronchus/lung disease. These data are shown in Table 1. In this regard, Canada is no different from other industrialized societies.

Data are also available at the municipal level and, as Table 2 indicates, men in Hamilton-Wentworth are most likely to die from circulatory disease (such as heart disease), cancer (lung cancer is ranked first followed distantly by prostate cancer), and respiratory disease (Dickson et al., 1995).

Table 2: Leading causes of male mortality of Hamilton-Wentworth residents, 1990

Cause of Mortality	Male Deaths (out of 1,765 deaths)
Circulatory	706
Cancer	532
Respiratory	150
Ill-Defined	132
Injuries/Poisoning	96

Adapted from: Dickson et al., 1995, p. 57

Whereas mortality statistics indicate causes of death, morbidity statistics indicate the acute and chronic conditions with which individuals live. According to Statistics Canada (1994) the chronic conditions men suffer from are varied. It can be seen in Table 3 that arthritis and rheumatism, skin or other allergies, and hypertension are most prevalent, though these vary with age. For example,

arthritis and rheumatism, heart disease, hypertension, diabetes, emphysema, and emotional disorders are more prevalent in older segments of the population whereas the prevalence of hay fever and allergies decreases with age (Statistics Canada, 1994).

Table 3: Prevalence (%) of health problems among the Canadian male population age 15 years and over, Canada 1991

Chronic Health Problem	Prevalence (%)
Arthritis and rheumatism	16
Skin or other allergies	16
Hypertension	16
Hay fever	11
Migraines	5
High cholesterol	9
Digestive other than ulcer	7
Emphysema	7
Heart trouble	7
Asthma	6
Emotional disorders	4
Stomach ulcer	4
Diabetes	4

Adapted from: Statistics Canada, 1994, p. 27

Such data reflect the definitions of experts and they have guided medical research and health promotion activities. However, the data in themselves tell us relatively little about the causes of death and ill-health among men. For this we need to turn to models which seek to explain the determinants of health. In the following sections I trace the primary models which have guided research and policy. First I examine the medical model which is the traditional approach and still the main paradigm of health. Next, I discuss an approach which has been emphasized much more frequently in the past decades which focusses on individual lifestyles. Then I examine social-structural explanations which have been less commonly accepted despite a considerable research literature that draws attention to the influence of the broader society on health. All of these seek to explain health status in general as well as the source of specific health problems. Finally, I focus on explanations which pay particular attention to men's health, arguing that masculinity and men's roles have an important effect on their health.

Explaining Men's Health Problems

The Biomedical Model

The biomedical model affiliates the etiology of disease to a specific cause.[1] Modern scientific medicine is most often associated with the biomedical model (Morgan et al., 1993) which became part of the medical education process in the early twentieth century. Torrance (1992) notes that early in the

twentieth century the medical education process was made scientific, medical licensing procedures were standardized across Canada, and by the 1920s the health care system was characterized by improvements in curative medical and surgical therapy. With the general acceptance of the medical profession as an effective way to treat illness, health care moved out of the house and into hospitals (Torrance, 1992). The medical profession, specifically physicians, dominated the health care system and worked in accordance with scientific methods upheld by their profession.

The scientific methods that characterize current allopathic medicine are based on the biomedical model and, therefore, make this model one of the dominant explanations of the cause of disease. As defined by Clarke (1992), the biomedical model:

> is based on the assumption that disease is an objectively measurable pathology of the physical body that results from the malfunctioning of parts of the body. All diseases are eventually explainable through a close analysis of the biological components of specific individual human beings. (p. 224)

Biomedicine, in accordance with the scientific method employed by allopathic medicine, focusses on the altered functioning of parts of the human body at the cellular level that can be corrected through chemotherapeutic, surgical, or as Clarke calls them, other "heroic" means. Sickness is limited to what biology is able to define as abnormal.

However, biomedical studies using scientific methodology have not been complete in explaining sickness. As Morgan et al. (1993) note, the biomedical model is criticized for defining disease too narrowly according to cellular pathology. It is argued that the etiology and distribution of disease should also be considered from a social and psychological standpoint (Morgan et al., 1993). Also, Morgan et al. (1993) argue that the scientific methodology used by the biomedical model may not be as objective and value-free as it claims to be (see also Jesser, 1996). Approaches to disease and the application of disease labels are influenced by social forces (Morgan et al., 1993). Finally, the biomedical model is criticized for having "medicalized" society. Zola (1997) indicates that biomedicine holds the power in North American society to define aspects of the human body as "healthy" or "ill". In turn, he suggests, such definitions lead the individual to define health and illness in terms of medical definitions rather than in terms of normality and abnormality for the individual body (Zola, 1997).[2]

With respect to men's health, it is not known whether men understand their health in terms of definitions provided by medicine. One clue is provided by Blaxter's study of health and lifestyles. The percentage of British males and females stressing biology as the cause of disease for society in general was negligible. Even when asked to consider the cause of their own ill-health, biology figured last in explanations for the cause of disease (Blaxter, 1990).

The Lifestyle Model

The second model of disease causation is rooted in lifestyle. The lifestyle model explores disease causation in terms of the pattern of living people choose to adopt for themselves. Clarke (1992) defines ill-health according to the lifestyle model as:

> the result of individual actions based on personal decisions regarding style of life such as (1) exercise, (2) stress management, (3) diet, (4) smoking, (5) substance use and abuse, (6) sexual behaviour, and (7) other behaviours such as using a seat belt or observing the speed limit. (pp. 226-227)

Thus, the lifestyle model is directly linked to "way of life". Researchers such as Herzlich and Pierret (1986) explain that the concept of "way of life" implies a multitude of potential causes or combination of causes, all of which reflect society's understanding of ill-health at a given point in time. For example, prior to the 1960s, ill-health was often associated with germs in urban environments, while after 1960 explanations of ill-health by lay individuals often focussed on pollution (Herzlich & Pierret, 1986). However, since the early 1980s, Herzlich and Pierret argue that individual lifestyle is often cited as the cause of modern day health problems.

Various aspects of lifestyle have been explored in research. One such lifestyle behaviour is associated with diet, specifically a diet that is unbalanced nutritionally and is characterized by excessive food intake. Health and Welfare Canada (1993) reports that one-quarter of Canadians face increased health risks because they are overweight. Health and Welfare Canada also examined

the relationship between smoking and general health practices. Statistics showed that males who smoke are also more likely to participate in other health risk behaviours associated with alcohol consumption, exercise, nutrition, seatbelt use, driving while intoxicated, and sexual behaviour (Health and Welfare Canada, 1993). Therefore, lifestyle practices play an important role in the attainment and maintenance of health.

Although individual lifestyle actions are at the root of ill-health according to the lifestyle model, lifestyle has a social element as well. The media and government have vested interests in promoting certain lifestyle habits. As Herzlich and Pierret (1986) point out, lifestyle or "way of life" is essentially social, reflecting contemporary society. For example, unhealthy lifestyle practices are often communicated through advertisements for products (such as fast food and beer) that do not promote health. However, the mass media also promote healthy lifestyle practices by communicating to the public how to improve individual health through diet, exercise, and stress reduction (Weitz, 1996). In addition, Canadian and American governments spend millions of dollars on education campaigns to encourage the public to improve their health through specific lifestyle habits (Weitz, 1996). However, even though government health-promotion campaigns are designed in part to benefit the population, Edginton (1989) notes that governments also have a "hidden agenda" in promoting healthy lifestyles. For example, by encouraging the population to adopt a healthy lifestyle, government expenditures on health care

can be reduced. Therefore, lifestyle is not entirely individual given the influence of broader social structures.

Despite the social structural influence on lifestyle, individual actions continue to be the focus of proponents of the lifestyle model. One of the problems with putting all attention on the individual is that individuals are then blamed for not taking the appropriate measures to prevent disease when disease occurs. Some arguments have even been made that, given the high cost of medical services, people who adopt unhealthy lifestyles should have less medical care (Crawford, 1997).

However, Crawford (1997) argues that in blaming the individual, serious discussion of social or environmental factors causing disease is averted. For example, environmental pollution, pesticide use, and food additives, to name just a few, are environmental hazards over which individuals are increasingly having less control (Crawford, 1997; see also Herzlich & Pierret, 1986). Relationships have also been established between low income and high infant mortality, diseases related to poor diet, and malnutrition (Crawford, 1997). Finally, focus on the individual obscures the class structure of work and workers' lack of control over working conditions (Crawford, 1997). Therefore, while authors like Crawford do not deny that individual behaviour can affect health, individuals cannot be separated from the environment and social structure in which they live.

Given the significant social influence on individual lifestyle practices, especially through wide-reaching sources such as the media, it is not surprising that lay perspectives on health have reflected individual lifestyle as a contributor to the cause of disease. For example, in Blaxter's (1990) study on health and lifestyles, both males and females considered lifestyle to be the primary cause of disease "for society at large", "for one's own life", and "for a range of diseases" (p.159). Blaxter says, "there is a high level of agreement within the population that health is, to a considerable extent, dependent on behaviour and in one's own hands" (p. 162). However, it is not known to what extent such reflections of lifestyle figure in the personal experiences of Canadian men with health and ill-health.

The Environmental/Social-Structural Model

The environmental/social-structural model suggests that a variety of environmental and social factors can be responsible for disease. According to Morgan et al. (1993), the physical and biological causes of disease often work in conjunction with a variety of other factors such as society and the environment (see also Nettleton & Brunton, 1995). Clarke (1992) defines ill-health according to the environmental/social-structural model as:

> the result of a complex of social-structural inequalities revealed by the relationships between disease and class; gender, race and ethnicity; environmental pollutants and containments; dangers in the workplace; and stress. (p. 225)

As a result, disease may be associated with biological pathology but the cause is rooted in a broader structure, namely the environment and/or society.

While the causes of disease may not be established as quickly as with allopathic medicine, the environmental/social-structural model removes the focus from the individual having created pathology to a broader sense of society having the responsibility for producing the pathology. According to Clarke (1992), examining how the environment and society produce disease is useful in the planning of disease prevention and health promotion programs that could potentially reduce the overall incidence of certain diseases. Coupled with Clarke's view, Morgan et al. (1993) point out the importance of the environmental/social-structural model in broadening the definition of health to include social and environmental factors rather than basing health on individual responsibility alone.

As with the lifestyle model, illness resulting from social-structure/the environment can have one or more causes. One cause that is strongly reflected in sociological literature is the relationship between social class and health. As social class increases (as measured by education, income, or occupational status) illness decreases (Weitz, 1996). For example, heart disease occurs three times more often among low-income earners than it does among the affluent (Weitz, 1996). Furthermore, the compromised living conditions of lower classes make individuals more vulnerable to disease (Syme & Berkman, 1997).

The workplace is another structural cause of illness. Working with dangerous materials and/or under dangerous conditions in the workplace is an obvious health hazard but the workplace environment may also have many imperceptible hazards that often go undetected. For example, Edginton (1989) reports that video display terminals (VDTs) in the workplace have been a growing cause of health concern because of undetected radiation being emitted from terminals. However, because cancer and radiation "experts" claim that VDTs are safe, changes are not made to work environments and many VDT users still suffer from health problems resulting from working in front of a VDT (Edginton, 1989).

Finally, the effects of participating/not participating in the workforce have also been examined. Leeflang, Klein-Hesselink, and Spruit (1992) studied the effects of long-term unemployment on 796 thirty to fifty year old Dutch men and found that men experiencing long-term unemployment suffered more ill-health than employed men. Unemployed men reported an increased number of depressive and physical complaints as well as self-reported chronic diseases (Leeflang et al., 1992). Another study by Thorslund, Wärneryd, and Östlin (1992) quantitatively examined the work-relatedness of disease using Swedish workers' own assessment of whether or not their job was the cause of ill-health they had experienced. Thorslund et al. found that 40.2 percent of the entire male study population (sample size of 12, 664 men) said that they suffered from

a long term illness and of that group approximately half attributed their illness to previous or present working conditions.

One of the characteristics of environmental/social-structural causes of ill-health is that often the causes are linked, with one cause leading to another. For example, Blane (1991) describes how manual work is more physically demanding and dangerous than non-manual work, but he also noted that manual workers usually have a much smaller income than non-manual workers. Therefore, individuals working under conditions of manual labour face the "double jeopardy" of both hazardous working conditions and low-income that is associated with poorer health. While the combinations of environmental and social-structural causes of ill-health can lead to endless debate, the model helps to explain the scope of disease causation. As Edginton (1989) suggests, improvements to health will not necessarily come from simply expanding health services or improving technology; rather, they will also need to come from improving the environmental and social-structural elements of our society.

The three models examined in this section have been used to explain the causes of disease for the population in general. However, research on men's health in particular has included another factor in its explanations, that is, masculinity. The following section will discuss masculinity research in relation to health as it is presented in current literature.

Masculinity and Men's Roles

In the late 1970s and 1980s, an attempt was made to study masculinity "scientifically" with the development of masculinity scales. One of the more common scales used in masculinity research is the Bem Sex Role Inventory (BSRI) (Annandale & Hunt, 1990). The BSRI is administered as a self-completion questionnaire and relies upon the individual's endorsement of a series of adjectives judged to be culturally characteristic of either males or females (Annandale & Hunt, 1990).

