2000

Men's health: How men understand the concept of health and how this understanding shapes actions

Craig T. Thompson
Edith Cowan University

Edith Cowan University

Copyright Warning

Men's Health: How Men Understand the Concept of Health and how this Understanding Shapes Actions

By:
Craig T. Thompson

Honours Dissertation
Social Work Department
Edith Cowan University
(Bunbury Campus)

2000

USE OF THESIS

The Use of Thesis statement is not included in this version of the thesis.

Abstract

The purpose of this research was to explore how men understand the concept of health, and how this understanding shapes actions. This dissertation developed as a result of both working at a Community Health Centre, and having an awareness that in Australia, statistics indicate that men's health is steadily deteriorating.

A theoretical framework implementing the concepts of health, socialisation (masculinity) and cognition was utilised to guide the research. The research involved interviewing six male participants, who were university students ranging in age from 20 to 40 years. Participants were questioned regarding their perceptions of health and health management. Interview transcripts were analysed utilising a symbolic interaction perspective, where the five major themes of family / friends, personal experience, exercise, food, and seriousness of concern emerged.

The results of the study indicate that when analysing the five major themes, the concepts of health and cognition impacted upon participants responses to health concerns and health management. In contrast, men did not explicitly discuss masculinity as impacting upon health concerns or health management. Future research to explore how men understand the concept of health and how this understanding shapes actions could focus upon age differences, gender comparisons, or individuals not studying at university.

Statement of Sources

I certify that this thesis does not, to the best of my knowledge and belief:

- Incorporate without the acknowledgment any material previously submitted for a degree or diploma in any institution of higher education;
- Contain any material previously published or written by another person except where due reference is made in text; or
- Contain any defamatory material.

[redacted]

(Craig Thompson)

24/02/01

(Date)

Acknowledgements

I would like to acknowledge the following people for their contribution in helping me complete this thesis dissertation:

To my family, for their encouragement during my time in completing this project.

To Carlie, for her time, dedication and assistance in supporting me whilst undertaking this honours project.

To the six men who participated in the interviews. Without their willingness to discuss their understanding of health and health management, this study would not have been possible.

To my supervisors Susan Young, Elizabeth Lindsey and Pauline Meemeduma for their time, energy and assistance with this study.

Table of Contents

Chapter 3: Research Inquiry

Chapter 4: Results

Chapter 5: Research Analysis

List of Diagrams

List of Appendices

Chapter 1 – Men's Health

Introduction

The primary purpose of this research is to address the issue of how men understand the concept of health, and how this understanding shapes health actions. The essence of this chapter will be to introduce the area of men's health. This introduction will include a review of the men's health literature, an illustration of the state of men's health using current statistics, and a definition of health that will be used throughout the dissertation. Furthermore, this chapter will present a brief overview of the concepts that will be used to examine the research purpose. The concepts analysed (cognition, socialisation and health) allow for a theoretical framework to explore how men understand the concept of health, and how this understanding shapes actions / in-actions.

The purpose in addressing this question in my research resulted from experience working for a Community Health centre, and its under utilisation by men. This community health centre was funded by the Department of Health and had a primary role "to promote, protect, maintain and restore the health of the people of Western Australia" (Western Australia Department of Health, 2000). The experience working at community health informed me that the services offered by the department were predominantly utilised by women, eg check-ups, injections and general health inquires. Few men accessed the services offered.

Speculative reasons may be given into why few men accessed the services available within the Community Health Centre. These included:

- men were working long hours and did not have time to access the agency
- men did not see themselves as needing the services offered
- men did not feel comfortable attending the agency.

There may be many hypothetical reasons derived to explain the reasons why men did not utilise this health centre as frequently as women. An examination of the health literature, however, highlights similar conclusions that "men make less use of health services than women" (Fletcher, 1995, p. 34). Research within the literature illustrates that:

- men generally do not care for their health as much as women and are more likely to ignore health problems than see a doctor (Wilson, 1998, p. 21).
- there is a higher health service utilisation by females than males in Australia (Huggins, Somerford, & Rouse, 1996, p. 9.1)

The present Minister for Health, Dr Michael Wooldridge has illustrated the non-visibility of men utilising health services, resulting in a concern about men and their health. Wooldridge (1998) asserts: "many men tend to neglect their health as they are less likely to visit a general practitioner, even when they suspect they need treatment" (p. 15) [*My underlining*]. These research findings clearly indicate that there is a concern associated with men and their attitudes towards health services. The comment made by Dr Wooldridge raises a suggestion that men are not accessing services even when they are aware, (non-awareness being an understandable reason) of health concerns.

The low utilisation of health services by men is a concern when considered against health indicator statistics for men in Australia. Statistics supported in men's health literature (Men's Health Network, 1999; Burkitt, 1999; Fletcher, 1995) have all concluded that men's health is worse than women's. The statistical evidence clearly highlights a pattern that men engage in higher risk indicators than women (see Diagram 1.1).

Health Risk Indicators	**Male**	**Female**
Are more Overweight / obese (%)	44.7%	31.0%
Smoke excessively –according to NHMRC (%)	32.1%	24.7%
Drink at excess levels (%)	14.9%	7.5%
Exercise of sport / recreation (%)	64.9%	67%

Sources: Australian Bureau of Statistics, 1998
Australian Institute of Health and Welfare, 1996

Diagram 1.1 - Percentage of male and female population who engage in health risk / non risk activities.

Diagram 1.1 highlights the findings that men engage in higher health risk activities when compared to women. The statistics highlight the percentage of men engaging in health risk activities such as excessive smoking and drinking is greater than women in Australia. Furthermore, the statistics also indicates that the percentage of men, when compared to women, participate in less physical exercise. In addition, it is the findings of these statistics that men are engaging in a greater percentage of higher health risk indicators, which leads to a comparison of health consequence indicators.

It is these health risk indicators, and their illustration through statistical evidence, that results in men having higher health consequence indicators than women. This is evident in the latest research relating to the life expectancy of men and women. The research concludes that on average, "a newborn male will live to 75.6 yrs, compared to women at 81.52 yrs" (Australian Bureau of Statistics, 1998, p. 5). Further research illustrating higher health consequence indicators for men than women is highlighted in Diagram 1.2.

Health Consequence Indicators	**Male**	**Female**
External causes of death:		
• suicide	1931	462
• motor vehicle accidents	1398	544
• homicide	223	103
• poisoning by drugs / medication	218	79
Internal causes of death:		
• lung/ bronchus /trachea	4821	2053
• health disease	15024	12801
• alcohol consumption	2521	1139
Diagnosed with the HIV disease:	592	64

Source: Australian Bureau of Statistics, 1998

Diagram 1.2 - Health consequence statistics during 1997/6

An examination of the findings from the Australian Bureau of Statistics (1998), indicate that, when compared to women, a greater number of men are dying from engaging in certain health consequence indicators. Examples illustrating large discrepancies in the activities of the genders resulting in morbidity include death by suicide, motor vehicle accidents, alcohol consumption, lung cancer, drug use and HIV diagnosis. These examples from the statistics indicate that between the genders, men's health is of concern when compared to women's. In

comparing the large discrepancies between men and women's health statistics, these findings inform that men's health issues should be a concern to all people in Australian society.

> It should be a concern to all Australians that "a nation that claims to be one of the healthiest in the world, harbours major inequalities in health status within its population. Not only is there a concern for the highly publicised Aboriginal and women's health issues in Australia, but a major area of importance regarding health, that relating to men, is forgotten. Simply, there is a silence in Australia regarding the area of men's health " (Health for all Australians, 1998, p. 1).

What is causing the crisis in men's health?

> There is an ongoing, increasing and predominantly silent crisis in the health and well being of men. Due to a lack of awareness, poor health education and culturally induced behaviour patterns in their work and personal lives, men's health is deteriorating steadily (Men's Health Network, 1998).

There may be many reasons to explain the silent crisis regarding men's health in society. The Men's Health Network (1998), however, identifies three components that are resulting in the steady deterioration of men's health. The three fundamental factors identified are a lack of awareness, poor health education, and a culturally induced behaviour pattern.

Lack of Awareness: One cause relating to the steady deterioration in men's health, according to Men's Health Network (1998), is the issue regarding an insufficient awareness in the public population thus, resulting in a lack of men's health promotion. Unlike the publicity given to women's health concerns, such as breast and cervical cancer, men's health does not receive equal attention by the Health Department. This is highlighted in the literature which asserts that "it seems men have been forgotten by health services, an impression supported by the recent revelations in the press that eight times less money is spent on men's health than women's" (Deville - Almond, 2000, p. 28). Given this finding, it is no wonder men's health is worse when compared to women's, thus emphasising the deterioration of men's health in society.

Genderised culture: A further factor that helps explain the silence regarding men's health in Australia relates to the way men are portrayed in western society. Men are classified in society through their role that increases their health concerns. As highlighted in the literature "men are socialised to engage in high-risk activities" (Perry, 2000, p. 29). Such risk categories include work conditions, role in family, media portrayal and recreational activity. Risk factors underpinning men's health concerns are also supported by stereotypes in society. Common statements include 'men don't cry', 'tough men don't get sick' or 'I feel embarrassed going to the doctor' are examples of a view affecting men's health in general.

These factors increase the risk categories of the silent issues concerned with men's health, thus increasing the steady deterioration of men's health in society. This deterioration in men's health and the silence associated with this decline has many implications that will affect society. Associated issues that will be affected with the continuous decline in men's

health include the impact this has on both the structure of the family (financial, function) and production (labour, consumer) of society.

Education: A final component that may explain the silence regarding the deterioration in men's health is education. When compared to women's health, there is little interest put into the area of men's health. As is illustrated, "with the massive interest and upsurge in women's health and feminist issues, it is not surprising that so much energy goes into producing programs, whilst men's health is not viewed as an interesting topic for education and training" (Luck, Bamford, & Williamson, 2000, p. 233). It is these authors' view that indicates there is a lack of education about men's health when compared to women's.

Defining Health

Health is a complex concept, with debates occurring in the health literature regarding what this term is trying to describe. The most notable definition used within the health literature to define health has been complied by the World Health Organisation (WHO) in 1947. WHO defines health as "a state of complete physical, mental, and social well – being, and not merely the absence of disease or infirmity" (Australian Bureau of Statistics, 2000, p.1).

In order to examine how the WHO (1947) defines health, and thus approaches the topic of health, one must understand both the cultural position of health during the 1940s and the values held within this viewpoint. Firstly, a perception of health in the 1940s highlights that there was a traditional viewpoint surrounding the concept of health. This traditionalist view of health encompassed the notion that "if an individual displayed no disease symptoms, that

individual was considered healthy" (Anspaugh, Hamrick & Rasato, 1991, p. 2). It was based on this traditionalist view that helped towards the structural definition of health by WHO in 1947.

Furthermore, a close analysis of the health term described by WHO informs one of the values used to understand and define the health concept. The WHO definition asserts: "health extends beyond the structure and function of one's body to include values and reasoning" (Hahn & Payne, 1991, p. 1). It is from this analysis of health that allows the concept of health to be understood within the existence of a disease. This understanding of health illustrates that "you don't have to be a picture of health to be satisfied with it" (Hahn & Payne, 1991, p. 1).

In examining the literature, many scholars are critical of this definition of health by WHO. Scholars such as Dintiman & Greenberg (1986), Payne & Hahn, (1991) and Montgomery & Morris, (1990), view the WHO definition as a conceptually static entity. As Barnes (1987) asserts, the WHO definition of health is "overly idealistic and implying health is a static entity, which limits potential to affect health" (p. 2). The WHO definition is criticised by scholars as being overly idealistic for a number of reason. Firstly, it is viewed as a state that is impossible for human beings to attain. Secondly, the literature argues that the WHO (1947) definition of health "puts forward a rather absolute view of health by suggesting that we are all unhealthy unless we attained complete physical, mental and social well-being" (Aggleton, 1990, p. 8).

As a result of this criticism regarding the health defined by WHO (1947), scholars (Hahn & Payne, 1991) argue that health can be viewed as a holistic concept, that is, health should be

studied as a multi-faceted concept comprising mental, physical, emotional and spiritual issues. Health is rather viewed as a concept that moves along a continuum, emphasising that there is always potential for an individual's health to change. An individual change on a continuum of health is related to factors such as physical health, activity levels, career and work commitments.

For the purpose of this study, health will be viewed as a concept encompassing the components of social, mental, physical and emotional implications. Men's health will also be viewed as non-static entity, moving along a continuum from an individual's understanding of healthy / non-healthy (Diagram 1.3).

