



‘The average Scottish man has a cigarette hanging out of his mouth, lying there with a portion of chips’: prospects for change in Scottish men’s constructions of masculinity and their health-related beliefs and behaviours

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Men’s apparent resistance to recommended health practices and their engagement with ‘high-risk’ behaviours has been associated with an increased risk of morbidity or mortality. Recent work has highlighted the need to think critically about the health-promoting behaviours that men appear reluctant to engage in, as well as examining those they embrace, and explore the gendered meanings that men attribute to their beliefs and behaviours. This article presents men’s discussions of the ‘practices of masculinity’ and examines their relation to, and implications for, men’s health-related behaviours as articulated in 15 focus group discussions (59 participants in total). The data capture both the experiences of men who felt pressured to engage in behaviours that may be harmful to their health in order to appear masculine and the accounts of those who regarded themselves as freer to embrace salutogenic health practices. Less is known about the circumstances that might encourage men to re-think their engagement in performances of masculinity that have potentially detrimental effects on their health. The data presented here suggest that ageing, illness, and fatherhood were some of the experiences that prompted men to re-evaluate their health practices.

Keywords: sociology of health; health behaviour; identity

Introduction

Scotland is consistently ranked as having one of the worst records for malignant cancers, lung cancer and respiratory disease in Europe (Gillis *et al.* 1988, PHIS Scotland 2001). The West of Scotland, in particular, is known for its high rates of coronary mortality and morbidity which has earned the City of Glasgow titles such

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as the 'sick man of Europe' and the 'heart attack capital of the world' (BBC May 7 1999, Fracassini January 9 2005). Scottish men are reported to have the lowest life expectancy in the UK (GROS 2004–2006). Social inequalities have been shown to be particularly striking in Glasgow (McCloone and Boddy 1994, Dorling 1997, Shaw *et al.* 1999, Hunt *et al.* 2001). This may explain why the 'long-established male disadvantage in health' seems particularly marked in this part of the world (Watson 2000, p. 22). However, higher morbidity and mortality rates among men in Scotland (WHO 2006) have also been attributed to an:

...unhealthy lifestyle, one that involves little exercise, a heavy alcohol intake and a propensity to smoke. In addition, the Caledonian diet, which is often deep fried, fat soaked and lacking in fruit and vegetables, contributes to one in every five Scottish men dying of heart disease before he reaches the age of 75..... Each day (health professionals) face the results of the average Scottish men's poor health

(Leishman and Dalziel 2003, p. 92).

Encouraging men, '*even Scottish men*', to care for their health has been presented as a particular 'challenge' for health professionals (Leishman and Dalziel 2003). However, few studies have explored in detail how Scottish men view their own health or their health-related beliefs and behaviours (Mullen 1993, Watson 2000, O'Brien *et al.* 2005, Emslie and Hunt in press). Consequently, it is difficult to establish whether Scottish men's experiences and descriptions of their own health-related behaviours bear any resemblance to the social and cultural construction of the 'average Scottish man'.¹

The concerns that have been expressed about Scottish men's health behaviours are located within a wider discussion about the 'state of men's health' (Baker 2001). Large-scale empirical studies and analyses of men's health across Europe (White and Cash 2003), Australia (Van Buynder and Smith 1995) and the United States (Verbrugge 1985) suggest that higher mortality rates for men compared to women is a pattern that is common to most societies (see also Tsuchiya and Williams 2005, Barford *et al.* 2006, White and Holmes 2006). Men are argued to be more 'fragile' or vulnerable to injury, disease and death at every stage of the lifespan from conception to old age (Stillon 1995, Kraemer 2000). Men's apparent resistance to recommended health practices and their engagement with 'high-risk' behaviours has long been considered to be one of the main explanatory factors (Waldron 1988, Waldron 1995, Waldron 2000, Courtenay 2000a, Courtenay 2000b, Watson 2000, Courtenay 2002). Such discussions have prompted health promotion strategies aimed at 'bringing home' to men the dangers of living up to a 'macho' image and engaging in 'risk-taking' behaviours which are typically presented to be influenced by the 'knowledge, attitudes and beliefs of men' (DoH 2003).

More recent work highlights the need to think critically about the health-related behaviours that men appear unwilling to engage in, as well as examining those they embrace, and explore the gendered meanings that men attribute to their beliefs and behaviours (Wight 1999, Courtenay 2000, White and Johnson 2000, Emslie *et al.* 2006, Robertson 2006a, b). Developments in sociological theories of gender, and masculinities in particular, have focussed more attention on the empirical study of how male bodies are experienced by men in every day life (Watson 2000, Chapple and Ziebland 2002, Robertson 2003, Oliffe 2005) and the 'social practices of masculinity' (Connell 1995, Sabo and Gordon 1995, Connell 2000, Haywood and Mac an Ghaill 2003, Payne 2004) and their relationship to men's health.

The theory of gender as social practice is derived from theorists such as Goffman (1977) and Bourdieu (1990) and suggests that gender identity and the gendered body are socially constructed and:

...produced and expressed through our movements, gestures, facial expressions, manners, ways of walking, and ways of looking at the world... even basic activities such as teaching children how to move, dress, and eat are thoroughly political, in that they impose on them an unspoken understanding of legitimate ways to (re)present their body to themselves and others

(Moi 1991, p. 1030–1031).