While studies using the BSRI are not conclusive, they demonstrate how masculinity has been linked to ill-health. For example, the study by Annandale and Hunt (1990) reports that sociological debates on gender have associated masculinity with better health in men and femininity with poorer health in women. The authors studied a total sample size of 985 men and women in Glasgow and their findings suggest that masculine traits in both men and women are beneficial to health for either sex (Annandale & Hunt, 1990). However, an American study by Kaplan and Marks (1995), that studied 84 males and 117 females, suggests that men possessing more feminine than masculine traits experience better health.

"Typical" male behaviours associated with masculinity have also been examined in relation to men's health. For example, masculinity has often been associated with risk-taking behaviour putting men at greater risk of injury and accidental death (Veevers & Gee, 1986; Waldron, 1995). In addition,

behaviours associated with masculinity (such as not expressing emotion and being self-confident) have also been associated with increased risk for men to develop coronary heart disease (Helgeson, 1995). Finally, sport and masculinity have been examined for their effect on men's health. As White, Young, and McTeer (1995) report, the acceptance of risk and tolerance of pain are connected to masculinity in sport. Similarly, the physical power and fitness required of sports, especially in a professional capacity, are connected to the masculine body (White et al., 1995; see also Tiihonen, 1994).

Finally, a small number of studies have begun addressing men's experiences with severe health problems. For example, Gordon (1995) looked at testicular cancer and focussed on the coping strategies men employed when their reproductive organs and sexual functioning were threatened. Gordon conducted 20 face-to-face interviews with men who had testicular cancer at some point in their lives. Of the various strategies used almost all of the men interviewed coped by focussing on their ability to carry out their major roles once they physically recovered from the cancer (Gordon, 1995). Gordon explains that the roles men adopted varied from traditional (defining testicular cancer as a "fight"; defining themselves as unemotional, stoic, and protective of their women; and relying on their partners to treat them as desirable sexual beings) to untraditional (becoming more expressive emotionally; becoming more relationship-oriented; and becoming more concerned about the well-being of others).

Other research by Charmaz (1995) explored the identity dilemmas of chronically ill men. Charmaz found that on one hand men felt encouraged by traditional assumptions of masculinity to try and recover and resume the regular activities associated with a valued life. On the other hand, traditional assumptions of masculinity limited the credible responses men could make to their disease. Therefore, according to Charmaz, the experience men have with chronic illness depends on the traditional assumptions of masculinity with which the individual identifies.

Studies have also begun to examine men's experiences with specific aspects of their ill-health. For example, a study by Olesen, Schatzman, Droes, Hatton, and Chico (1990) explored the experiences 107 individuals from San Francisco had with everyday mundane ailments such as headaches, colds, sore throats, constipation, back ache, and the like. Olesen at al. (1990) focussed on how individuals defined the self and found that when experiencing mundane ailments the definition of self was in constant reformation around the physical aspects of being. Unfortunately, the study findings by Olesen et al. are not distinguished by sex even though the study indicates that both males and females were studied. Regardless, the study does provide some general information on the everyday mundane ailments that may be problematic for men.

Other studies, however, were more gender-specific. For example, a study by Saltonstall (1993) examined the everyday health experiences of men and women. By using gender as a distinguishing factor Saltonstall interviewed nine

white, middle-class men and twelve white, middle-class women, ages 35 to 55 and found that both men and women associated health with "well-being" and with what one did with one's body. However, men's perceptions of health also included elements of individual responsibility such as being in control of their bodies; getting enough exercise, sleep, and proper food intake; and balancing time between work and health activities (Saltonstall, 1993).

While the health problems identified in the latter studies seem to be quite varied, a common theme does exist among them as much of the research currently available on men's health tends to revolve around traditional male roles and social expectations of the male gender. Stated differently, research has focussed on the effects of ill-health on men's capacity to carry out socially defined activities.[3] For example, the work of Leeflang et al. (1992) and Thorslund et al. (1992) focus on work which is commonly associated with the male role of "breadwinner". Studies by Annandale and Hunt (1990), Kaplan and Marks (1995), Veevers and Gee (1986), and Waldron (1995) reflect research done on common masculine attributes (such as risk-taking behaviour and not expressing emotion) which may affect men's health. Finally, the research of Gordon (1995) and Charmaz (1995) demonstrate how men work with traditional and untraditional masculine roles in coping with or overcoming illness. Therefore, based on the literature review, it is evident that although research on men's health addressed a number of health issues, in these respects, the

studies tend to reflect socially established expectations of the male role and men's capacity to meet these expectations.

Gender identity is the socialized part of the self and for men identity is based on how the male understands, relates to, and internalizes masculine behaviour (Harris, 1995). Literature on masculinity has had both a structural and a cultural emphasis. Structurally, society is stratified according to those who are masculine and those who are feminine. In a society considered to be patriarchal, such as Canada, masculinity affords the individual certain privileges over femininity (see Pleck, 1995). Culturally, society sets standards for appropriate male behaviour (Harris, 1995). For example, Table 4 on the following page illustrates some of the traits that comprise masculine ideology including: stoicism, ignoring pain in the body; sportsmanship, learning to compete and win; having a good work ethic, working for a living; being a breadwinner, providing for and protecting their families; and being a tough guy, not showing emotion (Harris, 1995).

As mentioned previously, studies have explored the relationship between men's health and masculinity where masculinity is not only a variable to be studied, but is also an explanation for the health problems men experience. For example, in the work of Annandale and Hunt (1990), Kaplan and Marks (1995), Veevers and Gee (1986), Waldron (1995), and Helgeson (1995), masculinity is associated with specific traits (such as those mentioned above) that are commonly associated with the poor health that men experience. Furthermore,

Table 4: Ideological Masculine Traits

Attribute	Explanation
Adventurer	Men take risks and have adventures. They are brave and courageous.
Be the Best You Can	Do your best. Do not accept being second.
Breadwinner	Men provide for and protect family members. Fathering means bringing home the bacon, not necessarily nurturing.
Control	Men are in control of their relationships, emotions, and job.
Hurdles	To be a man is to pass a series of tests. Accomplishment is central to the male style.
Money	A man is judged by how much money he makes and the status of his job.
Playboy	Men should be sexually aggressive, attractive, and muscular.
President	Men pursue power and status. They strive for success.
Self-Reliant	Asking for help is a sign of weakness. Go it alone. Be self-sufficient and do not depend on others.
Sportsman	Men enjoy playing sports, where they learn the thrill of victory and how to compete.
Stoic	Ignore pain in your body. Achieve even though it hurts. Do not admit weakness.
Superman	Men are supposed to be perfect. They do not admit mistakes.
Tough Guy	Men do not touch, show emotions, or cry. They do not let others push them around.
Warrior	Men take death defying risks to prove themselves and identify with war heroes.
Work Ethic	Men are supposed to work for a living and not take handouts.

Adapted from: Harris, 1995, pp. 12-13

Harrison, Chin, and Ficarrotto (1995) claim that the current difference in life expectancy between men and women (women living longer than men) may be attributed to the socialization of men into the masculine role. Therefore, masculinity is often linked to the ill-health that men experience.

Gaps in Our Understanding of Men's Health

Each of these types of explanations has been used implicitly in studies of men's health and the focus of research has often been on the general health status of men or else the problems that have been the main sources of mortality and morbidity. However, apart from information on men's perceived health status (as very good, good, fair, or poor, for example) we know very little about how men view their own health. Few studies have explored what men consider to be their main health problems and we know relatively little about how they perceive and explain these problems.

Studies of women's health have suggested that there is a difference between the ways women's health has been defined and the problems women talk about when asked about their health. For example, health research and policy on women have tended to focus on women's reproductive systems. However, when asked about their health problems women commonly talked about stress, anxiety, and tiredness (Walters, 1992, 1993, 1994). I am not aware of similar research that has addressed men's health concerns in the context of their daily lives. In an attempt to define men's health problems most

studies have used the conceptual categories of experts and/or existing academic models. As a result, we know very little about what health problems men identify as being of concern to them.

Given this apparent gap in the literature, this study focuses on men's own views of their health. It is a qualitative study that aims to document what men consider to be their main health problems, as well as what they believe to be the health problems of Canadian men in general. Do men speak mainly of the main causes of mortality and morbidity or do other problems dominate their accounts? In addition to documenting the problems of greatest concern to men, I explored the ways in which men understand health and the particular health problems they experienced. In doing so, I was curious to find out to what extent their explanations reflected the models discussed earlier in this chapter. Do men speak in terms which are related to a biomedical view of health? Do they emphasize the lifestyles approach and recognize an individual responsibility for health? Or do they describe ways in which their health is influenced by broader social forces? To what extent do they talk about ways in which men's roles and expectations associated with masculinity affect the health problems they experience?

The following chapter outlines the methods I used to gather data and this serves as a basis for subsequent chapters which discuss the findings of the research.

CHAPTER TWO

RESEARCH METHODOLOGY

In this chapter I start with a brief review of the way in which qualitative research is an asset to social science inquiry in general and the current study in particular. This is followed by a discussion of the use of the lay perspective in understanding health and ill-health. I then explain the methodology used to collect and analyse data and conclude with reflections on the research process.

Qualitative Research

Qualitative studies can be used in various ways to enrich research findings as qualitative methodology employs strategies that are fundamental to social science inquiry. According to Patton (1990), several interconnected themes are emphasized in qualitative inquiry. These themes include: studying real world situations as they unfold naturally; using inductive analysis; focussing on whole phenomena rather than parts; gathering detailed descriptions; conducting research with personal contact and insight; assuming changes in the research process relevant to the setting; assuming each case is unique; placing findings in proper spatial context; and maintaining empathic neutrality (Patton,

1990). Patton argues that these themes emerge in qualitative inquiry regardless of the specific method chosen.

Qualitative methodology can also be used as a complement to quantitative methodology. First, qualitative methods generate large quantities of data that allow researchers to document and interpret the various ways in which people understand their experiences with health and disease (Baum, 1995). Secondly, as Armstrong and Armstrong note, qualitative research "can test the reliability of quantitative data, can collect information not accessible to survey techniques and can indicate areas that should be included in quantitative analysis" (1983, p. 26). Further, Armstrong and Armstrong note that qualitative information can explain statistics and explore relationships between experiences. Finally, qualitative methodology is useful in exploratory studies where little is known about a particular topic (Babbie, 1995).

Given the little that is known about men's own experiences with health and ill-health, a qualitative approach is best suited to exploring the area further. Data collection and analysis using qualitative methodology are also shaped by sociological theories or perspectives and so in the following section I outline the lay perspective as it relates to this study of men's health.

The Lay Perspective

According to Conrad (1987), the understanding of illness can be approached from two perspectives. The first perspective is that of the *outsider.*

An outsider orientation tends to view illness from outside the experience itself and sees the patient, disease, or illness as something to be affected (Conrad, 1987). For example, outsider approaches to understanding illness sociologically include the sick role and the study of illness behaviour (Conrad, 1987). The second perspective is that of the *insider*. An insider's orientation focuses more directly on the subjective experience of illness. One way of subjectively understanding the subjective experiences of men regarding their health and illness is by investigating lay perspectives.

The lay perspective allows the perceptions of individuals to be realized outside the context of sociological theory. Similar to the concept of *verstehen* (understanding) that is important to theory such as symbolic interactionism, the lay perspective also places emphasis on understanding. According to Calnan (1987), the lay perspective attempts to "understand lay people's actions in terms of the meaning that they place on those actions" (p. 8). Furthermore,

> ...the lay person is typified in this approach as one who is active and critical, who has his or her own complex system of ideas about health and its maintenance and illness and its management, who manages their [sic] own health requirements, and who is discriminating in their use of professional medical advice and expertise. (p. 8)

Thus, investigating and documenting the lay perspective allows information to be gathered outside of broad frameworks of complex theoretical paradigms. This allows the subjects of the research to speak for themselves through the data.

Exploring men's health from the lay perspective is critical in understanding men's perceptions of their health and ill-health in the context of day-to-day living.

Lay perspectives are shaped in a number of ways. As Nettleton (1995) notes, lay perspectives are influenced by people's experiences with their structural location, cultural context, personal biography, and social identity. Lay knowledge is generated by a variety of factors that shape perceptions of health and ill-health. The mistake of oversimplifying the lay perspective should not be made. As Blaxter (1983) points out, "patients, too, have models of disease, which are a part (though not the whole) of their concept of illness" (p. 60).

This focus on lay perspectives will allow men's understandings to emerge without the predetermined assumptions of sociological theory. That is to say, in this study I seek to develop a more comprehensive understanding of the health of men by focussing on men's own definitions and concerns, rather than those of experts, policy makers, and academics. The following section will examine the data collection strategies I used.

Research Methodology

Individual, standardized open-ended interviews were used to collect data. According to Strauss and Corbin (1990), individual interviews allow for effective collection of a full range of opinions from individuals (Strauss & Corbin, 1990). Also, interviews allow for the immediate clarification of questions resulting in a more thorough answer by the participant (Babbie, 1995). The benefit of using a

standardized open-ended format for the interview is that questions are carefully worded and arranged with the intention of maintaining a methodical approach to asking questions (Patton, 1990). Patton also states that, given the standardized format of the interview, little variation occurs among questions resulting in more systematic collection of information from participants.