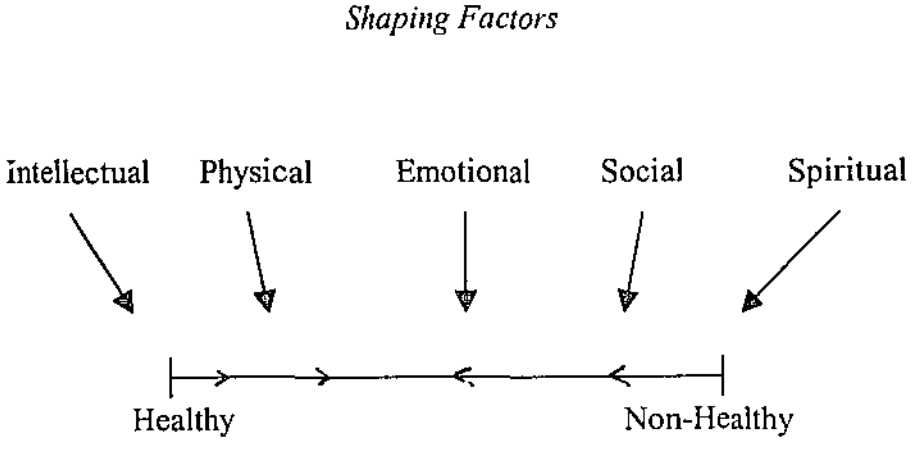

Diagram 1.3: The Health Continuum

The health continuum illustrated in diagram 1.3 portrays an individual's health as a non-static condition that is always subject to change. The arrows on the diagram indicate the continual change and direction in which one moves along the health continuum. This direction and change is based on the persons' perception or understanding of their health. The diagram further illustrates that this change and direction on the continuum, relating to the individual's

perception of their health is shaped by five factors, thus - social, physical, intellectual, emotional, and spiritual dimensions of health. The five dimensions (cited in Hahn & Payne, 1991, p. 8) relate to the following characteristics:

- Physical - level of susceptibility to disease, body weight, strength, visual acuity, and coordination.
- Emotional - coping with stress, flexibility, productivity, satisfaction levels.
- Social - social abilities, grace, skills or insight towards others
- Intellectual - ability to act on information, clarifying values and beliefs, decision making ability.
- Spiritual - religious beliefs, relationship with other members of family, willingness to help others.

Health Literature

In examining men's health research, the literature has primarily focussed on two major areas. These include both the medical area of health, and the individual's associated traits affecting their health. The medical perspective of health has primary focus on scientific research that examines the issues facing men in society. This medical perspective focuses primarily on health issues when men consult a practitioner. This curative perspective of men's health within the literature has focussed on the medical conditions with which men are currently facing in society. These medical areas of focus include prostate cancer (Sladden & Dickenson, 1993), testicular cancer (Antrobus, 1987; Rosella, 1994), impotence (Morrison, 1990) and circumcision (Davey, 1997).

A further area of men's health literature has focussed on the causal relationship life factors (traits) has on affecting health. Common traits that have been analysed, in conjunction to examining the factors affecting men's health, include unemployment (Zlotnick, 1992), education (Ross & Wu, 1995) and socio-economic status (Paul, 1995). Such studies focussing on the relationship between life factors and how these factors affect health, have illustrated that certain traits affect health more than others. For example, poverty is purported to affect health. This is highlighted in the literature where Paul (1995) asserts "there is no longer any doubt that poverty is the greatest barrier to creating and owning health" (p. 28).

Men's Health Conclusion

An analysis of health issues illustrates that there is a large discrepancy in men's health concerns, when compared to women. These differences in health status between each gender is supported in recent editions of Australian Bureau of Statistics (1998) & Australian Institute of Health and Research (1996). This overwhelming comparison in health statistics indicate that men's health in Australia needs to be examined as a separately identified field, not compared to women.

Literature that has specifically examined the area of men's health has focussed on two areas – medical and trait associated issues. These two areas of focus examine concerns for men when they consult a doctor or issues affecting men's health, not how men understand and conceptualise health. As previously stated by Wooldridge (1998) "men tend to neglect their health as they are less likely to visit a GP, even when they suspect they need treatment" (p. 15). It is this comment, even when they suspect they need treatment that is central to

understanding how men perceive their own health. Only through an analysis of understanding how men conceptualise the concept of health, may one begin to realise possible reasons why men do not utilise health services as frequently as women.

Research Focus

The primary focus of the research is to explore how men understand the concept of health, and how this understanding shapes action / inaction. An examination of the literature reveals that in Australia, the majority of research has been concerned with the manifestation of medical conditions facing men, and the relationship health has on trait associated factors. There has been no study completed in Australia that has focussed upon a cognitive framing for analysing how men understand the concept of health.

The conceptual framework that this research will focus upon in order to examine a cognitive reference to men's health, includes areas relating to socialisation, cognition and the construction of health in western society. I will use these concepts of health, socialisation and cognition in an exploratory study into how men understand the concept of health, and how this understanding shapes actions / inaction's.

Socialisation will be used as a concept within the research to explore how beliefs, stereotypes and cultural expectations affect men's health. It will be illustrated through these societal expectations that a construction of masculinity has been formed influencing men's perceptions of health. Cognition will also be analysed as a concept to understand how men perceive health, and how this understanding shapes actions / inactions. The concept of cognition will examine published theories (Goldstein, Kelly) that help develop an

understanding of human behaviour. Health as a concept is examined to illustrate the influence women's health has had on the construction of men's health in Australia. Through an examination of the Women's Health Movement (1970s), can one understand how this continues to impacts on men's health.

This exploratory study will focus on how men construct or understand the concept of health, (using a conceptual framework of socialisation, cognition and health) and illustrate how this understanding shapes health action / in-actions (Diagram 1.4).

Shaping Factors

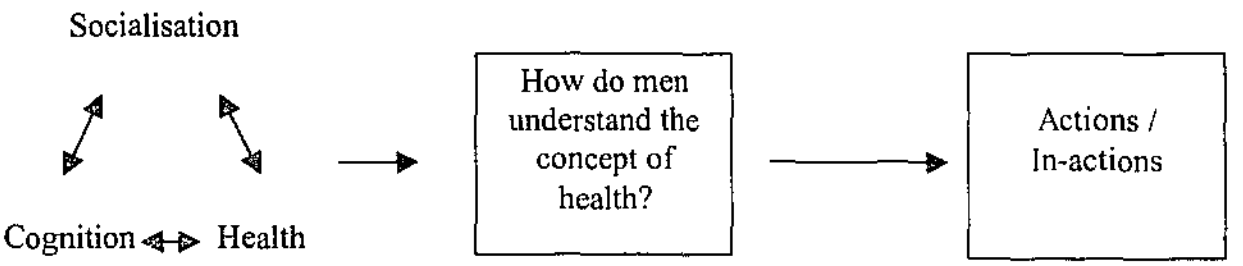

Diagram 1.4 – The Research Focus

The essence of this exploratory study is to examining how men understand the concept of health, and how this understanding shapes actions / in –actions towards health. This research has several questions to address. These questions include:

- 1) How do men understand the concept of health?
- 2) What factors shape this understanding of health?
- 3) How do men locate themselves on a continuum of health / non- - health?
- 4) What factors shape this location on the health continuum?
- 5) How does men's understanding of health act to inform health decision making?

There are many reasons why I am undertaking this research into how men understand the concept of health, and how this understanding shapes health action / inaction. Firstly, to contribute knowledge about men's health to the general population, to help explore possible reasons for the silent crisis facing men's health in Australia. Secondly, to add to my own body of knowledge that relates to men's health. Finally, this research will be contribute to knowledge regarding men's health that may help improve health planning policy in the 21st century.

Chapter two presents the theoretical framework of this dissertation.

Chapter 2 - Theoretical Framework

Introduction

The purpose of the research is to address how men understand the concept of health and how this understanding shapes health actions. This research has three objectives. Firstly, to contribute knowledge about men's health to the general population, to help explore possible reasons for the silent crisis facing men's health in Australia. Secondly, to add to my own body of knowledge that relates to men's health. Finally, this research will be contribute to knowledge regarding men's health that may help improve health planning policy in the 21st century.

The essence of this chapter will be to provide a theoretical framework, guided by the concepts of health, socialisation and cognition, to explore the status of how men understand the concept of health and how this understanding shapes action. This theoretical framework will further be utilised to analyse the results of the study.

The essence of using a framework guided by the concepts of health, socialisation and cognition is three-fold. Firstly, the concept of health is used within the framework to illustrate why men's health is an important area of research. This will allow for an in-depth analysis of how men's health has been constructed within the literature. Secondly, the concept of socialisation will be to examine how society portrays gender practice. This analysis illustrates how society's expectation and roles have led to a construction of a masculine practice towards health. Finally, cognition is also used within the framework to understand thoughts

of human behaviour. This analysis of human behaviour allows for a theoretical perspective into understanding the reasons for men's behaviour towards health.

This chapter will be structured by examining the concept of health, socialisation and masculinity in detail.

Health

Men's Health - Why?

The health research available indicates interest in naming and separating the issues associated with the historical origins of men and women's health. An examination of the literature available on women's health (Mcquistion, 1997; Wass, 1994; National Women's Health Policy, 1989; Hunt, 1996; National Women's Health Program, 1993) illustrates that it became an area of concern during the 1960s with the establishment of the Women's Health Movement (WHM). This movement utilised notions of feminism (Jackson and Jones, 1998) and empowerment (Broom, 1991) to educate women about their bodies in order to construct a new social order regarding their health. This construction of a new social order occurred to fight against society's perceptions of women's health held by men. It was through the WHM and their concerns for health improvements that led to national policy changes being developed in Australia during the 1980s (National Women's Health Policy, 1989; Paul, 1993).

In contrast to women's health, the literature concerning men's health reveals a differing historical origin. Although the construction of the WHM specifically focused on changing the social order to improve the health of women, the literature reveals that no such movement was constructed to improve men's health. As highlighted, "a men's health movement never really existed, other than a few loosely linked temporary groups" (Luck, Bamford, Williamson, 2000, p. 57).

Although the literature argues that a men's health movement never existed, there is evidence to illustrate this movement tried to become established. Although a men's health movement tried to become established in the early 70s by various community groups in the USA and UK, the establishment of such a movement resulted in little consideration about the issue. One argument for this lack of interest in this movement related to a sexism challenge to women –

> "men tried to liberate themselves from the constrictions of their position (masculinity), but this did not lead to a direct action to challenge sexism towards women" (Luck, Bamford, & Williamson, 200, p. 57).

A further argument that related to the lack of interest in a construction of a men's health movement relates to the way men were portrayed in society. That is, men were regarded as the standard, where research upon other groups (women, children) was compared against men.

The recent disclosure in the literature reveals that men's health has only recently become an area of concern (Luck, Bamford & Williamson, 2000; Fletcher, 1995). This concern has been

founded on statistics (Australian Bureau of Statistics, 1998) illustrating men's health consequence indicators are comparatively worse than women's. As such men's health has become a major area of concern - not just recognised and used as a standard of care towards other groups. This has been highlighted with "many general practitioners (women and men) becoming increasingly vocal in advocating attention to male health needs" (Fletcher, 1995, p. 1).

Men's Health - Australia

The area of men's health has recently become a popular issue for research, with attention being raised by the health statistics of Australian men. Achievements in addressing the concerns for men's health issues, was initiated in 1995 with a national men's health conference held in Melbourne. It was from this initial conference that resulted in funding being placed into the area of men's health to address concerns. The developments into men's health that resulted from the Melbourne conference included "a draft national policy. a second national conference (Fremantle, 1997), a House of Representatives Standing Committee seminar and report, and the development of task forces, advisory groups, policy and strategy on men's health in many states, including WA" (Connell, Schofield, Walker, Woods, Butland, Fisher, et al, 1998, p. 65).

The recognition of issues about men's health has resulted in research being conducted that has specifically focussed on understanding how men have constructed this concept. As Connell, Schofield, Walker, Woods, Butland, Fisher, et al (1998) asserts "practice of research has been integral to the development of men's health and what it has evolved to mean" (p. 67).

The Construction of Men's Health

An examination of the literature (Men's health 1998; Fletcher, 1996; Luck, Bamford, & Williamson, 2000) surrounding men's health, illustrates that it has been constructed around the area of women's health. Fletcher (1996) asserts men's health is constructed through a comparative analysis to women's health. It is through this comparison with women's health that "is typically characterised by men's greater premature mortality, disease and higher death rates at all ages" (Connell, Schofield, Walker, Woods, Butland, Fisher, et al, 1998, p. 66).

The literature also reveals that men's health is usually compared to women's health, evidenced in "patterns of health differences suggest that men suffer a health disadvantage that is at least comparable to, if not greater than women's" (Connell, Schofield, Walker, Woods, Butland, Fisher, et al, 1998, p. 66). This comparison with women's health suggests policy and services should be available to men in order to address specific health issues.

