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submitted for the degree of

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"When the whole 'bloke' thing starts to crumble ..."

Men's access to chronic illness (arthritis) self management programs

Lisa Gibbs, B.Sc. (Hons)

Submitted for the fulfilment of the requirements for the degree of Doctor of Philosophy

Health and Behavioural Sciences
Deakin University

October 2003
I certify that the thesis entitled

"When the whole 'bloke' thing starts to crumble"

Men's access to chronic illness (arthritis) self management programs

submitted for the degree of

Doctor of Philosophy

is the result of my own work and that where reference is made to the work of others, due acknowledgment is given.

I also certify that any material in the thesis which has been accepted for a degree or diploma by any other university or institution is identified in the text.

Full Name.................. LISA GIBBS............................

Signed..............................

Date.............................. 22.04.04

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Dedication

This thesis is dedicated to the memory of my husband Ray, whose belief in me gave me the confidence to undertake this PhD, and the courage to continue with life after his death. It is also dedicated to my son Thomas, who brings joy and meaning to my life even in the darkest times.
Acknowledgements

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Abstract

This thesis explores the issue of men’s access to chronic illness self management programs from a social constructionist perspective. A combination of research methodologies was used: a quantitative analysis to confirm gender differences in levels and patterns of service use; a qualitative analysis to gain an increased understanding of the factors affecting men’s access; and a trial to test the application of the research findings. The clients and services of Arthritis Victoria were chosen as the setting for this research.

The quantitative analyses were conducted on contingency tables and odds ratios and confirmed that men were under-represented as service users. The analyses also identified gender differences in patterns of service use. The qualitative analysis was based on a series of in-depth, semi-structured interviews. It was undertaken from a grounded theory approach to allow for the development of theoretical explanations grounded in the data. It was found that men’s decisions to access chronic illness self management programs were strongly influenced by dominant social constructions of masculinity which constrained help-seeking and health management behaviour. However, the restrictive influence of hegemonic masculinity was progressively undermined by the increasing severity of the chronic condition until a crisis point was reached in terms of the severity of the condition or its impact on lifestyle. This resulted in a reformulation or rejection of hegemonic masculinity. The described conceptual framework was consistent for men from diverse social groupings, although it appeared less prominent in both younger and older men, suggesting that dominant social constructions of masculinity have the greatest influence on health decisions during the middle stage of adulthood when work and family obligations are greatest.

The thesis findings informed the development of some guiding principles for reviewing the structure and delivery of chronic illness self management services for men. The guiding principles will have direct application in the planning of Arthritis Victoria programs, and implications for other chronic illness self management programs in Australia, and also in Western countries with a similar health and socio-cultural setting to Australia.
superman (it's not easy)
by Five for Fighting

I can't stand to fly
I'm not that naive
I'm just out to find the better part of me
I'm more than a bird
I'm more than a plane
I'm more than some pretty face beside a train
And it's not easy to be me

I wish that I could cry
Fall upon my knees
Find a way to lie 'bout a home I'll never see
It may sound absurd
But something I need
Even heroes have the right to bleed
I may be disturbed
But won't you concede
Even heroes have the right to dream
And it's not easy to be me

Up ahead away, away from me
Well it's alright, you can all sleep sound tonight
I'm not crazy or anything

I can't stand to fly
I'm not that naive
Men weren't meant to ride with clouds between their knees
I'm only a man in a silly red sheet
Digging for kryptonite on this one way street
Only a man in a funny red sheet
Looking for special things inside of me
Inside of me, inside of me, inside of me

I'm only a man in a funny red sheet
I'm only a man looking for a dream
I'm only a man in a funny red sheet
And it's not easy
It's not easy to be me ...

(Ondrasik 2001)
1.1 Rationale

It is the aim of this thesis to increase understanding of what kinds of chronic illness self-management programs men would want to access.

Increasingly it is being recognised that there are gender differences in the utilization of primary health care services and in health management behaviours. There is growing evidence, for instance, that women are more likely to use general health services than men (Australian Bureau of Statistics 1996; Baum 1998; Courtenay 2000a), that men and women access health services in different ways and for different reasons (Broom 1991; Hegelson 1995), and that women can influence the health management behaviour of men (Denner 2000; Norcross et al. 1996). In fact, men’s health has emerged as a prominent academic and public issue (Wadham 1996; Baker 2001).

However, there has not been a similar focus on gender differences in utilisation of chronic illness self-management programs. This is a particularly important issue given that “Chronic, non-communicable diseases are currently responsible for around 70% of the total burden of illness and injury experienced by the Australian population” (National Public Health Partnership 2001:9). The current Commonwealth Government Sharing Health Care Initiative (initially known as the Chronic Disease Self Management Initiative) was part of the Enhanced Primary Care Package, and was listed as a priority in the health budget for four years with an allocation of $14.4 million (Commonwealth Department of Health and Aged Care 2000). The focus of the Sharing Health Care Initiative was on mature people (50 years and over) with co-morbidities. As shown below, the self-management of chronic illness has become a health priority area for government departments across Australia:

• The National Public Health Partnership released *Preventing Chronic Disease: A Strategic Framework* (National Public Health Partnership 2001). This report was endorsed on 31 May 2001 by the Australian Health Ministers’ Advisory Council to provide a basis for further national collaborative action. It sets out a framework for the prevention and control of chronic non-communicable diseases in Australia.

• The Commonwealth Department of Veterans’ Affairs lists self-management of chronic conditions, and gender specific health needs, among its seven health priorities in its ‘Health Promotion Strategic Plan’ (Commonwealth Department of Veterans’ Affairs 2001).

The following additional initiatives are listed as an extract from ‘Preventing Chronic Disease: A Strategic Framework’, developed by the National Public Health Partnership (2001:11):

• The Preventable and Chronic Disease Strategy, Territory Health Services

• The Chronic and Complex Care Initiative in NSW;

• The Eat Well, Australia national nutrition strategy, developed by the Strategic Intergovernmental Nutrition Alliance (SIGNAL), under the National Public Health Partnership;

• The North Queensland Chronic Disease Strategy (Indigenous);
• The formation of the National Vascular Disease Prevention Partnership by a group of leading health non-government organisations;

• The development of the Smoking, Nutrition, Alcohol and Physical Activity (SNAP) framework for general practice by the Joint Advisory Groups on General Practice and Population Health;

• The Gatehouse Project in Victoria, designed to promote mental health and emotional well being in schools, but which has also demonstrated an impact on other risk factors, such as smoking; and

• National Mental Health Strategy, National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000, which aims to address many of the psychosocial factors and social determinants associated with chronic disease risk.

The efficacy of self management programs in changing behaviour and improving health outcomes for patients with chronic illnesses in a cost-effective manner is well established (Gibson et al. 1999; Lorig et al. 1999; Smarr et al. 1997; WA Research Unit 2000; Wagner et al. 1996; Winkler et al. 1989). However, while this is being recognised in government health policies, the evidence of significant under-utilisation of these programs by men has not been similarly addressed as a related policy issue. This thesis will address the gap in the current discourse on chronic illness and self management programs by exploring the factors affecting men’s access to chronic illness self management programs.

The focus in this thesis on arthritis and related conditions, as a representative chronic illness, is also timely. The period 2000-2010 has been sanctioned by the United Nations and the World Health Organisation, as Bone and Joint Decade. "The decade aims to improve the health-related quality of life for people all over the world who have musculo-skeletal conditions. This includes people with arthritis and other rheumatic disease" (Arthritis Victoria 2001:5). Arthritis is a major cause of disability and chronic pain in Australia:
It affects an estimated 3.1 million people (as at June 2000) or approximately 16.5% of Australians. ... Almost 60% of all people with arthritis are of working age (15-64 years). ... The overall financial cost of arthritis in Australia is enormous – approaching $9 billion (1.4% of domestic product) in 2000. ... Rheumatoid arthritis in particular is recognised as one of the major health reasons for leaving work early (Access Economics Pty Limited 2001:1).

Due to the widespread impact of arthritis on the Australian population, it was identified as one of seven national health priority areas in the National Health Priority Areas Initiative. This initiative involves a national collaboration on chronic diseases by the Commonwealth, State and Territory governments (National Health Priority Action Council 2002).

Whitehead (1995) suggests that there are four policy levels at which strategies can be employed to reduce inequalities in health: strengthen individuals (Level 1); strengthen communities (Level 2); improve access to services (Level 3); encourage economic and cultural change (Level 4). The strategies described in this thesis were designed to improve access to services (Level 3), and include a combination of quantitative and qualitative research approaches. This combination of research approaches is useful in order to gain an increased understanding of the interaction between gender and the experience of illness (Annandale and Hunt 2000; Popay and Groves 2000).

1.2 Overview of the thesis

As indicated by the title of this thesis, “When the whole ‘bloke’ thing starts to crumble ...”; Men’s access to chronic illness (arthritis) self management programs, the key research questions to be addressed are:

- Why aren’t men participating in existing chronic illness self management programs?
• What kinds of self management programs would men with a chronic illness want to access?

The first section of the title of this thesis, "When the whole 'bloke' thing starts to crumble", is drawn from an interview with one of the research participants (referred to in this thesis as 'Harry'), in which he describes the emotional and psychological impact of a chronic condition. Harry's comments are discussed in section 5.1.5: I can take care of myself.

A considerable amount of research has been undertaken both in Australia and overseas relating to men's under-utilisation of health services. However, these studies have been almost exclusively based on quantitative analyses and addressing primary health issues and/or services. There are very few men's health studies that have any of the following features (Lumb 1997; Connell 1999), and none that combine all three of the elements of this thesis, i.e.:

• a combination of quantitative and qualitative methodology
• a focus on the needs of men with an existing chronic illness
• an investigation into the accessibility of self management programs.

The research questions will be explored from a social constructionist perspective and will be reported in terms of the four main stages of research as outlined below.

Chapter Two will contain the literature review. This provides an opportunity to explore current theories about masculinity and other social determinants such as socio-economic status, cultural grouping, sexuality and geographic location. These factors all interact in their influence on men's health behaviour. The literature review also includes a review of men's health initiatives, undertaken from a social marketing perspective. This will allow consideration of successful and unsuccessful approaches to the development and marketing of men's health promotion.
The research methodology is described in Chapter Three. It provides the context and theoretical framework for the research activities. A particular focus on the clients and services of Arthritis Victoria allowed detailed exploration of the issues. The quantitative analysis was conducted on contingency tables and odds ratios. The qualitative analysis was undertaken using a grounded theory approach, and incorporated participatory research strategies.

The quantitative findings are reported and discussed in Chapter Four. Statistical analyses of Arthritis Victoria client population records were conducted to explore the relationships between gender and service utilisation. This helps to define the area of study under investigation.

Chapter Five contains the report and discussion of qualitative findings. A series of interviews involving 17 men with chronic arthritis, and 4 partners, was undertaken to identify any themes relating to access issues and/or attitudes to self management programs influencing decisions of whether or not to participate.

The applied findings are reported and discussed in Chapter Six of this thesis. A trial of research findings was carried out in a health setting. The trial was designed to assess whether the increased understanding of men’s health behaviour resulting from the research findings could be translated into strategies for developing and delivering chronic illness self management programs for men.

The thesis conclusions are presented in Chapter Seven. The research findings and trial outcomes also informed the development of guiding principles for health organisations interested in providing gender sensitive programs to men with a ‘lived-with’ chronic illness as defined by Charmaz (1995 – see section 2.1.2: Chronic illness). These guiding principles are described in Chapter Seven as an adjunct to the overall thesis conclusions. They have wider applications for chronic illness self management programs provided by organisations in countries with a similar health and cultural setting to Australia.

Supporting documentation has also been attached as Appendices to this thesis to provide further information and clarification regarding the research process.
2.1 Introduction

A social constructionist, gendered analysis of health will be adopted in this thesis, as advocated by Broom (1998) and Doyal (2001), rather than an oppositional stance between men's and women's health. This gendered approach acknowledges the social element in health differentials and the complexity of interacting factors such as socio-economic status, age, linguistic and cultural diversity, sexuality and geographic location.

This literature review will explore the findings in the men's health literature that form the context for the subject of this thesis. In particular, it will review masculinity theories, gender differences in levels and patterns of health service use, health promotion initiatives targeting men, and research into men's attitudes to health services.

2.2 Definitions

Definitions of some of the main terms used throughout this thesis are provided below to establish the meaning of the terms being applied to the research findings.

2.2.1 Chronic illness

It is important to make the distinction between chronic and acute illness because of the difference in the experience and management of the two types of illness.

An acute illness is generally a condition of short duration, usually lasting only days or weeks, with a specific onset. The condition heals on its own or in response to rest and/or treatment. The health care system is largely based on care of acute
conditions, as is patients' understanding of the role of health care services (Holroyd and Creer 1986; Thorne and Robinson 1989; Owen and Lennie 1992).

A **chronic illness** is a long-term condition, usually lasting years and often continuing for the rest of the individual's life. It may develop gradually or have a sudden onset. The symptoms may be intermittent or ongoing, and may be variable or progressive in nature. There is often no known cause or cure for the condition (Holroyd and Creer 1986). There is a range of definitions and labels being used for chronic illness in Australia that vary according to the professional discipline and the perspective of the authors (Macs et al. 1996; National Public Health Partnership 2001; Walker 1999). For the purposes of this thesis, the terms 'chronic illness', 'chronic disease', and 'chronic condition', will be used interchangeably. The definition that has been adopted is the one proposed by Charmaz:

Chronic illness means experiencing ongoing or intermittent, recurrent, irreversible, and often, degenerative, symptoms of a disease process (cf. Freund and McGuire 1991). I focus on what it means to have a disease, not on objectivist medical definitions, and address two of Conrad's (1987) subtypes of chronic illness: "lived-with-illnesses" (e.g., multiple sclerosis, chronic fatigue syndrome, renal failure, diabetes, postpoliomyelitis syndrome), which force adapting without immediate life threat, and those "mortal illnesses" (e.g., heart attack, stroke, cancer) that sufferers view as life-threatening and have lasting consequences whether or not they (a) know about these consequences and (b) experience immediate symptoms (1995:287).

Charmaz' definition makes the distinction between chronic conditions on the basis of whether they were life threatening conditions or not, and whether or not the individual experiences symptoms. The conditions being profiled within this thesis, i.e. arthritis and related conditions, are generally not accompanied by immediate life threat, although there is growing evidence that rheumatoid arthritis contributes to premature mortality (Lorig et al. 1987). Arthritis and related conditions also tend to involve a variety of symptoms that can be extremely painful and can
involve considerable loss of function. This is consistent with the description used by Charmaz for “lived-with-illnesses”.

The distinction between conditions with or without life threat is relevant to this research because life threatening illnesses may alter the health management response of the individual. Verbrugge (1985) notes that variability in response to illness is minimized for conditions that involve an immediate life threat. By focusing on “lived-with-illnesses” rather than “mortal illnesses” it is possible to explore the variability in men’s response to their condition and perception of self management services, and thereby gain a greater understanding of the issues affecting access to services.

The particular type of chronic illness being profiled in this thesis is arthritis. The word “arthritis” simply means inflammation of the joint. However, the term is generally used to refer to over 150 different musculoskeletal conditions. “Musculoskeletal conditions are the most common cause of severe long-term pain and physical disability affecting 25% of Australians” (Arthritis Foundation of Victoria Inc. 2000:24). Musculoskeletal conditions account for 27.5% of consultations with health professionals (Australian Bureau of Statistics 1995). Brief descriptions are provided below of the specific types of arthritis referred to within this thesis:

- **Osteoarthritis** is the most common form of arthritis and involves degeneration of the cartilage within the joint, resulting in localised pain and stiffness. The age at onset is generally between 45 and 90. It affects both men and women (Lorig and Fries 1995).

- **Rheumatoid arthritis** involves inflammation of the synovial membrane resulting in damage to bone, ligaments, tendons, cartilage, and the joint capsule. This is generally experienced as swelling, warmth and pain in the joints, fatigue, stiffness, muscle aches and fever. Age at onset is usually between 20 and 50. It affects women more than men (Lorig and Fries 1995).
• **Fibromyalgia** involves sleep disturbance, muscle contraction, overall aching, tender points in muscles and ligaments, and fatigue. Age at onset is usually between 35 and 60 years of age. It affects women more than men (Lorig and Fries 1995).

• **Ankylosing spondylitis** affects the spine, often causing severe backache and stiffness. Other joints such as the hips and shoulders can also be involved. The age at onset is usually between 16 and 35 and it affects males more frequently than females (Motley 2001a).

• **Gout** involves the formation of crystals of urate in the joint space resulting in pain and swelling of the joint. It usually affects one joint at a time, most commonly the joint of the big toe. The age of onset is usually between 40 and 50. It is affected by diet and is more frequent in males than females (Motley 2001b).

• **Osteoporosis** occurs when bones lose calcium and become more fragile and brittle. This can result in bone fractures. The age at onset is usually over 60. It affects both men and women although it is more frequent among women (Osteoporosis Australia date unknown).

• **Polymyalgia rheumatica** involves muscle pain and stiffness, usually affecting the neck, shoulders and hips. The age of onset is usually over 50 and most commonly around 70 years of age. It affects women more often than men (Arthritis Victoria 2002b).

• **Psoriatic arthritis** is an inflammatory type of arthritis that is associated with the skin condition, psoriasis. There are several types of psoriatic arthritis which vary in severity and the joints that are affected. Generally it involves stiffness, pain or swelling in the affected joints, and fatigue. The age of onset is usually between the ages of 30 and 50, although it can develop at any age. It affects both men and women (Motley 2001c).
• **Juvenile arthritis** refers to cases where the age of onset of arthritis is less than 16 years of age. There are seven different forms of arthritis affecting this age group that vary in terms of patterns of symptoms, severity, prognosis and age of onset. They all involve pain and stiffness of certain joints and are sometimes associated with eye conditions (Arthritis Victoria 2002a).

Arthritis is similar to most chronic conditions in that it responds well to a wide range of self management approaches including re-organisation of daily activities, exercise, relaxation techniques, joint protection, massage and application of heat and/or cold packs. Information about the condition and its management, and support from others with the condition, are also important factors in raising an individual’s confidence in their ability to manage their condition in partnership with their doctor and other relevant health professionals (Lorig and Associates 1996).

### 2.2.2 Self management

‘Lived-with’ chronic illnesses (Charmaz 1995) tend to have an ongoing impact on the daily life of the individual and usually have no known cure. Therefore, appropriate treatment involves a combination of medical care and self management techniques:

The three most distinguishing features of the self-management model are (a) dealing with the consequences of the disease; (b) being concerned with problem solving, decision making, and patient confidence, rather than prescription and adherence; and (c) placing patients and health professionals in partnership relationships. Health professionals are responsible for the medical management of the disease, and the patient is primarily responsible for the day-to-day management of the illness (Lorig and Associates 1996:xiv).

Integral to this approach is the individual’s confidence in their ability to self manage. This is referred to as self-efficacy. It is not enough for people to learn the
tools of self-management or even to have the required skills. They have to believe themselves capable of doing it (Lorig and Associates 1996).

There are varying definitions of self-management however the common element is that “the patient is responsible for managing some aspect of their illness” (WA Research Unit 2000:3). For the purposes of this thesis, the definition for self-management will be the same as the one adopted by the Commonwealth Government for the Sharing Health Care Initiative:

‘Self-management interventions’ recognise the psychosocial factors involved in having a chronic disease, and aim to help sufferers learn and practise the skills necessary to carry on an active and emotionally satisfying life in the face of one or more chronic conditions. Effective self-management is based on a partnership between patients, their families and health professionals, where the patient is encouraged to play an active role in monitoring and managing symptoms and signs of illness, managing the impacts of illness on functioning, emotions and interpersonal relationships, and adhering to treatment regimens (Centre for Advancement of Health 1996:1).

Any programs providing information, education, exercise or peer support, represent a service designed to assist people to self manage. **Chronic illness self management courses** incorporate all of the elements of self management, as well as meeting the criteria for true self management education which includes:

(a) content presentation focused on patients’ perceived needs, (b) practice and feedback in new skills, including decision making and problem solving, (c) attention to emotional and role management in addition to medical management, (d) use of techniques to increase patients’ confidence in their ability to manage their conditions, and (e) emphasis on the patients’ active role in the physician/patient relationship (Lorig 1996b:680).
Chronic illness self management programs may be offered as a disease-specific course, for example the Arthritis Self Help Course. Alternatively, courses such as the Better Health Self Management Course are offered to people with more than one chronic condition. Even disease-specific courses have a generic component that is relevant to all chronic conditions, dealing with issues such as fatigue, doctor-patient communication, fluctuations in health status, and emotional reactions to an uncertain future.

2.2.3 Men's health

The concept of ‘men’s health’ has developed over the past twenty years as part of a growing concern over men’s poor health profiles. The recognition that the traditional ‘masculinist’ and ‘medicalised’ approach to health care did not meet women’s needs, has extended in recent years to a recognition that it also does not meet men’s needs (Broom 1998; Connell 1999).

This progressive shift through the women’s health movement to the more current ‘men’s health movement’ is reflected in contemporary definitions of men’s health, such as the definition offered by Fletcher:

A men’s health issue is a disease or condition unique to men, more prevalent in men, more serious among men, for which risk factors are different for men or for which different interventions are required for men (2001:68).

This definition implies a comparison with women’s health. However, Broom (1998) warns against a simple contrast between men and women, noting similarities between the sexes, and differences that may align more closely with other social determinants. Instead, Broom promotes recognition of the subtle interaction between gender and health that can shape exposure to health risks and experience of illness. This is supported by Connell (1999) who points to the interplay between people’s social environments and gendered interactions and its role in determining health opportunities and constraints.
Within this thesis, the reluctance of men to access services was highlighted in a comparative quantitative study of gender differences in service use. However, the focus of the qualitative phase of the thesis shifted to socio-cultural influences on men's approach to health management, as recommended by Broom and Connell, acknowledging the influences of dominant social constructions of masculinity on men's health behaviour, and the interacting influences of other social determinants. This socio-constructive perspective informed a structural approach to service delivery to minimise any conflict between positive health behaviour and dominant social norms about 'acceptable' masculine behaviour.

2.3 Masculinities

The field of masculinity research is problematic due to difficulties in defining masculinity according to Clutterbaugh (1998). Clutterbaugh argues that definitions of masculinity are circular because it is not possible to identify groups of individuals who exhibit a particular form of masculinity until we have an idea of what constitutes that type of masculinity, and that cannot be done until we can study a group of individuals who exhibit a particular construct of masculinity.

However, for the purposes of this thesis, the focus will be on similarities in men's health behaviours, rather than identifying characteristics of different types of masculinities. For that reason, the contemporary perspective in men's health literature will be adopted. This perspective recognises socio-cultural influences on men's health behaviour, particularly masculine identity (Broom 1998; Connell 1999). This will not be represented or discussed according to a single model of masculinity but rather by a range of possible masculinities that shift over time and place, and operate in a hierarchy (Connell 1999). The term 'masculinities' is explained in the following sections and will be used throughout the thesis to represent the range of masculinity options that are available to men.
2.3.1 Variations in masculinities

Masculinities can differ according to socio-economic status and even in different settings, e.g. workplace and school. As such, it will be important to recruit participants across social groupings and in different contexts. However, the likelihood of diversity within a given setting also needs to be acknowledged:

Diversity is not just a matter of difference between communities; it is equally important that diversity exists within a given setting. Within the one school, or workplace, or neighbourhood, there will be different ways of enacting manhood, different ways of learning to be a man, different conceptions of the self and different ways of using a male body (Connell 1998:3).

This suggestion that the variation in masculinities is not aligned with existing social groupings highlights the difficulties in identifying and accessing men who enact different forms of masculinity. As already noted, this problem with current masculinity research was explored in detail by Clatterbaugh, who commented that, “It may well be the best kept secret of the literature on masculinities that we have an extremely ill-defined idea of what we are talking about” (1998:27). He suggested that vague, relative descriptions are useless in providing reliable definitions of masculinity or means of understanding the behaviours and attitudes of groups.

The position taken in this thesis will be based on a social constructionist perspective on gender, and the understanding that multiple masculinities operate within our society. Every effort will be made to sample across social groupings and different constructs of masculinity in order to canvass a wide range of opinion and experience. However, it is acknowledged that difficulties in defining masculinities and accessing representatives of different constructs of masculinity, will be a limitation of the recruiting process. This is discussed further in the section 3.5.7: Collection of demographic information.
2.3.2 Hierarchy of masculinities

The various forms of masculinity, according to Connell (1999) and Pease (1997b), do not have equal status but operate in a hierarchy, both in relation to women and in relation to each other. This results in the marginalisation of subordinate masculinities. The dominant masculinity is referred to as hegemonic masculinity, i.e. the most honoured or desired, not the most common. Hegemonic masculinity, like other masculinity constructs, may vary for different social groupings and shift over time and place. However, the construction is generally understood as being "competitive, strong, aloof, independent, powerful, in control and controlling, an inability to express feelings for fear of ridicule and a fear of being intimate with other men, for fear of being accused of being homosexual" (Huggins 1995:209).

Courtenay (2000b) suggests that gender should be viewed as a dynamic social structure residing in gendered social transactions rather than in the individual. This is explored further by Connell who explains that hegemonic masculinity cannot be ignored, however men will position themselves differently in relation to it, depending on the forms of masculinity they identify with:

Many men live in a state of some tension with, or distance from, hegemonic masculinity. They may actively dislike the pattern, or adopt some parts of it but not others, or content themselves with a muted form of it ... This is an important reason why we cannot take the conventional stereotype of masculinity as necessarily the truth of men's lives. Yet all men living in a given culture must come to terms, somehow, with that culture's hegemonic masculinity (1999:59).

An individual's position in relation to hegemonic masculinity will also interact with his cultural context. Gilbert and Gilbert (1998) note that Aboriginal/Islander men face the same challenges as Australian men of Anglo-Saxon background, in relation to hegemonic masculinity. However, they also experience some additional tests that arise from their position in a cultural minority, their
experience of racism and for many, the experience of poverty and violence due to
the destruction of their traditional society by colonisation.

The position of migrants is similar to indigenous men. They must also address the
challenges of Australian hegemonic masculinity, with some extra tests that arise
from their position in a cultural minority (Gilbert and Gilbert 1998), as well as
addressing the influence of hegemonic masculinity from within their cultural
group (Connell 1999). New migrant groups are rejected more readily, and young
men in particular find they have to fit the masculinity expectations of the society
in which they live to be accepted, for example through sport, body type and
rejection of authority to compensate for a perception of cultural inferiority.

Men who do not practice heteronormative sexuality are also relegated to
subordinate masculinities. In fact, homosexuality and bisexuality have been
described as forms of masculinity (Gilbert and Gilbert 1998) in opposition to
hegemonic masculinity. The rules on acceptable masculine behaviour can shift
dramatically over time and culture, especially in relation to homosexual practices
(Carrigan et al. 1987) but in current Australian society, hegemonic masculinity is
opposed to ‘feminine’ behaviour. For this reason, sexuality is a defining element
in the construction of an individual’s masculinity. A man who is homosexual may
still exhibit many of the traits of hegemonic masculinity. However, Courtenay
states that these traits are aspirations rather than true forms of hegemonic
masculinity. "The endorsement of hypermasculine beliefs can be understood as a
means for gay and bisexual men to prove to others that, despite their sexual
preferences, they are still ‘real’ men" (2000b:1392).

The existence of a dominant form of masculinity may be the reason why there are
significant gender differences in certain types of health behaviour, despite the
various forms of masculinity operating within Australian society. It is possible
that adherence to some overriding tenets of hegemonic masculinity places
constraints on the health behaviour of individuals practicing subordinate
masculinities.
It is not feasible within the confines of this thesis to define each type of masculinity operating within Australian society, nor is it necessary. What is needed is an understanding of the common elements to each of the masculinities that, when confronted with chronic illness self-management programs, are likely to prevent participation. What may be found instead, as a result of the research undertaken for this thesis, is that there are no generalisable features, or alternatively, that common elements arise from reformulation, reliance or rejection of characteristics of hegemonic masculinity (Gerschick and Miller 1995). These possible responses are described in the next section (section 2.3.3: Chronic illness and masculinities).

2.3.3 Chronic illness and masculinities

Chronic illness can involve pain, fatigue and reduced strength and flexibility, thus undermining the image of strength and independence that is associated with hegemonic masculinity. These symptoms can result in a restriction of activities, such as favourite leisure time activities, reduction in alcohol consumption due to medication, and reduced working capacity. The impact of a chronic illness can even result in an early retirement. In current society, work is a central means of establishing masculine identity (Hegelson 1995; Rubin 1983), so any impact of illness on work represents a threat to that identity (Watson 2000). Charmaz (1994) described various workplace scenarios where men manipulated their working conditions or lied about their chronic illness to maintain their work identity and capacity.

Some chronic conditions can affect the individual’s ability to perform daily living tasks independently such as dressing, washing or gardening, placing them in a role that involves dependence on others. These changed situations of dependence can undermine the man’s role within the family and as a result impact significantly upon family relationships (Commonwealth Department of Human Services and Health 1996; Martin 1995). The unpredictability and uncertainty of chronic illness can also undermine the traditional male role of ‘being in charge’ (Cameron and Bernardes 1998). "Chronic disorders with an unpredictable prognosis especially,
such as rheumatoid arthritis or multiple sclerosis, can test adaptive capacities to the full: work, relationships, and future plans have to be seen from a totally different perspective” (de Ridder et al. 1997:553).

All of these changes can have a devastating effect on a person’s self image and may force a man to reassess his masculinity in response to life experiences (Gordon 1995). Gerschick and Miller (1995) describe a combination of strategies employed by men to come to terms with masculinity and physical disability. These strategies are characterised by reformulation, which entails men’s redefinition of hegemonic characteristics of masculinity on their own terms; reliance, reflected by sensitive or hypersensitive adoptions of particular attributes of hegemonic masculinity; and rejection, characterized by the renunciation of hegemonic standards and either the creation of one’s own principles and practices or the denial of hegemonic masculinity’s importance in one’s life. The terms reformulation, reliance and rejection were developed by Gerschick and Miller to describe men’s response to physical disability. However, they are also relevant and useful in studies of men’s adjustment to chronic illness.

Charmaz (1995) points out that masculinity is determined by both self ascription and external ascription. Chronic illness can undermine the factors that have previously sustained a man’s place in the gender order. Therefore, following the development of a chronic condition, men can find they are being perceived differently by others and have been relegated to a position of marginalised masculinity (Connell 1987; Messner and Sabo 1990; Sabo and Gordon 1992; Morris 1993; Charmaz 1995; Gerschick and Miller 1995). This may explain men’s apparent reluctance to acknowledge illness. They may need health services that can be accessed more privately, such as via the internet, or computer based exercise programs, to minimise their risk of losing their social position in the gender order. The marginalisation that occurs through chronic illness is multiplied (rather than additive) if the individual belongs to more than one marginal group (Vernon 1998). For example, if their social status in the gender order is already undermined by a sexual orientation or cultural background that does not meet the ideals of hegemonic notions of masculinity, men may experience multiple marginalisation.
It is clear that health workers need to be sensitive to the possibility that men with a chronic illness may be experiencing a crisis, not only in terms of their health status, but also their sense of their own masculinity (Cameron and Bernardes 1998; Watson 2000). This supports the focus of this thesis being specifically on men with a chronic illness, rather than drawing on previous studies and research into health promotion programs targeting ‘healthy’ men.

There is considerable research on the psychological adaptation of individuals to illness, in relation to coping methods adopted (de Ridder et al. 1997; Felton et al. 1984; Macs et al. 1996; Suls and Fletcher 1985), and shifts in adaptation over time (Morris 2001). As this thesis takes a social constructionist, gendered perspective on health, rather than an individualistic psychological analysis, this literature was not considered relevant and will not be reviewed.

Feifel and colleagues (1987) also explored coping methods. They suggested that there are three major coping modes in those with chronic illness: confrontation, avoidance, and acceptance-resignation. They proposed that these coping modes vary according to whether the illness is life-threatening (e.g. cancer, myocardial infarction), or not (e.g. arthritis, dermatitis, orthopedic low back pain). That is, they suggest that the choice of coping method is situational rather than determined by personal style. The coping modes described by Feifel and colleagues are similar to the strategies of reformulation, reliance and rejection described by Gerschick and Miller (1995). However, the emphasis on gender and masculinity in Gerschick and Miller’s theory makes it more relevant and useful to this thesis.

Stage of life should also be considered as a potential factor affecting men’s reaction to a chronic condition. Laslett describes four ‘Ages’ in life in his exploration of ageing:

First comes an era of dependence, socialization, immaturity and education; second an era of independence, maturity and responsibility, of earning and of saving; third an era of personal fulfilment; and fourth an era of final dependence, decrepitude and death (1989:4).
This concept of the stages of life is useful in considering the role of independence and responsibilities on health management behaviour, however its linearity fails to recognise the potential for people to be situated in more than one stage and to shift both backwards and forwards through stages, particularly for people experiencing the unpredictable progress of a chronic illness.

While it is clear that personal adjustment to chronic illness influences health management behaviour, this thesis takes a social constructionist perspective that acknowledges the social element in health behaviour and the complexity of interacting factors such as gender, socio-economic status, linguistic and cultural diversity, age, sexuality and geographic location (Broom 1998; Connell 1999). In particular, the influence of hegemonic masculinity on men’s response to chronic conditions will be explored (Connell 1999; Gerschick and Miller 1995). Only men who have moderate to severe chronic illness will be recruited as participants. ‘Healthy’ men may be operating under different forms of masculinity and be unable to accurately predict how they would behave if they developed a chronic illness.

2.4 Men’s health issues

In recent years there has been growing concern about men’s health because of their poor health statistics as a social grouping. Compared to women, men have been found to die younger, experience higher rates of accident and injury, suicide more often, and use health services less often (Courtenay 2000a; Huggins 1997). While health profiles vary in different regions, the high incidence of avoidable health problems in men’s health profiles remain consistent.

Issues relating to men’s health status form part of the broader context of this thesis. Therefore, it is important to note that while there are reported cases of gender bias and misinterpretation of results in studies of health status (Wingard 1984; Pease 1997b; Courtenay 2000b), and some contradictory studies (Verbrugge 1985; Waddell and Float 1986), there is overwhelming evidence of
gender differences, with men consistently demonstrating poorer health statistics (Wingard 1984). While some researchers have argued that the health differentials are biologically based (Harrison et al. 1992), others note the influence of gender on employment options, sporting activity, participation in health protective behaviours (Broom 1998; Naslund 1997; Weiss et al. 1996), and tendency towards risk taking behaviour (Baum 1986; Broom 1998). There is also some evidence that gender differences in health interact with social factors (Courtenay 2000b), such as income (Woods 1997; Hayes 1998; Ziguras 1998), age (Nathanson 1977), trends in the social acceptability of certain behaviours (Waldron 1995), marital status (Avnet 1967; Wingard 1984), and sexuality (Hart and Flowers 2001).

Health issues are also exaggerated for Aboriginal/Islander men. “Approximately 120,000 Australian men identify as Aboriginal or Torres Strait Islander peoples” (Commonwealth Department of Human Services and Health 1996:29). Their life expectancy is approximately 20 years less than an Australian non-Aboriginal male (Healthlink 1997; Woods 1997). While it is difficult to obtain accurate population estimates because of varying definitions of Aboriginality and methods of collecting data (Baum 1998; Miller 2002), the significant differential between non-Aboriginal and Aboriginal Australians is clear. Health studies that include both Aboriginal and non-Aboriginal Australians at different life stages, need to acknowledge that this differential will limit the scope for comparison or meaningful generalisations.

Living in rural and remote areas introduces additional pressures on the health of Australian men. Many will be dealing with decreasing profitability, increasing poverty, high unemployment, declining population, rising suicide rates and high rates of accidental injury and death (Baum 1998). About 26% of Australia’s population live in rural areas and only 3% in remote areas. The Aboriginal community constitutes a significant proportion of the population in the rural (3%) and remote areas (23%) (Australian Bureau of Statistics 2002). According to Torzillo and colleagues, “While Aboriginals as a nation experience a poor health profile, there are significant differences in the patterns of illness seen between urban and remote area communities” (1992:199).
Conversely, Baum (1998) reports that overseas-born Australians generally have better health status than those born in Australia (see also National Health Strategy 1992; Powles and Gifford 1990). However Baum does caution that, “data from self-reported health and illness surveys may be less reliable for immigrants as they may not be culturally sensitive” (1998:195-6). This overall pattern masks some interesting variations between different groups of migrants. Some diseases are more common among migrants than among those born in Australia. Examples include some genetically determined disorders and some infectious diseases such as Hepatitis B and tuberculosis. “Refugees are a special category of migrants who may have particular types of health problems. Some refugees have been victims of torture and, as a result, may often experience mental health problems (UNCHR 1995)” (1998:196).

Men who do not practice heteronormative sexuality, may be confronted with additional health problems. As noted by Hart, “A gay man is not only exposed to the same risks as other men of the same social class, education, region or origin and ethnicity, but he has to contend with additional, gay-specific, health risks” (2001:225). These risks relate not only to sexual health issues but also to the risks that arise from homophobic elements in society, increasing the potential for social ostracism, assault and/or discrimination in health service provision, with the associated physical and mental health implications (Commonwealth Department of Human Services and Health 1996). This illustrates how some men may live in a state of tension with hegemonic masculinity (see section 2.3.2: Hierarchy of masculinities and how this conflict between societal and personal views of ‘acceptable’ forms of masculinity can have significant health implications.

Ageing of the Australian population is contributing to an increase in the prevalence of chronic disease (WA Research Unit 2000). Given the interaction between chronic illness and masculine identity as discussed in section 2.3.3: Chronic illness and masculinities, issues associated with healthy ageing are likely to become an increasingly important factor in men’s health.
The interaction between gender and other social determinants of health will be addressed in this thesis by exploring attitudes towards relevant health behaviours, with participants from diverse social groupings.

Gender differences in levels and patterns of service use will be discussed below to demonstrate that the issues being explored within the context of chronic illness self management programs are a widespread health phenomenon.

2.4.1 Different levels of health service use

Lower male participation rates in health service use seem to be a widespread phenomenon, as indicated by the Australian National Health Survey in 1995 which showed that women were more likely than men to take some kind of health action (80.1% compared with 70.3% of men) (Australian Bureau of Statistics 1996), including the use of health services. “Except for visits to outpatients and emergencies, and for physiotherapist/hydrotherapist services, the rate for women exceeded that of men for all health services” (Baum 1998:200). Mathers also reports that “Working age women report 40% more hospital episodes, 35% more doctor visits, 16% more outpatient visits, 24% more dental visits and 25% more other health professional visits than working age men. These differences are broadly consistent with health service utilisation patterns reported from administrative data collections” (1995:22). However, Broom (1991) in her review of the literature does draw attention to limited evidence that the sex difference is minimal in rates of consultation for serious conditions such as cancer.

Gender differences in service use are not restricted to Australian services. Courtenay (2000b) reports that the phenomenon is so widespread and accepted in American society, that men’s under use of services is accepted as the norm and women’s health promoting behaviours are viewed as excessive, thereby reinforcing men’s avoidance of health services. “In contrast, in some non-Western societies, discrimination against females has prevented them from obtaining as much medical care as males, and this type of discrimination has been linked to gender differences in roles and power” (Waldron 1988:204).
It is important to examine why gender differences in health service use exist so that, as suggested by Broom, they can be taken into account in planning health services:

Compared with men, women may engage a different process, or invoke different criteria, in the decision to take illness-related action such as consulting medical professionals, reducing activity, taking medicines, or going to bed. Once again, this difference need not be construed as a problem, but can instead be understood as a variation with costs and benefits to all concerned, which could usefully be taken into account in planning health services (1991:51).

This thesis will include an in-depth qualitative analysis of men’s attitudes to chronic illness self management programs to arrive at a clearer understanding of barriers and motivations to program use. This will help to identify ways to develop acceptable and accessible programs in future.

2.4.2 Hegemonic masculinity versus positive health behaviour

A common explanation for the gender difference in use of health services is the conflict between health behaviour and hegemonic constructions of masculinity. Men are expected to not show pain, to be self-sufficient and not appear weak (Baum and Cooke 1986; Nathanson 1975; Verbrugge 1985). Pease (1997a) draws on a range of studies when he identifies the relevant aspects of masculinity as being: the association of masculinity with physical strength and instrumental competence; the socialisation of men to ignore the needs of their bodies; and fear of an association between femininity and involvement in health services. Hegelson (1995) reported a negative, and often hostile attitude among some of the men in her study towards doctors, hospitals, and having to ask for help. Courtenay suggests that this aversion to seeking help from health services also arises from cultural beliefs that “men’s bodies are structurally more efficient than and superior to women’s bodies” (2000b:1389).
The notion of a tension between masculinities and help-seeking for illness was
developed further by Courtenay who suggested that health-related beliefs and
behaviours can be a means of constructing or demonstrating gender. As a result,
"masculinities are defined against positive health behaviours and beliefs"
(Courtenay 2000b:1389). Courtenay noted that this might be more pronounced in
marginalised men who have limited resources for demonstrating their masculinity.
This not only means that men are likely to avoid seeking help for pain or illness to
try to appear strong; as a result of socialisation, they may even fail to be aware of,
or recognise, feelings and symptoms that they perceive as signs of weakness
(Hegelson 1995).

There is a suggestion in the men’s health literature that women find it easier to ask
for help because they are more accustomed to a dependent role (Morris 1993;
Pease 1997b; Cameron and Bernardes 1998). This does not recognise the
variability in women’s response to illness - some women are, like many men,
uncomfortable seeking help (Elliott 1996). Nor does it explore the range of
possible meanings that women attach to help-seeking behaviour, such as a
perception that ‘asking for help’ is a way of being assertive, taking control and
making something desirable happen, rather than being a dependent, inferior act.
This alternative perception of help seeking was evident in wives’ comments in the
interviews for this thesis, as discussed in section 5.1.4: “We’re expected to be a
kind of rock of strength for others”.

Some men do consistently adopt positive health behaviours and are proactive in
managing their health. However, according to Courtenay (2000b), the form of
masculinity demonstrated by these men is not among the most common forms
enacted by men and is not representative of hegemonic masculinity. Elsewhere in
the literature, the engagement of self-management practices to improve health
outcomes as a reaction to a serious and/or long term illness is described as using
hegemonic masculinity as a resource, as a way of ‘taking charge’ (Cameron and
Bernardes 1998). In this sense, ‘taking charge’ by adopting self-management
practices, represents a reformulation of masculinity (Gerschick and Miller 1995),
rather than a rejection of hegemonic masculinity constructs as implied by
Courtenay (2000b). This suggests that organisations providing chronic illness self management programs need to be more tuned in to the ways that gender and health link together (Cameron and Bernardes 1998).

In fact, health organisations may have a role in encouraging a reformulation (Gerschick and Miller 1995) of masculinity constructs. Dominant masculine imagery has been used successfully in health promotion initiatives targeting men (see section 2.5). By supporting a reliance on hegemonic masculinity these strategies encourage men to engage in positive health behaviours that would otherwise be associated with femininity. Adaptation of programs to current dominant constructs of masculinity represents a reorientation of health services as advocated by the Ottawa Charter for Health Promotion (World Health Organisation 1986). However, caution should be used in the application of these strategies. As discussed in section 5.2.8: "That's advertising, that's hype", links with hegemonic masculinity can be alienating for men with a chronic illness if they have been forced to reject or reformulate their masculinity values in response to the impact of the condition on their lives and thus no longer align themselves with hegemonic masculinity (Gerschick and Miller 1995).

These issues of hegemonic masculinity and men’s concept of health represent socio-cultural barriers to health service use by men. Structural issues such as inflexible work environments can also cause difficulties for men needing to access services. It has been suggested that gender differences in employment options lead to a greater degree of inflexibility in the working lives of men. Charmaz suggested that job flexibility is more of a class issue than a gender issue. "Most working-class jobs permit little flexibility. Middle-class jobs, in contrast, allow men more control over timing, scheduling, pacing, and using space during work” (1994:285). Waldron (1995) explored the impact of job flexibility on help seeking behaviour by reviewing a range of relevant studies, including; a study by Marcus and Siegel (1982) who found evidence of only a modest contribution from employment status to gender differences in physician visits for chronic illnesses; studies that demonstrated there is no consistent difference between the help seeking behaviour of employed women and of housewives (Cleary et al. 1982; Nathanson and Lorenz 1982); and studies showing that women are just as likely as men to report
inconvenience in arranging time for a physician (Verbrugge 1982; Waldron 1983). Waldron concluded that flexibility in employment and other role obligations are not the main source of gender differences in physician visits. These findings support the social constructionist perspective of this thesis that acknowledges the interacting influences of dominant social constructions of masculinity and other social determinants on health behaviour, rather than a focus on structural issues alone.

It might be expected that the apparent incompatibility between positive health behaviours and masculinity would only apply for men who identify with hegemonic masculinity. However, the earlier evidence of gender differences in health status and in utilisation of health services does suggest that the influence of hegemonic masculinity impacts upon the health behaviour of many men. This thesis will explore ways of developing self management programs that address the constraints of hegemonic masculinity, thereby increasing men’s access to chronic illness self management programs.

2.4.3 Crisis care

The general reluctance among men to use health services inevitably results in a ‘crisis care’ approach to health services, i.e. a tendency for men to wait until their condition has reached crisis point before seeking help (Cameron and Bernardes 1998). Button reported that, “A study of Australian men being treated for impotence found almost half waited more than a year to seek help - despite the severe impact it was having on their lives” (1999:3). Delays in help-seeking for impotence may have been linked to the importance of sexual performance in dominant social constructions of masculinity. Men may have been reluctant to acknowledge their condition for fear of undermining their masculinity status.

However, there are other studies such as Verbrugge (1985), Waldron (1988), Mor and colleagues (1990) and Broom (1991) reporting that gender variations in response to illness become less marked when the condition is more serious.
Baum and Cooke (1986) suggest that this tendency for men to delay help-seeking may arise because they often have a support service at home in the form of wife/mother. This reflects the traditional gender roles of the male as 'breadwinner' and the wife as 'homemaker/mother'. These patterns are shifting in Australian society but have a continuing influence in many households (Commonwealth Department of Human Services and Health 1996).

Delays in help seeking may also be linked to men’s concepts of health, as described by Watson. He conducted a series of 90 in-depth unstructured and semi-structured interviews with 30 men and found that their definitions of health: “were essentially pragmatic and grounded in the need to fulfil everyday gendered obligations” (2000:67). He explained this further by reporting that:

What is striking about the ways in which informants talked of ‘being fit’ is the possibility that, as used by the men in this study, fitness may have a significance beyond the rather narrow medical or health educator’s concept of physical and (to a lesser extent) mental fitness. That is, fitness as a concept has a social dimension by which the men in this study measure their ability to undertake the social obligations to work, partner, family, friends and community that are made explicit in the ways in which they articulated ‘male’ roles (2000:70).

Watson’s findings suggest that men’s perception of when it is appropriate to seek help is closely linked to their capacity to fulfil their work and social commitments, i.e. as long as they are able to work, they are fit. Age was also relevant to this concept of health. Watson (1993; 2000) reported that the men expressed a belief in the body’s ability to heal itself that only becomes impaired with age and injury/illness wearing the body down. This may mean that men access services more readily when they are older. Alternatively, it could mean that men avoid accessing services because doing so would suggest that they are ageing.

Watson’s concept of self-mastery over health was supported by Saltonstall who conducted a study into concepts and practices of health involving white, middle-class, middle-aged male and female participants. Saltonstall reported that:
Men frequently referred to healthiness as 'keeping' or 'being in control' and 'minding' one's body. Men seemed to imagine themselves as having a 'power over' relationship to their bodies (1993:9).

This sense of self mastery over health is likely to work in opposition to help-seeking health behaviours.

Broom challenged the popular notion that men are prone to ignore symptoms, and that men's poorer health status is a result of their reluctance to seek medical care. She noted that, "...a recent American study found that women who have symptoms of a heart attack are more likely than men to delay calling an ambulance (Meischke et al. 1993)" (1995:3). This indicates that health behaviour may also be linked to expectations - women are believed to be less likely to get heart attacks and are therefore less likely to treat symptoms seriously. Therefore, the likelihood of delaying seeking care until crisis point is reached may be dependent upon the nature of the condition and perceptions of personal risk for that type of condition.

Decisions about whether to access health services may also be influenced by other social factors, such as affordability (particularly in relation to services not covered by Medicare) (Baum 1998; Ziguras 1998), and cultural beliefs. For example, Leahy (1997), adopting a term used by members of the Aboriginal community, reported that Aboriginal men are afraid of seeing a doctor in case they are told they have a 'bad sickness', need to go to hospital, or are going to die. This leads to poor attendance of Aboriginal men at health services.

2.4.4 External influences

The expectations and responses of others have an important role in validating an individual's choice of masculinity. This external influence appears to extend to illness behaviour. Cooling and Sladden (1997) suggest that men are often treated differently by general practitioners, especially male doctors, with a "She'll be
right mate!” attitude. This is supported by Courtenay’s (2000a) review of a range of studies that showed that clinicians spend less time with men and provide them with fewer and briefer explanations. They are also less likely to diagnose depression in men (Courtenay 2000b). Similarly, Thoreson and colleagues’ study of male counsellors showed that:

Despite their low endorsement of the overall norms for the traditional male role, even at this low endorsement level, the traditional attitudes and beliefs regarding masculinity were found to relate to… seeing male clients as having career concerns rather than personal concerns (Thoreson et al. 1993:314).

Broom (1991) in her review of women’s general health care studies, reported that doctors were more likely to be condescending in response to women patient’s questions, providing less technical responses and defining women in terms of their domestic roles. These studies of men’s and women’s health care may reflect an overall tendency for health providers to treat patients according to hegemonic expectations of the social behaviours and social obligations of men and women.

However, earlier research on gender difference in patient care indicated that there was no gender bias. Waldron reviewed various studies and concluded that there is “little gender difference in physicians’ recommendations for a given condition” (1988:203). Similarly, Verbrugge (1985) argued that other than some minor studies, there is no compelling evidence to support reports of gender bias in physician diagnoses and treatments.

Research does indicate that significant others can have a positive influence on men’s health care seeking behaviour. A study of the influence of women on the health care-seeking behavior of men, found that “women play a potentially critical role in encouraging men to seek primary care and other health services” (Norcross et al. 1996:479). In a study by Pinnock, O’Brien and Marshall, “The wife was commonly stated as a trigger in seeking assistance… The women’s groups also confirmed this role for women” (1998:372). Cameron and Bernardes also found evidence of “common gender role assumptions about concern and responsibility
for people’s health being generally and properly the domain of women. Some men acknowledged this as being both the norm and how they themselves behave in their families” (1998:678). Women as an influencing factor will be explored further in both the quantitative and qualitative phases of this thesis.

Gender differences in levels of health service use support the need for a gendered approach to health which explores the reasons for the differences, including the influence of others, and ways to ensure services are accessible across the community. This is the approach being taken in this thesis.

2.4.5 Different patterns of health service use

Not only do men seem to utilise health services at different rates to women, they also seem to use them in different ways. This is evident in a range of studies, as described below, and is explored further in Chapter Four, Quantitative Findings. Identifying gender differences in patterns of health service use will assist in developing self management programs that meet the needs of men with a chronic illness.

According to Walker, when men do present to health services they tend to express their problem in ways that fit social constructions of masculinity. For example, “I’m so busy with work that I’m always tired and have no time to talk at home (i.e. I can’t communicate with my family). My wife is unattractive (i.e. I have a sexual problem)” (1986:53). This supports the contention of this thesis, that dominant social constructions of masculinity have a significant role in influencing the way men approach health services.

Hegelson (1995), in her review of a range of studies of rehabilitation programs, reported that men, particularly those that situate themselves within a hegemonic model of masculinity, are less likely to identify with other patients, compared with women; are less likely to attend support groups; and are more likely to choose to exercise with healthy people rather than other patients. These findings have implications for the relevance of Arthritis Victoria’s services to men. The services
explored by Hegelson, that is exercise classes and support groups, are among the self management programs offered by Arthritis Victoria.

Other examples of gender differences in patterns of service use, according to Banks (2001), include women’s preference for health information from peers, magazines, books and television. Men were less likely to rely on the experience of their peers. Health promotion information from leaflets and advertising was more likely to be accessed and responded to by middle class men rather than working class men. Courtenay (2000b) reports that men use substances to a greater extent than women although there is limited understanding of the reasons.

It is important to be aware that although social constructions of masculinities have a central role in relation to health management behaviour, they may not always be the dominant influence. Cameron and Bernardes caution that, “Gender or masculinity may not always be central in men’s perceptions of their identity or in their interaction. So it is vital to be cautious about assuming too much about the impact of gender in all settings and for all men at all times” (1998:688).

Therefore, other social determinants may be more instrumental than masculinity in influencing certain health-related behaviours at certain times. Saag and colleagues (1998) report that urban/rural status may be an important factor in service utilisation early in the illness pathway. Rural status can also be a factor in the reluctance of Aboriginal and Torres Strait Islander men to attend health services to discuss their health problems, “... in many rural and remote areas, this is because men’s health is Men’s Business, and the involvement of women in care and treatment may be inappropriate” (Commonwealth Department of Human Services and Health 1996:30; Saag et al. 1998).

Thus, according to the literature, it appears that social constructions of masculinity have a significant influence on the ways in which men use health services, in interaction with other social determinants such as socio-economic status, cultural background, age, geographic location and sexuality. This social constructionist perspective will be applied to the study of men’s access to self management programs in this thesis, although Rogers and colleagues note that it
is difficult to identify which social groups are likely to undertake self-care because, "Empirical results regarding socio-demographic characteristics as correlates of self-care are inconsistent" (1999:136). Pescosolido also cautioned that using social demographics to measure patterns of behaviour "falls into the structuralist trap of a static and homogenous view of culture. Social characteristics can be bad proxies for social networks except under conditions of network homogeneity" (1992:1108). However, she also acknowledges that it is recognized in the sociology literature that "most social interaction does, in fact, occur between and among persons who are members of some common group" (1992:1108). This allows for the identification of the influence of social determinants on health behaviours as they emerge from the data, provided broad assumptions are not made about their influence, and the interacting influences of other social and structural elements of the environment are acknowledged.

Similarly, identifying the varying influences of different constructions of masculinity can be problematic. However, it is likely that, in relation to health behaviour, all masculinities are constrained by existing social constructions of hegemonic masculinity.

These issues were explored in the research for this thesis by recruiting across different social groupings and, within the limitations of the methodology, across different constructions of masculinity.

2.5 Health promotion initiatives targeting men

As a first step to considering what measures health organisations need to adopt to increase men's access to health programs, it is useful to explore what measures have been taken by other health initiatives and to learn from their experiences. To this end, a review of health promotion programs that have targeted men was conducted to identify strategies successful in attracting male participants. This review was undertaken from a social marketing perspective which is discussed in section 2.5.1: Social marketing. It is intended to be a representative rather than a comprehensive review. Extracts from this review formed part of a Men's health
chapter, submitted for publication in *Hands on Health Promotion* (Gibbs and Oliffe forthcoming 2004).

2.5.1 Social marketing

The review of health promotion programs targeting men was conducted in reference to social marketing principles (Blair 1995; Strauss and Corbin 1990):

Social marketing and health promotion are similar in that both attempt to change behaviour or reinforce existing behaviours. Health promotion generally focuses on the health needs of the individual as identified by the health promoter or epidemiologic data. This produces a scientifically sound program, but if it is not sensitive to consumers’ needs it is unlikely to be embraced by the intended target group (Blair 1995:528).

The statement above by Blair, that social marketing by being sensitive to the target group is likely to be more effective than a simple promotion of health messages, is supported by Watson (2000) who suggests that health promotion does not consider the lived experiences of the individuals being targeted, and thereby risks being irrelevant and ineffective. Piper (1997) supported a social marketing approach rather than the biomedical, prescriptive approach of ‘well men clinics’. He suggested ‘well men clinics’ place responsibility for health on the individual and in doing so fail to recognise structural influences on health, and socio-cultural influences such as masculinity constructs on health behaviour. Similarly, Huggins noted that “Health promotion strategies continually target the behaviour and miss the fundamental issue of the social construction of gender and the way the culture dictates the way people behave” (1995:212). For this reason, social marketing is likely to be a more useful approach in the targeting of chronic illness self management programs to men, and is more consistent with the social constructionist perspective of this thesis.

Social marketing relies on an understanding of the social issues for the target market when considering a particular concept. This understanding of the
motivations of the target market is then used to develop an approach based on the traditional business marketing mix of product, price (benefits vs costs - economic, social, behavioural, psychological, geographic and physical), promotion, and place (distribution channels) (Blair 1995). The concepts of social marketing will be drawn upon in this thesis to both evaluate existing men’s health promotion initiatives and to develop strategies for the targeting of chronic illness self management programs to male clients.

Patterns of strategies used to target men were apparent in the review of men’s health promotion initiatives, when considered in relation to the social marketing mix of product, price, promotion and placement. In the context of this review the elements of the mix were best described as:

- Linking the health message with priority issues for men
- Different ways of talking about health
- Different settings for health programs
- Different ways of distributing health promotion information.

### 2.5.2 Linking the health message with priority issues for men

Due to socio-cultural and structural barriers to men’s involvement in health behaviours, health management is often given a low priority by men. Precedence is given to work, family responsibilities, and often leisure activities. Identifying issues of concern to men and linking the health message with one of those priority areas can be an effective way of demonstrating that the ‘product’ is relevant to men. For example, a Quit smoking campaign that targeted men in the Greek community in Sydney, Australia, focussed on the protective nature of the male towards his family by questioning who would look after his family if he died (Taylor et al. 1998). A similar approach was used in an advertisement in the New York Times (St Vincent’s advertisement 2002). It promoted the use of stereostatic radiosurgery for lung cancer by showing an image that suggests a father-son relationship, linking parental responsibility with use of the health service (see Figure 1: Advertisement for radiosurgery).
"I have lung cancer."

Stereotactic Radiosurgery lets me get on with my life.

At St. Vincent's, we've created a patient-centered, compassionate and accessible cancer center with the most advanced radiation, chemotherapy and surgical options. The combination of all the latest technologies is AVAILABLE ONLY at ST. VINCENT'S — providing the most effective treatment, with virtually no side effects or damage to healthy tissue.

St. Vincent's is one of the few Varian Learning Centers in the U.S. — leading cancer specialists from NY and across the U.S. come to St. Vincent's to observe how the latest advanced technologies like Respiratory Gating and IMRT improve patient outcomes and quality of life.

Let us help you or someone you love.
For information and a free brochure, call 1-888-44-CANCER (1-888-444-2623).

St. Vincent's Comprehensive Cancer Center
www.svccc.org
328 W. 13th Street, New York City (between 3rd & 9th Aves.)

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Figure1: Advertisement for radiosurgery
Egger initiated the Australian ‘Gutbusters’ program after talking to men in the Newcastle Steelworks about their beer bellies. Egger found that overweight men were more concerned about the appearance of their pot bellies, rather than the health implications of being overweight. Smith reported on Egger’s findings after talking to overweight men:

Telling men they should worry about diet and blood pressure will get you nowhere. But all men want to look good, and once you get rid of the pot belly you’re well on the way to solving heart, diet and blood pressure problems as well (1994:60).

As a result, Egger developed ‘Gutbusters,’ a weight loss program for men, which has recruited over 50,000 men since its inception (Gutbusters 1999). Gutbusters focuses on men’s body image to encourage them to change their eating and exercise patterns. The logo reflects the program goals (see Figure 2: Gutbusters logo). The lettering of the ‘G’ and the ‘B’ in the Gutbusters masthead mirrors the large belly of the cartoon image of an overweight man standing next to it.