Each interview employed the same schedule of ten questions which can be found in Appendix A. Prompts were also included on the interview schedule to probe for further information when necessary. The first two questions approached men's health generally with the intention of introducing the respondent to the subject matter:

1. What do you think are the three most important health problems facing men in Canada?

2. What do you think it means to be healthy?

The next two questions more specifically addressed the health of the individual:

3. Do you consider yourself to be healthy?

4. What are the main health problems that concern you?

The fifth question took two forms and the participant was asked the question in only one form. The intention of using two versions of questions was to determine if men said that they experienced similar problems regardless of question format. It also provided an opportunity to see which format encouraged men to provide a fuller response. The first version of the question read as follows:

5a. I'm going to give you a list of men's health concerns that has been compiled from various sources. I'd like you to take a few minutes and do two things with each item on the list. Firstly, I'd like you to check off whether or not you have been at all worried or concerned about the problem during the past year. Some of the problems may not have occurred to you but may have caused you some concern. For example, the possibility of getting prostate cancer may have worried you. The second thing I'd like you to do is check off whether or not you have actually experienced the problem in the past year. I know that you may find some of the items on the list to be fairly personal. Remember that all of your responses are confidential so please try to provide answers to the best of your ability. Do you have any questions?

The participant then completed the list of fifty health issues for men. The list of health issues was compiled earlier from various media sources including journals, magazines, and newspapers (Greenwood, 1996). The second version of the fifth question read:

5b. Can you tell me about the health problems you have had in the last twelve months?

If question 5a was asked, follow up questions included:

6. Of those health problems that you indicated from the list, what are the two that bother you the most?

7. Thinking back to the list of health issues, what do you think affects your level of health?

These questions provided participants with the opportunity to elaborate and explain their responses to the previous list of health issues in question five.

If time permitted participants were asked two further questions:

8. What do you think are the main social problems facing men in Canada?

9. Do you think that men and women differ in how they cope with not feeling well?

These two questions addressed the social component of men's health and reverted the discussion back to a more general level. Finally, I gave all the respondents a chance to reflect back on the interview:

10. Have I missed anything? Is there anything else about men's health that you think we should discuss?

In this way the men had an opportunity to introduce ideas not covered in the interview, and the question also allowed for a definite conclusion to the interview.

Sample Selection and Recruitment

The total sample includes twenty participants. As can be seen in Table 5 on the following page the men ranged in age from twenty-four years to seventy-four years. Six respondents were single (never married), twelve were married, and two were divorced. All married and divorced men had children while none of the single men had any children. Educational background, employment status, and income were varied. The highest level of education completed ranged from high school to attainment of a doctoral degree. Respondents' employment status varied from unemployed to corporate executive and their yearly household income ranged from less than $10,000 to over $150,000.

Table 5: The Sample

Demographic	Number
Age:	
20 - 29 years	4
30 - 39 years	2
40 - 49 years	4
50 - 59 years	6
60 - 69 years	3
70 - 79 years	1
Marital Status:	
Married	12
Single	6
Divorced	2
Children:	
no children	6
one child	2
two children	11
nine children	1
Highest Level of Education Completed:	
doctorate	2
master's degree	4
university professional-program degree	1
university undergraduate degree	6
university diploma	1
college diploma	1
trades certificate	2
high school diploma	3
Employment Status:	
employed	17
unemployed	1
retired	2
Household Income:	
less than $10, 000	1
between $10, 000 and $19, 999	1
between $30, 000 and $39, 999	1
between $40, 000 and $49, 999	1
between $50, 000 and $59, 999	2
between $60, 000 and $99, 999	3
between $100, 000 and $150, 000	3
over $150, 000	5
no response	1

A technique similar to the snowball sampling method was used in recruiting respondents. According to Babbie (1995), snowball sampling begins with a few relevant subjects who provide referrals to other potential respondents. However, in lieu of subjects providing referrals, I gave information sheets to individuals known to me and they distributed the papers to potential respondents unknown to me. The purpose of the information sheet (this can be found in Appendix B) was to introduce and explain the purpose of the study to men who were potential candidates. A general outline of the interview process along with guarantees of confidentiality were also included on the sheet. Potential respondents were provided with a phone number to call for additional information and/or to express interest in being a study participant. What actually happened was that men who were willing to participate tended to let the individual who distributed the information sheet know of their intention. That person then contacted me with the name and telephone number of the potential respondent, I called him, and an interview time was arranged.

Data Collection and Analysis

Data were collected from twenty men in individual interviews. Nine interviews were conducted in the Lower Mainland of British Columbia and eleven interviews were conducted in Southern Ontario between March 1997 and September 1997. Interviews took place in the homes of the participants except on three occasions, where an agreed-upon meeting place was chosen. All

participants were informed of the option that they could withdraw from the study at any time. A copy of the consent form (see Appendix C) was given to each participant to sign. The anonymity of participating subjects was guaranteed through the use of coding numbers, so that the names of the respondents did not appear on any of the interview sheets. Furthermore, consent forms with the participants' names were kept separate from any papers that recorded information acquired in the interview. Participants were assured that there would be no mention of their names or identifying information in the reporting of findings. On average, each interview lasted approximately one hour and all were tape recorded and transcribed.

Data were analysed using inductive methodology. According to Babbie (1995), induction involves the development of general principles from specific observations. The first step in analysing the data was compiling men's definitions of health and the health problems that were of concern to men. These data were summarized in point form to simplify the recognition of common themes. The second step in data analysis involved the extraction of common themes in order to understand how men "make sense" of their experiences or concerns with health. The emergence of common themes was determined by how often similar understandings and explanations arose. When larger patterns of categories could be identified a core theme was extracted.

Methodological Considerations

The strength of qualitative research in general comes from its ability to produce valid data because of the depth with which concepts can be explored (Babbie, 1995). For example, qualitative research allows for participants to actively describe and define the experiences that are part of their lives (Armstrong & Armstrong, 1983). Similarly, in the current study on men's health qualitative methodology afforded the participants the liberty to articulate answers beyond set categories of responses. Thus, by using qualitative methodology in data collection, it was more likely that the concepts intended for measure were actually being measured.

In addition to capturing a broad range of data, qualitative interview methods allowed for observation, conceptualization of themes, and exposure of research gaps in relation to men's health. As Armstrong and Armstrong (1983) note, qualitative research can result in suggestions for new areas of investigation. Given the exploratory nature of this study, the findings will provide the basis for further inquiry into the area of men's health.

While validity is a strength of this qualitative study, the reliability and generalizability of the findings are limited. For example, literature indicates that the personal nature of the observations and measurements made by the researcher may result in findings that cannot necessarily be replicated by another researcher (Babbie, 1995). Similarly, the personal characteristics of the researcher in the current study may influence the research findings. However,

an attempt was made to mitigate the problem of reliability by formulating specific questions and probes that asked for specific information but did not require interpretation by the researcher. For example, when participants were asked about the health problems that they experienced, men identified specific problems, such as heart disease and cancer, that were not open to additional interpretation on the part of the researcher. Therefore, while different researchers may elicit different responses to the questions asked, the questions themselves remained a reliable part of the research methodology.

With respect to generalizability, it must be noted that the research findings of the current study were not intended to be reflective of all men. Rather, the purpose of the study was to explore men's health and extrapolate the initial themes that will generate research questions and serve as a foundation for future inquiry. Thus, given the study objectives and parameters, generalizability is not an important issue.

Reflection on the Research Process

It is always helpful to reflect on the research process particularly in exploratory research. Several aspects of this research warrant mention. For example, the structure and length of the interview were problems for several respondents. Approximately three-quarters of the participants expressed difficulty in scheduling the one hour or more stated as being necessary for the interview. Participants who expressed difficulty in arranging the interviews cited

work as the biggest barrier. Working long hours during the week meant that they were reluctant to give up leisure time on the weekend/days off for the interview. Therefore, many interviews were conducted after work (when respondents were visibly fatigued) or between day and night shifts (when time was limited as a result of the respondent having to return to work).

Two steps were taken in an attempt to mitigate the problem men had with the length of the interview. First, whenever possible, extraneous prompts were reduced or eliminated. This reduced the number of times the interview was side-tracked into areas that were not entirely relevant to the subject matter. Secondly, questions eight and nine were not asked if there was insufficient time. This strategy resulted in less data on the strictly social aspects of health in general but it did allow for greater concentration on the subject of men's health.

In addition, time constraints allowed me little time for rapport-building at the start of the interview. This may be the reason that some respondents hesitated in answering personal questions making further probing necessary which, in turn, was more time-consuming. However, by the time the interview ended, sufficient rapport had been established and participants continued to volunteer more personal and in-depth comments well after the tape recorder was turned off. In order to capture some of the data, I attempted to recall and tape-record respondents' comments on the drive home following the interview.

Gender may have been an issue in the interview schedule, which was created from a female perspective. Given the assumption that men and women

communicate differently, limited resources were available to guide the development of questions so as to reflect the vernacular that men are most accustomed to hearing. As a result, men in the study did not always identify with some of the terminology used and sought clarification of certain terms. For example, *concern* and *worry* may not be words that men use to describe health, particularly when they do not have life-altering illnesses, as participants often clarified that they really did not "worry" about any health problem. As well, participants did not always express themselves using many words and articulated their responses without a lot of elaboration. The difference in the use of language between males and females may certainly be a result of socialization as, even participants noted in the interviews, men are encouraged to be "strong and silent" and to keep their experiences to themselves.

Gender was also a factor in the research process particularly when the health issue being discussed was of a more personal and/or embarrassing nature for the men being interviewed. Health issues pertaining to male sex organs were particularly troublesome and were rarely introduced into the discussion by respondents. Consequently, I introduced such topics by means of the check-list of men's health issues. When "more embarrassing" topics arose, men were visibly uncomfortable, provided shorter answers, and used extraneous words such as "umm", "like", and "you know" more than usual. While men did not indicate that they would have been more comfortable speaking to another

male or older female, it is important to recognize that the level of participants' comfort with the interviews is an issue with data collection.

Being a female researcher was also associated with different degrees of acceptance of my role as researcher. At times, I was able to develop rapport fairly effortlessly with younger respondents since they tended to assume a sense of familiarity with me because of our common age group. Some health issues, often associated with younger age cohorts, were easily introduced into the interview because the information was common knowledge for people of "our" age group. However, it was necessary at times to be conscious of the need to probe for further information despite what both the researcher and respondent already knew about the topic. One drawback of the shared age group was that some men mistook probes asking for more information for my having a personal interest in them. In fact, two respondents said that they enjoyed the "conversation" (interview) very much and asked me to go out for dinner at a later date, an offer which I declined.

Older respondents may have had a little more difficulty with my gender and age in accepting my role as researcher. Many of these men felt they were at liberty to comment extensively on the research methodology and I inferred it is because I am a young woman. Of particular concern for some of the older respondents was the use of a qualitative approach and, in an attempt to mitigate their concerns, I discussed the benefits of qualitative methodology. Other men did not fully comprehend the scope of the study or why the study was being

conducted. Some of the older participants, despite being given detailed information, spoke of the study in terms of being a "project" and a few asked what "course" the data were being used for. Whether an older and/or a male researcher would have received similar comments is not known. It would be interesting to note respondents' reactions in similar studies conducted by male and/or older researchers. However, one of the benefits of older respondents reacting as they did was that the process of being interviewed may have been a little less threatening, resulting in a more "comfortable" interview.

Overall, the research process seemed to be greatly influenced by the length of the interview and by sex differences between the participants and the researcher. Certainly any number of unknown factors could have contributed to some of the data collection difficulties. Interview dynamics, however, suggest that researchers and respondents of a different sex and/or age group may obtain different results. While the latter can be said about qualitative research in general, such factors may be especially important to consider when the research topic is related specifically to gender.

The following two chapters will present the research findings reflecting the study objectives. In particular, chapters three and four will examine what men consider to be their main health problems as well as the health problems of Canadian men in general. Furthermore, the ways in which men understand health and the particular problems they experienced will also be presented.

CHAPTER THREE

MEN'S HEALTH-RELATED PROBLEMS

In this chapter, data reflecting the first two research objectives will be presented. First, I discuss the concepts of health as defined by respondents during the research interviews. Understanding the concept of health, as recounted by the respondents, is helpful in establishing a reference point that can be used in discussing research findings related to men's perspectives on ill-health. The second main section focusses on the research findings regarding the respondents' major health problems and concerns about their health.

Men's Concepts of Health

When respondents were asked, "What do you think it means to be healthy?", most responded by describing health in functional terms. For example, men said:

> [Health is] Carrying out your everyday activities without being hindered. (interview 001; p. 5; l. 168)
>
> ...if you decide to do something you can get up and do it. (interview 013; p. 3; l. 86-87)
>
> I just want to feel...capable. I just want to feel like I can do what I wanna do. (interview 016; p. 4; l. 145-146)

Generally, respondents' concepts of health can be grouped in two categories: physical and mental. The following sections will discuss components that contribute to men's concepts of physical and mental health. Each of these aspects of health could influence men's ability to perform their day-to-day activities.

Components of Physical Health

While research participants indicated that physical health included the absence of disease, their concepts of health were not limited to simply being free of biological pathology. Rather, all the men I interviewed spoke of the active process involved in leading a day-to-day lifestyle that will achieve and maintain physical health. With respect to activities having the greatest impact on physical health, men most often mentioned the following: being active/exercising; eating a proper diet; and having a sense of balance between work and leisure or a balanced lifestyle. As each activity is considered an essential component of men's concepts of physical health, I discuss each of these in turn.

Being Active/Exercising

All men interviewed strongly associated physical activity and exercise with well-being and the concept of good physical health. Although the media tend to focus on the biological benefits of exercise on the human body, this was not the

primary emphasis in the interviews. Instead, respondents placed the greatest emphasis on the importance of activity and exercise in their capacity to effectively function. Most participants indicated that introducing regular activity and/or exercise into their lifestyle contributed to their increased physical capability to function. Only two of the twenty men interviewed suggested that exercise actually prevented disease.