Although all men are subject to health issues, a closer analysis of the health statistics that portrayed men's health as disadvantaged against women's health could be argued to be misleading. The statistics that portray men's health as having major health differences between women can not be generalised to all men in society.

> "Aboriginal and Torres Straight Islander men, NESB men, men with disabilities, gay men, men of low socio-economic status and rural men, are those normally identified as bearing the burden of men's health disadvantage" (Connell, Schofield, Walker, Woods, Butland, Fisher, et al, 1998, p. 66)

These statistical issues using certain men to analyse men's health against women illustrates that social issues need to be examined. One implication that governs an analysis of men's health informs that "social disadvantages produces the margins of differences between men and women's health patterns" (Connell, Schofield, Walker, Woods, Butland, Fisher, et al, 1998, p. 66). Research that has compared women and men under similar social situations, indicate women are more likely to show an initiative towards better health conduct than men. According to the Australian Institute of Health and Welfare (1996), women with the same kind of social disadvantages as men generally disclose better outcomes of injury and illness. These findings highlight there are social issues associated with men's health that haven't yet been measured to explain health pattern differences when compared with women.

This illustrates that overall the term *men's health* is often used as a generic label to explore the issues surrounding men's health concerns. Rather such a label should be greater qualified as to its essence in context. For example more specific usage of the label in research or discussion would result in less more continuity towards men's health. Such specific labels could include 'interest in men's health' or 'men's health outcomes'.

Men's Health - Women's Health

The examination of men's health literature indicates there has been no defined framework for understanding the area of health for men in Australia. Huggins, Somerford, & Rouse (1996) asserts men's health "has not occurred as part of a coordinated national or state strategy within a clearly defined framework" (p. 1). It is this dilemma facing men's health that could result in an attempt to derive a health specific model to tackle men and their construction of

health. It is the issue that men's health has no defined framework, scholars argue men's health may imitate women's health. As asserted " in order to get somewhere with men's health it will frantically duplicate the most obvious health model - Women's Heath Movement" (Fletcher, 1995, p. 2).

An example of men's health that began duplicating the women's movement is illustrated through the establishment of men's health centres in Sydney during the 1980s. Men's health centres were established to address men's health concerns through separate gender issues. An examination of the construction of men's health as separate gender issues was based on a framework that informed the construction of women's health in the 1960s. A duplication of the women's health model for men's health, however, would be unable to recognise the important differences between the gender pathways in health.

The argument for establishing a framework for understanding men's health separate to women's health is based on two key recommendations (Fletcher, 1995). The first recommendation refers to the way men's health needs to be tackled is different than it was for women in the 1970s. An examination of the men's health literature reveals that the majority of people concerned with this area of research is equally proportional in the genders. "Activists for men's health are just as likely to be women as men" (Fletcher, 1995, p. 3), illustrating separate circumstances surrounding the construction of women's health. Women's groups were formed in the 70s to fight for changes in the social order allowing women to take control of their health (through their bodies), a concern not facing men.

The second recommendation men's health should not be duplicated on the WHM model relates to the differing position of men in society than women were in the 1960s. The WHM

was concerned about changing the values and perceptions relating to female health held by the dominant bureaucratic structure controlled by men. The task centred on the construction of a men's health model is not the subordination based on gender, but rather to "change the perceptions and values of men's decision making roles" (Fletcher, 1995, p. 3).

Summary

In summary, following the success of the WHM in demonstrating gender specific health issues, men's health concerns have become recognised as disorganised. There remains an absence of a satisfactory framework for dealing with the area of men's health concerns, and as a result the WHM framework has been used as a template. Men's separate health concerns are worthy of attention as indicated by their health status.

The construction of men's health does illustrate that there is no clearly defined framework for understanding the area of men's health. The social implication of certain men, together with the area associated with social issues discussed in the research, illustrates difficulty in examining the reasons of health difference with women. Given this finding in the research, there is an indication the gender – based issues or social implications are the specific reasons for health difference between men and women. This is highlighted by Connell, Schofield, Walker, Woods, Butland, Fisher, et al, (1998) who asserts: "men's health is an outcome of some combination of social disadvantage and some – ill defined quality called maleness" (p. 67).

Socialisation

Introduction

Socialisation is defined by Durkheim (cited in Ritzer, 1992) as "the processes by which the individual learns the ways of a given group or society – by acquiring the physical, intellectual and moral tools needed to function to society" (p. 101). The concept of socialisation will be specifically utilised in this dissertation to examine how society portrays male gender practice. This analysis illustrates how society's expectation and roles have lead to a construction of masculine practice towards health.

Defining Masculinity

During the past century, the literature (Connell, 1995) indicates that researchers have had a complex task in understanding the term masculinity as a single phenomenon. As a result, masculinity has become difficult to define. The result of a difficulty in defining masculinity as a single phenomenon has led researchers to examine this term under cultural specific contexts. This was evidenced by Connell (1995) who asserted "masculinity is a recent historical product, that looks at gender in a culturally specific way" (p. 68). Due to the cultural specificity of masculinity, four main strategies have been established in an attempt to define this term under specific cultural contexts. The four strategies are essentialist, positivist, normative and semiotic methods.

According to Buchbinder (1994) an essentialist perspective towards defining masculinity argues that masculine and feminine traits are innate in all individuals. Thus to examine masculinity, this perspective usually "picks a feature that is core of masculine, and hangs an account of men's lives on that" (Connell, 1995, p. 68). A positivist argument to defining masculinity however, is based purely on gender. As such masculinity is the term given to a pattern of men's lives in any given culture. A normative perspective inturn argues that, masculinity is the social norm for the behaviour of men. This perspective of masculinity recognises the difference between the genders, illustrating how men ought to be. Finally, a semiotic definition to masculinity is based on " a system of symbolic differences in which masculine and feminine places are contrasted – thus masculinity is in effect, defined as not femininity" (Connell, 1995, p. 70).

The four approaches discussed above to examining masculinity have led researchers to illustrate that there is no one clear definition. Although there is no specific definition, these approaches illustrate there is the "need to focus on the process and relationships through which men conduct gender lives" (Connell, 1995, p. 71). This quote emphasises that the key to examining masculinity understands that this term arises in a system of gender – relations.

> "Masculinity, is simultaneously a place in gender –relations, the practice through which men engage that place in gender, and the effects of these practices in bodily experiences, personality and culture" (Connell, 1995, p. 71).

Australian Masculinities

Masculinity is a key concept that is used within the Australian culture to analyse the position of men as constructed by society. An historical analysis of masculinity allows an understanding of how masculinity has been constructed to understand the role of men in society within a cultural context.

The dominant European identity of man emerged, "when Australia was a pioneer society and was faced with the difficulties and problems of colonisation, in a country which appeared harsh and tough by European settlement" (Tacey, 1997, p. 29). The identity of masculinity that emerged was based on an imagery of men working on the pastoral landscape of the continent, and was central to the notion of mateship, rebel bushrangers (Ned Kelly) and bush – men turned soldiers who fought in Gallipoli. Thus the construction of the Australian identity of masculinity, based on the perceived nature and features of the physical environment, was born: "the self – sufficient, egalitarian, bronzed man of ANZAC legends" (Connell, Schofield, Walker, Woods, Butland, Fisher, et al, 1998, p. 62).

Urbanisation further illustrated how masculinity was constructed in Australia. The result of urbanisation saw class inequalities emerge around cities. High-class people were separated from other classes, resulting in these people holding prominent positions in society. As such the construction of masculinity being associated with power and authority by holding powerful positions was born. The notion around the role of women in society was formed,

in that women should not have to financially support the family, rather this was a job that males should fulfil.

This division of labour structured both jobs and leisure activities suitable to men. Masculine jobs developed, "providing a vast area of men's work (labourer) and a masculine hierarchy" (Connell, Schofield, Walker, Woods, Butland, Fisher, et al, 1998, p. 62). Masculine activities were established including drinking at a young age, engaging in physical contact sport. This construction of sport as showing masculine activities "symbolises competitiveness between men, a key symbol of masculinity in Australian culture" (Connell, Schofield, Walker, Woods, Butland, Fisher, et al, 1998, p. 62).

The era of immigration in the 1950s saw a new perspective towards masculinity, brought to the Australian continent by the Greeks, Italian and later 1970s, Vietnamese. The result of the influx of immigrants to Australia lead to differing masculinities emerging within the Australian culture. Furthermore, homosexuality emerged as a separate masculinity to the traditional heterosexual beliefs of men, illustrating differing masculinties emerging in Australia.

The 1970s and the beginnings of the second wave of feminism challenged the domination of men over women. The result of the challenge of the feminist movement has led to many men being under pressure from society to change their view about masculinity.

Framework For Examining Masculinity

The essence of discussing the historical context of men's portrayal in Australian culture illustrates that masculinity is constructed according to the cultural context. According to Connell (1995), the emergence of masculinity in cultural contexts is known as masculinity arising through a system of gender – relations. As such masculinity constructed upon gender – relations illustrates how masculinity is structured through a reproductive arena – that is, how gender practice is formed, based on societal expectations of what the male gender is able to do. In essence, masculinity is used in a culturally specific context to understand actions of men resulting from society expectations of gender practice.

There are numerous ways in which society's expectations can structure gender practice. Three areas that highlight how the process of gender practice can be established is through the individual, culture and institutions.

One way to understand gender practice is through an analysis of the individual. This analysis of practice examines each person's personality or character. Thus, this argues that how individuals construct masculinity depends upon their personality. Culture is also used to discuss how society can establish gender practice. This illustrates that " gender is organised in symbolic practice that may continue longer that an individuals life " (Connell, 1995, p. 72). This argues that the establishment of masculinity in a cultural context can be structured in the historical context of society.

Finally, institutions through the avenues of the state (Tolson, 1977), schools (Browne & Fletcher, 1995; Mac an Ghaill & Haywood, 1996) and work (Hoyenga & Hoyenga, 1993) are examples of how gender practice may also be constructed within society. For example masculine constructs can be established within the state through men holding top positions within institutions. This argument illustrates that in men holding top positions of society, results in the occurrence around "gender practice of promotion, internal division of labour and systems of control, policy making and practical routines, and ways of mobilising pleasure and consent" (Connell, 1995, p. 73).

In examining the areas of the individual, institution and culture, gender practice of masculinity are effected by the social context of society. Thus the social environment constructs how gender is considered, the effects of gender and the power of gender. However, the social environment also has strong implications on the analysis of masculinity in relation to the concepts of race and class. Thus, masculinity must be analysed as a whole system, comprising other social structures – social context.

Different Masculinities

The examination of race and class within the construction of masculinity illustrates multiple masculinities occur within society and include black versus white or working class versus middle class. Recognising multiple masculinities allows for an "analysis and explanation of how the dominant form of masculinity (hegemonic) retains its power amongst men in society" (Connell, 1995, p. 74). Four key perspectives that help explain how the dominant form of masculinity retains its power are understood through the concepts of hegemony, subordination, complicity and marginalisation.

Hegemony refers to "the cultural dynamic by which a group claims and sustains a leading position in social life, where at any one given time, one form of masculinity rather than another is culturally exalted" (Connell, 1995, p. 77). Hegemony argues that masculinity is the commonly accepted view of the domination of men over women. Inturn, subordination occurs towards males in the area of sexuality that is relating to the domination of heterosexuals over homosexuals. As a result of such subordination, homosexual males are symbolically expelled from the hegemonic masculinity.

Complicity on the other hand is an area that explains how the dominant hegemonic masculinity is able to retain its power in society. Men engage in masculinity through activities that "allows their masculinity to be constructed in a way that realise the patriarchal dividends between men and women, without the tensions or risk of being the front-line troops of the patriarchy" (Connell, 1995, p. 79). The activities illustrate that men are complicity with the sense of patriarchal dividends between men and women, allowing a hegemonic masculinity to dominate.

Finally, the concept of marginalisation examines the issue of how different masculinities are constructed in society. The area of marginalisation highlights how areas such as race and class, separates people from dominant masculinity, in order for the hegemonic masculinity to retain its power over men.

The four concepts of hegemony, subordination, complicity and marginalisation highlight how the dominant masculinity retains power over men in society. An examination of masculinity centred on gender practice needs to be focused in the context of the social environment. The

four concepts illustrate the importance of recognising multiple masculinities existing in society. This allows one to recognise that is unrealistic to explain masculinity within society using gender as a single concept. It is important to recognise that in order to understand the construction of masculinity, one must go beyond the concept of gender to recognise other socially constructed issues such as race and class that are used to construct a position of multiple masculinities in society.