![GutBusters logo](image)

**Figure 2: Gutbusters logo**

Men’s fitness and health magazines also commonly focus on desirable body image and/or performance to promote health messages (Baker 2001b).

### 2.5.3 Different ways of talking about health

According to dominant notions of masculinity, health services and positive health behaviours are linked with femininity (Pease 1997a). The health initiatives
targeting men as reviewed in this study sought to offset this perception by aligning the health program with heteronormative, hegemonic masculine behaviour. This reduces the ‘price’ of attending by minimising the perceived threat to masculinity. It is achieved by various strategies such as making the programs gender specific, adopting language traditionally associated with men, linking the program with hyper-masculine activities, and avoiding the health message.

The primary technique used by the health promotion programs to reach men was to simply establish a men’s program. This straightforward technique seems to be particularly useful in raising men’s awareness of the personal relevance of the program. Gutsbustes even goes as far as saying “Men are different” - clearly making a distinction between men’s and women’s weight loss programs. They also use headings such as “Judges, Doctors and Wharfies” (Gutsbustes 1999), in an effort to include all classes of men while still referring to occupations traditionally constructed as ‘men’s jobs’.

Secondly, the use of male-friendly language in the promotional material was a favoured technique in reaching men, often incorporating the use of humour. The ABC television series called The Problem with Men (Beyond Productions Pty Ltd & The Australian Broadcasting Corporation 1997) used humorous banter between two ‘mates’, comedians John Clarke and Brian Dawes, to steer viewers through potentially confronting men’s health issues. Kehily in her study of the role of humour among young men in school argued that humour, particularly using disparaging remarks, is a technique for the enactment of masculine identities (Kehily 1997). Similarly, Lyman (1987) described the use of humour to establish male group bonding in a University setting.

However, different ways of talking about health most commonly took the form of mechanistic symbolism, such as the ‘Mechanical Man’, an image of a part machine, part man that was used in a national health promotion campaign in the United Kingdom to encourage men to have ‘maintenance’ checks (National Health Service ) (see Figure 3: Image of “Mechanical Man”). A health education program conducted in Alice Springs targeted middle-aged men by promoting the

Figure 3: Mechanical Man
health checks as a ‘chassis check’ (Mabbutt 1998). A program promoting health checks for men in Western Australia also relied on mechanistic metaphors, advertising the health checks as a ‘Pit Stop’. “We’re trying to prompt them to take preventative maintenance on their own vehicle, their own body, so to speak, because we recognise the fact that they do that for their cars, their vehicles,” noted Alston (7.30 Report 2001).

The Tune Up for Life program, a Pfizer sponsored men’s health initiative, incorporated a Tune-Up Van as a mobile site for health checks, Tune Up for Life men’s health seminars and Tune-Up leaflets in doctor’s waiting rooms. The advertisements for this program used mechanistic metaphors and informal language such as, “Dealing with clogged pipes”, “Getting out of permanent overdrive”, “Clearing the sludge in your pipes”, “How to avoid getting stuck in neutral”, “Learn how you can keep running on all cylinders”, plus “Heaps of useful stuff to take away with you”.

This mechanistic imagery is compatible with hegemonic masculinity by being linked with machinery and car maintenance, areas traditionally associated with ‘acceptable male behaviour’ in a heteronormative environment. It is also consistent with people’s concepts of health, as reported by Saltonstall (1993). Following interviews with white, middle class, middle aged men (9) and women (12), it was found that health was seen as being achieved through maintenance:

This conceptualization refers to the contemporary notion that the body is like a machine and must be maintained because it is believed to be subject to ageing, deterioration, disease, and abuse by oneself and others (1993:10).

However, the personal relevance of these mechanistic images to all men cannot be assumed. The multiple masculinities noted by Connell (1999), mean that not all men have an affinity to cars and car maintenance. The ‘Mechanical man’ advertising campaign in the United Kingdom, referred to above, used the slogan “Just what everybody needs: a maintenance manual for a healthier nation”. Significantly, this advertisement was referred to in Watson’s (1993) qualitative
study in north-east Scotland of 30 working class and middle class men aged 30-41. The image was criticised by some of the participants because it showed a perfect body that was not achievable but was an ‘oversimplified’ or inappropriate representation of the masculine body. They saw it as a desirable object, perhaps with homoerotic associations. However, the author also noted elsewhere that participants use mechanical metaphors when referring to the body, and having control over it. It is not clear from Watson’s report whether these contradictory responses were from the same or different respondents.

A number of health promotion programs also used prominent sports celebrities as an alternative or additional measure to attract male participants. Dick Johnston, a former Australian racing car driver, is the spokesperson of the Tune Up for Life program. Similarly, Joe Namath, a football legend in the USA, was the face of an arthritis health promotion campaign, called “Arthritis Huddle™”, developed by pharmaceutical companies to accompany the release of new arthritis medication. The health messages were couched in football terminology such as “developing a winning game plan” and are delivered by Joe Namath:

As quarterback of the Arthritis Huddle, I hope to get everybody off the sidelines and motivate patients and doctors to team up and take a proactive approach to treating their osteoarthritis. We may have a lot to overcome, but I know from experience, that the keys to victory are determination and teamwork (Boehringer Ingelheim Pharmaceuticals and Abbott Laboratories 2002).

As sporting success, particularly in sports such as football, is a means of demonstrating hegemonic masculinity (Sabo and Panepinto 1990; Whitson 1990), this use of a sporting celebrity and sporting terminology ties the health message in with ‘acceptable’, heteronormative male behaviour.

Information about supporting research and/or endorsements, and money back guarantees, are also used by programs such as Gutbusters to support the value of the program, and thereby minimise the perceived ‘price’ in terms of time wasted or negative results.
In rural areas, the involvement of community leaders is another measure used to enhance the credibility of programs such as the Men’s Health Nights (Gibson and Dennen 2000). The Men’s Health Nights were conducted as part of the MAN Model, a model for men’s health promotion in rural Australia. These nights, like many others, used an introductory information session format to allow men to collect information quickly and anonymously. Many men are wary of programs that involve the sharing of personal information because it is not consistent with social norms about ‘acceptable’ masculine behaviour and boundaries regarding intimacy and self-disclosure of vulnerability (Pease 1997a). Gutbusters involved an initial six week program and then monthly support over a 12 month period. The ongoing component was provided as an at-home kit with phone support, which ensured anonymity and minimal loss of face if the program was not completed. In his review of Britain’s National Health Service Helplines, Banks (2001) discussed the merits of an anonymous, confidential service for men. Anonymity allows men to maintain a distance from the perceived feminising association with health services (Pease 1997).

2.5.4 Different settings for health promotion programs

Health settings are often unfamiliar environments to men because of a tendency to under-utilise health services (Australian Bureau of Statistics 1996; Baum 1998; Courtenay 2000a). They can also be perceived by some men to have feminine associations because they are linked with help-seeking and admission of vulnerability, characteristics to which hegemonic masculinity is opposed (Courtenay 2000b; Pasc 1997a). For this reason, some health initiatives sought to distance themselves from those environments and to relocate to ‘male-friendly’ environments, that is, environments that are linked with behaviours that are perceived to be acceptable in terms of hegemonic masculinity. This ‘placement’ is likely to be more accessible to men. For example, the growing popularity of golf in Europe was identified as a way of reaching men with the message about preventive healthcare. Pfizer, a pharmaceutical company, sponsored the establishment of Men’s Health Centres at Ryder Cup qualifying golf tournaments.
to provide health checks and sexual health education to men attending the
tournaments. Over one million people attend the Ryder Cup tournaments, 60 per
cent of which are men. Pfizer anticipated providing health checks to
approximately 10,000 people over the course of the 12 tournaments throughout
Europe.

Men’s Health Nights, organised in Australia as part of the MAN Model, were
usually held at social or recreational venues such as the local pub or golf club,
rather than a community health or medical venue. Collectively these nights, held
predominantly in rural locations, have attracted in excess of 8,500 Australian men
from diverse social groupings (Gibson and Denner 2000). Similarly, the Pit Stop
program in Western Australia was positioned at the entrance to drag racing meets
on the highway in remote areas of Western Australia, encouraging men to
undergo health checks before they enter. Taking services to where men already
are, rather than expecting them to attend existing services, is more likely to
encourage high attendance (Fletcher 2001).

Some programs have been successful conducting health promotion programs in
the workplace. This is an important consideration given the importance of work
for men in our society (Hegelson 1995; Watson 2000). Following the introduction
of a workplace-based men’s health project in Tasmania, Were reported that “given
the right approach, opportunities and organisational support, rural blue-collar men
will participate in health promotion activities at their workplace” (1997:411).
However, Were also noted the associated problems of unavailability/varying
support from management, lack of suitable testing area, unreliable equipment at
unreasonable costs, poor availability of general practitioners and specialists, and
distance to travel for some workers. Similarly, Gibson and Denner stated that:

The ultimate success of these programs depends largely on the willingness
and capacity of the employers to support men’s health programs in the
workplace, in terms of organizational change, attitude and resources
There is potential for men to avoid attending health programs in the workplace in order to protect their privacy and avoid any stigma associated with having a chronic condition. This was raised by some of the men interviewed for this thesis (see section 5.1.1: "Nobody wants to be in a position of vulnerability"). However, workplace programs do help to overcome the practical barrier of attending health programs in work hours. Adjusting the timing of programs can also help to increase accessibility by choosing a time that allows men to attend outside of standard business hours. It was not considered possible to review issues relating to workplace programs within the parameters of this thesis. However, issues relating to the timing of programs was explored in section 5.1.7: There's no space for it.

'Enter-Educate' is a term derived from the words 'entertainment' and 'educate'. It is used to describe the delivery of pro-social educational messages using an entertainment medium (Robey et al. 1998). In French-speaking African countries this approach has been used to deliver a family planning and HIV/AIDS prevention message to men in a context that is socially acceptable:

In many French-speaking African countries the national population policy does not specifically address men, which makes it difficult to gain support for men's programs. Often, cultural and religious opposition to family planning/contraception make it difficult for family planning to be discussed in public. Men's attention can be attracted by using an entertainment format - the "enter-educate" approach - which has proved effective in many countries (Robey et al. 1998).

In Africa, music has a powerful role that operates across borders, cultures and languages. The "Wake Up Africa" campaign harnessed music as a medium for reaching men and educating them about HIV/AIDS prevention (Robey et al. 1998). It was conducted in French-speaking African countries and involved a music program on the theme of HIV/AIDS prevention, featuring 30 African musicians. It was supported by a live concert, a music video, a CD, an audio cassette, multi-media coverage and merchandise.
Are you playing the game right?

When you're faced with a tricky situation, you've got to know what you're doing, and make the most of your choices.

Know the difference between fact and fiction. And don't be afraid to get a little coaching.

Long term and permanent methods of family planning are designed for couples who want smaller families.

Clinics, doctors and Community Based Distributors will help you choose the right method for you and your partner.

Play the game right. Once you're in control, it's easy to be a winner.

FAMILY PLANNING... IT'S YOUR CHOICE

*Long term and permanent methods include the loop and implants. Male and female sterilization are permanent methods.

Figure 4: Are you playing the game right? Campaign advertisement
Another common technique is to distribute information through women's networks, recognising women's traditional role as the health carer in the family (Norcross et al. 1996; Courtenay 2000b). Norcross and colleagues in their study of the influence of women on the health care-seeking behavior of men, concluded that "... enlisting the support of women is seen as a potentially cost-effective means of encouraging men to utilize primary care services" (1996:479). This technique was used successfully in Australian country towns as part of the MAN Model by leaving information pamphlets about Men's Health Nights in the local women's hairdressing salons (Gibson and Denner 2000).

This of course does not address the needs of single men or those in same sex relationships. The Gay Men's Health Project at the Central Sydney Area Health Service (Millan, 1997) noted that gay men have the same health problems as straight men but because of different socialisation and the stress of living in a homophobic society, they have additional health concerns. Health care roles within same sex relationships were not discussed. In a survey of people living with HIV/AIDS, in which 93% of the sample was male and 84% reported homosexual or bisexual contact as a likely factor in transmission, doctors specialising in HIV/AIDS were cited as the most important source of information about treatments for HIV/AIDS. In addition, respondents relied on HIV/AIDS related newspapers and magazines, the gay press and HIV positive friends for information about both treatment and about living with HIV/AIDS. Partner/lover was a less common source of information about treatments (15%) and about living with HIV/AIDS (23%) (Gricerson et al. 2000).

Hart and Flowers (2001) hypothesise that despite the differences between gay and straight relationships, there is still likely to be a protective health effect from long term relationships, similar to that experienced by heterosexual men (see also Macintyre 1992). However, they do not speculate about whether one or both of the partners would take on the role of health carer in the relationship. Kitzinger and Coyle (1995) in their review of research on lesbian and gay relationships note that cohabitation is less common in same sex relationships. They speculate that this may be due to the various stresses associated with living openly in a homosexual relationship within a heterosexist society. Partners who are not
cohabiting may have a lesser role in influencing each other's health care decisions. Therefore, it may be more useful to target homosexual men directly rather than trying to reach them via their partners. This highlights the fact that consideration of other social determinants needs to be included in the search for appropriate ways to distribute information to specific groups of men. The issue of the partner’s influence on health care decisions in same sex relationships is explored further in the qualitative phase of this thesis.

In summary, the health promotion initiatives I have described are examples of the current trends to target men by using social marketing strategies. These strategies tend to reflect dominant masculinity constructs, for example by using pubs as a venue or sports celebrities as presenters. The difficulty with this approach is that it reinforces the very constructions of dominant masculinity that constrain men’s health behaviours. Paradoxically, it has been effective in changing men’s health behaviour and therefore may be a useful transitional phase with the ultimate goal being generic services for men and women that are gender sensitive. It is unclear whether this transitional approach is necessary for men with a chronic illness.

These findings are not conclusive until programs that were not successful in attracting participants are also considered. It is difficult to obtain information about unsuccessful programs because they are less likely to be the basis of conference papers, journal articles, or multimedia reports. However, the few examples described below do offer additional insights.

Malcher reports on poor attendance at one of the health screenings organised as a follow up to a Men's Health Night in Daylesford:

... it took place at the local golf club, timed to coincide with the hit off for the Saturday competition. We screened 35 men, including quite a number of younger men. Our next 4 sessions were night sessions, planned for the local Community Health Centre: 4 men attended the first of these, despite publicity. The next session was at a local pub: 40 men came. We interpreted that as a clear indication that men will go where they feel
comfortable, and so we had our next 2 sessions there also, with similar attendance (1997:459).

Malcher's experience demonstrates the importance of venue in making health programs accessible to men and supports the significance of dominant constructs of masculinity in health promotion. This issue is explored further in the research findings of this thesis (see section 5.1.9: "I like a professional environment").

Piotto (1999) also reported poor attendances at an afternoon organised as part of a "Focus on Fathers" project being organised by Noarlunga Health Services in South Australia. The design of this family day was based on informal discussions with men who used the Health Services. It was held on a Sunday afternoon, just before Father's Day, at a local sporting club. It involved free activities for Dads and their children, a speaker about parenting primary children, and a free barbecue. It was advertised via leaflets, newspaper advertisements, and local networks, but nobody turned up except other community health workers interested in how the program was accessing men. It is difficult to know why this event was not successful in attracting men but it may be because it did not include all of the social marketing mix. It was held on a Sunday afternoon, rather than an evening during the week, and did not have sports celebrities to attract participants. The social element of the barbecue set-up may also have deterred men who prefer the anonymity of an information session. Women's networks were not mentioned as a means of distributing the promotional material. As all of the Focus on Fathers events were poorly attended, it may also have something to do with excluding the mother from family activities. When Local Relationships Australia ran a night on raising boys in the area, it was well attended by both men and women.

An "Osteoporosis and Men" event, organised by Arthritis Victoria as part of Arthritis Week 2000 in Australia, was cancelled due to lack of interest. While the commonly used strategies of a gender-specific event, male images on the promotional material, and the use of a sports venue (Richmond Social Club) were utilised, there was no research into the target group before the event and in fact the target group itself was ill-defined. As such, it was a simple health promotion
activity - delivery of the health message with minimal consideration of the related social issues for that target group. Given the limited public awareness that osteoporosis affects men, a public awareness campaign may have been a more suitable first step.

The above campaigns suggest that a limited application of the social marketing mix is unlikely to result in success in attracting male participants. Adequate research into the social issues for the group being targeted, combined with a thorough consideration of all of the elements of the social marketing mix; product, price, promotion, and placement, is most likely to result in a program that is successful in reaching its target group of men.

As in most cases, there are exceptions to the rule. The Men's Health Clinic was established at Freemason's Hospital in Melbourne, Australia 1996 (Williamson 1999). It is a self-referring clinic that provides health services and conducts regular information seminars. The women patients of the Women's Health Clinic initiated the idea of the clinic. Flyers for the health seminars are sent to the women's mailing base. Men's Health Clinic flyers are sent on blue paper and the Women's Health Clinic flyers are sent on pink paper. Advertisements are also placed in local newspapers. The men's health seminars are held in the hospital and are conducted by medical staff. They have covered a range of topics including impotence, stress management, obesity, healthy hearts and prostate problems. These seminars have proven to be consistently popular with up to 70 men attending on each occasion. The health services in the clinic have also been popular. This program utilised some of the successful strategies mentioned in the above review such as the agenda being based on consumer-identified needs, distributing information via women's networks, clearly establishing a gender-specific program, using the information session format, and conducting them in the evening. However, it did not use a 'blokey' context. 'Blokey' is an Australian colloquialism used to describe a hyper-masculine approach. The use of a hospital setting is also unusual as it places the program clearly within the health context. It is possible that the men who utilised the men's health clinic and the associated information sessions, were more likely to have a chronic condition and therefore were more familiar with a health setting.
The Prostate Cancer Patients Information Program (PCPIP), conducted in Western Australia in early 1997, was another example of a program that did not rely on tactics associated with dominant social constructions of masculinity. The program involved evening sessions held at a house next to the hospice, and used medical and allied health professionals as leaders (Dale 1997). It appears to have been successful in reaching its target group as indicated by a need for a larger venue and repeat programs. The failure to use a social setting, celebrity presenters, women’s networks or a context aligned with ‘acceptable’ masculine behaviour, contradicts the review findings about successful strategies. However, it did incorporate an initial needs assessment, an evening time slot, and an information session format. The success of the program, despite limited attention to specific strategies to target men, may be due to a difference in the needs and motivations of men with a chronic illness compared to men attending a health promotion program. This is supported by the increased attendance of men at self management programs targeting people with a severe or multiple chronic conditions compared to those targeting people with mild to moderate arthritis (Lorig 2000c). Alternatively, it may not be necessary to include masculinity markers in the promotion of a program for prostate cancer because it is perceived as being a ‘man’s disease’. Exploration of this issue is particularly pertinent for this thesis because it indicates that successful marketing strategies for health promotion programs may need to be reassessed in the context of chronic illness self management programs.

The Victorian AIDS Council and Gay Men’s Health Centre conduct a range of programs for HIV positive gay men (Perri 2000). These programs are considered to be well-attended with an average of 8-10 men attending each course. The unstructured peer support programs run for about six weeks and are usually held at the Positive Living Centre in St Kilda, unless a number of participants come from another area, in which case a community centre would be used. Occasionally they conduct one-off workshops about HIV prevention in saunas and bars. The peer support programs are run on demand, which usually results in approximately ten programs being held each year. The agenda is participant driven. “Love, Sex, Plus”, a structured program, is also conducted for HIV positive men. This
program was new in 1997 and was launched as part of a relationships campaign. It attracts similar numbers to the other programs for HIV positive men, and has good ongoing attendance. Phone-based information and peer support is also available.

All of the programs provided by the Victorian AIDS Council and the Gay Men’s Health Centre are advertised via the telephone information service, word of mouth, referral from friends, and HIV specialist general practitioners. The services are well known in their target community. They are not actively promoted and masculinity issues are not considered in the structure and delivery of programs. Perri (2000) suggested that any reluctance among gay men to access health services would be more likely to arise from stigmas associated with sexual health rather than from expectations of hegemonic masculinity to display strength and independence.

These programs for HIV positive men demonstrate the importance of awareness of the social issues affecting the particular group of men being targeted, i.e. sexuality and chronic illness, rather than assuming that accommodating hegemonic notions of masculinity is appropriate for all men.

This review demonstrated that it is possible to develop health promotion programs that are accessible to men by using a social marketing approach. In most cases this was demonstrated by using marketing strategies that demonstrated a reliance or reformulation of hegemonic masculinity (Gerschick and Miller 1995). In particular, strategies such as gender-specific programs, avoidance of the health message, the manipulation of language to align the program with ‘acceptable’ male behaviour, use of a social setting, presence of sports celebrities, distribution of information via women’s networks, and an information session format, were commonly used. Demonstrated understanding of the specific group of men being targeted, appeared to be essential to the social marketing mix. It is not clear whether the strategies employed for health promotion programs are appropriate for chronic illness self management programs, as there is some indication that the needs of men with a chronic illness are different from healthy men and those with an acute illness. However, a major part of this thesis consists of a series of interviews with men, designed to identify the issues affecting men’s decisions to
participate in a chronic illness self management program. This will help to highlight which of the strategies employed successfully by health promotion programs are likely to be relevant to men with a chronic illness.

2.6 Research into men’s attitudes to health services

A number of men’s health research studies have been conducted in Australia to survey men’s attitudes to health services (Men's Health Teaching and Research Unit 1997; Millan 1997; O’Hehir et al. 1997; Piotto and Kekem 1998). These surveys provide some useful insights into men’s service needs but are not specific to men with a chronic illness.

The Noarlunga Health Service conducted a survey of men in the southern region of metropolitan Adelaide in 1998. This survey was administered by local service providers as part of their daily interactions with men. Piotto and Van Kekem (1998) report a low rate of return for the study (33 participants) but do not report on how many declined to participate. The sample was also biased as it was drawn from men already attending health services. However, the detailed information collected on each of the survey areas did provide some useful insights into service delivery issues for men. These findings showed that the men’s preferences for particular service features were remarkably similar to those identified by women in Broom’s (1997) study of women’s health centres (except of course that the men in the Piotto and Van Kekem study spoke of men-specific services). “The friendliness of staff, an informal environment, women-only spaces, and availability of support and activity groups and child care were all mentioned as valued resources that women would recommend to other services” (1997:278). Significantly, the Noarlunga survey findings also showed that men were more likely to respond to the sort of strategies being employed by the MAN model for the Men’s Health Nights (Piotto and Kekem 1998). The MAN Model is a model for targeting health promotion programs to men, operating predominantly in rural Australia. It is described in detail in section 2.5: Health promotion initiatives targeting men.
The findings of the Rural Men's Health Study (O’Hehir et al. 1997) were also consistent with the strategies used for the Men's Health Nights, in particular, the use of social venues for health programs, eliciting community support to give the program a local 'feel', and the use of female networks to spread health messages. The role of women in influencing men's decision to participate in health programs will be explored in both the quantitative (see section 4.2: Results) and the qualitative (see section 5.2.2: "Your spouse says stop complaining...") phases of this thesis. A unique outcome of the Rural Men’s Health Study was a recommendation to focus on 'family health' rather than a gendered approach to health. This may not be appropriate for chronic illness self management programs where people with a specific type of condition are being targeted, although partners/carers are usually welcome to participate as well. The Darwin Men's Health Needs Analysis showed preference for men-only services but found very low support for a social or workplace venue for health services (Men's Health Teaching and Research Unit 1997). This was in direct contrast to the experiences of the Men's Health Nights conducted as part of the MAN model (Gibson and Denner 2000). The reason for this response was not reported but it does show the importance of checking local social issues before applying existing models of health programs.

There appears to be conflicting results in the research about whether services need to operate out of business hours to be accessible to men. Support for out-of-hours services was reported by the Noarlunga Health Service survey (Pliotto and Kekem 1998), a report on Community Health Services for Men in the Southern Area of Adelaide (Baum and Cooke 1986), and the Darwin Men's Health Needs Analysis (Men's Health Teaching and Research Unit 1997). However, Baum and Cooke (1986) noted that when services were held in the evening, men were still less likely to attend. Overall, males unrestricted by work commitments were more likely to use services than working men. This is consistent with anecdotal evidence from Arthritis Victoria and is explored further in section 5.1.7: ‘There's no space for it’. Other surveys, such as the Gay Men’s Health Project (Millan 1997), report conflicting responses on this issue. The Men’s Health Report 2000 (Gibson and Denner 2000) found mixed responses overall, although men in Victoria overwhelmingly stated no when asked if they would use health services.
more if they were available after hours. There is no evidence in any of the reports of men being asked why they gave a particular response. It may be that some of the men felt that they would normally only use services when they are so sick that they cannot work, in which case the hours of operating are irrelevant. This is supported by the interview findings in this thesis, as discussed in section 5.1.11: "I got to the stage where I couldn't work".

This review of the results of other studies into men's attitudes to health services raises some pertinent issues about service features and methods of delivery. However, it is important to note that many of the studies survey specific social or geographical groupings of men, most of them survey men who are already attending a health service or program rather than those who are not, and none of the studies focus on the specific needs of men with a chronic illness. Therefore, the results of these studies are not conclusive for the subject of this thesis, but do provide some guidance for the qualitative analysis of the results.

2.7 Summary of literature review

The review of the literature has highlighted a difference in the rates and patterns of health service use by men and women, and between different groups of men. This thesis will investigate quantitatively if similar gender differences are apparent in relation to chronic illness self management programs. The qualitative phase of this thesis will also develop an understanding of the influences on men's decision to access services. The literature review indicated that men's health behaviour is influenced by a number of interacting social determinants. The role of masculinities in particular appears instrumental but difficult to define. While a comprehensive analysis of multiple masculinities is beyond the parameters of this thesis, their impact will be explored in two ways: as it relates to certain role expectations that constrain health management; and as they are raised and addressed by the men in the interviews. This in turn raises questions about how to provide health programs that are gender sensitive. The literature review showed that health promotion programs that demonstrate a reliance or reformulation of hegemonic masculinity are more accessible to men. However, it is not clear
whether these strategies would be appropriate in the development of gender-sensitive health programs for men with a chronic illness. This will be explored within the qualitative and applied phases of the thesis. The next chapter will outline the theoretical framework and research activities of this thesis.
Chapter Three

Research methodology

The research methodology adopted for this thesis utilises a combination of techniques to explore men’s access to chronic illness self management programs. Quantitative analyses are employed to establish the extent and nature of gender differences in self management service use. Qualitative techniques provide an opportunity to achieve a greater understanding of the issues affecting men’s decisions about service use. The combination of quantitative and qualitative approaches being employed in this thesis is consistent with current research directions (Annandale and Hunt 2000; Carpenter 2000). Annandale and Hunt note that:

Within the emerging ‘new’ framework it is important to consider ways in which quantitative and qualitative research can be combined so that we can look in depth at how men and women respond to and actively engage with the gender order in ways that influence their health (2000:30).

Finally, an application of the findings in a trial setting assists in the development of guiding principles for health organisations targeting men.

3.1 Research setting - Arthritis Victoria

Chronic illness self management programs are used throughout the health system to minimise symptoms and slow the progress of chronic conditions. It is impossible within the constraints of this thesis to review all chronic illness self management programs in depth. The services and client population of Arthritis Victoria were chosen as the research setting for detailed analysis in this thesis, because they are representative of the chronic illness self management environment in Australia, and because my own professional links with it provided me with the necessary background knowledge and access to data and resources (see section 3.5.4: Researcher-researched relationships).
Arthritis Victoria is a non-government, community service organisation committed to improving the musculoskeletal health of the Victorian community by empowering individuals and communities to enhance their quality of life. Self management is one of the key values underpinning the organisation’s mission statement and the organisation philosophy (Arthritis Foundation of Victoria Inc. 2000). Arthritis Victoria had also been a key player in the Commonwealth Government’s adoption of the Shared Health Care Initiative and therefore its programs are representative of the chronic illness self management programs likely to be operating under the Government policy (Commonwealth Department of Health and Aged Care 2000).

Arthritis Victoria provides a range of information, exercise, education and peer support programs which all address some aspect of self management. These services include three types of self management courses incorporating a comprehensive range of self management techniques: the Arthritis Self Management Course; the Osteoporosis Self Management Course; and the Better Health Self Management Course - a self management course for people with more than one chronic illness.

The programs used by Arthritis Victoria to achieve its mission are well supported by research (Dale 1997; Goeppinger and Lorig 1997; Lorig et al. 1999; Minor et al. 1989). However, it is pertinent that the recurring feature in all of the research supporting the use of information, education and exercise programs in the management of arthritis, is the limited representation of men in the research samples. In fact, they consist predominantly of female, Caucasian, well-educated participants with osteoarthritis (Goeppinger and Lorig 1997; Lorig et al. 1985; Minor et al. 1989). Male participation levels in the research studies range from 17% - 21%. This is even lower than the male participation rates in the Arthritis Victoria Telephone Information Service (23%), as reported in Chapter Four: Quantitative Findings. This shows that under-representation of men is an issue for arthritis self management programs.
A brief comparison of men's participation rates in various chronic illness self management programs is displayed in Table 1 to demonstrate the commonality of men's under-representation as service users. This supports the applicability of the Arthritis Victoria results with chronic illness self management programs generally.

**Table 1: Male participation rates in chronic illness self management programs**

<table>
<thead>
<tr>
<th>Program</th>
<th>Male participation rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthritis Victoria Telephone Information Service (1997)</td>
<td>23%</td>
</tr>
<tr>
<td>Cancer Helpline (Metcalf et al. 1997)</td>
<td>22%</td>
</tr>
<tr>
<td>Asthma Telephone Information Service (Irving 2002)</td>
<td>23%</td>
</tr>
<tr>
<td>Epilepsy Foundation Telephone Information Service (Adamson 2002)</td>
<td>26%</td>
</tr>
<tr>
<td>Arthritis Self Help Courses (Goeppinger and Lorig 1997; Lorig et al. 1985)</td>
<td>17% - 21%</td>
</tr>
<tr>
<td>Chronic Disease Self Management (Lorig 2000b)</td>
<td>40%</td>
</tr>
<tr>
<td>Living with Cancer (Todd 2001)</td>
<td>33%</td>
</tr>
</tbody>
</table>
The comparison of participation rates shows that men are under-represented as users of a range of chronic illness self-management programs. There appears to be a higher rate of participation in the Living with Cancer and the Chronic Disease programs. The Chronic Disease Self Management course is targeted at people with more than one chronic condition, with moderate to severe effects. In Australia this course is referred to as the Better Health Self Management Course because it was found that many people did not fully understand the term ‘chronic disease’ and some equated it with ‘terminal disease’. The higher rate of male participation in the Living with Cancer and Better Health courses may be because these courses cater to people with conditions that have a greater impact on lifestyle, or are perceived as being more serious and/or life-threatening. De Ridder and colleagues report that:

A number of studies show that especially life-threatening diseases, such as cancer and heart diseases, call for more problem-oriented coping (such as search for information) than do other diseases such as diabetes or rheumatic conditions, which do not seem to cause the same amount of alarm (Brown et al. 1989; Reifel et al. 1987; Felton et al. 1984; Zautra and Manne 1992). (1997:558)

This comparison of male participation rates demonstrates that under-representation of male clients is a common issue for health organisations providing chronic illness self-management programs. Therefore, Arthritis Victoria is an appropriate research setting for a study of men’s access to chronic illness self-management programs.

3.3 Ethics approval

A letter of support, subject to Deakin University Ethics approval, was received from Arthritis Victoria in June 1999. This letter confirmed that support would be given for the research undertaken for this thesis, including access to existing data sources (see Appendix 1: Arthritis Victoria letter of support).
The Deakin University Ethics Committee granted approval in September 1999 for the research for this thesis (ref. EC 158-99) to be undertaken from 1 October 1999 to 30 September 2002.

3.4 Quantitative research activities

This section will detail the research activities undertaken to conduct a quantitative analysis of the client record data from the Arthritis Victoria Telephone Information Service. The aim of this phase of the thesis was to confirm the existence of gender differences in levels and patterns of self management service use.

3.4.1 Collection of service use data

The relationship between gender and service utilization was studied using data collected from the Telephone Information Service of Arthritis Victoria. The Telephone Information Service is usually the first point of contact between a client and Arthritis Victoria. Information is provided about various types of arthritis and related conditions and their management. It also acts as a referral service to internal and external self-management programs. As noted by Maisiak and colleagues, “a telephone information service can stimulate positive behaviours for arthritis patients” (1990:218).

All calls, letters or visits from clients of the Telephone Information Service are recorded on a contact sheet that includes demographic information and service details. There were 5,992 such contacts made in 1997, and it is a sub-sample of these data that are used in this thesis.

Inclusion and exclusion criteria were established to determine which records would be analysed. Only records that related directly to an individual with arthritis were included. Records related to general inquiries unconnected with an individual with arthritis were, for example, excluded.
Only data relating to clients between the ages of 18-75 were included. People over 75 were excluded because of gender differences in mortality rates (Baum 1998:178) and the potential for this to skew the results. It was also felt that a higher rate of people over 75 would be living in some form of assisted accommodation such as a nursing home, and the differential patterns of health service utilization of this group could confound the results.

Records related to individuals who had previously contacted Arthritis Victoria were excluded from the quantitative analysis. This ensured that each record related to a unique event and a unique individual; i.e., no individual appears more than once in the final data.

The remaining cases represented 61% (n = 3,633) of the initial database.

3.4.2 Arthritis prevalence data

Data on prevalence levels for different types of arthritis were not available for Australian populations. The prevalence estimates used for comparison in the analysis of gender differences in participation rates were drawn from a number of different studies and informed sources, the majority of which are based on United States or Canadian populations. There are limitations to the accuracy and breadth of these figures, as noted below:

- All forms of arthritis
  The figures reported in Willcox (date unknown) and Badley and Wang (1998) are based on self-reported figures. However, as the data being used in this thesis are also based on self-reported conditions, a direct comparison is appropriate.

- Ankylosing spondylitis
  The Ankylosing spondylitis figures were quoted from an Arthritis Foundation of Australia information brochure. The original source of the data is unknown. According to Klippel and Dieppe, "The previously held
view that it is rare in women is no longer valid; indeed A.S. is not uncommon in women” (1998:6.20.1).

- **Fibromyalgia**
  
  Fibromyalgia is a condition which is difficult to diagnose. Lawrence and colleagues (1998) show a variation in estimates across studies, reflecting differences in diagnostic or classification criteria and force of palpation used by investigators.

- **Gout**

  Klippel and Deippe (1998) report that it is difficult to determine precise prevalence rates because the condition tends to come and go, and is easily misdiagnosed, particularly if self reported. They also note that the epidemiology of the condition is shifting, resulting in an increasing prevalence among women over time, although there is still a higher incidence of gout in men than in women.

  The prevalence rates for gout reported by Lawrence and colleagues are based on self-reporting data and “may overestimate prevalence by as much as 100%” (1998:791). However, as the data being used for gout in this thesis are also based on self-reported conditions, a direct comparison is appropriate.

- **Osteoarthritis**

  According to Lawrence and colleagues (1998), estimating the prevalence of osteoarthritis is difficult for 3 reasons. First, objective diagnoses require radiographic evidence but this does not necessarily correlate with experience of symptoms. Second, radiographic evidence is joint specific, and third, estimates vary according to how severe the condition needs to be for inclusion. The estimates used for comparison in this thesis were based on clinically defined osteoarthritis according to diagnosis by history and examination.
• Osteoporosis

It is difficult to achieve accurate reporting of the prevalence of osteoporosis because of the range of measurement techniques used and sites tested (Klippel and Dieppe 1998), and because the condition is often undetected unless fracture occurs.

• Psoriatic arthritis

There are variations in prevalence figures for psoriatic arthritis because of inconsistent rheumatologic and dermatologic criteria (Klippel and Dieppe 1998).

• Rheumatoid arthritis

According to Lawrence and colleagues, “These estimates are based on data that may no longer be accurate, given recent data suggesting a declining incidence of RA in the USA (Cunningham and Kelsey 1984; Dugowson et al. 1991)” (1998:784).

Clearly, many of these conditions are not easily classified and much of the data is based on self-reported data that can be unreliable. They are being compared with the Telephone Information Service data I accessed from Arthritis Victoria, which is also self-reported. However, a possible relationship between the male gender role and self-report of symptoms was reported by Hegelson. She cites two studies of college students that showed that “trait masculinity was associated with the self-report of fewer physical symptoms (Heiser and Gannon 1984; Robbins, Spence et al. 1991)” (1995:72). This suggests there is a possible under-estimate of incidence among males. As this would only be likely to decrease the size of the effect in the calculations, it was not considered a problem for this thesis.

Therefore, prevalence estimates should be considered a useful but general guide to enable us to gauge whether the gender differences in calls to the Telephone Information Service are based on gender differences in health behaviour or simply reflect gender differences in the prevalence of arthritis and related conditions.
3.4.3 Analysis of data

Contingency tables were analysed to determine if a relationship existed between gender and other variables to test the hypotheses about gender differences in levels and patterns of service utilization (Kinnear and Gray 1995). An alpha level of .05 was adopted as the arbitrary level of significance. Odds-ratios were also calculated to estimate the comparative odds of an event occurring (Norusis 1994). In addition, confidence intervals were calculated to determine if the percentage of men contacting the Telephone Information Service for different types of arthritis was consistent with the expected proportions based on prevalence levels within the general population (Agresti and Caffo 2000).

3.5 Qualitative research activities

This section will detail the research activities undertaken for the qualitative phase of the thesis, consisting of a series of in-depth, semi-structured interviews and a feedback process involving research participants, health service providers and self management course leaders. The aim of this part of the research was to gain an increased understanding of the factors affecting men’s access to chronic illness self management programs. Specifically, a grounded theory approach and a participatory research approach were applied to the collection and analysis of data.

3.5.1 Grounded theory

Grounded theory was adopted for the qualitative phase of this thesis, providing both a theoretical framework for the study and a specific approach to the collection and analysis of the data.

Grounded theory was collaboratively developed by Glaser and Strauss and is based on the idea that a theory should be formed through the collection and analysis of research data. It should not be developed in isolation and then data collected to prove or disprove it (Glaser and Strauss 1967). Glaser and Strauss
claimed that inductive development from social research is essential to the
generation of a useful theory:

One does not begin with a theory, then prove it. Rather, one begins with an
area of study and what is relevant to that area is allowed to emerge
(Strauss and Corbin 1990:23).

According to Strauss and Corbin (1990), a theory developed using grounded
type approach should meet four central criteria - 'fit', 'understanding',
'generality' and 'control'. If it has been carefully induced from diverse data, it
should fit the area being studied. It should make sense to both the research
participants and to relevant practitioners. It should be applicable to a variety of
contexts and it should provide control of action.

This generation of a theoretical explanation is a dynamic process and occurs
throughout the research - both arising from the research process and directing the
research process. The research process consists of the collection of data through
social research in conjunction with the coding of data into categories and the
analysis of the categorised data. The analysis of the data involves making constant
comparisons and asking questions to refine concepts and explore connections
(Strauss and Corbin 1990). This allows the development of an understanding
'grounded in' the data to emerge.

As explained by Charmaz, "Coding, the initial phase of the analytic method, is
simply the process of categorizing and sorting data. Codes then serve as
shorthand devices to label, separate, compile, and organize data" (1983:111).
This typically begins with simple, concrete, and descriptive codes and progresses
to more abstract, conceptual categories as the research process continues. The
words used by the participants can be applied in the creation and description of
categories. This type of coding is called in vivo coding (Charmaz 1983). In this
thesis, the research findings have been organised under in vivo headings.

Coding occurs in two phases, beginning with an initial searching phase,
highlighting what is defined and discovered in the data. This provides an
opportunity to shape the data collection by identifying emerging issues and exploring them further through the interviews. In this way, successive interviews become an opportunity to pursue new ideas and concepts as they develop.

The second phase of coding is referred to as ‘focused coding’ (Charmaz 1983). Codes that were created in the initial phase are selectively applied to large amounts of data. This provides an opportunity to build and clarify a category and to explore interweavings between the categories. Relevant literature can also be used to sensitise the researcher to potential patterns and themes in the data, to expand and clarify the codes, and to assist in the emerging analysis (Charmaz 1990). Glaser and Strauss acknowledged that other ideas and models can be drawn on to explain the data but cautioned that, “the generation of theory from such insights must then be brought into relation to the data, or there is great danger that theory and empirical world will mismatch” (1967:6).

Memo writing is an additional tool that can be used throughout the research process by the researcher to record thoughts about patterns emerging from the data (Charmaz 1983). Memos about the participants and each interview experience can also be recorded to provide additional insights into the underlying meanings in participants’ accounts.

In summary, grounded theory emphasises the development of theoretical explanations through a data driven, inductive process that occurs in interaction with the collection, coding, and analysis of data. The steps used in this thesis to analyse the data are described in section 3.5.9: Analysis of interview data.

3.5.2 Sensitising concepts

Drawing upon existing concepts and other health research models or theories is a useful grounded theory technique to aid the development of questions and raise the researcher’s sensitivity to patterns within the data (Charmaz 1990). Care must be taken that familiarity with related literature and/or the situation being studied
does not shape the analysis to the extent that the researcher is closed to the development of new ideas or blinded to the themes within the data. This is discussed further in section 3.5.4: Researcher-researched relationships.

Connell's (1995; 1998; 1999) theories on multiple, hierarchical masculinities, and Gerschick and Miller's (1995) theories on reliance, rejection and reformulation of hegemonic masculinity among men with disabilities, were used as sensitising concepts in the qualitative research process of this thesis, to aid a gendered analysis of health behaviour.

Other ideas and models from health literature were also drawn upon to help explain the concepts that emerged from the data, in a manner consistent with grounded theory (Glaser and Strauss 1967). As discussed below, there were various health models that had general applications to the themes that emerged from the data collected for this thesis.

Rogers and colleagues (1999) reviewed the different types of health models available for health research. They commented that psychological models, including social-psychological models such as the Health Belief Model, were limited because they did not acknowledge that help-seeking behaviour is influenced by social context to a much larger extent than individual psychological traits. Similarly, Rogers and colleagues suggested that rational choice models of decision-making were limited because they assume that individual's decisions are made after weighing up the costs and benefits of a particular situation, and yet, "Active decisions about health are not always made" (Rogers et al. 1999:66).

In reference to socio-behavioural approaches, Rogers and colleagues note that they are:

... limited in explaining delays in the seeking of care and reasons underlying patterns of referrals. ... the model is best for accounting for acute conditions requiring hospitalization; it is less relevant for accounting for illness trajectories and use of care for more chronic groups ...

(1999:68)
This type of model is clearly not appropriate for this thesis given the focus on chronic care and illness trajectories. The emphasis of all of the above models on individual choice rather than socio-cultural influences did not appear useful in a gendered analysis of health behaviour.

Conversely, the social process approach moves away from this emphasis and instead focuses on socially constructed decisions:

The social process approach to utilization focuses on the interaction of the patient with others, and views motivation and determinants of decision making as subject to the influence of a wide range of factors often beyond an individual's control. Central to this conceptualisation of help seeking is the notion of illness as a social rather than a medical category (Rogers et al. 1999:69).

The social process approach recognizes the interaction between individuals and their social environment. As noted by Pescosolido, "Individuals are neither puppets of some abstract structure nor calculating individualists; people both shape and are shaped by social networks" (1992:1109). The social process approach to utilization of health services appeared more useful in understanding interview data on help-seeking behaviour, although models of this approach generally relate to primary care rather than self management services. Zola proposed a model identifying five non-physiological triggers to the referral process:

1. The occurrence of an interpersonal crisis.
2. Perceived interference with personal/social relations.
3. The 'sanctioning' of ill-health in one individual by another.
4. Perceived interference with vocational/work-related activity.
5. Temporalizing of symptomology - 'if it doesn't get better by ... I'll see a doctor' (1973:683).
This model was very relevant to the issues that emerged in this thesis, particularly its consideration of the influences of social environment, functional changes, working capacity and changes over time. Therefore, it was adopted to help explain the research results. However, it did not specifically address a gendered analysis of health. The theories of Connell (1999), as described in section 2.3: *Masculinities*, explore the role of dominant social constructions of masculinity in shaping men’s health behaviour and utilisation of health services. Similarly, Gerschick and Miller’s (1995) theories, as described in section 2.3.3: *Chronic illness and masculinities*, outline strategies of reliance, reformulation and rejection of masculinity constraints invoked by men in response to physical disability. These theories were used as sensitizing concepts from the beginning of the research process and were found to be particularly useful in explaining the themes that emerged from the data in this thesis (Glaser and Strauss 1967). The relevance of these themes to the data is demonstrated by characteristic examples throughout the Qualitative Findings (see Chapter Five).

In summary, ideas and models that had a social constructionist perspective, allowed for a gendered analysis of health, and operated within the context of self management rather than primary health services, were drawn on in this thesis to explain the patterns and themes emerging from the data. Watson’s (2000) theories on men’s concepts of health, as described in section 2.4.3: *Crisis care*, were also drawn on in the analysis of the role of hegemonic masculinity in influencing adjustment to chronic illness.

In addition, a structuralist perspective was relevant to this thesis, acknowledging that the ‘system’ can prevent people from behaving in ways that are health enhancing (Noack 1987:46). As noted by Courtenay, “culture dictates everyday interactions and social and institutional structures help to sustain and reproduce men’s health risks” (2000b:1387-1388). The implication of this approach is that health organisations can introduce structural changes that will encourage changes in health behaviour. Social marketing principles, as outlined in section 2.5.1: *Social marketing*, were utilised in the application of the research findings to service delivery, to improve the accessibility of services to men and thereby encourage increased positive health behaviours among men.
3.5.3 Participatory research

Research participants were involved in the research process for this thesis in the following ways:

- Clarification of interview transcriptions where required (see section 3.5.9: Analysis of interview data)
- Feedback on a summary of preliminary findings (see section 3.5.9: Analysis of interview data)
- Feedback on a final summary of research findings (see section 3.5.9: Analysis of interview data)
- Feedback on a flyer developed for a trial Men’s Arthritis Information Night (see section 3.6.1(c): Consumer input).

This involvement of the research participants in the research process suggests a form of participatory or collaborative research (Petras and Porpora 1993). However, these terms are used broadly in the literature and care must be taken to ensure they do not misrepresent the methodology used.

The various models of collaborative and participatory research differ in terms of the degree of involvement of the community members and the power relationship between the researcher and the community or client being served (Pyett 2000). Nyden and Wiewel (1992) describe collaborative research as involving an equal relationship between the ‘researcher’ and the ‘client’. This was not the case in this thesis. Participant feedback contributed to the development of the theories emerging from the data but participants were not involved in the design or direction of the research process.

The essential elements of participatory research, according to Petras and Porpora (1993) are the direct involvement of the researcher with a specific community, and an understanding of the researcher’s responsibility to contribute something to the community in return for the contributions the community makes to the
research. Petras and Porpora examine three models of participatory research that they describe as the 'parallel process model', the 'mutual engagement model', and the 'University of Central America (UCA) model'. The mutual engagement model involves an interactive relationship between the researcher and the community, with mutual involvement in both the research and the community. The UCA model involves an interactive relationship between the University and the community. The parallel process model is described as one where, "the researcher and the researched might pursue their parallel objectives independently while engaging in a mutually beneficial exchange" (1993:112). It is a minimal form of participatory research but does involve some reciprocity through various means such as producing research documentation that can be used to contribute to change, non-academic publications and presentations, strategy building, and ethical responsibility.

The parallel process model of participatory research is consistent with the approach adopted in this thesis. The researcher controlled the research process but participants were involved directly in the development of the theories. The involvement of the participants was in the form of a reference group rather than as part of the research team. This is supported by Wadsworth (1991) who suggests that it is essential to refer to reference groups to accurately identify the group's needs and the best solutions. Inclusion of participant feedback in this thesis was driven by a commitment to achieve results that reflected the lived experiences of the men with arthritis. The views of health practitioners were also sought to benefit from their experiences and the insights they had gained from working with men with chronic conditions. As mentioned at the beginning of this section, the reference group was invited to provide feedback on the preliminary and final analysis, see section 3.5.9: Analysis of interview data. This included a draft version of the Guiding Principles for health organisations targeting men with a chronic illness. They were also invited to provide feedback on the applied phase of the research, i.e. the Trial Men's Arthritis Information Night (see section 3.6.1(c): Consumer input). This feedback process is also consistent with qualitative research techniques to demonstrate the credibility of the research findings, as discussed in section 3.5.5: Quality of the research process.
The steps taken to ensure reciprocity in the research process included the provision of information about Arthritis Victoria services to interested interview participants, and the development of measures to encourage organisations to make structural changes to increase the accessibility of self management programs to men with a chronic illness. These measures are discussed in section 3.5.10(a): *Workshop with health workers*, section 3.5.10(b): *Training seminar for self management course leaders*, section 6.1: *Trial Men’s Arthritis Information Night*, and section 7.2: *Guiding principles for health organisations targeting men with a chronic illness*. Non-academic (Gibbs 2002a) and academic (Gibbs 2001a; Gibbs 2001b; Gibbs 2003a; Gibbs 2003b) presentations have also been conducted for health workers, and advice has been given to staff of Arthritis Victoria and the Arthritis Men’s Support Group. Guiding principles for health organisations targeting men with a chronic illness were also developed as an outcome of this thesis (see section 7.2). Development and submission of research articles based on the research findings to health industry journals is also planned following thesis submission.

Therefore, a transfer of knowledge has taken place and will continue to take place but the majority of it has been directed to health organisations rather than the individual community members who participated in the research undertaken for this thesis. However, men with chronic illnesses will be the direct beneficiaries of that transfer of knowledge. This is consistent with the socio-cultural and structural perspectives of this thesis that recognise external influences on men’s health behaviour rather than adopting a ‘victim-blaming’ approach.

### 3.5.4 Researcher-researched relationships

One of the underlying assumptions of the grounded theory approach is that, “Each of us brings to the analysis of data our biases, assumptions, patterns of thinking, and knowledge gained from experience and reading” (Strauss and Corbin 1990:95). In fact, it is these very experiences and knowledge that provide us with theoretical sensitivity, “the attribute of having insight, the ability to give meaning to data, the capacity to understand, and capability to separate the pertinent from
that which isn’t” (1990:42). There are certainly some significant personal experiences in my life that have informed this thesis and necessarily influenced the direction taken and the analysis of the findings.

As a person with rheumatoid arthritis, I was well aware of the day-to-day realities of living with a chronic condition. As a previous staff member of Arthritis Victoria, I had also been exposed to other people’s experiences living with various types of arthritis and related conditions, and I was familiar with the range of medical and self management services available to assist people in those circumstances. In fact, it was during my time at Arthritis Victoria that I became conscious of the under-representation of men as clients of these services and the lack of knowledge among the mostly female staff about how to address that situation. This ‘insider’ knowledge of arthritis and its management is likely to have enhanced my discussions with the men due to a commonality of experience.

It is possible that my links with Arthritis Victoria may have prevented the men from expressing a negative perspective of Arthritis Victoria services. I suspected this was the case in the comments by interview participant, Phillip, when he was discussing why he had not used Arthritis Victoria services (see section 5.2.3: “It hasn’t been suggested to me by my doctors”). He explained that his doctors had not suggested it and he was restricted to their recommendations because of his status as a WorkCover claimant. Yet, elsewhere in the interview, he described how he had suggested a different treatment option to his doctors and had received their support. I also wondered if Kevin was aware that I was a mother with arthritis, and the author of the Arthritis Victoria publication, Juggling Sore Joints and Babies, A Guide for Parents and Grandparents with Arthritis and Related Conditions, when he referred to the difficulties for mothers with arthritis (see section 5.2.6: “Because it was designed for men...”). However, I made a clear statement in each interview that I no longer worked for Arthritis Victoria and that there should be no concerns about expressing any negative comments about its services.

Two and a half years before I began my research, my husband was diagnosed with terminal cancer, and through him I experienced at a personal level the impact of a
chronic condition on a man's life. Over the four years of his illness he was forced to reconstruct his assumptions about work, fitness, his role in the family, and notions of independence. This helped me to understand some of the issues raised in the interviews undertaken for this thesis. The research activities also helped me to understand my husband's experiences.

Thus, as explained above, given the relevance of my personal experiences, my research methodology incorporates heuristic inquiry "... a variation of qualitative research that involves detailed analyses of patients' experiences by an investigator who also has the same chronic condition" (Robbins 1998:227).

While my knowledge and experience were aids in the development and analysis of this thesis, it was important to ensure that they did not restrict my perspective or block my ability to see what was significant in the data. As part of the analytic phase of the thesis, I utilised the grounded theory techniques outlined by Strauss and Corbin (1990), as discussed in section 3.5.1: *Grounded theory*, to help analysts open up their thinking about the phenomena being studied. These techniques include: the use of questioning; single word/phrase analysis; systematic comparisons with either similar or unrelated phenomenon; the 'flip-flop' technique, i.e. turning the concept upside down and exploring the opposite possibility; and waving the red flag, i.e. being alert to warning signs.

The fact that I am female may be either a limitation or strength when interviewing men. According to Baum and Cooke, "Women in equal or superior positions pose a threat for men who define themselves in traditional terms" (1986:12).

Conversely, Hegelson (1995) and Folland (1986) report that males may talk more freely with females than other males. The research studies conducted by Charmaz (1995) and Yelland and Penrose (1995) demonstrate the effectiveness of a female interviewer in studies of masculinity and chronic illness. Brown (2001), in her methodological review exploring gender and interviewing, raised the interplay of power with gender and the potential for a female interviewer to feel threatened by an aggressive interviewee. Conversely, Flood (2000), in his review of studies on the sex of the interviewer, suggested that female interviewers may have an advantage over male interviewers because the interviews are less likely to be
characterised by the information based, disinterested and 'jokey' manner of male-to-male talk.

It is possible that my status as a female interviewer may have affected the men’s responses to questions about the gender of participants and leaders, as discussed in section 5.2.6: "Because it was designed for men...". It did not appear to be an issue for interview participant, Kevin, who identified as a bisexual man. He stated his preference for male leaders when discussing personal issues but acknowledged his preparedness to discuss those issues with me (see section 5.2.6: "Because it was designed for men..."). Some of the men may have felt inclined to demonstrate adherence to dominant social constructions of masculinity to me as a female interviewer. I tried to offset this possible effect by mentioning that I also have arthritis, thereby demonstrating that I was familiar with the experience and restrictions of arthritis. Conversely, others may have felt less pressured to align themselves with hegemonic masculinity because my status as a female may have made our relationship less competitive than a male-male interview.

As I was experienced in interviewing, the advantages of my position as interviewer seemed likely to outweigh the disadvantages. The culture, language, socio-economic status and sexuality of the interviewer are also important factors to consider. However, as this thesis aimed to sample across all of these areas, it would have been difficult to provide a ‘matched’ interviewer for each interviewee. As mentioned previously, my professional and personal experiences with chronic illness provided a common ground with the participants.

The interactive relationship between the researcher, the research participants and the research process is acknowledged in social constructionist grounded theory (Charmaz 1990). Charmaz notes that, "a social constructionist perspective assumes an active, not neutral, observer whose decisions shape both process and product throughout the research" (1990:1165). The influence of the research on participants’ perceptions was evident for interviewee, Peter, who commented that he had not seen himself as a person with arthritis until I called him about the research (see section 5.2.1: "I didn’t realise that I was needing help"). A number of the participants also expressed interest in using the self management services
described to them during the interview, showing that their perception of services was altered as a result of the interview process.

As the research progressed, a relationship also developed with some of the participants beyond the research boundaries. This is consistent with feminist methodology in social science (Acker et al. 1983; Punch 1998). As noted by Oakley:

"... the goal of finding out about people through interviewing is best achieved when the relationship of interviewer and interviewee is non-hierarchical and when the interviewer is prepared to invest his or her own personal identity in the relationship" (1988:41).

Oakley suggests that an equal relationship is most likely to occur when there is least social distance between the interviewer and the interviewee, such as when they have shared the same critical life experiences or belong to the same minority group. It may have been the shared experience of arthritis that contributed to the personal relationship that was formed with some of the interviewees. For example, Kevin suggested we catch up after the research period to chat about common interests, Ted wanted to come to my graduation ceremony, and Ian and I spoke about ongoing communication about the Arthritis Men’s Support Group. My discussions with Peter had always involved a sharing of personal experiences with arthritis and ideas relating to our respective research into men’s issues. This mutual respect reflects the minimisation of any power relations arising from gender difference (Brown 2001) or from the researcher-researched status.

3.5.5 Quality of the research process

While there is general agreement about the methods of demonstrating research quality and methodological rigour in qualitative research, the terminology used to describe those measures is not always consistent. The terms “validity”, “reliability” and “generalisability” are widely used (Baum 1998; Kirke and Miller 1986; Rice and Ezzy 1999) and have clear parallels with the measures used to
assess the quality of quantitative research. However, care must be taken to ensure this does not lead to assumptions about comparative measures of rigour between qualitative and quantitative research (Cobb and Hagemaster 1987; Guba and Lincoln 1994). Qualitative and quantitative research analyse different things in different ways and therefore application of the same assessment concepts or even similar terminology is inappropriate and misleading. Instead, the terms “credibility”, “confirmability”, “transferability”, and “dependability” can be more usefully applied to qualitative research (Lincoln and Guba 1985) and were adopted for the purposes of this thesis.

**Credibility** is a measure that refers largely to the study design and the research processes. It is based on various factors as listed below (these factors are explored in more detail in the following sections of this chapter):

- researcher’s credibility (see section 3.5.4: *Researcher-researched relationships*)
- appropriate sampling techniques (see section 3.5.6: *Recruitment of interview participants*)
- appropriate data collection (see section 3.5.8: *Interview format*)
- triangulation techniques (see section 3.5.10: *Triangulation techniques*) - the use of different data sources, different methods and sometimes multiple investigators (Lincoln and Guba 1985).
- ‘Member checks’ - informal and formal testing of interpretations and conclusions with members of stakeholder groups to demonstrate the credibility of the constructions formed (Lincoln and Guba 1985). This is consistent with the participatory research approach adopted for this thesis, as discussed in section 3.5.3: *Participatory research*.
- methodical data analysis (see section 3.5.9: *Analysis of interview data*)
- negative case analysis – refining the theory against ‘negative’ cases, i.e. cases that don’t fit (for example section 5.1.11: “If I got to the stage where I couldn’t work” addresses the differences between working men and retired men). Lincoln and Guba (1985) caution that the process of negative case analysis is close to the quantitative technique of developing.
a hypothesis, checking data against it, and continually refining until there are no negative cases.

- clear communication of results -- the thesis findings have been and will continue to be circulated in a variety of academic and industry forums (see section 3.5.3: Participatory research).

The remaining measures of research quality refer largely to the research results:

**Confirmability** is similar to the member checks described above. It refers to the use of a source outside the research team to confirm the results. Keeping an audit trail of the research process, such as this thesis, is a technique that can be used to demonstrate that the findings are grounded in the data (Lincoln and Guba 1985).

**Transferability** refers to the applicability of the findings to other settings. According to Lincoln and Guba (1985), all the researcher can do with regard to transferability, is to provide a detailed description of the research context to enable others to consider whether a transfer would be relevant and meaningful to a separate, 'receiving context'.

**Dependability** refers to the consistency of the research over time (e.g. two phases of coding were undertaken for this thesis), researcher or method (e.g. the comparison in this thesis between the different phases of the research, and between this thesis and other similar studies).