Also, respondents associated increased physical capability from exercise with a masculine image. Although respondents said that they did not feel the need to have the physique of a body builder, they did feel that society promoted an ideal for the male body as having some bulk from muscle. For example, men said:

> ...if you had to draw a picture of a guy, you know, not a stick figure or anything like that but, like, a real person... I'd bet you'd draw them [men] slightly larger [than females], I'd bet you'd draw them with more muscle. (interview 001; p. 6; l. 212; 218-219)

> ...they equate it [health] to sort of physical prowess... I think men are more, more competitive by nature and therefore they kind of judge health by competitive benchmarks. You know, swimming, running, you know, lifting weights. (interview 004; p. 5; l. 177-178; 190-191)

> ...I think in our society there's sort of an emphasis in some ways for men to be...occasionally breadwinners but I think more importantly warriors in a way. Like, we still get in fights...we just have physical challenges thrown at us a little bit more often. Women don't...usually get challenges from other women to, you know, step outside the bar and scrap it out. (interview 016; p. 5; l. 172-178)

A masculine image was not only connected to physical size but also to fulfilling what men saw as part of the male social role. Men link the masculine image to activity/exercise and the latter provides the method by which to increase men's ability to carry out their socially expected physical roles.

Respondents also saw activity and exercise as contributing to stress reduction and they felt that this in turn affected their physical and mental health. The amount of physical activity and/or exercise men felt was necessary for stress reduction varied. For example, some men indicated that simply participating in an enjoyable leisure activity (such as gardening, walking, or golf) was enough of a diversion to reduce stress and provide health benefits. Other men felt that heavy exertion during exercise (such as running, cycling, or swimming) was the best method of stress relief. Regardless of the diversion or workout intensity, respondents believed that leading a lifestyle of regular activity and/or exercise allows the mind to release its stress through the body and that in turn leads to better physical health.

Diet

Diet was the second most frequently identified determinant/component of physical health. Contrary to common associations made by women, respondents did not view diet in terms of its effect on their appearance. Rather, diet was viewed from a biological perspective, that is, the effect that "eating

properly" has on the body. For example, having an "improper diet" was viewed as a potential cause of disease. As one participant said:

> ...if you're overweight, problem eating, not eating properly, it's all connected to the heart problem down the line. (interview 011; p. 1; l. 21-22)

"Proper diet" was also seen as having qualities of disease prevention:

> ...a lot of studies seem to indicate that, you know, certain sort of foods tend to extend your longevity. For example, a high fibre diet, low fat diets help keep out the cancer, the cancer cell collection down. (interview 004; p. 3; l. 102-105)

Participants who indicated that diet contributes to physical health explained that the best diet was one of moderation of food intake. Men who had tried fad diets (such as eating only proteins or carbohydrates) stated that those diets were more of a hindrance to health than a benefit:

> ...I think perhaps we run into trouble swinging from one extreme to another. Perhaps not eating any red meats and not eating any breads and all you do is go from one extreme to another. (interview 005; pp. 3-4; l. 121-123)

Instead, moderation was identified as providing a balance of a broad range of the nutrients needed for physical health. Through the consumption of predominantly "healthy foods", men felt they could keep their physical bodies healthy.

Balanced Lifestyle

Men's concepts of physical health also included achieving a balance of activities in their lifestyle. For example, having hobbies was important to these men in order to counteract the stressors they experienced in daily life. One participant said:

> ...it's managing the stress. That's, you know, your recreational activities...you've gotta have a life [outside of work]. If you've got a life then you've got health. (interview 017; p. 3; l. 94-95; 101)

Rest was another important factor associated with balancing lifestyle activities. For example, respondents felt that sufficient rest helps to balance the many activities that consume hectic daily schedules:

> ...it's such a fight to stay conscious everyday. It's very, very taxing on the human body, to be awake as long as we are awake. (interview 002; p. 4; l. 133-135)

Balancing lifestyle activities was associated with moderation in activities which, in turn, was seen as a stress reducing mechanism leading to physical health.

In reviewing the data it is interesting to note that all of the components of physical health that men emphasized were based on individual lifestyle. The participants did not cite broader social conditions or structures as being responsible for physical health. As well, men did not speak directly in terms of biology being a determinant of health. Rather, respondents' concepts of physical health stemmed entirely from the perspective of what men could do to

control their health through their daily lifestyle. In this context, it can be noted that the men interviewed assumed individual responsibility for physical health.

Components Affecting Mental Health

The element of personal responsibility that men associated with their physical health was very clear. In contrast, their descriptions of men's mental health as a function of daily living were more complex. Although respondents indicated that good mental health was often within the control of the individual, the means by which it was acquired were not always clear. Furthermore, respondents also stated that there are aspects of mental health that are not directly within the control of individuals, particularly those that are biologically-based. Thus, respondents' concepts of mental health can be grouped into two broad categories: controllable state of mind and state of mind lacking control.

State of Mind and Control

Men describe elements of mental health as "thinking positively", "being comfortable", and "being able to manage stress". In using such terms, mental health was viewed as a state of mind which generates a feeling of control over men's ability to function and accomplish more physical goals. For example, respondents stated:

> Feeling good? You feel that...you're capable of functioning mentally and physically in a very, uh, strong capacity. You're able to deal with issues, uh, and challenges that are presented or that occur in your daily activities, in your work...yeah. (interview 006; p. 4; l. 133-135)

> ...if you have a good mental health of mind it can handle that stress immediately. Umm, I remember once being told of a story where...if you had to swallow a frog, when would you swallow a frog? In the morning or afternoon or evening? And if you swallow the frog in the afternoon or evening there's a lot more stress in your life because you'll worry about that frog that you eventually have to swallow...So, it's always better to swallow the frog in the morning, get it over with, get it out of your life and I think that is what is good mental health...Swallow the frog and move on. Get the task done and move on and I think that's just good mental health of mind to do that. (interview 005; p. 4; l. 141-145; 147-148; 151-152)

Thus, according to the study findings, mental health was viewed by the participants in terms of what the state of the mind allows the body to accomplish. In successfully accomplishing day-to-day activities men reported feeling, as one participant phrased it, "mentally happy" (interview 015; p.2; l.73).

State of Mind and Lack of Control

Men in the study viewed other aspects of mental health as not being within their direct control. For example, biologically-based problems (such as those resulting from chemical imbalances or genetics) were viewed as distinct

from emotional experiences where men indicated some degree of control. One respondent, in referring to biologically-based mental problems, said:

> ...people have mental disorders. It's different than if they are emotionally just, you know, not feeling well or, had a bad day... (interview 012; p. 3; l. 91-93)

In addition, the subconscious mind was described as being physically capable of creating or suppressing disease:

> ...your mind is a marvellous tool and, uh, if you subconsciously need a defence and illness is one way, uh, you know, when you're in school you can easily develop a stomach ache and fever because you don't want to write the exam...So, as it works you can talk yourself into various forms of illnesses. (interview 013; p. 3; l. 96-98; 100)

While men could more definitively express the control they had over some aspects of their physical health, respondents' concepts of mental health were more divided. Controllable aspects of mental health were those states that men could "talk themselves into" in order to accomplish physical tasks. Aspects of mental health that did not afford men control, however, were those that were removed from the individual's ability to directly alter. In either case, respondents' views of state of mind were individualistic; that is, factors external to the individual were not discussed as potentially creating problems with state of mind.

In summary, data indicate that men in the study sample view health largely from the perspective of control. Physically, in order to effectively function in daily activities, respondents indicated the need for individuals to control

aspects of lifestyle including: being active/exercising; having a good diet; and maintaining a proper balance in daily activities. In terms of the mental aspect of men's health, respondents spoke of having and not having control over states of mind that affected mental health. Within individual control was the ability for men to effectively manage stress, think positively, and generally to be mentally content. Out of the realm of individual control were states of mind related to mental disorders and subconscious thoughts that could directly affect health. In totality, however, respondents recognized an interconnectedness between the physical and mental components of health, each contributing to the other. Having outlined the respondents' concepts of health in general, the following section will discuss men's perceptions of their own health, men's health concerns, and men's experiences with ill-health.

Men's Own Health Problems and Concerns

Men's Perceptions of their Own Health

The majority of the men interviewed thought of themselves as being healthy. More specifically, out of twenty men interviewed, seventeen responded positively to Question 3, "Do you consider yourself to be healthy?" and only three men did not. Those men who considered themselves to be healthy attributed their state of health to their physical well-being achieved through diet and exercise. For example, participants stated:

> ...I try to eat healthy...I eat a lot of fish...I try to minimize use of oils when I cook...Most of all I do a lot of running... I try to keep my fitness level up. (interview 004; p. 6; l. 202; 204; 206; 212-213)

> ...[I] just, uh...try to keep active, try to eat decently. (interview 009; p. 3; l. 121)

> ...well it's the nineties and it's such a big thing. I mean, I think we all, we all try to watch what we eat...I mean, I exercise regularly... (interview 011; p. 6; l. 223-224; 234)

When speaking of their own health, men placed little emphasis on the importance of balancing daily activities. Instead, men associated their own health with feeling good about being involved in activities such as exercise. For example, one participant said:

> It's an outlook for me. I just truly enjoy doing it. Like, some people say I'm so disciplined and I'm not disciplined. They don't understand. I just truly enjoy, I get caught up in it for no particular reason. (interview 017; p. 5; l. 183-185).

However, even though they considered themselves to be healthy, men often qualified their assessment of their health. For example, of the seventeen men who felt they were healthy, six expressed a sense that they could be healthier. Qualifying statements seemed to help men put their personal level of health into a particular "measurable" context. For example, participants stated:

> Mm-hmm. I think I am [healthy]. I probably eat too much starch and fatty foods. (interview 005; p. 6; l. 233)

> Yeah, I think [I'm healthy]. Physically, I think I get enough exercise...[but] I always like to do more, you know. (interview 001; p.5; l. 193; 195; 197)

Use of qualifying statements seems to indicate that the participants saw their own health in varying degrees and not as a definitive state of having or not having health.

Interestingly, elements of mental health, such as the components affording and restricting control, were not mentioned by men as contributing determinants of their own health. Instead, men cited experiencing stress and explained that they still considered themselves to be healthy because they believed that exercise significantly improved the body's ability to reduce stressful feelings. Furthermore, when respondents talked about improving their own health the emphasis was placed on improving the physical component of their own health. Mental health was not mentioned as something requiring improvement among healthy men. Therefore, the lack of focus on mental components of health in participants' personal identification with health may suggest that men predominantly associate their own health with physical health.

A minority of men interviewed, three out of twenty participants, did not consider themselves to be healthy and they associated their health status with their unhealthy lifestyle.[4] They emphasized their poor diet and lack of exercise. However, unlike men who felt they were healthy, the three participants who stated they were not healthy also spoke of their mental health. They talked about social-structural problems such as experiencing too much stress at work and facing social pressures. For example, respondents said:

> Umm, it's [work] very stressful for me sometimes, like now. Very stressful. I know it's going to be stressful for the rest of my life...my whole life is going to be worried about making money... (interview 002; p. 8; l. 296-297; 301-302)

> It's a tough age to be at to be emotionally healthy...Trying to get a job, trying to, you know, find somebody in terms of, you know, long term relationship, trying to do this, trying to do that...it's really tough. (interview 002; p. 8; l. 361; 363-365)

The respondents also identified problems that reflected problems with their individual state of mind:

> [Regarding exercise]...I mean, umm, I don't know quite what I'm waiting for or what inspiration I'm looking for but it just doesn't seem to be there. (interview 007; p. 3; l. 111-112)

> I feel myself lacking in...mentally...An incapacability [sic] to think things, to respond to questions quickly. (interview 003; p. 5; l. 171; 173)

In examining data on those men who consider themselves healthy and those who do not consider themselves entirely healthy, it is evident that men place different emphasis on physical and mental health. Men who considered themselves to be healthy spoke of their physical health. Their good physical health was most often attributed to their lifestyle. On the other hand, men who did not consider themselves to be healthy spoke of mental health issues such as stress, concern for the future, and lack of motivation. Respondents attributed their poor mental health to factors that reflected social-structural causes, such as work.

Men's Own Concerns

During the interviews respondents were given two opportunities to express their views regarding their own health concerns. Initially, they were presented with an open-ended question regarding men's main health problems and concerns, "What are the main health problems that concern you?". Subsequently, during the interview men were asked to complete a checklist of health issues where they could indicate specific health concerns (for a list of health problems please see Appendix A, Question 5a).[5]

The open-ended question (please see Question 4 in Appendix A) revealed that the respondents' primary health concerns were cancer and heart disease:

> I guess cancer concerns me...Because it seems to have no... umm...no conditions to how you can get cancer. Like, it can attack anybody, anytime, anywhere. (interview 005; p. 10; l. 417; 419-420)

> Yeah, uh, for me it's heart...it does worry me because there could be the genetic component of health that is...past practices that we have. (interview 007; p. 4; l. 146; 157-158)

However, men also expressed the view that while certain diseases like cancer and heart disease caused them to be concerned, their more immediate worry was not having a healthy and well-balanced lifestyle. For example, one respondent said:

> I'm aware, like, by eating properly and exercising properly, not overdoing it, not overeating or not over-exercising, by not doing that but just eating what's right...I'd be a healthier person. (interview 003; p. 7; l. 277-278; 280)

Most participants associated their unhealthy lifestyle with the probability of developing more serious diseases, such as cancer or heart disease.