Masculinity and Health

Although there are multiple masculinities within Australian culture, the notion of a dominant masculinity appears to exist. An examination of health highlights that the dominant masculinity plays an important issue in the construction of male behaviour. One issue that constructs masculinity with health relates to the way men are portrayed within the public domain. Generally, masculinity requires males to be in the public domain, that is "as breadwinners, competitors, aggressors, or defenders" (McGrane & Patience, 1993, p. 37). It is this stereotype of masculine behaviour that is evident within the Australian culture that results in many health issues arising for men.

The construction of the work force as a hierarchical structure has an effect on men's health. The stereotype constructed by society is that men are breadwinners in society, which results in men working away from home or trying to climb the corporate ladder. As a result, "the process of making masculinities (doing gender practice), result in certain health issues (accidents, violence, stress) to rise" (Connell, Schofield, Walker, Woods, Butland, Fisher, et al, 1998, p. 60). The acceptance of men engaging in certain activities also has a detrimental effect on their health. Participating in competitive sport may result in health issues occurring.

These health issues include injuries, which are a result of participating in activities that may be considered aggressive, violent or physical.

A further construction of the attitude in Australian culture that has an effect on men's health relates to physical appearance and performance of men (Connell, 1997). One example of men affecting their health to perform relates to the issue of anabolic steroid use. Drugs are used in sport to "produce physical power and aggression in order to win" (Connell, Schofield, Walker, Woods, Butland, Fisher, et al, 1998, p. 61). This example of men engaging in high-risk behaviour to achieve competitiveness may be a result of meeting society's expectations of the male role.

Cognition

Introduction

> "Since the beginning of recorded history people have expressed curiosity about the operation of the human mind, largely because they believe that behaviour, particularly voluntary action, is a result of mental processes" (Ellis & Hunt, 1993, p. 2).

The above quotation highlights that individuals have a curiosity in relation to examining human behaviour. The fascination in knowing how the human mind influences people's

understanding and behaviour within their environment, that has led to the development of the field known as cognitive psychology. It is through such a field of analysis that allows for an examination of the thoughts and process in men's understanding of health.

There are many definitions of Cognitive Psychology, one such definition by McWalters (1990) is "the mental act or process by which knowledge is acquired" (p.135). In contrast Bourne and Russo (1998) define cognitive psychology as "the sum total of knowledge and skills, put to use for the purpose of thinking, categorising, abstracting, reasoning, problem solving, organising, planning and deciding what to do" (p. 258). Although there are many differing definitions, for the purpose of this dissertation, Cognitive Psychology will be used to analyse men's reasoning for behaviour This reasoning of human behaviour is a process that allows one to "generate and evaluate situations, and inturn, reach conclusions" (Lefton, 1997, p. 244).

The key to cognitive psychology is that mental processes play a fundamental role in the psychological functioning of human behaviour. The ability to "deal systematically with personal, social and world wide problems in a way that by passes trial and error" (Bourne & Russo, 1998, p. 258) [*My underlying*]. This ability to understand the way humans deal with their environment in a systematic manner, both by utilising and ignoring certain stimuli as knowledge for engaging in behaviour has interested psychologists over the last half of the twentieth century.

Historical Developments of Cognitive Psychology

The emergence of cognitive psychology began around the early 1960s. Prior to the 1960s, the different schools of thought that have dominated the field of psychology have constructed the study of the human mind. These schools of thought initially began in 1878 with the work of Wilhelm Wundt and since has included a structuralist, behaviourist and neobehaviouralist approach to examining the human mind (Ashcraft, 1994). Such techniques utilised by the differing schools of psychology to examine the human mind include human memory recall and examining observable behaviour. It wasn't until the 1960s that three significant events occurred that lead to the structure of the human mind through cognitive analysis. These events were:

1) The work of Noam Chomski and his continued criticism of behaviourism,
2) Research into the area of verbal learning, and;
3) The relevance of computer machinery as an approach to understanding the human mind.

Noam Chomski: Chomski's studies in 1959 criticised the behaviourist position that unobservable mental processes occurring within the brain could not explain human behaviour. Chomski believed that mental processes occurring in the human brain governed language and argued that "humans follow rules when they generate language - rules that are stored in memory, rules that imply mental processes" (Ashcraft, 1994, p. 32).

Verbal learning: Research conducted into the area of verbal learning and its implication to memory recall led to the emergence of cognitive psychology. Tulvin and Sperling, 1960 (cited in Ashcraft, 1994) assert "when words to be learned were unrelated, subjects were still able to recognise them, a strategy of recall that was clearly coming from within the organism" (p.33). This study highlighted that when asked to recall verbal words, mental processes were occurring within the human mind.

Computer Technology: A third and final development that led to the emergence of cognitive psychology was the computer. This link between a computer and the human mind was governed by the notion that "computers take in information, do something with it internally, then eventually produce some observable product" (Ashcraft, 1994, p. 33).

The analogy of the human brain to the way a computer operated was central to the work of Newman & Simon in 1958. According to Newman and Simon, the human brain is a "symbol - manipulating machine, where its operations involved interpreting the symbols fed into it, and then performing the operations that those symbols specify" (Ashcraft, 1994, p. 33). It was this analogy that argued the link between the computer and the human brain, allowing for a study of the mind as a tool for understanding human behaviour.

Assumptions of Cognitive Psychology

There are three primary assumptions that guide research within the field of cognitive psychology. These assumptions are:

1) Mental processes exist

2) Humans are active information processors

3) Mental processes can be revealed by time and accuracy measures

Mental Processes: The single most important feature is that humans possess mental processes and "they are lawful systematic events, which can be studied systematically" (Ashcraft, 1994, p. 34). This position is in sharp distinction to the viewpoint held by the behaviourist perspective.

Active Information Processors: A second issue relating to the assumptions of cognitive psychology is that humans play an active role in their behaviour and thought. Cognitive psychologists argue that "humans actively process the environment stimulus around them, selecting some of that environment for processing, relating those selected parts to already known information in memory, then doing something as a result of this processing" (Ashcraft, 1994, p. 35). This perspective illustrates that people act on their mental processes, that is, they think about the activity, situation, stimulus, and then respond accordingly.

Time and Accuracy Measures: A final assumption is that mental processes are measured on reliable and objective measures. These measures are "quantifiable, open to scientific scrutiny and easily relocated" (Ashcraft, 1994, p. 34). Time and accuracy are the two notable measures used to examine human behaviour. The time that elapses between a stimulus and a subsequent response allows for an analysis of the mental processes occurring during this period. In comparison, accuracy allows researchers to examine mental processes occurring when a subject's responsive behaviour to a stimulus is incorrect.

Theoretical Application

Many theories have been developed to explain the mental processes that occur when an individual engages in behaviour. There are many theories that argue differing perspectives to explain the role of the human brain when analysing human behaviour.

Kelly (1963), Goldstein (1986), Werner (1982), Frankl (1969) and Lantz (1978) constructed notable theories that were derived to analyse the human thought process. The two theories examined involve an analysis of the work produced by Howard Goldstein and George Kelly.

George Kelly: One psychologist to theoretically suggest that cognitive processes play a fundamental role in understanding human behaviour was George Kelly. Kelly (1905 – 66) developed the Personal Construct Theory. The fundamental assumption of Kelly's theoretical framework is that in "making sense of the world and what it means to be a person, is the basis that underpins all of what constitutes their behaviour and experiences" (Atkinson, 1996, p. 50).

According to Kelly, the key to understanding how people make sense of their world is that each person must be seen as an individual. In order to understand behaviour, Kelly (cited in Pervin, 1990) asserts "individuals perceive events according to already existing structure, and behave in relation to their interpretation of the events"(p. 224).

Kelly's theory views each human being a scientist, which is based on the notion that each person uses constructs to guide behaviour. As Kelly (cited in Pervin, 1990) asserts "people experience events, perceive similarities and differences amongst these events, formulate

constructs (interpreting and categorising events) to order phenomenon, and on the basis of these constructs, seek to anticipate events" (p. 229).

The essence of Kelly's Personal Construct Model is based on the framework that personal constructs are central to understanding an individual's behaviour.

> "To understand a person's cognitive process, one must know something about the constructs the person uses, the events submerged under these constructs, the way in which these constructs tend to function, and the way in which they are organised in relation to one another to form a system" (Pervin, 1990, p. 234).

Only by knowing the constructs people use to interpret their social world, may one start to understand future behaviour. It is this notion of people developing personal constructs that Kelly examined how to understand human behaviour. This is evident as according to Kelly, these constructs help guide future behaviour. As Kelly (1963) asserts:

> "it is the future that tantalises man, not the past" (p.53).

Howard Goldstein: Howard Goldstein has also constructed a theory to understand human behaviour. Goldstein developed his theory as a framework to increase understanding of why humans behave in a certain manner when faced with social experiences.

Goldstein also argues that each person must be viewed as an individual. As asserted:

> "any one particular event in life does not present itself in a uniform or finished manner, each of us will attend to this event in a somewhat different way, that is, how each of us think about the event will be governed by different meanings placed on the event that arises out of prior experiences in history" (Goldstein, 1986, p. 34).

Goldstein's position regarding mental processes affecting human behaviour can be expressed through the view that people place meaning on events. This meaning is governed by thoughts based on previous experiences from the surrounding environment. According to Goldstein, this prior experience and knowledge helps individuals place meaning and structure to what they "believe, know and can explain" (Goldstein, 1986, p. 37). Three mental strategies people use to structure meaning about their environment are attention, thinking, and interpretation.

Attention: Attention refers to "the way people perceive things" (Goldstein, 1986, p. 38). Goldstein argues attention is central to how individuals interpret their environment. Individuals interpretations of their world are based on the notion that they both accept and ignore stimuli from current experiences based on their understanding of previous life events. The ability to understand what others are receptive to within their environment allows for an analysis of human behaviour.

Thought: The argument that people use metaphors to guide thinking assists Goldstein to understand and explain an individual's behaviour. Metaphors are the "concepts and symbols that people use to explain themselves" (Goldstein, 1986, p. 40). The ability to understand the concepts and symbols individuals use to put meaning to stimuli within their environment, allows one to understand a reason for behaviour.

Interpretation: Another mental process that people use to express behaviour, according to Goldstein is the way people interpret stimuli within their environment. That is "the mind searches for order and meaning by transforming seemingly random experiences of living into patterns that are personally and socially comprehensible" (Goldstein, 1986, p. 42). It is this ability of the human mind to interpret previous life experiences by placing meaning to stimuli that guide behaviour.

An analysis of both Kelly and Goldstein's work highlights two theoretical perspectives to explain human behaviour. These two theorists argue differing positions to understand behaviour, indicating there is no conclusive way to articulate human behaviour. The work of Kelly and Goldstein allows one to build a conceptual framework about mental processes within the human mind, which are the principal determinants of behaviour.

Chapter Conclusion

The essence of this chapter has been to provide a theoretical framework to help explore how men understand the concept of health and how this understanding shapes health actions. This theoretical framework has been structured around a detailed examination of the concepts of health, socialisation and cognition. The concept of health has been discussed within the framework to illustrate why men's health is an important area of research. This has allowed for an in-depth analysis into how men's health has been discussed in Australia both at a national and state level, and how the WHM framework should not be used as a template to structure the concern's surrounding men's health issues. The concept of socialisation has also been examined as an important aspect of the theoretical framework used in this dissertation.

Socialisation has examined how society portrays gender practice. This analysis illustrates how society's expectation and roles have lead to a construction of a masculine practice towards health. This analysis of masculinity has involved providing a framework to understand masculinity, illustrating differing masculinites emerging in their cultural context and giving a historical overview of how masculinity has been constructed with the cultural context of Australia.

Finally, cognition is also used within the framework to understand thoughts of human behaviour. Cognition has been examined through discussing the historical developments and assumptions of cognitive psychology, together with illustrating Kelly and Goldstein's theoretical applications towards explaining future behaviour.

The theoretical framework, guided by the concepts of health, socialisation and cognition are used in order to explore how men understand health and how this understanding shapes actions.

Chapter 3 will present the results of this dissertation.

Chapter 3 – Research Inquiry

Introduction

This chapter is divided into six sections. The first four sections: 1) epistemology, 2) theoretical perspective, 3) methodology, and 4) methods are based on the work of Crotty (1998). Section five discusses the ethical considerations, while section six examines the limitations of the study. These six sections are to be used as a framework to guide the reader throughout this chapter.

Epistemology

Epistemology is primarily concerned with "providing a philosophical grounding for deciding what kinds of knowledge are possible and how we can assure that they are both adequate and legitimate" (Crotty, 1998, p. 8). It is through an epistemological grounding that the research is able to guide the theoretical perspective through the philosophical understanding of how people arrive at knowledge.