These terms will be referred to throughout the description of research activities to demonstrate the quality and trustworthiness of the research process and the research findings.

### 3.5.6 Recruitment of interview participants

Maximum variation sampling was used to recruit the 21 research participants to allow identification of common patterns emerging from the variation between men.
For small samples a great deal of heterogeneity can be a problem because individual cases are so different from each other. The maximum variation sampling strategy turns that apparent weakness into a strength by applying the following logic: Any common patterns that emerge from great variation are of particular interest and value in capturing the core experiences and central, shared aspects or impacts of a program (Patton 1990:172).

For the purposes of this thesis, three sources of variation were sought among the men in the recruitment sample:

1. **Extent of participation in self management programs**
   The recruitment sample included men who had no experience of self management programs, men who had some experience of self management programs and men who had extensive experience of self management programs. It was anticipated that differences between participators and non-participators would provide insights into the motivators and barriers to accessing self management programs.

2. **Social demographics**
   The diverse characteristics of major social groupings in Victoria were used as a central criteria for constructing the sample (Patton 1990). This was intended to:
   - Allow exploration of the variation in experiences for men from different social groups such as age, socio-economic status, geographic location, sexuality, and cultural and linguistic diversity
   - Identify important shared patterns that cut across different social groups
   - Obtain results that have transferability, that is, are applicable to a variety of contexts within Victoria, and other locations with a similar social composition.
This methodology allows for an appreciation of the uniqueness of individuals’ experiences and an acknowledgement of the influences of social determinants, while focusing on common patterns emerging from those differences. As noted by Patton:

The evaluator using a *maximum variation sampling* would not be attempting to *generalize* findings to all people or all groups but would be looking for information that elucidates programmatic variation and significant common patterns within that variation (Patton 1990:172).

A demographic questionnaire was administered to all interviewees to determine the extent of social variation among the participants. This is discussed further in section 3.5.7: *Collection of demographic information*.

3. **Self-labelled masculinity**

A question regarding self-labelling of masculinity was included in the demographic questionnaire administered to all interviewees to demonstrate that men who identify with different types of masculinity were included in the recruitment sample. This is discussed further in section 3.5.7: *Collection of demographic information*.

Recruitment was restricted to men with moderate to severe arthritis. Time since diagnosis ranged from 4 months to 25 years. The majority of the men were recruited via Arthritis Victoria networks. In addition, four interviewees were recruited via a rheumatologist, and one each via a GP and a rural community health educator. Two other recruits were personal contacts. It is clear that my personal and professional contacts were a useful resource in the recruitment of interviewees. A possible limitation to this recruitment process is that a few of the interviewees were already friends or acquaintances and this may have influenced their responses. I felt that this might have been the case in some of Bruce’s responses, particularly when we touched on personal issues and on his relationship with his ex-wife – a good friend of mine. One of these instances is noted in section 5.2.2: *“Your spouse says stop complaining and go and see someone”*. 
In addition to the recruitments outlined above, one participant was recruited via the Aboriginal Health Service. The service experienced difficulties in identifying a patient who fitted the criteria for the thesis because they do not usually have an ongoing relationship with their patient population, and tend to lose contact with patients after they have been referred to specialists (Query 2002). ‘Gary’, a client of the Aboriginal Health Service with severe arthritis, and the husband of an Aboriginal staff member, was recommended as a suitable Aboriginal recruit despite the fact that he was a white Australian. It was suggested that he was still a relevant person to interview because he is very much a part of the Aboriginal community. Being Aboriginal is not so much about blood but is determined by the person identifying with the community and the community recognising them as a part of it. Therefore, if someone has been socially and culturally part of the community over a long period of time, they can be considered as Aboriginal (Query 2002). This is supported by Miller who reported that self identification was accepted in the 70’s as a significant factor in determining Aboriginality, “… people could claim Aboriginality if they fitted three criteria: indigenous ancestry, self-identification and community acceptance” (2002:19). Indigenous ancestry is often difficult to establish due to the tradition of oral, rather than written history in Aboriginal communities. Self-identification and community acceptance are often central to inclusion in Aboriginal communities.

Brown (2001) in her methodological review of gender and interviews discusses difficulties in recruiting men and possible reasons for their apparent reluctance to be interviewed. This was not experienced as a difficulty in the recruitment process for this thesis. The majority of men who were approached were happy to be involved.

Some wives were also included in the interview process to explore the role of partners in influencing the decisions of men to access self management programs. Those responsible for the MAN model, a successful rural men’s health initiative, found that because of wives’ traditional responsibility for family decisions about health care, they can often offer valuable insights into the reasons for men’s health behaviours (Denner 2000; Gibson and Denner 2000). This is supported by
Norcross and colleagues who state that, "Women exert an important influence on the decisions of men to seek health care" (1996:475). Pinnock also included female partners in a qualitative study of older men's concerns about urological health because "... men referred to them as important prompts to address health issues and to provide a contrasting view of men's issues of concern" (1998:369).

In-depth, semi-structured interviews were subsequently conducted with 17 men and 4 women. This fits the guide provided by Baum (1998) that 12 to 20 data sources or sampling units are likely to be needed in studies when looking for disconfirming evidence or trying to achieve maximum variation. An additional 8 men had been invited to participate in the research for this thesis. Of these, 2 declined the invitation to participate because of other commitments, 3 withdrew before the interview took place for health, family and work issues, and 3 had to be cancelled by the interviewer due to a death in the family.

### 3.5.7 Collection of demographic information

All interview participants were provided with an information sheet (see Appendix 2), a consent form (see Appendix 3), and a brief demographic questionnaire (see Appendix 4) prior to the interview. The questionnaire was designed to establish the range of social groupings represented in the sampling, as discussed in section 3.5.6: Recruitment of interview participants.

The tables below show the range of social groupings represented in the recruitment sample. The small numbers of interviewees per social grouping do not allow for conclusions to be made about specific differences between social groups. However, this information did assist with the analysis and interpretation of the results by indicating possible associations between certain health management behaviours and social determinants that could be explored in further research.

The age groups in the demographic questionnaire were selected to match the Arthritis Victoria Telephone Information Service database records, and thereby
allow some comparison of age-related findings between the quantitative and qualitative analyses.

Table 2: Age groups of participants

<table>
<thead>
<tr>
<th>Age group</th>
<th>18-25</th>
<th>26-40</th>
<th>41-60</th>
<th>61-75</th>
<th>Over 75</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>2</td>
<td>3</td>
<td>7</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Partners</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

There was a spread of age groups in the recruitment sample with the majority aged between 26 and 60. This is similar to the weighting in the Victorian population. At 30 June 1998, the largest numbers of Victorians were in the 20 to 44 years age group, although the largest increase during the 12 months to 30 June 1998 was in the 50 to 54 years age group (Australian Bureau of Statistics 1999).

Table 3 shows that participants came from a range of educational backgrounds.

Table 3: Educational level of participants

<table>
<thead>
<tr>
<th>Education</th>
<th>Primary only</th>
<th>Secondary</th>
<th>Passed Year 12</th>
<th>Tertiary diploma/trade</th>
<th>University</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Partners</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

The majority of participants had a tertiary diploma or trade certificate, but all levels of education were represented. Although most of the participants’ schooling experiences were from public schools, there were representatives from private and Catholic schools.
Table 4: Type of school attended by participants

<table>
<thead>
<tr>
<th>School type</th>
<th>Catholic</th>
<th>Private only</th>
<th>Public and private</th>
<th>Public only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Partners</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

Three of the participants did not complete the section of the questionnaire relating to type of school. Two of the participants who did not complete this question were born in other countries, so it is possible that the categories had no meaning for them. One of these participants also omitted the question about whether he attended single sex or co-educational schools. Once again this may have been because he did not understand the question. It is also possible that this question was left unanswered because men felt uncomfortable or self-conscious about the limited level of education they had received.

Twelve of the men identified as Anglo/Celtic. One of the men identified as Anglo/Celtic but is referred to in the thesis as a member of the Aboriginal community. This was discussed in detail in section 3.5.6: Recruitment of interview participants. The remainder identified as UK/European, Greek, Chilean, Italian, and Filipino/Asian. Two of the partners identified themselves as Anglo/Celtic, one as Polynesian/New Zealander and the other as Italian. These cultural groups are representative of the Victorian population. As at 30 June 1996, approximately 25 per cent of the population of Victoria were born overseas (Department of Immigration and Multicultural Affairs 1999). The United Kingdom, Greece, Italy and New Zealand were among the six largest birthplace groups. In 1998-99 the Phillippines was seventh in the top ten source countries for settler arrivals to Victoria (Department of Immigration and Multicultural Affairs 1999). The estimated resident indigenous population in Victoria at 30 June 1996, as a proportion of the total State population was 0.5 per cent (Australian Bureau of Statistics 1998).
Identification of sexuality was not included in the initial demographic questionnaire. However, as the research proceeded, in line with a grounded theory approach, it emerged as an important element because of its potential influence on the interaction between gender and health. As a result, references to the gender of partners were noted and the role of both opposite and same sex partners in influencing health decisions were explored.

One of the seventeen men (6%) identified as homosexual and one identified as bisexual (6%). According to a national survey measuring Sexual identity, sexual attraction and sexual experience among a representative sample of adults (Smith et al. 2003), 1.6% of Australian men identify as homosexual and 0.9% identify as bisexual. The rest of the men interviewed referred to female partners and so it was assumed that these men identified as heterosexual, although it is acknowledged that due to the complexity of human sexuality, a heterosexual relationship does not necessarily equate to heterosexual identity (Smith et al. 2003).

The majority of the interviewees were either retired (35%) for medical or age related reasons, or were working full time (41%).

**Table 5: Work situation of participants**

<table>
<thead>
<tr>
<th>Work situation</th>
<th>Retired</th>
<th>Unemployed</th>
<th>Student</th>
<th>Part time/casual/domestic</th>
<th>Full time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>6</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Partners</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

The men that were working were in a range of roles – health services, research, managerial, information technology, entertainment industry, motor mechanic and farmer.

Table 6 shows that there were varying levels of self-reported health status.
Table 6: Self-labelled health status of participants

<table>
<thead>
<tr>
<th>Health status</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>3</td>
<td>8</td>
<td>6</td>
</tr>
</tbody>
</table>

This measure was included to demonstrate that participants had moderate to severe conditions. The symptoms they reported and the apparent impact of those symptoms on daily life, as related in the interviews, often appeared more severe than the self report of health status would indicate.

The questionnaires also gave participants an opportunity to indicate if they would use any of the masculinity terms commonly used in the media (e.g., sensitive new age guy, macho, sports mad, yuppie) to describe themselves. A list of stereotypical masculinity labels was provided to men and they were invited to select as many applicable labels as they wanted. Some of the men selected ‘Other’ and defined their own masculinity, rather than using the stereotyped labels provided. This question was originally used in the Living As Men Survey (Lambevski 2000), a study of urban Australian men’s work, pleasure and health. It was designed for a survey sample that was mainly middle class, Anglo-Saxon men, aged 25-45 years old.

The self-labelling of masculinity terms did not provide a clear allocation of the masculinities of each participant. Labelling is problematic anyway because of the difficulties in defining masculinities (Clatterbaugh 1998), as noted earlier in the thesis (see section 2.3.1: Variations in masculinities). However, sampling across social groupings and masculinity stereotypes did indicate that opinions had been sought across a wide variety of men. This contributed to the transferability of the results, one of the central criteria in grounded theory for judging the applicability of theory to a phenomenon (Strauss and Corbin 1990).

Table 7 indicates that a range of masculinities were represented in this thesis, although it became apparent over the interview period that the self-labelling question was problematic when used cross-culturally because of men’s
unfamiliarity with terms that are strongly linked with the Anglo-Australian culture. Men who were unfamiliar with the terms were encouraged to use their own words to describe themselves. For example, Mario, an Italian man, ended up selecting two of the less ambiguous labels, i.e. ‘regular guy’, and ‘sports mad’. Loo described himself as a ‘Greek man’, ‘outdoors’, ‘nature’.

Table 7: Percentage of participants for each masculinity label

<table>
<thead>
<tr>
<th>Label selected</th>
<th>% of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Macho</td>
<td>11.8</td>
</tr>
<tr>
<td>Nerd</td>
<td>0</td>
</tr>
<tr>
<td>Ocker</td>
<td>5.9</td>
</tr>
<tr>
<td>Regular guy</td>
<td>52.9</td>
</tr>
<tr>
<td>Sensitive new age guy</td>
<td>23.5</td>
</tr>
<tr>
<td>Sports mad</td>
<td>35.3</td>
</tr>
<tr>
<td>Surfer</td>
<td>0</td>
</tr>
<tr>
<td>Traditional</td>
<td>29.4</td>
</tr>
<tr>
<td>Yuppie</td>
<td>5.9</td>
</tr>
</tbody>
</table>

Labels also appeared to have different meanings for different age groups. In particular, the labels often seemed inappropriate/irrelevant to older men. This may be due to a lessening influence of masculinity labels on men in older age groups (see section 5.1, Avoidance of health issues). It may also be because increased years and life experiences make it difficult to select from a limited selection of labels (Connell 1998), or because the development of stereotypical labels occurs in a youth dominated media environment (Baker 2001b).

There also appeared to be a perception among the men interviewed that the labels ‘nerd’ and ‘ocker’ were undesirable and hence there was a reluctance to identify with them.

As shown in Table 8, some of the men selected a combination of labels that appeared to represent contrasting forms of masculinity, such as ‘ocker’ and ‘snag’ (‘snag’ stands for sensitive new age guy). This supports Connell’s (1998) theories
about the multiple masculinities available to men and their tendency to shift over time and place.

Table 8: Self labelled masculinities of individual participants

<table>
<thead>
<tr>
<th>Participant</th>
<th>Macho</th>
<th>Nerd</th>
<th>Ocker</th>
<th>Reg guy</th>
<th>Snag</th>
<th>Sports mad</th>
<th>Surfer</th>
<th>Traditional Aussie male</th>
<th>Yuppie</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adam</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bruce</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
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3.5.8 Interview format

The interviews were semi-structured to allow them to be flexible and free flowing. They were guided by an interview protocol of possible questions. This protocol set some parameters for the discussion but was broad enough to evoke unidentified issues (see Appendix 5). This is essential in a study undertaken with a grounded theory approach because it allows the theory to be data driven rather than the reverse (see section 3.5.1: Grounded theory). Following a preliminary analysis of the first stage of 10 interviews, the interview protocol was refined and adjusted to reflect the issues being raised (see Appendix 5), as discussed in section 3.5.9: Analysis of interview data. One question was dropped because it seemed to cause some confusion. This was the question where I presented two scenarios about ‘someone I knew’ who was being proactive in response to moderate arthritis, and ‘someone I knew’ who was being reactive in response to severe arthritis. Although this question was useful in some cases in eliciting attitudes towards the use of health services, it seemed generally to cause confusion about what I was asking them. Added to the protocol were questions about:

- whether the age group of other participants in a program was an issue
- whether a medical venue would make it easier to justify time off work
- whether a medical certificate would make it easier to justify time off work
- whether a doctor or rheumatologist had recommended accessing self-management programs
- their health beliefs about the cause of their condition.

These were all issues that had arisen in the course of the initial interviews.

All interviews ended with a general discussion, usually with a question about any suggestions they would have to make programs more accessible to men. This was
included to elicit any additional ideas that had not come through in the interview. It also allowed the interview to end on a neutral topic to allow positive closure as suggested by Charmaz (1990). Several of the interviewees also ended the discussion by noting how useful they had found the interview as a way of exploring their own feelings about their condition and its impact on their life.

It was originally planned to conduct focus groups as well as interviews, but men’s reluctance to participate in group discussions emerged in interviews as a significant deterrent to the use of self management services. Therefore, interviews were used exclusively as a more appropriate approach. Interviews also provided a means of revealing variations and differences in views, rather than the stereotypical view usually generated in focus groups (Gilbert and Gilbert 1998).

The interview questions were designed to explore men’s awareness of existing services, their level of use of self management services to date, factors which have influenced their service use to date, and factors likely to influence their use of services in the future. As part of the interview process, I also asked the interviewees to comment on the effect of three different advertising slogans I had prepared. The three slogans were developed specifically to explore the importance of language used in promotional material. The predominance of females in health services can lead to an inadvertent gender bias in program promotions. For example, Arthritis Victoria had 14 females and 2 males employed in the Education and Services Department in 2002 (Deakes 2002). Each advertising slogan carried effectively the same message but was delivered using different language designed to demonstrate reliance or rejection of hegemonic masculinity, or a gender-neutral message to allow reformulation of hegemonic masculinity (Gerschick and Miller 1995).

Slogan 1:

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<td>We can help you to manage.</td>
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<td>Call Arthritis Victoria now on 9530 0255.</td>
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92
This slogan was designed to represent a rejection of the requirements of hegemonic masculinity that men maintain control, be self sufficient (Baum 1986; Huggins 1995; Nathanson 1975; Verbrugge 1985), and avoid the feminising association with health services (Pease 1997a). It was anticipated that the men interviewed would reject this message.

Slogan 2:

**Arthritis – Real Men Take Charge**

Get your toolkit here!

**Arthritis Victoria 9530 0255**

Conversely, slogan 2 was designed reflect a reliance on hegemonic masculinity by promoting self-sufficiency and using hyper-masculine language. It was anticipated that the men interviewed would be more likely to respond to this slogan, in line with similar strategies identified in section 2.5: *Health promotion initiatives targeting men*, for example the ‘Pit Stop’ program in Western Australia (7.30 Report 2001), the ‘Mechanical Man’ promotion in the United Kingdom (National Health Service), and the ‘Arthritis Huddle’ in the United States of America (Boehringer Ingelheim Pharmaceuticals and Abbott Laboratories 2002).

Slogan 3:

**Arthritis – Something Can Be Done**

For more details contact Arthritis Victoria on 9530 0255
This is a slogan that has actually been used by Arthritis Victoria. It was selected for this exercise because it appeared to be neutral to the characteristics of hegemonic masculinity that promote stoicism and independence. Instead it provided a simple positive message about arthritis. It was anticipated that men would appreciate the positive message but would be more likely to respond to slogan 2 because it was more effective in minimising any conflict between dominant social constructions of masculinity and help seeking from health services.

The slogans were presented in two different orders. For the first set of 10 interviews, they were presented in the order of slogan 1, slogan 3, then slogan 2. In the final stage of 11 interviews, the slogans were presented as slogan 1, slogan 2, and then slogan 3. This had no apparent impact on the responses received. The issue of gendered promotional material was explored further in a workshop conducted with people working in the field of Men’s Health, as part of the 4th National Men’s and Boy’s Health Conference (see section 3.5.10(a): Workshop with health workers).

All interviewees were informed of the strategies being employed to ensure confidentiality and anonymity. Information on Arthritis Victoria services was also provided to all who were interested, as a way of reciprocating for their contribution as research participants (Acker et al. 1983) (see section 3.5.3: Participatory research).

Some participants became emotional during the interview and reported at the end that they had found the opportunity to talk about their experiences very helpful. It had helped them to think about their condition and to consider the impact it had on their lifestyle and their self-image. This is consistent with Oakley’s (1988) discussion of the research process in her study of women’s transition to motherhood. She found that the majority of women interviewed were affected by the interview. Generally it led them to reflect more on their experiences, reduced their anxiety and gave them an outlet for their feelings.
To achieve the informal atmosphere and open discussion needed to explore men's attitudes, it was necessary to adjust my interviewing style to the different styles of the interviewees. For those men who were articulate and interested in exploring the topic, it was only necessary to add an occasional trigger question. More regular probes and more detailed explanations were needed for those who were inclined to respond succinctly, who were unfamiliar with the issues, or who had not previously thought about the reasons for their actions. Brown (2001) in her methodological review of gender and interviewing noted the experiences of McKee and O'Brien (1983) who found that men were less communicative than women and less expressive about feelings and emotions. Men can also use humour as a 'mask' to feelings in the interviewing context. Brown reviews a range of studies that report on difficulties in getting men to talk in interviews, "when they did, many of them had a joking style, and treated questions lightheartedly" (2001:189). I did not encounter this difficulty in my interviews. In some cases, the men spoke of previous instances when they had used humour to discuss their situation with their male peers. Perhaps they were able to tell me about those experiences because they had gone through a process of re-evaluating their masculinity in response to the demands of their chronic condition (see Chapter Five: Qualitative Findings), or perhaps it was easier because of the rapport that had developed between us in the interview, and/or because I was female, as discussed in section 3.5.4: Researcher-researched relationships. In some cases, men laughed as they were telling me about a painful experience. This use of humour as a tool to manage the experience and presentation of emotions (Kehily 1997) was discussed in the analysis of the results (see section 5.1.1: "Nobody wants to be in a position of vulnerability" and section 5.1.4: "We're expected to be a kind of rock of strength for others").

Two of the men interviewed had English as a second language and it was often necessary to reframe my questions to clarify meaning. Fortunately, their wives were present and were able to help clarify some points of confusion, either in terms of my questions, or their answers. In both cases, English was a second language for the wives as well, although they were more proficient. The risk of using the wives as translators is that they may have placed their own interpretations on the questions and on the answers. Occasionally the wives would
answer on their husband’s behalf and in one instance, Rose questioned Mario’s response and he changed it accordingly. This ‘interference’ seemed to be partly because the wives also had arthritis and were interested in being involved. It also reflected their role as the health coordinator for their husband. As this was the reason for including some partners in the interview process, it was a useful observation.

This prohibitive influence of the partner’s presence also existed when I was interviewing the wife and the husband was present. For example, Keith was present for some of my interview with his wife Nancy. When I realised she was unconsciously checking her responses with him, I suggested that the process might work better if he was not present during our interview. He was happy to leave us to it. It was not possible to ask the wives to leave during the interviews because of their supporting roles as translators.

Male partners were not recruited for the interview process. However, insights about the role of same sex partners were gained from Peter who identified as homosexual, and Kevin who identified as bisexual.

All of the interviews were conducted at a venue chosen by the interviewee to ensure that it was a comfortable environment for them and to minimise any inconvenience from being involved. In most cases, this was the interviewees’ homes. On a couple of occasions an office at Arthritis Victoria was used, and for one interview I organised access to an interview room at a local community centre.

3.5.9 Analysis of interview data

The collection and analysis of the interview data was conducted using a grounded theory approach (see section 3.5.1: Grounded Theory). A participatory research approach was also used (see section 3.5.3: Participatory research) to show respect for the lived experiences of the participants, to benefit from the value of participants’ and health practitioners’ insights into the issues, to demonstrate the
credibility of the results (see section 3.5.5: Quality of the research process), and to encourage the development of self management programs that are accessible to men (see section 7.2: Guiding principles for health organisations targeting men with a chronic illness).

All but one of the interviews were tape-recorded with the permission of the interviewee and then fully transcribed. One of the men requested that I email him the questions as he was too busy to set aside time for a phone or face-to-face interview. As a result, I emailed him a copy of the interview protocol and he emailed back his response. As it was one of the later interviews the interview protocol had been refined. It is possible that his request for an emailed list of questions was partly because he was uncomfortable with an interview format and the prospect of having to discuss his condition in a more personal way. The virtually anonymous process and the flexible, efficient format of email provided a useful alternative that may be more in keeping with dominant masculinist notions of preferred modes of service delivery. Lorig (2000) conducted a back study over the internet and reported 50% of participants were men. However, all of the other men interviewed for this thesis appeared comfortable with the face-to-face interview format.

Each transcription was checked at least once against the original recording to ensure the reliability of the transcript. The recordings of the interviews with Adam and Francis had sections that were difficult to hear and transcribe. To ensure the accuracy of my data, I rang Francis and clarified some responses with him, and I arranged for Adam to check the transcript against the recording with me, to clarify some of the difficult sections. I also took the opportunity to explore some of Adam’s responses further during our second meeting.

The transcripts were entered into N-Vivo 1.1 qualitative software for thematic coding and analysis, consistent with a grounded theory approach. Concurrent collection and analysis of data is an integral part of the grounded theory approach (Charmaz 1983). In this study, coding and analysing the data in two blocks addressed the time constraints posed by the interview schedule. The first coding and analysis occurred halfway through the schedule of interviews, the second at
the end of the interview phase. This two-stage approach also provided a means of demonstrating the reliability of the results.

Memos were written within two days of each interview to record the interview conditions, any aspects about the participants and/or the interview process that may have influenced the responses, and any new ideas or apparent relationships between concepts that emerged during the interview or occurred to me as a result of the interview (Charmaz 1990). New ideas or relationships between concepts were then explored in successive interviews, such as Francis’ suggestion that a medical certificate would assist him to take time off work to attend a self management course (see section 5.1.9: “I like a professional environment”).

In order to develop an understanding of the issues influencing men’s involvement in self management programs, it was necessary to draw out the commonalities in the data. Unfortunately, it is inevitable that in this process some of the individual personal experiences are not mentioned or fully acknowledged. This reflects the tension between respecting the lived experiences of the individual and needing to translate their experiences into abstract, general terms for the purposes of the research (Acker et al. 1983).

Pseudonyms were assigned by the researcher to each participant to protect the anonymity of their responses. This process was explained in the Research Project Information Sheet (see Appendix 2). The inclusion of a significant number of quotes in this thesis and the use of pseudonyms rather than an initial, or other signifier, were strategies that were deliberately employed as a humanising element to acknowledge the personal journeys and perspectives shared by the men in the interviews and to illuminate the findings. Place names and names of friends and family were also altered by the researcher to maintain anonymity.

Some repetitive speech mannerisms and interviewer interjections, such as, “Yes” and “Okay” were left out to avoid obscuring the essential information. However, where they indicated the speech patterns or the hesitations of the speaker in a way that was relevant to the point being raised, they were left in. I occasionally added clarifying statements in brackets.
As work status and age proved to be the most significant correlates to men’s decisions regarding access to self-management programs, they were included as identifiers for each quote. Wives were identified in relation to their husbands, because it was their influence on their husband’s health behaviour that was explored in the interviews.

The coding and analysis consisted of reading through the transcripts and coding the data according to the concrete issues emerging from the interviews. The data was then organised into these categories and studied to identify commonalities and variations. Further coding for processes, actions, assumptions and concepts was also carried out (Charmaz 1990). This is consistent with the initial coding phase as described by Charmaz (1983) and described in section 3.5.1: *Grounded theory*.

The patterns that emerged as a result of the coding and analysis of the first set of interviews was organised into a summary of preliminary findings that was used to guide the interview protocol for the remaining interviews and to highlight the issues that needed to be explored further. This process of writing up a summary of the findings assisted me greatly in clarifying and developing the conceptual framework that was emerging for each category (Charmaz 1990). The preparation of conference papers (Gibbs 2001a; Gibbs 2001b) and non-academic presentations (Gibbs 2002a; Gibbs 2002b) throughout the research process was a similar aid to the analytical process.

The preliminary findings also provided an opportunity to seek feedback from the contributors. A *Summary of the preliminary analysis* (see Appendix 6) was mailed to all of the participants in the first set of interviews, and also to the health workers who had referred participants to me, i.e. Arthritis Victoria managers, a rural health education nurse, and a rheumatologist. It was sent to keep them informed of the progress of the research and, as part of the participatory research approach, to invite their feedback to contribute to the development of the final theories. A feedback sheet was included for their convenience (see Appendix 7).
Feedback was received from 3 of the men and from the rural health education nurse. The feedback received was positive and included some issues to consider for the next phase. Feedback relating to the findings has been incorporated into Chapter Five: *Qualitative Findings*. In addition, Kevin commented on the research methodology. He made a point of saying that he liked the style in which the *Summary of preliminary findings* were presented because he felt that it did not have the detached feel of academic papers that often do not recognise the personal experiences of those involved. He appreciated the way the comments of individuals were brought out in the form of quotes and was gratified to see that some of his were used and that their intention had been understood. He thought the representation of the range of experiences was positive and said he valued the range of perspectives which was further evidenced through the use of a range of quotes. He felt it was clear that the summary did not reflect any preconceived conceptions. This was very encouraging and gave me a heightened consciousness of my responsibility to consider the personal impact on the research participants of the research findings and the way in which they are delivered.

As a result of the preliminary analysis and the feedback received, some questions were dropped from the interview protocol and some additional probes included (see section 3.5.8: *Interview format*). After the remaining 11 interviews, the initial coding phase was carried out again on the entire data set without any direct reference to the preliminary exercise. This ‘starting again’ was done to ensure the reliability of results and enabled further refinement of the categories, which were “constantly compared within a category to establish consistency, and across categories to establish clear boundaries” (Tesch 1990:24). The memos I had recorded throughout the research process were also incorporated into this process. For example, during the interviewing and transcribing, I recorded the memo:

There seems to be a pattern emerging that while men-only programs may help to attract men to try a program (motivating factor because they make it more obviously personally relevant), mixed programs do not appear to be a deterrent.
This memo helped me to clarify the boundaries between two issues of gender - the gender of program participants, and gendered promotional material.

Focused coding was then undertaken to build and clarify the final categories and reflect the complexities of issues affecting men's access to self management programs (Charmaz 1983). This process resulted in the original codes being developed into conceptual frameworks as my understanding of the data became more complex and more precise, and as the relationship between concepts became clearer. The writing and rewriting of these findings for this thesis (see Chapter Five) was a crucial phase in the development of the conceptual frameworks into theories. It allowed identification of problems with the conceptual framework, clarification of variations in patterns of behaviour, and sharpening of concepts (Charmaz 1990).

Another Summary of the research findings (see Appendix 8) was sent to all of the participants and all of the health practitioners involved in the qualitative research phase. Once again, it was sent to keep them informed of the progress of the research and also to invite their feedback. The summary was emailed to all contributors who had provided an email address and posted to all others. This time, a range of possible modes of feedback was suggested – phone, email, mail, to accommodate varied preferences among the participants. Some of the following issues were taken into account when considering appropriate modes of feedback for each participant:

- Providing a written response may have been difficult for some men, depending on which of their joints are affected by arthritis. This was raised by Kevin as a difficulty when responding to the Summary of preliminary analysis. He asked if I could call him for feedback on any future material.
- Follow-up phone calls were made to those participants who seemed to prefer this method when I was seeking feedback on the flyer for the Men's Information Night (see section 3.6.1(c): Consumer input).
- Time was highlighted in the interviews as a major issue for men, preventing participation in activities outside of work and family. This may
have made it difficult for men to find the time to read and respond to material sent for feedback. Feedback sheets, phone calls, and email messages were all used as ways of minimising the time commitment of the participants.

- Some men may have been intimidated by the prospect of responding to a University research study. This may also have affected their responses within the interview and could also be responsible for a reluctance to access health services. Follow-up phone calls were made to some men to personalise the process.

- Follow-up phone calls or emails were not made to those men who had appeared reluctant to provide feedback at earlier stages in the research, to respect their right to choose not to reply.

Feedback was received from seven men, two partners and two practitioners. Two of the men I called asked me to call back the following week to give them more time to read the summary. When I called back, one was ready with feedback and the other was in hospital having a minor medical procedure. I left a message inviting him to call me back if he had any comments he wanted to pass on. He did not respond so I assumed he either had no feedback or did not wish to give any feedback. In the interview with Leo, a Greek man, it had been necessary to rephrase some of the questions to aid his understanding. He also mentioned that he had difficulty understanding health information written in English but did rely on his daughter to translate. In my letter to him accompanying the summary, I offered to explain the summary in person or over the phone if necessary. When I spoke to him in the follow-up phone call and once again offered to provide more explanation, he said that he had understood most of it and opted to leave it there. When I asked if he had agreed with the parts he understood, he said that I had done well and he agreed with most of it. He mentioned that there were some parts he did not agree with but did not remember what they were. He said they were not big things. I would have liked to explore this further but felt it would have been pushing him as he had already said he would like to leave it there. It was unclear if he was unwilling to continue because he was embarrassed by his limited
understanding, because he did not agree with or was uncomfortable with my findings, or simply because he was not interested in being involved any further.

The feedback that was provided was consistently positive. The contributors indicated that the results made sense and were informative. A few, such as Tarsha and Mervat, mentioned that they had never realised how complex were the issues affecting men’s health behaviour. Mervat, a general practitioner, said that while she had been aware of some influences on men, such as dominant masculinity constructs, she had not considered others, such as the role of females and the need to be careful about the use of humour. This and other specific comments about aspects of the findings have been incorporated into Chapter Five: Qualitative Findings: Why are men reluctant to use self management programs?

The increased response during the second feedback process indicates that the customised approach to the mode of feedback was more appropriate to the participatory research process by taking into account the needs of the research participants.

The outcome of this research and feedback process was the refinement of the theories emerging from the data and their formation into the qualitative and applied findings of this thesis.

3.5.10 Triangulation techniques

The patterns that emerged from the categorisation and cross-comparison of information formed the basis of theoretical propositions about the issues affecting men’s participation in chronic illness self management programs. These propositions were then checked against the findings from other sections of the thesis as a triangulation technique to develop general principles for marketing these programs to men in future. Triangulation is a technique that involves the use of different data sources and different methods to demonstrate the credibility of the findings and the research process (Lincoln and Guba 1985) (see section 3.5.5: Quality of the research process).
Additional methods of triangulation were used in the collection of data. A workshop was conducted in one instance, and a training seminar was utilised in another, to explore with practitioners some of the issues emerging from the interviews with men.

3.5.10(a) **Workshop with health workers**

A workshop was conducted at the National Men's and Boy's Conference held at the University of Western Sydney in September 2001.

I originally planned to restrict the workshop to men with a chronic illness because I wanted to explore their reactions to the images and language used in different promotional material. However, I eventually chose to make the workshop open to all men because otherwise participation would equate to a public declaration about their condition that they may not have been ready to make in that setting. To be able to identify those participants who had a chronic illness, I had copies of the participant demographic forms and consent forms for participants to complete.

The flyer I used at the workshop (see Appendix 9) was deliberately worded to incorporate the initial findings from the interviews I had conducted with men with arthritis. In particular, it had the following features:

- 'Men' in the header, to make it clear it was relevant to men
- 'You can help', to appeal to their willingness to help others, rather than being seen to need help
- 'rate various models', this was considered less alienating than any suggestion of a discussion group
- reference at the bottom to men with a chronic illness, to attract a relevant consumer group
This flyer was included as an insert in the Conference satchel. However, because the workshop was not listed correctly in the Conference program, the workshop was also announced by the Conference organisers at one of the morning sessions on the day the workshop was to be held. As a result, some of the participants decided to attend without having seen the flyer. This resulted in two women attending.

Six people participated in the focus group, four men and two women, and my supervisor was also present as scribe, but not participating. The limited response to the workshop would suggest that the flyer was not successful. However, the artificial setting of a Conference, and problems in relation to Conference administration, made it difficult to draw any conclusions. The topic of the workshop was not included in the actual program, although a flyer was included in the satchel and program organisers mentioned the workshop earlier in the day. The workshop was also located in a building away from the main activities and was on the first day of the Conference when people were still trying to find their way around and may not have read all of the materials in their satchel. Three of those that attended had not even seen the flyer. One responded to the earlier announcement, one was the previous presenter, and one was the chairperson for the session.

All participants were asked to complete a consent form and a demographic form. Two of the participants completed the consent form but did not sign it. This was a recurring problem with the consent form because the signature section at the bottom of the sheet was often overlooked. I was able to collect signed consent forms from these men by mail after the Conference. Because I was expecting only men to attend, I only had the men’s demographic form and so asked the female participants to leave out the masculinity question. The profile of the workshop participants gave the workshop more of a focus on the professional, rather than the personal, experiences of the participants. This proved equally informative in the consideration of promotional techniques for programs targeting men.
The goal of this focus group was to explore advertising techniques that are used to attract men. A range of posters from Arthritis Victoria, Osteoporosis Victoria and the Department of Human Services, were displayed around the room to stimulate discussion and to represent different advertising techniques. The original flyer, used to advertise the workshop, was also part of the exercise. Members of the focus group commented on the issues raised in the workshop from both a personal and a professional perspective. Due to the personal content of some of the responses, I assigned pseudonyms to each of the participants.

Issues raised at the workshop were incorporated into Chapter Five: *Qualitative Findings*.

3.5.10(b) **Training seminar for self management course leaders**

I was invited by Arthritis Victoria to be part of a training update for self management course leaders and to conduct a seminar session based on my findings about improving men’s access to programs. Forty leaders were present, some of whom were health professionals and some peer leaders. Only one of the participants was male.

Before discussing my research findings with the leaders, I asked them about their experiences in recruiting men for their courses. The leaders identified problems relating to recruiting men and successful strategies that had resulted in higher rates of male participation. It is significant to note that both the problems and the successful strategies raised by the leaders were consistent with the findings of this thesis. Specific references to the leaders’ comments have been incorporated into Chapter Five: *Qualitative Findings*.
3.5.11 Research limitations

There are a number of possible limitations to this thesis, some of which have already been discussed. My status as a female interviewer was explored in section 3.5.4: Researcher-researched relationships. Methodological issues relating to the following aspects of the thesis have all been addressed as indicated:

- arthritis prevalence data (see section 3.4.2: Arthritis prevalence data)
- defining masculinities (see section 2.3: Masculinities)
- recruiting across masculinities (see section 3.5.7: Collection of demographic information)
- Aboriginal participant (see section 3.5.6: Recruitment of interview participants)
- Different methods for collecting feedback on the findings (see section 3.5.9: Analysis of interview data).

Another methodological issue that was relevant to my research was collecting data at a single point in time. As Feifel and colleagues propose:

A more stringent test of this consideration would be to investigate the coping modes of patients suffering from nonlife-threatening illnesses at the beginning of their sickness compared to more advanced periods of the disease after some chronicity has set in. It may well be that coping modes which are salutary in the early stages of illness do not possess similar efficacy and usage at later points in time of sickness (1987:98).

Collecting data at a single point in time was a feature of this thesis. However, this issue was addressed by interviewing men at different stages in their illness and seeking their feedback at different points in the research process.

I am also aware that the parameters of the current thesis may limit the transferability of the results. Focusing on men with arthritis or a related condition
who are living in Victoria, allowed me to analyse the issues in more detail but limits the scope of the findings. Disease-specific findings still have some applicability to other conditions because self-management programs generally contain a mix between disease content and self-management practices. A large component of self-management programs focus on the generic consequences of 'lived-with' chronic illness such as fatigue, fluctuations in health status, and emotional reactions to an uncertain future. Issues such as these are common for most conditions and therefore findings in relation to one type of chronic illness self-management course have relevance to a self-management course for another type of chronic illness. However, a related study on a different illness and/or in another location would greatly assist in building a body of research on this topic and an understanding of the needs of men with a chronic illness.

3.6 Applied research activities

This section will detail the research activities undertaken for the applied phase of the thesis. A trial of the research findings was undertaken, and some guiding principles were developed for establishing chronic illness self-management programs that are accessible to men. The aim of this research phase was to explore the practical applications of the research findings.

3.6.1 Organisation of a Trial Men's Information Night

A trial of the strategies arising from the thesis findings was conducted to further establish the confirmability and transferability of the results. This trial took the form of a Men’s Arthritis Information Night

3.6.1(a) Format

Arthritis Victoria readily agreed to develop a trial program with the aim of increasing the participation of men in their services. The focus was particularly on the "hard to reach" men of working age. In keeping with my findings, I recommended that the program:
• Be specifically for men
• Have an information night format
• Use a medical/health setting, such as the Arthritis Victoria premises
• Be held early evening on a weekday
• Be conducted by expert presenters
• Include both male and female presenters
• Be open to wives and partners as well
• Act as a one-stop shop, allowing participants to access resources and register for services
• Be free of charge.

As a result, a Monday evening men’s information session was planned. This consisted of a succinct overview of types of arthritis, medication, pain management, self management, and Arthritis Victoria services. Previous staff member, Bill O’Connor, also spoke of his personal experiences in managing the condition and the benefits of using self management services. A range of resources was on display and there were opportunities to register for various services on the night.

In order to remain consistent with the commitment to anonymous participation, names and addresses were not collected from men on arrival. However, they were asked how they heard about the night to aid in the evaluation of the trial (see Chapter Six: Applied Findings). At the end of the night, the majority of the men were also asked which age group they belonged to in order to confirm that the target group had been reached.

3.6.1 (b) Flyer

An advertising flyer was developed specifically for the trial event (see Appendix 10). As it would act as the primary promotion tool for the event, considerable thought was given to the language and content of the flyer. This was informed by the findings of the qualitative research, which will
be referred to briefly in this section to allow meaningful explanation of the research methods.

The flyer included the following features:

- The word “Men” was the main heading to encourage men to read the flyer and to signify that the information night would be relevant to them (see section 5.2.6: “Because it was designed for men…”).

- Questions about symptoms and their impact on lifestyle were included to help men to determine if their condition had reached a point that warranted accessing health services (see section 5.2.1: “I didn’t realise that I was needing help”). The focus on symptoms and their impact instead of diagnosis was intended to include men who had not consulted a doctor about their condition and therefore had not received a diagnosis. It also included those who were not aware that the term ‘arthritis’ covers a whole range of musculo-skeletal and rheumatic disorders.

- It was stated clearly that the night was free of charge, to remove cost as a potential barrier. Cost can be a particular issue for people with moderate to severe conditions because of the medical costs involved and the potential impact on an individual’s capacity to work (see section 5.1.8: “Cost is a huge issue”).

- The event was described as a “Fast Track Information Night”. The term “Fast Track” was intended to indicate that it was a time saver rather than time waster. As reported in section 5.1.7: “There’s no space for it”, the prospect of wasting time was found to be a barrier to men’s participation in self management services. The term “Information Night” indicates that there would be no requirement for personal input, allowing anonymity if desired. This is consistent with the research findings that men were often reluctant to attend anything
that involved sharing of personal experiences (see section 5.1.2: "Less than masculine for needing a support group"), and instead preferred to be able to 'check things out', before committing to any further involvement (see section 5.1.10: "You haven't committed to anything").

- The presenters were referred to as 'Expert' to demonstrate the credibility of the information (see section 5.1.10: "You haven't committed to anything") and once again to reassure men that it would not be a waste of time.

- The credibility of the event was also supported by the Arthritis Victoria venue. The qualitative results clearly showed that men with moderate to severe arthritis were more likely to consider attending services at a health venue (see section 5.1.9: "I like a professional environment").

- The timing of a service targeting working men is problematic. As the qualitative phase of this thesis showed, work is the single greatest barrier to service use. Therefore, providing the service out of business hours seemed advisable. However, men's concepts of health are often linked to their ability to fulfil their social obligations such as work. This means that as long as they are still working, they do not believe it is appropriate to access health services (see section 5.1.11: "If I got to the stage where I couldn't work"). On a practical level, men with a chronic illness are also often too tired to attend services at the end of the working day, and weekends are generally considered family time. It was not possible to conduct a workplace program for the purposes of the trial, so a weekday evening was chosen. The start time of 7.00pm was set late enough to allow men to get there after work. Refreshments were also provided for those coming straight from work. The finish time was kept to 8.30pm to ensure it would not be too late for those
who were tired after work and to reassure potential participants that a minimal commitment was involved.

- The flyer stated that partners were welcome because the qualitative results show that mixed gender events are not a deterrent to men (see section 5.2.6: "Because it was designed for men...”). The importance of having a gender specific event was to demonstrate that it is appropriate and relevant for men to attend, not to exclude women. The qualitative research findings also showed that partners can often act as an important stimulus to attend, and that men often prefer to attend health services with their wives (see section 5.2.2: “Your spouse says stop complaining and go and see someone”).

- The slogan “Something can be done” was used on the flyer because it was so positively received in the research interviews and, of the slogans presented for consideration, was found to be the slogan most likely to encourage action (see section 5.2.8: “That’s advertising, that’s hype”).

- A male contact person was provided on the flyer. Both a male and female person were originally going to be on the flyer to accommodate the different preferences of callers (see section 5.2.6: "Because it was designed for men...”), but the female staff member organising the event was away in the two weeks leading up to the event.

- Email and website details were included on the flyer to accommodate people who preferred the convenience and/or anonymity of these forms of communication (see section 5.1.10: “You haven’t committed to anything”).

- Simple English was used in the wording of the flyer to enhance understanding and to minimise language barriers (see section 5.2.8: “That’s advertising, that’s hype”).
• The use of humour was deliberately excluded to avoid causing offence and to minimise the language barrier. As discussed in section 5.2.8: "That's advertising, that's hype", the experience of moderate to severe arthritis is a difficult and serious issue, and some men felt the use of humour in advertising would be trivialising the lived experience of the condition. The research findings also show that humour made it difficult, if not impossible, for people with English as a second language to understand the message.

• The flyer was copied onto colour paper to attract attention. Blue was chosen as a colour that is often associated with males.

The flyer was printed up at low cost and without the benefit of design advice. An offer to assist with the design was received from one of the research participants after feedback had been sought, but we were not able to accept his offer at that late stage because the flyer was due to go out and the staff member coordinating the trial was going on leave.

3.6.1 (c) Consumer input

The flyer was sent to the research participants for feedback before finalising it for distribution. Graham and Gary were the only ones not sent a flyer. Graham, a farmer, was not included because the research findings suggested that a modified approach would be appropriate for rural areas, incorporating local community leaders and networks. Gary, a member of the Aboriginal community, was also not included because he made it clear that the only thing that might be likely to encourage him to attend a self management program was if it was held at the Aboriginal Health Service. However, as noted below, Eric and John responded very positively to the flyer and the idea of attending the information session, even though they, like Gary, had seemed unlikely to access services. This changed response was not expected otherwise the flyer would also have been sent to Gary.
The flyer was sent to fifteen men using their preferred mode of communication, as identified when feedback was sought on the summary of research findings. Feedback was received from thirteen. Two did not respond to the request for feedback. I followed up as arranged with one of the participants, and also called two others because I suspected they might have been waiting for my call. For all of the others, I waited for their call, to respect their right not to reply if preferred. A delayed response was received from Kevin and Phillip. Some responded by email and some by phone. All of the feedback was passed on to Helen Stead, the Arthritis Victoria staff member coordinating the trial, and many of the suggestions were incorporated into the final version of the flyer or into the distribution plan. All of the participants responded positively to the flyer with some providing constructive suggestions about the content of the flyer and/or its distribution.

The feedback from Eric was particularly significant. He showed a real reluctance to access Arthritis Victoria services during the original research interview and said he would only be likely to do so if he could not work any longer, and yet after seeing the flyer he wanted to attend. “I am disappointed I will not be in Melbourne that week … as reading the flyer generated enough interest for me to want to attend. I hope that if enough support is shown that another night might be organised for another time perhaps at a different venue...maybe over the western side of Melbourne.” He finishes his email with the comment, “Best wishes for the night. I am disappointed I am not able to attend.”

Similarly, John said he would have liked to attend but would be away, and yet in the original interview he did not show much interest in accessing additional Arthritis Victoria services.

The interest shown by Eric and John indicated that the flyer was appropriately worded. However, it is also possible that their involvement
in the research and/or their relationship with me as the researcher had changed their attitude to self management services.

Eric supported a number of the features on the flyer, “The concept of a ‘fast track information night’ appeals to me as it sounds like it’s a night that means business and has a purpose. The fact it is free is also a plus”. He also suggested that we add the Arthritis Victoria website to the final version.

While it is important to acknowledge that the participants may have been unwilling to give negative feedback, the comments received indicate that the flyer was worded appropriately in terms of the group it was trying to reach. Once again, the extent of the feedback also supported the use of a customised mode of communication.

The feedback from Peter, who is also a researcher in the area of men’s studies, was based on both his personal and professional experience. He suggested that the sub-headings refer to men with arthritis rather than pain or stiffness. However, this directly contradicted our approach on this issue. After considering his comments we decided to stick with the original wording but we did follow his suggestion to change the mention of ‘kids’ to ‘family’. As Peter is homosexual, this reminder to include men who do not have kids, was also an important reminder that some wording can exclude men of different sexualities.

Responses were received from men of all different ages, and all indicated that the flyer was good and clear. One of the older, retired men would have liked it to be held in the day, which is consistent with the research findings that retired men are more interested in daytime sessions because they do not have the restrictions of work commitments (see section 5.1.7: “There’s no space for it”). However, as Arthritis Victoria was trying to reach men who would not normally attend services, the trial was targeted at working men. He also suggested including challenging, specific questions such as “You could be bushwalking with people 20 years younger!” but this level
of specificity was not consistent with the broad, inclusive approach being adopted.

Importantly, those men who had English as a second language found the flyer easy to read and understand. Mario was planning to attend after reading the flyer, but did not come in the end for reasons unknown.

Phillip, aged in his twenties, mentioned that the wording of the flyer was simple and straightforward for older men. When I queried if he saw it as targeting older men, he hesitated, then agreed because he had the impression the flyer was targeting men who would not normally seek help, and his own perception was that this was a characteristic of older men as compared to younger men. His comments in the original interview, as discussed in section 5.2.4: "A whole lot of people sitting around comparing operation scars," indicate that he may also have assumed that the flyer was targeting older men because of his perception that arthritis was associated with ageing, and Arthritis Victoria was for older people.

Leigh Garwood, the Chief Executive Officer at Arthritis Victoria, also provided feedback to Helen Stead. He suggested that the commanding tone of "Attention All Men" would turn him off, and just "Men" as a heading, would keep his attention. He felt that "musculo-skeletal" was too hard to understand and should be replaced with "arthritis, osteoporosis and other chronic conditions." He also suggested that "Light refreshments provided" be added. These changes were all included.

3.6.1 (d) Distribution

The distribution plan for the flyer was based on the research findings that showed that men are more likely to act on information about health services received from their doctors, including information in waiting rooms (see section 5.2.3: "It hasn't been suggested to me by my doctors"), women in their family, or recommendations from friends and associates (see section 5.2.2: "Your spouse says stop complaining and go and see
someone”). It was also speculated that using male-friendly distribution points would help to overcome the dominant social construction of masculinity that associates health services with feminine behaviour (see section 2.5.5: Different ways of distributing health promotion information), similar to the techniques often used by health promotion programs targeting men.

Approximately 2000 copies of the flyer were mailed to community sites in localities deemed to be within easy travelling distance of the Arthritis Victoria venue. Male-friendly sites such as hardware stores, liquor stores and service stations were targeted. Community sites such as pharmacies, community centres and local newspapers were included, as recommended by Lorig and colleagues (1996). Approximately 250 of the flyers were sent to Arthritis Victoria volunteers and new Arthritis Victoria members to encourage word of mouth advertising. This is highlighted as an information pathway for men in both section 3.5.10(b): Training seminar for self management course leaders and section 5.2.2: “Your spouse says stop complaining and go and see someone”.

In order to promote the event via recommendation from a health service, the flyer was mailed to rheumatologists practising in Victoria and copies were supplied to the Arthritis Victoria Telephone Information Service to inform and send out to new callers where relevant. Details were also posted on the Arthritis Victoria Website Calendar and were published in the Southcity GP Services newsletter.

The extent to which the flyer was displayed and promoted at each of the target venues is not known. Due to time constraints leading up to the event, the flyer was not included as an insert in Arthritis Update, nor was it possible to distribute it to women’s hairdressers or men’s service clubs as was originally planned. This means that women’s networks, a common health information pathway for men, were not utilised in this trial.
3.6.2 Guiding principles for health organisations

Practical findings that emerged from the literature review and the quantitative, qualitative and applied research were combined to develop guiding principles for health organisations interested in establishing self management programs for men with a 'lived-with' chronic illness. These guiding principles were attached to the Summary of research findings and sent to participants and contributors for feedback. The feedback received was very positive. Jenny, a community health educator, commented that, “Your guiding principles are going to be a tremendous help to health workers who are planning programs. It will be great to be able to use them as a checklist for a best practice approach.” Any comments or suggestions about specific aspects of the guidelines have been noted in the relevant parts of Chapter Five: Qualitative Findings or section 7.2 Guiding principles for health organisations targeting men with a chronic illness.

The quantitative, qualitative and applied findings are reported and discussed in the following three chapters.
Chapter Four  Quantitative Findings - Measuring gender differences in utilisation of Arthritis Victoria services

4.1 Introduction

The literature review (see Chapter Two) revealed clear gender differences in levels and patterns of health service use. However, the bulk of the research related to primary care services. Very little research has been done on gender differences in use of chronic illness self-management services. For this reason, a statistical analysis of the client records of the Arthritis Victoria Telephone Information Service was carried out to investigate whether similar gender differences were occurring in relation to these programs.

4.2 Results

It was not always the case that the person with arthritis was the person to contact the Telephone Information Service (TIS). In 22% of cases it was a friend, family member or health worker who contacted the service on the person’s behalf. Table 9 shows the breakdown of the gender of the person with arthritis by the relationship of the person who contacted the TIS. This was a significant relationship ($\chi^2=68.4$, df=2, p=0.000). The results showed that women (81%) were more likely than men (68%) to call on their own behalf, whereas family or friends were more likely to call on behalf of a man with arthritis (28%) rather than a woman with arthritis (16%). Put another way, women were almost twice as likely to call the TIS on their own behalf than men (OR=1.99; 95%CI: 1.67 to 2.36).
Table 9: Gender differences in the relationship with the person who contacted TIS
(column percentages are shown parenthetically)

<table>
<thead>
<tr>
<th>Contact</th>
<th>Gender of person with arthritis</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female</td>
<td>Male</td>
<td>Total</td>
<td></td>
</tr>
<tr>
<td>Self</td>
<td>2256</td>
<td>568</td>
<td>2824</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(80.7)</td>
<td>(67.8)</td>
<td>(77.7)</td>
<td></td>
</tr>
<tr>
<td>Family or friend</td>
<td>438</td>
<td>236</td>
<td>674</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(15.7)</td>
<td>(28.2)</td>
<td>(18.6)</td>
<td></td>
</tr>
<tr>
<td>Researcher/health or</td>
<td>101</td>
<td>34</td>
<td>135</td>
<td></td>
</tr>
<tr>
<td>exercise worker</td>
<td>(3.6)</td>
<td>(4.1)</td>
<td>(3.7)</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>2795</td>
<td>838</td>
<td>3633</td>
<td></td>
</tr>
</tbody>
</table>

Age appears to be a contributory factor in determining who makes the call for information and services, as indicated by a three-way analysis of gender, age and contact person (Table 10). It was found that for females with arthritis, there was a significant relationship between age group and relationship to the person calling TIS ($\chi^2=48.3$, df=4, p=0.000). The results show that younger women (85%) rather than older women (74%) are more likely to call on their own behalf. Conversely, older women (22%) are more likely than younger women (12%) to have a family member or friend call on their behalf.
Table 10: Gender and age differences in the relationship with the person who contacted TIS
(columm percentages are shown parenthetically)

<table>
<thead>
<tr>
<th>Gender of person with arthritis</th>
<th>Contact person</th>
<th>Age group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>18-40</td>
</tr>
<tr>
<td>Female</td>
<td>Person with arthritis</td>
<td>410</td>
</tr>
<tr>
<td></td>
<td>(85.1)</td>
<td>(84.5)</td>
</tr>
<tr>
<td></td>
<td>Family or friend</td>
<td>56</td>
</tr>
<tr>
<td></td>
<td>(11.6)</td>
<td>(12.4)</td>
</tr>
<tr>
<td></td>
<td>Researcher/health or exercise worker</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>(3.3)</td>
<td>(3.1)</td>
</tr>
<tr>
<td>Total</td>
<td>482</td>
<td>1275</td>
</tr>
</tbody>
</table>

| Male                            | Person with arthritis | 98 | 269 | 201 | 568 |
|                                 | (56.3) | (67.9) | (75) | (67.8) |
|                                 | Family or friend | 64 | 109 | 63 | 236 |
|                                 | (36.8) | (27.5) | (23.5) | (28.2) |
|                                 | Researcher/health or exercise worker | 12 | 18 | 4 | 34 |
|                                 | (6.9) | (4.5) | (1.5) | (4.1) |
| Total                           | 174 | 396 | 268 | 838 |

A significant relationship was also found for males with arthritis, between age group and relationship to the person calling TIS ($\chi^2=20.2$, df=4, p=0.000). However, the results show that for men, it is the older age group (75%) rather than the younger age group (56%) who are more likely to call on their own behalf.
Whereas, younger men (37%) are more likely than older men (24%) to have someone call on their behalf.

It is not known whether service contacts made on behalf of men with arthritis were initiated by the person with arthritis or independently by the caller. Anecdotal evidence from staff at the Telephone Information Service, however, suggests that in those instances when someone calls on behalf of a male with arthritis, the call tends to be made without the man's prior knowledge. Because of the inherent difficulty in determining the knowledge of the person with arthritis about a call made to the TIS on their behalf, the remaining analyses relate only to calls made to the TIS by the person with arthritis him or herself. This additional exclusion reduces the sample to a size of 2,824 cases.

<table>
<thead>
<tr>
<th>Age group of person with arthritis</th>
<th>Gender of person with arthritis</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-40</td>
<td></td>
<td>410</td>
<td>98</td>
<td>508</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(18.2)</td>
<td>(17.3)</td>
<td>(18)</td>
</tr>
<tr>
<td>41-60</td>
<td></td>
<td>1077</td>
<td>269</td>
<td>1346</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(47.7)</td>
<td>(47.4)</td>
<td>(47.7)</td>
</tr>
<tr>
<td>61-75</td>
<td></td>
<td>769</td>
<td>201</td>
<td>970</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(34.1)</td>
<td>(35.4)</td>
<td>(34.3)</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>2256</td>
<td>568</td>
<td>2824</td>
</tr>
</tbody>
</table>

The age factor does not appear to apply when only calls made by the person with arthritis are considered. Table 11 shows the breakdown of age group of the person with arthritis by gender of the person with arthritis. There was no significant relationship between age group and gender for people who contacted the TIS on
their own behalf ($\chi^2=0.451$, df=2, p=0.798). These results indicate that the age factor is more relevant when considering calls made by someone else on behalf of the person with arthritis, whereas males calling for themselves are equally likely to be young, middle-aged or older men.

Of the 2,824 contacts to the TIS made by the person with arthritis, 20% were made by males with arthritis. The difference between the proportion of males and females contacting the TIS can be regarded as an important indicator of service utilization if it does not reflect the difference in the prevalence of arthritis between males and females in the general population. The overall gender difference in the prevalence of arthritis is generally estimated to be 2:3, males: females (Willcox; Badley and Wang 1998; Lawrence et al. 1998). The results from the Arthritis Victoria Telephone Information Service show that 23% of client calls were about men and 77% were about women with arthritis, i.e. an approximate ratio of 1:3, lower than the prevalence estimate for the general population. Unfortunately, data on prevalence of different types of arthritis are not available for the Australian population. They were inferred, therefore, from two published sources based on United States and Canadian data (Klippel and Dieppe 1998; Lawrence et al. 1998).

Table 12 shows the estimated percentage of males with arthritis in the population. The estimates were disaggregated by the specific condition (e.g., Ankylosing Spondylitis, Fibromyalgia, Gout, etc.) and the source of the estimate is indicated. The number of females and males contacting the TIS in 1997 is indicated for each condition. The percentage of the people contacting the TIS who were male is also shown for each condition, with the 95% confidence interval around the estimate in the right most column (Agresti and Cafo 2000). Around a quarter of the sample (25.1%) contacting the TIS had a condition for which population estimates were not available, or for which the cell sizes were too small for meaningful comparisons and these are shown in the row next to the condition “other”.