Despite expressing awareness about developing cancer or heart disease, half of the men interviewed qualified their answer by saying that they really did not worry about health problems in general. These respondents indicated that worrying about any problem was "a waste of time" and that they would simply "deal with" problems as they came. For example, participants said:

> Well, I guess, uh, you know, cancer [is a concern] but... you know...other than eating properly you can't really do much about it. You know? (interview 004; p. 8; l. 310-311)

> And maybe if I do have cancer or, or going to have it in the later years maybe that's a nice way to have it and I'm not going to worry myself sick thinking about it...There are a lot of other things I'd rather worry about...I'll take it as it comes and I won't concern myself with it now. (interview 005; p. 11; l. 448-449;451;453)

In these respects the men interviewed claim that they do not spend much time worrying about something over which they have limited control such as their future health problems.

When twelve participants were presented with a check-list that identified specific health issues (Appendix A, Question 5a) they reported a greater range of health problems that concerned them. These are presented in Table 6. The health concerns that were mentioned most frequently were testicular and prostate cancer. Next in frequency were: cancer in general; accidents at home, work, or sport; not doing enough exercise; and problems with working and being

a parent. These were followed by stress; being overweight; problems with children; and problems in relationships with other family members (excluding partner or significant other).

Table 6: Health-related Problems: Men's Concerns

	Worried %		Worried %
LIFE-THREATENING PROBLEMS		**FAMILY/RELATIONSHIP PROBLEMS**	
Prostate cancer	66.7	With children	50.0
Testicular cancer	66.7	With other family members	50.0
Other cancer	58.3	With wife/partner	33.3
Stroke	41.7	With friends	16.7
Heart disease	33.3	Lack of interest/enjoyment of sex	16.7
Lung disease	33.3	Loneliness	16.7
Suicide attempts	0.0	Widowhood	0.0
CHRONIC HEALTH PROBLEMS		**WORK PROBLEMS**	
Arthritis	33.3	With working and being a parent	58.3
Allergies	25.0	Health/safety hazards at work	41.7
Diabetes	25.0	Health/safety hazards at home	33.3
High cholesterol	16.7		
Hypertension	16.7	**LIVING PROBLEMS**	
Migraine/chronic headaches	8.3	Accidents in general (not road)	58.3
		Money problems	41.7
REPRODUCTIVE/ RELATED PROBLEMS		Housing	25.0
Impotency	33.3	Race/ethnic/relig. discrimination	25.0
Sexually transmitted diseases	25.0	Road accidents	25.0
Sterility	25.0	Transportation	16.7
HIV/AIDS	16.7		
Urinary tract infection	8.3	**PERSONAL ATTRIBUTES**	
		Uneasiness with aging	33.3
MENTAL HEALTH ISSUES		Baldness	16.7
Stress	50.0		
Anxiety	41.7	**LIFESTYLE HEALTH RISKS**	
Tiredness	33.3	Not doing enough exercise	58.3
Not feeling confident	25.0	Being overweight	50.0
Depression	16.7	Drinking too much alcohol	33.3
Disturbed sleep	16.7	Being underweight	16.7
		Smoking	16.7
VIOLENCE		Non-prescription drug use	8.3
Effects of sexual assault	0.0		
		MEDICAL CARE	
		Dissatisfaction with medical care	16.7

These findings show that men's worries about their health tend to relate to potentially disabling or life threatening diseases such as cancer and heart disease. However, men also indicated health-related concerns that did not correspond to disease. For example, respondents mentioned several low-level mental health concerns, particularly stress (and to a lesser extent anxiety, tiredness and not feeling confident), that affect them on a day-to-day basis. Yet, current literature does not reflect mental health issues as part of men's health concerns.

Furthermore, the findings also indicate that there are other health-related issues with which men are concerned but which are not directly linked to disease. Men identified concerns with: family (problems in relationships with children and other family members); work (problems with working and being a parent); lifestyle (not doing enough exercise and being overweight); and general living (accidents in the home and in sport-related activities). As a point of comparison, more respondents cited concern with family relationships than they did with reproductive/related problems. This suggests that men have concerns with the problems that affect them on a day-to-day basis. However, current literature has neglected to discuss the day-to-day problems, such as those indicated here, that play a role in men's lives.

The problems that were a source of worry to respondents were often not the problems they had experienced. It is the latter to which I now turn.

The Health Problems Men had Experienced

Although the primary health worries respondents identified were prostate and testicular cancer, the problems these men experienced included a large number of problems associated with mental health. That is to say, respondents' primary health *concerns* were linked more to life-threatening diseases such as prostate cancer and testicular cancer, and included concern over lifestyle risks that could lead to life-threatening disorders. However, as Table 7 illustrates, men's actual *experiences* with ill-health were linked more to mental health issues in the form of stress, tiredness, and anxiety as well as problems with lifestyle and family.

All of the respondents were presented with the check-list of health issues to guide discussion of their health experiences (Appendix A, Question 5a). Stress was most frequently reported as a health problem experienced in the twelve months prior to the interview. Out of twenty respondents, thirteen reported experiencing stress. Tiredness ranked second, while anxiety, not doing enough exercise, and problems in the relationship with their partner or significant other ranked third.

These findings suggest that men's experiences with ill-health on a day-to-day basis do not necessarily reflect the life-threatening illnesses that literature has often examined. For example, heart disease and prostate cancer are commonly associated with men's health. However, these health issues were not actually identified by respondents as problems they experienced. Lung disease

Table 7: Health-related Problems: Men's Experiences

	Experienced %		Experienced %
LIFE-THREATENING PROBLEMS		**FAMILY/RELATIONSHIP PROBLEMS**	
Prostate cancer	0.0	With children	20.0
Testicular cancer	0.0	With other family members	20.0
Other cancer	0.0	With wife/partner	30.0
Stroke	0.0	With friends	5.0
Heart disease	0.0	Lack of interest/enjoyment of sex	15.0
Lung disease	10.0	Loneliness	15.0
Suicide attempts	0.0	Widowhood	0.0
CHRONIC HEALTH PROBLEMS		**WORK PROBLEMS**	
Arthritis	20.0	With working and being a parent	25.0
Allergies	20.0	Health/safety hazards at work	15.0
Diabetes	10.0	Health/safety hazards at home	10.0
High cholesterol	10.0		
Hypertension	5.0	**LIVING PROBLEMS**	
Migraine/chronic headaches	15.0	Accidents in general (not road)	25.0
		Money problems	15.0
REPRODUCTIVE/ RELATED PROBLEMS		Housing	15.0
Impotency	0.0	Race/ethnic/relig. discrimination	15.0
Sexually transmitted diseases	0.0	Road accidents	25.0
Sterility	0.0	Transportation	10.0
HIV/AIDS	0.0		
Urinary tract infection	0.0	**PERSONAL ATTRIBUTES**	
		Uneasiness with aging	15.0
MENTAL HEALTH ISSUES		Baldness	10.0
Stress	65.0		
Anxiety	30.0	**LIFESTYLE HEALTH RISKS**	
Tiredness	45.0	Not doing enough exercise	30.0
Not feeling confident	25.0	Being overweight	25.0
Depression	10.0	Drinking too much alcohol	15.0
Disturbed sleep	25.0	Being underweight	15.0
		Smoking	20.0
VIOLENCE		Non-prescription drug use	20.0
Effects of sexual assault	0.0		
		MEDICAL CARE	
		Dissatisfaction with medical care	15.0

was the only life-threatening problem respondents reported experiencing in the twelve months prior to the interview. Furthermore, respondents did not indicate experiencing health problems associated with their reproductive (genitourinary) systems. Rather, respondents' experiences primarily reflect mental health

issues particularly in relation to stress and tiredness. These findings suggest that factors external to the individual, social factors, may play a significant role in men's experiences. Men also identified experiencing problems with family, mainly in their relationships with their wives/partners, but also with children and other family members. It is interesting that respondents noted such problems given that sociological health literature seldom examines the male role in families outside of men being the "breadwinner". Therefore, as the respondents' experiences indicate, men's health may be related more to factors that affect them on a day-to-day basis than current studies suggest.

Respondents were also asked to identify the two health problems that bothered them the most. Specifically, of the health problems men reported experiencing, respondents were asked to pick the two that were most bothersome for them. While the question was intended to extract the bothersome *experiences* respondents had with their own health, many of the men included their concern over developing a disease as an *experience*. Given this interpretation of the question, problems related to stress and fear of terminal illness such as cancer were most frequently mentioned. When asked why they mentioned these, many respondents spoke of some or all personal control being lost with each health problem. For example, about stress participants said:

> ...I think that's [stress] more common in my life...Like, I know I have diabetes but that's more in control. I try to control stress but I have to work harder at that. (interview 012; p. 7; l. 284; 286-287)

> [With stress] You find yourself, if you're not careful, really not caring and allowing yourself to fall into things like, there is the ability to drink too much, there is the ability to not worry about what you eat, and say "who cares, nobody else cares about me"...stress can be a very significant leverage point with regards to just how you fell and you act...(interview 007; p. 6; l. 239-241; 243-244)

Concerns over feeling a loss of control was even more evident as respondents talked about the onset of potentially terminal illnesses. Some said:

> Well, I think everyone fears getting cancer. It's more in the limelight, you know. Like, eventually you have to go but, uh, how you gonna go no one knows...And then it happens and you don't know it. (interview 006; p. 6; l. 243-245)

> A lot of diseases manifest themselves visually and you can deal with it but cancer is kind of in the city of, you know, it's got you before you know about it. (interview 013; p. 10; l. 386-387)

> ...heart disease because it kills...sort of everything has the potential to contribute to what seems to be the sort of master cylinder that exists. (interview 007; p. 6; l. 214; 222-223)

Therefore, the health problems that bothered men in the study were not only ones they experienced in their daily lives but also those that they feared might impact on their lives in the future. The concern over the impact of cancer on men's health stemmed from their perceived inability to control the onset of this potentially fatal disease. However, with the exception of terminal illness, men did feel that they had some control over their health and ill-health through their lifestyle. When asked what factors they thought men can control most that affected their level of health respondents cited diet, exercise, alcohol consumption and stress management as primary factors in preventing ill-health.

Summary

In summary, data analysis indicates that men's concepts of health include both physical and mental health. Men associate physical health with activity/exercise, a proper diet, and a balance of work and leisure activities. Mental health was linked to aspects over which men had control, such as having a positive state of mind, and those over which men lacked control, such as biologically-based mental illness.

Even though respondents spoke of physical and mental health, most of these men described their own good health in physical terms. However, participants who did not consider themselves to be healthy included mental factors in their explanation of what contributed to their own state of poor health.

The health concerns of the men interviewed predominantly reflected physical problems that were potentially disabling or life-threatening: prostate cancer and testicular cancer, in particular. On the other hand, when they spoke of the health problems they had actually experienced, respondents spoke of problems associated with mental health. For example, stress and tiredness ranked quite highly as problems that men experienced in the year prior to the interview.

Chapter Three revealed how men's concerns and experiences with ill-health are based not only in health problems, such as identifiable disease, but also in broader health-related issues such as state of mind, lifestyle behaviours, and family relationships. Such findings indicate that factors external to the

individual, particularly society as a whole, are reflected in men's identification of health concerns and experiences. Given these findings, in the following chapter I turn to explanations respondents provided for their health problems.

CHAPTER FOUR

MEN'S EXPLANATIONS OF HEALTH-RELATED PROBLEMS

In looking at the problems which men report we have already seen that they face problems with mental health, particularly stress and tiredness. Respondents also reported problems in family relationships (particularly with their wives or partners) and in adopting healthy lifestyles. We have also seen how they emphasized lifestyles and aspects of men's roles when talking about physical and mental health. In this chapter I discuss these issues in greater detail and show the ways in which men explained their own health status as well as the health status of Canadian men in general.

Men's Explanations of Ill-health

Men's explanations of their ill-health and experiences with ill-health reflected the lifestyle and social structural models. Their comments also reflected issues of choice and control. For example, when participants talked about their experiences with ill-health, they referred to their physical ill-health often citing lifestyle activities, such as improper diet, lack of exercise, and insufficient rest, as contributing factors to their ill-health. Participants said:

> [My ill-health results from] doing too much of some and not enough of the other [laughs]...But in the last three years, umm, I've gone, you know, up two inches in waist size from a thirty-six to a thirty-eight and on occasion the thirty-eight inch waist feels uncomfortable. But I'm still not doing anything about it other than thinking that I'll watch what I eat and diet a little bit. The exercise thing just doesn't seem to come. (interview 007; p. 8; l. 300; 322-325)

> I don't get a lot of sleep. Like, I'll get up at like nine, say, and I probably won't go to sleep until like twelve or one... usually. See, that's a long time during the day. That's a long time for somebody to be up, and conscious, and thinking...You're up and that's a huge factor in...our health... (interview 002; p. 4; l. 138-142)

Although participants attributed their physical ill-health to "improper" lifestyle activities they also acknowledged that they had the choice and the ability to control the outcome of their lifestyle activities. In this we see the elements of individual responsibility which are characteristic of the lifestyle model of health. One respondent said:

> ...like if I'm too heavy then it's hard on my [arthritic] knees...I went up to two-twenty-five for a while, yeah. Then I dropped like fifteen, twenty pounds so it made a big difference. (interview 009; p. 9; l. 350-351; 357-358)

It is interesting to note that when the respondents' physical ill-health could not be explained through lifestyle activities, men spoke of a lack of control over the biological processes occurring in their bodies. For example, one man explained:

> You know, we can exercise, we can make our heart strong, we can eat properly, we can watch our weight, uh, and all that but when it comes to cancer there just doesn't seem to be any one way to say, "this is what you do to not have it". ...I think guys like to be in control over a little bit of what's gonna happen... (interview 011; p. 3; l. 109-111; 114-115)

Respondents appeared to have a sense of what they could and could not control.