The epistemology that will be used to guide the methodology is constructivism. Constructivism argues that human knowledge is based on the view that "meaning is not discovered but constructed – meaning comes into the existence in and out of our engagement with the realities of the world" (Crotty, 1998, p. 8). This illustrated the notion that people assign meaning in different ways, even in relation to the same phenomenon. That is, "meaning is constructed by human beings as they engage with the world that they are interpreting" (Crotty, 1998, p. 43).

Constructivism is used as a philosophical underpinning of the research as it allows for the examination into how men construct their own perceptions of health within their environment.

Theoretical Perspective

A theoretical perspective is the "philosophical stance informing the methodology and thus providing a context for the process and grounding its logic and criteria" (Crotty, 1998, p. 3). The theoretical perspective that will be used for this study is symbolic interactionism.

The essence of symbolic interactionism is to allow the researcher to understand the "basic social interaction whereby we enter into the perceptions, attitudes and values of a community, becoming persons in the process" (Crotty, 1998, p. 8). This theoretical perspective focuses upon the other individual and on the interaction with their thoughts and environment. Thus symbolic interactionism is concerned with "fully explaining individuals' particular decisions and actions and with demonstrating the impossibility of explaining these by predetermined rules and external forces" (Wallace and Wolf, 1980, p. 198)

Symbolic Interactionism originated from the work of Herbert Blumer (Blumer, 1969). Blumer argued that there were four key concepts that were central to the notion behind symbolic interactionism. These perspectives were the self, self –interaction, development of self and symbolic meaning.

The self is "an acting organism, not as a passive receptacle that simply receives and responds to stimuli" (Wallace and Wolf, 1980, p. 193). That is, the self can guide and act on its environment. Self – interaction also plays a role in the symbolic in that people can analyse behaviour through internal conversations. According to Mead, the "internal conversations one has with oneself are essential because they are the means by which human beings take things into account and organise themselves for action" (Wallace & Wolf, 1980, p. 196). Through the processes of internal conservations for future actions, one is rehearsing for the preparation to understand the role of others.

The development of self is a concept used by symbolic interactionists to illustrate how people understand others through meaning. Meaning is "when different attitudes and use of significant symbols have the same input to all concerned" (Wallace &Wolf, 1980, p. 198). Finally, symbolic meanings are significant within symbolic perspective for explaining another's reason for decisions and actions. Symbolic meaning through symbols "allow the same meaning for all individuals of a given society – they respectfully arouse the same attitudes in the individuals making them as they arouse in the individual responding too them" (Wallace & Wolf, 1980, p. 200).

It is through the use of symbols that allows one to be able to interpret or define each other's actions. Although symbols allow the same meaning for individuals within a society, the recognition of differing masculities existing within society's results in individuals attributing different meanings to symbols.

From these four fundamental perspectives, assumptions have emerged in the symbolic interactionism perspective to address the importance of meaning in human behaviour, the source of meaning and the role of meaning during interpretation. The three central assumptions to symbolic interactionism, summarised in Denzin and Lincoln (1994) are

1) Human beings act toward things on the basis of meaning that they have for them,
2) The meaning of things arise out of the social interaction one has with ones fellows, and;
3) The meanings of things are handled in and modified through an interpretive process used by the person in dealing with the things they encounter.

1) Human beings act toward things on the basis of meaning that they have for them: Guiding this first assumption within symbolic interactionism is that consciousness is vital in understanding the processes of future action. "Individuals designate differing objects to themselves, give them meaning, judges their suitability to act, and makes decision on the bases of this judgement"(Wallace and Wolf, 1980, p. 204). It is based on this process that people give meaning to future events or objects. That is, "people engage towards things on the basis of meaning the things or objects have for them, due to the process they give meaning to or make conscious of" (Wallace & Wolf, 1980, p. 204).

2) The meaning of things arise out of the social interaction one has with one's fellows: The essence of this assumption is that meaning for an individual is based on a social context. This illustrates that "the meaning of a thing for a person grows out of the way in which other persons act towards the person with regards to the thing" (Wallace & Wolf, 1980, p.

205). That is the meaning that arises for an individual is based on the interaction with others in society.

3) The meanings of things are handled in and modified through an interpretive process used by the person in dealing with the things they encounter: This final assumption for symbolic interactionism argues that humans are able to handle meaning through the process of internal conversation. That is, "the process of internal conversation people arrive at a making decisions" (Wallace &Wolf, 1980, p. 206). This assumption focuses on the indicators one makes to oneself through the internal conversation that allows one to come to a decision to interact.

The application of symbolic interactionism is utilised as the form of research inquiry to explore how men understand the concept of health and how this understanding shapes health actions. This theoretical perspective is used to understand how participants construct an understanding of health and how they utilise this understanding towards health management.

Methodology

Crotty (1998) sees methodology as "the strategy, plan of action, process or design lying behind the choice and use of particular methods or linking the choice and use of methods to the desired outcome" (p.3).

Exploratory and inspection techniques informed the design of the methodology used to guide this study. This methodological approach was used to examine the "process by which

individuals both define the world from the inside and at the same time identify their world of objects" (Wallace & Wolf, 1980, p. 214).

The use of exploratory design allowed the research to analyse the social world of the individual. This analysis allowed for more information to be established for a better understanding of the individual and how they interpreted their world. An inspection technique to inform the design of the methodology allowed the researcher to move away from the descriptive account of the study to analyse the context. This allowed the researcher to analyse how the individuals use information to understand their social world.

The reason for the methodology of exploratory inspective design for this study was based on the desire to explore how men understand the concept of health and how this understanding shapes action / inaction. Each of the two methodological approaches described above allowed the researcher "to get close to the empirical world of the individual and dig deeply into it" (Wallace & Wolf, 1980, p. 215).

Methods

The methods section in this study is to illustrate the "techniques or procedures used to gather and analyse date related to the research questions" (Crotty, 1998, p. 3). This methods section will be divided into four areas: 1) Entry into Sample, 2) The sample criteria, 3) Data Collection, and 4) Data Analysis

The study involved interviewing University men about how they understand the concept of health and how this understanding shapes health actions.

Entry into Sample: Entry into the sample population was generated through knowledge of students at University. This research project was initially raised to possible participants during casual meetings with fellow students. Students were then approached on an individual basis and informed about the research in greater detail. Students also discussed their concerns about participating in the study. Subsequent time was then given to possible participants in order for them to decide whether to be part of the study.

The Sample Criteria: The following criteria for subject selection was specified:

- Subjects were male,
- Subjects were eighteen years or older,
- Subjects attended Edith Cowan University, Bunbury,
- Six students approached the researcher showing interest in participating in the study, and;
- No person was rejected from participating in the research process.

Data Collection: This data collection section will be sub divided into four sections. These areas include 1) First meeting, 2) Instrumentation, 3) The Interview, and 4) Transcript.

After talking to students on an individual basis, men further interested in participating within the research initiated personal contact with the researcher. This initial contact allowed participants the opportunity to question the researcher and seek information about issues such as confidentiality. The process outlined during this consultation was that there would be two

points of contact: 1) First meeting and 2) A tape-recorded interview. The original tape would be destroyed, kept in a securely locked cabinet by the researcher or become the participant's property at the end of the research process. A date and time was arranged for the first meeting of six future participants.

First Meeting: This initial meeting was arranged with students so they could discuss their thoughts and issues regarding participation in the research prior to the interview being recorded. The research informed the participant that if he had any difficulty in the proceedings of the research interview, he could withdraw. It was in-turn stipulated to the participant that if he di ntinue to proceed with the interview he could still withdraw at any time. In each of these cases, this first meeting occurred at a neutral venue – coffee shop, University grounds.

Instrumentation: The interview schedule was based on a semi-structured interview schedule consisting of two specific areas: 1) socio – demographic details, and 2) five broad questions relating to the essence of the research study (Appendix A).

The socio – demographic details covered the participant's age, length of time at University, course being studied, marital status and place of birth. These were the initial questions the researcher asked. These questions were asked to both gather information and to ease the participant into the interview process.

The five broad questions were open-ended, which were outlined in the data analysis section of this dissertation. The researcher asked differing in-depth information to individual participants as these questions were based on responses given. This technique allowed the

researcher to have a more conscious understanding of how the participant understood and interpreted the scope of the research.

The Interview: The interview occurred after the initial meeting where a time and place was mutually agreed between researcher and participant. The location of the interview was conducted either on the University grounds or in the setting of the participant's home. Prior to the commencement of the interview, the participant both read the information sheet (Appendix B) outlining the essence of the research and signed a written consent form (Appendix C).

Transcript: The tape was transcribed verbatim. Reference to issues such as background noise, intensity of voice, emotional tone and non-verbal communication was not recorded within the transcriptions. The transcriptions were forwarded to each participant.

Data Analysis: The data analysis strategy used for this research was qualitative. This qualitative strategy involved the process of theme identification, ie symbols used by participants to explain and discuss health understanding and actions.

The participant's responses were analysed according to the five key questions of the research.

These questions included:

- How do men understand the concept of health?
- What factors shape this understanding of health?
- How do men locate themselves on a continuum of health / non –health?
- What factors shape this location on the continuum?

- How does men's understanding of health shape the way they manage their health?

Reliability and Validity provide the benchmark to measure data analysis. According to Lincoln and Guba (1995), the key concept to providing reliability and validity in qualitative research is trustworthiness. This concept of trustworthiness can be established through four terms. These four terms are credibility, transferability, dependability and conformability.

Credibility: The essence of credibility (internal validity) can be established within qualitative research through many processes informing the data analysis. Credibility is gained in this study through this process of referential adequacy. This technique refers to the researcher "surrendering raw data to the archives of the study" (Lincoln & Guba, 1985, p. 313). This is established within this study as the researcher utilises responses given by participants as a form of data analysis.

Transferability: Transferability (validity) requires the researcher to "provide a data base that makes transferability judgements on the part of the potential appliers" (Lincoln & Guba, 1985, p. 316). The method applied during this study to achieve transferability included the analysis of participants' responses through the method known as 'thick description'. This method involved analysing the context and circumstances that participants described in their responses to interview questions.

Dependability: Dependability in qualitative research involves the establishment of reliability. This study met the criteria of reliability by the researcher continually questioning the process

of the study. This continual examination of the research process allowed the study to meet ethical considerations.

Conformability: The issue of conformability (objectivity) was also established within the research. The use of recording information both by machine and written presentation (transcripts) informs conformability within the research. This is possible, as such reference to recorded information has produced an audit trail stemming from the inquiry, results in the ability to cross reference and systemise the data analysis.

Ethical Considerations

An ethical consideration for this study was protecting the participants from potential harm. According to Kidder & Judd (1986) "human reaction to stress and behaviour under stressful conditions may induce a wide variety of unpleasant emotional states for a participant" (p. 482). The sensitive nature of the study topic emphasises the vulnerability of participants to potentially harmful emotional issues when discussing their perceptions and understanding of health. The structure of the research process allowed the participants to have maximum control over discussing such issues. Informing the participant that they could withdraw at any time, together with allowing participants adequate time to respond to questions, sought to maximise control for participants.

The issue of confidentiality was also a major ethical consideration for the study. This was an issue given the sensitivity of the topic and the depth of information discussed during the interview. Methods were utilised within the study process to identify the participant's request for confidentiality. The nature and methodology used within the study was used in order to

conceal the identity of participants. No names or possible information identifying participants were used in this analysis process. This process of data analysis, through using participant numbers (1-6) enables the concealment of participant's identity, but allows participants to identify their contribution within the final research project.

The issue of the participant requesting knowledge of the true nature of the research topic was an ethical consideration for the researcher. According to Kidder & Judd (1986) withholding information about the research in which a person consents to participate is a questionable process" (p. 470). The issue of sensitivity and analysis of the research topic emphasises the vulnerability of the participant. The research utilised methods to inform the participant of the study. Participants were given an information sheet prior to the commencement of the interview outline the purpose of the study, together with the knowledge that they could ask any questions about the study prior, during or at the completion of the research process.

Limitations

Due to the paucity of knowledge in the area of men's health, and how men understand and act towards this issue, it is only possible to speculate that there are two populations. These two populations include an active population of men who want to discuss and talk about their understanding of health and an inactive population.

Further limitations of this study are that the researcher knew the participants and they were selected from a University background. This limitation indicates that answers given by participants may have been based on a collaborative or shared understanding of the topic. The

researcher may have failed to explore deeply into the answers given by participants due to researcher and participant having a shared understanding of the responses.

A further limitation of the study was utilising five broad questions to structure a symbolic interactionist approach into how men understand the concept of health and how this understanding shapes health actions. A symbolic interactionist process to structuring an interview process in order to explore and analyse participant's understandings of their social world, may have been more open, and not structured according to five questions. Thus the five broad questions may have guided the participant responses, and not given them adequate opportunity to talk about health as they structure it according to their interpretation of the social world.