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Table 12: Gender differences in participation rates compared to prevalence estimates

<table>
<thead>
<tr>
<th>Condition</th>
<th>% Males (Pop.)</th>
<th>TIS Contact</th>
<th>% Male (TIS)</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ankylosing spondylitis</td>
<td>83.3(^1)</td>
<td>37</td>
<td>21</td>
<td>36.2*</td>
</tr>
<tr>
<td>Fibromyalgia</td>
<td>15.0(^1)</td>
<td>173</td>
<td>16</td>
<td>8.5*</td>
</tr>
<tr>
<td>Gout</td>
<td>82.5(^1)</td>
<td>7</td>
<td>34</td>
<td>82.9</td>
</tr>
<tr>
<td>Osteoarthritis</td>
<td>40.0(^2)</td>
<td>809</td>
<td>226</td>
<td>21.8*</td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>25.0(^1)</td>
<td>359</td>
<td>29</td>
<td>7.5*</td>
</tr>
<tr>
<td>Polymyalgia rheumatica</td>
<td>25.0(^1)</td>
<td>24</td>
<td>4</td>
<td>14.3</td>
</tr>
<tr>
<td>Psoriatic arthritis</td>
<td>50.0(^1)</td>
<td>19</td>
<td>12</td>
<td>38.7</td>
</tr>
<tr>
<td>Rheumatoid arthritis</td>
<td>25.0(^1)</td>
<td>279</td>
<td>67</td>
<td>19.4*</td>
</tr>
<tr>
<td>Other</td>
<td>n/a</td>
<td>549</td>
<td>159</td>
<td>22.5</td>
</tr>
<tr>
<td>Total</td>
<td>n/a</td>
<td>2255</td>
<td>568</td>
<td>20.1</td>
</tr>
</tbody>
</table>

* \(p<.05\)

For five of the 8 conditions, significantly fewer males contacted the TIS than would be expected given the prevalence of the condition among males in the population. That is, the 95% confidence interval surrounding the estimated percentage of people who were males contacting the TIS (the column on the

right), fell below the prevalence of the conditions in the population (column second from the left). For three of the conditions there was a substantial (greater than 10) percentage points difference between the percentage of people contacting the TIS who were males and the percentage that could be expected given the prevalence among males in the population.

For three conditions there was no significant difference. Two of the estimates (polymyalgia rheumatica and psoriatic arthritis) were in the direction of the significant results reported above and one estimate (gout) was almost exactly the same as the population estimate (82.9 v. 82.5). This may be because there is community recognition that gout is a condition that affects predominantly men and that it is affected by dietary intake. It may also be because gout tends to be characterised by acute, painful episodes that require attention rather than a gradual onset.

The relationship between gender and mode of contact with the TIS is another potentially important issue affecting access (Table 13). There is some suggestion that men prefer more anonymous modes of service delivery (Banks 2001).

Table 13: Gender differences in mode of contact (column percentages are shown parenthetically)

<table>
<thead>
<tr>
<th>Mode of contact</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone</td>
<td>2169</td>
<td>529</td>
<td>2698</td>
</tr>
<tr>
<td></td>
<td>(96.1)</td>
<td>(93.1)</td>
<td>(95.5)</td>
</tr>
<tr>
<td>Face-to-face</td>
<td>78</td>
<td>34</td>
<td>112</td>
</tr>
<tr>
<td></td>
<td>(3.5)</td>
<td>(6)</td>
<td>(4)</td>
</tr>
<tr>
<td>Written</td>
<td>9</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>(0.4)</td>
<td>(0.9)</td>
<td>(0.5)</td>
</tr>
<tr>
<td>Total</td>
<td>2256</td>
<td>568</td>
<td>2824</td>
</tr>
</tbody>
</table>
There was a significant gender difference in the mode of contact ($\chi^2=9.865$, df=2, p=0.007). However, this difference may, in reality, be of little practical import. Both males and females overwhelmingly (in excess of 90%) tend to use the telephone as their mode of contact with the TIS. The difference between males and females appears to lie in the slightly greater use of face-to-face contacts by males (6%) than females (3.5%).

Table 14 shows the relationship between the gender of the person with arthritis and the reason for the contact.

### Table 14: Gender differences in reason for contact

<table>
<thead>
<tr>
<th>Reason for contact</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>General information about condition</td>
<td>929</td>
<td>213</td>
<td>1142</td>
</tr>
<tr>
<td></td>
<td>41.2%</td>
<td>37.5%</td>
<td>40.4%</td>
</tr>
<tr>
<td>General information about management of the condition</td>
<td>740</td>
<td>208</td>
<td>948</td>
</tr>
<tr>
<td></td>
<td>32.8%</td>
<td>36.6%</td>
<td>33.6%</td>
</tr>
<tr>
<td>Pain management</td>
<td>37</td>
<td>20</td>
<td>57</td>
</tr>
<tr>
<td></td>
<td>1.6%</td>
<td>3.5%</td>
<td>2%</td>
</tr>
<tr>
<td>Exercise and recreation</td>
<td>204</td>
<td>36</td>
<td>240</td>
</tr>
<tr>
<td></td>
<td>9%</td>
<td>6.3%</td>
<td>8.5%</td>
</tr>
<tr>
<td>Education</td>
<td>37</td>
<td>2</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td>1.6%</td>
<td>0.4%</td>
<td>1.4%</td>
</tr>
<tr>
<td>Emotional issues</td>
<td>41</td>
<td>10</td>
<td>51</td>
</tr>
<tr>
<td></td>
<td>1.8%</td>
<td>1.8%</td>
<td>1.8%</td>
</tr>
<tr>
<td>Medication</td>
<td>37</td>
<td>15</td>
<td>52</td>
</tr>
<tr>
<td></td>
<td>1.6%</td>
<td>2.6%</td>
<td>1.8%</td>
</tr>
<tr>
<td>Reason for contact</td>
<td>Female</td>
<td>Male</td>
<td>Total</td>
</tr>
<tr>
<td>-------------------</td>
<td>--------</td>
<td>------</td>
<td>-------</td>
</tr>
<tr>
<td>Diet</td>
<td>48</td>
<td>19</td>
<td>67</td>
</tr>
<tr>
<td></td>
<td>2.1%</td>
<td>3.3%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Alternative/unproven remedies</td>
<td>24</td>
<td>9</td>
<td>33</td>
</tr>
<tr>
<td></td>
<td>1.1%</td>
<td>1.6%</td>
<td>1.2%</td>
</tr>
<tr>
<td>Aids and equipment</td>
<td>68</td>
<td>11</td>
<td>79</td>
</tr>
<tr>
<td></td>
<td>3%</td>
<td>1.9%</td>
<td>2.8%</td>
</tr>
<tr>
<td>Arthritis Victoria services</td>
<td>46</td>
<td>11</td>
<td>57</td>
</tr>
<tr>
<td></td>
<td>2%</td>
<td>1.9%</td>
<td>2%</td>
</tr>
<tr>
<td>Other/unknown</td>
<td>45</td>
<td>14</td>
<td>59</td>
</tr>
<tr>
<td></td>
<td>2%</td>
<td>2.5%</td>
<td>2.1%</td>
</tr>
<tr>
<td>Total</td>
<td>2256</td>
<td>568</td>
<td>2824</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

There was a significant gender difference in reason for contact ($\chi^2=29.550$, df=11, p=0.002). The majority of service contacts (74%) for both men and women were seeking information about the nature of their condition and/or its management. However, when reviewing the breakdown of the figures in Table 14, it can be seen that women were more likely than men to be interested in information about their condition whereas men were more likely to be interested in management of the condition. Further differences are evident in women's preference for information about exercise and recreation, education, and aids and equipment. Conversely, men were more likely to call about pain management, medication, and diet. This difference in emphasis may indicate that women tend to seek an understanding of the condition to enable management of the course of the disease, whereas men are more interested in symptomatic relief. Significantly, there was no gender difference in tendency to call about emotional issues.
4.3 Discussion

The quantitative research component of this thesis shows that the gender differences in the extent and patterns of use of primary health services are also occurring in relation to self-management services for people with arthritis and related conditions.

There is support for the hypothesis that men with arthritis (particularly for some specific conditions such as ankylosing spondylitis and osteoporosis) are less likely to contact the Arthritis Victoria Telephone Information Service than women. This was so, even after taking into account the lower prevalence of arthritis in men.

The data also supported the contention that men and women access the services in different ways. Women were more likely to call on their own behalf and men (particularly younger men) were more likely to have a family member or friend call on their behalf. There is anecdotal evidence, however, to suggest that this reflects the traditional role of women attempting to influence the self-management behaviour of significant men in their lives. This is a concern because Maisiak and colleagues’ study exploring the follow-up action of users of an Arthritis Telephone Information Service, found that those who made the call for themselves were more likely to engage in positive health behaviours. They note that:

The surrogate callers may have failed to convey useful information to the referents and may not have had a positive influence on them. In addition, symptomatic individuals who used the service themselves may have been more motivated to act than the referents of surrogate users. Support services may need to encourage surrogate callers to have the referents contact the service directly (1990:218).

Miasiak and colleagues do not raise the possibility that surrogates may make the call without the referent’s knowledge, although it would still be advisable in this case to encourage surrogate callers to have the person with the condition contact the service directly.
The pattern of family members calling on behalf of men is consistent with studies reporting on the role of women as the health coordinators of the family (Cameron and Bernardes 1998; Norcross et al. 1996; Pinnock et al. 1998), as discussed in section 2.4.4: *External influences*. It also reflects the qualitative findings of this thesis in relation to the role of women in raising men’s awareness of self-management options and encouraging them to seek help (see section 5.2.2: "Your spouse says stop complaining and go and see someone").

Another important finding was that men and women appeared to contact the Telephone Information Service with different aims. Women were more likely to seek an understanding of the condition to enable management of the course of the disease. Men appeared more interested in symptomatic relief. This has potential implications for the delivery of services. It was not clear whether this difference in focus reflected gender differences in general knowledge of, acceptability of, interest in, or access to, certain self-management options. The qualitative findings indicate that it may occur when men are not aware of other service options (see section 5.2.4: "A whole lot of people sitting around comparing operation scars"). It may also be due to the limited amount of time men were prepared to allocate to health management (see section 5.1.7: "There’s no space for it"). Therefore, the apparent tendency for men to seek symptomatic relief, including medication, may actually represent an effort to find a ‘quick’ fix’ solution. This may be further influenced by a misunderstanding of the nature of chronic conditions and therefore an expectation of a cure (see section 5.1.5: "I can take care of myself").

The increased tendency for men to seek information about medication is an important result, given the contradictory evidence on gender differences in drug use. According to Verbrugge, drug use by women remains higher even when morbidity is controlled, and suggests that, “this is partly explained by their greater access to care, attitudes about symptom care, and psychological traits” (1985:170). Whereas, Courtenay (2000b) states that men’s greater use of substances is well known. Courtenay also notes that, “while men’s greater use of substances is well known, the reasons why men are more likely to use substances are poorly understood and rarely addressed” (2000b:1396)(his emphasis).
The fact that men and women seek information/services about emotional issues to the same extent may seem surprising at first, given men's apparent reluctance to talk about their conditions or share their emotions (see section 5.1.1: "Nobody wants to be in a position of vulnerability" and section 5.1.2: "Less than masculine for needing a support group"). However, it is less surprising when it is revealed that men are unlikely to access services at all until their condition has reached crisis point, and when that happens there is a need for compassionate services providing emotional support (see section 5.1.11: "If I got to the stage where I couldn't work").

In summary, the quantitative analysis of the Arthritis Victoria Telephone Information Service revealed gender differences in extent and patterns of service use. The reasons for those differences will be explored in the next chapter, Chapter Five - Qualitative Findings: Why are men reluctant to use self management programs?
Chapter Five Qualitative Findings - Why are men reluctant to use self management programs?

The qualitative phase of this thesis consisted of a series of in-depth, semi-structured interviews with 17 men with moderate to severe arthritis, and with 4 of their partners. The focus of the interviews was on their awareness of the self management services available to them, the extent to which they had accessed self management services, and possible factors contributing to their decisions about whether or not to access services.

The over-riding themes that emerged from the analysis of these interviews were:

- The tendency for men to avoid acknowledging and dealing with chronic illness. This appears to occur as a result of dominant social constructions of masculinity that operate in opposition to positive health behaviour. As a result, men's health behaviours are influenced by the extent of their reliance, rejection or reformulation of hegemonic masculinity (Gerschick and Miller 1995).

- Men's reluctance to access chronic illness self management services is exacerbated by a limited awareness of service options, arising once again from traditional masculinity norms that dictate that health responsibilities are a feminine concern (Courtenay 2000b).

This avoidance of health issues and limited awareness of health management options, expresses itself in a variety of ways but is particularly striking because it is evident in men across diverse social groupings. This supports the contention by Connell (1999) that regardless of the forms of masculinity that men identify with, they must all come to terms with hegemonic masculinity.

Section 5.1: Avoidance of health issues, explores the various ways in which men avoid health issues because of a fear of being perceived as weak or vulnerable, a fear of ageing, the expectation from others that they be strong, a need to maintain control, a perception of having no time for health management because of work
and family commitments, and the impact of the condition on financial independence. Practical issues such as the setting and the format of self management courses are also explored. Ultimately, it is found that men in the middle stages of life with work and family responsibilities are unlikely to access self management services until their condition has progressed to crisis point. All of these barriers to accessing self management services are linked to the constraints of hegemonic masculinity, in particular, the traits of strength, independence and stoicism. In many cases they are also associated with men's concept of health as being defined by their ability to work (Watson 2000). The role of health beliefs is also explored.

Section 5.2: Limited awareness of self management options, will explore the residual influence of traditional gender roles within Australia on men's level of awareness of when health action is required and what action to take. The role of partners, doctors, and friends in influencing those decisions will be examined. The effect of previous experiences, perceptions about the nature of self management services, service features and promotional tools, will also be explored in terms of their impact on men's awareness of and participation in self management services.

5.1 Avoidance of health issues

Men's tendency to avoid acknowledgement of chronic illness manifests itself in various ways that are linked with hegemonic masculinity, requiring men to be strong, independent and stoic. Working capacity is also strongly related to delays in accessing self management services.

5.1.1 "Nobody wants to be in a position of vulnerability"

A reluctance to let others know about their condition was a common issue for many of the men interviewed for this thesis. There was a perception that this would place them in a position of vulnerability, either in relation to their jobs, or in terms of their social (i.e. masculinity) status. This is consistent with Pinnock and colleagues' (1998) study of older men with a urological condition. They
found that men across a range of social groupings were reluctant to talk about health issues. However, the men spoke freely within the focus group setting of the study, causing the authors to speculate that, "it was the social context, rather than any inherent behaviour pattern in men, which made them reluctant to talk" (1998:372).

Adam and Eric discussed their reluctance to speak about their condition in a work environment because they felt it would place them in a vulnerable position. Adam had retired from work because of his health, six years earlier. He has more than one chronic condition:

I think the biggest thing is, and I can only speak from my own experience, is that most men won’t, don’t like to admit that there’s a problem in existence. That’s the biggest thing in the first place. And particularly while they’re in the workforce and even more so in today’s work climate, nobody wants to be in a position of vulnerability. So where they might have been tempted to do something about things, because of their employment situation then they say, I’m not going to show any weakness here either.

Adam, retired, age group 41-60

Adam’s use of the word ‘weakness’ is significant because it demonstrates the perception imposed by hegemonic masculinity that ill health represents weakness. To admit to that weakness places men in a vulnerable position that is perceived by them to threaten their status in the hierarchy of masculinities and in the workplace.

Eric also has more than one chronic condition. He was still working full time and expressed concern that if his condition was known, it could affect his employment:

I work in the sports industry and so probably there’s a focus there on people being fit, people being well. When you have a problem that seems to set itself up as chronic, it becomes a bit of a stigma perhaps that you
feel that because you’re not as fit and as able as what you were when you were younger that it may have affected your employment. So you feel that if you were involved in services, that word would spread. People would find out that you had arthritis.

Eric, employed full time, age group 41 – 60

Eric was conscious that the sports industry he worked in had a particular focus on physical fitness and this placed an additional pressure on him to keep quiet about his condition. He felt that if he used self management services, there was a risk that word would spread. He refers to the “stigma” of being labelled as a person with a chronic illness, as if it is a ‘shameful’ position to be in. This indicates a reliance on characteristics of hegemonic masculinity by Eric, and perhaps by the sporting industry generally. Significantly, Eric did not consider that using self management services might help him to keep his condition secret by minimising the impact of the condition, and he certainly did not question the validity of his concerns about others knowing about his condition. Eric’s anxiety about revealing his condition in the workplace and his avoidance of self management practices mirror the comments of the men in Broom’s study of the gendered experience of diabetes type 2:

In particular, men emphasise the intrusion of demanding working conditions on their ability to adhere to recommended diabetes regimens. ...And some of them express anxiety about possible frank discrimination or job loss if their diabetic status is discovered, or if their diabetes management is permitted to intrude into the workplace (2003:24).

Similar concerns were also expressed by some of the women in the study. Although, as noted by Broom:

Because more men than women participate in the labour force, and because employment has traditionally been thought to play a larger part in men’s self-identity, this is more likely to be an issue for diabetic men (2003:7).
Eric's concern with keeping his condition secret was also consistent with Charmaz' (1994) findings about men with a chronic illness. She reported on situations where men manipulated their circumstances to protect their work situation. Kevin described a similar approach to his work situation, as described later in this section.

Eric also spoke of the regular pain caused by his condition, and the way that it restricted his activities and affected his working and family life. And yet he did not feel it was appropriate to talk to his family about it:

I've got a good relationship with my family, my marriage is great but a lot of the time I keep to myself about it because they don't want to hear all the time I feel crook or whatever, so it's a bit of an act sometimes ... Which is a bit hard, but then how much of your own baggage do you put on someone else?

Eric, employed full time, age group 41-60

Eric felt the strain of acting as if he was okay when he was feeling crook. He kept it to himself but also got frustrated when people, including his family, did not understand what he was going through:

If you've got something that people can see that you're injured and not well and all that sort of stuff, they'd probably treat you differently, but people don't know that you've got sore things or whatever, yeah I don't know. It's a bad thing isn't it? ... The thing that pisses me off sometimes is my family don't understand. I'm sure sometimes they think I'm whingeing ... people don't understand ...

Eric recognised that the nature of his condition meant that his pain and illness was usually not visible to others. He was annoyed that this meant that people did not understand what he was going through and yet he did not question his determination not to share his experiences and his feelings about it. This demonstrates how a reliance on hegemonic masculinity can prevent men from
being open about the impact of their condition even with those closest to them and even when it is counter-productive in terms of social support.

There appeared to be some contradictions in Harry's comments about his willingness to talk about his condition with his friends. It eventually emerged that he had different groups of friends with whom he would discuss things in different ways. With some of his friends he only ever mentioned it in a 'jokey' way. When asked why he did this, he explained that he was hoping someone else might have information to help him, but he also wanted to avoid sympathy and a perception that he was weak ("less than perfect"), so he hid his feelings within the safe boundaries of humour:

It must have been subconsciously - if I mention it in a jovial form, one, it will sort of not show that I'm worried about it so it won't invoke sympathy or "Oh poor bloke he's less than perfect," but by mentioning it hopefully by some chance there might be someone out there who might say, "Oh gee, well then all you need to do is this to fix it."

Harry, unemployed, age group 41-60

Significantly, Harry recommended the use of humour in reaching men when he provided feedback on the preliminary analysis of the research findings. He recommended watching John Clarke's ABC The Problem with Men video to inform this thesis on the use of irony in men's approach to health.

The use of humour was mentioned in the Draft National Men's Health Policy (Commonwealth Department of Human Services and Health 1996) as a strategy often used by men to distance themselves from health subjects. This is partly because traditionally, men have not been socialised to network on health issues in the way that is widely accepted in relation to work issues. Humour is also a way of discussing difficult subjects without acknowledging the underlying personal and emotional struggle. Being able to laugh about a personal struggle is a way of demonstrating strength rather than weakness and is therefore acceptable behaviour in terms of hegemonic constructions of masculinity.
Kehily (1997) in her study of young men in school describes the use of humour to
display emotional strength. This is achieved through humorous exchanges i.e.
‘verbal sparring’, or ‘a slanging match’. However, the situations described by
Kehily appeared to be more of a competitive mechanism for the young men to
assert their position against their peers in the gender hierarchies rather than to
demonstrate control over their own physical or emotional struggles. Lyman also
discusses gender and humour:

...jokes reveal the way social organisations are gendered, namely, built
around the emotional rules of male bonding. In this case study, gender is
not only the primary content of men’s jokes, but the emotional structure of
the male bond is built upon a joking relationship that “negotiates” the
tension men feel about their relationship with each other, and with women

The studies described by Kehily and Lyman focus largely on situations where
gender is the primary content of men’s jokes. However, in this thesis, there was
more evidence of men using joking to trivialize personal anguish in an effort to
demonstrate strength and to mask vulnerabilities, thereby allowing them to
“maintain the emotional structure of the male bond” (Lyman 1987:150).

Harry did not just use humour in his conversations. He also had tattoos on his feet
that were usually visible because he worked in the marine industry, often with
bare feet:

I used to have tattoos on my feet, my right foot said “I’m tired”, my left
foot said “Me too” … until I got sick of that joke and I had them covered
over with other tattoos.

Harry, unemployed, age group 41-60

Harry may have used the tattoos as a means to draw attention to his condition in
the hope of eliciting some information. He was also demonstrating his strength at
the same time, not only by joking about his pain but also because of the traditional
association between tattoos and toughness.
Another way of discussing the impact of illness in a manner acceptable to hegemonic masculinity, is to link the issue to a manly or challenging endeavour. Harry noted with amusement that, "...it's one of the only confessions that people make, or men will make - this injury when I was doing something really incredible!". Kevin also referred to this practice of covering up the 'weakness' caused by the condition, by presenting it as something 'acceptable' like a sporting injury:

... in work situations I would lie and I became a relentlessly practiced liar. I would say to people, "Oh, I had a bit of an injury on the weekend playing footy", and that brings about social inclusion. People love you if you say you have a footy injury, they say (whispers) "Oh right okay, how's it going?" I mean you say to people in a work situation, "Well I've actually got quite a lot of inflammation in my feet at the moment," and in work situations, if I'm honest, basically people would be very uncomfortable ...

Kevin, casual work, age group 41-60

Kevin felt that discussing his condition honestly would make other people uncomfortable because it was perceived as a weakness to have physical limitations as a result of a chronic illness. So instead he chose to lie and present his condition as a result of a sporting injury, a sign of strength rather than weakness, in terms of hegemonic masculinity. Charmaz (1994) describes similar scenarios where men with a chronic illness lied to maintain their work identity. It is also similar to Broom's (2003) study that describes both men's and women's anxieties about revealing their diabetes status in the workplace, and to Eric's approach, as described earlier in this section, where he kept his condition secret in order to protect his work status. In doing this, Kevin chose to fit with external expectations of masculinity rather than his own sense of masculinity:

In a sense I was becoming a practiced liar and I didn't want to be like that. ... I headed out into life with a real commitment to being honest about my life and if I'm honest, sort of challenging the structures that encourage us to be dishonest.
Kevin was very conscious that the lies he told were consistent with what society expected of him and yet the practice of lying did not fit with his own understanding of what it means to be a person of integrity. This gave rise to a conflict between his concept of himself as a person with integrity, and dominant social expectations of masculine behaviour.

Kevin’s condition challenged his ability to identify with characteristics of hegemonic masculinity in a way that his identity as a bisexual man had never done:

> Ironically, I would find it easier to speak on national television about my sexuality than arthritis because for me arthritis involves acknowledging my physical disability …

Kevin, like many of the men, perceived physical disability as something undesirable. In this instance, he mirrored the comments of several of the other men interviewed, in not wanting to acknowledge publicly that he has a condition that diminishes his physical capacity. In doing so, he would be admitting weakness and risk being relegated to a subordinate masculinity.

Even when Harry did speak about his condition to his friends he was reluctant to speak about his experiences in any depth.

> Generally, I keep it general. Like they say, ‘Oh you’ve got sore feet’, I say ‘Yeah, yeah, I think I’ve got arthritis’. I still say to them, I think … or it’s believed that I have. … I just don’t want to admit to it, still. And they say, ‘What are you doing about it?’ And I said, ‘Oh well I’m taking dribs and drabs and special shoes and inserts and doing exercises’ and they go, ‘Oh yeah is it working?’ I said ‘Oh, moderately, you know, there’s an adjustment to do, it’s a real pain in the arse’. And they go, ‘Oh yeah, oh what are you doing next week?’

Harry, unemployed, agc group 41-60
Harry’s experiences with his friends were similar to Kevin’s experiences at work, demonstrating how the expectations of others can impact on a man’s sense of acceptable behaviour in relation to dealing with an illness. The level of discussion that was “allowed” within this group of males was limited to informational and Harry was still reluctant to acknowledge that the arthritis had been diagnosed. This reflected his fear of being relegated to a subordinated masculinity if the condition was acknowledged as being permanent and therefore represented an ongoing loss of strength and independence.

Harry had another group of male friends who were prepared to work outside the traditional discourse of hegemonic masculine discussions, but even within this group, the discussion about Harry’s illness experiences appeared to be limited by the comfort level of the group:

Even with my more introspective friendships, we tend to go more onto the spiritual, emotional, metaphysical discussions, just, “How’s the state of your brain?” That’s probably more relevant to us. The physical discussion still gets left by the way, we’re actually not interested in each other’s physical ailments. We will mention them, but we’re more willing to talk about the effect it’s had on us.

The group of friends Harry described here seemed to have reformulated hegemonic constructs of masculinity and engaged in more introspective discussions. However, they still avoided discussing each other’s ailments. This suggests that although Harry’s discussions with his friends were limited in different ways, they may all have been influenced by the hegemonic notion that men ‘do not ask for help’:

We don’t sit down with our mates and discuss how distraught we are, we flippantly describe what a drag it is and we might find it convenient to blame everybody else for why we feel so terrible but when we’re feeling really bad, you’re there on your own, you may as well feel like crawling off into a hole. Whereas if you’re a woman you ring up your best friend and burst into tears, … And it’s encouraged, and it works but it doesn’t
with blokes. They position themselves and squirm mentally, trying to find a way to deal with it, for a really long time, like I did.

Harry described men’s reluctance to share feelings, resulting in a sense of isolation when things are really bad. He noted that this private, isolated struggle is what happened to him and seemed disappointed in the lack of support among men:

There’s no exchange of information by men who have got it. They’re not admitting it to anyone else. And that’s what I’m interested in. That’s why I came to that meeting. I just sort of thought, who are these people my age that have arthritis?

There is a suggestion here that there was an issue of “seeing”, Harry needed to visualise what other men with arthritis looked like, as if they are an alien or stigmatised group, to see if he belonged to that group. Yet, even when Harry lamented the individual, private approach to arthritis by men, he spoke of an interest in an exchange of information rather than emotional support. In doing so he seemed to be endeavouring to present his service needs within a framework of ‘acceptable’ masculine behaviour. This tendency for men to present their problem in ways that fit dominant social constructions of masculinity (Walker 1986) is discussed in section 2.4.5: Different patterns of health service use. Harry’s referral to information needs versus his veiled references to emotional needs is also explored in section 5.1.11: “If I got to the stage where I couldn’t work”.

Harry raised, as a point of contrast, the tendency for women to support each other in their struggles. As quoted, he acknowledged the external influences on these gendered behaviours – “it’s encouraged”:

Women are coming from a caring point of view in the exchange of information. They care for their friends and family but men exchange information for power. Like, ‘I’ll give this information that makes me incredible in your eyes and you’re beholden to me’.
Harry suggested that sharing information is linked to caring for women but represented a loss of power for men asking for help. This perception of gendered roles in relation to sharing of information is consistent with dominant social constructions of gender. However, when asked, Harry did not see asking for help from a professional organisation in the same light, because “that’s their job”.

Phillip, a younger man, had to give up work as a tradesman because he developed a repetitive shoulder injury. He did not seem to have any difficulties about being open about his condition and the restrictions it placed on him. His friends were aware of his condition and his subsequent limitations, as were his new employers. While Phillip seemed to regret not being able to do all he used to do, there was no evidence of reluctance to talk about the condition or concern about vulnerability in the workplace:

It’s not something I talk about all the time because it’s part of my life … and so they’re all aware of it. I try not to sound like I’m whingeing. And there are points where it’s really bad and if someone asks me to do something, I have to say, ‘I’m sorry I can’t help you’ … like my friend moved out yesterday. I couldn’t help him … He didn’t ask me because he knew straight away … and same with my girlfriend and other friends, and people at work … if I’m asked to do something at [work] and I fear that it might hurt myself … they will take that and respect that, you know, find another way of getting round it.

Phillip, student and casual work, age group 18-25

Phillip said he did not talk about his condition because he did not want to sound like he was whingeing. Once again this is consistent with hegemonic notions of masculinity that require strength and stoicism. However, Phillip did not appear to be endeavouring to hide his condition and its effects. Unlike Eric (as described earlier in this section), he felt that people in his life were aware of his physical limitations because the condition impacted upon all areas of his life. He seemed to feel comfortable in saying he could not do something, and felt that those limits were respected by his friends and work supervisors. This indicated that Phillip had rejected hegemonic notions of masculinity and also that he was not experiencing
any external pressures to comply with masculinist norms. The contrast between Phillip’s workplace experiences and those described by Eric and Kevin (as described earlier in this section) reflects the importance of the way health issues are framed and responded to in the workplace.

Phillip’s lack of concern about the perception of others may also have been influenced by the fact that he had been told his condition would heal eventually if managed appropriately. Therefore, he was likely to regain his strength and independence. His apparent rejection of hegemonic masculinity constructs in terms of work capacity may reflect the fact that Phillip’s condition resulted from a work injury and therefore was perhaps more ‘acceptable’ according to masculinity norms. At the time of the interview he had also embarked successfully on a career change that may have helped to mediate any difficulties he had experienced in relation to a change in work status.

However, during the interview, Phillip did talk about the impact of the condition on his recreational pursuits, and the loss of power and confidence that went with that:

I’ve always been physical throughout my childhood and my teenage years. Friend, guy I live with now, we’d always go canoeing on weekends, used to play squash heaps, tennis heaps ... and I’ve lost all of those things. I can’t do those and I probably won’t be able to do them for many years, so there’s (sort of laughs) ... I don’t know how to explain it but it’s just sad for me because I’ve lost a lot of things that I love to do in my life. Even, I’m a really keen swimmer when I’m fit and I’ve been swimming as part of my rehabilitation for my shoulder but if it’s inflamed, don’t swim because any movement is going to make the muscle inflame even more. ... And even just general pleasures in life, going to the beach, swimming in the ocean, it’s scarier for me now ‘cause I don’t have the power that I used to ... I just haven’t got the strength in my shoulders to be able to feel confident about not stopping myself from drowning (half laugh) ... setting up tents, camping, you know, everything (half laugh).
In this part of the interview, where Phillip is describing the impact of the condition on his recreational lifestyle, he gave a half laugh occasionally, which did not appear to be true amusement but rather an attempt to laugh off the issues that are causing a personal struggle for him. The attempt to laugh off the seriousness of it, as was highlighted by Harry earlier in this chapter, is an attempt to disguise the emotional struggle that this lifestyle change has represented for him.

Phillip talked of a loss of power, strength, confidence, and mateship. This active, leisure part of his lifestyle appeared to be more critical to his sense of self and his own masculinity than his work status or perceptions of how others may see him. This may reflect the fact that he is still at an early stage in life when leisure pursuits may still be first priority. In contrast, the priorities of the men interviewed in the middle stages of life, appeared to be more closely linked with work and family responsibilities. It may also reflect the fact that Phillip was getting adequate support in his workplace but may not have been getting enough in relation to the impact of his condition upon his recreational pursuits.

In summary, men’s reluctance to talk about their condition was linked to a fear of losing status at work, in their families, and among their friends, and potentially being relegated to a marginal masculinity. Men also noted the pressure of expectations from others to meet hegemonic notions of masculinity and be strong and independent.

5.1.2 “Less than masculine for needing a support group”

The tendency of many of the men to avoid talking about their condition often extended to wariness about participating in self management services. The leaders at the self management course leaders update (see section 3.5.10(b); Training seminar for self management course leaders) reported that male participants were often reluctant to act or even acknowledge that they needed help. Men were more likely to be comfortable with the idea of accessing self management services if
they could present it as a way of helping someone else, or if their condition had become so severe that they needed to talk to someone who understood.

Eric talked freely about his condition and the problems it was causing him, and continued to chat about it when the interview was finished. Yet, he was very wary about the prospect of going to any sort of program provided by Arthritis Victoria because he expected he would need to talk about his circumstances. He had a limited understanding of the nature of services available. This is discussed further in section 5.2.4: “A whole lot of people sitting around comparing operation scars”. He was wary of using services, not just from a fear of sharing but also from a fear of being confronted by his own disability:

I don’t know if it makes you feel any better to sit in a room with a group of people who’ve all got it and say I’ve got arthritis and this is what my story is. … I’ve been in a group situation with say health related issues, the only thing that happens sometimes is that you walk away and you say, “Well, phew, I’m not so bad after all. There’s always someone else worse off than me”. And I’m not sure whether that’s the truth. Well, I mean I know there’s people worse off than me but that still doesn’t help me sometimes when I get up in the morning and can hardly walk and all that sort of stuff, I mean I feel sorry for those people too but that frightens me … I think, is this what I’ve got to look forward to? That’s what goes through my head - that it will just deteriorate. … And you think to yourself, that’s not really good.

Eric, employed full-time, age group, 41-60

There appear to be a number of issues tangled up in Eric’s concern about attending a support group. First of all, he did not think it would help him to talk about his condition. This is linked to the hegemonic notion of masculinity that men do not talk about weakness or feelings. His condition appeared to have progressed to a point that it was having a significant impact on his life. He began to say that it would help to know that others are worse off than him, that he is more able in comparison to other people with arthritis, rather than less able than other men his age. He appeared to find this reassuring. However, he immediately
questioned whether it was in fact true. Either way he did not want to be confronted by the truth because he might either have to acknowledge the extent of his condition, or he might be faced with a vision of a future where it gets worse. Both scenarios were frightening for him and he actually used the words ‘frightens me’. This conversation indicates that Eric was actively practicing avoidance as a way of managing his condition. This is consistent with Feifel and colleagues’ (1987) proposal that there are three possible coping modes in response to chronic illness, confrontation, avoidance, or acceptance-resignation.

Kevin had also practiced avoidance in managing his condition until he got to such a difficult point in his experiences with arthritis that he had to talk to someone about it. At this stage he found support groups helpful, where talking to others had not been:

...in many situations talking openly about things doesn’t help because people can feel so threatened by it that their response is actually quite profoundly alienating. They say things like, ‘Well, you’ve got to think positively haven’t you?’ And you sort of go, ‘Well yes I’m trying but that doesn’t sort out my financial problems, that doesn’t sort out the fact that when friends invite me out for dinner I can’t go because I can’t pay for the restaurant and I don’t want my friends paying for me’. ... But what I found with the self-help group was people understood what I was talking about.

Kevin, casual work, age group 41-60

Kevin had found talking to others about his condition ‘alienating’ because they were not able to understand his experiences and therefore gave responses that undermined his efforts. He was conscious of others’ expectations that he demonstrate hegemonic masculinity by being independent and not showing weakness. This was evident in his refusal to attend social events because he could not pay for himself. Conversely, he found that when he spoke to people with arthritis, they understood what he was going through. He felt that the common experience of the condition was essential regardless of gender or social circumstances:
Even if people were sometimes from quite different financial circumstances ... whilst many men, including myself, might experience this as a gender issue, I believe it’s not purely a gender issue because there are women who are independent who struggle to support themselves and their situations can be just as difficult in some ways.

Here he acknowledges the dominant socially constructed gender roles in relation to financial independence, and yet rejects them. This contradiction in attitude was apparent in Kevin’s comments about other issues throughout the interview and seemed to suggest that Kevin is in a transitional phase in terms of his own masculinity, shifting from a reliance on many of the characteristics of hegemonic masculinity, to a rejection of dominant social expectations of gendered behaviour.

In contrast to Kevin, there was a wariness among many of the men about attending programs and having to provide personal input, of being in a situation that involved the sharing of experiences. Self management course leaders also reported that male participants were often reluctant to express how they felt. Adam raised concerns about being involved in a men’s group in particular. His first comment was that he would advise against men’s programs because of “not wanting to feel that you’re any different to anyone else”. This showed that he was more comfortable operating within dominant social expectations of men. He spoke further on his concern about men’s programs, in both our first and second discussion:

I’ve got all sorts of thoughts about the men’s group that you don’t want to feel that you’re stepping over the boundary. ... By stepping over the boundary, I guess I’m talking about the issue of masculinity, probably a fear of being seen by someone as less than masculine for needing to be part of that support group.

Adam, retired, age group 41-60

Adam seemed to be linking the need for a support group as a sign of weakness. His use of the word “fear” shows how signs of weakness can be critical in
undermining a man’s position in society’s hierarchy of masculinities. He explained further in our discussion that it was the perception of others, those who do not need a support group, that was of concern. He also expressed a belief that men’s groups are perceived by others to be linked to homosexuality:

I do think there is a perception out there that a men’s group may have an element of homosexuality. I don’t believe that, but I have heard that perspective pontificated at the bar and the local footy clubrooms and in comedy routines. I heard the other day, something like, ‘the bikies would bash it, the footy club would take it away on an end of season trip, the homos would form a self help group, and the lesbians would workshop a support network’.

Adam related this in a ‘jokey’ manner, but presented it as a widely held view of a men’s support group. Each of the options, and the language used to describe the different groups, fit squarely within hegemonic characteristics of masculinity. The tough guys use violence to resolve an issue, and the sporting guys go away together and party over it. In contrast, those who talk about the issue and share their feelings are working in opposition to characteristics of hegemonic heteronormative masculinity, and therefore are grouped with homosexuals because homosexuals engage in behaviour that is in direct opposition to a central tenet of hegemonic masculinity, i.e. heterosexuality (Gilbert and Gilbert 1998). It is pertinent that Adam had heard these views in the pub and the football clubrooms, sites and socio-cultural spaces that also fit within the parameters of hegemonic masculinity. It is also consistent with the findings of Kehily (1997) and Lyman (1987) who show that men use sexist and sexual references in humour to demonstrate their belonging in male bonding groups. Lyman commented that, “... jokes were also targeted at homosexuality, to draw an emotional line between the homosocial male bond and homosexual relationships” (1987:156).

Adam said, above, that he did not share this perception of support groups and was quite definite that it would not influence his decision to join a support group:
No. And I say that very strongly as I’m no longer involved with the Arthritis Men’s Group but I want to emphasise I’m not attending due to lack of time, not a reflection of the above attitudes.

Adam may have chosen to reject these notions of masculinity, an option described by Gerschick and Miller (1994b; 1995), but this hegemonic masculinist framework (Connell 1995) is the measure against which men have to make decisions. This is highlighted for Adam by the contradiction between the circles he mixes in and the views they are espousing, with his own behaviour. This contradiction is also reflected in his choice of labels for his own masculinity in the demographic questionnaire completed by all participants. Adam chose “regular guy”, “sports mad”, “ocker” and “sensitive new age guy” to describe his own masculinity. The combination of “ocker” and “sensitive new age guy” was unexpected from this question because superficially the labels appear to describe opposite types of men. Yet by choosing them both, Adam demonstrated the true problematics of masculinity labels and the way that they can operate at different levels and in different settings, as described by Connell (1999) in his theories on masculinities.

The image of support groups, as described by Adam, is one which would deter participation by those who rely on hegemonic masculinity and its association with “an inability to express feelings for fear of ridicule and a fear of being intimate with other men, for fear of being accused of being homosexual” (Huggins 1995:209) as described in section 2.3.2: Hierarchy of masculinities. Participating in a support group or course only becomes acceptable for many men, if the action of participating can be presented as going there to help others. That is, if it can be voiced in a way that is consistent with dominant social constructions of masculinity (Walker 1986).

In the interviews, ‘helping others’ was commonly expressed as a motivation for attending group programs, such as Ian when asked about his involvement in the Men’s Support Group that had been formed at Arthritis Victoria. Since retiring, Ian had become an arthritis water exercise participant, and had used other Arthritis Victoria services. He had only recently become involved in a newly
formed Arthritis Men's Support Group. When asked why he was involved in the men's group, he explained, "I want to see if I can give something back in terms of experience".

According to the self management course leaders at the Arthritis Victoria Leader's Update, many men attend self management courses on the pretext of supporting their partners, but gradually participate themselves as an individual with arthritis.

Graham showed a similar approach. During the interview he had shown no interest in attending any self management services and avoided all health services where possible:

See I don't go back and back to doctors. I have to go to the doctor every now and then to get some blood pressure tablets and I'm forced to do that, otherwise I wouldn't be there.

Graham spoke of being "forced" to attend the doctor's, basically against his will ("otherwise I wouldn't be there"). This seems to be a way of demonstrating that he was not showing weakness in seeing the doctor unnecessarily. However, when Graham was presented with the scenario of a man with severe arthritis who was considering accessing self management services, he said:

Well I'd certainly encourage him to go. I don't know if I'd say I'd come with him or not, but I might. I might say, 'Oh look I'll go'. If he was a bit doubtful about going then I might say, 'Alright, well look c'mon we'll both go'. ... Could do.

Graham, self-employed, age group 41-60

This showed that Graham was more likely to consider accessing a self management program if he could construct it in a way that showed strength rather than weakness and therefore still fit within the constraints of hegemonic masculinity. This reassertion of hegemonic masculinist characteristics is also evident in a tendency for some men to dominate discussions within courses. This
tendency was noted as one of the issues of concern by the self management course leaders in the workshop discussion.

The only other situations where Graham would consider attending a program, was if it was being run by someone he knew, or was being promoted via local farming networks. He said his reason for attending in this situation would be to help the local organiser. This approach appears to be typical in rural communities. Local networks have been used by many health programs to increase participation in rural communities (Gibson and Denner 2000; O’Hehir et al. 1997).

Graham suggested that networking was the best way of encouraging men to attend a local program:

Well I would think that you’d try and find two or three people and get them to encourage others to come with them … If Bob next door came to me and said, ‘I’m going to go to this arthritis thing, if you want to come along’. Well we’d probably all go along the first time, one or two might go the second time and the third time we’d probably drop out. That’s the nature of going to anything.

He further explained that previous programs have approached two or three locals and asked them to invite six people each to a first meeting. It appeared that the power of local networking was so strong that this was likely to result in good attendance, but continued involvement was dependent on the value of the program.

Paul, a participant in the workshop with men’s health practitioners, recognised this pattern of behaviour. He worked in a rural district and said it was a common scenario for men to attend programs to do someone else a favour. This is consistent with Walker’s (1986) findings on men’s use of community health services. As mentioned previously, Walker noted that when men do present to health services they tend to express their problem in ways that fit dominant social constructions of masculinity.
5.1.3 “And then you’re getting old”

A number of the men were deterred from accessing self management services because they saw it as a risk to their self image. Accessing services meant being confronted by the prospect of ageing and disability.

As evidenced by Eric’s comments below, there was a perception among many of the men that arthritis only affected old people:

I always felt that arthritis and the related sort of diseases were for old people. Whereas I have seen these isolated cases of people with Juvenile Arthritis but I didn’t feel it was all that prevalent in our society, and … going to a group or something like that would be, I suppose - and then you’re getting old …

Eric, employed full-time, age group 41-60

Eric’s comments show that he saw those conditions and services as being age-related. Therefore, if he accessed the services, he was aligning himself with other service users and identifying as an old and/or disabled person.

Harry was also surprised to get arthritis in his forties. His image of arthritis was linked to an undesirable body image, “old people with big knuckles”, in direct contrast to the image of a strong young man as embodied by hegemonic masculinity:

I only know one person my age with arthritis. One bloke who’s admitted to having it, and the only other people I know are old people with big knuckles. And I think that I shouldn’t have it, it’s just outrageous.

Harry, unemployed, age group 41-60

Harry strongly rejected his own identity as a person with arthritis (“it’s just outrageous”) because he perceived it as being associated with old age and an undesirable body image. There was also a sense of embarrassment or shame about
having arthritis at his age when he mentioned that he only knows one person his age who ‘admitted’ having it.

Harry’s understanding of arthritis was based on osteoarthritis, the most common type of arthritis. Osteoarthritis is more prevalent among older people and generally develops as a result of wear and tear in the joints, as described in section 2.2.1: Chronic illness.

Yeah, no idea that young people got it. I thought some friend who got it only got it because he drank so much or he was sort of a carpenter, he was lifting heavy things, he had arthritis in his shoulders and his hands and wrists, and I thought that was the reason he had it.

Harry’s reference to his friend’s drinking habits and work related activities suggested that he linked these behaviours with the development of the condition. This health belief about personal responsibility for the development of arthritis is partly reflected in his beliefs about the cause of his own condition, as discussed in section 5.1.6: “I think my problem is hereditary”.

Peter and Bruce also equated arthritis with ageing. They both remembered a grandparent suffering with a similar condition. Peter described his image of a person with arthritis - “It’s my grandmother”. His grandmother had rheumatoid arthritis. Similarly, Bruce referred to his grandfather whose hands were deformed by arthritis. Peter and Bruce talked about the terrible pain their grandparents had suffered with their arthritis, implying that to them, identifying as a person with arthritis represented both old age and pain.

Fear of ageing is strongly related to arthritis not only because it is perceived as being an old person’s condition but also because the experience of arthritis is very similar to the concept of ageing, i.e. being stiff and slow, no longer able to do things, and feeling frail and uncertain because of pain and fatigue.

Joe, at the workshop with men’s health practitioners, selected a picture of an older man smiling and leaping into the air, as his favourite among the health program
advertisements displayed in the workshop. He said it represented his idea of how he would like to be at that age. James related to another advertisement showing a healthy older man because he was from a similar age group. This supports the interview findings above of a link between concepts of personal health and ageing. It also reflects a common desire to maintain body strength and activity levels as long as possible.

Watson (2000) reported on a link between ageing and men’s understandings of health. Informants expressed a belief in the body’s ability to heal itself. This concept of self healing is related to the need to be in control which is a feature of hegemonic masculinity. The sense of a loss of control that occurs with the development of a chronic illness is explored in section 5.1.5: “I can take care of myself”. The self-healing ability is only expected to become impaired through age and/or injury or illness wearing the body down (Watson 2000). This means that the need to use health services may be perceived by men as a sign that they are ageing and losing self-mastery, which can in turn threaten their sense of masculinity.

The concept of a self healing ability that becomes impaired with age was evident in many of the men’s comments within this thesis. Kevin was very conscious that his experiences with arthritis did not match his concept of health:

I find it very much involves what I was socialised to believe and told, which is that you’re young and healthy and you head out into the world and you achieve and then when you get to seventy things start to slow down and die. Or you get sick and you die. In the meantime you should just be healthy. And I failed on that score and I’m very conscious of that. …I experience it as a failure and I’ve worked very hard to try and change that but I still experience it as a failure.

Kevin, casual work, age group 41-60

Kevin’s condition was severe and had significantly altered his working capacity. While he had initially resisted accessing health services, as discussed in section 5.1.11: “If I got to the stage where I couldn’t work”; he had eventually reached
crisis point and had subsequently become more proactive in exploring service options. His experience of his health as a failure gives some insight into why other men may avoid acknowledging and acting upon poor health, if doing so represents failure. This implies that ‘successful’ men are able to control illness, a concept which was raised in some of the other interviews (see section 5.1.5: I can take care of myself).

The younger men did not express the fear that the development of a chronic condition represented premature ageing. In fact, the issue of ageing appeared to be irrelevant to young men who had just entered adulthood. When middle aged and older men’s work was affected by their condition, they saw it as a sign of ageing and were threatened by the prospect of impending retirement. When the younger men had to stop work because of their condition they saw it as a temporary interruption and, in the case of Phillip, a chance to embark on a new direction in his career. It is not clear whether this is because they are young enough to believe they are ‘immortal’, have time to ‘start again’, or whether it is due to less rigid notions of hegemonic masculinity in younger generations, reflecting a shift in dominant social constructions of masculinity over time (Connell 1999).

Francis had to resign from a relatively new job to be able to have hip replacement surgery:

I just looked back at myself and I can’t do this anymore, I won’t have any life, a regular life, like everyone else has. ... I have to concentrate on my health, ‘cause once I get my health back I’ll be able to do whatever I want – go back to work, do travel, do the things that I want to do. ... It was a big deal for me ... I’d rather sacrifice anything for my health because if I’ve got a job and I’m really unwell, it’s not worth it. I can always get it back.

Francis, employed full-time, age group 18-25

Francis resisted the prospect of surgery and having to resign from work but eventually his condition had deteriorated to the point that it was a necessary step to be able to continue working in the future. Francis saw this loss of work status
as a temporary measure. In relation to his job, he said, “I can always get it back”. After he had recovered from his surgery, Francis was able to find a new job and was working again at the time of the interview.

Thus, Francis did not appear to equate loss of work as a sign of ageing. However, he was conscious of his young age as a person with arthritis when he participated in a water exercise group with participants who were significantly older than him. He was conscious that he was different to the other participants but overcame this awkwardness when he realised that they had their experiences with arthritis in common:

At the start it felt a bit weird because I was much younger, I was 16 and they were all 60 to 70 year old people. It was a bit difficult. But as times go on, I start talking to them, it didn’t seem so bad, they go along there as well, so it’s not just age, you get the same circumstances as well, so since you still have arthritis as well, you can talk about it and because they have more experience they can advise me as well.

Francis, employed full-time, age group 18-25

Francis reformulated the experience of disparity in ages by representing the other participants as senior to him in terms of experience, “because they have more experience they can advise me as well”. In this way he protected his position as a younger person. He did identify as a person with a disability but not as a person who is ageing prematurely.

The fear of ageing did not appear as much of an issue for the men from non-Anglo Saxon backgrounds. The focus for them seemed to be more on life stage rather than age, that is, whether they were working or retired, married or single, had young children or adult children. These indicators of life stage appeared to be more significant in determining variations in responses rather than age. This was reflected in Tarsha’s comments in reference to her ex-husband when we were discussing techniques to attract men to health programs:
I think it helps to be part of the promotion of a session for older men, family men, like Bruce. I’d look at the availability of their time, have they got family responsibilities …

Tarsha, Bruce’s ex-wife, age group 26-40

Tarsha referred to Bruce as an older man and yet he was in his early 30’s at the time of the interview. This appeared to be because she was talking about targeting services to men with family commitments, and was perhaps making a comparison with the sort of services that may target her younger single brother, who was in his 20’s.

When Phillip had to give up work, as well as a whole range of other things such as recreational activities that were central to his life, the issue was not so much about ageing as about strength and work identity. Phillip had to reformulate his working identity from a physical labourer to a role in the media:

… getting this freelance work at the end of last year, working in television, helped me realise certain passions in my life that I’d started in high school doing media and things like that and then had to break because full time work was more important and I had a job and I concentrated on that. So I sort of neglected those areas and getting back into that freelance work helped me realise, even when I had my shoulder injury, it was partly because I needed some skills and some proper training to get into an area where I wasn’t going to be a labourer all my life. And physical labour wasn’t something I was scared of at all. I started building a house for myself three years ago before this had happened and I got injured and I had to stop, which was a really tough decision.

Phillip, student and casual work, age group 18-25

Phillip’s shift in the value he placed on the different types of work is evident when he said he originally saw full time physical work as being more important than his media interests. Even though he had changed to a career working and studying in media, he explained that physical labour is not “something I was scared of”. This suggests that Phillip originally adhered to hegemonic notions that
physical labour is man’s work and that he had to reformulate his understandings of legitimate work practices to accommodate the physical restrictions his condition placed on his work options. Part of Phillip’s reformulation of his work situation was to present his new activities in a way that demonstrated strength of character rather than physical strength:

I went to this acting workshop the other night and I was really scared of going because I’ve never done any performing and the reason I went was because I knew I was scared of it. … my life is starting to go that way, doing things that I don’t have too much confidence in but I have great passion for, so I can turn that around and have the confidence and keep the passion.

In presenting his new working and training pursuits as a challenge, Phillip presented a new way of being strong and thereby still accommodated the expectations of strength inherent in hegemonic masculinity. His role as a freelance worker was also likely to provide a sense of control, similarly consistent with notions of hegemonic masculinity.

Peter’s reluctance to attend Arthritis Victoria was linked primarily to concern about being identified as a person with a disability, about having to adopt a self-image that he was not ready to accept, despite the fact that he’d had HIV and chronic asthma for many years. Having other chronic conditions may make it harder rather than easier to accept a new illness identity. As forecast in section 2.3.3: Chronic illness and masculinities, Peter may have been avoiding further marginalisation on top of what he had already experienced as a result of his homosexuality and his existing chronic illnesses (Vernon 1998).

I think in the back of my mind would be - I had this with HIV too - the idea that the clientele of a place called Arthritis Victoria would be a different kind of clientele to one that I fit into. … There is a labelling thing that happens I think. I do not want to accept myself as a person with
arthritis, and going along there would be taking a step down that road. I want to resist that I guess.

Peter, employed full-time, age group 26-40

His concern that he would not “fit” the clientele was exacerbated by the fact that his image of a person with arthritis was described elsewhere in the interview as “knobby knuckled grandmas”. As discussed earlier in this chapter, Peter’s grandmother had rheumatoid arthritis and so for him there were age, gender and disability connotations to identifying as a person with arthritis. Peter was resisting a self image as a person with arthritis and he felt that accessing services would mean that he had to accept that label.

Peter reported that his perception of the target group for an event for men with arthritis was “Grand-dads”. He said that for him to consider himself as part of the target group, it would have to be for, “Younger men with arthritis! You’d have to be very, very specific!”.

Despite his experience in managing his other chronic conditions, Peter was also concerned that if he accessed services, he may be seen to be seeking help prematurely:

I like Grandmas so I wouldn’t mind spending time with them, but just the idea that I might turn up there and they’d say (long pause), “What are you making such a fuss about?”

This difficulty in recognising when help is needed is linked to the characteristics of hegemonic masculinity that state that men are independent and stoic and do not ask for help. As will be discussed later in section 5.2.1: “I didn’t realise I was needing help”, this results in many men waiting until it is undeniable to themselves and to others that they are justified in seeking help. The pressure these overriding constructs place on all men is particularly evident in Peter’s case. As a man who identifies as gay, has two other chronic illnesses, and is a researcher who specialises in men’s studies, it may be expected that he would have reformulated or rejected these expectations at some previous stage in his life.
Instead it appears that these issues had to be renegotiated with each successive illness scenario.

These findings show that men are reluctant to access self management services because of a perception that service users are old or disabled. Men in the middle stages of their life were particularly threatened by signs of ageing such as reduction in working capacity and loss of work, whereas younger men saw loss of work as a temporary measure to allow rehabilitation to take place. Fear of ageing was also less evident among older men and those approaching aged retirement. According to Ted’s feedback on the Summary of research findings, older men may not perceive self management services as being for the ‘old and disabled’. He noted that he does not see them like that. This may not be an issue for him because he already sees himself as aged and is comfortable with that:

I think I’m already there. My attitude to life is far more relaxed now. I delight in being older than other people.

Ted, retired, age group 61-75

Ted went on to explain that he probably took pleasure in his age because he is still relatively fit. In this way, Ted’s age and his involvement in self management services may actually provide him with a means of demonstrating his strength and fitness compared to his peers and thereby allow him to meet standards of hegemonic masculinity.

Charmaz (1994) reported consistent findings in relation to age. She found that age and life stage were a factor in men’s adaptation to illness, reporting that it was the middle aged and younger interviewees who took a long time to deal with the impact of the illness on their self image. Charmaz also reported a class factor, “Older working-class men were resigned to their situations and built lives around illness. Middle-class men sought to make illness and disability meaningful, to recast them into something through which positive identification could be made” (1994:277). This class difference is also reflected to some extent in my findings. The resignation evident in Gary’s comments contrasts with the self analysis expressed by Harry and Peter.
Gary, although not an Aboriginal, identified as being part of the Aboriginal community and was recognized as such by the Aboriginal community. Gary had retired 20 years previously from work because of his condition. He was aware of Arthritis Victoria but when asked why he had never contacted them he said, “I didn’t seem to worry about it, you know, I can handle things meself”. This comment also reflects a belief in the self-healing properties of the body and a sense of self-mastery, as discussed in section 5.1.5: “I can take care of myself”.

Gary’s response to a question about what sort of services might help him, suggested that he was resigned to his situation and disinterested in making any changes:

I think it’s up to the individual, you know and so I don’t scrm to worry about anythink [sic]. … Just contented in home, watching TV and all that. … you get used to it. … you can’t go out to football and all these other places, because I got me two hips done as well. And me ankles, and so you’re frightened of, you might get knocked over or pushed in crowds. You can’t get public transport, or go out mainly to places, but yeah, you just got to learn to get used to it. … my leg is straight, yeah. … It’s a new thing that’s confining me.

Gary, medically retired, age group 41-60

Gary described significant limitations to his lifestyle and a fear of being knocked over in crowds and yet he described himself as ‘contented’, saying that ‘you get used to it’. His apparent acceptance of retirement and the restrictions his condition placed on his lifestyle and his independence, suggest a rejection of dominant masculinity constructs. However, his reluctance to use health services is consistent with the stoicism prescribed by hegemonic masculinity. It may be that his reluctance to access self-management services was more of a cultural issue, given his readiness to access the Aboriginal Health Service (discussed further in section 5.1.9: “I like a professional environment”). As noted in section 2.4: Men’s health issues, the life expectancy of men in the Aboriginal community is
approximately 20 years less than an Australian non-Aboriginal male (Healthlink 1997; Woods 1997). Therefore, assumptions about Gary’s perception of his life stage may be invalid. His responses may be more meaningfully compared with older, retired non-Aboriginal men. Consideration should also be given to Charmaz’ (1983) findings in research at a rehabilitation institute for the physically disabled. She found differences in staff and patient’s concepts of time that also appeared to be class-based. Professional staff had a linear view of time with the expectation that patients would work to achieve small incremental gains toward a future goal. Conversely, patients perceived time as cyclic, moving “from present to present, from crisis to crisis” (1983:113). Hence, they were content to simply pass time waiting for change, and saw no benefit on working towards targets. Gary’s position seemed consistent with the patients in Charmaz’ study. Perhaps his apparent resignation and lack of action (see section 5.1.5: “I can take care of myself”) was simply ‘passing time’ and ‘waiting for change’. Gary’s resignation also appeared to be linked to his previous experiences with rehabilitation programs that he described elsewhere in the interview as “not worth it”. Rogers and colleagues (1999) noted that prior experiences of illness and health care could influence perceptions of health services.

James, in the workshop for men’s health practitioners, related that after a negative experience at a men’s group he was wary of attending any other men-only sessions. His problem was not so much with the quality of the event but with the fact that he had reacted emotionally to the discussion and “really felt quite mortified by that”. He was uncomfortable that his actions were not consistent with the stoicism prescribed by hegemonic masculinity.

The influence of class on adaptation to chronic illness was inconsistent in this thesis and any results should be considered inconclusive due to the difficulties in clearly identifying class status based on the information collected. For example, at times men with a low educational level lived in a wealthy neighbourhood, and vice versa. Employment status was incomplete and only available for men who were still working. Not surprisingly given the nature of the recruitment sample, a
lot of the men were retired or unemployed for medical reasons. Generally, the
differences in responses to illness seemed more in line with the severity of the
condition and the life stage of the man, rather than socio-economic status.