In addition to explaining their physical ill-health through lifestyle, participants often spoke of the stress, tiredness, and anxiety they experienced as created mainly by social structural influences. Once again, the issue of control emerged in the interviews. For example, many participants identified stress as the cause of their ill-health and they did not feel that they always had control over stress.

Two social structural factors were emphasized by respondents as contributing to their experiences with stress: work and men's gender roles. The nature of the stress of work was commensurate with the positions men held at their place of employment. For example, police officers and a high school teacher who were interviewed claimed violence in the workplace was a contributor to their stress. Respondents who worked for non-profit organizations experienced stress in worrying about potential bodily harm and men who worked in business settings indicated that their stress was related to job performance and productivity. Men did not feel that they could necessarily control their levels

of stress because of the role expectations at their place of employment. For example, respondents said:

> With work...any disease that might be transmitted through bodily fluids...I really have to keep an eye open...there's really nothing that you can do. I mean, you still have to do your job. [I don't worry] Because if I did I'd drive myself crazy...And there's enough stress at work as it is. (interview 011; p. 8; l. 314-315; 320-322; 326)

> At work, my job is performance-related so when performance is good then obviously the stress is lower and when it's bad the stress is higher. (interview 012; p. 7; l. 253-254)

> ...I think the cause of that [health problem] was stress. I think that was stress-related. I was in a very high-pressure job...I was striving so hard that, as I say, I think stress is a big factor. It just made me slow down. It just made me slow down. (interview 017; p. 12; l. 494-495; 497-498)

In these ways, men in the study spoke of their limited control over stress-related factors that can cause them ill-health.

Respondents also indicated feeling stress as a result of their expected role in society. While participants did not speak in terms of "masculinity" per se, they did indicate that they perceived their social role as "breadwinner". As such, it was important to them to secure good employment to provide for their present or anticipated future families. For example, respondents said:

> We're brought up to, to kind of think of men as the provider, you know, provide the family and, buy a house, buy a car, just that kind of thing...And you need money to do that and you need a job... (interview 011; p. 18; l. 744-745; 747)

> I'm really strongly motivated to work hard in life so that we [the respondent and his family] are financially comfortable. That being a cause of maybe more stress in my life than it needs to. (interview 005; p. 13; l. 534; 539)

Such comments also show how stress arising from definitions of men's roles as primarily breadwinners are also linked with the stress they experience in their work roles: it is important that they are successful.

In reviewing the research findings on men's explanations of their own ill-health and their experiences with ill-health, a common theme of control emerged. Men in the study tend to measure the quality of their health and ill-health through various control mechanisms. For example, men felt that they had a choice and the ability to control their own lifestyle, which could have direct implications for their physical health. At the same time they acknowledged that social structural influences, such as the workplace and traditional gender role expectations, afforded men little opportunity to control the level of stress that could influence their health. Yet, the problems of greatest concern to men, testicular and prostate cancer, afforded them little control and men implied, implicitly at least, that these were biologically based.

Men's Explanations of the Health of Canadian Men

When asked to comment on the three most important health problems facing men in Canada, the participants most often identified heart disease and cancer. In addition, the lifestyle of Canadian men was seen as a major health concern. Respondents linked lifestyle to various health problems of Canadian men and they felt that lifestyle decisions afforded men control over some of their health problems. However, they also recognized that lifestyle alone did not account for the development of certain diseases, such as cancer, where little is known about the causes of the disease. In order to get a better sense of how respondents explained the health of Canadian men, the following sections discuss these themes of lifestyle and the unknown etiology of disease.

Lifestyle

Almost all of the twenty men interviewed cited at least one aspect of lifestyle as being a health issue for Canadian men. Respondents recognized that lifestyle decisions could allow men to control the development of many health problems including heart disease. However, they felt that Canadian men in general do not always adopt healthy lifestyles. This meant that men often had inadequate exercise, poor dietary habits, were overweight or obese, and addicted to both legal and illegal substances. For example, respondents said:

> I, I think that's [being overweight] just a general function of less time to exercise and...eating the wrong things... Umm, people are getting, it seems, bigger and bigger

> and bigger and itself has a significant amount of negative impact on your health because of the stress on the body. (interview 007; p. 1; l 34-35; 37-38)
>
> I think everybody likes to be physically fit and perhaps not as many people are physically fit as should be or would like to be. [Extra weight is] just far more work on your body's organs...it increases heart disease, things like that. (interview 010; p.1; l. 15-16; 21-22)
>
> I think alcohol is a huge, uh, maybe a silent killer if you will. ..it's a major contributor of poor health and eventual death of men. (interview 004; p. 2; l. 46-47; 49-50)

Poor lifestyles were thus seen as important contributing factors in the development of illness or disease which in turn can result in death or reduced quality of life. Respondents felt that change in lifestyle was an individual responsibility that a man could take to avoid disease and improve the quality of his health.

Unknown Etiology

Whereas several men felt that the risk of heart disease could be diminished by a healthy lifestyle, cancer was less readily affected by lifestyle choices. Other than not smoking, participants felt that there was very little Canadian men could do to prevent the disease. Cancer was difficult to understand as it was not perceived to be amenable to cure or to prevention. For example, respondents said:

> Cancer, umm, it seems almost to me that everything you read and touch is, you're prone to have cancer so, umm, it's difficult to put your finger on what, like, is the sure

> thing that causes cancer. (interview 005; p. 2; l. 58-60)
> ...it's so final...Today we don't really have any cure for it... (interview 008; p. 1; 18; 20)

Prostate and testicular cancer were most frequently mentioned, but most men who listed cancer felt that any cancer was problematic for Canadian men.

It is interesting that respondents' explanations of the health of men in Canada differed somewhat from their explanations for their own ill-health. For example, respondents largely attributed individual responsibility in the form of lifestyle activities to the health problems of Canadian men. However, explanations of their own ill-health, while including lifestyle factors, also more broadly included social structural causes, such as work and social roles. The reason for this difference in explanations is not indicated in the research findings and additional research could further explore this discrepancy.

In review, it can be noted that respondents indicated two main health problems for men in Canada: heart disease and cancer. The causes of these illnesses could be grouped into two categories: lifestyle and unknown etiology. Lack of regular exercise, a poor diet, being overweight, and substance abuse are the main elements of lifestyle that participants felt were problematic for Canadian men. By not controlling individual lifestyle, respondents felt that men were contributing to the development of some diseases, such as heart disease. Cancer prevention and a lack of a cancer cure were other major concerns for

men in Canada. Prostate and testicular cancer were specifically cited as areas of concern, but cancer in general was considered a major health problem.

Summary

In this chapter I have shown how respondents explained ill-health in relation to their own health and the health of Canadian men in general. An underlying theme of control emerged as men discussed their own health and described their experiences with ill-health. Respondents were most concerned about developing diseases over which they had little control. For example, cancer was predominantly identified as a health threat over which men felt they had little control. The element of control was also evident as respondents discussed experiencing stress that was most often linked to work and men's social role of "breadwinner". When explaining the health problems of men in Canada as a whole, respondents indicated that lifestyle and diseases of unknown etiology were factors that contributed to or caused ill-health. Thus, lifestyle was a common theme that men in the study viewed as contributing not only to their own ill-health but also to the ill-health of Canadian men in general as lifestyle afforded men the ability to control the factors contributing to their ill-health.

CHAPTER FIVE

RESEARCH REVIEW AND FUTURE DIRECTIONS

Men's experiences with health on a day-to-day basis have seldom been examined from their own perspectives. By using qualitative methodology, this study has been able to explore the concerns and experiences with ill-health of a sample of men as well as their opinions of the health problems of Canadian men in general. Although structured in some respects, the interviews provided men with the opportunity to discuss their health outside of predetermined categories. It was important to explore men's own explanations of health problems given that men's understandings of health are seldom reflected in current literature.

The focus on men's health has often been on the major sources of mortality and morbidity. For example, statistics have revealed that men most commonly die from heart disease, lung disease, and cerebrovascular disease (Statistics Canada, 1997). Men's main chronic conditions include arthritis, allergies, and hypertension (Statistics Canada, 1994). Yet, when we talk to men, we see that, while they are concerned about issues such as cancer, there are also a number of day-to-day problems which they experience. For example, the low level mental health problems, such as stress, tiredness, and anxiety, that many respondents reported experiencing have often been neglected by

literature. These problems are not usually considered in the typical approach to men's health. In this respect, the findings mirror those in studies of women's health (Walters, 1992, 1993, 1994) which have shown that many women report problems such as tiredness, stress, anxiety, and depression, though these have often been neglected in discussions of women's health.

In recognizing that men experience stress, tiredness, and anxiety further research is indicated in documenting the nature of men's experiences with low level mental health problems and the way in which these problems are linked with the day-to-day features of men's lives. Given that men reported some of the same problems that women report raises the question of whether these can be traced to the nature of gender roles (as Walters has argued) or whether they arise from the shared aspects of men's and women's lives.

In addition, similar to the research conducted by Walters (1992, 1993, 1994) on women and Blaxter (1990) on health and lifestyles, men's understandings of health did not explicitly reflect the biomedical model. The explanations men use to understand the causes of their own ill-health strongly reflect lifestyle and, to a lesser extent, social structure. Biomedicine was only reflected in men's understandings, albeit implicitly, when men discussed health problems that they could not otherwise explain, such as cancer. However, when respondents spoke about problems like cancer, they did not discuss biology per se. Rather, men in the study spoke in terms of having or not having personal control over disease prevention.

As current allopathic medicine is dominated by the biomedical model in its explanations for the causes of disease, the question arises of the extent to which lay views are medicalized. According to Zola (1997), in defining health and illness in terms of medical definitions, individuals are also led to define their own health in similar terms. However, data analysis indicates that men in this study did not define their health problems in medical terms. One can argue that this discrepancy in defining health problems may have been a byproduct of the structure of the interview schedule which did not reflect medical concepts or medical terminology. Thus, by not structuring questions using medical terms, respondents may have had a reduced opportunity to express themselves using medical terms. If medicalization is as firmly implanted in our society and as far-reaching as some researchers claim it to be, it is then reasonable to assume that men's explanations of their health would have been more explicitly reflective of the biomedical model. Nevertheless, it would be interesting to know to what extent medicalization influences men's day-to-day experiences with their health. It is hoped that future studies will be able to address this gap in the research literature.

As previously mentioned, data analysis suggests that men in the study placed a strong emphasis on lifestyles when attempting to explain their health and the health problems they experienced. More specifically, respondents talked about diet and exercise as the major factors affecting their physical health. For example, men linked exercise to the stress-relief that they believed

was needed for good mental health. Although respondents' answers strongly reflected lifestyle as a determinant of health, it is not clear why men associated lifestyle with health and ill-health. On one hand literature suggests that lifestyle seems to be the dominant discourse on health as reflected in the media and government health promotion campaigns. On the other hand, literature on masculinity points to gender roles as socializing men toward being "sportsmen" and "warriors" (see Harris, 1995, pp. 12-13). Thus, according to the literature, there could be many explanations of how men come to adopt their current understandings of health. By examining external factors, such as the influence of social structure on men's health, a better understanding of men's health could be achieved. This greater insight into understanding the effects of broader social structure on men's health could lead to more effective ways of communicating health information to men.

Given the emphasis that men in the study placed on lifestyle in explaining their health problems, it is interesting to note that they did not focus on individual or social constraints to living a healthy lifestyle. For example, respondents did not speak of the inability to afford nutritious food or fitness equipment, nor did they attribute not getting enough exercise to factors outside of themselves. The only constraint that emerged was a remark by a bachelor who noted that he did not eat well because he hated cooking only for himself. One would assume that such findings may be related to some of the respondents in the study sample having a good income and/or stable employment. However, data analysis

indicated that even respondents in the low-income demographic category did not mention factors that precluded them from participating in healthy lifestyle activities.

It is not clear why these men did not focus on lifestyle constraints. If one is to draw from literature, it can be hypothesized that control may be a factor that prevents men from discussing lifestyle constraints. For example, Saltonstall (1993) found that men associated health with being in control of their bodies. As well, traditional masculinity holds that men are in control of themselves and the situation around them (see Harris, 1995, pp. 12-13). Thus, a conclusion may be drawn that if men admitted to constraints over controlling the onset of disease through lifestyle, men might feel that they were not living up to the social expectation of what a "real" man represents. While such thought is only a hypothesis based on current literature, it would be interesting to test this hypothesis and explore how gender roles affect men's admissions of barriers to their health.

As discussed in previous chapters, social structure was also a theme that emerged in the respondents' explanations of their health. In particular, they cited work and traditional gender role expectations as the two main causes of stress that influenced their health. Work was viewed as a source of stress because of the nature of the employment these men had. According to respondents, physical safety and job security were two major categories related to work that they found stressful. In addition, men in the study found traditional

gender role expectations to be stressful given that many respondents saw themselves as the primary breadwinners of the family.