A further limitation with this study is in relation to the topic of focus. It appears that there has been no previous research into the area of how men understand the concept of health and how this understanding shapes health actions. This apparent lack of previous studies within this area has limited resources for this analysis of university students.

A final limitation of this study relates to the knowledge base and time opportunity that was available to the researcher. Inexperience on behalf of the researcher may have resulted in only utilising university students as participants for the study. Furthermore, increased time available to the researcher may have resulted in pursuing further the discussion with the participants to fill in or add to their previously provided information.

Chapter four will present the results of the study by identifying the notable themes that emerged from the transcripts.

Chapter 4 – Results

Introduction

This chapter presents a description of the results regarding how men understand the concept of health and how this understanding shapes health actions. The results will be presented in a qualitative format, resulting in analysing themes that emerge from the interview transcripts. In order to explore men's understanding of health and how this understanding shapes health action transcript quotations will be used to present the data.

The responses provided by the participants were a result of the five questions that were used as the 'guiding tools' during the interview process. These questions were:

1) How do men understand the concept of health?
2) What factors shape this understanding of health?
3) How do men locate themselves on a continuum of health / non-health?
4) What factors shape this location on the health continuum?
5) How does men's understanding of health shape the way they manage their health?

The amount of time participants spent answering each question varied. Participants discussed answers to questions in length, resulting in each interview lasting approximately 30 minutes. Further questions emerged from the participant's responses, resulting in a semi – structured interview format.

Participants were eased into the interview process by responding to demographic questions, before proceeding into a discussion about how they understood the concept of health. From the interview transcripts, the researcher interpreted that participants discussed health as being positive, that is in terms of being happy, having a healthy body, trying to keep fit due to undertaking exercise, or as a whole package of the body being able to function and operate. A 31 yrs old participant who appeared to be easy going, family oriented, and had a holistic approach to life captured the concept of health as a whole package. In response to the question what health meant to him, this participant asserted:

> 'Health means a number of things, being physically fit is one of them. Health is also in the mind and spirit as well. Having a healthy mind is seen as the complete package..., you can be physically fit but if your mind or spirit is not fit, then you are not going to do as well as you can. I see health as the whole package that make up the human body' (Participant 5)

It was this understanding of health as comprising the whole package of the human body, that a number of participants were able to illustrate their positive perception about health. It was through the participants' understanding of health that appeared to structure their responses to the following question within the interview.

To provide a picture of how men understand the concept of health and how this understanding shapes actions, major themes were derived from the interview transcripts. Five themes that emerged from the transcripts were 1) Family / Friends, 2) Personal Experience, 3) Exercise, 4) Food, and 5) Seriousness of concern. These were the major themes that emerged from the transcripts, as they were repetitive throughout participant's responses.

Family / Friends

The theme of family / friends emerged in a number of responses provided by the participants to the questions within the interview. The responses using this theme ranged across differing contexts during the interview. This theme emerged in relation to the factors that had influenced participants' understanding of the term health. Many participants illustrated that their understanding of health was based on factors such as people from their childhood. This was noted in a response made by a 24-year-old who appeared to be very relaxed, inactive and influenced by his mother:

> 'I think I've learned most about health issues from my parents, you know we learn health issues from them. I guess the reason for this is that my mother's a nurse and she is always talking about good health sort of things, you know like not smoking' (Participant 1)

This response made by the participant illustrates that family members may impact on men's understanding of health. Further responses which illustrate that family structure during childhood may impact on men's conception of health was made by a 40 year old, who appeared very relaxed in life and had a strong interest in his family. This participant asserted:

> 'I suppose my understanding of health is a result of living with old relatives when I was young. Chronic coughs, heart problems or injuries related to work. As result, I see health as an avoidance of pain, rather fitness is related to health. I see fit people as health, you know, trying to keep as fit as possible.' (Participant 4)

A similar response was made by a 20 yr old in describing factors that lead to his perception of health. From the interview it appeared that this participant was very active, interested in sporting activities and having a healthy masculine figure. When questioned about his perception of health, this participant asserted:

> ' My understanding of health relates to issues of personal health. I know that as I get older I will get different sicknesses than now. You see, I have watched throughout my childhood how my mates / friends have changed as they get older. And my parents as well, they have had health problems as they get older, like HBP and other conditions. This is why I think health is related to having a healthy body'
> (Participant 2)

The theme of family / friends also emerged in the context of participants discussing how they manage their health. Participants described the management of health as a result of issues occurring towards friends or family. The perception of participants providing examples about a close family member and their health issues was discussed in their concerns about possible future health issues. One response included:

> 'Yeah I have to say that I do care about future health concerns. My uncle has just had his prostate removed. That is concerning for me, as well genetics ... HBP and stroke are the two big ones in our family. I do check my blood pressure in a regular interval to make sure it is at a safe level' (Participant 1)

The emergence of family / friends in responses provided by participants illustrates that such people help to construct and influence the management of health issues. Participants

continually refer to childhood experiences and knowledge about family health concerns as impacting on their understanding of health, together with their health actions. This may appear to indicate that participants describe health as being positive, was a result of conceptualising a view of 'unhealthy' from issues and experiences during childhood.

Personal Experience

Personal experience emerged as a theme when participants responded to how they understand the concept of health and how this understanding shapes health actions. Personal experience emerged in participants' responses in a number of differing issues throughout the interview. Personal experience was discussed in relation to factors influencing men's understanding of health. Participants supported the conceptualisation of their understanding of health by referring to and giving examples of situations they had previously experienced. A 36-year-old participant who appeared to have an holistic approach to life circumstances, easy going and sensitive, responded:

> 'How I understand health has been shaped by personal experience. I've been physically healthy as medically wise goes.... I think mentally, I have been stressed or ill and overwhelmed, depressed, etc.... You don't feel healthy even though you are in body. Spiritually, I think you have to have some sort of belief system in place. That is why the term health means to me when all 3 (mental, physical, spiritual) come together' (Participant 6)

The issue of personal experience appeared to have a major impact on how participants conceptualised their understanding of health. Participants were able to reflect on personal experience that had influenced their understanding of health.

The concept of personal experience was also raised as participants discussed how they managed their health concerns. Personal experiences regarding health issues enabled participants to describe examples that have influenced the way they manage their health concerns. One example of how participants managed their health concerns included:

> 'I have learned to manage my health injuries from playing sport. To give you an example ... last year I had a groin injury, left it as I thought it would get better, it didn't and it affected my sport. Went to the chiropractor, and it was fixed straight away. So now with injuries I have had personal experience, I am now ready to go to the doctor to get them fixed, cos injuries do affect the way I play sport. I now don't like to play with an injury' (Participant 2)

The above example highlights how personal experiences from previous health concerns inform the management of health, based on their conceptualisation of health. Health in this example was constructed as being able to play sport, thus based upon personal experience health management actions are to overcome or manage health issue that impedes this activity. It appears that personal experience does impact on how men understand health, and how this understanding shapes actions.

Exercise / Fitness

The concept of exercise was a further theme that emerged from an examination of the transcriptions. Exercise emerged as a theme in a number of answers to questions that were utilised to structure the interview. Participants utilised the theme of exercise in relation to how they conceptualised good health. This involved participants describing how they would describe the term 'good health' if it appeared on a health continuum scale. A participant responded:

> 'I would say that good health would be if you did exercise. That is supposedly 20 minutes / 3 times per week. So if you did this and you had a healthy mind as well, you would be leading towards the good health. You know, if you don't do exercise, you don't feel healthy' (Participant 3).

Another participant responded:

> 'I guess to describe good health, fitness would be the immediate thing. Someone who is very active and does lots of sport. Being able to participate in mainstream activities, not restricted because of health pain or injury' (Participant 4)

A major issue that participants discussed in describing good health was exercise. The theme of exercise emerged in participants' responses to how they manage their health. The way participants managed their health around exercise was structured according to how they conceptualised health. One participant conceptualised an understanding of health as trying to keep fit. Thus this participant, who appeared to be friendly, active, caring and knowledge about health concerns, illustrated he managed his health actions around exercise:

> 'Well I don't drink, try to exercise when possible through the engagement of sport. I also believe exercise is important. Since I was young I have always competed in sporting events. People have always told me exercise is important for managing health' (Participant 2).

A further response by a participant who understood the concept of health as the importance of having a healthy body responded:

> 'I maintain my levels of health in a number of ways. Well I do exercise and I am always trying to improve my diet and take vitamins to give me more energy to hopefully prevent colds"(Participant 3).

The theme of exercise was utilised by participants in describing how they managed their health. Participants were able to explain their health actions through exercise in a context relevant to their understanding of health. This indicates that how men understand the concept of health, shape health actions.

Food / Eating

The theme of food / eating was used by participants when responding to a number of questions. One issue that participants utilised this theme was in relation to factors describing where they would locate themselves on a health continuum (Good / Ok / Poor). Participants were able to utilise food / eating in describing reasons for their current health position along this continuum. One participant responded

> "I know that when I eat too many fatty foods in a week I don't feel healthy. I guess it has been one of those weeks. I don't feel healthy, so next week I try to make sure I eat at least three healthy meals, I know eating healthy foods is important because I have friends who are good examples of being unhealthy because of eating fatty foods. This is why I would describe myself on a health continuum between good and ok' (Participant 3).

A further response included:

> 'I would describe myself on a health continuum between good and ok, just a little past ok. The reason for this is that I do bugger all exercise, but I don't smoke or heavy drink. I eat a reasonably good diet. I eat reasonably healthy because mum has always told me the importance of eating healthy foods. You know, don't eat junk food, have it once in a while, but not everyday' (Participant 1)

The theme of food has emerged in responses by participants to reasons how they describe their current health status. The examples participants provided illustrates they have both learned and observed the importance of eating health foods from others. Although they understand the importance of eating healthy foods, participants' responses to describing their current health status indicates their action is not always shaped by this knowledge. Thus responses illustrate participants' actions are not always consistent to the perception about health. This illustrates that although participants understand the concept of health in term of a positive construction based on issues such as eating healthy, exercising and having a healthy body, actions do not appear to be supportive of this understanding.

Seriousness of Concern

The final concept that appeared when examining the transcripts was seriousness of concern. Seriousness of concern was raised when participants discussed issues surrounding how they would both manage their health and what actions they would take about a health issue. The responses given by participates to how they manage health issues is exemplified in the following transcript quotations

> 'With injuries I am a bit of a procrastinator. I kind of slack off and will indulge in a beer or a pizza. I know what's got to be done but I just slack off at times. I would act on a health issue if it made me uncomfortable or I thought it was serious' (Participant 5).

> 'The way I would manage a health concern is that I would leave it for as long as I could ... but if it got to the point where I thought I would need to go to a doctor, I would go to the doctor. Only go to the doctor if it couldn't heal by itself, like secondary things, you know gastro and things like that' (Participant 3).

> 'Depending on the injury. I would leave it if I didn't think I was too bad, otherwise I would go to a doctor. Injuries I can see I am not worried about, but injuries I don't know why it has happened I would go to the doctor' (Participant 2).

> 'The way I would manage an injury is that if there was no obvious side effects of the injury I would probably not act. I would expect it to fix itself up. And I would only go and do something if it became unbearable' (Participant 4).

The above transcripts illustrate that men's actions towards health issues depend heavily on the seriousness and effects of the health concern. Participants' responses illustrate that only certain health issues would be acted upon. This highlights that health concerns reach a level of concern with the participant before action is taken. These responses to health concerns are consistent with many participants' description of health. That is, health is structured around a notion that is positive towards the participants, that is being physically fit, having a healthy body or completing exercise.

This conception about participant's actions towards health concerns at a level only when it causes pain (unbearable, uncomfortable) is consistent with their conception and understanding of the term health. This illustrates that participants only respond to health concerns when it is not similar to their conception of health. For example, if the injury or illness is not causing pain, it is not a concern, as it doesn't affect their behaviour. This highlights the conception that how one understands the concept of health is supported by health actions.

Summary

In summary, it appears that of most concern to these participants, who although sharing some characteristics, also differing in age and other life experiences, is that health management will only occur under certain circumstances. Although participants discuss their understanding of health as being positive, health actions only occur when it reaches a level that is of concern.

Chapter Five will analyse the results of the study through a linkage to the theoretical framework that guides this study.

This page has intentionally been left blank

Chapter 5 – Research Analysis

Introduction

The essence of this chapter is to analyse how participants understand health and how this understanding shapes action. This chapter will be divided into three sections. These include: 1) an analysis of the results, 2) how this study met the objectives outlined in chapter one, and; 3) suggested avenues for future research.