According to Safilios-Rothschild (1970) variation in illness behaviour resulting
from cultural and social origins, personality organisation, type of interpersonal
relations, and life experiences, disappears when the symptoms are severe,
continuous and incapacitating. Safilios-Rothschild does not explore differences
arising from gender or age. However, she does suggest that variability in illness
behaviour occurs when there is more choice in action taken, without necessarily a
heavy health penalty associated with those choices. This may explain the fact that
variations in health management practices in this thesis generally seemed to be
aligned with the severity of the condition.

Similarly, Verbrugge (1985) states that where a condition is severe, and
particularly if it develops rapidly, there is not much choice in terms of action to be
taken and so gender differences are likely to be small. “In contrast, it is non-fatal
chronic diseases with bothersome symptoms and milder acute problems that are
most likely to reveal gender differences, due to psychosocial factors, in the timing
and extent of health actions” (1985:171). This supports the notion that the
constraints of hegemonic masculinity tend to discourage men from seeking help
until it is undeniable that help is needed.

5.1.4 “We’re expected to be a kind of rock of strength for others”

An individual’s masculine identity is not just determined by self image but also by
others’ expectations and perceptions (Charmaz 1995). Therefore, there is a risk
for men in letting others know about the development of a chronic condition, a
change in functional capacity, and/or the need to seek help. It can change others’
perceptions of him, resulting in a shift in his place in the gender order to a
position of marginalised masculinity (Charmaz 1995; Connell 1987; Gerschick
Vernon (1998) also notes that this marginalisation can be multiplied if the
individual belongs to more than one marginal group, e.g. in terms of sexuality or non-Anglo background.

Kevin was very conscious that he was no longer able to meet social expectations of men. He listed a whole range of settings in his life; work, social life, recreation, and financial independence, where he was unable to meet the standards prescribed by hegemonic masculinity:

I have been profoundly affected by normal social expectations of men. We should be self-reliant. We should be capable of finding all the answers. ... It took me years, it took decades, well for one decade at least, where I never told anyone I was affected by arthritis. I covered it up totally. Friends of mine, closest friends, didn’t know that I was profoundly affected. I would scarcely speak to my doctor about it but it was when I got to the point where I couldn’t walk up a flight of stairs, I couldn’t continue working in the work that I love, I was broke, I couldn’t go out for dinner with friends, I couldn’t go on holidays, my life was just closing in on me, that I had to look carefully at the social expectations on me. I had to look carefully and think well what does our society expect of men ... We’re expected to find the answers ourselves, we’re expected not to need support from others, we’re expected to be a kind of rock of strength for others. And I’ve had women friends and women partners, basically been very clear with me that my role is to be supportive to them while somehow I’m meant to magically find these resources within myself. And I don’t have them. They’re not there.

Kevin, casual work, age group 41-60

Kevin’s reliance on dominant social constructions of masculinity meant that for years he tried to hide his inability to meet the prescribed characteristics. He was conscious that these social expectations are applied to men generally and, as discussed below, also spoke of the role of women as complicit in propping up dominant social constructions of masculinity. Kevin identified as a bisexual, but he did not, at this point in the interview, refer to the expectations of men in his relationships. However, at another point in the interview, he did explore the role
of both female and male partners in encouraging him to access health services and described both as being supportive in different ways. This will be discussed further in section 5.2.2: "Your spouse says stop complaining and go and see someone". This apparent contradiction in his description of the reaction of women to his condition may simply reflect different responses from different women in his life. One of the scenarios he described was a social situation rather than domestic:

Instead of saying men won't look for help we need to look at the enormous pressure on men not to look for help. I'll give you an example from my experience. In my early 20's when I tried to talk to friends about the effect of my inflammatory arthritis, quite honestly women were much more derisory, they simply laughed at me and I learned very quickly not to talk about it. It wasn't that I didn't want to talk about it. ...I said something like, 'I can't drink wine because I get joint pain'. And they'd say, 'Oh where do you get that?' And I'd say, 'I get it in my toes'. And they just laughed their heads off. You know like, 'Hear this about Kevin, this is the funniest thing, he gets pain in his toes when he drinks alcohol!' And I used to think, well it's actually not that funny (laughs).

Kevin laughed when he related this incident but not because he thought it was funny. The significance of the event to him made it clear that this had been a painful experience emotionally. His jovial tone when he described it seemed to be employed to disguise the hurt he had experienced at their comments. As noted by Lyman, "the joke form is a kind of male pedagogy in that, in one guy's words, it teaches "how to keep control of your emotions"" (1987:155). This use of humour to hide feelings was discussed in section 5.1.1: "Nobody wants to be in a position of vulnerability".

The reaction of the women to Kevin's explanation supports his sense of a lack of support and understanding from women. This may be due to women's complicity in upholding masculinist norms, the inability of youth to empathise and/or a reflection that he was seen as "less male" and therefore a figure of fun because of his sexuality and/or his physical condition. It is significant that the lack of support
he experienced in a social environment is interpreted by Kevin as pressure not to seek help and reflects the reliance of many men on women to validate the condition and confirm the need to seek help. It also shows that Kevin used similar tactics to Harry in seeking advice, as described earlier in this chapter. Harry used humour to raise his condition flippantly with his friends, in the hope that someone might give him some advice. As Harry noted, “because I wasn’t taking it seriously no-one else obviously would.” Similarly, Kevin shared details about his condition in a party atmosphere, and possibly adopted a jovial tone to explain his circumstances. This mismatch between the content of what he was saying and the humorous framing of the conversation may also have contributed to the reaction of the women.

Kevin’s ongoing difficulty in meeting the tenets of hegemonic masculinity due to the impact of his condition forced him to reassess masculinist norms and to reject them in order to accommodate the reality of his life:

I had to look really critically at the social expectations on men and the extent to which I’d absorbed those and to say to people “no”, and then it occurred in very immediate circumstances … going out to Tullamarine [airport] and just the simple thing, when a friend says ‘Oh can you pick up that suitcase’, and having to say, ‘No I can’t’.

Kevin had made a clear choice to reject behaviours prescribed by hegemonic masculinity in order to accommodate the physical restrictions of his condition, and yet it was an ongoing struggle. The simplicity of not being able to help a friend with a suitcase at the airport forced his admission of ‘weakness’ in a very public way. Similarly, social experiences reinforced his non-adherence to hegemonic masculinity because the impact of the condition on working capacity meant that he was unable to define himself by his work identity:

There are also issues where our society does, I believe it’s fair to say, expect men to define themselves more … by the work that they do, and for men who are unable to work or for who work is really difficult, as it is for me, it’s just relentlessly difficult in social situations. I mean I went with a
friend last Saturday night to a party, to two parties, and always the first question they would ask is, ‘What do you do?’ And I say, ‘Well I’m looking for work at the moment and I’ve worked at a number of different things’ and you can sort of see people saying, ‘Oh you look okay, you come across verbally as fine, and you’re 43 years old and unemployed, what on earth is going on?’ And so a social situation that for many people would be light hearted and enjoyable, for me is actually a reassertion, an exploration of difficulty. I explain to people, or do I explain? Do I not explain?

Kevin appeared to be in a transitional phase, where he recognised that he could no longer accommodate expectations of hegemonic masculinity but had not yet reconciled this in terms of his interactions with others. He was still trying to negotiate a new masculine identity that was a comfortable alternative.

Kevin’s difficulties in accommodating his lack of a career are consistent with Skord and Schumacher’s comments that, “Just as working is a source of positive male identity, not working is usually stress producing and aversive for the newly disabled male” (1982:285). Skord and Schumacher suggested that those who are ‘role rigid’ (i.e. rigid control of family, committed to role of breadwinner) were more likely to have difficulty adjusting to a loss of work status. The impact of a loss of work on an individual’s masculine identity is also noted by Watson (2000), Hegelson (1995) and Singh (1997). People with a chronic condition have to undergo huge adjustments in relation to work, relationships and future plans (dc Ridder et al. 1997).

Kevin described elsewhere in the interview the struggle he experienced rejecting the occupational expectations of his family that were integral to the concept of masculinity in the family environment:

...you might think that I’m able to step outside masculinity but I can comfortably step outside some forms of masculinity but the masculinity I was encouraged to adopt as a child was that I had to be occupationally successful in a pretty narrow range of occupations. I didn’t step outside of
that, it didn’t present itself as a choice to me and it didn’t really get resolved until ... I stopped attending classes ... I mean most human beings are capable of stepping out of social expectations in one area but not in every area.

Kevin may have been referring to his bisexuality when he related that he was comfortable stepping outside some parts of dominant masculinity, thereby acknowledging that having sex with a male partner places him outside the expectation of heterosexuality inherent in hegemonic masculinity. However, it did not occur to him initially to reject the occupational expectations imposed on him by his family. His eventual rejection of those expectations required a reformulation of his masculinity that may have given him a heightened consciousness of other’s expectations in relation to occupation. By the time of the interview, Kevin’s condition had caused him to shift occupations several times and he was working on a casual/part time basis. This meant that Kevin had to undergo a secondary reformulation of his masculinity in relation to occupation, with the inherent risk of being relegated to an even more subordinate masculinity.

These external pressures on men to adhere to those masculinist ideals of strength, resistance to pain, and independence were also implicit in partners’ accounts of the men’s behaviour, even when the men’s lack of action frustrated the partner.

Mary, Graham’s wife, expressed frustration at men’s reluctance to go and seek help for illness:

I think when women become unwell we tend to immediately go to find out what it is because if you’ve had a family and brought up children you can’t afford not to feel well because you’ve got to look after everybody ... but there seems to be some great resistance on the part of the men and they just don’t want to face up to it, they battle on, but they grizzle on too, which is really frustrating.

Mary, Graham’s wife, age group 41-60
Mary’s statements here reflect gender differences in the perception of seeking help, supporting my comments in section 2.4.2: *Hegemonic masculinity versus positive health behaviour*. Mary saw seeking help as a way of maintaining control and a way of minimising the impact of ill health on herself and her family in order to fulfil the traditional caring role of wife and mother (Doyal 1995). This is consistent with dominant social constructions of femininity in which women are responsible for caring for their family. She perceived men’s reaction to illness as a refusal to acknowledge it and was frustrated that they “battle on” but also complain about it. It is unclear what is the greatest source of frustration for Mary: the fact that Graham does not act on his ill health, or the fact that he continues to complain about it. It may be that his complaints about his ill health are the greatest source of frustration because they do not comply with Mary’s notion of appropriate illness behaviour, which is to seek help. Nor do they comply with masculinity norms, which require men to be stoic.

However, Mary’s explanation of Graham’s reluctance to access health services suggests that she supports hegemonic models of masculinity that require men to be strong and independent and to place work obligations above personal health:

... the farmers work all year and they work all day and with the daylight saving nobody says oh it’s only a 9 to 5, they just keep on going and keep on going and in many cases the average age of the Australian farmer is a lot older these days and a lot of them are working on their own. The kids have gone off, they don’t want to be on the farms so the men aren’t supported in many cases, and I guess that they just feel that they’re the only one that’s keeping everything going and can’t get sick or even if we are feeling sick you just can’t take time off because we’ve just got so much to do.

In Mary’s comments above she seemed to accept the masculinist norms influencing Graham’s health behaviour. Mary also recognised that work is a structural barrier because of the economic necessity of ‘keeping everything going’. She did not question the gendered organisation of their roles on the farm, referring to herself in the previous quote as being responsible for bringing up the
children and looking after everybody, and her husband as being responsible for working on the farm. However, previously in the interview, Mary questioned some of the dominant social expectations on men in relation to health behaviour. When discussing the likelihood of Graham attending different models of health programs, she said “he thinks he’s so busy that he has not got the time to do these things”. This shows that she recognises that his prioritising of work over health is a choice. Graham also reported that Mary had questioned his tendency to give precedence to his work:

Mary says, ‘You’re not really the biggest show in the world, of course you can get away’, but when you’re a one man band … you’ve got to work in with other people too. It’s not always that easy.

Graham, self employed, 41-60

Graham, here and elsewhere in the interview, justified his choice to place work over health on the basis of the structural barriers to accessing health services, i.e. a ‘one man band’ working in with other people.

Tarsha also expressed frustration at Bruce’s inaction in relation to his ill health. He had accessed some health services but still experienced considerable pain from his condition:

…he was just so grumpy all the time because his feet were so painful and it really got to me because I’d think, I’m living with a grump here 24 hours a day because of his feet. Go and do something about it! And he just wouldn’t and because I’d constantly be on him, because he was constantly grumpy. It was just a vicious cycle.

Tarsha, Bruce’s ex-wife, age group 26-40

However, Tarsha perceived his lack of action as a form of strength. She implied that the ability to endure pain is an admirable masculine trait:

His Dad … soldiers on no matter what, absolutely. I see that man as sick as a dog, you know, really, really sick and he won’t do a single thing about
it. He won’t complain, you’ll see he’s half dying there but nothing, and I think Bruce has seen that strength in his father and it’s just about having that strength and being strong and being portrayed to be strong.

The repetition of the words ‘strength’ and ‘strong’ reflected Tarsha’s admiration for Bruce’s ability to put up with the pain and not take action. This contradiction in her frustration with Bruce’s health behaviour and yet her perception of it as a show of strength, shows the tensions between striving for the hegemonic ideal and dealing with the realities of a chronic condition.

Tarsha’s reference to Bruce’s strength in resisting pain is mirrored in Bruce’s comments about pain. When discussing how bad his condition would have to get to justify taking time off work to do a self management course, Bruce commented:

Well, I think that would come down to individuals, and personally speaking I’ve always been one of high tolerance, pain tolerance so it would have to be pretty bad. It sounds bad but I’m just like that. I can take a lot of pain. … When I was a child I used to jump off roofs and it wouldn’t bother me. It hurt but I wouldn’t flinch. I’d just keep on playing.

Bruce, employed full-time, age group 26-40

Elsewhere in the interview, Bruce had seemed open to the idea of accessing self management services and yet here, he placed great store in his ability to resist pain. He even related stories of his pain tolerance as a child when he was not only able to tolerate pain he could also hide the pain — ‘It hurt but I wouldn’t flinch’. This shows a strong reliance on hegemonic masculinity that was also evident when he quoted work and family responsibilities as being the reason he had not accessed self management services yet:

I guess I don’t know what really stops me. It’s hard to put a finger on it, basically a big balance of time and finances, and it’s making the time that’s the hard thing to do. …my Dad’s going through a bad time/phase at the moment. He’s got to start chemo. …and the kids are far from me, they live in Ringwood which is about 23km’s, but what’s even worse is that the
person that I see now, she lives in Frankston which is even farther, 46km's away. So it's, for me, time is very hard.

Bruce laughed in an embarrassed way when he was relating these significant personal issues in his life. The fact that we knew each other socially prior to the interview may have made it difficult for him to acknowledge these difficulties in his life, particularly because sharing of anxieties and vulnerabilities goes against masculinist norms. This is discussed further in section 3.5.4: Researcher-researched relationships.

Bruce's willingness to put his own health needs aside in order to fulfil his family obligations, reflects health behaviours and beliefs that are described by Courtenay (2000b) as a means of constructing or demonstrating gender. On the one hand, Bruce said he was comfortable with the idea of attending programs. However, by resisting his pain and putting his family before his own needs, he was defining his masculinity against positive health behaviours.

Eric also tried to push through the pain at times. He described how "sometimes I have to really force myself to do something that I don't really feel like doing or it hurts me to do it". Eventually, the severity of his condition forced him to make adjustments:

I used to spend a lot of time out at the footy grounds and it got to the stage where I had to make a decision whether to go over the fence or under the fence, and now I can't do either. To get over the fence is a real effort and to get under the fence is a real effort. Now I look for the gate.

Eric, employed full time, age group 41 – 60

Eric's experiences at the footy grounds provided a clear measure for him of the degeneration of his condition. It also provides a useful metaphor for the periodic adjustments the men have to make to accommodate the physical and social restrictions placed on them by their conditions.
5.1.5 “I can take care of myself”

The issue of self-mastery or control over health (Saltonstall 1993; Watson 2000; Watson 1993) emerged repeatedly in the interviews with the men, particularly those who exhibited a reliance on hegemonic masculinity, and was often reflected in the observations of their partners. However, it could be expressed in different ways.

As discussed in section 5.1.3: “And then you’re getting old”. Gary appeared to be resigned to his situation and chose lack of action as a way of taking control of his condition. He spoke of being able to handle things himself and yet he had retired because of his condition and continued to experience pain, loss of function and lifestyle restrictions. He was sceptical about the benefits of being involved in self management programs after his experiences in numerous treatment and rehabilitation programs. His positive experiences with the Aboriginal Health Service meant that only programs linked to this service were likely to receive his consideration. Watson noted that in line with men’s sense of self-mastery over health, “Sometimes, no action or a different action to that proposed by a health professional was seen as the most rational action by a lay person” (2000:65). As discussed in section 5.1.3: “And then you’re getting old”, Gary’s lack of action may also have arisen from cultural and class-based influences.

Graham also chose lack of action, giving other obligations a higher priority than his own health. In response to the scenario of a man called ‘Steve’ whose condition was giving him regular pain and was restricting his work and lifestyle, Graham commented, “His name’s Graham not Steve”, linking ‘Steve’s’ situation to his own. When asked why he did not take the same action as Steve and do a self management course, he responded, “Oh, I don’t know. Just too independent, always been the boss and doing things my way. I’ve never had time to listen to someone else.” Graham saw participation in self management programs as involving a loss of control, despite the fact that self management is based on the philosophy that health care is self driven and enables an individual to take increased control over the management and the course of the condition (Centre for Advancement of Health 1996). Self management course leaders also noted that
fear of losing control seemed to be a factor deterring men from participating in courses.

Eric's concept of health centred on the belief that he could look after himself. This belief in the body's ability to self repair has been discussed previously as a concept commonly held by men (Watson 2000). It is linked to a need to maintain control and is associated with the characteristics of strength and independence that are integral to hegemonic masculinity. The concept of self healing had always worked for Eric in the past, but due to the progress of his condition, was no longer working:

I suppose the other thing too is that I sort of pride myself on my body and I did tertiary qualifications in phys.ed. and that sort of stuff and so I figured that, you know, I've always been under the opinion that I can look after myself, but I can't beat this one ...

Eric, employed full time, age group 41 – 60

Eric's desire to "beat this one" shows that he saw his condition as the enemy and had adopted a confrontational approach to his situation. Feifel and colleagues (1987) describe this as one of three major coping modes in those with chronic illness: confrontation, avoidance, and acceptance-resignation. The fact that Eric had adopted confrontation reflects the severity of the condition's impact on his life. Feifel and colleagues describe confrontation as being most commonly adopted in life-threatening illnesses.

Eric seemed unsure of what action to take to improve his condition and yet was not conscious of any threat to his masculinity. He made this comment below without any prompting on the issue, although of course the focus of the interview questions and the research topic may have made him conscious that issues relating to masculinity were being explored:

I don't feel that there's any threat to my manhood or anything because I've got arthritis. I feel frustrated that it's not something you can cure, they can't seem to be able to give you something and say it's fixed.
Eric did not seem to have grasped the concept of chronic illness, that is, a long
term condition for which there is generally no known cause or cure. His
expectation of a ‘cure’ is more consistent with care of acute illnesses and also
reflected the patterns that were evident earlier in this thesis, in Chapter Four:
Quantitative Findings. It was found that men were more likely than women to be
contacting the service about ‘quick-fix’ options, whereas women were more likely
to be exploring long term management strategies.

Kevin also struggled with the concept of a chronic illness. He described the
difficulty he had in accepting that it was not going to go away and it would
continue to impact upon his life in ways that he had never anticipated:

... basically it was a huge battle, internal battle to get my head around the
fact that I had a long term, chronic, restricting illness ... and it took me
about ten years ... to come to terms with that ... It’s not so much that in a
sense it was at odds with my sense of myself as a man but it was also at
odds with my sense of myself as a person. ... Rightly or wrongly as a child
I absorbed the issue that I could do anything I want to ... I had to accept I
can’t in a whole lot of ways ... So it’s part of the broader process of
learning to accept that life is very different from what I would like it to be
and life is very different from how I was taught it would be and life is very
different from how I expected it to be. And struggling to accept that.

Kevin, casual work, age group 41-60

The significant issue for Kevin seemed to be the contrast between his expectations
of how he would experience his life which was based on what he was ‘taught’ by
family and society to expect, and the reality of his life. His struggle to accept the
differences seemed to include a grieving process for the man he thought he would
be. This required huge shifts in his self image and suggested a loss of control over
his sense of his own identity. He did not see it as primarily a gender issue and yet
his loss of independence, of a sense “that I could do anything I want to”, is a
central tenet of hegemonic masculinity. It has been discussed previously, that the
impact of a chronic illness can relegate men to a marginalized masculinity (Charmaz 1995; Connell 1987):

I mean the notion that I would have to leave 3 different occupations because of a health condition. If you said that to me at the age of 16 ... ‘Kevin, you’re going to leave 3 different jobs ... That you’re going to be unable to find money to go and see a film on a Saturday night, because you can only afford to go on a Monday at midday because that’s when the tickets are $4.00’. I just would have thought, you’re talking about somebody else’s life. ... So there’s been a huge struggle to fit the reality into my life.

Kevin spoke about the specific changes in his life that reinforced the dissonance between his expectations and the reality of his life. In doing so, he referred to circumstances that undermined his status in terms of hegemonic masculinity, i.e. poor health, inability to maintain a job, and lack of financial independence. All of these circumstances were undermining Kevin’s sense of his own masculinity.

Harry also described the wide-reaching emotional implications of a chronic illness for men:

It’s funny all that emotional stuff ... it is entirely debilitating, even more than the pain. I’m really fortunate, I just have a huge support system around me of family and friends and there’s a lot of positivity existing in my life, but I recognise the debilitation that occurs with all that emotional stuff and psychological, loss of self-esteem, you know this whole bloke thing that sort of crumbles when you’ve been told that you’ve got this pain and physical limitations which may not go away for the rest of your life, and that mortality thing, and then when it hits somebody who’s a similar age to myself, mid to late 40’s, it’s just like, for God’s sake there’s nowhere to turn. And when you go out, and you have friends of the same age who don’t have that pain or they’re sort of kicking the footy around, it’s really hard to control and manage that loss of confidence in their company. It’s just so ohhh, you know, with pain comes unemployment and
that whole financial thing as a background and at this stage of our lives when a lot of us are getting on top of things financially, some people’s kids have just grown up and left home. It’s all starting to look rosy, it’s the baby boomer sort of expansiveness … and if you haven’t got that, then in the face of it, even in a much larger cultural group, you’re really up against it. So for people who don’t have that support system, to get over that as just a transition stage it must be hugely uncomfortable … I’ve been really in darkness these last few months, for various reasons and a lot of it is attributable to the new information – ‘You’ve got arthritis’.

Harry mentioned “the whole bloke thing that sort of crumbles” which aptly summarised the difficulties he experienced with the impact of a chronic condition in areas such as sporting ability, employment prospects, and financial independence. These are all areas of life that are traditionally used to demonstrate adherence to and compatibility with hegemonic masculinity. Harry described the emotional adjustments to these changes as being “even more debilitating than the pain”. This is a clear message to health organisations not to ignore the emotional needs of men with a chronic illness despite the social norm that men do not talk about their feelings. It is significant to note that, as reported in Chapter Four: Quantitative Findings, there were no gender differences in Arthritis Victoria Telephone Information Service contacts about emotional issues. Kevin, Francis and Harry all talked about the benefits of talking to someone else in the same situation. Accommodating emotional and informational needs in the formatting of self management programs is discussed further in section 5.1.10: “You haven’t committed to anything”.

Harry credited his social support system with helping him to undergo the transition necessary to cope with the diagnosis of arthritis. Although the diagnosis of a chronic condition made him conscious of his own mortality, and concerned about his status in relation to his peer group of “baby boomers”, this was counteracted by the positive influence of his family and friends. The role of family and friends in supporting men with a chronic condition is explored further in section 5.2.2: “Your spouse says stop complaining and go and see someone”.

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Peter had managed to reformulate his masculinity constructs to work in a positive way to achieve health management goals and regain a sense of control over his HIV status. Cameron and Bernardes (1998) note that masculinity can actually be a resource when dealing with a serious health problem if it is reformulated to adopt a ‘take charge’ role in relation to the management of the condition. Significantly, for Peter this reformulation of masculinity constructs to allow a self-management approach to be adopted, appeared to be a process that had to be activated for each new situation as it arose, or more particularly for each new chronic health condition:

...with HIV for example, I’ve taken on a role as a health consumer in that, and it took a while to work out how it was going to work for me but in a way it’s been through intellectualising the problem and then becoming more competent at managing it than my doctor is, and that’s worked for me and I’m sure I could get around arthritis in the same way ...So maybe for me it would be around getting a sense of arthritis as a technical problem to be resolved, which would help me to engage with it.

Peter, employed full time, age group 26-40

Peter’s way of dealing with a chronic condition by “intellectualising the problem” and treating it as a “technical problem to be resolved”, is an example of how the hegemonic notion that health services and health behaviours have feminine associations (Courtenay 2000b) can be overcome by positioning the behaviour within a context of masculinist norms. This action of repositioning health behaviour is consistent with successful measures to encourage positive behaviours in men as described in section 2.4.2: *Hegemonic masculinity versus positive health behaviour* and in section 2.5: *Health promotion initiatives targeting men.*

Peter had experienced success with reformulation of his masculinity as a means of coping with HIV, and yet he did not immediately adopt it as a way of coping with arthritis. For those men who had more than one chronic condition, this was a common story. For example, Adam and Eric had both been through medical treatment and rehabilitation programs for heart conditions and yet did not link those experiences to their adjustment to arthritis.
Adam mentioned that when he first went to Arthritis Victoria he “had this blinkered view of self help groups, a whole lot of people sitting around comparing operation scars” despite the fact that he had previous experience of support groups:

It was about 35 I had a heart attack and open heart surgery and I guess that realisation slows you down a fair bit and I got involved with a cardiac rehab program … the socialisation results from the people involved in the program … were sensational. I probably found it more difficult because of the age gap, probably went 35, 60ish and up (laughs).

Adam, medically retired, age group 41-60

Adam had clearly had a positive experience of a support group in relation to cardiac rehabilitation, although his consciousness of his young age compared to the other participants may have influenced his reluctance to become involved in self help groups at Arthritis Victoria. He first became involved at Arthritis Victoria as a volunteer. As discussed in section 5.1.2: “Less than masculine for needing a support group”; some men participate in programs on the basis that they are helping others, and thereby maintain their sense of control and independence. It was Adam’s exposure to the programs offered by Arthritis Victoria, rather than his previous experience managing his heart condition, that encouraged him to become involved in the self management of his own arthritis:

I was very impressed with the sort of work they were doing and in that course I felt I learnt so much about arthritis and management in a short time, I thought, ‘Gee I really want to know some more about this’. And I thought the best way to learn something was to actually go and run a course …

Adam’s ongoing involvement in the self management programs provided by Arthritis Victoria continued to be primarily as a volunteer leader. This reflects Adam’s reformulation of his masculinity constructs by presenting himself in a position of authority while allowing him to practice positive health behaviours.
Eric’s heart condition meant that he’d had a similar experience to Adam in undergoing surgery and participating in a cardiac rehabilitation program:

I had a slight heart attack a couple of years ago and they sent me to a rehab clinic. I said to the people who were there ... I was probably the youngest, and I said, ‘Where are all the old fat people?’ Because that’s what I thought, old fat people have heart attacks. And they said, ‘They die’.

Eric, employed full time, age group 41 – 60

Eric spoke elsewhere in the interview of his perception that users of Arthritis Victoria services would be old (discussed in section 5.1.3: “And then you’re getting old”). On the basis of the above quote, it appears that his previous experience with management of a heart condition had actually influenced him against self-management services for fear of ageing, rather than made him more comfortable with the concept. This is consistent with Rogers and colleagues’ (1999) comments about the influence of previous experiences on perceptions of health services.

Harry did not have another chronic condition. However, he did demonstrate a progression through stages of coping that included a period of reliance on dominant masculinity constructs and then a reformulation of hegemonic masculinity when the pain became too severe and he was forced to give up work. He was able to recognize those two stages in his life:

I’ve got fallen arches, flat feet which has been a condition all my life ... so I’ve lived with this in the peripheral and sometimes centre of my life and it finally worsened or collapsed to a condition where I couldn’t any longer ignore it. But either concurrently or as a result of the final collapse of my ankles this inflammation which we call arthritis, that sort of occurred at the same time. So I don’t really know how long I’ve had it, thinking it was just sore feet. ... I might have had it for a long time but just put it off as standing up for too long and it wasn’t painful enough to do anything.

Harry, unemployed, age group 41-60
It appears that Harry had put off seeking advice about his feet for several reasons. Firstly, because it was an ongoing condition, secondly he assumed it was a result of standing up for too long. The implication of this is that it would go away when he decided to rest. As Harry explained later in the interview, he worked in the marine industry and spent all day on his feet without shoes. The other reason for not seeking help is that it had not reached a pain level where Harry felt it would be ‘acceptable’ to seek help. This showed that at this stage in his life he was ascribing to expectations of hegemonic masculinity. He was conscious of that initial influence on his behaviour. When asked why he had not sought treatment for his feet at an earlier stage, he said with a smile and then a laugh, “Why didn’t I? Because I’m a real guy - and there’s nothing wrong with me!” He then confirmed in a more serious tone that adhering to masculinist norms was the reason for the delay:

Yeah, that was the whole thinking. Nothing beyond that at all. I can put up with this because I’ve got too many other important things to do.

Harry was very conscious that his delay in seeking help for his feet had been driven by his need to match the ideals of hegemonic masculinity and deny any physical weakness. However, the loss of work and the pain he experienced as a result of his condition forced Harry to reformulate his concept of masculinity to accommodate self management practices. Harry reflected on his previous denial of his health needs:

Ah I just accept that’s the nature of men, you know that’s all it is. … It changes, with maturity one tends to get into finer definitions of oneself. There’s a whole matter of self-esteem and who you see yourself as, and who you think the rest of the world sees you as. I would hope it gets more real for me to be able to not be caught up in other people’s images of who I’ve been.

Harry took an essentialist view of his previous behaviour, saying it was “the nature of men” and yet he then mentioned how he has changed and also talked of
trying not to get caught up in external expectations. In doing this he actually demonstrated Connell’s (1998; 1999) theories about the availability of plural masculinities that can shift over time and place, and are positioned in relation to a given culture’s hegemonic masculinity.

Harry went on to describe his new approach to managing his health:

And the whole idea of keeping things to yourself and not whingeing about a sore foot is more to do about mastering of ourselves, where you manage who you are and how you feel in a way which has got more grace in it, which has more reservation and which has a great degree of responsibility about how you change it. And that’s also balanced by honesty with my wife who shares the home and life, and that sense of connection with my very close male friends who are just as honest with me about how they’re going. Friends who I’ve known for thirty years and we can exchange all manner of grievances and pains and triumphs just because we wish to keep the other one updated authentically.

Harry’s reformulated masculinity allowed him to explore self-management options for his condition and to share information about his condition and his feelings with his friends and his wife. However, he described this new approach in terms of control and “self mastery”, and in doing so demonstrated how he had reformulated characteristics of hegemonic masculinity to fit his circumstances (Gerschick and Miller 1995). Earlier in the interview he also described how he was unable to admit to another group of male friends that his condition had been diagnosed. This was discussed earlier, in section 5.1.1: “Nobody wants to be in a position of vulnerability”, and once again demonstrated the shift in Harry’s masculinity over both time and place.

Harry’s description of his adjustment to his condition and his new approach to it, is remarkably similar to the findings reported by Lindsey (1996). Lindsey conducted a qualitative study that tried to capture the reasons why some people remain effectively healthy despite having a chronic illness or disability. In her interviews she elicited the themes of: honouring the self; seeking and connecting
with others; creating opportunities; celebrating life; transcending the self; and acquiring a state of grace. Harry in his discussion above, spoke of "self-esteem", "grace", "honesty with my wife", and "sense of connection with my very close male friends". It was not within the scope of this thesis to measure the comparative health of the participants in any meaningful way. However, on the self rating measure in the demographic questionnaire, Harry did rate his own health as good despite the fact that his condition had contributed to him stopping work four months earlier:

So I've had a really wonderful life physically and then all of a sudden everything seemed to get sore over this last year and I've just tried to ignore it, and I can't any longer work the way I used to so I have to make all these adjustments and a lot of the adjustments are about disciplining myself to do things which I never thought about before. So it is advice I'm needing and there's a structure of exercise and so forth that I needed to be advised on, and the self help is me actually sticking to it in a disciplined way with a result possible, or predictable result.

Harry's comments here reflected how he, like Peter (see section 5.1.5: "I can take care of myself"), had reformulated his view of health care from something that should be ignored, to a problem to be solved and a chance to regain control. This is evident in his talk of "discipline" and a "predictable result". In this way, he was manipulating the characteristics of hegemonic masculinity to work to his advantage.

Phillip's methods of coping with his condition also shifted over time. The first two years after his injury he describes as a "stagnant" period in his life:

In the two years previous to starting studying, I wasn't doing much at all. I was just living. I wasn't working. I was seeing the doctor every fortnight and doing my stretches and wasn't getting better. It was like a stagnant part of my life where there was no moving forward and if anything, I was moving backwards very slowly, and that was hard for me psychologically.

Phillip, student and casual work, age group 18-25
The stagnation referred to by Phillip seemed to be linked to the fact that he wasn’t working or studying, he was “just living”. This supports the contention by Watson (2000) that work is central to a man’s masculine identity. Phillip described feeling more positive about his situation when he took a more active role in his health management:

... the balance is shifting and I’m starting to believe more and more that my actions are helping my mind as well as my mind’s helping my actions.

Phillip became more positive about his condition when he felt like he was establishing a mind-body connection that was giving him some sort of control over his condition. Phillip was then motivated to become engaged in as much self management and treatment programs as he could. However, at the time of the interview, he was struggling with the prolonged experience of a chronic illness and the sense that he had only limited control over the progress of his condition:

Throughout this whole injury I’ve always believed that there’s a lot in my mind that controls getting better and staying in a sort of slump, and that’s something that actually I have had doubts over now because I haven’t got better ...

Phillip described an internal struggle with a belief in his self mastery over his body, and the conflicting evidence of a condition that at times seemed beyond his control. This struggle was similar to the one experienced by Eric, as described earlier in this section, and yet had occurred in a different context for Phillip. Phillip adopted a more active health management role as a way of reasserting control over his situation. He described elsewhere in the interview the improvement of his condition over time, and yet he was discouraged by the fact that he was not able to fully control it.

Francis’ experiences were similar to Phillip’s, perhaps reflecting a greater recognition and acceptance among younger men of the benefits of active health management. Phillip believed that younger men were more proactive about health
management than older men. He talked about this when he provided feedback on
the flyer produced for the trial program, as reported in section 3.6.1(c): *Trial of
findings*. This was not supported by the quantitative results, see Chapter Four:
Quantitative Findings which showed that younger men were more likely to have
calls made to the Arthritis Victoria Telephone Information Service on their behalf,
and males calling for themselves were equally likely to be young, middle-aged or
older men.

Francis, like Phillip, went to considerable lengths in an effort to control his
condition through self management practices but his condition deteriorated and he
had to accept that surgery was a necessary part of his health management plan:

I thought it was going to go away so I was doing these exercises, then I ... 
went by myself to the pool and did all my exercises, and just ate the right
food and I thought I'd get better that way, which isn't going to do it.

Francis, employed full-time, age group 18-25

Francis had used a whole range of self management strategies but his goal was to
make the problem "go away" rather than minimize its impact. In this way he
treated his condition as an acute condition rather than a chronic condition. He also
avoided the hip surgery that had been advised by his doctors and so was not
applying true self management principles which involve a partnership and
cooperative approach between individuals and health professionals. In this sense,
Francis was similar to Phillip and Eric in his efforts to gain control over his body
and to self heal, as discussed earlier in this chapter. Eventually, Francis had to
reassess his situation and reformulate the masculinity constructs in his life to
accommodate the realities of his condition:

It’s the last resort ... a whole lot of joint surgery is actually a challenge
because I left it too long. It was already known that my other hip was bad
as well. Left it too long, exercise etc didn’t help. It took a while for the
surgery to finish because the hip was pretty damaged. It actually affected
my back as well. If I had done it earlier, it would have been better for
doctors. It would have been faster. Yeah, you've got to move fast.
Anyway, I was a bit stubborn.

Even though Francis had previous experience with surgery and knew from that experience that he needed to act before the joint deteriorated too far, he still felt the need to try and assert control over his situation. He was not prepared to consider surgery until it was "the last resort". This shows the influence of hegemonic masculinity on men's health behaviour, even if they have reformulated their sense of masculinity. In describing his "stubbornness" in delaying surgery despite the health risks, Francis may also have been trying to demonstrate to me that despite his condition he met the stoicism requirements of hegemonic masculinity.

Piper (1997), in his discussion of the limitations of well men clinics for health education, noted the importance for men of maintaining control. He suggested that clinics should aim to enhance self-empowerment in men, focusing on the individual's capacity to direct his own life while "acknowledging the wider factors which shape it" (p49). Self management philosophies are also based on the enhancement of self efficacy, that is, a belief in one's ability to take responsibility for the day-to-day management of the condition, in partnership with the health professionals who are responsible for the medical management of the condition (Lorig and Associates 1996). The challenge for health organisations therefore, is to demonstrate to men that self management programs represent a means of maintaining control rather than relinquishing it.

5.1.6 "I think my problem is hereditary"

The men interviewed for this thesis reported varying beliefs about the cause of their condition. This appeared to be a contributory factor determining the health action they adopted, consistent with Klonoff and Landrine's report:

What people choose to do when confronted with an illness may be related, in part, to the underlying commonsense beliefs about the cause of the
illness. Subjects reported being less likely to seek medical attention and more likely to try and treat the problem themselves if they thought the illness was caused by emotional or natural factors (Klonoff and Landrine 1994:416).

Francis spoke of a genetic cause for his condition. However, he referred to it more in terms of the doctors’ beliefs, rather than his own:

All I can basically say is what the doctors tell me, which is that it’s genetic. No-one in my family has arthritis like this, so there’s no history there with anyone and the closest one around is an aunt with arthritis so I don’t know why it’s really genetic, the doctors don’t even know why it’s there and what causes it. I think I just have to accept it and not think about why I have it, because there’s no use.

Francis, employed full-time, age group 18-25

Francis has Ankylosing Spondylitis, a condition that is often characterized by a genetic marker. However, Francis was sceptical about the doctors’ suggestions that the condition was genetic because there was no-one else in his family with Ankylosing Spondylitis. His rejection of the hereditary factor may explain why he adopted an active role in the management of his condition, becoming involved in water exercise groups, courses and support groups.

Graham was convinced that his arthritis was hereditary because his mother and grandmother had arthritis:

I think my problem is, I’m convinced you know, hereditary. I’m a great candidate for arthritis. My mother had bad arthritis. My father’s mother had arthritis, my father died about the age I am now so he didn’t get too bad, but you know I was always a candidate for it. And I think I’m pretty well convinced there’s not a hell of a lot can be done for it.

Graham, self employed, age group 41-60
Graham's belief in the inevitability of his condition seemed to be the basis for him believing that there were minimal treatment or management options. This would explain his choice of non-action in relation to the management of his condition. However, Graham then went on to speak of his belief that his condition was caused by his farming:

I suppose all I know is, the farmers seem to be the ones that are all aches and pains, the other people in the community don't seem to worry so much. But I don't know whether it's the chemicals we've used in the past. We've all been bogged and had to get out of it one way or another, and you've overloaded your back or your knees or whatever. You obviously do things like that because you have to. Just to get out of a situation that you shouldn't really do in the first place.

Graham, self employed, age group 41-60

Graham suggested that most farmers have arthritis and that it is caused by the work that they do. This connection between farming and arthritis is supported by Jordan and colleagues (1995), who reported that arthritis is probably more common in rural areas. They suggested that this may be due to sociodemographic factors and the physical demands of rural occupations. Their report was based on a study of osteoarthritis of the hip and knee. Graham has osteoarthritis of the knee.

Graham not only believed that farmers have a high incidence of arthritis, but that others do not. This perception of difference between farmers and non-farmers seems to reinforce his belief in the contribution of farming practices to the development of arthritis, and a belief in the inevitability of the process. It is inevitable to him because, as he says elsewhere in the interview, "I've never been off the farm. I've always been a farmer". And, as a farmer, "You obviously do things like that because you have to". In this sense, his dual beliefs about the cause of his condition, i.e. hereditary and occupationally based, were compatible because he saw them both as being beyond his control.

He mentioned elsewhere in the interview that he had modified some of his farming practices to accommodate his condition, especially when he hired
farming help. But generally, Graham chose no action, medication, or 'quick-fix' options (as described in the section 5.2.5: "I'm a sceptic about some things"), because he had no intention of stopping farming:

Every farmer's the same ... We all just take the anti-inflammatories and press on with the job.

Graham's preference for medication to manage his condition was consistent with Chapter Four: Quantitative Findings, as discussed in the previous section, which showed a preference among men for information about symptomatic relief rather than disease understanding and management. Elsewhere in the interview, Graham rejected the idea of rest to help manage arthritis:

I don't think you'll find a farmer that thinks rest is going to really fix things. I think time fixes, not rest. You just wait long enough it will come good.

Graham's statement that "time fixes, not rest", is consistent with Watson's (2000) findings that men see the body as being able to heal itself until age, injury or illness wear the body down. It also shows a strong acceptance of the hegemonic model of masculinity that encourages a show of strength by pushing through the pain and avoiding health services. His expectation that things are going to be "fixed" is similar to Eric’s search for a cure (discussed in section 5.1.5: "I can take care of myself", and section 5.2.4: "A whole lot of people sitting around comparing operation scars") and suggests that he has not fully comprehended the chronicity of his condition.

There was also evidence in this thesis that the coping methods originally chosen in response to a condition will be changed if the condition and its impact on lifestyle become severe enough. Harry had experienced difficulties with his feet and ankles throughout his life. The inflammatory condition had only developed in the period prior to the interview. He expressed very strong personal beliefs about a causal relationship between his star sign and his painful feet:
... if I've had sore feet, chronic sore feet all my life, I had put it down to
the fact that I'm a Piscean whose symbol is the fish and in certain
teachings and practices/philosophies, fish don't have feet they have fins.
So I'm never meant to have feet and so it's no wonder that in all the time
I've spent at sea and in the water which has been my chosen environment,
that when I get sore feet it's only predictable that I should, because I'm
flapping around on deck, usually in bare feet.

Harry, unemployed, age group 41-60

Harry clearly feels a strong affinity for his star sign and sees links between the
Piscean symbol and his chosen career. Originally, his response to his condition
was dominated by his belief in its inevitability:

Every Piscean friend that I have has a similar problem ... just absolutely
undeniable, so you just live with it, you can't do anything about it.

However, like Graham he appeared to have more than one belief about the cause
of his condition. Harry commented on his working conditions, suggesting that
working constantly in bare feet on hard surfaces would have contributed to his
problem:

And over thirty years I've spent twenty of them in bare feet on hard decks,
you know jumping out of the rigging and walking around on beaches and
so forth, and no support whatsoever ...

Harry also spoke of his refusal of treatment when he was young as being a
contributory factor:

My ankles used to click together playing football. My mother took me to a
doctor. He said. "Oh he's got to have built up shoes, he's got to build up
the heels of his shoes to make his ankles go out, so his feet don't give him
trouble". And of course that wasn't a very fashionable thing to be wearing
for a ten year old, so I said. "No, I'm not going to wear club feet shoes".
And so the prediction came true. So there are different things wrong with
my feet, why I'm in pain. However, the arthritis is this new development, which may or may not be related to that physical condition.

Harry's development of different health beliefs appeared to have arisen in conjunction with the escalation of the condition. However, he was still unsure of where the arthritis diagnosis fitted in relation to these beliefs. The development of different beliefs about the cause of the condition also gave Harry scope to consider health options other than no-action, so that he progressed from no-action to an active self-manager. This progression was driven by the increasing seriousness of his condition to a critical point when it became necessary to stop working. It is also discussed in section 5.1.5: "I can take care of myself"; in terms of a progression from reliance on the constructs of hegemonic masculinity to a reformulation of those characteristics.

This thesis partially supports the notion by Klonoff and Landrine (1994) that health actions are influenced by health beliefs about the cause of the condition. However, the relevance of the causal belief and subsequent action seems restricted to initial coping methods and does not account for changes in coping methods over time and in response to increasing severity of the condition. The interview findings of this thesis indicate: men may have conflicting health beliefs about their condition; they may change over time; and this may allow for different coping methods to be utilised. There also needs to be caution in applying Klonoff and Landrine's findings to this thesis because they are referring to influences on seeking medical attention whereas the focus of this thesis is on accessing self management services. The patterns in health behaviour in this thesis more closely fit Watson's (2000) report on men's concepts of health, and Gerschick and Miller's (1994b; 1995) model of reliance, reformulation or rejection of characteristics of hegemonic masculinity.
5.1.7 "There’s no space for it"

One of the reasons repeatedly offered for not accessing services was lack of time because of work commitments. In fact work, and its demands on time and energy, was the single largest barrier to accessing self management services.

Peter and I were discussing the things that deter him from attending self management services:

... they’re mostly geared for people who are disabled by their illness and so if you’ve got a full time job and a life outside that job then there’s no space for it.

Peter, employed full-time, age group 26-40

In this statement, Peter made it clear that work was a significant barrier to him accessing self management services. It was also clear that he had assigned his work and other aspects of his life a higher priority than managing personal health. The reason for this became clear in the comment he made next, "I don’t need it enough to make the space for it". This shows that he did not feel that he had reached the point where self management services were warranted. And yet he described throughout the interview how his condition was impacting upon his working life, his home life and his social life. Peter’s stoicism demonstrates the influence of hegemonic masculinity. Lack of awareness of when it is appropriate to seek help is also evident, as discussed in section 5.2.1: “I didn’t realise that I was needing help”. His response to his condition may have been influenced by the advice he had received from his doctor that his condition, Ross River virus, would go away after six months. However, at the time of the interview it was one year after onset.

The precedence that Peter gave to work commitments was particularly evident when he considered the possibility of attending a self management course involving weekly two hour sessions, over a period of six weeks:
I haven’t been in Melbourne for 6 weeks in a row since I moved here, so taking on a 6 week course would require some planning for me and I guarantee that there’s not a whole lot of flexibility in those courses.

Peter did not consider adjusting his work program to accommodate the course even though he recognised that there was unlikely to be flexibility in the timing of the course. This reluctance to adjust work programs to accommodate health related activities is consistent with the work of Saltonstall (1993) and Hegelson (1995) who noted work tends to be given precedence by men, and health related activities are perceived as being of secondary importance.

Graham spoke repeatedly of time pressures throughout the interview, in particular the difficulty attending health services because of the demands of his work commitments on the farm. When told about the range of services offered by Arthritis Victoria he said, “Those sort of things are really out of the question for me though because I wouldn’t have time to organise it properly”.

Harry explained that this perception by men that they do not have time to access self management services really represents concerns about wasting time on something of little value:

… that’s why blokes don’t go to ongoing courses, they feel like they’re being robbed of their time on something that’s really not as important as work, sport, recreation.

Harry, unemployed, age group 41-60

This image of health activities ‘robbing’ time that belongs to work, family or recreation reflects the low priority being placed on health and the low value being placed on the self management services. It was also evident in self management course leaders’ reports that male participants often report that they do not have time to practice new health actions between course sessions. This idea of time being wasted was also reflected in Peter’s comments when he was considering the conflict between his work commitments and program times:
… if my rheumatologist just said to me go to Arthritis Victoria, I wouldn’t. It’s not specific enough, I need to know why would I go there, what would they do for me, how long would it take, when could I do it …

Peter, employed full-time, age group 26-40

Peter’s mention of the doctor’s recommendation is significant because for many men the doctor is a primary source of medical information (Pinnock et al. 1998). This is discussed further in section 5.1.9: “I like a professional environment” and section 5.2.3: “It hasn’t been suggested to me by my doctors”. However, Peter was not prepared to accept a recommendation from his rheumatologist to go to Arthritis Victoria unless he could be convinced that it was not going to waste his time. This view of health as being less important than work is consistent with hegemonic masculinity, where precedence is given to the role of ‘breadwinner’ and health management is associated with feminine behaviour (Courtenay 2000b).

Harry commented on men’s perception of health:

It’s very low priority. …to dedicate time on a course to health, that’s a major hurdle to get over and I don’t know what would change that.

Harry, unemployed, age group 41-60

Harry viewed health as being very low priority and suggested that it is difficult to get men to allocate time to it, regardless of other commitments. However, Harry had recently begun accessing self management services himself, in response to the deterioration of his condition. This contradiction between his views and his actions reflects his transition from a reliance to a reformulation of hegemonic masculinity constructs, as discussed in section 5.1.5: “I can take care of myself”.

But it is not only socialisation that encourages this prioritizing of work over health. Structural barriers can also limit access to services. As noted in the Draft National Men’s Health Policy, “Often the realities of rural life are that it is either impractical to take time out for ill-health, or health and welfare services are just too far away” (Commonwealth Department of Human Services and Health
1996:32). This was certainly reflected in Graham's comments about the inconvenience of going to the doctor:

... you know it's half the day gone, by the time I stop what I'm doing and back here and get cleaned up. I can't just sort of go from the office and pop in there because I'm usually covered in grease and crap. ... anytime a doctor refers you to someone, you've got to go to Bairnsdale [closest town to his farm]. Well that's a day gone virtually ... but then in the middle of summer I wouldn't go to Bairnsdale during the day anyway ... I won't go out anywhere I can't hear on the radio. I like to know what's going on out in the farm. I want to be involved in it not away from it. So I just don't go out.

Graham, self-employed, age group 41-60

The practical difficulties for a farmer in accessing health services involve traveling long distances, an unpredictable work environment and the inconvenience of having to clean up and change before leaving. However, Graham's difficulty with the travel distances is also linked to his reluctance to relinquish a sense of control over what is happening on the farm. This demonstrates the interplay between structural and social influences on Graham's behaviour. The economic necessity of giving precedence to work commitments represented another structural barrier for many of the men interviewed.

The practical difficulty of travel distance, unpredictability of work, and the need to change into clean clothes were also mentioned in the interview with Bruce as significant when he had been working as a tradesman:

I'm always moving so it could be Melton one day, the next day I'm in Ferntree Gully [two suburbs of Melbourne] ... come home covered in cement stains.

Bruce, employed full-time, age group 26-40

This shows that tradesmen encounter similar structural barriers to those faced by rural workers.
When Graham did manage to overcome the practical difficulties of accessing health services, he was conscious of any time being wasted and mentioned, “I just don’t like waiting around in surgeries”. Peter and Francis also mentioned that they were concerned about wasting their time while waiting to see someone, and would prefer to be able to make an appointment:

I’d rather go somewhere where you can make an appointment, and have a reasonable time frame expectation of how long it’s going to take, what time you’ve got to be there, what time you’ll be leaving sort of thing. I don’t like going to places where you’re sitting in a waiting room for an unspecified amount of time until somebody’s free. I hate that. I get really frustrated.

Peter, employed full-time, age group 26-40

This concern about wasting time is a practical issue but also seems to be linked to a need to have some sort of control over the amount of time being allocated to the activity. Peter wanted to set clear parameters on the time being spent. There also seems to be a resistance to relinquishing power and allowing someone else to have control over your time, i.e. waiting “until somebody’s free”.

Francis also preferred being able to make an appointment to set parameters on the activity. If that could be done he was prepared to make adjustments in his timetable to accommodate the appointment:

I’d probably have to visit a service first and if it suits, make a time. … If I can get a time that suits me, a time that suits me, but if they schedule a time for a session, then I’ll make an adjustment …

Francis, employed full-time, age group 18-25

Francis’ repetition of the phrase “suits me” indicates that making an appointment is also a means for him to maintain some sense of control over the activity, and perhaps to minimize interruptions to work activities. This assertion of control and
protection of work commitments may reflect a reformulation of hegemonic masculinity traits to allow for the need for health services.

Therefore, it appears that the prioritizing of work over health results in reluctance to use any services that conflict with work obligations. This may also explain the findings of the quantitative analysis of the Arthritis Victoria Telephone Information Service, which showed that in contrast to women’s interest in understanding their condition and learning about long term management, men appeared more interested in ‘quick’fix’ symptomatic relief.

Not surprisingly, evening courses were considered the most convenient by working men. In the Arthritis Victoria Leader’s Update involving self management course leaders, the leaders reported that they had an unexpected increase in male participants when they held an evening course. However, the fatigue caused by the constant pain and the effort of continuing with work commitments can make it difficult for men with arthritis to attend evening courses. There are mixed findings in the research about whether men would be more likely to attend services out of business hours. The experience of Baum and Cooke (1986) was that regardless of the time the service was held, men were less likely to attend than women, and of those men who did attend, it was usually those without work obligations.

Eric confirmed that fatigue was a significant barrier to him attending evening courses:

The venue wouldn’t worry me. The hardest part for me … is time to do that. That’s the hardest part. Sometimes I’m so tired when I go home from work because of the arthritis, all I do is go home to sleep.

Eric, employed full time, age group 41 – 60

So for Eric, it was not only the time spent at work that prevented him from accessing services. It was also the fact that work was consuming all of his energy so that the remaining time was spent recovering.
Adam also explained how difficult it is to go back out in the evening, because of the fatigue that builds up after interrupted sleep and working all day in pain:

"Often you don’t realise at the time you’re pushing yourself because you’re in denial I suppose in lots of respects. Because you’re battling pain through the day, you don’t realise just how tired the day’s been. And then, particularly if you’ve got sore joints, your sleep tends to be disturbed when you roll over and all that sort of thing, so that all compounding too. You’d probably find excuses not to go because of the tiredness… And you probably wouldn’t even acknowledge to yourself you’re too tired to go."

Adam, retired, age group 41-60

Adam’s comments also reflect the pressures of hegemonic masculinity that resulted in him denying his pain, battling through his pain, making excuses not to go, and not even acknowledging to himself that he’s tired. This process of denial is evidence of the lengths that some men will go to in order to demonstrate their strength and avoid any indication of weakness, to themselves and others.

Running daytime courses instead of evening courses was the preferred option for retired men, but workplace courses were the only daytime option that working men were enthusiastic about, and only if it was suitable for their workplace. Bruce confirmed that a workplace program would be easier to access, “Oh yeah, yeah, that would be really good. It would be definitely good”.

Weekends did not seem to be a viable option. As commented by Adam, “It’s very difficult to run things other than a sporting or a lifestyle/relaxation thing on the weekend.” Many of the men saw the weekends as family or recreation time and were unlikely to consider attending a course, although some nominated Saturday morning as an option if necessary.

Being self employed and working for someone else were both mentioned as a barrier and an aid to taking time off. That is, those who were self-employed were likely to perceive it as being easier for people to take time off if they had sick leave, and those who were employed by others were likely to perceive it as easier
to take time off if you work for yourself. Therefore, this aspect of work circumstances did not appear to differentiate access. Work circumstances varied, but placing work as a priority is what acted as the barrier, particularly when attendance at programs conflicted with work commitments. As mentioned previously, this was often exacerbated by other pressures such as additional time problems for rural and trade workers because of the unpredictability of their work, travel distances, and the need to clean up and change before attending. Iorig and colleagues (1996) suggest that it may be necessary to re-structure six week programs to two half-day sessions for people in rural areas who have to travel a long distance.

5.1.8 "Cost is a huge issue"

Not only do men tend to be defined by their work in Australian society, work also determines financial status and independence – both significant issues in terms of masculinist status according to the dominant constructs in our society. This means that loss of work because of a chronic illness can have multiple ramifications.

The reality of financial hardship was common for several of the men interviewed, particularly those who had given up work because of their condition. For these men, and others, cost could be a barrier to using services:

Cost is a huge issue. I mean it’s absolutely a massive issue. For me, I basically once a fortnight would eat potatoes because I couldn’t buy food. ... So, it’s a huge issue.

Kevin, casual work, age group 41-60

Kevin became emotional at that point in the conversation, demonstrating what a critical issue his financial circumstances were in his life.

Kevin also described how his limited income impacted upon his life in terms of relationships:
How do I go about going into a relationship with somebody when our financial circumstances are often profoundly different? I’ve actually just ended a relationship with a woman I like very much, but I won’t go into all the reasons why we broke up, but I’d like to say our financial circumstances were utterly different. She’s on a good income ... where getting on a plane to go somewhere for a holiday is not an issue, it’s just a matter of getting out the plastic card. Which I’m not saying things are easy for her, she works hard, she works really hard and she earns good dollars. For me, I can comfortably go to the cut-rate screens of a film on a Monday afternoon because it’s $4. Do you know what I mean?

Kevin, casual work, age group 41-60

The impact of Kevin’s finances on his social options and in particular, the discrepancy between his financial circumstances and those of his partner, had a significant impact on his view of the relationship. It was not a matter of concern to her but it was to him:

... we went out for dinner just a few weeks ago just as we were breaking up. She paid for dinner and I still feel very uncomfortable about that but the alternative is we never go out to dinner. And she says to me, ‘For God’s sake Kevin, don’t be silly. I don’t have the challenges you’ve got financially, let’s just have a pleasant evening’ ... and I still feel the discomfort about that.

This reversal of traditional gender roles was very uncomfortable for Kevin and yet he did not see it as a gendered situation. He mentioned earlier in the interview that it was a matter of independence:

That it makes it very difficult and I don’t want her paying for me any more than she would want me to pay for her, even if I had plenty of money in my wallet. You know, I mean nobody wants that.

Kevin may not see this as a gendered issue because his social circles reflect the societal shifts in traditional gender roles that have been occurring in Australia.
However, as noted in the Draft National Men’s Health Policy, “the socialisation process that prepares men for this role change has moved at a slower pace” (Commonwealth Department of Human Services and Health 1996:19). This means that the expectations that men are financially independent, and that men pay for their partner’s dinner at a restaurant, are still features of hegemonic masculinity and men of all masculinities have to come to terms with that (Connell 1999).

Harry had also stopped working because of his condition and noted that, “I don’t have a spare dollar”. For that reason, he agreed that cost was a barrier for him in accessing services:

Oh it would bc at the moment because I’m unemployed, pending the management of my condition or at least the pain in my feet so that I can actually go out and confidently take another job and be able to do it.

Harry, unemployed, age group 41-60

Harry explained that his difficulty paying for services was directly linked with his employment status, which in turn was directly linked with his health status.

Leo had to retire early because of his condition but was now on an aged pension. Cost was also a barrier for him:

Yes, it is problem. All depends, because we pensioners now and cost count.

Leo, retired, age group 61-75

Cost was not an issue for some men, provided it was priced reasonably. However for others, just the possibility of a charge for a service was enough to make them wary of making enquiries. Making enquiries about the cost of health programs would represent a double admission of weakness and thereby risk to masculinity status, by demonstrating both a need for health services and a lack of financial independence.
Leo’s perspective on free services was common to most of the men interviewed, i.e. providing a service for free does not devalue it:

Oh no, some cases, not for arthritis, only for some other things yes. But I wouldn’t say that is for arthritis ...

Leo, retired, age group 61-75

Some of the men suggested that suspicions about ulterior motives are reserved for commercial enterprises. David had a similar view of the situation, noting that if it’s a service intended to help a person, presumably in contrast to a commercial service, then it was a bonus if it was free:

... if it’s something that’s going to help a person, whether it’s free or you’ve got to pay for it, you take advantage of it if it’s free. It’s as simple as all that.

David, retired, aged over 75

Given the financial difficulties experienced by many men with a chronic illness, health organisations providing self management services would be advised to minimize the cost of services and to display the cost clearly on any promotional material.