The notion that the men still see themselves as the primary breadwinner is interesting as it suggests that men's lives, especially in relation to their health, are more complex than what current research reflects. In particular, respondents associated the role of breadwinner with the increased stress of being a good provider. This expectation of being a good provider was true of respondents who were married or anticipated being married and planning a family in the future. With respect to respondents who were married, most reported feeling stressed over their role as primary breadwinner even though their wives were gainfully employed. The second income did not seem to deter men from viewing their role as primary provider and experiencing pressures induced by their socially defined roles.

In addition to feeling the stress associated with the role of breadwinner, respondents also said that, while being the family provider was stressful, it would be even more stressful for them if their wife earned more money than they did. Such responses suggest that a dichotomy exists in the current social structure. While the socially accepted roles of the sexes are changing (women are increasingly joining the paid workforce, men are more involved in child-rearing), gender roles as they are perceived by individuals continue to follow traditional forms. It is not clear why the differences in role expectation exist, nor is it well understood what forces help to define individual male roles as breadwinner. For

example, it is not clear if media portrayals of males are perpetuating stereotyped images of the "ideal" man, or is it that personal relationships between men and their families are continuing to place expectations on men to assume the role of primary breadwinner. Although one could argue that such questions are more relevant to the general discussion of masculinity and gender roles, the possibility of masculinity or gender roles influencing men's health cannot be ignored. Given that the role of primary breadwinner may affect men's health through increased stress, masculinity and male gender roles become important elements of men's health that warrant further study.

With the exception of focussing on the role of the breadwinner, data analysis revealed that limited emphasis was placed on gender as it related to men's day-to-day experiences with health and ill-health. The lack of a more explicit emergence of gender related themes in the data was somewhat surprising given the extent to which such topics have been discussed in literature. For example, research on masculinity and men's roles, emphasizes the importance of gender in men's daily activities (see Harris, 1995). With respect to health, literature indicates that men's experiences with acute illness such as testicular cancer have demonstrated how men's roles change to accommodate men's experiences with illness allowing men to retain a feeling of masculinity (see Gordon, 1995). Similarly, research on women's health has also linked gender to women's experiences with ill-health. In Walters' (1993) study, women's mental health was partly affected by the multiple responsibilities

women felt they had including work and taking care of family. Thus, according to literature, it seems that gender plays an important part of the lives of individuals.

Given the importance of gender roles, as seen through the literature review, it may be useful to further explore male gender roles in relation to their day-to-day experiences with health and ill-health. As is well known, traditionally men predominantly worked outside the home in the workforce while women worked in the home. Today, gender roles are not as clearly defined. Although research has documented some of the troubles women experience with respect to changing gender roles, little is known about men's changing roles. For example, the concept of the doubleday has often been recounted in studies on women as women struggle to find a balance between their paid work outside the home and the unpaid work they do within the home. The stress associated with the doubleday has been blamed for its negative impact on women's health.

However, men's roles are also changing as men assume more responsibility in the home for child care and domestic responsibilities (see Harris, 1995). Thus, research needs to address the effects of this role change on men's health. For example, does the change in men's roles mean that men are also beginning to experience the effect of a doubleday and, if so, how does this change affect men's health on a daily basis? It would also be interesting to know how men would describe their experiences with responsibilities that were previously associated with "women's work". Do men report more or different health problems as they experience a shift in their expected gender roles?

Finally, as gender roles change over lengths of time, research needs to look at generational trends and address the gaps that emerge in men's perceptions of the effect of gender roles on their experiences with health and ill-health.

Conclusion

This exploratory study examined men's perceptions of health and ill-health in the context of their daily lives. For men in the study, health had both physical and mental importance, although men tended to describe their own good health more in physical terms. With respect to ill-health, prostate and testicular cancer were men's primary health concerns as these diseases were viewed as potentially disabling or life-threatening. However, men's actual experiences with ill-health were more reflective of low level mental health problems, including stress and tiredness. An underlying theme of control emerged as respondents attempted to explain their concerns and experiences with ill-health. Respondents indicated that lifestyle was a significant contributor to both their own health and the health of Canadian men in general.

Given the importance of lifestyle, the influence of social structure, and the element of control expressed through this study, future research needs to reflect more specific experiences men have with health and their ill-health. For example, the impact of change in men's gender roles needs to be more closely examined in order to better understand men's health from their own perspectives. It would be a mistake to assume that because early research on

disease was conducted primarily from the perspective of males, that men's health has been adequately studied. As this study demonstrated, understanding men's health is a complex phenomenon that calls for continued research in order to better understand men's health and their experiences with ill-health. It is hoped that the concepts identified in this study will serve as useful groundwork in developing further studies that examine men's understandings of their health.

ENDNOTES

[1] The biomedical model is also referred to in literature as the medical model or biomechanical model. Given the idea that only one factor, namely biology, is responsible for the cause of disease according to the biomedical model, Morgan, Calnan, and Manning (1993) refer to it as a monocausal model of disease. Regardless of the name used the idea behind the biomedical model remains the same, that is, biological pathology at a cellular level is the cause of disease.

[2] The medicalization thesis is more complex than can be explored in this paper. A more comprehensive examination of medicalization can be found in Zola (1997).

[3] Women's health research can be used as a point of comparison. Socially, women's roles are most often associated with child bearing, child rearing, and nurturing. This is what women "do" in terms of social role expectations. The associations made between women's social roles and health were reflected in studies on women's health. When Walters (1994) examined women's health literature she found that a large focus was placed on women's reproductive systems. However, when Walters interviewed women, the problems women cited as affecting them on a day-to-day basis were not associated with their reproductive systems. Women cited stress, anxiety, and depression among their mental health problems (Walters, 1993) and stress, being overweight, headaches, and tiredness as their main day-to-day concerns (Walters, 1992, 1994). In this way, literature on men's health also reflects what men are socially expected to "do".

[4] Data did not reveal why some of the men identified themselves as being healthy despite qualifying their answers (with examples of why they were not entirely healthy) and why other men more directly identified themselves as not being healthy. It is not known at what level or severity men's health problems/concerns changed their personal identification with health from a positive one to a negative one. Exploration of such a matter is beyond the scope of this study but in further research may contribute to an understanding of how men "make sense" of their health.

[5] Question 5 in the interview schedule took two forms, of which respondents were asked one. Twelve respondents were asked question 5a and eight were asked question 5b. However, respondents had significant difficulty in answering question 5b and so all men in the study were given the list of health issues from question 5a to use as a discussion guide. Therefore, men's answers to both forms of question 5 were prompted.

APPENDIX A

Interview Number:_____

MEN'S HEALTH INTERVIEW SCHEDULE

This interview deals with your health concerns and your experiences with ill-health. The information you give in this interview is very important for our study on men's health. Your name will not appear on the questionnaire and all of your responses will be strictly confidential. If we come to a question that you prefer not to answer just let me know and we can skip over it.

A. I'd like to begin by asking you questions on the health of Canadian men in general.

1. What do you think are the three most important health problems facing men in Canada? (prompt: why is that/are those most important?)

I. _____

_____

_____

_____

II. _____

_____

_____

_____

III. _____

_____

_____

_____

2. What do you think it means to be healthy?
   (prompt: differences between males and females?)

3. Do you consider yourself to be healthy?
   (prompt: If yes...why do you say that? what do you do to stay healthy?
   If no...why do you say that?)

4. What are the main health problems that concern you?
(prompt: why do they bother you? are these current problems?)

5 (a OR b).a. I'm going to give you a list of men's health concerns that has been compiled from various sources. I'd like you to take a few minutes and do two things with each item on the list. Firstly, I'd like you to check off whether or not you have been at all worried or concerned about the problem during the past year. Some of the problems may not have occurred to you but you may have caused you some concern. For example, the possibility of getting prostate cancer may have worried you. The second thing I'd like you to do is check off whether or not you have actually experienced the problem in the past year. I know that you may find some of the items on the list to be fairly personal. Remember that all of your responses are confidential so please try to provide answers to the best of your ability. Do you have any questions?

Men's Health Issues

		Concern/Worry		Experienced	
		Yes	No	Yes	No
1.	Heart disease	❑	❑	❑	❑
2.	Lung disease (e.g. bronchitis, emphysema)	❑	❑	❑	❑
3.	Arthritis	❑	❑	❑	❑
4.	Allergies	❑	❑	❑	❑
5.	Migraine and/or chronic headaches	❑	❑	❑	❑
6.	Diabetes	❑	❑	❑	❑
7.	Hypertension	❑	❑	❑	❑
8.	High cholesterol levels	❑	❑	❑	❑
9.	Stroke	❑	❑	❑	❑
10.	Testicular cancer	❑	❑	❑	❑
11.	Prostate cancer	❑	❑	❑	❑
12.	Other types of cancer	❑	❑	❑	❑
13.	Anxiety	❑	❑	❑	❑
14.	Stress	❑	❑	❑	❑
15.	Depression	❑	❑	❑	❑
16.	Tiredness	❑	❑	❑	❑
17.	Disturbed sleep	❑	❑	❑	❑
18.	Road accidents	❑	❑	❑	❑
19.	Other types of accidents (home, work, sport)	❑	❑	❑	❑
20.	Loneliness	❑	❑	❑	❑
21.	Suicide or attempts at suicide	❑	❑	❑	❑
22.	Not feeling confident	❑	❑	❑	❑
23.	Smoking	❑	❑	❑	❑
24.	Drinking too much alcohol	❑	❑	❑	❑
25.	Being overweight	❑	❑	❑	❑
26.	Being underweight	❑	❑	❑	❑
27.	Not doing enough exercise	❑	❑	❑	❑
28.	Using non-prescription drugs	❑	❑	❑	❑
29.	Effects of sexual assault (e.g. molestation)	❑	❑	❑	❑
30.	Baldness	❑	❑	❑	❑
31.	Lack of interest in or enjoyment of sex	❑	❑	❑	❑
32.	Urinary tract infection	❑	❑	❑	❑
33.	HIV/AIDS	❑	❑	❑	❑
34.	Other sexually transmitted diseases	❑	❑	❑	❑
35.	Impotency	❑	❑	❑	❑
36.	Sterility	❑	❑	❑	❑
37.	Health or safety hazards at work	❑	❑	❑	❑
38.	Health or safety hazards at home	❑	❑	❑	❑
39.	Problems with working and being a parent	❑	❑	❑	❑

		Concern/Worry		Experienced	
		Yes	No	Yes	No
40.	Problems with children	❑	❑	❑	❑
41.	Widowhood	❑	❑	❑	❑
42.	Problems in your relationship with your partner or significant other	❑	❑	❑	❑
43.	Problems with relationships with other family members	❑	❑	❑	❑
44.	Problems with friends	❑	❑	❑	❑
45.	Money problems	❑	❑	❑	❑
46.	Problems with housing	❑	❑	❑	❑
47.	Transportation problems	❑	❑	❑	❑
48.	Dissatisfaction with the quality of medical care	❑	❑	❑	❑
49.	Uneasiness with aging	❑	❑	❑	❑
50.	Race/ethnic/religious discrimination	❑	❑	❑	❑

5b. Can you tell me about the health problems you have had in the last twelve months? (prompt: what was your experience with each problem? what helped you cope? what made the problem(s) better? what made the problem(s) worse? did you talk to anyone about the problem(s)? who did you talk to? did you see a doctor? did affect your work? did it affect your family? did it affect your friendships?)

6. Of those health problems that you indicated from the list, what are the two that bother you the most?
(prompt: why do you pick these? why didn't you pick [items indicated with "yes" on the list]?)

7. Thinking back to the list of health issues, what do you think affects your level of health?
(prompt: what do you think may have contributed or caused the health problems you have experienced in the past year?)

8. [If time permits] What do you think are the main social problems facing men in Canada? (at least two)
(prompt: why did you pick these?)

9. [If time permits] Do you think men and women differ in how they cope with not feeling well?
(prompt: why or why not? what about you, how do you cope with not feeling well?)

10. Have I missed anything? Is there anything else about men's health that you think we should discuss?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

11. Would you like a summary of the results of this study?
(remember: it takes a long time to sort through the data so it may be a while before you receive the results)

no ❑ yes ❑.....where should I send the results?

_____

_____

_____

_____

_____

Thanks for talking to me. I appreciate your time and effort.

Interview Number:_____

MEN'S HEALTH DEMOGRAPHIC DATA

The responses you provide on this sheet enable us to describe the sample of men that took part in the survey.

In order to protect your anonymity you are not required to put your name on this form. Instead, please provide the date, time, and location of the interview in the space below.

1. In what year were you born?

   _____

2. In what country were you born?

   _____

   If you were born outside of Canada, in what year did you come to Canada to live?

   _____

3. What is your marital status?

   single ❑ common-law ❑ married ❑ separated ❑ divorced ❑ widowed ❑

4. Do you live with anyone?

   no ❑

   yes ❑..... with: parent(s) ❑
   roommate ❑..... male ❑ female ❑
   partner ❑..... male ❑ female ❑
   spouse ❑
   other ❑.....please specify_____

5. Do you have any children?

   no ❑

   yes ❑..... How many children do you have? _____

   What are their ages? _____

   How many children live with you (this includes your spouse/partner's children and foster children)? _____

6. Other than children and/or your spouse/partner, do you have any dependents?

   no ❑

   yes ❑..... parent(s) ❑
   other relative(s) ❑
   other...please specify _____

7. Do you have a paid job?

   yes ❑..... description of work:_____

   average hours worked per week:_____

   no ❑

8. What is your/your family's main source of income?

   A. income from your own employment ❑
   B. income from your partner/spouse's employment ❑
   C. combination of income from own and partner/spouse's employment ❑
   D. parental income ❑
   E. social assistance ❑
   F. pension ❑
   G. other...please specify_____ ❑

9. Before taxes, into which one of the following broad categories does your yearly income (if living alone or with a roommate) or your yearly combined family income fall?