Analysis of Results

The analysis of participants' responses will include an understanding of the five themes that emerged from the interview transcripts. These themes were:

- Family / Friends
- Personal experience
- Exercise
- Food
- Seriousness of concern

The theoretical framework that was discussed in chapter two of this dissertation will guide the analysis of these themes. This framework was centred on the concepts of health, socialisation and cognition. Health illustrates why men's health is an important area of research. This will allow for an analysis of how men construct health. Secondly, the concept

of socialisation will be to examine how society portrays gender practice. This analysis illustrates how health has been linked to a socialisation of masculine practice (being male). Finally, cognition is also used within the framework to understand the thoughts that impact on human behaviour. This analysis of human behaviour allows a theoretical perspective into understanding the reasons for men's behaviour towards health.

The concepts of health, socialisation and cognition will be used as a theoretical framework to explore how men understand health and how this understanding shapes health actions.

Health: The concept of health was used in the theoretical framework to illustrate why men's health is an area of concern. Men's health is a concern as statistics illustrate that men die relatively younger than women. Due to the statistical findings illustrating a concern with men's health, this exploratory study has used the concept of health to determine how men understand health. The results of this study illustrate that men learn about health through two forms of socialisation. The two forms of socialisation include a formal and informal level.

On an informal level, participants discussed how family / friends and personal experience had influenced their understanding of health. Participants provided examples of learning about health as a result of their observations of familial health concerns impacting upon their understanding or management of health conditions. Participants' responses indicated that they learned about health from the observation of others is supported by a theoretical perspective offered by Albert Bandura. Bandura's (1977) Social Learning Theory asserts that people learn behaviour based on observation of others. Participants' responses indicated that they learned about health through family and friends. Thus, through the observation of

friends, together with information about health from family influenced how the participants' constructed their understanding and management of health concerns.

The responses provided by participants further indicated they have constructed an understanding of health based upon the formal structures of the Australian Health System. The responses indicated exercise and food as important aspects into how men have been socialised around health promotional issues. Health promotion can be defined as "the combination of educational and environmental supports for actions and conditions of living which are conducive to health" (Green & Kreuter, 1991, p. 17). The results of participants discussing health behaviour in relation to exercise and eating healthy is structured around the underlying principles surrounding health promotion in Australia. The development of health promotion is based on the voluntary participation of individuals in determining their own health practice. That is, shifting the health pendulum back and forth between a reliance on the government and institutions (cost containment), to heavy voluntary reliance on the individual and family responsibilities.

Furthermore the practical and strategic reasons towards a voluntary nature of health promotion includes, "it helps avoid public resistance or reaction to programs that might be perceived as propagandistic manipulative, coercive, political or commercially directed" (Green & Kreuter, 1991, p. 20). Health promotion strategies utilised by the health system include advertising through television and media outlets, development of programs, published literature, and research. The results of this study indicate that participants are influenced by health promotion in attempting to eating healthily and exercising on a regular basis. Further exposure for these participants to health promotion includes posters and educational

advertising at University. Thus health promotion appears to affect how men learn about health issues.

In summary, the results of the study indicate that participant understood the concept of health through informal and formal structures. This indicates family / friends, personal experience and health promotion are important in influencing participants' knowledge about health. This finding is supported in the literature, which asserts, " individuals habits such as drinking and exercising are influenced by the behaviour of friend and acquittances, advertising, and the community" (Better Health Commission, 1986, p. 4).

Socialisation: The concept of socialisation was used to examine masculinity. Masculinity was examined in order to describe how society's expectations and roles have led to gender practice. This concept was used to explore whether being a male affected participants' construction of health.

The results of the study indicated that participants did not describe their understandings of health and how this understanding shaped actions with reference to their masculinity, thus the responses were not gender specific. This illustrates that participants did not make reference to issues that specifically marked them as male. An analysis of these results illustrates that participants did not portray any roles, culture or society's expectations in relation to being a male when discussing health and health behaviours.

It appears that the issue of masculinity in relation to health behaviours was not supported from the results of this study into how men understand health and how this understanding shapes health actions. One could however postulate that participants' reluctance to seek

medical assistance unless the issue was serious is based on the notion of men as strong and fearing vulnerability – hence a socialised attitude.

Cognition: The concept of cognition was also used within the theoretical framework of this study to explore how men understand the concept of health and how this understanding shapes health actions. Cognition was discussed as a concept to explore how thinking about health may explain health behaviour. The results of the study indicate that participants' actions around health issues were related to the themes of seriousness of concern and personal experience.

Seriousness of concern involved participants discussing that they would only act on a health issue if they believed there was a concern. Participants reported that acting on a health concern would only occur if it became 'unbearable or uncomfortable'. These results illustrate that participants would only act on a health issue if they thought it was of concern. An understanding of health did affect participants' behaviour as they viewed health to be the absence of a disease, or being able to function. The result of this study show that men view health in a positive sense is supported by the literature (Broom, 2000). If these men construct health positively, they are likely to act on a concern when they no longer view their health as positive. Thus it appears from the results of this study that participants will not act on a health issue unless it undermines their concept of health.

A second theme that emerged from the study illustrating how men's understanding of health affects behaviour was personal experience. Personal experience was reported as influencing how men understood health issues as participants expressed that the likelihood of acting on a

health issue depended on the seriousness of concern. If participants had experienced the concern before, the level of severity relating to that concern would determine health actions. Conversely, if participants had not experienced the concern before, and/or had limited knowledge about the issue, they were more likely to act on the concern. These results illustrate that personal experience influence men's conceptualisation of health and how this shapes behaviour.

In analysing the concept of cognition, the results of the study illustrate that the work of Kelly may be utilised to explore participants' health behaviour. Kelly's Personal Construct Theory demonstrated that in order to "understand a person's cognitive process one must know something about the constructs the person uses" (Pervin, 1990, p. 234). In this study, the constructs used by participants to construct health meaning were the absence of disease or the presence of uncomfortable/unbearable pain (seriousness of concern). In knowing the participants' construction of health, Kelly argues that we are able to understand their cognitive processes and as such start to predict future behaviour.

An example of how one participant thinks about health, thus influencing health behaviour relates to participant number four. In this example participant number four stated that he viewed health as the avoidance of pain. Understanding how this participant constructs health as the avoidance of pain will help to predict future health behaviour in terms of continuing to avoid pain. Only by knowing the constructs people use to interpret their social world, may one start to understand future behaviour.

Furthermore, the results of the study indicate that Goldstein's work can also be applied to participants' responses in understanding health. Goldstein argued that "how each person thinks about events will be governed by different meanings placed on the event that arises out of prior experiences" (Goldstein, 1986, p.34). From the results it appears that participants discussed prior experiences as influencing their behaviour in relation to health concerns. As previously discussed, if participants had experienced the concern before, the level of severity relating to that concern would determine health actions. Conversely if participants had not experienced the concern before, and/or had limited knowledge about the issue they were more likely to act on the concern.

This personal experience which influenced behaviours was evident in that "individuals place meaning and structure to what they believe, know and can explain" (Goldstein, 1986, p.37). In order to explain an individual's behaviour, Goldstein argues that people use metaphors or symbols to guide thinking. It is a theory relating to symbols (symbolic interaction) that argues that "human beings act toward things on the basis of meaning that they have for them". In relation to this study, participants act towards health concerns based on the meanings that they have assigned to the concerns.

An example of how one participant acted towards his health concern relates to participant number two, who discussed acting on a groin injury because it interfered with his ability to play sport. This health action was based on the meaning assigned by this participant to the injury. The participant views health as being related to being active. As this injury prevented the participant from being active, health action was taken to reduce the effect of this injury.

Furthermore, it appears that socialisation impacts on how participants construct health behaviour through symbols illustrating the meaning of health has arisen for participants out of social interactions with others. It can be illustrated that participant two provided an example of symbolic interaction when he stated his construction of health related to having a healthy body. This constructed was based on interactions with others including friends and parents.

Symbolic interaction argues that the meanings of things are handled in and modified through an interpretive process used by the person in dealing with things they encounter. That is "people use a process of internal conversation to arrive at making decisions" (Wallace & Wolf, 1980, p.206). It appears that participants utilise symbols when deciding to take action on a health concern. As health is viewed as a positive entity, it appears they make cognitive decisions regarding whether to act on a health concern if they view this concern as impacting on their positive perception of health. This is illustrated as participant four asserts that he tries to keep fit in order to avoid pain, chronic coughs, heart problems or injuries.

Summary: In summary, this study supported the concepts of health and cognition but not masculinity. Health was supported as the results indicated that men learnt about health through socialisation at both an informal and formal level. This was supported in the research analysis as men discussed learning about health through themes of exercise and food, indicated through knowledge gain from family / friends, personal experience and health promotion. The concept of cognition was further supported as the results indicated that how men understood health shaped their behaviour and management of concern. The themes of personal experience and seriousness of concern were discussed by participants to help inform actions. The concept of socialisation was not supported in the research findings as results of

this study did not indicate that how men understood health or acted on health behaviour was related to masculine roles or expectations constructed by society. It appears however that one may postulate that men's reluctance to get help unless it is serious relates to the notion of men as strong and fearing vulnerability - hence a socialised attitude. The work of Kelly, Goldstein and Blumer was also analysed in relation to the results of the study to help explore how men understand health and how this understanding shapes actions.

Objectives of study

The second section of this chapter will analyse how the study met the original objectives outlined in chapter one. The objectives were

- To increase the general populations' knowledge about health, to help explore possible reasons for the silent crisis facing men's health in Australia.
- To contribute to knowledge regarding men's health that may help improve health planning policy in the 21st Century.
- To add to my own body of knowledge that relates to men's health.

***To contribute knowledge about men's health to the general population, to help explore possible reasons for the silent crisis facing men's health in Australia*:** This study has increased the general population's knowledge about the silent crisis-surrounding men's health. This study has explored how men understand the concept of health and how this understanding shapes actions, by illustrating the issues that men discuss when talking about health. Issues that arose included five themes of family, personal experience, exercise, eating and seriousness of concern.

Furthermore, this study has explored possible reasons for the silent crisis facing men's health in Australia. The results of the study indicate that men procrastinate about health issues and only act when the health issue is a concern. This conception of men acting on a health issue when it is a concern is supported by men's understanding of their own health on a continuum. These men view themselves as having good health. It is only when participants view themselves as having ill health, due to a concern becoming unbearable or uncomfortable, do they decide to act on this health issue. This perception of health may contribute to the silent crisis regarding men health in Australia, that is men act on a health issue when it is a cause for concern, sometimes this action is too late.

***To add to my own body of knowledge that relates to men's health*:** The results indicated that my own body of knowledge regarding men's health was increased from undertaking the study. This increase in knowledge was gained from learning how health promotional issues such as eating and exercise were important in influencing participant's health behaviours. Furthermore, I gained a confirmation about my own perception and understanding of health. My understanding about health was confirmed by the responses given by the participants. Beliefs about health were supported by the responses given by the participants in how they understand health and how this understanding shapes actions.

***To contribute to knowledge regarding men's health that may help improve health planning policy in the 21st Century*:** This objective was met by undertaking the research process. One issue that was highlighted in the results of this study was that health promotional issues such as eating and exercise were impacting upon men's understanding of health. This may help to confirm that current health promotional issues from eating and exercise are important issues

for men to consider when they think about health. Future health planning policy towards men health may be to continue this health promotion.

A further health planning policy was to focus on socialisation within the family. Results of the study indicate that this focus group has an impact towards how men construct and understand health and how this understanding shapes actions. The increase in health planning policy towards the family may help to contribute to a greater understanding of knowledge regarding men's health.

A further issue in this study for future men's health planning policy is that it appears men's understanding of health influences behaviour. Such health planning policy could include a continued increase in general health promotion and discussion groups for men to talk about health, which are facilitated by men. Increasing health-planning policy to focus on changing men's conception of health may contribute to a better understanding of knowledge regarding men's health.

Future Research

The final section of this chapter is to highlight possible avenues for future research regarding men's health. From this study it appears that research needs to continue to explore how men understand health and how this understanding shapes actions. Further avenues for men's health research could include focussing on gender comparisons, people not studying at university, people with a disability, age differences, or people who have migrated to Australia. It is only through increased research that knowledge will be gained to further explore the reasons why men's health has become an area of concern in Australia.

Bibliography

Aggleton, P. (1990). Health. London, UK: Routledge.

Anspaugh, D.I., & Hamrick, M.H. & Rosato, F.D. (1991). Wellness: Concepts and application. St Louis: Mosby Year Book

Antrobus, M. (1987). The neglected sex. Nursing Times 83(5) 31-33.

Ashcraft, M.H. (1994). Human memory and cognition. NY, USA: Harper- Collins College Publishers.