5.1.9 “I like a professional environment”

Significantly, the men interviewed had all taken time off work to attend medical appointments but it did not occur to them to take time off work to attend information or self management courses. This is partly due to the central role attributed to doctors in relation to health management (Pinnock et al. 1998). However, it also reflects the low value attributed to self management programs. This is most likely linked to the fact that most people are familiar with a medicalised approach to health management within an acute care framework (Lorig 1996a; Owen and Lennie 1992). There is still limited awareness of the role of self management in the treatment of chronic illness, particularly among men,
which will be discussed further in section 5.2.1: "I didn’t realise I was needing help" and section 5.2.4: "A whole lot of people sitting around comparing operation scars". Therefore, it appears that holding self management programs in a medical setting may help to increase the credibility of programs and assist men to justify taking time off work to attend.

Leo said he would not have taken time off work to attend a self management program. However, he gave a different response to the prospect of a program held at the hospital:

Oh well, if it’s an appointment with the hospital, I have to go, I have to take time off.

Leo, retired, age group 61-75

Because of the language barrier in this interview, it is possible that Leo misunderstood and was referring to a medical appointment at the hospital. Either way, he made it quite clear that he did not consider it acceptable to take time off work to attend a self management program, but did not hesitate if he had to attend something at the hospital.

Bruce also felt that the use of a health or medical setting would make it easier for him to justify taking time off work:

I think at Arthritis Victoria or a hospital would make a difference rather than a local sports club, for me personally, if I had to justify it for work reasons and tell my manager.

Bruce, employed full-time, age group 26-40

Francis agreed that holding programs in a hospital setting would assist him to organise time off work. However, he saw it as a way of demonstrating the seriousness of the problem, rather than the credibility of the program:

…if you can tell your boss you’ve got an appointment at the hospital it would sound more serious and it would be a bit more stronger reason … It
would be good as well if during the seminar they could ask if you need a note for work.

Francis, employed full-time, age group 18-25

This may also reflect Francis’ concern about appearing weak if he asked for time off work for a less “stronger reason”. Francis also suggested that providing a note or medical certificate for work would further assist in justifying time off work. This suggestion was explored in interviews with other research participants.

Phillip agreed that this was an appropriate approach, based on his experiences as a WorkCover claimant:

I have to be referred to go and see these things. Even those it was my idea. I said to the doctor, ‘I’ve been told there’s a really good Chinese herbalist. What would you say to me going and trying it out?’ …so I sort of claim on WorkCover. I have to have a referral. Both my GP and my chiropractor said ‘great, it’s really good you’ve found another possible means of healing yourself’ and they’re fully supportive of that. So if I said to ‘em, I’m going to go and see Arthritis Victoria - ‘that’d be great, we’ll write a referral for you and make it as easy as possible’.

Phillip, student and casual work, age group 18-25

Mario also agreed that a medical certificate would be helpful but seemed uncertain and, because of the language barrier, it was not clear if he fully understood that question. Leo was unsure if this would have improved his chances of being given time off work to attend before he retired. “Maybe, dunno. I wouldn’t say yes they got to say okay, but they might.” As many of the men were already retired for age or medical reasons, this issue was not relevant to them.

Arthritis Victoria is now in negotiations with a health insurance fund about a trial program that would allow members of the fund to claim for self-management courses. This would obviously help participants by alleviating the cost of participating in the course and could also increase its credibility among patients and doctors, thereby helping to justify taking time off work to attend.
The preference among the men interviewed for medical, health or community settings rather than recreational venues was also based on a perception that they were more appropriate venues for self management programs. Pubs and sporting venues were generally not seen as appropriate for discussion of confidential, personal, health issues. Ted confirmed this belief when he provided feedback on the Summary of the research findings. It was also consistent with the findings of the Darwin Men’s Health Needs Analysis (Men's Health Teaching and Research Unit 1997) but was in direct contrast to the experiences of the Men’s Health Nights conducted as part of the MAN model (Gibson and Denner 2000) and other studies (see O’Hehir et al. 1997), as explored in section 2.5.4: Different settings for health promotion programs.

Some men did like the idea of a social venue. Bruce had agreed that a health or hospital setting would make it easier for him to arrange time off work, but he did like the idea of a sporting venue for a self management program:

Yeah! The local soccer club, yeah with the sporting association, or the gym or the swimming centre. I go sometimes swimming. Yeah, that would be interesting if it was there. I don’t frequent pubs that much…. I guess if it was a sports club, you would be in your own … (searching for right word), a friendly environment that you’re used to, so it’s a lot more comforting and, you know, ‘hey I know you, I see you at the gym all the time’.

Bruce, employed full-time, age group 26-40

Bruce seemed to like the idea of attending an event at his own sports club because both the venue and the people were familiar. This meant he would be within his own ‘comfort zone’.

However it seemed generally, that the medical or health environment would be more inclusive for men with a chronic illness. Harry explained that he preferred Arthritis Victoria to a social venue because he needed to know that it was a professional environment:
I like a professional environment because it gives the subject credibility and so that’s what I’m looking for when I go to a group. I have to check their bona fides if you like to make sure that at least I’m with people who I can trust with the dissemination of information. It needs to be at a level where it’s been researched and the information’s reliable, and so that’s sort of a requirement for the venue that I had when I first went.

Harry, unemployed, age group 41-60

Harry’s concern with the quality of the information may be a means of ensuring that the time allocated to health management is not wasted, given that health management, as discussed earlier in the chapter, is considered a low priority. His focus on researched information and the formal venue may also be linked to men’s medicalised view of health management, where the doctor is the primary source of help (Pinnock et al. 1998). Phillip also espoused a medicalised view of health management in his comparison of a hospital versus a pub setting:

If it was a pub and it had to do with medical information, I’d be a bit disorientated as to why it was at a pub (laughs). At a hospital, that would make sense, I don’t necessarily like hospitals, because they’re very sterile and have a certain smell and just vibe about them...

Phillip, student and casual work, age group 18-25

Phillip did not like hospitals but he saw it as a logical setting for a health discussion. He did not see any link between a session covering “medical” information and a pub setting. Kevin was more concerned about confidentiality when he rejected the idea of a social venue:

I’ve spoken to a couple of men’s health workers about these issues and their comments were, look pubs are fine for a very open forum but if you want to have a discussion where people can speak more honestly about their lives you need to have a venue where people aren’t just walking in and out, you also need to discuss the issue of confidentiality … clubs and golf clubs do quite often have a room that you can hire for the night where it’s kind of in a neutral social setting but it provides that level of kind of
protection or privacy where people don’t feel that they’re just part of sort of the wash of people rushing through.

Kevin, casual work, age group 41-60

Kevin’s need for “protection or privacy” reflects his recognition that in talking about his experiences and his feelings, his actions separate him from the behaviours promoted by hegemonic masculinity. Therefore he wanted to separate himself physically by being in a “separate room”, away from the “wash of people rushing through”. This may be a particular issue within a pub because it is traditionally a domain for the public demonstration of hegemonic masculinity.

Peter was against the pub as a venue because he had asthma and had to avoid anywhere that might be smoky. Leo also felt that a recreational setting like the pub was inappropriate:

No, no pub. … pub is a pub, is different. People there drinking, talking, you want somewhere where everybody sit down and listen to what they say about the arthritis.

Leo, retired, age group 61-75

Leo made a distinction between the behaviours that are appropriate at a pub, i.e. drinking and talking, versus the behaviours that are needed at an information session, i.e. everyone sit and listen to the information provided.

This apparent preference for medical or health settings rather than recreational settings, is actually in conflict with characteristics of hegemonic masculinity that associate involvement in health services with femininity (Pease 1997a). The comfort with health settings may be a result of the ongoing exposure to medical services that occurs with ‘lived with illnesses’ like arthritis. It does contradict Hegelson’s review of studies of men with coronary heart disease. She reported that, “A number of men spontaneously revealed negative, if not hostile, attitudes towards doctors, hospitals, and having to ask for help” (1995:85). However, the negative attitude towards health services exhibited by the men in Hegelson’s study appears to be based on a belief that they can take care of themselves, rather
than a difficulty with the actual setting. It should also be noted that heart disease is a “mortal illness” rather than a “lived-with” illness, in that it represents an immediate life threat, but individuals with the condition may not be aware of, or conscious of, ongoing consequences and/or symptoms (Charmaz 1995). Therefore, it may have a different sort of impact on individuals’ use and perception of services.

There may also be cultural issues that need to be considered. Gary had shown no interest in attending any of Arthritis Victoria services until he considered the possibility of one being held at the Aboriginal Health Service. His immediate response to that scenario was, “Oh yeah, I’d go”. Query (2002), a doctor at the Aboriginal Health Service, commented that mainstream services are just not culturally sensitive/appropriate for Aboriginals and therefore not inclusive. He agreed that the Aboriginal Health Service would be preferable to mainstream services and said it would actually be more typical of Aboriginal men to avoid health services altogether. Generic services, by endeavouring to be all-inclusive, can in fact fail to meet the specific needs of some community groups. For this reason, consideration of venue needs to account for the particular groups of men being targeted.

Travel distance is often more of an issue than venue. Many men, particularly older men, were not interested in traveling far at night. Lorig and colleagues (1996) refer to the importance of researching the range that people in the target group are prepared to travel. They note that sometimes people may be prepared to travel a reasonable distance in one direction, but prefer not to cross a busy highway or train crossing in the other. Peter raised travel as an issue because he relies on public transport:

It would depend where it was and how accessible it was to public transport. …If it was close, …somewhere that I could walk to, or somewhere that I could get to quickly. It’s not so much getting there as getting home, if something goes ‘til 10.30 I don’t want to stand around for an hour on a tram stop.

Peter, employed full-time, age group 26-40
Peter’s concern about accessibility by public transport seemed to be tied in with a concern about wasting time on unproductive activities. This was matched by Phillip’s avoidance of long distances:

It would more be distance of location. If something was an hour’s drive away I would go - ‘I don’t think so’.

Phillip, student and casual work, age group 18-25

Similarly, David’s only distinction between venues was travel distance:

It would be very nice if it was local of course, so you don’t have to travel too far but apart from that, it wouldn’t worry.

David, retired, aged over 75

What none of the men mention, but may be an important factor, is the discomfort often experienced by people with arthritis when they are sitting or standing for long periods of time, as they would need to do for a long drive or when waiting for or using public transport.

For men who have a chronic illness, a health setting was not seen as a problem, perhaps because of their increased exposure to medical environments. In fact, it was often a preferred option because it was seen as an appropriate setting for serious discussion about a serious matter. Travel was also an important factor, and for some the only factor, in the suitability of a venue.

5.1.10 “You haven’t committed to anything”

The prospect of a single information session seemed to be the most appealing format for men, particularly if it is conducted by an expert in the field. This allows men to come on an anonymous basis without the risk of either committing to something more substantial that will be a waste of time or that will require
personal input. They were generally not interested in committing to further involvement until they had an opportunity to check it out and assess it.

Bruce related his preferred options for services and the order in which he would be inclined to consider them:

I think the one that grabs me the most would be the seminar first, information gathering, which would lead you to a group discussion, which then you would assume, you’ve passed one stage, you’re at the group stage, then you’re prepared to do the six weeks. That’s when you commit I guess. That’s how I see it.

Bruce, employed full-time, age group 26-40

Bruce explained his preference for an initial information session:

You haven’t committed to anything. You’re just committed there to listen. You just take the information if you want to continue or you just walk out the door, bye-bye.

The concept of commitment was taken very seriously by the men and may reflect the notion of reliability, as a feature of hegemonic masculinity. Ted was also wary of committing to something until he had established it would be relevant to him, because once he committed to a program he would see it through even if it turned out to be boring:

That’s probably my concern, that I’m committing myself to six weeks to something that might be boring and tedious ... if I did the first, I wouldn’t feel like reneging on the rest of them, whether I enjoyed it or not.

Ted, retired, age group 61-75

Ted and Bruce’s cautiousness about taking on a new commitment was significant. It supports earlier discussions on concerns about wasting time (see section 5.1.7: “There’s no space for it”), but also highlights the importance given to making a commitment. Once a commitment is made it is given precedence over perceptions
of service value and concerns about wasting time. The priority given to commitment by Bruce and Ted was not demonstrated by all of the men. Graham mentioned how his involvement in community programs tended to dwindle over successive meetings.

For those who were interested in sharing experiences at either an emotional or practical level there was also an interest in a group discussion format:

I think I'm more inclined to go to a more personal environment. The seminar where you're just sitting in a crowd of people, listening to someone speak, I think I'd find it hard to concentrate on what was going on. I'd like to be participating a bit more, so the group discussions and things like that might suit me more.

Phillip, student and casual work, age group 18-25

Phillip preferred the option of a group discussion that was more personal, rather than the anonymity of an information session. However, he did comment later in the discussion that an information session could be useful as an introduction to other services. Phillip's willingness to share his feelings and experiences with others suggests a rejection of hegemonic masculinity that was only evident in men who had experienced a crisis in relation to their condition, most often involving a loss of employment.

For those who were interested in learning more about self management, there was a definite interest in a course format. These were more likely to be men who had demonstrated a reformulation of dominant social constructions of masculinity and were seeking to regain a sense of control over their condition (see section 5.1.5: "I can take care of myself").

David was already attending water exercise classes to manage his condition. He felt that if he was going to attend an additional program at Arthritis Victoria, he was more likely to consider a self management course:
I think as a course where you learn to manage your condition. I think that's very important.

David, retired, aged over 75

Harry liked the idea of the self management course. He gave his view of why some of the men had preferred the idea of an initial information session rather than consecutive visits:

That’s true in essence, of men generally, and I would have subscribed to that up until this point. However, I also recognise that use of a structure, a disciplined activity, a meeting that I have to attend, is sometimes useful for me in order that I do it. So I'd be definitely interested.

Harry, unemployed, age group 41-60

Once again, as raised in section 5.1.5: "I can take care of myself", Harry takes an essentialist perspective of men’s behaviour and yet then describes how he diverges from the masculinist norm. His interest in the course format seems to be based more on a need for structure and discipline to help him to maintain his commitment to self management, rather than on the different content and delivery style offered by the course. There is almost a suggestion that he sees himself as being at risk of slipping back into his previous style of health management, i.e. no action. This may indicate that he is still in a transitional stage in his reformulation of masculinity constructs and may still be going through a process of self-negotiation.

Even for those who were interested in a course format, there were often barriers to attending, particularly because of the commitment of time required - a two hour session, one night a week, for six weeks. It has already been discussed earlier in section 5.1.7: "There’s no space for it", how Peter was reluctant to make any adjustments in his work schedule to accommodate a six week course. Adam spoke from his experience as a self management course leader:
I think getting people to ... the self management courses over a six week period, in my experience, is not as attractive to males as it is to females, mainly because they perceive themselves to be too busy and indispensable.

Adam, retired, age group 41-60

Adam felt that the prolonged period of the commitment to a self management course was the greatest barrier. However, as will be discussed in section 5.2.4: "A whole lot of people sitting around comparing operation scars", men were not familiar with the nature of a self management program, and as discussed previously in section 5.1.2: "Less than masculine for needing a support group", men were often wary about getting involved in a situation where everyone is sharing their experiences. For this reason there were barriers to the group format.

Overall, the introductory information session seemed the most inclusive of all possible formats. Younger men may even resist the exercise programs that are readily accepted by older men, because of the association with others with a disability. As mentioned in section 2.4.5: Different patterns of health service use, men are more likely to choose to exercise with healthy people rather than other patients (Hegelson 1995).

Sports celebrities are commonly used to attract men to health programs, as discussed in section 2.5.3: "Different ways of talking about health". However, this tactic did not appear likely to be particularly useful in attracting men with a chronic illness. While those who were interested in sport felt it might attract them, there was a stronger interest in having an expert presenter who would provide useful information:

I think I'd be more interested if there was a really hot specialist who was going to talk about it. I'd be more interested in hearing expert opinion rather than peer opinion.

Peter, employed full-time, age group 26-40

Peter's preference for expert opinion rather than peer opinion also reflects a medicalised approach that is more consistent with an acute care model and does
not recognise the value of others’ experiences in the day-to-day management of the condition.

As with venue and format, the interest for men with a chronic illness was in getting credible, useful information to help mitigate the significant impact their condition was having on their lives. The use of a sports celebrity was seen as a trivial approach to a serious issue.

Kevin noted that although sports figures are very relevant for some people, for others a sportsperson has an assumption of ‘perfect’ health about them. This can reinforce a sense of personal difficulty for those with an illness by emphasising the loss of strength and fitness that occurs with a chronic illness. However, a sportsperson can be an effective role model for a health program if that person is acknowledging the same chronic condition as the target audience, as this can challenge the stereotype of the sportsperson being invulnerable.

Personal contact appeared to be the most important component in service delivery for men. It was mentioned as either the primary factor or a follow-up option in discussions about preferred mode of contact. Similar results shown in Chapter Four: Quantitative Findings demonstrate the credibility of these findings. It was found that both males and females overwhelmingly tend to use the telephone as their mode of contact with the Arthritis Victoria Telephone Information Service. The difference between males and females appears to lie in the slightly greater use of face-to-face contacts by males than females. Very few clients rely on written contact.

For those men who received the Arthritis Victoria members’ magazine, written articles were a useful source of information. Written material and visits were also preferred by those from linguistically and culturally diverse backgrounds to help overcome the language barrier. The provision of written or verbal information in other languages is an important additional aid to service use. Joe, in the workshop for men’s health practitioners, noted the need for culturally appropriate imagery in advertising material.
While it is important to offer information on the internet, there are many who do not have computer access and/or are not computer literate. Some of the men interviewed appreciated the convenience of accessing information over the internet:

I’m just starting to use the internet as an information source. … you can do it at your own leisure, and you can download it if you wish, all that sort of thing.

John, part time or casual work, aged over 75

Eric was not so positive about his experiences with the internet. He had used it to access information about his condition and found it a negative experience:

The internet’s full of rubbish, that’s all. That’s all doom and gloom that stuff. … I got a bit sceptical towards medical sites actually. I reckon the drug companies and all that sort of stuff, they’ll tell lies.

Eric, employed full time, age group 41 – 60

It is not clear why Eric felt that the information on the internet was “rubbish” but he had clearly been disturbed by the information he had obtained there because this was not the only point in the interview that he referred to information about arthritis and its prognosis as “doom and gloom stuff”. It is possible that he accessed an internet site with unsupported claims about arthritis. It is also possible that he accessed a reputable site but the information he recovered conflicted with his expectations about his condition. Eric seemed to have a limited understanding of chronic conditions, as explored in section 5.1.5: “I can take care of myself”, section 5.2.1: “I didn’t realise that I was needing help”, and section 5.2.4: “A whole lot of people sitting around comparing operation scars”. His previous negative impressions of arthritis information may be one of the reasons why Eric responded so positively to the flyer that was distributed for the trial of findings, as discussed in section 3.6.1(c): Consumer input, despite showing no interest in self management programs during the interview. The positive message that “Something Can Be Done” may have been a welcome change from the other messages he had received about his condition.
Peter was more positive about the usefulness and convenience of the internet as a source of information. He was accustomed to having it as a resource in his workplace:

If I’m looking for information, I’d rather use the internet ... Because I’m good at it, and it doesn’t take very long and I can do it at work in between other tasks ... If I’m looking for advice, I’d rather have it in person, I’d rather go somewhere.

Peter, employed full-time, age group 26-40

Time and convenience were the main benefits for Peter, although he did mention that he’d rather receive advice in person. This was common among those who appreciated internet access. There was still a suggestion that personal involvement in programs has added benefits in terms of feedback and interaction:

The internet is accessible for me at work ... you want feedback too, so rather than just seeing what’s there, you also want the interaction with other people to see what helps with them, or what doesn’t help ... but if they had the chat site or whatever for the ones that are really into it. I’d rather personal, one-to-one.

Bruce, employed full-time, age group 26-40

Bruce shows an understanding of the importance of peer support and role modelling in developing self management behaviours. His interest in sharing experiences is consistent with his preference for a group discussion format, as reported earlier in this section. This apparent willingness to share experiences and feelings contrasts with his other statements about strength and his ability to “take a lot of pain” that suggest a strong reliance on hegemonic masculinity.

Phillip was comfortable with computer technology but definitely preferred the personal contact that comes with a phone call or a visit:
I’m fairly technology friendly but I really think being in touch with a real person makes a big difference. It makes me feel a lot more secure about and confident in the information that I’m being given, and there are certain questions with little bits of detail that I might need, that I would like to ask, and I can’t ask a computer, or the internet. … Hearing someone’s voice makes a big difference too I think. You can at least know, obviously if it’s male or female, or how interested they sound, and also how much they care. … A visit would be ideal because you can see someone’s eyes as well and you know they’re not bored or uninterested or they’re just doing their job and so forth. I prefer visit, definitely.

Phillip, student and casual work, age group 18-25

Phillip’s interest in personal contact appears to be driven by two concerns. Firstly he wanted to be sure that he received personalised rather than general information and would be able to ask additional questions. Secondly, he was very interested in establishing whether the person was interested in him or was just doing their job. This sensitivity to the compassion of the service provider was also evident in Harry’s evaluation of services, as explored in the section 5.1.11: “If I got to the stage where I couldn’t work”. It also supports the findings of Piotto and Kekem in their study of male users of health services. They reported that many men preferred services “where they were treated with respect and dignity” (1998:13), and that the attitude of service providers was an important service feature.

This preference for personal contact over complete anonymity may highlight another difference between men with a chronic illness and those with an acute or no condition. The impact of moderate to severe chronic conditions on lifestyle, work, family and self identity, may increase men’s need for personal contact when they decide to access services. Some men’s preference for personal contact may also be a way of ensuring they do not waste their time with irrelevant information, as discussed in section 5.1.7: “There’s no space for it”. Personal contact was sometimes seen as more efficient because it provided direct access to more personally specific information.
5.1.11  "If I got to the stage where I couldn't work"

It became apparent through the interviews that men had waited for a major crisis to occur before deciding to access self management services. Zola described “the occurrence of an interpersonal crisis” as one of five non-physiological triggers to the referral process. However, he explained that a crisis:

... does not mean that the symptoms have led to a crisis or even vice versa, but that the crisis called attention to the symptoms, caused the patient to dwell on them and finally to do something about them (1973:683).

In this thesis, the crisis did arise as a result of a flare up or progression of the symptoms, and tended to be personal rather than interpersonal.

As described in section 5.1.4: “We’re expected to be a kind of rock of strength for others”, Kevin's condition had reached the point where it represented a major crisis affecting virtually every facet of his life, before he accessed self management services:

The reality is my life’s completely gone sideways, in economic and occupational terms. In spiritual terms it hasn’t. In spiritual terms, I think the struggle to try and be a decent human being, I think is the same struggle.

Kevin, casual work, age group 41-60

It is pertinent that Kevin said his life had gone “sideways” rather than “stagnant” or “backwards” as described by Phillip earlier in section 5.1.5: “I can take care of myself”. This may be because Kevin seemed to have a sense that he was leading a completely different life than the one he expected, as discussed in section 5.1.5: “I can take care of myself”, rather than an interruption to his original life path. As explored further below, it suggests that he was still struggling to accept his circumstances and to develop a new sense of his identity.
Kevin had already detailed all of the services and treatment options he had explored. He then pointed out the journey he had taken to reach the point where he was proactive in the management of his condition:

Can I also say, it took me a very long time. That is partly a reflection of having had the condition over 20 years. It’s partly a reflection of having really battled depression. It’s partly a reflection of having thought carefully about suicide and thought well, what are my choices? Do I seek help or jump off a cliff? And I went along to see my rheumatologist about this issue at the time, to say how I was getting very disheartened by the extent to which I was affected by arthritis and she said, “Well it’s not going to kill you”. And I said “Hold on, if I jump off a cliff that kills me”, and I could see her sort of mentally take two and think well yes he’s got a point there. … I’ve thought carefully about well, what can I do? I can’t change immediately the pain in my feet, maybe I can change how I feel about it. Maybe I can find other people who are similarly affected and have a word to them about what they’ve found helpful.

It is clear from this discourse that Kevin had reached a major crisis point in his life before seeking help. In fact he describes his decision as a choice between suicide and seeking help. The prospect of seeking help may have been particularly difficult for him because he did not believe that anything could be done to change his experience of the condition on a physical level. Therefore, he was trying to come to terms with the idea of seeking help on an emotional level. As discussed previously, this process of sharing experiences and feelings is not consistent with hegemonic masculinity (Huggins 1995). The struggle Kevin experienced in reaching a decision to participate in a support group involved a rejection of those masculinity constructs that had been restricting his health behaviour.

Adam related in his interview that he decided to contact Arthritis Victoria after he retired. Similarly, Harry had accessed self management services soon after he had stopped working. He described the impact his condition was having on him at the time of the interview:
Painful to walk and saps my energy. Feel tired and fatigued all the time ... I've stopped doing what I normally do, completely. There's been other circumstances in my family which precluded me working in the time since I've been diagnosed. However, it's all I could do to leave the house every day and just travel for a short while in the car. And standing for more than a couple of hours at a time is very painful.

Harry, unemployed, age group 41-60

Finding standing painful must have been a particular problem for Harry because his job in the marine industry had involved being on his feet all day without shoes on. His condition had escalated to the point that it was extremely painful, made him tired all the time, stopped him doing the things he would normally do, and affected his working capacity. This is the point that he decided to access self management services. Prior to this he had not felt his condition was painful enough, as discussed in section 5.1.5: “I can take care of myself”.

Baum and Cooke (1986) found that men tend to seek help in crisis, rather than as a preventive or management step. Patterns of health service utilization generally show that there is less gender difference in service utilization when the condition is more serious (Mor et al. 1990; Verbrugge 1985; Waldron 1988). Feifel and colleagues (1987) proposed that the choice of confrontation, avoidance or acceptance-resignation as a coping style is determined by the seriousness of the illness rather than the individual's personal style. This is consistent with my findings that men appear to be located on a continuum of help-seeking behaviour and that their position on that continuum is largely determined by the severity of their condition and its impact on lifestyle.

However, Feifel and colleagues also stated, “Results indicated that life-threatened patients used confrontation significantly more than did non life-threatened patients in dealing with their illness” (1987:91). The interview findings in this thesis indicate that non life-threatening illness can also trigger confrontational coping methods if the condition is severe enough. The diagnosis of a condition as life-threatening may simply be a more immediate trigger for men that the
condition is serious, it will not go away, and that health management is both necessary and justified.

The pattern of delaying access to self management services until a crisis point was reached, seemed to be an unspoken rule of hegemonic masculinity because it was evident in many men’s intentions as well as actual behaviours. Those men who had not accessed self management services anticipated that they would only do so if a crisis occurred. When providing feedback on these findings, Ian noted that this reported reluctance among men to participate was consistent with his experiences in trying to recruit men for the Arthritis Men’s Support Group. They had embarked on a widespread campaign to recruit men and had only received a call from one elderly man who was not prepared to go out in the evenings. Conversely, when Peter provided feedback on the *Summary of research findings* he noted that he had different results in his research in the area of men’s health:

> The most surprising difference was the great extent to which men were buying into a range of support services (particularly newspaper advertised quack services ...), while at the same time avoiding the kind of solutions offered by traditional medical practice (eg talk to your GP about it ...). Perhaps the difference lies in notions of the “legitimacy” of the health complaint - particularly ... where there are no clear community standards about “normal” functioning, and worrying about them challenge masculinity in the way that you have identified.

Peter, employed full-time, age group 26-40

This is not necessarily an inconsistency in results. The Quantitative Findings (see Chapter Four) show that men seem to pursue ‘quick-fix’ options rather than education and self management. It is also reflected in Eric’s comments, as reported in section 5.1.5: “I can take care of myself”, and Graham’s comments in section 5.1.6: “I think my problem is hereditary”. This search for a quick solution seems to be linked with an expectation of a cure rather than an understanding of the nature of chronic illness.
Gary had been forced to give up work because of his condition and still resisted the idea of using self management services. He speculated on what would have to change in his life to make it worth him contacting Arthritis Victoria:

Oh, I’m not sure … I’d have to be worse … I’d have to be in a wheelchair and all that. You know, where I wouldn’t be able to help myself. And I’d probably ring ‘em.

Gary, medically retired, age group 41-60

Gary identified a deterioration of his condition to the point that he was reliant on a wheelchair, as the point when he could consider accessing self management services. This was partly due to scepticism about the value of such programs because of past experience with rehabilitation programs. However, as mentioned above, this temporalizing of an acceptable point to seek help from health services, at a point that most would consider a major life crisis, was typical of the men interviewed for this thesis. The other men interviewed were most likely to say they would access services if their condition escalated to the point that they could not work any more. “Temporalizing of symptomology” and “Perceived interference with vocational work-related activity” are both listed by Zola (1973) as triggers to the referral process. Perhaps Gary’s extension of that crisis point to reliance on a wheelchair reflects the avoidance of mainstream health services evident among the men in his Aboriginal community.

During the interview, Eric related how his condition was causing him considerable pain and fatigue and was affecting his working and home life, and yet he did not feel he was at a stage where he needed to access self management services:

I’m still not at that sort of stage where I still think I can probably manage myself … It’s funny you know, it would probably be if I got to the stage where I couldn’t work.

Eric, employed full time, age group 41 – 60
Graham’s condition gave him regular pain and caused him to modify his farming practices and yet he, like Eric, did not feel he was at the stage where he needed to access self management services. He may have been doubtful about the efficacy of self management techniques because the strategies he’d been given at the pharmacy had only provided limited, temporary relief. Graham predicted what would have to change before he was likely to access self management services:

If I can’t get through the day. … Yeah, when I can’t do it I have to do something.

Graham, self-employed, age group 41-60

Mary, Graham’s wife, also suggested that Graham would have to reach this point before accessing services:

Oh, possibly if he was really unable or if he started to become unable to farm because this is his total and utter life and passion, and he says he has no intention of retiring ever and he’s going to be carried out of here in a box, heaven forbid. I think that only if his whole way of life, his day-to-day living is really challenged by the arthritis that he would probably start to think, hang on a minute I’ve got to really do something.

Mary, Graham’s wife, age group 41-60

Mary’s comment reinforced Graham’s prediction that he would only access self management services if he was no longer able to farm or get through the day, i.e. a complete loss of working capacity. The Draft National Men’s Health Policy noted that:

The socialisation process that inculcates male roles and behaviours is often said to be particularly strong in rural areas. It follows, then, that the aspects of masculinity that are impacting negatively on men’s health generally may be amplified in rural areas: rural men have been socialised to be strong and in control (Commonwealth Department of Human Services and Health 1996:32).
This is evident in Graham’s strong commitment to push on through the pain as long as he can keep working.

The men set clear parameters of when they would seek help, usually if they were unable to continue working. These temporal predictions were supported by the actual behaviour of the men who met those same parameters and sought help following loss of work. This indicates that there is a point prescribed by hegemonic masculinity of when it is acceptable for men to actively engage in health management practices.

These attitudes to the primacy of work are clearly linked to men’s socialization in our society as ‘primary breadwinner’. As noted in the Draft National Men’s Health Policy, “While the reality of the male as sole provider and chief has changed, the socialisation process that prepares men for this role change has moved at a slower pace” (Commonwealth Department of Human Services and Health 1996:19). This provides some explanation for the precedence men continue to give to work over health.

Verbrugge gives less importance to the role of socialization, reporting that:

... women and men with comparable health problems and work roles seek out medical care and restrict their activities at the same pace. Thus men are not delayers compared to women. But women take more time off for the problem, and they are more likely to abandon employment in response to a serious problem (1985:170).

However, this refers to medical care rather than self management programs. Verbrugge also fails to acknowledge that the fact that women took more time off and were more likely to abandon employment in response to illness reflects gender differences in social constructions of health and work.

More relevant to this thesis is the work by Watson (2000; 1993) exploring men’s concepts of health. Men interpret ‘fitness’ as their ability to fulfil their social obligations in relation to work and family. Therefore, they see themselves as fit as
long as they are able to continue working. This makes it extremely difficult for health organisations to reach men at an earlier point in the pathway of their illness. If men see themselves as having adequate health as long as they can fulfil their work and family obligations, then the challenge for health organisations is to reconstruct concepts of health and/or to promote the role of preventive health measures as a means of maintaining working capacity.

The extreme crisis that led to some of the men seeking self management services also left them feeling vulnerable and in need of emotional support which is atypical of the needs expressed by men with less severe conditions. This tendency to delay seeking services until men have reached a physical, psychological and emotional crisis point, is reflected in the quantitative analysis of the Arthritis Victoria Telephone Information Service, which showed that men and women were equally likely to be calling about emotional issues (see Chapter Four: Quantitative Findings).

Harry described a fast, information-based service as the best format for attracting men:

To satisfy men’s requirement for immediate information … all the breakdown of all the drugs presently available on the market and a list of side effects and effectiveness … men feel terrific when they get 3 or 4 information sheets and take them home and read them quietly … bring all that fundamental stuff up to any new person, any new male sufferer and say, ‘look, do yourself a favour, read all that in a sitting, it will only take half an hour,’ or something like that, and just give them all that is fundamental. Because blokes love a whole body of information … to know where they stand in the scheme of things.

Harry, unemployed, age group 41-60

Harry spoke of men needing “all the information and knowledge and understanding” and “all that fundamental stuff” but also suggested that it should be available as a quick, easy read to take home. This would be a difficult request to meet. However, once again Harry demonstrated the contrast between the
mythology of ‘ideal’ masculinity and the practised reality, in his explanation of the reason he decided to contact Arthritis Victoria. It was more about personal engagement and directly contrasted with the scenario he had presented as being desirable for men (see section 5.1.5: ‘I can take care of myself’ and section 5.1.10: ‘You haven’t committed to anything’ for other examples):

Exasperation at a textbook, clinical response from the rheumatologist I was seeing, which didn’t really involve me as the person who owned the condition. So I had picked up the pamphlets about the Arthritis Foundation and read them and where it said about the level of support that was offered, by being able to phone and just the explanations in the pamphlet were more compassionate than what the rheumatologist had shown in her diagnosis and two or three meetings. So that sounded like … there’ve got to be some real people over there that would be actually interested in me.

According to this description, Harry’s rheumatologist had provided a service that matched the delivery style he had advocated for men, and yet he was “exasperated” at this “clinical response” and was attracted instead to the more “compassionate”, “personal” style of the Arthritis Victoria services. The role of the rheumatologist was mentioned by a number of men in relation to their need for personal support. Some of the rheumatologists had provided that level of support and some had not but either way it appeared to be something that was being sought by the men. This need for a compassionate response was mentioned in section 5.1.10: “You haven’t committed to anything”. It was so strong for Harry that it motivated him to act on the Arthritis Victoria pamphlets:

So I think it was the personal approach that was I looking for and it just seemed personal the way that it was presented so when I rang, just one day my feet screaming and thinking well I can’t go back to the rheumatologist, the drugs that she prescribed to me were terrible and some of them worked and some of them were terrible side effects I was getting from them. So I thought, well I have to look for an alternative and that’s when I rang and it was coincidentally a week before that meeting was scheduled.

Harry, unemployed, age group 41-60
Harry’s search for personal support seemed to have been driven by the severity of his condition as it progressed. He had picked up the Arthritis Victoria pamphlets in the waiting room at the rheumatologist but he did not act on that until his feet were “screaming” and he was disillusioned with his medical options. This suggests that Harry, like Kevin, was seeking emotional support as a last resort in his efforts to cope with his condition, and gives us some clues about the importance of emotional support in addition to information during this crisis period. Health organisations providing self management services should therefore be aware that although information sessions are a format most likely to attract male participants earlier in the illness pathway, men who have reached crisis point are more likely to be looking for emotional support. Conducting all sessions in a personal and compassionate manner may be critical in providing the support that is needed and in encouraging men to become engaged in self management practices.

Phillip had to give up work because of his condition, but as it was a WorkCover claim he had been well supported by medical and allied health services and was engaged in self management practices. At the time of the interview, he had undergone a career change, had returned to study and was generally experiencing an improvement in his circumstances, but still spoke of a crisis as being the likely impetus if he was to access Arthritis Victoria services:

... part of me trying to stay positive about this is being in self control and not needing to rely on medical assistance and things like that. Like, I know enough about my injury to be able to keep up my exercises, my stretching to improve my shoulder. I think I’d only go to something like that if I was running out of ideas of how to improve and get better and at the moment I’m not. I’m doing really well and feeling a lot more positive about fully recovering, so it would still again be a matter of going downhill and getting worse. At this point in time, I’m positive and don’t feel like I need moral or group support or things like that.

Phillip, student and casual work, age group 18-25
Phillip felt he had regained control over his condition so he was reluctant to relinquish that control to any health services. As discussed in section 5.2.4: "A whole lot of people sitting around comparing operation scars", the lack of understanding of the nature of self management programs often influences a reluctance to access them. Phillip seemed to expect that Arthritis Victoria services only consisted of "moral or group support". Phillip saw Arthritis Victoria services as a last option that would only be useful if he "was running out of ideas" and "going downhill and getting worse". This is despite his proactive approach in relation to Chinese herbal medicine, which was reported previously, and despite the fact that he says elsewhere in the interview that he has doubts about the level of control he has over his condition. However, it should be recognized that he had already benefited from self management programs provided by other service providers as part of his WorkCover entitlements.

This pattern of delaying help-seeking until a crisis occurs is consistent with one of three possible illness careers described by Safilios-Rothschild:

Despite their awareness of abnormal symptoms, which they may or may not define as illness, are unwilling to assume the sick role and forfeit their social roles. Mostly these individuals are those who cannot "afford" to fall sick or who cannot take the time. ... They may "give in" to their illness only when it becomes so severe that it drastically interferes with the performance of the very social roles which they deem to be crucial in their lives (1970:65-66).

Safilios-Rothschild links this illness career with "Upper middle class men with strong career attachments"(1970:66). However, this illness career was consistent in this thesis with working men of all levels, perhaps reflecting shifts over time since the Safilios-Rothschild study was conducted. Variation in my findings, as described below, was related more to the life stages and working status of the participants.

There were exceptions to the pattern of crisis driven help seeking. It was found that older men in the retirement phase of their lives more readily accessed
services. This appeared to be because the barriers of work had disappeared and there was an acceptance that bodies require maintenance when they age. In this context, exercise seemed an acceptable health management option:

I can cope in every way. I don’t need special equipment or special attention. I’ll go about my normal daily work without any trouble … without a lot of trouble. I mean, it’s not as easy as it was 20 years ago … we felt it (water exercise) was more or less a preventative thing. We’re certainly not going to cure anything but it might help prevent it getting worse. Need the exercise.

John, part time or casual work, aged over 75

John reported that his arthritis was not having a significant impact upon his life despite the fact that he’d had two knee replacements. He saw water exercise as a way of preventing his arthritis from getting worse, rather than a way of managing existing symptoms. This was typical of the older men interviewed who saw water exercise programs as a way of maintaining their health. They may also have seen it as a way of demonstrating their strength and fitness despite the onset of ageing and chronic illness. This preventative approach to health management was not evident among the men in the middle stages of life.

Hawkes and Holm explored the acceptability of exercise programs in their study of gender differences in exercise habits. They reported that, “Leisure-time physical participation was clearly higher among men” (1993:170). They also stated that, “…when promoting exercise participation among healthy adults, one should remember that few individuals need convincing that exercise would benefit their health” (1993:171).

The greater readiness of older adults to accept their vulnerability to illness and to engage in preventive acts has been noted elsewhere (Charmaz 1994; Sarafino 1994; Watson 2000). However, Cameron and Bernardes suggest that “…older men may tend to see symptoms as part of the ‘normal’ ageing process, rather than an illness, which may contribute to late referral. Older age may compound disadvantages of masculinity” (1998:685). Pinnock and colleagues (1998) suggest
that it is attitudes to ageing that affect behaviour. In their qualitative study of older men’s concerns about their urological health, they found that men either encouraged preventive activity to minimize the effect of ageing, or chose a lack of action because of a belief that symptoms were simply a sign of growing old. This differentiation was not so evident in my findings, which showed that post-retirement, men were ready to access services, particularly exercise programs, to manage existing conditions and to prevent further deterioration.

The apparent interaction between age, or more particularly life stage, employment status and health partly explains the results from the quantitative analysis of the Arthritis Victoria Telephone Information Service (see Chapter Four) which found that younger men are more likely to have someone else call for them, whereas older men are more likely to call on their own behalf. Older retired men are free of the constraints of work and are therefore free to access the services themselves. They are also less likely to be influenced by the constraints of hegemonic masculinity because, according to Watson (2000; 1993), men’s concepts of health generally include an expectation that wear and tear will occur with ageing and will undermine the body’s ability to maintain itself.

Mor and colleagues explained the differences in older men’s response to illness in their study of symptom recognition and help seeking among cancer patients:

... older colorectal patients were significantly less likely than younger patients to notice their own symptoms, but those older patients who did notice symptoms were significantly less likely to delay in seeking care than were younger patients. The problem for these elderly patients is therefore not hesitancy but difficulty associating symptom experience with the possibility of cancer (1990:263).

Older men who already have a chronic condition may be particularly prone to ignoring symptoms because they may assume that the symptoms are part of their existing condition, rather than the result of a new condition that requires additional treatment.
For men who were approaching retirement age, retirement rather than inability to continue working was the new parameter they set on accessing services. The wives interviewed also described retirement as the point at which their husbands were likely to act. This was consistent with Pinnock and colleagues’ findings in relation to access to doctors:

Both men’s and women’s groups commented that, after retirement, men were much more willing to go to the doctor, confirming that time off work and having to support the family act as a barrier to accessing doctors. In the rural groups, this was complicated by the time it took to travel to the doctor (Pinnock et al. 1998:372).

The significance of work as a barrier shows the interplay between socio-cultural and structural influences, i.e. it becomes both acceptable and achievable after retirement to seek help from health services.

The time between diagnosis and help seeking from self management services varied considerably and did not appear to be a factor in decision making among the men interviewed. As discussed in section 2.2.1: Chronic illness, arthritis may be characterized by gradual development or immediate onset. The symptoms may be constant or episodic, the condition may be stable or progressive. These characteristics tend to fluctuate for the individual and across individuals. As such, it is not meaningful to compare experiences on the basis of time since diagnosis. However, over time people do become more skilled at managing their conditions simply by making adjustments in their everyday lives and in this way they often adopt a series of self management techniques independently over time (Maes et al. 1996; Rogers et al. 1999; Safilios-Rothschild 1970; Verbrugge 1985).

Rogers and colleagues reported on a shift in health care notions over illness careers:

Similarly, and confirming other sociological research, those who were further along illness careers often seemed to expect less from primary care and seemed to have firmer views about where the boundaries should be
between self or lay management of illness and the seeking of formal health care. (This was particularly evident in relation to mothers who had children suffering from asthma and those with musculo-skeletal problems such as arthritis) (1999:204).

In relation to the men in this thesis, this would only be true of those who had experienced a crisis in relation to their condition. Time was not sufficient in eliminating the barriers to participation in self management programs, unless time meant that they had reached retirement and the significant barrier of work had been removed. Therefore, it was the interaction between the severity of the condition and the life stage of the individual that appeared to be instrumental in determining when help was sought from self management services, rather than time since diagnosis.

The life stages referred to in my findings appear to relate to the different stages of the lifecourse discussed by Laslett (1989). However, Laslett’s ‘four ages’ were not entirely useful to an analysis of the data because in this thesis there appeared to be a further division within the phase referred to by Laslett as the ‘Second Age’ and refers to working life. There would be a closer correlation if the early part of the ‘Second Age’ is recognised as overlapping with the end of the ‘First Age’, which is a period of learning. Alternatively, Arber and Cooper (2000) refer to three main life stages; childhood, working age, and retirement/later years. Once again these categories do not acknowledge the differentiation evident in my findings between young, single working men and working men with families. However, Arber and Cooper do acknowledge the interacting factors of age and family:

Analysis of gender differences in health inequalities during the main years of working life, defined here as 20-59, is complex, because of the need to take into account how women’s (and men’s) family roles, as well as their socio-economic position, impact on health (2000:131).

The life stages described by Laslett (1989), or by Arber and Cooper (2000) do not correspond with my findings. Therefore, they were not considered useful to an
analysis of the results and will not be referred to elsewhere in this thesis. Instead, a range of terms such as young men, middle stages of life, and retirement phase have been used to differentiate between the different groups of men studied. At times a reference is also made to men who have retired for medical reasons, as compared to aged retirement, because it indicates the level of impact the condition has had on their lives. The "Fourth Age" used by Laslett to describe the final period of decrepitude and dependence, was not explored in this thesis.

The possibility of age interacting with self management behaviour was raised by Jenny, a rural community health educator, in response to the Summary of preliminary findings. She queried, "Does the response to arthritis change with the men's age? E.g. is responding to a crisis more likely in younger men? Or are younger men more likely to perceive their situation as a crisis?" This was explored as part of the second phase of interviews. It was found that the avoidance of health issues that was prevalent among working men in the middle stages of their lives, was less striking among younger men who did not yet have family obligations and were still establishing their career and their work identities. However, Kevin was surprised at this finding because it did not correlate with his experience as a young man. In his feedback on the Summary of research findings, he noted that when he was younger he found his arthritis 'impossible to deal with' and could not talk to friends about it because it was so far away from anything they had experienced or could imagine. He commented that now they are all in their forties, they all have experience of illness in their families and have a greater understanding of it. Kevin felt that accessing self management services for younger men was more likely to be driven by a fundamental step, i.e. "My life has changed forever and I'm going to have to deal with it." This was not entirely consistent with the views of the young men interviewed for this thesis. Phillip, as reported in section 3.6.1(c): Consumer input, believed that younger men are more proactive in adopting positive health behaviours. Kevin agreed that this may be true for more articulate men but wondered about men who are less articulate. He has had experience working with young unemployed and noted the high percentages that are illiterate and also innumerate, particularly among the men. Kevin's comments provide a useful reminder of the limitation of a small qualitative sample in representing a population as a whole. Therefore, while these
Research findings can provide an increased understanding of patterns of behaviour, and every effort has been made to recruit across diverse social groups, they cannot be considered predictive or all-encompassing.

5.1.12 Summary

The recruitment of men who had and those who had not participated in self management programs was based on an expectation that differences between these two groups of men would provide insights into the motivations and barriers that exist when a man is deciding whether to access these services. However, during the research process, and in keeping with the grounded theory approach, it became clear that there were no clear differences between the two groups. In fact, particpants and non-participants appeared to be located at different positions on a continuum of disease severity rather than positioned in dichotomous categories. The decision to access services seemed to depend largely on where they were located on this continuum. For most men, participation occurred, or was predicted to occur, when the condition and/or the restrictions it caused, became too great to ignore any longer.

While there was variation in the personal experiences of the men, there were some common issues affecting their decisions to access self management services. The most significant over-riding influence was dominant social constructions of masculinity that require men to be strong, independent and in control, and also associate health management with feminine behaviour. Many men were driven to adhere to these characteristics by avoiding talking about or seeking help for their condition even when it was impacting significantly upon their health status and their working and social lives. In some cases, men used humour to discuss their condition, or accessed services on the pretext of helping someone else. By doing this they were able to bypass the constraints of hegemonic masculinity by demonstrating their stoicism and strength in another way.
Men’s health management behaviour also seemed to be driven by a concept of
health that equated fitness with the ability to fulfil social obligations in relation to
family and work. This meant that men did not feel it was appropriate to seek help
while they were still able to continue working. The level of commitment given to
work obligations, in keeping with hegemonic masculinity notions of the male as
‘breadwinner’, also meant that it was the single largest barrier to accessing health
services. If work and self-management service times conflicted, precedence was
given to work. This meant that work operated as both a socio-cultural and a
structural impediment to participation.

The perception of health services as being for old or disabled people was another
factor contributing to men’s reluctance to access them. Using services meant
being aligned with other users, and therefore identifying as old or disabled. Both
of these options were associated with a loss of control or ‘self-mastery’ over the
body. They were also considered undesirable images and carried the risk of being
relegated to a subordinate form of masculinity. For the younger men it appeared to
be more of an issue of not belonging among older service users, rather than a fear
of ageing.

The interaction between these various barriers to participation meant that men
typically avoided seeking help from self-management services until their
condition had escalated to a crisis point in their life and it was undeniable that
help was needed. This crisis was usually represented by an inability to continue
working. As work is generally a central means of demonstrating adherence to
hegemonic masculinity, loss of work status had the potential to severely
undermine a man’s sense of his own masculinity and precipitate an emotional
crisis in addition to the physical and social trauma being experienced. At this
point, men tended to shift from a reliance on hegemonic masculinity to a
reformulation or rejection of dominant masculinity constructs (Gerschick and
Miller 1995) to accommodate their loss of work status, their need for help from
health services, and their engagement in health management practices.

Men who were still establishing themselves in the work phase of their lives, or
had finished it, were not as restricted by the constraints of social constructions of
masculinity because they did not have the competing priorities of family responsibilities (in the case of young men) or work obligations (in the case of retired men). This allowed them to give health a higher priority. Their experiences may also reflect an increased flexibility in social constructions of masculinity for successive generations of men (Commonwealth Department of Human Services and Health 1996).

Older men were also less restricted by hegemonic masculinity because of a recognition that ageing results in wear and tear and a diminished ability to self heal. This meant that in this study, young, single men and older, retired men were more likely to access services before the impact of their condition reached crisis point.

While there was some evidence of a relationship between health beliefs and health actions, other factors such as men’s life stage and the severity of their condition were found to be more significant influences on their decision to engage in self management behaviour.

Health organisations providing self management services need to consider these gender issues in order to develop services that men with a ‘lived-with’ chronic illness would want to access. In particular, services need to be structured in a way that minimises conflict with work obligations, and acknowledges the interaction between central tenets of hegemonic masculinity and the impact of a chronic condition. Guiding principles to assist organisations in the development of services sensitive to the needs of men with a ‘lived-with’ chronic illness are outlined in section 7.2, Guiding principles for health organisations targeting men with a chronic illness. Additional considerations arising from many men’s limited awareness of self management options, will be discussed in the next section (see section 5.2).
5.2 Limited awareness of self management options

The internalization of dominant social constructions of masculinity conflicts with the development of health management skills. Courtenay (2000b) noted that according to hegemonic ideals, health and safety are irrelevant, and asking for help and health management is feminine. This influence was evident in the interviews conducted for this thesis. The socialization process that prepares men for the traditional roles prescribed by hegemonic masculinity (Commonwealth Department of Human Services and Health 1996), left many of the interviewed men unaware of when it is appropriate to access self management services and what services are available to them. Some men were also sceptical about the value of self management services.

The main tools for overcoming limited awareness seemed to be recommendations from doctors, friends, and family. Gender specific programming was useful in demonstrating the relevance of programs to men. The language and content of advertising material also influenced men’s perceptions about the personal relevance of the program.

5.2.1 “I didn’t realise that I was needing help”

A common barrier to help seeking seems to be the lack of awareness or recognition by men of when help is needed - of the point when it is appropriate to seek help. There seems to be a delay in accessing services until the need to seek help is undeniable, both to themselves and others:

I didn’t realise that I was needing help. I’d been told at 20 years of age that the legs were to last until I was 40 years of age because basically they wouldn’t do a hip replacement prior to that. So I figured that all I had to do was wait twenty years! ... And at that stage I think I was still doing as much as I could to physically prove that it wasn’t a problem. You know,
such as playing sport, playing cricket, all sorts of probably not really bright things.

Adam, retired, age group 41-60

Adam was diagnosed at a young age. His denial of his condition and his efforts to prove “that it wasn’t a problem” were expressed in his efforts to keep playing sport. This would have demonstrated to his peers that he still fitted within dominant social constructions of masculinity. But his behaviour was also due to a lack of awareness that he needed help, and that help other than surgery was available.

At the time of the interview, Peter did not see himself as a person with arthritis, and assumed that since his type of arthritis would go away, he did not need help to manage it:

Until you rang up, I never thought of myself as a person with arthritis. It was just something that has happened to me in the last 12 months or so and it hadn’t actually woven itself into my identity yet, in a way that other things that are wrong with me have … And because it’s a reactive arthritis … there’s always the feeling that it’s going to go away sometime soon. Even though that sometime soon has passed really.

Peter, employed full-time, age group 26-40

Peter was conscious that his selection as a participant in this thesis had altered his perception of his condition. He seemed to be continuing to reassess his position as the interview progressed, as indicated by his comment that as a reactive arthritis it would “go away sometime soon”, and then the realisation that, “sometime soon has passed really”. This example of the influence of the interview process on the interviewee’s response was explored in section 3.5.4: Researcher-researched relationships. As we talked about the impact of the condition on his life and the fact that it had not gone away in the time frame predicted, Peter started to consider the possibility that he might benefit from self management services:
I actually need people to say to me that where I am now is sufficiently bad that I need to go ... That occasionally not being able to do up a button, not being able to get through a whole house worth of housework, getting up late in the morning, being stiff in the morning, you know, those are danger signs. Go now, or else you’re going to be ... you know ... disabled.

Even though Peter was able to identify all of the signs that he needed help, he felt that he needed to hear from someone else that it was time. This fits with Zola’s health model which described, ‘sanctioning’ – “one individual taking the primary responsibility for the decision to seek aid for someone else” (1973:684), as one of five non-physiological triggers to the referral process.

Peter recognised that there were risks in delaying seeking help but did not trust his own judgement about when it was appropriate to act. This may reflect an adherence to traditional gender roles that assign responsibility for health decisions to female members of the family. The failure to recognise when help is needed, is also part of the socialisation of men to ignore pain, and to try to appear strong (Courtenay 2000b).

To recognise that help is needed, the individual also needs to understand that the condition is chronic and is not going to go away:

I don’t believe anyone says good things about arthritis from the point of view that it can be controlled. All they do is talk doom and gloom stuff - that it’s chronic, it’s never going to be cured. And that’s the hardest thing to come to grips with a lot of days, is that you’ve got something they can’t cure. ... normally if you’ve got a cold or you’ve got something else, you go to the doctor and they cure it, but now with this thing they’re telling me they can’t cure it. I don’t know that it was pushed enough about the positive side of it.

Eric, employed full-time, age group 41-60

Eric was having difficulty coming to terms with the information he had received about the treatment and prognosis of his condition because it did not fit with the
approach to acute conditions with which he was familiar – the idea that you go to a doctor and they cure it. Eric equated the concept of ‘control’ with ‘cure’, when in fact control of a chronic condition is achieved by minimising the impact of the symptoms, and slowing the progress of the condition. This shows that although Eric had been told he had a chronic condition, he still did not fully understand what it meant. Until he did reach that level of understanding he was unlikely to be open to self management options.

5.2.2 “Your spouse says stop complaining and go and see someone”

Recommendation seems to be the most powerful means of encouraging men to use self management services. In most cases, those who heard about the organisation through someone else were inclined to access the service, and those who had not, speculated that they would have been more likely to access the service if it had been recommended.

Wives often had a role in encouraging their husbands to take action to manage their health. Many of the wives attended health services with their husbands. Leo noted that he might prefer a program involving both men and women because then, “Maybe, may take my wife too”. Some wives went as far as booking their husbands into programs on their behalf:

Well June actually saw this advertisement and booked me into it and I’ve been doing it ever since.

John, part time or casual work, aged over 75

It was interesting to get the partner’s perspective on their role in encouraging their husbands. Mary encouraged Graham to take action, although he accessed services independently of her:

… if you see a person who’s obviously not feeling well and they’re always in pain or they’re always grumping and they’re always grizzling and telling you, and I don’t know how many times that I would have said to
him, "Look don't tell me, I'm not a doctor. Go and tell a person who
knows. Okay, I can't help you. You have to help yourself, and the first
step towards helping yourself is you must go and tell someone and get
help!"

Mary, Graham's wife, age group 41-60

It is clear from Mary's account that Graham told her when he was in pain and she
advised him to seek medical help. This reflects the traditional role of women as
health carers in the family (Norcross et al. 1996; Courtenay 2000b), as discussed
in section 3.5.6: Recruitment of interview participants. However, as mentioned
previously in section 5.1.1: "Nobody wants to be in a position of vulnerability",
Eric did not feel comfortable talking about his condition with his wife and family.

Graham also described how Mary encouraged him to seek help:

I suppose, as with most people, your spouse says stop complaining and go
and see someone, and I can see that happening to most people.

Graham, self employed, age group 41-60

Graham obviously felt that Mary's role of encouragement was standard within
relationships. It was not clear whether he saw it as the wife's responsibility or a
role of mutual support for partners.

Sometimes the encouragement from wives had no apparent influence on their
husband's behaviour. Tarsha described herself as having a very active role in
trying to encourage her ex-husband, when they were still together, to manage his
condition more effectively. She also tried to encourage her brother to look after
his sporting injury:

I really put a lot of effort into both of them, I mean pressuring them. I
know that's not a good thing to do sometimes because ... it might start to
sound like you're nagging. And that's what they said that I was doing!

Tarsha, Bruce's ex-wife, age group 26-40
Tarsha seemed to have taken responsibility for the health outcomes of her husband but felt that he resisted taking her advice because he saw it as nagging.

I’d constantly be on him because he was constantly grumpy, it was just a vicious cycle. And the more I nagged him, the more he didn’t want to do it. … So there was no winning that situation.

Tarsha elaborated on this during the interview and said that this difference in approach to health management was a source of conflict between her and Bruce. She felt that in the end she had a negative influence on Bruce’s view of health management services. However, Bruce said that he had not resisted accessing services because of her ‘nagging’, in fact he said that her comments had not influenced his decision either way:

She wouldn’t put me off no. She didn’t, I choose. You saw the positives in what she was trying to say. It wasn’t because she’s constantly coming at me - me saying ‘No I’m not going for spite’s sake’. It wasn’t that way.

Bruce, employed full time, age group 26-40

Bruce acknowledged that Tarsha had been active in encouraging him but denied it had been a deterrent. His comment, “She didn’t, I choose”, suggests that he may have been asserting his independence within the interview for my sake - demonstrating his control over his health, particularly because they were no longer together. The potential for this interaction between the interviewee and the interviewer was discussed in section 3.5.6: Recruitment of interview participants and section 3.5.4: Researcher-researched relationships.

Julia, a health worker at the workshop for men’s health practitioners, reported on the active role of women in encouraging men’s involvement in the health system:

We found that when we looked at family planning and services, when you looked at who was the primary client, the person who made the appointment, it was almost 100% women. But when you looked at the secondary client, at how many people actually came through the door and
being examined, it was almost 50-50 because they came with their
husbands, or they came with their partners, to discuss whatever, sexual
problems, fertility problems, but it was almost always the women who
make that first contact and dragged the bloke along. Even if it was the
man’s issue which was the primary issue, it was their wives making the
appointments.

Julia, participant in men’s health workshop

When Rose, Mario’s wife, provided verbal feedback on the Summary of research
findings, she confirmed that she was responsible for coordinating health matters in
their family. Ted also supported this finding in his feedback. Mervat, a general
practitioner, found it interesting because she had not considered this
differentiation in roles as being a factor affecting the health behaviour of her male
patients.

There are many studies that support this finding of the influence of female
partners on the help seeking behaviour of men (Cameron and Bernardes 1998).
Norcross reported that “Men were 2.7 times more likely than women to be
influenced to seek health care by a member of the opposite sex” (1996:475).
Pinnock and colleagues also reported on the influence of women on men’s health
behaviour:

According to men, women (usually wives) have a major role in assisting
them to seek help. This role may be detecting a health problem (drawing it
to their attention as a health problem), finding out information about it,
making suggestions about what to do or pushing their husband to seek

The authors raised the concern that men who are not married may be particularly
vulnerable to poor health management, but they did not consider the position of
men in same sex relationships.