A. less than $10 000 ❑
B. between $10 000 and $19 999 ❑
C. between $20 000 and $29 999 ❑
D. between $30 000 and $39 999 ❑
E. between $40 000 and $49 999 ❑
F. between $50 000 and $59 999 ❑
G. between $60 000 and $99 999 ❑
H. between $100 000 and $149 999 ❑
I. over $150 000 ❑
J. no response ❑

10. What is the highest level of education that you have completed?

A. have had no schooling ❑
B. elementary school ❑ completed grade_____
C. high school ❑ completed grade_____
D. trades certificate ❑
E. non-university certificate ❑
F. college diploma ❑
G. university diploma ❑
H. university bachelor's degree ❑
I. university undergraduate professional degree ❑
J. master's degree ❑
K. doctorate ❑
L. other _____

If you are mailing this questionnaire, please use the addressed stamped envelope provided.

Thank you again for your time and participation in the study.

APPENDIX B

[Department of Sociology
McMaster University letterhead]

Information Sheet

Researcher:	Lidia Martinus (M.A. candidate)
Title of Research Project:	Exploring Men's Health in the Context of their Daily Lives: A Qualitative Study

The following information attempts to explain the research project named above and what you can expect as a study participant.

To begin with, the study of men's health is a new and growing area of sociology. Traditionally, health for both men and women had only been examined biologically, that is, explanations for ill-health came from examining cells in the human body. However, biology alone was unable to explain the *experiences* individuals had with health and ill-health on a daily basis. Various factors, including the women's movement, helped bring about more research on women's health experiences, however, to date men's health experiences on a daily basis have been minimally addressed. Therefore, this study aims at developing a better understanding of men's day-to-day experiences with health and ill-health.

"Exploring Men's Health in the Context of their Daily Lives: A Qualitative Study" is the Canadian component of a larger international study on health. The information gathered in this study may act as a foundation upon which further studies can be built thereby contributing to a better and more holistic understanding of men's health. A master's thesis will also be written from the information collected in this study.

Data for this study is being gathered through face-to-face interviews with the researcher. Interviews conducted to date have lasted just over an hour, however, your time limitations will certainly be respected. The interviews take on a conversational format and there are no right or wrong answers. As a participant you will be asked for your views on health in general as well as personal concerns with health and experiences with ill-health. All responses are strictly confidential and you as a participant remain anonymous (your name will *not* be written on the interview sheets). You also have the right to refuse to answer any question(s) and you can withdraw from the study at any time. This study is conducted in accordance with ethics stipulations as enforced by McMaster University.

If you have any questions or concerns please do not hesitate to contact me, Lidia Martinus, at(905) 525-9140, extension 23617 (or at _____).

Your contribution of information to this study is very valuable and will be greatly appreciated.

APPENDIX C

[Department of Sociology
McMaster University letterhead]

Statement of Informed Consent*

Exploring Men's Health in the Context of their Daily Lives

Researcher: Lidia Martinus (M.A. candidate)
Department of Sociology
McMaster University
Hamilton, Ontario

The purpose of this study is to explore the health concerns of men and experiences men have with health in the context of day-to-day living. The health of men has not been extensively studied from the perspectives of men.

Data for this study will be gathered through individual interviews conducted by the researcher. If permission is granted interviews will be audio-tape recorded and transcribed. You are guaranteed anonymity and upon completion of the study all audio tape recordings will be erased. Your name will not be recorded on the interview schedule.

Findings will be presented in a final report to be submitted as partial fulfilment of the requirements for the degree of Masters of Arts in Sociology. You may request a copy of the final report.

You may withdraw from the study at any time and have the right to refrain from answering any questions without fear of reprisal. Participation is strictly voluntary.

This project is conducted in accordance with the requirements outlined by the President's Committee on Ethics of Research on Human Subjects.

If you have any questions about this study or your participation in the study please feel free to call Lidia Martinus at (905) 525-9140, extension 23617.

Statement of Consent: I have read the information regarding this study presented on the other side of this consent form. I have been given the opportunity to ask questions about the study. I understand that if I agree to participate my involvement will consist of an individual interview to be conducted by Lidia Martinus. I have been given the opportunity to decline being audio-taped.

I understand that the information I provide will be treated as confidential and my anonymity will be guaranteed. I realise that I may withdraw from the study at any time.

I agree to be involved in this study and participate in an interview.

Participant's Name (please print)	Researcher's Name
Participant's Signature	Researcher's Signature
Date	Date

*A copy of this consent is to be signed by the participant prior to the interview.

Your contribution of time and information to this research project is very much appreciated. Thank you.

REFERENCES

Annandale, E., & Hunt, K. (1990). Masculinity, femininity and sex: an exploration of their relative contribution to explaining gender differences in health. *Sociology of Health and Illness*, *12* (1), 24-46.

Armstrong, P., & Armstrong, H. (1983). Beyond numbers: Problems with quantitative data. *Alternate Routes*, *6*, 1-40.

Babbie, E. (1995). *The practice of social research* (7th ed., pp. 39-62; 80-108; 131-158; 360-374). Belmont, CA: Wadsworth Publishing Company.

Baum, F. (1995). Research public health: Behind the qualitative-quantitative methodological debate. *Social Science and Medicine*, *40*(4), 459-468.

Blane, D. (1991). Inequality and social class. In G. Scambler (Ed.), *Sociology as applied to medicine* (3rd ed., pp. 109-128). Toronto, ON: Bailliere Tindall.

Blaxter, M. (1983). The causes of disease: Women talking. *Social Science and Medicine*, *17*(2), 59-69.

Blaxter, M. (1990). Health and lifestyles. New York, NY: Tavistock/ Routledge.

Calnan, M. (1987). *Health and illness: The lay perspective* (pp. 1-40). New York, NY: Tavistock Publications.

Charmaz, K. (1995). Identity dilemmas of chronically ill men. In D. Sabo & D. F. Gordon (Eds.), *Men's health and illness: Gender, power, and the body* (pp. 266-291). Thousand Oaks, CA: Sage Publications.

Clarke, J. N. (1992). The medical care system: Critical issues. In, *Health, illness, and medicine in Canada* (pp. 224-248). Toronto: McClelland & Stewart.

Conrad, P. (1987). The experience of illness: Recent and new directions. In J. A. Roth & P. Conrad (Eds.), *Research in the sociology of health care: Volume 6* (pp. 1-31). Greenwich, CT: JAI Press.

Crawford, R. (1997). Individual responsibility and health politics. In P. Conrad (Ed.), *The sociology of health and illness: Critical perspectives* (5th ed., pp. 393-401). New York, NY: St. Martin's Press.

Dickson, L. L., Heale, J. A., & Chambers, L. W. (1995). *Fact book on health in Hamilton-Wentworth* (3rd ed.). Hamilton, ON: Health Priorities Analysis Unit, McMaster University.

Edginton, B. (1989). *Health, disease and medicine in Canada* (pp. 1-25; 79-114). Toronto, ON: Butterworths Canada.

Gordon, D. F. (1995). Testicular cancer and masculinity. In D. Sabo & D. F. Gordon (Eds.), *Men's health and illness: Gender, power, and the body* (pp. 246-265). Thousand Oaks, CA: Sage Publications.

Greenwood, J. (1996). [List of men's health issues as reflected in various forms of media]. Unpublished raw data.

Harris, I. M. (1995). *Messages men hear: Constructing masculinities* (pp. 9-20). Bristol, PA: Taylor & Francis.

Harrison, J., Chin, J., & Ficarrotto, T. (1995). Warning: Masculinity may be dangerous to your health. In M. S. Kimmel & M. A. Messner (Eds.), *Men's lives* (3rd ed., pp. 237-249). Needham Heights, MA: Allyn & Bacon.

Health and Welfare Canada (1993). *Canada's health promotion survey 1990: Technical report* (pp. 91-101; 126-137). Ottawa, ON: Minister of Supply and Services Canada.

Helgeson, V. S. (1995). Masculinity, men's roles, and coronary heart disease. In D. Sabo & D. F. Gordon (Eds.), *Men's health and illness: Gender, power, and the body* (pp. 68-104). Thousand Oaks, CA: Sage Publications.

Herzlich, C. & Pierret, J. (1986). Illness: From causes to meaning. In C. Currer & M. Stacey (Eds.), *Concepts of health, illness and disease* (pp. 73-96). New York, NY: Berg Publishers.

Jesser, C. J. (1996). *Fierce and tender men: Sociological aspects of the men's movement* (pp. 3-17). Wesport, CT: Praeger.

Kaplan, M. S., & Marks, G. (1995). Appraisal of health risks: The roles of masculinity, femininity, and sex. *Sociology of Health and Illness, 17*(2), 206-221.

Leeflang, R. L. I., Klein-Hesselink, D. J., & Spruit, I. P. (1992). Health effects of unemployment--I. Long-term unemployed men in a rural and an urban setting. *Social Science and Medicine*, *34*(4), 341-350.

Morgan, M., Calnan, M., & Manning, N. (1993). *Sociological approaches to health and medicine* (pp. 11-44; 76-207). New York: Routledge.

Nettleton, S. (1995). *The sociology of health and illness* (pp. 36-67). Cambridge, MA: Polity Press.

Nettleton, S. & Bunton, R. (1995). Sociological critiques of health promotion. In R. Bunton, S. Nettleton, & R. Burrows (Eds.), *The sociology of health promotion: Critical analyses of consumption, lifestyle and risk* (pp. 91-99). New York: Routledge.

Olesen, V., Schatzman, L., Droes, N., Hatton, D., & Chico, N. (1990). The mundane ailment and the physical self: Analysis of the social psychology of health and illness. *Social Science and Medicine*, *30*(4), 449-455.

Patton, M. Q. (1990). *Qualitative evaluation and research methods* (2nd ed., pp. 7-142). Newbury Park, CA: Sage Publications.

Pleck, J. (1995). Men's power with women, other men, and society: A men's movement analysis. In M. S. Kimmel & M. A. Messner (Eds.), *Men's lives* (3rd ed., pp. 5-12). Needham Heights, MA: Allyn & Bacon.

Saltonstall, R. (1993). Healthy bodies, social bodies: Men's and women's concepts and practices of health in everyday life. *Social Science and Medicine*, *36*(1), 7-14.

Statistics Canada (1994). *Health status of Canadians*. Ottawa, ON: Author.

Statistics Canada (1997). *Mortality–Summary List of Causes, 1995*. Ottawa, ON: Author.

Strauss, A. L. & Corbin, J. (1990). *Basis of qualitative research*. Newbury Park, CA: Sage Publications.

Syme, S. L. & Berkman, L. F. (1997). Social class, susceptibility, and sickness. In P. Conrad (Ed.), *The sociology of health and illness: Critical perspectives* (5th ed., pp. 29-35). New York, NY: St. Martin's Press.

Thorslund, M., Wärneryd, B., & Östlin, P. (1992). The work-relatedness of disease: Workers' own assessment. *Sociology of Health and Illness*, *14*(1), 57-72. Tiihonen, A. (1994). Asthma--The construction of the masculine body. *International Review for the Sociology of Sport*, *29*(1), 51-62.

Torrance, G. M. (1992). Socio-historical overview. In J. Coburn, C. D'Arcy, G. M. Torrance, & P. New (Eds.), *Health and Canadian society: Sociological perspectives* (2nd ed., pp. 6-32). Richmond Hill, ON: Fitzhenry & Whiteside.

Veevers, J. E. & Gee, E. M. (1986). Playing it safe: Accident mortality and gender roles. *Sociological Focus*, *19*(4), 349-360.

Waldron, I. (1995). Contributions of changing gender differences in behaviour and social roles to changing gender differences in mortality. In D. Sabo & D. F. Gordon (Eds.), *Men's health and illness: Gender, power, and the body* (pp. 22-45). Thousand Oaks, CA: Sage Publications.

Walters, V. (1992). Women's views of their main health problems. *Canadian Journal of Public Health*, September-October, 371-374.

Walters, V. (1993). Stress, anxiety and depression: Women's accounts of their health problems. *Social Science and Medicine*, *36*(4), 393-402.

Walters, V. (1994). Women's perceptions regarding health and illness. In B.S. Bolaria & H.D. Dickinson (Eds.), *Health, illness and health care in Canada* (2nd ed., pp. 307-325). Toronto: Harcourt Brace.

Weitz, R. (1996). *The sociology of health, illness, and health care: A critical approach* (pp. 15-81). Scarborough, ON: Wadsworth.

White, P. G., Young, K., & McTeer, W. G. (1995). Sport, masculinity, and the injured body. In D. Sabo & D. F. Gordon (Eds.), *Men's health and illness: Gender, power, and the body* (pp. 158-182). Thousand Oaks, CA: Sage Publications.

Zola, I. K. (1997). Medicine as an institution of social control. In P. Conrad (Ed.), *The sociology of health and illness: Critical perspectives* (5th ed., pp. 404-414). New York, NY: St. Martin's Press.