Atkinson, R.L. (1996). Hilgard's introduction to psychology. Fort Worth: Harcourt Brace College Publishers

Australian Bureau of Statistics (2000). Australia Now – A statistical profile: Health: Health status.
Available online: http://www.abs.gov.au/websitedbs/c31121...ofile

Australian Bureau of Statistics (1998). 1998 Causes of Death. Australian Cat. No: 3303.0, Canberra, Aust: Australian Government Publishing Services.

Australian Bureau of statistics (1998). Year Book 1998. Cat. No: 1301.0, Canberra, Aust: Australian Government Publishing Service.

Australian Institute of Health and Welfare (1996). Australia's health 1996. Canberra, Aust: Government Publishing Services.

Baldock, C.V., & Cass, B. (1988). Women, social welfare and the state in Australia. Sydney, Aust: Allen & Unwin

Bandura, A. (1977). Social learning theory. Englewood Cliffs, N.J: Prentice – Hill.

Barnes, A. (1987). Personal and community health. London, UK: Baillier, Tinclall.

Benjafield, J.G. (1993). Cognition. Englewood Cliffs, NJ: Prentice-Hall Inc.

Better Health Commission (1986). Looking forward to better health. (1), Final report. Canb: Australian Government Publishing Services.

Blumer, H. (1969). Symbolic interactionism: Perspective and method. Englewood Cliffs, NJ: Prentice – Hall Inc.

Bourne, L.E., & Russo, N.F. (1998). Psychology: Behaviour in context. New York: W.W. Norton.

Broom, D.H. (1991). Darned if we do: Contradictions in women's health care. Sydney, NSW. Allen & Unwin.

Browne, R., & Fletcher, R. (1995). Boys in schools: Addressing the real issues – behaviour, values and relationships. Sydney: Finch Publishing.

Browning, B. (1992). Exploiting health: Activists & Government versus the people. Vic, Aust: Brown Prior Anderson.

Buchbinder, D. (1994). Masculinites and identities. Melb, Aust: Melbourne University Press

Burkitt, G. (1999). Strategies for dealing with men in general practice. Australian Family Physician, 28(8) 773-774.

Connell, R.W. (1995). Masculinities. St Leonard, NSW: Allen & Unvin.

Connell, R. (1997). Australian masculinites: Health and social change. Keynote address to The Second National Men's Health Conference, Fremantle WA, Esplanade Hotel (Oct 29 – 31), p. 14 – 21.

Connell, R.W.,& Schofield, T., & Walker, L., & Wood, J., & Butland, D.L., & Fisher, J., & Bowyer, J. (1999) Men's health: A research agenda and background report. Report submitted to the Commonwealth Department of Health and Aged Care, Canberra: AusInfo

Crotty, M. (1998). The foundations of social research: Meaning and perspectives in the research process. St Leonards, Aust: Allen & Unwin

Davey, R.J. (1997). Circumcision: The unkindest cut of all. In The Second National Men's Health Conference, Fremantle Western Australia. Esplanade Hotel. (Oct 29 –31), p. 265-277.

Denzin, N.K. (1989). Interpretive interactionism. Applied social research methods series, Vol 16. London: Sage Publishers.

Denzin, N.K., & Lincoln, V.S. (1994). Handbook of qualitative research. Calif, USA: Sage Publications Inc.

De-Ville-Almond, J. (2000). Man troubles. Nursing Times, 96(11), 29-30.

Dintiman, G.B., & Greenberg, J.S. (1986). Health through discovery. New York; USA: Random House

Eisenberg, B. & Ruthclotter, S. (1998). Living the legacy: The women's rights movement 1848-1998.
Available online: www.Legacy98.org/move-hist.html.

Ellis, H.C., & Hunt, R.R. (1993). Fundamentals of cognitive psychology. Madison, Wis: Brown & Benchmark.

Fletcher, R. (1995). An introduction to the new men's health. Newcastle, NSW: The men's health project: University of Newcastle.

Goldstein, H. (1986). A framework for cognitive humanistic practice. In (Eds) Goldstein, H., & Hilbert, H., & Hilbert, J. Creative change: A cognitive – humanistic approach to social work practice. London: Tavistock Publications.

Green, L.W., & Kreuter, M.W. (1991). Health promotion planning: An educational and environmental approach. Second edition. London, UK: Mayfield Publishing Company.

Hahn, D.B., & Payne, W.A. (1991). Focus on health. St Louis: Mosby Year Book.

Health for all Australians (1998). Health for all Australians. Report to the Australian Health Minister's Advisory Council & the Australian Health Ministers Conference. Canberra, Aust: Australian Government Publishing Service.

Hoyenga, K., & Hoyenga, K. (1993). Gender –related differences: Origins and outcomes. Mass, USA: Allyn & Bacon.

Huggins, A.K., & Somerford, P., & Rouse, I. (1996). A report on men's health Western Australia 1996. School of Public Health, Curtin University in collaboration with Epidemiology Branch, Health Information Centre, Health Department of Western Australia.

Hunt, L. (1996). Social movements and the construction of health knowledge: A case study of women's health movement. Dublin, Ireland. Economic and Social Research Institute.

Jackson, S. & Jones, J. (1998). Thinking for ourselves: An introduction to feminist theorising. In eds (Jackson, S. & Jones, J.). Contemporary feminist theories. NY, USA: New York University Press.

Kelly, G.A. (1963). A theory of personality: the psychology of personal constructs. NY, USA: Norton and Company Inc.

Kirk, J., & Miller, M.L. (1986). Reliability and validity in qualitative research. London: Sage Publications Inc.

Kidder, L.H., & Judd, C.M. (1986). Research methods in social relations. NY, USA: CBS College Publishers.

Lantz, J. (1978). Cognitive therapy and social casework. Social Work 23, 361 - 366

Lefton, L.A. (1997). Psychology. Boston: Allyn & Bacon.

Lincoln, Y.S., & Guba, E.G. (1985). Naturalistic inquiry. London: Sage Publications

Lingard, B., & Douglas, P. (1999). Men engaging feminism: pro feminism backlashes and schooling. Buckingham, UK: Open University Press.

Luck, M. & Bamford, M. & Williamson, P. (2000). Men's health: Perspectives, diversity & paradox. Oxford, UK: Blackwell Science Ltd.

Mac an Ghaill, M., & Haywood, S, (1996). Understanding masculinities. Buckingham, UK: Open University Press.

McGrane, T., & Patience, A. (1993). Masculinity: Implications for adolescent for sexuality in Australia. In (eds) Men's Health: The forgotten issue. Melb, Aust: Ausmed Publications.

McWalters, M. (1990). Understanding psychology. Sydney: McGraw – Hill.

McQuistion, L. (1997). Suffragettes to she devils: Women's liberation and beyond. London, UK, Phaidon

Men's Health Network, (1998). The crisis in men's health. Available on-line: http://www.men'shealthnetwork.org.

Men's Health Network, (1999). The silent health crisis. Available on-line: http://www.men'shealthnetwork.org.

Montgomery, B. & Morris, L. (1990). Your good health. Melbourne, Vic: Lothian.

Morrison, H. (1990). Impotence. Nursing Times, 84(32) 35-37.

National Women's Health Program (1993). National Women's Health Program: Evaluation and future directions. Canb, ACT. Australian Government Publishing Services

National Women's Health Policy (1989). National Women's Health Policy: Advancing Women's Health in Australia. Canb, ACT. Australian Government Publishing Service.

Paul, P. (1995). Healthy, wealthy and why? Social Alternative, 14(2), 28-32.

Paul, S. (1993). Women's health project. Southern Metropolitan health service. Sept 1993. Health Department of Western Australia.

Perry, M. (2000). Dead men walking. Nursing Times, 96(11), 29-30.

Pervin, L.A. (1990). Handbook of personality: Theory and research. New York: Guilford Press.

Ritzer, G. (1992). Sociological theory: Third Edition. NY, USA: McGraw-Hill International Editions.

Rosella, J.D. (1994). Testicular cancer health education: An integrative review. Journal of Advanced Nursing, 20, 666-671.

Ross, C.E., & Wu, C. (1995). The links between education and health. American Sociological Review, 60, 719-745.

Sarantakos, S. (1993) Social research: Third Edition. Melbourne, Aust: McMillian Education Australia.

Sladden, M, & Dickinson, J. (1993). Effectiveness of screening for prostate cancer. Australian Family Physician 22,(8) 1385-1392.

Tacey, D. (1997). Masculinity, change and healing: Negotiation academic and popular perceptives on men's health issues. The Second National Men's Health Conference, Fremantle WA (Oct 29 –31), 22 – 34.

Tolson, A. (1977). Limits of Masculinity. London, UK: Tavistock Publications Limited.

Turner, F.J. (1996). Social work treatment: Interlocking theoretical approaches. New York: Free Press.

Wallace, R.A., & Wolf, A. (1980). Contemporary sociological theory: Continuing the classical tradition. Englewood Cliffs NJ: Prentice-Hall Inc.

Wass, A. (1992). The new legitimacy of women's health services. In whose interests. In eds (Smith, A.). Women's health in Australia. Armidale, NSW: University of New England.

Werner, H. (1982). Cognitive therapy: A humanistic approach. New York: Free Press

Western Australian Department of Health (2000). Health Profile: Overview Available online: www.health.wa.gov.au

Wilson, A. (1998). Why are men less healthy than women? In eds (Healy, J.). Issues in society: Men's health. (3). The Spinney Press.

Woolridge, M. (1998). A message for men: Family doctor week. In eds (Healy, J.). Issues in society: Men's health. (3). The Spinney Press.

Zlotnick, C. (1992). Unemployment & health. Nursing & Health Care, 13(92) 78-82.

Appendix A - Questionnaire

Demographic Details

- Age
- Length of time at university
- Partner: Yes/No
- Place of Birth

Question 1 **– How do men understand the concept of health?**

- What does the term health mean to you?
- Can you explain what comes to mind when you hear the word health?

Question 2 **– What factors shape your understanding of health?**

- Reflecting on your previous answer can you explain why you describe the word health the way you do?
- Can you give reasons for describing health the way you do?

Question 3 **– How do men locate themselves on a continuum of health/non health?**

- On a health continuum scale, how would you describe your health at the present?

Good OK Poor

Question 4 **– What factors shape your location on this continuum?**

- What factors affect how you describe your health at present?

Question 5 **– How does men's understanding of health shape the way they manage their health?**

- What measures do you take to maintain or improve your level of health?
- What factors would you think about before acting on a health incident?
- Can you describe what actions you would take if you were concerned about your health?
- When do or would you find it necessary to act on a health issue?
- What illnesses are important enough to consider taking action on? Why some but not others?
- Do you consider the possibility of future health concerns and if so what actions do you take?

Do you have any questions you would like to raise about the interview?

Thankyou for participating in this interview?

Appendix B – Information Sheet

Craig Thompson
Edith Cowan University
Social Work Department
Bunbury WA 6230

7th September 2000

Dear Future Participant

INFORMATION FOR CONSENT FORM

This information sheet is intended to provide you with an understanding of the study that I am undertaking to complete my Social Work Honours Degree. I am researching how men understand the concept of health. I wish to examine how men understand the concept of health, as statistics about health in Australia show men's health as steadily deteriorating. The interview will ask questions to discuss perceptions about how you understand health. Interview questions will ask you how you understand health, what factors shape this understanding, how you locate yourself on a health continuum, what factors shape this location, and how you understand action as a component of health.

My research is restricted to men over the age of 18. The interview time and location will be mutually agreed between researcher and participant. The participant enters the interview on a voluntary basis and no payment will be made. Participants have the right to refuse to participate in the interview, and a re able to withdraw at any time without prejudice or (negative) consequences. The interview will be taped and transcribed, after which the tapes will be made available to the participant or destroyed.

This information sheet has outlined the essence of my honours' project. However, if you require more information regarding any aspects of the interview, please do not hesitate to contact my supervisor or myself.

Thank you for taking the time to read and consider this information sheet. I look forward to seeing you at a future date.

Yours sincerely

C. Thompson
Social Work Student
Telephone: 9791 6586

Elizabeth Lindsay
Supervisor
Telephone: 9734 2527

Appendix C – Consent Form

Craig Thompson
Edith Cowan University
Social Work Department
Bunbury WA 6230

7th September 2000

Dear Future Participant

CONSENT FOR SOCIAL WORK HONOURS INTERVIEW

Thank you for your interest in my research topic regarding men's health. Prior to the commencement of your participation in this research study, the following form must be completed.

I _____ confirm that:
(Your Name)

- I have read the information sheet that form part of this document,
- I was given the opportunity to ask questions,
- All my questions were satisfactorily answered,
- No pressure is put on me to participate, and;
- I voluntarily signed the consent form.

Signed at _____ on the _____.
(Place) (Date)

Signature of participant _____.

Signature of witness (optional) _____.