In this thesis, male partners appeared to take a similar role to female partners in
encouraging men to seek help about their condition, but they did not always have
adequate knowledge of health services to assist their partners to identify appropriate action. Peter commented on his partner’s influence on his decisions to access health services:

He’s actually the one that made me go to the doctor in the first place. He was watching me get up and down off the couch and just saying there’s something wrong with you, you’ve got to go to the doctor. He just hounded me for a couple of days. So if he knew about Arthritis Victoria I would have been there by now.

**Peter, employed full time, age group 26-40**

Peter described his partner as putting pressure on him to seek help for his condition. Peter appeared to have accepted his partner’s role as the health coordinator in their relationship. This is evident in his comment that ‘if he knew about Arthritis Victoria I would have been there by now’, showing that the stimulus to take action was likely to come from his partner rather than himself. This is consistent with his comment reported in the previous section (section 5.2.1: “I didn’t realise that I was needing help”), that he needs someone to tell him when he is bad enough to need services:

Well he doesn’t tell me to do things very much, and so when he does tell me to do things, and he’s particularly conscious of my health and the fact that he thinks I don’t look after myself properly. So when he tells me, he’ll hound me for a couple of days, so if he thinks something’s bad then it probably is.

Peter seemed to trust his partner’s assessment of when it was time to seek help. Peter’s distancing of himself from responsibility for health management is congruent with hegemonic masculinity but, as discussed previously in section 5.1.3: “And then you’re getting old”, is contradicted by his active management role in relation to his other chronic conditions.

Peter commented on whether he adopted the same role for his partner:
Oh, to a lesser extent. I manage him in a whole range of ways and I try not to extend my management of him too far. He's got a kind of tendency to be dependent about things, which is one of the things I like about him, and I've got a tendency to be kind of dominating, which is one of the things I don't like about myself, so trying to keep that in some sort of balance.

Within this relationship, Peter and his partner seemed to have assumed different roles in relation to health management. Peter seemed to link these roles with dominant social constructions of femininity and masculinity, describing his partner as dependent and himself as dominant. This model of "butch-femme" roles is no longer accepted as representative in homosexual relationships but as a myth that reflects a heteronormative interpretation of same sex relationships. Instead an egalitarian model is considered more typical of heterosexual relationships (Peplau 1988; Weeks et al. 2001). However, Weeks and colleagues do note that in reality, the interrelation of other social factors can result in differential power within a same sex relationship. This may be reflected in Peter's comments about his partner's dependence. Alternatively, Weeks and colleagues also suggest that negotiation of roles within the relationship can lead to specialisation rather than equal sharing.

Kevin was not in a relationship at the time of the interview. His relationship with a female had ended just prior to the interview. However, Kevin did speak of the role of previous partners in supporting his decisions. It was helpful to get his perspective on the role of partners because as a bisexual man he has had relationships with both men and women. After discussing the roles various partners had in influencing his health management decisions, Kevin commented on differences between same sex and opposite sex partners. Kevin felt it was difficult to compare because, "my heterosexual relationships have been more enduring and more on a day-to-day level than my homosexual relationships". He noted that he had not cohabited with any of his male partners. This was raised in the literature review as a factor potentially minimising male partners' influence on men's health behaviours (see section 2.5.5: Different ways of distributing health
promotion information). Kevin also noted the competitiveness that he felt tends to exist in homosexual relationships:

I think it's also fair to say, in my sexual relationships there have been subtle unresolved issues of competitiveness ... and I think that has affected the issue we're talking about. ... I do think it's very difficult for men not to be affected by the pressure to compete with each other ... even in the most intimate relationships.

Kevin, casual/part time work, age group 41-60

This sense of competitiveness between men would make it difficult to acknowledge weakness and a need for help, even to your partner. As mentioned briefly in section 5.1.1: "Nobody wants to be in a position of vulnerability", this reluctance to reveal weakness can also be experienced by men in a heterosexual relationship if they rely on dominant social constructions of masculinity. Kevin described female partners as encouraging him to access health services:

... women partners have been very kind and gentle and also quite affirmative about saying, "Kevin there are issues in your life you've got to deal with", not so much, "you've got to go and see the doctor now" but rather, "Kevin what are you going to do about the work situation? You've got to do something and move forward in your life". At the same time Dale, who I would say I had a rather wonderful but it was a complex relationship, I mean he's absolutely adamant with me, he says, "Kevin you've got to get on with your life, you're stagnating, you're just stuck in a hole, you're not moving forward, what are you going to do?" So, the style has been different but he certainly also put pressure on me ... he works as an architect, he works very hard, and really struggles and he says to me, "I give my absolute best to my work, you should be giving your absolute best to walking or whatever it is you're going to do" and very direct with me about that.

Kevin described the approaches of his male and female partners as being very different, and yet based on his description of their comments, they seem very
similar. In both scenarios they were encouraging him to reassess his life and move forward. The focus of both was on change and positive health behaviour, rather than on specific health management options or services. Perhaps the difference was in the “gentle” manner of the women in their comments and the “direct” manner of the men.

Baum and Cooke (1986) suggest that men who are single, in same sex relationships, or are not in a supportive relationship, may access services earlier because they are not benefiting from a support service at home in the form of a wife or mother. However, this was not evident among the men interviewed for this thesis.

Men were sometimes influenced by family members other than their wives. However, it was still likely to be female members of the family. Harry spoke of the different influences of his wife and his mother on his decision to seek help for his condition. He spoke initially of his wife’s role and then his mother’s:

… she’s an extremely caring person and felt really sorry for me … but such is the nature of our relationship that unless I was willing to actually go out and do something she knows that she can’t push me to go beyond that point. … one of the main motivators was actually my mother because she was so sorry for me that I was in pain, I wanted to put her out of her misery by getting better.

Harry, unemployed, age group 41-60

Harry says that both his wife and his mother were sorry for him and yet it was the opportunity to please his ill mother that encouraged him to act. Harry saw his proactive health behaviour as a chance to help someone else, “to put her out of her misery”. This is consistent with the tendency described in section 5.1.1: “Nobody wants to be in a position of vulnerability”, for men to feel more comfortable accessing health services if it can be presented as a way of helping someone else. This allows them to maintain their position of strength in relation to others, and to disguise their own need for help, thus maintaining their masculinist status in relation to hegemonic masculinity.
Francis was first diagnosed with arthritis at the age of twelve. At the time of the interview he was 25 years old and living at home. He described his parents as being a significant encouragement to him to participate in self management programs:

My parents obviously encouraged me to participate in these programs and services ... they would always just remind me I had arthritis and I had to deal with it. The only thing is, I had arthritis when I was 12, and I’m 25 now. I turn 26 soon, and that time was my teenage years.

Francis, employed full-time, age group 18-25

Francis pointed out that his parents’ influence had applied mostly in his teenage years.

According to Leo, a Greek man with English as a second language, children also had an important role providing translations of health literature and explanations of how the health systems work.

Nance described herself as being active in encouraging her husband Ian to attend self management programs:

... particularly in his working days when he tended to sort of put things off because he was busy and going to work Monday to Friday, and the awkwardness of doctor’s appointments and one thing and another and he tended to put things aside. It’s only sort of basically since he’s retired that, you know I’ve sort of been encouraging him, and his health situation altering, that he’s become more proactive and doing something about the difficulty he’s got.

Nance, Ian’s wife, age group 41-60

However, Ian gave more significance to the role of a friend with arthritis who recommended various programs:
... and with getting involved with the hydro through the Community
Health Centre, that was through a friend who had the problem and she
advised me about that and also advised me about the Tai Chi as well and I
sort of just worked on her advice on the matter, you know, sort of her
experiences.

Ian, retired, age group 41-60

Ian saw his friend as providing advice rather than encouragement. He was
prepared to follow her recommendation because she spoke from experience. This
is consistent with the experience of Arthritis Victoria self management course
leaders. They noted in the Arthritis Victoria Leader’s Update that male
participants were more likely to attend if a previous participant had recommended
the course to them.

The influence of a friend or acquaintance that has benefited from the program was
particularly evident among older men. This may be because the incidence of
arthritis increases with age (Access Economics Pty Limited 2001) and therefore
older men are more likely to have acquaintances affected by arthritis. Ted strongly
confirmed that friends and acquaintances had influenced his decision to access
services in his feedback on the Summary of research findings. He noted that his
friend’s recommendation had been critical to him accessing services because he
was unlikely to have heard about them or considered them in any other way.

It may also be more comfortable for older men to discuss their condition with
their friends because of the belief, as first mentioned in section 2.4.3: Crisis care,
that ‘wear and tear’ occurs with ageing. The greater health networking of older
men among their friends and associates, was mostly in relation to exercise
options. This result contradicts Banks’ (2001) statement that men tended not to
rely on the experience of their peers. However, Banks does not explore age
differences in regard to this issue and therefore may be referring to the reluctance
among younger men to discuss their condition with others or be associated with
people with a similar condition. These issues are explored within this thesis in
section 5.1.1: “Nobody wants to be in a position of vulnerability” and section
5.1.3: “And then you’re getting old”.

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Kevin's mention of the role of friends was unsolicited in the interview. He explained that they had an important role in supporting him:

...and I'd like to say that for me, my friends play a huge role in my life, and my friends I expect to be supportive of me as I expect myself to be supportive of them, and they have almost as much pushed me to deal with these issues as my partners have ... it's actually from having come from a family that was not very supportive. So I've had to create an alternative to that.

Kevin, casual work, age group 41-60

Kevin had developed a network of friends that acted as a family support for him. Rogers and colleagues, in their review of studies of social networks, report on research that shows a distinction between the influences of family networks and friendship networks. "Some researchers have found that large friendship networks tend to encourage the use of professional services, while large family networks tend to support self-reliance" (1999:111).

The size of social networks was not measured or explored in the interviews of this thesis, and based on the individual comments of the men, there was no obvious link between type or size of social network and level of service use. Rather, as already discussed, the differences in levels of service use seemed to be governed by the interaction between severity of condition, life stage and working status. Rogers and colleagues acknowledge the inconsistencies in the research about the influence of social networks on service use:

Reviewed overall, research findings about the importance of social networks in relation to service use have been inconsistent and differ according to condition, type of health action, and population group under consideration. There are also suggestions that social networks are not good predictors of health services utilization, or are only of significance in combination with other factors (1999:113).
The findings of this thesis indicate that the influence of friends and family varied according to the social circumstances of the men interviewed. However, partners were more likely to influence men’s decision to access self management services. Female partners often had a role in encouraging men to take health action and in directing them to appropriate service providers. Same sex partners appeared to provide similar levels of encouragement but had less awareness of appropriate health services. Friends with experience of a service were also an important source of encouragement, particularly for older men.

This confirmation of the role of others in encouraging men’s health management behaviour, helps to explain the results reported in Chapter Four: Quantitative Findings, which showed that men were more likely than women to have someone else contact the Arthritis Victoria Telephone Information Service, rather than call on their own behalf.

5.2.3 “It hasn’t been suggested to me by my doctors”

There were many instances among the interviewed men of referrals from general practitioners and/or rheumatologists to hydrotherapy or allied health professionals. However, recommendations to explore the self management services provided by organisations like Arthritis Victoria were generally not being provided by health professionals. There were some examples where it did occur; for example, referral to a course, or a phone link-up with another patient to discuss the experience of surgery and its outcomes. However, the tendency not to refer to self management services was not surprising given that the patient information pamphlet, Your Rheumatologist, produced by the Australian Rheumatology Association (2002), does not include self management services in its description of treatment options. Instead it takes a medicalised approach and describes only those services provided by the rheumatologist or by allied health professionals such as physiotherapists or podiatrists. It is clear from comments by the men and their partners that a recommendation to access self management services from the doctor, or even a display of relevant leaflets in the waiting room,
would be a powerful influence on men to seek these services at an earlier point in the progress of their condition.

Harry described how reading Arthritis Victoria pamphlets had led to him contacting the organisation (see section 5.1.11: *If I got to the stage where I couldn’t work*). He had come across the pamphlets in the specialist’s waiting room:

> It was sitting in the waiting room of the rheumatologist that I went to see. However, she never mentioned it as a source of information.

Harry, unemployed, age group 41-60

The effectiveness of placing self management information in a medical waiting room may be due to several factors. By being available in a medical environment it may be seen to fit within the medicalised notion of health care held by many people (Lorig 1996a; Owen and Lennie 1992). It may be because the men simply have nothing else to do so they have time to read it. It may be because the men are at the doctor so they are at a point where they have recognised they have a problem and are ready to act in some way. There may also be an implied endorsement of the service by the doctor. Ted speculated about whether the availability of a leaflet in the waiting room suggests that the service is supported by the doctor:

> Well, probably, from the point of view that it’s in the doctor’s surgery, I would think that obviously they - well do they? Does the doctor make the decision to have these leaflets or does his staff make the decision? But it’s an appropriate place to find them, surely. That’s what I would think on it.

Ted, retired, 61-75 age group

Ted seemed to have initially assumed that there was an endorsement of the service by the doctor. It was only my question that caused Ted to stop and query that assumption, but he still concluded that it was an appropriate place to find information on self management services. This supports the contention above that
finding pamphlets in waiting rooms positions the service within a familiar medicalised framework that is actually more consistent with acute care.

Alternatively, there is evidence that a doctor’s failure to recommend services or display information about them is often interpreted as a decision by the doctor that those services are not relevant to the patient. Phillip was reluctant to consider accessing Arthritis Victoria services because they had not been recommended by his doctors:

So yeah, it does interest me. I don’t think I’ve investigated it more because ... it hasn’t been suggested to me by my doctors, and the whole thing with my injury and being on WorkCover is, taking the advice from my doctors. They’re the people who are helping me manage it because we’re now in like a legal sense, I’m binded by an insurance company to my actions that have huge repercussions, and it hasn’t been suggested to me so I haven’t thought about it.

Phillip, student and casual work, age group 18-25

Phillip seemed to feel that any new initiatives in his treatment should be instigated by the doctors, and presents this as an inflexible arrangement because of the legal circumstances associated with his WorkCover claim. And yet, Phillip relates later in the interview that when he heard about a Chinese herbalist, he checked it with his doctors and then tried it with their support (see section 5.1.9: I like a professional environment). He also mentions that he could do the same for Arthritis Victoria. Phillip may have used his WorkCover obligations as an excuse for not contacting Arthritis Victoria, to deflect any potential pressure from me to use the services. He was aware of my connections with the organisation. Given his later comments, the interview process appears to have altered his position. The potential for my links with Arthritis Victoria and my role as interviewer to influence responses was raised in section 3.5.4: Researcher-researched relationships.

Phillip explained why he thought his doctors had not mentioned Arthritis Victoria programs to him:
Maybe because WorkCover has all these different areas of assessments. ...I don’t know. I really haven’t thought too much about it. (pause) Maybe they feel like they’ve got all the information that I might need? ... I’ve told him all about the operations around the house I have to do and we’ve sat down and worked out what’s the best way to do it, you know, if it is sore then if it’s possible to ask a friend to hang ‘em out or you know ...And so we’ve done most of the assessing of my lifestyle related to my injury, on our own.

Phillip did not consider using Arthritis Victoria services, partly because he did not recognise its relevance to him and partly because it was never suggested to him by his doctors. Phillip speculated that his doctors had not mentioned it because they did not think that he needed it. The WorkCover team of health professionals were providing the same sort of services that he might be able to access at Arthritis Victoria. The examples he gave of the different activities they had done were similar to the examples he had been given in the interview about the type of activities he might experience by using WorkCover services.

Some men also interpreted the lack of referral from their doctors as a scepticism about the value of those programs generally. Eric commented on whether he would consider going to a self management program:

Yeah, see the interesting thing, talking about the Arthritis Society, neither the GP or the rheumatologist have mentioned that ... And I’m just thinking back ... when I go to his rooms, and I wait twenty minutes or so, there’s nothing in the rooms to read about it.

Eric, employed full-time, age group 41-60

The implication in Eric’s comments is that if the GP or rheumatologist has not mentioned it, then it’s not something worth considering. The fact that there was no literature on Arthritis Victoria in the waiting rooms seems to be interpreted by Eric as a further sign that his doctor did not believe in the value of the program.
Graham also felt that if the programs were any good then the doctor would have mentioned them:

Probably means that he’s not all that rapt in it either, probably hasn’t convinced himself about it. If he was convinced about it he’d probably convince me. If he got feedback from other patients saying this is really good.

Graham, self employed, age group 41-60

Graham assumed that if the doctor had not mentioned the services then he either did not think they were any good, or he did not have enough information to convince him that they were worth recommending. Interestingly, Graham mentioned feedback from other patients as being a source of information for the doctor on the value of the program. It is not clear how those other patients were supposed to have accessed the programs - i.e. independently or referred by a sceptical doctor.

The only cases where a recommendation from the doctor was not likely to be acted on was when the person felt they were coping with their condition, had not yet come to terms with the chronicity of their condition, or were demonstrating a strong reliance on hegemonic masculinity. However, a referral could still encourage these men to access self management services earlier than they would have otherwise, particularly if their condition was progressive. The level of influence of a doctor’s recommendation may also depend on the individual’s evaluation of the doctor and prior beliefs about the value of such services. As noted by Rogers and colleagues, people use a variety of different information sources both official and unofficial and sometimes conflicting. “Perceptions of the credibility of information may also be affected by the extent to which it fits with prior experiences of illness and health care and by opinions about the information producers” (1999:198).

Doctors were generally perceived by the men to be the main source of medical information and support. This is consistent with the findings of Pinnock and colleagues (1998), as reported in section 5.1.9: “I like a professional
environment". However, a couple of the men expressed dissatisfaction with the level of service provided by their doctors. Harry, as described in section 5.1.11: "If I got to the stage where I couldn't work", was exasperated with the clinical response of his rheumatologist. This motivated him to explore the more personal services offered by Arthritis Victoria. Harry's experience may reflect the reports of several studies that men are often treated differently compared to women patients by doctors, with a greater focus on medical rather than emotional needs (Hegelson 1995; Courtenay 2000b). However, as discussed in section 2.4.4: External influences research results on this topic are inconclusive.

It appears that targeting doctors as distributors of information about self management programs may be an effective strategy. Maisiak and colleagues (1990) report that intervention from others can be an important stimulant to positive health behaviours. Their findings were based on a study of follow-up action taken by users of an Arthritis Telephone Information Service. They showed that men were more likely to enter hospital for treatment following contact with the Telephone Information Service. The authors of the study suggest that this might reflect a greater reluctance of men to receive treatment unless specifically encouraged. The importance of the encouragement is that it not only helps men to recognise that help is needed, it also makes it clear that help-seeking will be perceived by others as justified – an important consideration for men influenced by dominant social constructions of masculinity that prescribe strength and independence. As already mentioned, the credibility of the information source is critical and given that doctors are generally perceived by men to be the main source of medical information (Pinnock et al. 1998), it is not surprising that the findings of this thesis indicate that doctors are a powerful influence on men's decision to either access or reject self management services. This is a particularly important issue for men's access to chronic illness self management programs because although the focus of self management is on the patient taking responsibility for the daily management of the condition, this is done in partnership with the doctor and it is the responsibility of the doctor to provide the information needed by the patient (WA Research Unit 2000).
5.2.4  "A whole lot of people sitting around comparing operation scars"

Some of the men interviewed were completely unaware of Arthritis Victoria's existence. Others were aware of the organisation, either through the media or word of mouth, but had little or no knowledge of the services available. Bruce, a fully employed man in his early thirties, gave a response that was typical of those who were completely unfamiliar with the services. When asked if he knew what Arthritis Victoria did, he said, "No, no idea." Those who felt they did know what Arthritis Victoria provided often assumed that it was support groups only. Adam, a retired man in his fifties, said his initial view of support groups was, "a whole lot of people sitting around comparing operation scars". This was typical of the views expressed by many of the men.

Eric, a fully employed man in his fifties, had the perception that services only spoke of "doom and gloom stuff". He was not aware of any positive messages in relation to the management of arthritis. His consideration of any health services was coloured by his disillusionment with previous experiences accessing information about arthritis (Rogers et al. 1999). As discussed previously in section 5.2.1: "I didn't realise that I was needing help", Eric was still struggling to accept the chronic illness model and the fact that the focus was on management rather than cure. For this reason, Eric's efforts to gain information about arthritis from his doctors and from the internet had been a negative experience. Because no-one could tell him what he wanted to hear - that it could be cured - he did not believe that there was anything good to say about arthritis and therefore, did not believe that Arthritis Victoria had anything to offer him.

Phillip was aware of Arthritis Victoria and its services, and yet did not consider himself a potential client.

I think being a younger person, arthritis might not be affecting me as yet and who knows it might actually be affecting me in small ways, I'm not sure. I've sort of tended to be as active as possible to keep my body in shape and since my shoulder injury in particular, that's gone down a lot so I've had a lot of low self esteem and not been too positive about my
physical ability to do certain things and that's made me a bit more conscious of the fact that down the track there'll be repercussions of what's occurring now.

Phillip, student and casual work, age group 18-25

Phillip's comments about being a younger person suggest that he sees Arthritis Victoria as being relevant to older people. The effect of his shoulder injury on his fitness, and subsequently his self esteem, raised Phillip's awareness of the possibility of arthritis in the future. This reflects a consciousness of the 'wear and tear' that is associated with ageing in many men's concept of health, as discussed earlier in section 5.1.3: "And then you're getting old". However, by not recognizing his current condition as being included in Arthritis Victoria services, Phillip also demonstrated a limited knowledge of the scope of their services and their client base. Instead, he assumed that Arthritis Victoria would only be relevant to him if osteoarthritis developed in his shoulder as a long term outcome of his current injury.

Those men who were aware of Arthritis Victoria services were members who were already using one or more of the services and were receiving the Arthritis Victoria newsletter. Even then, some of the men were not aware of the full range of programs available to them.

The lack of knowledge and/or misconceptions about services that was displayed by almost all of the men interviewed, may explain the gender differences in reason for contact reported in the quantitative analysis of Arthritis Victoria Telephone Information Service. This analysis showed that men were under-represented as clients, and when they did use the service they were more likely to seek information about pain management, medication, and diet. That is, men were more interested in symptomatic relief, rather than exercise, education programs, or aids and equipment. This difference may be largely a result of men's limited awareness of the other service options available to them. As discussed in section 5.1.7: "There's no space for it", it is also likely to be driven by men's perception that they do not have the time to spend on personal health care.
5.2.5 "I'm a sceptic about some things"

Some of the men interviewed were sceptical about the value of self management programs and stated that as a reason for not accessing them. This was often based on limited knowledge or understanding about the range and nature of the programs available. Negative past experiences with specific services could also affect men’s perceptions of health or government services generally.

In some of the interviews, the men were asked to comment on the behaviour of two fictional men with arthritis to explore their perceptions of proactive self management behaviour. One of the men (called either ‘Jack’ or ‘Steve’) was described as accessing self management services to help him with severe arthritis that was causing significant pain and preventing him from working. The other, ‘Bill’, was accessing self management services to help him manage his moderate arthritis and try to prevent it from interfering with his work and lifestyle. As discussed in section 3.5.8: Interview format, this question was not included in the later interviews because it seemed to cause confusion for some of the interviewees. However, Eric’s scepticism about the value of self management services was clear in the comments he made about Jack and Bill’s actions.

When Eric was presented with Jack’s scenario, someone who has reached crisis point and decided to seek help from self management services, he said:

Well, it almost conjures up an image of someone who’s probably reaching out for last straws. There’s nothing else left, I suppose he’s at the point where you’d say I’ve tried everything else I might as well try this. I’ve got nothing to lose have I?

Eric, employed full-time, age group 41-60

Eric’s comments suggest that he sees self management services as being something he would only try as a last resort, and only because there is nothing to lose at that point, not because there is any expectation of getting results. Eric was asked how he would respond if Jack was a friend of his and told him what he was planning to do:
I wouldn’t say anything. I wouldn’t say this is wrong or you’re wasting your time. No, I wouldn’t say that.

This further indicates that Eric did in fact think that accessing self management services was a waste of time, he would just refrain from saying it to someone else considering those services. This was confirmed by his response to Bill’s scenario, i.e. someone who was being proactive about self management:

Yeah it’s interesting, from the point of view that I suppose all my life I reckon I was a person that doesn’t take risks and that I probably calculate things before I do things ... and to me, if you don’t know what’s going to happen, it’s sort of like risk isn’t it. You don’t know if you’re going to waste your time or whatever. It’s really hard, like if someone said to me I can cure your arthritis, you’re going to be a new man, you’d go and do it wouldn’t you? But from what I’ve worked out that can’t be true so I’m probably a little bit, I’m a sceptic about some things too I suppose. I can understand, I see rehab and that sort of stuff and I see people in there. The things that people can do and utensils they can use, the claw or something like that. Now that’s clever. I’m not at that stage I suppose. Yeah, I suppose the thing comes back to, as I said before, it’s probably a self-centred thing. What’s in it for me? If I’m only going to do this, is it going to improve my life or just going to cost money ...

Many of the men responded on a personal level to either Jack or Bill, as Eric did above, and would answer as if it were their own actions being considered. Eric’s identification with Bill shows that he saw himself as being moderately affected by his condition. However, he did not adhere to Bill’s chosen course of action. Eric’s discussion about calculating the risks and benefits of using self management services, shows that he was making a clear choice not to access them because they represented a cost in terms of time and money without any promise of adequate benefits. However, this was not necessarily an informed choice. It was based on an undeveloped understanding of the nature of arthritis, and subsequent unrealistic expectations of services. He was not interested in spending time on a service if
there was no promise of a cure. He acknowledged the benefits of aids and equipment but did not feel they were relevant to him at this stage.

Eric’s scepticism about an arthritis related service may also have been fuelled by a dissatisfaction with the information services he had accessed via internet. Eric had been proactive initially about seeking information over the internet and had been disappointed with the information he had found and what he perceived were negative messages about arthritis. This is discussed in more detail in section 5.1.5: “I can take care of myself”, and reflects the dissonance between Eric’s health expectations, and the likely prognosis and recommended treatment for arthritis. His initial negative experience with arthritis information services was then applied to all other arthritis management services. This pattern is consistent with Rogers and colleagues’ (1999) findings that prior experiences influence perceptions of the credibility of information.

Similarly, Graham’s scepticism seemed to be partly based on negative experiences with outside agencies coming into rural areas and trying to effect change:

I suppose I don’t know about the arthritis people, but so many of these government agencies, like the Department of Agriculture and Conservation, whatever they are now, you go along and really they’re there just to justify their job, they’re not really doing any good at all. I suppose I get very sceptical about all organisations like that.

Graham, self employed, age group 41-60

Graham applied those negative experiences with government services to health services as well – “all organisations like that”. This distrust of outside health services was noted in the Draft Men’s Health Policy as being common to rural men:

... as they value experience rather than theory, rural men are less likely to trust the advice of medical practitioners, especially if they are not from a
trusted local network, even if such advice is sought (Commonwealth Department of Human Services and Health 1996:32).

This distrust of theories, and emphasis on experience, was clearly evident in Graham's description of programs initiated by outside agencies:

I think we've all been soured off on those sort of things a bit by going along to the local school or somewhere, they'll have a system where they want to have a new way of selling livestock or something. ...but you come away at the end feeling, 'well that's alright for the boffins but it's not going to work in everyday life for us'. Things have really got to work here, not just be in theory. I think you'll find that a lot of people are a bit soured off by that because there's been so many organisations trying to tell us that you should do it their way.

Significantly, Graham was more likely to go along if there was a local element, i.e. if it would help a friend, was being run by a local community leader, or was being promoted through local networks, as described in section 5.1.2: "Less than masculine for needing a support group". Graham's thoughts were also reflected in his actions. While he was not interested in accessing any self management programs conducted by health organisations, he had tried several remedies recommended by local acquaintances and local pharmacy staff:

I've tried to do those things that people have said are good. Somebody said, wear a bandage on your knee, I tried that. That's alright in the winter when you've got long trousers on but when you've got shorts on, the next thing you find is that the bandage is rolling down your leg and that's not as easy. ... I listen to people in the local pharmacy shop when they say rub this stuff on that they put on the horses. ... that makes it all cold and numb for a while but after a while it's pretty much the same again. I think we get back to what your local GP tells you, there's not much that can be done, learn to live with it. Been told that always at the doctors.
Graham's preparedness to listen to recommendations from other locals seems
typical of the information pathways that operate in rural areas. Even when he'd
had limited success with one of the recommendations, he was prepared to try a
different one, and seemed less critical of the local sources of information than he
had been of outside agencies, saying that the reason the remedies had not worked
was because, as the doctor said, "there's not much that can be done". Men's
health programs conducted in rural areas (Gibson and Donner 2000; O'Hehir et al.
1997) have effectively capitalized on this reliance on local information pathways
in the formatting and promotion of Men's Health Nights, to minimise scepticism
about the program. This social marketing strategy is reported in section 2.5.3:
"Different ways of talking about health".

5.2.6 "Because it was designed for men, I thought I might learn something"

A pattern gradually emerged in the interview data showing that while programs
that include both men and women are not a deterrent to men, men-only programs
may help attract men. Most men expressed ambivalence about the gender of other
participants or the leader but there was nevertheless evidence that it still played a
part in attracting them to programs and/or affecting their comfort levels. This may
be because it acts as a trigger that notifies men of the program's relevance, and
also indicates that they will fit in among the clientele.

The fact that the Arthritis Men's Support Group was promoted as being for men
was clearly one of the motivating factors that encouraged Harry to attend:

And because it was designed for men, I thought, I might learn something
... and I thought, well okay, let's go and talk to other people who have got
it, other blokes, and see whether I'm unusual in experiencing this or
whether they're common effects.

Harry, unemployed, age group 41-60

Harry is encouraged to attend the men's group because he feels it is likely to be
relevant to him, as a man with arthritis. However, he is also seeking to be
reassured of a commonality between his experiences and those of others, i.e. to find that his experiences are not unusual. This reflects the isolation he had been feeling and his need to connect with others with whom he could identify. Harry’s sense of isolation was discussed in more detail in section 5.1.1: “Nobody wants to be in a position of vulnerability”.

Harry’s need to connect with other men may have been more pronounced at that stage in his life because the impact of his condition was threatening his status in terms of socially constructed dominant masculinities, as described in section 5.1.5: “I can take care of myself”. The men’s group may have offered an opportunity to re-establish his sense of belonging among men and yet when asked later in the interview if he would have still attended the group if it were for both men and women, he said, “it wouldn’t have made any difference.”

Bruce was similar to Harry in his position on gender issues. He had stated earlier that he had no concerns about attending a mixed group, and he said that he would prefer a female leader because he described them as “just gentler, easier to talk to sometimes”. And yet Bruce raised the Gutbusters weight loss program as an example of a promotion he responded to because of the male focus:

What’s an example is something that got me, was Gutbusters. ... It grabs you. ... because it was specifically for men, that’s why it grabbed me. I thought, oh, that hit a nerve within me.

Bruce, employed full time, age group 26-40

Once again, it was the fact that the program was specifically for men that appealed to Bruce. It helped him to identify with the program. This indicates that promotional material needs to be gender specific to demonstrate its personal relevance and to enhance awareness. However, as the presence of women does not appear to deter men from attending, it seems acceptable to advertise a program for men and indicate that partners are welcome to attend. Some of the older men and those from linguistic and culturally diverse backgrounds mentioned that they preferred to attend with their wives. This may have reflected the wife’s role as the
health care coordinator in the family, as discussed in section in 3.5.8: Interview format.

A few men felt that it was important for organisations to offer occasional men-only sessions to provide an opportunity to explore the gendered experience of certain issues, and to allow men to speak more openly amongst themselves:

I do generally prefer to go to things that are just one gender ... I just think it’s a thing about men that if they’re together and they’re there because of health, then they’ll open up more about it if there aren’t women there, particularly if they’re women that they’re married to or related to.

Peter, employed full time, age group 26-40

Peter’s personal preference was for men-only events. He seemed to feel that all men would be more open in a group without women, particularly women with whom they have a relationship. This is a significant comment considering Peter is homosexual, and may indicate that he is less comfortable confiding in women. However, when asked if he would be more comfortable in a group of gay men, he said, “Nuh, the opposite actually. I find gay men in groups really irritating!” It is possible that Peter’s preference for being in a group of heterosexual men is an effort to comply with dominant social constructions of masculinity and avoid the feminising associations of support groups with women or with gay men.

Kevin preferred services that involved both men and women but felt there was a need for gender-specific events to explore sensitive or gender-related issues:

... around specific issues there would be times when I would prefer to work with men and those are basically men-specific issues, such as self image, physical self image. My physical body in its appearance is profoundly affected by arthritis. I’ve narrow shoulders because my shoulders didn’t develop properly. I mean that’s just one example ... One is work, finances, I mean finances are not gender specific but there are gender specific parts/components in it. Thirdly, physical well-being, let me be more specific, sex! I mean I’m affected due to making love. When I
make love it's like gravel being crunched onto itself ... Like the sound. And that's something that, sure I might be comfortable talking to you now, but I would at some point prefer to be able to talk to other men about what's it like feeling embarrassed about the sounds in my shoulders ...

Kevin, casual/part time work, age group 41-60

The issues Kevin raised as warranting gender-specific programming are issues he had struggled with, and was still struggling with, as part of his personal experiences with arthritis. Kevin's need to explore these issues with other men may be similar to Harry's, in that he was seeking a commonality with other men at a time when his condition was threatening his sense of his own masculinity, as explored in section 5.1.1: "Nobody wants to be in a position of vulnerability". However, Kevin was comfortable in raising those issues with me. The impact of my status as a female interviewer is discussed in section 3.5.4: Researcher-researched relationships.

Elsewhere in the interview, Kevin also spoke of occupational issues as being gendered and relevant to a men-specific session, and felt that they were further differentiated by class:

I think it's partly a class issue, if you're coming from a background of working as a gardener, basically not in a white collar kind of area, I'd say in some ways the gender issues are sharper. ... If a man's worked as a gardener and he wanted to swap occupations to something where he can continue working in respect of arthritis, it's not so obvious where you go to. Whereas if you're in a white collar occupation, if for instance, you might work as a teacher and you might have to work standing up, you might quite easily, not necessarily easily, but possibly quite easily swap over into administration, do you see what I mean?

Kevin's suggestion that gender issues are sharper for certain classes of workers, reflect gender differences in choice of occupation, and supports Chermaz' (1994) contention that most working class jobs permit little flexibility.
The suggestion that men-only sessions were required for discussion of certain issues, was only raised by men with work experience in an academic environment. It is difficult to know whether this is relevant, and whether there are class-based differences in the men’s perceptions of gender issues. It is possible that it was actually their experience with group work/research/interviews that made them more conscious of the impact of group dynamics. The other men interviewed were less likely to have had this experience in their workplace. Those men who did suggest that there was a need for men-only discussions, and/or contact people, acknowledged that women were likely to be facing similar difficulties but felt that they would be experiencing them in different ways. This shows a recognition of the social construction of gender and health:

I did sometimes feel that a men’s self help group would be really helpful because for men and women it’s not that the issues are more difficult for one than the other. I mean I’ve listened to quite a number of women talking about the difficulties of looking after a young baby when their joints may be inflamed to the point that they can’t pick the baby up ... that’s obviously a profoundly difficult issue for a mother. ...So I want to be clear, it’s not that I think that the issues are more difficult for either men or women, but they’re not identical issues.

Kevin, casual/part time work, age group 41-60

Kevin was aware of the difficulties faced by both men and women with arthritis but felt that they were likely to experience them in different ways. He may have raised the example of a mother because he was conscious that I was a mother with arthritis. As mentioned in section 3.5.4: Researcher-researched relationships in relation to the potential influence of the interviewer on the interviewee, I am not sure if he was aware that I was the author of Juggling Sore Joints and Babies, A Guide for Parents and Grandparents with Arthritis and Related Conditions (Gibbs 1998). However, he did not make any direct reference to me at this point in the interview.

Peter was also conscious of the gendered organisation of illness experiences and its relevance to participation in services:
... there's a gendered organisation to all of that stuff you know. Even though the issues might be the same, the way of experiencing them, or the way of them playing out in their life, might be completely different. ... If I went along and there were a whole bunch of articulate women there who were able to talk about the problems in their lives, and they were a different set of problems to the ones that I have, even though they might at some categorical level be the same sort of problem, then I might not be encouraged to go back, 'cause I'd see it as a women's thing.

Peter, employed full time, age group 26-40

Peter felt that gender differences in the way problems are experienced meant that he would feel that a program dominated by women was not relevant to him, even if the problems being discussed were essentially the same as the ones he was facing. This is an important consideration for health organisations developing programs that are gender sensitive.

This notion of a gendered experience of disability was supported by Morris (1993) who explored the interaction of social constructions of disability and social constructions of gender. She suggested that disability confirms women's powerlessness in society, and conflicts with men's position of power:

This is not to say, however, that disabled men do not experience masculinity as an oppressive social construct, ... the consequences of the failure to measure up to what is socially defined as being a man can be devastating (1993:89).

Adam was not in favour of men's support groups. He suggested that there was "a perception out there that a men's group may have an element of homosexuality". This was discussed in detail in section 5.1.1: "Nobody wants to be in a position of vulnerability". Adam stated very strongly that he did not adhere to that view. However, he also did not see any benefits of having men-only programs:
Why would men open up more just because it’s other men, rather than men and women? We’ve got to educate them about the same things. It would depend on the topic I guess. ... on the one hand I can see that if a man joins a self help course he’s going to be 1 or 2 out of a group of 12 and that’s difficult, but I don’t know if having a men-only course would attract any more.

Adam, retired, age group 41-60

Adam did not adhere to the view of a need for gendered programming. He jokingly referred to Viagra and alcohol as gender specific topics, which in itself is pertinent because by identifying sexual performance and drinking as men’s issues he is operating within a framework of hegemonic masculinity. However, his position was that if the same issues were being covered, a mixed group was the best option. He did not feel that a men’s group would attract more men, nor did he feel that men would be more open in a men’s group as compared to a mixed group, although he did acknowledge that it might be difficult if there was only one or two men in the group.

Regardless of their views on the need for men-only sessions, mixed programs were considered appropriate for exploring more general issues to do with health information and health management. Adam suggested that the inclusion of both men and women could help by offsetting tendencies for competitiveness among men:

I don’t know whether I’m over-simplifying things in some respects in saying that most males are basically very competitive, and in a self management situation, I can see them sitting down and drawing up a plan for the next week for themselves. And if one guy’s going to walk 5km’s the next one walks six! (laughs) ... You end up doing a half marathon during the week! (laughs)

Adam, retired, age group 41-60

Adam felt that a group of men in a self management course would feel compelled to compete with each other by reformulating hegemonic constructs around
physical activity and success. Adam was an experienced self-management course leader and was concerned that this competitiveness would undermine the philosophies of self-management being promoted within the course. The self-management course leaders at the Arthritis Victoria Leader’s Update also noted that there was a tendency among some men to over-commit in terms of the health actions they are planning to perform between course sessions. As discussed in section 5.1.7: “There’s no space for it”, the opposite is true of some men who report that they do not have time to commit to any health activities.

Men’s attitudes about the gender of the program leader were also explored in the interviews. Ted mentioned that one of the water exercise leaders was male when we were discussing his introduction to a water exercise class that consisted of mainly female participants:

With the exercise group, well probably didn’t worry me, for the simple fact that one of the leaders was a man - one of the guys in the water, and I think he might have been the only man there. He was a guy from my church, without my knowledge, he was just there, so straight away I had a companion in the water. ... It probably helped. I wasn’t consciously aware of it helping but it probably did.

Ted, retired, age group 61-75

Ted was not bothered by the imbalance in the gender of participants because one of the leaders was a man that he knew from another community group. This was enough to reassure him that he fit within the group, but it does indicate that he may have felt less comfortable without that. Similarly, John was not concerned about the fact that there were mostly women in his water exercise class. He said, “Didn’t worry me one bit. I wasn’t even conscious of it”. However, John did state that he preferred a male leader for water exercise classes, but not necessarily for other programs such as an information session:

They tend to give us more vigorous exercises which I feel we need, and the ladies sometimes they seem to be slow in going from one exercise to another, you know, a bit of wasted time in between exercises ...I think the
men seem to be more switched on, not being sexist or anything here, it's just that that's just the way they are.

John, part time or casual work, aged over 75

John took an essentialist perspective saying that male leaders were more likely to give more vigorous exercises and less likely to waste time. This interest in 'serious' exercise rather than therapeutic movement appears to be an effort to reformulate hegemonic masculinity constructs around exercise and fitness. His comment about wasting time also reflects men's reluctance to spend time on health management activities, as discussed in section 5.1.7: "There's no space for it".

John's comments on gender differences in exercise needs may also have provided legitimacy for his presence in a group dominated by females:

... some of the ladies were very badly affected and they could not do the things that the rest of us could do and I think they needed a more gentle type of exercise, whereas the men who were mostly pretty fit and strong, want to do something a bit more vigorous. See, I really feel that there should be two types of water aerobics.

John described the women in his water exercise class as being weak and the men as being strong – distinguishing between the two groups by gender rather than severity of condition. This description suggests that within the water exercise class John was able to see himself as the strong, fit, male, consistent with the ideals of hegemonic masculinity and in opposition with femininity, in a way that was not possible when he was mixing among younger and/or healthier acquaintances.

Kevin felt very strongly that a male contact person was needed for male participants in self management programs:

I feel it's hugely important that men can be perceived, and that there be men who are, the contact person for the program. I'm not saying men only.
But it's really important that men affected by arthritis have the choice of talking to a man with arthritis. And there are some men who I'm certain would feel quite the opposite.

Kevin, casual/part time work, age group 41-60

Kevin’s view on the need for a male contact person is consistent with Baum and Cooke’s (1986) suggestion that men who adhere to a traditional form of masculinity can be threatened by women in equal or superior positions. It may also reflect the need for some men to identify with other men with arthritis, as discussed earlier in this section, to avoid a sense of isolation. It is pertinent to note that one of the self management course leaders at the Arthritis Victoria Leader’s Update noted that the involvement of a male health worker in promoting the course had resulted in an unexpected increase in male participants.

Kevin did acknowledge that some men would prefer to speak to a female. This is supported by the studies of Hegelson (1995) and Folland (1986), reporting that males may talk more freely with females than with other males. It was also noted earlier in this section that Bruce stated a preference for talking to females. These conflicting positions, and the ambivalence of many of the interviewed men in relation to this issue, suggest that it is advisable for health organisations to provide both a male and female contact person wherever possible. However, a male leader should be used to conduct men-only sessions designed to cover gender-sensitive issues.

It is important to be aware that social constructions of masculinities may not always be the dominant influence on health management behaviour, in the same way that race and ethnicity may not always be central to an individual’s identity (Blakemore and Boneham 1994). Various factors may be dominant at different times and settings and in different interactions. Concerns about gender were not as evident in the interviews among men from linguistically and culturally diverse backgrounds – except Bruce, who responded to the Gutbuster promotion. Mario and Leo were more concerned about language services. However, it is difficult to be sure that there were not other gender issues, because of the language barrier in the interview. As discussed in section 3.5.4: Researcher-researched relationships,
my presence as a female interviewer may also have influenced their responses as could the presence of the wives who were often assisting us in the communication of questions and answers. Joe, at the workshop for men’s health practitioners, raised another possibility. He suggested that, “European, or Italian men, would expect that health is a women’s issue and that women should be taking care of them - that mothering thing”. For this reason, men from these cultures may see it as being appropriate for women to be leading and participating in these programs.

The Draft Men’s Health Policy (Commonwealth Department of Human Services and Health 1996) noted that for Aboriginal and Torres Strait Islander groups in some rural and remote areas, health is men’s business. There were not any representatives from these areas among the interview participants. Gary, a member of the Aboriginal community who was interviewed, was not concerned about the gender of other participants or program leaders.

Kevin also raised a related issue in his feedback on the Summary of research findings. He felt that health organisations need to create an environment where it is possible for men to develop their own services, i.e. a consumer-driven process. He felt that this would allow for service development to be truly based on men’s needs and preferences.

5.2.7 “Oh wow, that’s me”

Advertising material can be helpful in encouraging men to stop and consider whether they might benefit from self management programs. However, this triggering of awareness is only likely to occur if the advertising material is specific enough to be clearly personally relevant. As already mentioned in section 5.2.6: “Because it was designed for men...”, gender specific advertisements help to attract men’s attention. Men often expect references to their specific condition or a reference to their life stage to recognise that the program is relevant to them:

… there’s a lot of blokes out there at this age, starting to fall apart at the seams and that may well be a way of marketing it to this particular age
group in their mid-40’s to mid-50’s, and being in their face, like saying do
you feel tired lately, run-down, unable to play with the kids? ... Things
that really are upsetting a lot of men.

Harry, unemployed, age group 41-60

In nominating issues that would reach other men, Harry is probably identifying
the issues that are most relevant to him. Role within the family and sense of
ageing are mentioned, but not loss of work. This may be because Harry sees his
work status as being temporary. Peter commented on whether age was an
important factor in service delivery:

I think the whole thing for me is about fitting in to the group and it might
just be that I’m at the age where age is a big thing and so it matters now.
But I go to an ... HIV exercise class where everybody’s at least 20 years
older than me and a lot sicker and a lot more frail and it felt funny at first
but after a while I actually enjoyed the fact that I was the young, fit one
(laughs).

Peter, employed full time, age group 26-40

Peter notes that age was relevant to him when he joined the group but he was able
to reconstruct his position within the group and enjoy a sense of superiority
because of his younger age and relative fitness, in a way that probably contrasted
with his experiences among his work and social peers. This was similar to John’s
experience of the water exercise class, as mentioned in section 5.2.6: “Because it
was designed for men...”.

Francis was also able to reconstruct his discomfort over age differences in his
water exercise classes, as discussed in section 5.1.3: “And then you’re getting
old”. Regardless of Peter and Francis’ adjustments to the age differences in their
classes, it is clear that age is a factor that has the potential to be a deterrent to men
considering participating in services. Therefore, it is advisable for health
organisations to consider age appropriateness in the formatting and advertising of
programs.
The need to be aware of socio-economic variables when targeting men was only raised by the most well-educated men, although Graham did agree that he would be more likely to respond to an advertisement targeting farmers with arthritis. For Peter, it was raised as an issue of belonging:

... there's a whole lot of things that make you feel more comfortable, and if it was a room full of university educated people, their gender might not be so important.

Peter, employed full time, age group 26-40

Peter was university educated and now worked in a university environment as an academic. Through the course of the interview with Peter it became clear that there was a fairly narrow scope of group membership that he was likely to identify with. It included university educated people, as noted above. Elsewhere in the interview he mentioned people in his age group and also that he preferred to be grouped with men – heterosexual men rather than homosexual men, despite his own identification as a homosexual man. This is discussed in section 5.2.6: "Because it was designed for men...", and suggests that making promotional material personally relevant is not just about matching people's social groupings, but also about matching the images they wish to project within their social environment.

Specificity of the condition was the most common factor raised by the men as an indication that a program was relevant to them:

I think it would be good to be able to talk to people with the same sickness as me. This is what I was doing as well before at Essendon Hospital. There was a class there. It was specialising in Ankylosing Spondylitis, which I have, and they said it was more of a male dominated sickness.

Francis, employed full-time, age group 18-25

Francis' preference for groups specialising in Ankylosing Spondylitis seems to be based on positive previous experiences, which has already been noted as an important factor in influencing perceptions of health services (Rogers et al. 1999).
Francis also noted that Ankylosing Spondylitis is more prevalent among men. This may have made the class seem more relevant to Francis because he perceived it as targeting men.

Bruce commented that he would be more likely to attend a program that was relevant to his condition than one that was for men with arthritis:

Not necessarily if it was just for everyone … it would be more attractive for me if it’d be specifically for feet.

Bruce, employed full time, age group 26-40

Phillip, like Bruce and Francis, suggested a program would need to be specifically about his condition for him to recognise that it was relevant to him:

Words relating, that I’ve heard. Basically that. Obviously it’s not a product in a brochure, that you’re attracted by colours and big impressive fonts and things like that, you just want content, the information’s the most important thing. So if I saw something to do with acute shoulder injuries and things like that - ‘oh wow, that’s me, I’ll have a look at that for sure, and see what they’ve got to offer’.

Phillip, student and casual work, age group 18-25

Phillip refers to the trigger of recognition being words that he’s heard, something familiar. He then narrows that down to the exact condition he has and notes that the packaging of the promotion is unimportant, it is the reassurance that the information is relevant that is critical. This also indicates that it will not be a waste of time – a motivating factor that is discussed in detail in section 5.1.7: “There’s no space for it”.

Men’s apparent need for personally specific messages is a difficult goal for health organisations to meet. Providing programs that are specific to a particular condition, rather than just a general disease, may have greater ‘pulling’ power but are an expensive and resource intensive process because of the smaller number of potential clients involved. This sort of condition-specific programming could also
be problematic for organisations in Australia at this time, given the shift in the field of chronic illness to a more generic delivery of programs in recognition of the commonality of many of the symptoms and experiences of chronic illness.

It is also important to recognise that in trying to reach specific groups of people there is an ethical limit in health promotion, a differentiation between informing people of their options and coercing people to attend. This is supported by the central tenet of self management, i.e. that it is self driven. However, it is appropriate to use social marketing principles to promote programs in a way that is relevant to the target group, as discussed previously in section 2.5: Health promotion initiatives targeting men.

5.2.8 “That’s advertising, that’s hype”

Three examples of possible advertising slogans were presented to the interview participants to gain some insight into the power of language as either a motivator or barrier to access. The same message was delivered in three different ways. The different versions were designed to be in contrast with, consistent with, or neutral to, hegemonic notions of masculinity.

Slogan 1:

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Arthritis
We can help you to manage.
Call Arthritis Victoria now on 9530 0255.
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This slogan was designed to contrast with the hegemonic notion of masculinity that men do not ask for help. The expectation was that this would be rejected by most of the men interviewed. In actual fact it was liked by some of the men, but generally appeared to have little impact:
Uh, I don’t think I would take much notice of it … It’s not specific and it’s very much of a broad generalisation.

John, part time or casual work, aged over 75

John quite clearly rejected this slogan on the basis that it was too general rather than because it was offering to help. He felt he would be more likely to act if the slogan was more specific to his condition. This is consistent with the findings of the previous section 5.2.7: “Oh wow, that’s me”, that there needs to be a trigger in advertising material to indicate personal relevance before men recognise that a service may be appropriate to them.

Bruce was similar to John. He said he would not respond to it because it did not seem relevant to him:

No, no it doesn’t put me off. It just doesn’t grab me. Arthritis is something that happens to someone else. I’ve got those pains but it’s not arthritis. I don’t know what it is.

Bruce, employed full time, age group 26-40

For Bruce, it was the term ‘arthritis’ that suggested to him that the slogan was irrelevant to him. His lack of awareness that his condition was a form of arthritis meant that he did not identify with the message. This indicates that the advertising does not just need to be condition-specific to be recognised as personally relevant, it also needs to incorporate the terminology used by the men, or mention symptoms, because of a lack of understanding of the meaning of some medical terms.

Men who were reluctant to seek help for their condition also did not recognise the personal relevance of slogan 1:
“We can help you to manage.” Well, I understand that. That’s fair enough. That’s not making any claims, saying they can help you manage it. . . I’m still not at that sort of stage. I still think I can probably manage myself.

Erich, employed full-time, age group 41-60

Eric seemed to respect the fact that this slogan did not make any claims that it could not meet. As discussed in section 5.1.10: “You haven’t committed to anything”, Eric had been disillusioned by other information sources and felt they were “all lies”. However, he did not respond to the slogan himself, which may be due to his reliance on hegemonic masculinity as discussed in section 5.1.1: “Nobody wants to be in a position of vulnerability”. Eric’s explanation for not responding to the slogan was because he did not feel he was at the stage where he needed help. For men who have difficulty recognising when help is needed (see section 5.2.1: “I didn’t realise that I was needing help”), it would be useful in advertising to identify the signs and symptoms that indicate help is needed, as well as, or instead of, naming the condition being discussed.

As anticipated, some men disliked the message of being helped. Kevin perceived the offer of help in slogan 1 as offensive:

The model here is we can help you, and to me the implicit model is actually patronising. These are issues of arthritis that I really struggle with. What I would be looking for in fact is images of men dealing with arthritis that I could relate to. I feel we live in a world where people are claiming they can help with things and very often what they’re doing is they’re looking after their careers and I’m sick of it. I’m really fed up with it. I would want to see images that acknowledge the challenges men are faced with, and show men dealing with those challenges.

Kevin, casual/part time work, age group 41-60

Kevin seemed to object to the idea of someone in a professional capacity offering to help without any personal experience of living with this condition. He seemed to feel that offers of help from people like this were unhelpful and not genuine.
Kevin was more interested in promotional material that reflected the experiences of real people and ways they had dealt with them. This is supported by Kevin’s own actions in participating in arthritis support groups.

Peter said he would not respond to slogan 1 because “It sort of implies that I’m not managing.” The offer of help in the slogan was taken as a personal slight by Peter because he perceived it as a suggestion that he was not coping, and perhaps by implication, not measuring up to masculinity norms which dictate that men remain in control.

Slogan 2:

**Arthritis – Real Men Take Charge**

Get your toolkit here!

Arthritis Victoria 9530 0255

This slogan was designed to comply with hegemonic notions of masculinity by encouraging a sense of control and using ‘blokey’ language. It was expected that this would be the slogan men would be most likely to respond to. However, this was not supported. Slogan 2 had a strong impact and most found it amusing but, contrary to expectations, it did not seem to be the type of slogan that the men interviewed would be likely to respond to.

The humour inherent in slogan 2 was a problem in some instances because it was not seen as appropriate for a serious matter such as arthritis:

I don’t think humour. I think because arthritis is pretty serious thing. I don’t think humour would be effective.

Francis, employed full-time, age group 18-25

Francis’ objection to the use of humour in relation to arthritis is supported by Lorig and colleagues’ comments that, “Illness is a serious matter, especially to the
ill. 'Treating it frivolously often causes anger' (1996:138). Francis did not seem offended by what he had read but he did feel that it would be ineffective because it was not sensitive to the seriousness of arthritis for the person experiencing it.

The use of puns was a problem because it obscured meaning for those without English as a first language. The meaning of the slogan had to be explained to Mario. Leo said he would not respond to it, 'maybe because I can't follow it properly.'

The reference to 'real men' had the potential to be offensive by inferring there are 'men who are not real':

Real men take charge. (laughs) (long pause) I'm not too sure about that. I don't like the inference that you've got real men and men who are not real.

John, part time or casual work, aged over 75

John objected to the direct reference to hegemonic masculinity and the suggestion that you are only a real man if you act in a certain way. This shows a rejection of hegemonic masculinity (Gerschick and Miller 1995) and a recognition and respect for the multiple masculinities available to men in our society (Connell 1998).

Some of the men did not identify with the 'macho' tone used. It was taken as an indication that the message was not personally relevant:

'Arthritis. Real Men Take Charge. Get your toolkit here.' Well, I didn't tick macho or ocker in that so... And a real man, I don't know. (laughs) What's a real man? It's a gender thing. No, that would probably deter me I think. Yep, it seems like they're trying to attract a certain, particular type of person, who likes to think they're in a certain category or they're stronger than some people for whatever particular reason. I'm just more interested in information.

Phillip, student and casual work, age group 18-25
When Phillip mentions that he did not tick macho or ocker, he is referring to the initial demographic questionnaire that included a request for the participant to indicate which masculinity labels he identified with. He was demonstrating a rejection of hegemonic masculinity and therefore did not relate to the slogan that is targeting people who adhere to masculinity norms (Gerschick and Miller 1995). Like John, Phillip is conscious of alternative forms of masculinity and questions the implication of hegemonic masculinity as a ‘superior’ form of masculinity. He rejects the strong hegemonic overtones of the message in saying that, “I’m just more interested in information.”

The ‘blokey’ references can be particularly alienating to men if their condition is impacting on their sense of masculinity:

That is going to appeal to some and not to others. … So to me, it’s a good effort. Unfortunately, and it’s really subjective, … ‘Real men’ immediately reminds me of the fact that I’m a failure in terms of masculinity.

Kevin, casual/part time work, age group 41-60

Kevin did not seem to find the slogan offensive. In fact he felt it would work for some people but it had a negative impact on him on a personal level. As discussed, in section 5.1.4: “We’re expected to be a kind of rock of strength for others”, the impact of Kevin’s condition had threatened his own sense of masculinity, so he felt the term ‘real men’ excluded him. This sense of exclusion from a desired masculinity status reinforced his sense of personal failure and forced him to reformulate his concept of hegemonic masculinity (Gerschick and Miller 1995).

Significantly, even men who demonstrated reliance on dominant masculinity traits (Gerschick and Miller 1995) did not respond to the advertisement. Bruce found it amusing but seemed to think it was trying to trick him into seeking help:

That’s more or less saying, ‘Come here chicken’ … and so it hits you on the ego side. What do you mean a real man? I’m a real man. A real man
takes pain. That’s a different sort of sense ... it wouldn’t change my mind.

Bruce, employed full time, age group 26-40

Bruce seemed to recognise that the slogan was encouraging reformulation of hegemonic masculinity norms (Gerschick and Miller 1995) to encourage service use but was not going to fall for it because he ‘knew’ that “A real man takes pain”. This shows the extent to which he relied on hegemonic masculinity. He was not prepared to reconsider his position when it was challenged, even when service use was promoted in terms that complied with hegemonic masculinity traits.

Similarly, Eric recognised the intent behind the wording of slogan 2 and rejected it as “advertising” and “hype” that did not appeal.

Placing a message in a specific ‘macho’ context risks excluding as many men as it includes. Paul, in the workshop for men’s health practitioners, noted that at a recent rural Tune-up for Life Men’s Health Night, he had not recognised Dick Johnson, the racing car driver who attended as a drawcard for participants, and so Paul felt that he did not fit the profile of the men being targeted. And yet later, Paul mentioned that in his capacity as a health worker, they had advertised men’s health seminars as ‘The Verandah Over the Toolshed’, referring to men’s ‘pot belly’ hanging over the genitals. He noted that, “Half the men who turned up had no idea what it meant but were intrigued to find out”.

While some of the men did think slogan 2 would be effective in reaching men, and they appreciated the humour and the technical approach, the overall difficulties with the ‘blokey’ language, indicate that the ‘blokey’ references used widely in health promotion activities may not be appropriate for use when targeting men with a chronic illness. This is consistent with feedback received from a rural health educator in response to the preliminary findings. She noted that, “They seem in accordance with my experience at Arthritis Victoria. I like the distinction made between men with a chronic illness and other men, regarding what might attract them.” She added in her feedback on the Summary of research findings that she supported my statements about the inappropriateness of a
‘macho’ approach for men with a chronic illness. Based on her experiences as a community health educator, she felt that it perpetuates men’s avoidance of health services. She reported that:

I was recently involved in a ‘Pitstop’ session in Rutherglen where we all dressed up in overalls and caps and checked ‘chassis, duco and exhaust’. It was very popular with the 30 or so men who came along. As you might expect, they were a relatively health conscious group with only three smokers for example.

Jenny, Community Health Educator

In her view, a ‘macho’ approach to health promotion only attracts men who are comfortable with both the ‘macho’ scene and health services. Given the marginalising effect of chronic illness in relation to ‘macho’ masculinity, this is not likely to include men with a chronic illness. However, Paul’s experiences suggested that clever language can be used effectively when targeting specific rather than broad groups in the community. ‘Blokey’ language may also be acceptable if it does not stereotype participants or challenge their masculinity. Regardless, the use of humour or ‘blokey’ language is likely to exclude men with English as a second language because of the difficulty in translating the meaning of the message. Ted expressed surprise at my recommendation to avoid using humour, when he provided feedback on the Summary of research findings. He enjoyed the use of humour and felt it can be effective in reaching people but then reflected that there are different styles of humour and people had misunderstood his joking in the past, and so concluded that it is perhaps safer to adopt a neutral tone. Mervat, a general practitioner, also expressed surprise at this recommendation when she provided feedback on the Summary of research findings. She had not considered the potential for humour to be offensive to people with severe conditions and found it a useful insight in her dealings with patients.

Slogan 3:

*Arthritis – Something Can Be Done*

For more details contact Arthritis Victoria on 9530 0255

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Advertising slogan 3 is an existing slogan that is used less often now but had been used commonly in the past by Arthritis Victoria. It was adopted for this exercise because it appeared to be gender neutral in terms of the characteristics of hegemonic masculinity. It was anticipated that this slogan would be well received by men but would not be as effective as slogan 2. In actual fact it was very positively received.

John felt that this slogan would be the best because it was positive:

> I think the last one (slogan 3) would be the most important one. ... something can be done is quite positive. Rather than the man having to take charge on his own, or not being a real man, this is something that can be done so you find out what can be done. Yes I’ll go for number 3.

John, part time or casual work, aged over 75

He contrasted the positivity of this slogan with the implied messages he perceived in slogan 2. He mentions again his rejection of the implication in slogan 2 of “not being a real man”. He also raises the point that slogan 2 promotes the idea that the man has to take charge “on his own”. This suggests that John is rejecting characteristics of hegemonic masculinity by accepting the need for seeking help for arthritis (Gerschick and Miller 1995).

Kevin appreciated the language used in slogan 3:

> To me that’s better. It doesn’t use the word help. Something can be done. It’s not pretending there’s an actual cure. I mean even in the flier that went out before this Men’s Arthritis Group. I can’t remember what it was, something along the lines of do you want to manage your condition better, or something like that. And I just thought, this isn’t about managing your condition, it’s about trying to have a life and to me ‘managing your condition’ is basically MBA [Masters Degree in Business Administration] speak. ... I don’t want an MBA conceptual framework applied onto my struggles of life. So to me that’s better. It’s not something should be, it’s

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real, something can be done. There are no magic solutions. We all know that. But something can be done.

Kevin, casual/part time work, age group 41-60

Kevin seemed to appreciate this slogan for a number of reasons. First, “it doesn’t use the word help”. He discussed in his response to slogan 1 his rejection of the notion of someone offering help. Secondly, he appreciated the realism of this offer. Given his long experience with severe arthritis, he is very familiar with the concept of a chronic condition and understands that it cannot be cured. Thirdly, he preferred the directness of the language as compared to the “MBA speak” of the first slogan. He discussed in his response to slogan 1 his cynicism about people offering health services as a career rather than from personal experience and compassion.

Bruce also responded to the relevance of the language in slogan 3:

Yeah, that would grab me more than these. ... I’d think more about dialling the phone number, something can be done, because you think, you’re at the stage now you think ohhh, something’s gotta be done, there’s something can be done, so.

Bruce, employed full time, age group 26-40

The phrase “something can be done” seemed to match the way Bruce would speak about his condition and so he responded to it in a way that he did not with the other two slogans. This suggests that advertising language can appear personally relevant simply by using everyday language and phrases that people can relate to.

Eric’s previous attempts to obtain information about arthritis had left him feeling that it was all ‘doom and gloom’, as discussed in section 5.1.10: “You haven’t committed to anything” and section 5.2.1: “I didn’t realise that I was needing help”, so he really responded to the positive message in this slogan:

This is more positive. “Something can be done”. It’s all positive. “We can help you manage” has the connotation of - you’ve got it, you can’t do
much about it, so we’ll give you some clues on how to manage it. This one here, “Something can be done”, to me conjures up the feeling - maybe we can make you feel better because let’s face it, people have got some self centred thoughts, they want to feel that they can feel better. Yeah, I think that’s a more positive thing.

Eric, employed full-time, age group 41-60

Eric was particularly responsive to the positivity of this message after his earlier disillusionment with information he had sought, and his struggle to understand the concept of a chronic illness. His repetition of the word positive showed that he appreciated the message that ‘something can be done’ about his arthritis. It is significant that he did not hear this message in the first slogan, “We can help you to manage”. Instead he interpreted that as a negative message that not much can be done, perhaps because it was challenging his reliance on hegemonic masculinity constructs in a way that slogan 3 did not.

Slogan 3, ‘Something Can Be Done’, did not have the same degree of impact as slogan 2, ‘Real Men Take Charge’, judging by initial facial and verbal expressions. However, it was inclusive in its message whereas slogan 2 excluded as much as it included and slogan 1, ‘We Can Help You to Manage’, often failed to include at all. According to men’s comments, slogan 3 was also seen as being more appropriately serious, and softer and more compassionate than slogan 2. It is possible that it was well received by the men interviewed because they had seen it previously and recognised it. However, none of them mentioned that it was familiar so it is difficult to determine if that was a factor. One of the interviewees had a negative response to slogan 3, saying it made him feel like a helpless victim. However, aside from this response, it was clearly the most inclusive of the slogans and the one most likely to elicit a positive response.

The appreciation of the positive message of slogan 3 appeared to be the reason most of the men chose this as the preferred slogan. Interestingly, this matched Samantha’s comments at the workshop for men’s health practitioners. She recommended the use of advertisements that came from a wellness rather than an illness model.
There was no apparent effect from changing the order of the advertisements. Nor was there any apparent class-related difference in responses, despite the contention by Banks (2001) as mentioned earlier, that middle class men were more likely to respond to health promotion information from leaflets and advertising.

Based on the participants’ responses to the gendered advertising slogans in this thesis, organisations targeting men with a chronic illness should aim to be positive, to develop a gender-neutral message, and encourage identification with the message by use of common language or by reference to symptoms and the impact of the condition, rather than using medical terminology.

5.2.9 Summary

The findings of this thesis reflect the impact of dominant social constructions of masculinity on men’s health management, in particular on awareness of their health needs and the health service options available to them.

Delays in accessing chronic illness self management services often arise from a failure to recognise when help is needed. This is sometimes due to a poor understanding of the different approach required in the treatment of chronic conditions as compared to acute conditions. Men often relied on others’ assessment of when help was needed.

The men interviewed also demonstrated a limited awareness and understanding of the self management services that were available to them. This was often exacerbated by a cynicism about health services, arising from previous negative experiences in the health sector or with ‘outside’ agencies in the case of the participants from the rural and the Aboriginal communities.

Recommendations from doctors were likely to be a powerful incentive to access services. Conversely, lack of recommendation from the doctor was likely to be a
powerful deterrent. Wives had a significant role in encouraging men to seek help and directing them to appropriate services. Male partners in same sex relationships also seemed to encourage men to take action but were unlikely to be aware of appropriate service options. Single men tended to be encouraged by friends to take positive health action. Friends or acquaintances already using the services were a common introduction for older men.

The findings of this thesis show that delivering ‘programs for men’ is an effective way of getting men’s attention and reassuring them that the program will be relevant, even though most men are comfortable with mixed gender programs and many prefer to attend with their partners. There was also evidence that the gender of leaders is important to some men, although some prefer a male leader and others a female leader. There seems to be support for men-only sessions when discussing issues that are gender sensitive.

The wording of promotional material can also be effective in triggering men’s awareness of the need for action and convincing them that a particular program is personally relevant. It is important to note that the ‘blokey’, hyper-masculine approach used in many health promotion programs to target men, has the potential to alienate men with a chronic condition if the impact of their condition is threatening their masculinity status. It also excludes men who do not identify with hegemonic masculinity. The use of humour has the potential to be seen as offensive because it trivialises the experience of chronic illness. The use of simple English is likely to be more inclusive. It is more easily understood by all men but particularly by men from diverse linguistic and cultural backgrounds.

Guiding principles to assist health organisations to target self management services to men are outlined in section 7.2: Guiding principles for health organisations targeting men with a chronic illness.
Chapter Six  
Applied Findings - How can self management programs be made more accessible to men?

The findings of the quantitative research phase of this thesis (see Chapter Four) provided information about gender differences in levels and patterns of service use. The findings of the qualitative research phase of this thesis (see Chapter Five) provided an increased understanding of the reasons for those gender differences. While qualitative research is effective in increasing understanding, it is generally not considered a useful tool to predict future behaviour. This limits the translation of the results into practical strategies for the development of targeted programs. However, Strauss and Corbin (1990) suggest that a theory developed using grounded theory approach should provide control of action and Charmaz in her application of grounded theory to social constructionist studies of chronic illness, stated that one of the features of a theory arising from the grounded theory approach is that it “provides a framework for making predictions” (1990:1164).

To demonstrate the confirmability of the results and to explore their transferability, the qualitative results of this thesis were compared with the quantitative findings, the review of health promotion initiatives targeting men, and other relevant research results. This led to the applied phase of the research that will be described in this chapter - the trial of findings and subsequently to the development of guiding principles for health organisations interested in establishing chronic illness self management programs that are accessible to men as reported in section 7.2.

6.1 Trial Men’s Arthritis Information Night

The Trial Men’s Arthritis Information Night was an opportunity to test some of the research findings about the practical measures that health organisations can undertake to develop self management programs that meet the needs of men. The
planning and organisation of the trial are described in section 3.6.1: *Organisation of a Trial Men's Information Night.*

### 6.1.1 Information night content

The content of the information night was based on the interview findings about apparent gaps in men's understanding of their condition and the treatment and service options available to them, and also on statements men made in the interviews about the information they would like to receive (see section 5.2: *Limited awareness of self management options*). The following topics were covered:

- The meaning of the term ‘arthritis’
- Types of arthritis and related conditions
- Differences between ‘acute’ and ‘chronic’ conditions and treatment approaches appropriate to each
- Medications commonly used for arthritis related conditions
- Service providers
- Pain management techniques
- A man’s personal perspective on the experience of living with arthritis
- Arthritis Victoria services and programs.

These topics were presented by a female pain management consultant who is a Manager at Arthritis Victoria, by a male volunteer with severe arthritis (a previous staff member of Arthritis Victoria), and by myself (also a previous staff member of Arthritis Victoria). Relevant literature in the form of pamphlets and information sheets were also made available.

### 6.1.2 Outcomes

Ten men and four women attended the Trial Men’s Arthritis Information Night. The women were all there to support their partners. The men had heard about the information night from the following sources:
• Girlfriend had seen flyer
• On display in rheumatologist waiting room
• Participant in the research undertaken for this thesis
• Wine merchant’s door
• Insert in Arthritis Victoria’s members’ magazine
• Arthritis Victoria website
• Included in information package received after inquiry to Arthritis Victoria Telephone Information Service
• Word of mouth
• Arthritis Victoria member
• Unknown

The spread of information sources for trial participants supports the use of a widespread advertising campaign but also demonstrates how hard it is to recruit multiple male participants, even when the promotional material and program design appear to have been targeted appropriately. It is important to note that the majority of participants were recruited through Arthritis Victoria’s own networks.

Arthritis Victoria required a minimum number of ten bookings for the night to go ahead. This number was achieved and although attendance did not reach the levels that would have been desired for an information night, it was the most that Arthritis Victoria had ever been able to attract to a men’s event, including separate targeted promotions of an Osteoporosis for Men event and an Arthritis Victoria Men’s Support Group. It should also be noted that ten men would have been considered a large turn-out if the event had been a self management course or a support group meeting.

What was most encouraging at the trial was the age group of the men attending. When the participants had all arrived, it appeared that the majority were in the age group that was considered hard to reach, i.e. the middle stage of life when work and family commitments are greatest (see section 5.1.11: “If I got to the stage where I couldn’t work”). Therefore, an effort was made to check the age groups
of the attendees at the end of the session to confirm the target had been reached. Table 15 shows the age breakdown, including actual ages and an estimation for those participants who left before being asked. The range of each age group corresponds with the groupings used for the quantitative and qualitative phases of this thesis.

Table 15: Age group of participants attending Trial Men’s Arthritis Information Night

<table>
<thead>
<tr>
<th>Age group</th>
<th>18-25</th>
<th>26-40</th>
<th>41-60</th>
<th>61-75</th>
<th>Over 75</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Estimate</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>2</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

Table 15 confirms that the trial program was successful in reaching the target group of men in the middle stages of their life. However, the actual work and family status of the men attending was not known.

The men seemed to find the night helpful and asked questions throughout. Most of the men stayed behind afterwards to ask more questions and to have a look at the resources available. Since that evening, two of the participants have registered for a self management course.

It was pertinent that some of the men inferred they were there for reasons other than helping themselves. One man in his late 20’s had been encouraged to attend by his girlfriend. He stayed afterwards and collected a lot of resources but all his questions were about his mother’s needs because she had rheumatoid arthritis. Another man said that although he had a bit of arthritis, he was really there to help him in his role as an Arthritis Victoria water exercise leader. This tendency to state the reason for attending as helping someone else was raised in section 5.1.2: “Less than masculine for needing a support group”. It seems to be linked to the pressure of dominant social constructions of masculinity to be independent and not to ask for help for oneself.
6.1.3 Discussion

The trial program was successful in reaching more men than had previously been achieved at a men’s event by Arthritis Victoria. However, the overall attendance levels were moderate for an information night. It is difficult to be conclusive about the reasons for the low uptake of the trial program. The attendance of men predominantly in the middle stage of life suggests that the program format and flyer were appropriate to the target group. It is possible that modifying features of the program in future such as the venue, design of the flyer, and media coverage, may help to increase its profile. However, based on the research findings, the most effective adjustments are likely to be:

- following up the mailout of the flyer to rheumatologists and GP Divisions to encourage them to display the flyer in their waiting rooms;
- distributing the flyer via women’s networks to capitalise on women’s role in encouraging the positive health behaviour of men in their family;
- and increasing the distribution of the flyer via existing Arthritis Victoria member and group networks to capitalise on word of mouth/recommendation as an important health information pathway for men.

Providing a female contact person in addition to the male contact person may also be helpful because, as discussed in section 5.2.6: “Because it was designed for men...”, some men are more comfortable talking to men and some are more comfortable talking to women.

6.1.4 Trial conclusion

The Trial Men’s Arthritis Information Night was an opportunity to test some strategies that arose from the research findings relating to the development and delivery of self management programs for men with a chronic illness. The success of the trial in reaching the target group of men demonstrated the efficacy of those strategies. The moderate level of attendance demonstrated the difficulties in
reaching large numbers of men with a chronic illness for a single event. Additional measures were recommended for future events targeting men and have been incorporated into the *Guiding principles for health organisations targeting men with a chronic illness* (see section 7.2). Conclusions about the overall thesis findings are contained in the following section, Chapter Seven.
7.1 Summary of findings

This thesis endeavoured to reach an understanding of men’s response to ‘lived-with’ chronic illness within the context of socially constructed masculinities and their apparent constraints on help-seeking behaviour. The incompatibility between men’s health behaviours and current delivery of self management programs was explored, with a view to rethinking program structure and delivery to better meet the needs of men, perhaps by offsetting some of the current barriers to participation. Arthritis self management programs were selected as representative of the ‘lived-with’ chronic illness self management environment in Australia.

The under-representation of men as users of acute health services is well-established in the Australian health literature (Australian Bureau of Statistics 1996; Baum 1998; Mathers 1995) but, prior to this thesis, had not been explored in the context of chronic illness self management programs. This thesis confirmed gender differences in the rate and pattern of self management service use and thus identified it as an important access issue.

Similarly, theories on masculinities (Clutterbaugh 1998; Connell 1999; Pease 1997b) and the tension between dominant social constructions of masculinity, health status (Cameron and Bernardes 1998; Courtenay 2000a) and working status (Charmaz 1994; Watson 2000) are well established in the gender literature. However, the findings of this thesis extended this understanding by exploring the health management behaviour of men with chronic illness and in particular their use of self management services.

It was found that men’s decisions to access chronic illness self management programs were strongly influenced by dominant social constructions of masculinity in Australia that require men to be strong, independent and in control.
(Huggins 1995). These influences constrained help-seeking and any health management behaviour that would undermine men's ability to adhere to these characteristics of hegemonic masculinity, particularly any activities that conflicted with work obligations. In this thesis, work was found to be the single greatest structural and social barrier to accessing self management services and was linked to a concept of health, as described by Watson (2000), that equates fitness with an ability to fulfil social obligations in relation to work and family.

However, the restrictive influence of hegemonic masculinity was progressively undermined by the increasing severity of the chronic condition until a crisis point was reached in terms of the severity of the condition or its impact on lifestyle, usually represented by an inability to continue working, resulting in a reformulation or rejection of hegemonic masculinity. Gerschick and Miller (1995) described the theory of reformulation, rejection or reliance on hegemonic masculinity, in relation to men with disabilities. In this thesis, Gerschick and Miller's theory was found to be equally applicable to the experiences of men with chronic illness and in fact it was the eventual reformulation or rejection of hegemonic masculinity that made it possible for men to access self management services.

This conceptual framework was consistent for men from diverse social groupings, although it appeared less prominent in both young and older men, suggesting that dominant social constructions of masculinity have the greatest influence on health decisions during the middle stage of adulthood when work and family obligations are greatest.

There appear to be only limited options in reaching men before they arrive at a critical stage in the progress of their condition. As all of the men interviewed had used primary care services, there is an opportunity for self management services to reach men via this interaction. This is a powerful intervention option as doctors are considered by men to be the primary source of health information (Pinnock et al. 1998). This thesis also showed that men were strongly influenced by doctor recommendations, and conversely that if self management programs were not
recommended by the doctor, men were likely to perceive it as a judgement by the
doctor that the programs were either ineffective or irrelevant to their condition.

Women’s networks and internal organisational networks can be effectively used
by health organisations (Gibson and Denner 2000; O’Hehir et al. 1997) to tap into
men’s reliance on health advice from female family members (Norcross et al.
1996; Pinnock et al. 1998). A tendency to rely on women as health coordinators
was evident in this thesis and was also reflected in men’s low awareness of the
health service options available to them. The findings of this thesis indicate that
male partners can also be actively encouraging their partners to seek help for their
condition. However, they may not be as well informed about health management
options as their female counterparts. Friends and acquaintances who have
experienced a program were also shown to be an important referral source for
men with a chronic illness.

Broom (1998) noted the importance of developing gendered health services in
recognition of the influence of gender on health behaviour. The review of men’s
health initiatives in this thesis demonstrated that it is possible to develop health
promotion initiatives that are accessible to men by using a social marketing
approach and operating within the constraints of hegemonic masculinity. In
addition, the findings in the qualitative and applied phases of this thesis represent
a first step in a social marketing approach to self-management programs for men.
The increased understanding of the factors encouraging and discouraging men
from participating in programs have revealed that some strategies commonly used
in health promotion programs should be avoided in programs for men with a
‘lived-with’ chronic illness. The difference in needs arises as a result of the impact
of chronicity, pain and functional loss on the individual’s sense of his own
masculinity. Popular strategies that should be avoided in programs for men with a
‘lived-with’ chronic condition include, ‘blokey’ references, humour in
promotional material, recreational venues, and sports celebrities. Men experience
chronic illness as a serious issue and expect chronic illness self-management
programs to respect that experience and to operate in a credible and serious way.
However, there were some strategies being employed by health promotion initiatives that were also likely to be relevant to men with a ‘lived-with’ chronic illness. These included gender specific programs, evening sessions for working men, an introductory information session format, holding events close to where men are situated, and distributing information via women’s networks. Researching the social issues for the group being targeted was particularly important. These findings have informed the development of Guiding principles for health organisations targeting men with a chronic illness (see section 7.2).

Thus, through exploring men’s access to chronic illness self management programs, this thesis has provided a greater understanding of gender differences in rates and patterns of service use, the reasons why men delay accessing services, and the reasons they eventually use them. Investigations also highlighted structural changes that are necessary to the development and delivery of self management programs that meet the needs of men with a ‘lived-with’ chronic illness.

Further, more extensive, research is required to confirm the apparent links between certain social determinants and health behaviours in men with a chronic illness, to investigate if the findings are consistent for different illness groups and in different social environments, and to explore men’s experience of self management programs once they have been accessed. Additional trials are also advisable to test the efficacy of the guiding principles.

7.2 Guiding principles for health organisations targeting men with a chronic illness

A practical outcome of this thesis is the development of guiding principles to assist health organisations to target self management programs to men with chronic illness. It should be noted that these principles will sometimes be different to those that have been successfully used for health promotion programs encouraging ‘healthy’ men to engage in preventative health behaviour. This is
consistent with the social marketing approach of these guidelines by ensuring that the approach is pertinent to the social issues of the target group in question.

For example, while an information session format is advisable as an initial introduction to services, it should also be noted that compassion must be evident in service delivery, and programs offering personal support are required for men who have reached a critical point in their experience of chronic illness.

Other strategies that may help to engage men at an earlier stage in the illness pathway are as follows:

- Challenge men’s health concepts that equate fitness with an ability to continue working
- Promote a preventative approach to health
- Encourage men to recognise self management as a way of maintaining a sense of control over health rather than relinquishing it
- Promote understanding of chronic health and its management as compared to acute illness
- Demonstrate the diversity of clients benefiting from services, in terms of age, gender, health status, cultural background, and sexuality
- Provide opportunities for consumer-driven service development.

On a practical level, health organisations would also be advised to:

- Provide men’s programs, making it clear that partners are welcome
- Provide both a male and female contact person
- Conduct programs at a locally accessible venue – consider availability of parking and public transport
- Conduct programs at a health venue rather than a social venue
- Use health/community venues/networks already being used by specific community groups (e.g. Aboriginal Health Service)
- Choose weekday evenings or workplace programs for working men
- Choose daytime programs for men who are not working
- Avoid the use of sports celebrities
- Use local identities, especially in rural areas
- Keep costs to a minimum and display them on promotional material
- Capitalise on community networks in rural areas
- Arrange for medical certificates/referrals where possible.

In addition, the following promotional strategies are likely to raise men’s awareness of when it is appropriate to access services and what services are available:

- Raise community awareness about the differences between acute and chronic conditions and their treatment, including the role of self management in the treatment of chronic conditions
- Promote self management services via the medical sector, including the display of leaflets in waiting rooms
- Distribute information indirectly to men via their existing health information pathways, i.e. wives, same sex partners, current service users
- Distribute information directly to men through men’s networks, e.g. men’s fitness magazines, male health workers
- Develop and advertise programs for men, with partners welcome. Where possible provide both a male and a female contact person. However, conduct occasional men-only sessions to cover gender-sensitive topics
- Use positive language in promotional material to reassure men of the efficacy of self management programs
- Gender-neutral language should also be used. This means avoiding conflicting with or linking with hegemonic masculinity. The word ‘Men’ should still appear in the title when promoting men’s programs
- The use of humour should be avoided. Instead, use simple English
- Refer to the symptoms or impact of the condition rather than using medical terminology
- Display a clear start and finish time on promotional material
- Encourage men to ‘come as you are’ so that men do not stay away simply because they have to change out of dirty work clothes.
These primary strategies incorporate considerations about the interacting influences of age/life stage, linguistic and cultural diversity, geographic location, and sexuality. However, health organisations endeavouring to develop gendered self-management services need to rely on an understanding of their client base and the social issues affecting the men they are targeting.
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16 June 1999

Mrs Lisa Gibbs
2017 Malvern Road
EAST MALVERN, VIC. 3145

Dear Lisa,

RE: Research Proposal

We were most interested to learn of your proposed research project "Why aren't men utilising community health programs", a matter of great interest to Arthritis Victoria and hence our discussions regarding the use made of Arthritis Victoria services as an example.

Pending the outcome of the decision of the Deakin University Ethics Committee, you will certainly be given assistance by Arthritis Victoria. This will include access to existing data sources.

We look forward to hearing more in due course.

Yours sincerely,

SHIRLEY CAULFIELD
Chief Executive Officer

Signature Redacted by Library
Appendix 2  Information sheet for participants
Research Project Information Sheet

Topic: Men's access to chronic illness self management programs.

My name is Lisa Gibbs. I am a Community Services Consultant with an Honours Degree in Psychology. I am currently enrolled as a Ph.D. Candidate in Public Health at Deakin University. This information sheet outlines the research study I am undertaking for my Ph.D. thesis, under the supervision of Dr Maria Pallotta-Chiarolli.

My research study will be exploring the issues which affect men’s access to chronic illness self management programs. I will also be studying other research in this area, and other men’s health initiatives. The goal is to eventually develop some guiding principles for the delivery of chronic illness self management programs to men.

I will be focusing my research on the clients and services of Arthritis Victoria. I have chosen Arthritis Victoria because of their interest in increasing the participation rates of men in their programs. I have been involved with Arthritis Victoria as both a staff member and then a consultant for the past six years.

You are invited to participate in this study. I am very interested in your views on what sort of factors are likely to encourage or discourage you to participate in self management programs, and your preferences for different types and formats of programs. For example, are you more likely to use services targeted specifically at men, do you need services out of business hours, or are you simply not interested in self management programs?

I would like to discuss these with you either in an individual interview, or with a small group of others (approximately 10 people). Interviews are likely to take approximately one hour. Focus group discussions are likely to take approximately two hours, with time for stretch breaks. If you have a preference for either the focus group or interview format, please let me know. The meeting rooms and times will be arranged to suit you, and any others involved, and will be as comfortable as possible for people with arthritis or a related condition. Some of the participants in focus groups will be asked if they would also like to be involved in a follow-up individual interview. I will also be inviting interested participants to act as a reference group for me, providing feedback via mail or phone, on later developments of the study.

Your involvement in the study is entirely voluntary. That means that your access to Arthritis Victoria and other self management programs will not be affected by whether or not you participate. If you do agree to participate in the study, you are free to end your involvement at any time without explanation. At this time, you can also withdraw any
information you have provided for the study and ask to have it returned to you or
destroyed.

Anyone who agrees to participate in this study will be asked to complete the consent
form and the brief questionnaire attached. The questionnaire will help me to organise the
focus groups and make sense of my research findings.

If it is O.K. with you, I would like to tape record the interviews and discussions so that I
can type up the information later. We will use first names only, or aliases, during the
taped discussions to protect your identity and you may turn off the tape recorder at any
stage. The tape recording and typed material will be stored in a secure place, separate
from participants’ names and addresses, and will be destroyed six years after the end of
the study. My supervisor and I will be the only ones with access to this information. Care
will also be taken to make sure that you cannot be identified by comments made in
research reports. Your real name will not be used and some details will be changed to
protect your identity.

All participants will be provided with a summary of the research findings at the end of
the research study (2002).

If you have any queries or concerns about this study, please feel free to contact me on
0417 337 667 or at lgibbs@deakin.edu.au, or contact my supervisor, Dr Maria Pallotta-
Chiarolli on (03) 9251 7198 or at mariapc@deakin.edu.au.

Should you have any concerns about the ethical conduct of this research project, please
contact the Secretary, Ethics Committee, Research Services, Deakin University, 221
Burwood Highway, Burwood, Victoria 3125. Tel (03) 9251 7123.

Thank you very much for your time and interest.

Lisa Gibbs
Ph.D. Candidate
Faculty of Health and Behavioural Sciences
School of Health Sciences

Burwood campus  221 Burwood Highway  Burwood Victoria 3125 Australia
Telephone (03) 9251 7777 Facsimile (03) 92446017

Research Project Consent Form

I, ........................................................................................................

of (address & ph. no.) .................................................................

.................................................................................................

Hereby consent to be a subject of a human research study to be undertaken
by Lisa Gibbs, PhD Candidate, Deakin University,

and I understand that the purpose of the research is to identify issues affecting men’s access to
chronic illness self management programs. The ultimate goal of the project is to make chronic
illness self management programs more accessible to men.

I understand that:
• I will be asked to participate in an individual interview and/or a focus group.
• I will be asked my views on the various self management programs available, ones that I am
likely or unlikely to use, and my preferences for different types of self management
programs.
• Lisa Gibbs will interview me for approximately one hour if I choose to be part of an
individual interview. This will take place at a mutually convenient time and place.
• Lisa Gibbs will act as facilitator of the focus group discussions which will take approximately
two hours, will involve approximately ten participants, and will be held at a time and place
which is convenient to the participants.
• I can choose not to answer any question asked in the interview/discussion.
• I can ask to swap from a focus group to an interview, or vice versa, if I wish.
• I may be asked if I would like to be part of a reference group for Lisa Gibbs, to give feedback
on later developments in the study.

I acknowledge
1. That the aims, methods, and anticipated benefits, and possible risks/hazards of the
research study, have been explained to me.
2. That I voluntarily and freely give my consent to my participation in such research study.
3. I understand that aggregated results will be used for research purposes and may be
reported in scientific and academic journals.
4. Individual results will not be released to any person except at my request and on my
authorisation.
5. That I am free to withdraw my consent to participate at any time during the study, in
which event my participation in the research study will immediately cease, and that at
this time I can also withdraw my consent for the use of any information obtained from
me previously for the study.

Signature: ................................................................. Date:   

.................................................................
Research Project Consent Form (Partner of person with arthritis)

I, ..............................................................................................................

of (address & ph. no.) ..............................................................................

..............................................................................................................

Hereby consent to be a subject of a human research study to be undertaken by Lisa Gibbs, PhD Candidate, Deakin University,

and I understand that the purpose of the research is to identify issues affecting men’s access to chronic illness self management programs. The ultimate goal of the project is to make chronic illness self management programs more accessible to men.

I understand that:
• I will be asked to participate in an individual interview and/or a focus group.
• I will be asked my views on the types of self management programs my partner is likely or unlikely to use, and the reasons for those selections.
• Lisa Gibbs will interview me for approximately one hour if I choose to be part of an individual interview. This will take place at a mutually convenient time and place.
• Lisa Gibbs will act as facilitator of focus group discussions which will take approximately two hours, will involve approximately ten participants, and will be held at a time and place which is convenient to the participants.
• I can choose not to answer any question asked in the interview/discussion.
• I can ask to swap from a focus group to an interview, or vice versa, if I wish.
• I may be asked if I would like to be part of a reference group for Lisa Gibbs, to give feedback on later developments in the study.

I acknowledge
1. That the aims, methods, and anticipated benefits, and possible risks/hazards of the research study, have been explained to me.
2. That I voluntarily and freely give my consent to my participation in such research study.
3. I understand that aggregated results will be used for research purposes and may be reported in scientific and academic journals.
4. Individual results will not be released to any person except at my request and on my authorisation.
5. That I am free to withdraw my consent to participate at any time during the study, in which event my participation in the research study will immediately cease, and that at this time I can also withdraw my consent for the use of any information obtained from me previously for the study.

Signature:..............................................................................................................

Date:......................................................................................................................

1 This question was drawn, with permission, from the ‘Living as Men’ study currently being conducted by Dr Sasho Lambovski.
Appendix 4  Demographic questionnaires
Participant Questionnaire

Men's access to chronic illness self management programs – Research project

Thank you very much for agreeing to participate in this research project. Listed below are a few questions I would like you to answer. They are all optional. However, any answers you give will help me to organise the focus groups and make sense of the research findings. Please bring this completed form to the focus group discussion or individual interview you are having with Lisa Gibbs. It will be numbered and stored with the discussion/interview records but will be kept separate from your name and address to protect your privacy.

Please feel free to contact Lisa Gibbs on 0417 337 667 or at lgbbs@deakin.edu.au, or via her supervisor, Dr Maria Pallotta-Chiarolli on (03) 9251 7198 or at mariapc@deakin.edu.au, at any time if you have any questions or concerns about this project, or if you would like to end your involvement.

What age group do you belong to?

(please circle the appropriate age group)
18-25 26-40 41-60 61-75 over 75

Which ethnic or cultural group do you belong to?

☐ Anglo/Celtic
☐ Aboriginal/Torres Strait Islander
☐ Other (please specify) .................................................................

Which country were you born in?

☐ Australia
☐ United Kingdom
☐ New Zealand
☐ Italy
☐ Former Yugoslavia
☐ Vietnam
☐ Greece
☐ Other
Do you have arthritis, or a related condition affecting your muscles, bones and/or joints?

☐ yes  ☐ no

Do you have an ongoing medical condition (one that is not arthritis or a related condition)?

☐ yes  ☐ no

Considering all the ways that your condition/s affects you, how well are you doing compared to other people your age?

☐ Excellent  ☐ Good  ☐ Fair  ☐ Poor  ☐ Very poorly

What is your work situation?

(Tick one box only)

☐ full-time work

☐ part-time or casual work

☐ unemployed

☐ student

☐ retired (for medical or age related reasons)

☐ mainly involved in domestic duties

☐ voluntary worker

☐ other (please specify) .................................................................

If you are in paid work, what type of job/occupation do you have?

(Tick one box only)

☐ managerial

☐ professional

☐ health services

☐ trade

☐ administrative

☐ sales and personal service
☐ plant and machine operation, or driving
☐ labour or related work
☐ military/police/security
☐ information technology
☐ finance
☐ other (please specify) ........................................................................................................................................

What is the highest level of education you have had?

(Tick one box only)

☐ primary school only
☐ attended high school/secondary school
☐ successfully completed Year 12 (ie Leaving Certificate/HSC/6th Form)
☐ Tertiary Diploma or Trade Certificate
☐ University qualifications
☐ other (please specify) ........................................................................................................................................

What type of high school did you attend?

(Tick one box only)

☐ private schools only
☐ public schools only
☐ Catholic systemic schools
☐ both private and public schools
☐ other

Was your school single sex or co-educational?

☐ single sex ☐ co-educational
Are you currently in an ongoing relationship?

☐ yes  ☐ no

Many times in the media and everyday conversation we hear the terms “sensitive new age guy”, “macho”, “sports mad”, “yuppie”, etc. to describe men’s perceptions of themselves and others. Would you use any of the terms below to describe yourself?¹

(Tick either the yes or no box for every item)

<table>
<thead>
<tr>
<th>Term</th>
<th>Yes</th>
<th>No</th>
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<tbody>
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<td>macho</td>
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<tr>
<td>other (please specify)</td>
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</tbody>
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Thank you very much for your help. Please bring this form with you to your interview/focus group discussion.

Lisa Gibbs
Participant Questionnaire (Partner of person with arthritis)

Men's access to chronic illness self management programs – Research project

Thank you very much for agreeing to participate in this research project. Listed below are a few questions I would like you to answer. They are all optional. However, any answers you give will help me to make sense of the research findings. Please bring this completed form to the focus group discussion or individual interview you are having with Lisa Gibbs. It will be numbered and stored with the discussion/interview records but will be kept separate from your name and address to protect your privacy.

Please feel free to contact Lisa Gibbs on 0417 337 667 or at lgbbs@deakin.edu.au, or via her supervisor, Dr Maria Pallotta-Chiarolli on (03) 9251 7198 or at mariapc@deakin.edu.au, at any time if you have any questions or concerns about this project, or if you would like to end your involvement.

What age group do you belong to?

(please circle the appropriate age group)

- [ ] 18-25
- [ ] 26-40
- [ ] 41-60
- [ ] 61-75
- [ ] over 75

Which ethnic or cultural group do you belong to?

- [ ] Anglo/Celtic
- [ ] Aboriginal/Torres Strait Islander
- [ ] Other (please specify) .................................................................

Which country were you born in?

- [ ] Australia
- [ ] United Kingdom
- [ ] New Zealand
- [ ] Italy
- [ ] Former Yugoslavia
- [ ] Vietnam
- [ ] Greece
- [ ] Other
Do you have arthritis, or a related condition affecting your muscles, bones and/or joints?

☐ yes  ☐ no

What is your work situation?

(Tick one box only)

☐ full-time work
☐ part-time or casual work
☐ unemployed
☐ student
☐ retired (for medical or age related reasons)
☐ mainly involved in domestic duties
☐ voluntary worker
☐ other (please specify) .................................................................

If you are in paid work, what type of job/occupation do you have?

(Tick one box only)

☐ managerial
☐ professional
☐ health services
☐ trade
☐ administrative
☐ sales and personal service
☐ plant and machine operation, or driving
☐ labour or related work
☐ military/police/security
☐ information technology
☐ finance
☐ other (please specify) .................................................................

What is the highest level of education you have had?

(Tick one box only)

☐ primary school only
☐ attended high school/secondary school
☐ successfully completed Year 12 (ie Leaving Certificate/HSC/6th Form)
☐ Tertiary Diploma or Trade Certificate
☐ University qualifications
☐ other (please specify) .................................................................

1 This question was drawn, with permission, from the 'Living as Men' study currently being conducted by Dr Sasho Lambevski.
What type of high school did you attend?

(Tick one box only)

☐ private schools only
☐ public schools only
☐ Catholic systemic schools
☐ both private and public schools
☐ other

Thank you very much for your help. Please bring this form with you to your interview/focus group discussion.

Lisa Gibbs

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Footnote: This question was drawn, with permission, from the ‘Living as Men’ study currently being conducted by Dr Sasho Lambevski.
Interview Protocol

The interview protocol for this research study is as follows:

- What health services are available for people with arthritis?
- Where do you tend to hear about services?
- What health services do you use? Why? Why not?
- What services do you think you would use now that you know they are there? Why? Why not?
- Why don’t you use the other services?
- In what ways do other people influence your decision to participate?¹
- Do you prefer programs that include group activities or those that are targeted at the individual?
- Do you prefer programs specifically targeting men, or for both men and women?
- What about time, venue, cost (too high or too low)?
- Provide 2 case studies, one at a time. The first describes a man in crisis with severe arthritis and unable to continue working. The second describes a man with moderate arthritis who wants to be able to manage better. Both decide to do a self management course... What sort of man do you think he is? What do you think about his decision? What decision would you make in those circumstances?
- How would a self management program have to be changed for you to decide to participate?
- What would have to change in your life before you would decide to participate?

These questions would obviously be adapted for those that do participate in programs, and for the partners of men with arthritis.

Interview Protocol for Partners

The interview protocol for this research study is as follows:

- What services has your partner used to better manage his condition?
- Do you feel there are other services he should be trying?
- Do you ever try to persuade him to use certain services? If so, how does he react?
- What do you think has to happen for him to decide to use a service?
- What puts him off using certain services?
- What services is he more likely to use?
- What about the following features:
  - group vs one-on-one
  - men only vs mixed
  - female vs male leader
  - single event v consecutive visits
  - time, venue, cost (too high or too low)?
  - internet
  - language of promo
Revised Interview Protocol

The interview protocol for this research study is as follows:

- What health services are available for people with arthritis?
- Where do you tend to hear about services?
- What health services do you use? Why? Why not?
- What services do you think you would use now that you know they are there? Why? Why not?
- Why don’t you use the other services?
- In what ways do other people influence your decision to participate?
- Do you prefer programs that include group activities or those that are targeted at the individual?
- Do you prefer programs specifically targeting men, or for both men and women?
- What about time, venue, cost (too high or too low)?
- Provide 2 case studies, one at a time. The first describes a man in crisis with severe arthritis and unable to continue working. The second describes a man with moderate arthritis who wants to be able to manage better. Both decide to do a self management course... What sort of man do you think he is? What do you think about his decision? What decision would you make in those circumstances?
- How would a self management program have to be changed for you to decide to participate?
- What would have to change in your life before you would decide to participate?
How can self-management programs be more accessible to men with a chronic illness?

Lisa: Did it ever occur to you to get help for your arthritis?
Adam*: No.
Lisa: Why do you think that is?
Adam: I think that I didn’t realise that I was needing help.

This paper provides a summary of the early findings coming out of the research into men’s access to chronic illness self-management programs. It has been prepared for people who were involved in the first round of interviews – to let them know what’s happening and also to get their feedback.

**Review of other research**

A review of research into gender and health showed that men tend to use health services less than women and in different ways. This appears to be influenced by society’s dominant image of masculinity that requires men to be strong, independent and in control.

**Arthritis Victoria records**

A review of Arthritis Victoria client records showed that men use services significantly less than women, even after taking into account the fact that arthritis is more common in women than in men. Women were more likely than men to contact the service themselves, whereas men were more likely to have a family member or friend contact the service for them. Women showed more interest in learning about their condition while men focused more on symptom management.

This confirmed that men access arthritis self-management services to a different extent, in different ways and for different reasons than women.

**Review of health programs targeting men**

A review of Australian health promotion programs targeting men showed that the successful programs tended to use ‘masculinity markers’. This included the use of ‘blokey’ language, holding events at pubs and sports clubs rather than medical venues, appealing to men’s lifestyle choices rather than pushing a health message, and distributing advertising to women for their husbands (or fathers, sons etc), rather than directly to men.

However, there was some evidence to suggest that a different approach is needed for men with a chronic illness.

* Names have been changed to maintain privacy.
Interviews with men

A series of interviews with men with arthritis or a related condition, and some partners, was conducted to understand why men do or don’t use self management services. This summary is based on the first set of interviews, held with 7 men and 3 partners. The interviewees came from a range of backgrounds in terms of age, occupation, where they live, sexuality, and the masculinity labels they chose to describe themselves. A second series of interviews is now being conducted with people who also come from a range of backgrounds. A total of approximately 25 people will be interviewed. The early findings from the first set of interviews are outlined below.

Decision to seek help

In almost all cases (it may not occur for older, retired men), the decision to seek help is made when the condition causes a crisis. This usually happens when:

- The pain becomes severe and/or constant, or
- The person is no longer able to do something which is extremely important to him – usually work; and
- The person realises that the condition is not going to go away (this is often accompanied by a fear of ageing and a threat to masculinity).

In all cases, the change is seen as being such a problem that it can no longer be ignored.

Kevin*: It took me years, it took decades, well for one decade at least, where I never told anyone I was affected by arthritis. I covered it up totally. Friends of mine, closest friends, didn’t know that I was profoundly affected. I would scarcely speak to my doctor about it, but it was when I got to the point where I couldn’t walk up a flight of stairs, I couldn’t continue working in the work that I love, I was broke, I couldn’t go out for dinner with friends, I couldn’t go on holidays, my life was just closing in on me, that I had to look carefully at the social expectations on me.

If their condition has not caused a crisis, then men have generally not used self management services and report that they will only feel it is necessary to go and seek help if they reach a point where they can no longer work. Men who are close to retiring age, report that they will wait until they retire before seeking help.

Important influences

While the decision to seek help is usually only made if a crisis occurs, there are other factors which influence how quickly the person actually contacts the service.

* Names have been changed to maintain privacy.
Masculinity
As previously mentioned, dominant images of masculinity in society that require a man to be strong and not to seek help, are a major barrier to contacting self-management services.

Adam: *I think the biggest thing is, and I can only speak from my own experience, is that most men won’t, don’t like to admit there’s a problem in existence. That’s the biggest problem in the first place. And particularly while they’re in the workforce and even more so in today’s work climate, nobody wants to be in a position of vulnerability, so where they might have been tempted to do something about things—because of their employment situation then they say, I’m not going to show any weakness here either.*

In some cases, having a chronic condition like arthritis can challenge men’s sense of their masculinity by affecting their ability to be strong and independent and to work. At these times they are often forced to question society’s expectations.

Kevin: *We’re expected to find the answers ourselves, we’re expected not to need support from others, we’re expected to be a kind of rock of strength for others. And I’ve had women friends and women partners, basically been very clear with me that my role is to be supportive to them while somehow I’m meant to magically find these resources within myself, and I don’t have them. They’re not there.*

Referral
Men are more likely to contact self-management services earlier if the service has been recommended by their doctor, or even if there are pamphlets in the doctor’s waiting room. However, if the doctor doesn’t mention self-management services, men may not be aware of what is available or that those services would be relevant. They may also assume that if the doctor hasn’t mentioned it to them, then the doctor doesn’t think it’s worth doing.

Lisa: *The fact that the doctor didn’t recommend it, what does that mean to you?*  
Graham*: Probably means that he’s not all that wrapped in it either, probably hasn’t convinced himself about it. If he was convinced about it he’d probably convince me. If he got feedback from other patients saying this is really good.*

Wives
Other research has found that wives have an important role in organising health care for the family. This was not entirely supported in these interviews. It seems that men usually make their own decision about using self-management services. However, the wife (or other female family member) does have a role in making men aware of what services are available. For this reason, it may be useful to distribute advertising for men’s programs to

* Names have been changed to maintain privacy.
women, rather than directly to men. As noted earlier, this has been used successfully by other health promotion programs targeting men.

At this stage in the study, the partner in same sex relationships does not appear to have the same role as female partners, in terms of raising men’s awareness of health services relevant to them. However, this will be explored further in the next phase of interviews.

**Other influences**

There are other influences on men’s decisions to use self-management services, such as awareness of what’s available and understanding of what programs offer.

Many men do not realise there are a range of services available, and do not have a clear understanding of how these services operate. As mentioned earlier, doctors and wives/mothers can have an important role in helping men to understand what services they could be using.

Men are more likely to consider a service if there is some sort of trigger that helps them to recognise that the service is relevant to them. This is why men-only services can be more successful in attracting men. Although men do not appear to be concerned about the prospect of using services for both men and women, they are more likely to realise that a men’s program will be relevant to them. It does not appear to be necessary to have male contact people or leaders for a program unless sensitive issues are going to be addressed, and even then some men feel more comfortable talking to a woman. However, a male leader is more likely to raise men’s awareness that the program is relevant to them.

There are also a range of advertising techniques such as language and pictures that can be useful in helping men to realise the program is for them, and for targeting specific groups of men. However, the sort of ‘blokey’ language used in health promotion programs to attract men, may not be appropriate when targeting men with a chronic illness. This sort of approach has the potential to alienate men whose masculinity has been threatened because of the impact of their condition on their strength and independence.

**Access**

The competing demands of work and the impact of a chronic condition can make it very hard for men to access self-management services. This is the biggest challenge for organisations wanting to make chronic illness self-management programs more accessible to men.

**Time**

* Names have been changed to maintain privacy.
Time is a problem for many men needing health services, because they tend to put work, family and other commitments before their own health.

It is hard for many men to attend programs during work time. It is even harder for men in rural areas and those involved in physical work, because of the additional time involved in changing and/or travelling. Most men are also reluctant to attend programs on a weekend because that time is committed to family, work around the house, and/or sport. This means that evenings need to be considered for health programs unless a workplace program can be established. However, evenings are a particular problem for men with a chronic illness because tiredness is so often a part of chronic illness and they are too exhausted to consider doing anything after work.

*Eric*: The venue wouldn’t worry me. The hardest part for me... in lots of cases, is time to do that. That’s the hardest part. Sometimes I’m so tired when I go home from work because of the arthritis, all I do is go home to sleep.

Time only stops being a problem when men have retired. However, early retirement can often occur because of the chronic illness. It should be the aim of all self-management programs to reach men before they are forced to retire because of their condition.

**Venue**

Interestingly, all of the men interviewed had taken time off work to see a doctor about their condition but none had considered taking time off work to attend a self-management program. For this reason it may be worth reviewing the venue for self-management programs. As noted earlier, a review of health promotion programs showed that holding health nights in non-health settings such as pubs and sporting clubs, had proved successful in attracting men. However, while most men may prefer to avoid a medical setting, men with a chronic illness can no longer avoid it. They are more concerned about the quality of services and making sure that the service is not going to be a waste of time. Therefore, the venue for chronic illness programs needs to be linked more to credibility rather than ‘male comfort zones’. Holding programs in a health/medical environment may achieve this and may also make it easier to take time off work to attend. Providing a ‘medical certificate’ or something similar, would also help to justify the time off work, and may allow them to take sick leave when they attend.

*Harry*: I like a professional environment because it gives the subject credibility and so that’s what I’m looking for when I go to a group. I have to check their bona fides if you like, to make sure that at least I’m with people who I can trust with the dissemination of information. It needs to be at a level where it’s been researched and the information’s reliable and so that’s sort of a requirement for the venue that I had when I first went.

* Names have been changed to maintain privacy.
Format

The format of the program seems particularly important when attracting men. Men seem reluctant to use services unless they know it will be relevant and useful. Exercise programs are generally recognised as being useful because they help to maintain or increase fitness, regardless of whether they help with the condition. However, there is a wariness about attending anything that requires personal input, such as a course or a discussion group, although once involved most men seem to enjoy and benefit from these programs.

*Eric:* I don't know if it makes you feel any better to sit in a room with a group of people who've all got it and say I've got arthritis and this is what my story is. I don't know if that's gonna really help me.

Organisations should provide an initial information session for all services, other than exercise programs, to encourage men to come along and have a look before making a commitment. The only exception to this rule is for men who are experiencing a major crisis in relation to their chronic illness. At this point they are less concerned about risk and more focused on getting immediate help and support.

*Kevin:* About five years ago I heard about a self help group called Young Adults Arthritis Group, a self help group and went along to that and I found that immensely helpful, psychologically, because I was really battling at that time.

Cost

There are many expenses involved in the treatment and management of a chronic condition. It can also affect the type of work and amount of work a person is able to do. For this reason, programs for men with a chronic illness should be provided at low cost.

Conclusion

It is clear that in order to reach men at an earlier stage in the progress of their illness, health services need to acknowledge that men have a different approach to health care than women. There are existing health services that demonstrate successful strategies in targeting men. However, the unique needs of men with a chronic illness need to be taken into account before adopting these strategies for self-management services.

*Adam:* In that course, I felt I learnt so much about arthritis and management in a short time, I thought, gee I really want to know some more about this.

* Names have been changed to maintain privacy.
Preliminary analysis – feedback

Name (optional):

☐ I didn’t really agree with the research findings.

For these reasons:

○ ...

○ ...

○ ...

☐ I agreed with the research findings.

Particularly for these reasons (optional):

○ ...

○ ...

○ ...

☐ I think you should also consider the following possibilities (optional):

○ ...

○ ...

○ ...

Thank you very much for your help!

Lisa Gibbs
Men’s access to chronic illness self management programs

Summary of research findings

The interviews conducted for this research revealed the unique personal experiences of men dealing with chronic conditions including stories of adjustment, perseverance and improvement, as well as difficulties and traumas. The focus of this study was on factors affecting men’s decision to access self management services, and more particularly, on finding out what might be discouraging men from accessing services.

The findings of this study showed that despite variations in individual experiences, there were some common issues affecting men’s decisions to access self management services. The most significant over-riding influence was masculinity norms that require men to be strong, independent and in control. There is also a traditional notion that health management is women’s responsibility. As discussed below, this resulted in a general tendency among men to avoid health issues and was also evident in a limited awareness of self management services. Health organisations need to be aware of these social influences on men’s health behaviour and introduce changes in the development and delivery of self management services to improve accessibility for men.

Avoiding health issues

Many men avoided talking about or seeking help for their condition even when it was impacting significantly upon their health status and their working and social lives. In some cases, men used humour to discuss their condition, or accessed services on the pretext of helping someone else. By doing this they were able to bypass the masculinity norms by demonstrating their strength in another way.

Men’s health management behaviour also seemed to be driven by a concept of health that equated fitness with the ability to meet work and family responsibilities. This meant that men did not feel it was appropriate to seek help while they were still able to continue working. The level of commitment given to work obligations also meant
that if work and self management service times conflicted, work came first. This meant that work was a significant barrier to participation.

Many men felt that self management services were for old or disabled people. This made them reluctant to use those services because if they did, it would imply that they were also ‘old’ or ‘disabled’. It was also seen as meaning that you had lost control or ‘self mastery’ over your body. Younger men did not have the same fear of ageing. However, they were conscious of not belonging among older service users.

The combined influences of masculinity norms, work commitments and fear of ageing or loss of control, were significant barriers to seeking help. Men typically avoided accessing self management services unless their condition became so bad that it was undeniable that help was needed. This usually occurred when they were no longer able to work. As work is generally a central means of establishing masculinity, loss of work status had the potential to severely undermine a man’s sense of his own masculinity and was often accompanied by an emotional crisis. At this point, men tended to reformulate or reject ideas of ‘acceptable’ male behaviour in order to adjust to their loss of work status, their need for help from health services, and their involvement in self management practices.

Men who were still establishing themselves in the work phase of their lives, or had finished it, were not as restricted by traditional notions of masculinity because they did not have the competing priorities of family responsibilities (in the case of young men) or work obligations (in the case of retired men). This allowed them to give health a higher priority. Older men were also less restricted by masculinity norms because of a general recognition that ageing results in wear and tear and a need for health services. This meant that retired men were more likely to access services before the impact of their condition reached crisis point.

While there was some evidence of a relationship between health beliefs about the cause of the condition and health actions, other factors such as men’s life stage and the severity of their condition were found to be more significant influences on their decision to use self management services.
Health organisations providing self management services need to consider these issues in order to make services more accessible to men. In particular, services need to be structured in a way that minimises conflict with work obligations, and acknowledges the influence of masculinity norms on health behaviour.

**Limited awareness of self management services**

The findings of this study show that many men have a limited awareness of when they should use self management services and what services are available to them. This reflects traditional notions of masculinity in which health management is considered the responsibility of women.

Many men had difficulty recognising when help was needed and often relied on others' assessment of when it was appropriate to access health services. This was sometimes due to a poor understanding of the differences between chronic conditions and acute conditions. Many people assume that when you are sick you go to the doctor and get it fixed. However, for chronic conditions that are long term and usually have no known cure, a combination of medical care and self management practices is required to get the best results.

The men interviewed were generally not familiar with the range of self management services that were available to them. In some cases men were also sceptical about the value of self management services because they had previous negative experiences in the health sector, or with ‘outside’ agencies in the case of the participants from the rural and the Aboriginal communities.

Recommendations from doctors were likely to be a powerful encouragement to try self management services. However, if the doctor did not recommend self management services, many men assumed that either they were not relevant to them, or that the self management services were no good. Wives had a significant role in encouraging men to seek help and sometimes in directing them to appropriate services. Male partners in same sex relationships also seemed to encourage men to take action but were unlikely to be aware of appropriate service options. Single men
tended to be encouraged by friends or family to take positive health action. Older men
tended to be introduced to self management services by friends or acquaintances
already using them.

The findings indicated that holding a ‘Men’s program’ was likely to get men’s
attention and would reassure them that the program would be relevant, even though
most men were comfortable with mixed gender programs. Many men preferred to
attend health services with their partners. This was particularly true for older men and
men from different language and cultural backgrounds. The gender of leaders was
important to some men, although some preferred a male leader and others a female
leader. There seemed to be support for men-only sessions to discuss issues that are
gender sensitive.

Promotional material using laymen’s terms to describe symptoms and their impact,
can be effective in triggering men’s awareness of the need for action. References to
particular age groups or interest groups may also help to demonstrate that the program
is personally relevant. This is best achieved by promoting the event as a “Men’s
program”. However, the ‘macho’ approach used in many health promotion programs
to target men, can alienate men with a chronic condition if their masculinity status has
been undermined by their condition. It also excludes men who do not identify with
masculinity norms.

Health promotion programs targeting men often use ‘male comfort zones’ such as
pubs and sporting clubs as service venues. This did not appear to be appropriate for
men with a chronic condition who were more concerned about a credible environment
that also provided some privacy.

The use of humour in promotional material can be seen as offensive because it doesn’t
reflect the seriousness of the chronic illness experience. The use of simple English is
likely to be more inclusive. It is more easily understood by all men but particularly by
men from different language and cultural backgrounds.
Guiding principles for the delivery of self management services to men with a chronic illness

These guiding principles were developed on the basis of the research findings (summary attached), on an international review of health promotion programs targeting men, and on a trial conducted with Arthritis Victoria.

Health organisations providing self management services need to be aware that the needs of men with a chronic illness are different than 'healthy' men being targeted in health promotion programs. The experience of chronic illness has an impact upon self image, lifestyle and perception of services. For example, an information session format is generally advisable as an initial introduction to health services for men because it provides an opportunity to access information quickly and anonymously without having to share experiences. However, when providing services for men with a chronic illness, compassion must be evident in service delivery. Programs offering personal support are often required for men who have reached a critical point in their experience of their illness.

Other strategies that may help to engage men at an earlier stage in the illness pathway are as follows:

- challenge the idea that fitness is measured by the ability to continue working
- promote a preventative approach to health that protects working capacity
- encourage men to recognise self management as a way of maintaining a sense of control over health rather than relinquishing it
- promote an understanding of the differences between chronic illness and acute illness, and the fact that chronic illness needs to be treated differently, i.e. with a combination of medical care and self management practices
- demonstrate the diversity of clients benefiting from self management services, in terms of age, health status, cultural background, and sexuality.

On a practical level, health organisations would be advised to:

- Provide 'Men's programs', making it clear that partners are also welcome
- Provide both a male and female contact person/program leader
- Conduct occasional men-only sessions to cover gender-sensitive topics
- Conduct programs at a locally accessible venue – consider the availability of parking and public transport
- Conduct programs at a health venue rather than a social venue
- Use venues/networks already being used by specific community groups (e.g. Aboriginal Health Service)
- Choose weekday evenings or workplace programs for working men
- Choose daytime programs for men who are not working
- Avoid the use of sports celebrities
- Use local community leaders and practitioners in rural areas
- Capitalise on community networks in rural areas
- Keep entry fees to a minimum and display them on promotional material
- Arrange for medical certificates for participants and/or referrals from doctors where possible to assist men who need to obtain sick leave from work.
- Liaise with private health funds to arrange for participants to claim for the cost of self management programs.

In addition, the following promotional strategies are likely to raise men’s awareness of when and where to use self management services.

- Promote self management services via the medical sector, including the display of leaflets in waiting rooms
- Distribute information indirectly to men via their existing health information pathways, i.e. wives, same sex partners, current service users
- Use positive language in promotional material to reassure men of the value of attending self management programs.
- Gender-neutral language should also be used. This means avoiding language which conflicts with masculinity norms that require men to be strong and independent. It also means avoiding ‘macho’ language or imagery. However, the word ‘men’ should appear in headings if possible.
- The use of humour should be avoided. Instead, use simple English and refer to the symptoms of the condition or the ways in which it impacts on lifestyle, rather than using medical terminology.
• Display a clear start and finish time on promotional material.
• Encourage participants to ‘come as you are’ so that men (e.g. tradesmen) do not stay away simply because they have to change out of dirty work clothes.

These primary strategies incorporate considerations about the interacting influences of age, language and cultural differences, geographic location, and sexuality. However, health organisations endeavouring to develop self management services that are accessible to men, need to also demonstrate an understanding of their particular client base and the social issues affecting the men they are targeting.
Men – You can help resolve some research issues!

Please come to a workshop - *Promoting men’s health services*, to rate various promotional models according to their appeal.

When: Thursday 27th, 2.30 – 3.00pm
Where: H Building
Conducted by: Lisa Gibbs
PhD Candidate, Deakin University

*(Feedback from men with a chronic illness will be particularly relevant).*
MEN...

Do you have joint pain or stiffness that won’t go away?

Is the pain making it hard for you to do your job?  

Is it affecting your leisure time or activities with your kids?

You are invited to a *FREE*

Fast Track Information Night

Expert presenters, including a pain management adviser, will provide information on the treatment and management of arthritis, osteoporosis and other chronic conditions.

Date          Monday 29 July
Time          7pm – 8.30pm
Venue         Arthritis Victoria
              263 Kooyong Road
              Elsternwick

Partners are welcome to attend. Light refreshments provided.

Something can be done!

To attend the Fast Track Information Night or for further information contact Bill Evans or Reception at Arthritis and Osteoporosis Victoria

Phone Toll free 1800 011 041 or (03) 8531 8000
Email billevans@arthritisvic.org.au
Website www.arthritisvic.org.au