Rather than conceiving of gender as being socially acquired through fixed social norms which ‘prescribe and proscribe’ (Thompson and Pleck 1986) how men and women should behave, gender is increasingly recognised as a ‘recurring accomplishment’ (West and Zimmerman 1991). Gender identity is understood to emerge from social interaction as the process of ‘doing gender’ (West and Zimmerman 1991, see also Saltonstall 1993, Williams 2000). In applying this theoretical work to the study of men’s health, Courtenay has argued that:

Many men and boys define their masculinity against positive health behaviours and beliefs... The carrying out of any one healthy behaviour can require a man to dismiss multiple constructions of masculinity.

(Courtenay 2000b, p. 11).

Such discussions have been influential in encouraging a shift away from the reductionism which has presented ‘risky’ behaviours as endemic to masculine culture (Lohan 2007). It is now commonplace to view masculinities as multiple, contested and dynamic (Hearn and Morgan 1990, Brod and Kaufman 1994, Kimmel 1994).

Empirical work, which has drawn on theoretical work on masculinities, has explored some of the complex ways in which health-related behaviours might be used to construct and negotiate masculinities (e.g. Saltonstall 1993, Robertson 2006a, O’Brien *et al.* 2007). Thus heavy drinking (de Visser and Smith 2006, 2007) or smoking (Hilton 1996, Hunt *et al.* 2004, Elliot 2008) may articulate a particular meaning for men with regard to what is considered acceptable behaviour (Courtenay 2000). Similarly men’s engagement with sports (Messner 1987) and studies of their dietary beliefs and behaviours have also been revealing about practices of masculinity (Roos *et al.* 2001, Wardle *et al.* 2004).

This article presents discussions with men living in Scotland about their health-related beliefs and behaviours. Through analysis of focus group discussions, we compare the perspectives offered by a range of men. We question to what extent and in what ways health-related beliefs and behaviours are connected to the social construction of masculinities. We also consider whether the gendered practices that men describe may have particular cultural meanings for participants given the social, historical and geographical context in which the research was located (Jackson 1991).

Method

Fifty-nine men participated in 15 focus groups. We sought diversity within the sample by age (range 15–72 years), occupational status, socio-economic background and current health status. We recruited men whom we anticipated would have had ‘everyday’ or unremarkable experiences of masculinity and health (largely by

accessing men in a range of occupations, such as gas workers, fire fighters) and groups of men that we anticipated may have had 'epiphanies' (Crabtree *et al.* 1993) prompting reflection on masculinity and health. This included groups with men who had prostate cancer, coronary heart disease, mental health problems and ME. The remaining groups included: men who shared experiences of recent health-related changes (principally diet and exercise), full-time carers for wives with serious health problems, students and long-term unemployed men. The majority of participants lived in central Scotland (Glasgow, Edinburgh, Dundee, Lanarkshire and Perthshire) and just one group was conducted with men of Asian origin reflecting the (relatively limited) ethnic diversity in this part of Britain. All names used are pseudonyms.

There is debate about whether groups of strangers are preferable to 'naturally occurring' groups, such as friends or work colleagues (Kitzinger 1994, Morgan 1997, Wilkinson 1993). Because of our aim to achieve particular dimensions of diversity, our fieldwork included both pre-existing groups ($n=10$) and specially convened groups ($n=5$). Drawing a group of strangers together was the only way to access people with certain experiences (e.g. men acting as carers, men with ME). The focus groups were conducted by RO between June 1999 and February 2001. Discussions with pre-existing groups were held in their usual meeting place. The research was presented to gatekeepers and prospective participants as a project on men's health, and information leaflets and invitation letters emphasised a general interest in men's health, and men's lives, but did not overtly highlight the issue of masculinity. Ethical approval for the study was granted by the University's Ethics Committee for Research on Human Subjects.

The focus group was used to engage men in prolonged discussion about the relationship between health-related beliefs and behaviours and masculinity. Discussion was facilitated using broad questions exploring participants' general views on men's health (e.g. how do you view your health? What prevents/facilitates men achieving optimal health?). Any passing mention of health-related behaviours (e.g. smoking, drinking, exercise) or beliefs (e.g. 'I drink twenty pints, it's expected, it's a man thing') were probed in detail. In the latter stages of the discussion, materials were used to focus participants on the area of masculinity and health and encourage them to explore explicitly their own health-related beliefs, behaviours and experiences in relation to their masculinities. The use of a card with a recent newspaper headline 'Masculinity is dangerous for men's health' was particularly effective at encouraging men to explore what masculinity was and how it related to men's health. Participants were prompted by the researcher and by other group members to provide examples of their own behaviours and to state how they might position themselves in relation to the 'masculinity' referred to in this statement.

Different ideas as to what constituted masculinity and how 'manhood' was expressed through behaviour were actively challenged and supported by group members. Indeed, questions posed by group members were 'perhaps more searching than the researcher might have dared to ask' (Wilkinson 1998, p. 118). Consequently, the data collected from these focus groups contain explicit accounts regarding the social construction of masculinity (in contrast to accounts generated in different contexts, for example through individual interviews) and 'tapped' into men's talk around health-related beliefs and behaviours more effectively by exploiting the 'co-construction of meaning' between participants (Wilkinson 1998), using 'their language and concepts, their frameworks for understanding the world'

(Kitzinger 1994), author's emphasis). We believe, as Morgan (1997) suggests, that this method was useful for generating data on subjects that are 'habit ridden' (such as health practices) or would not ordinarily be considered in such detail (masculinity).

All group discussions were taped with participants' consent, fully transcribed, then cross-checked with the tapes for accuracy by RO. The first stage of analysis, which involved identifying and interpreting themes to be developed in subsequent interviews, took place *during* data collection. All of the authors engaged in regular discussions about the data as fieldwork progressed to ensure that the themes developed in the research remained 'responsive to the context and the participants' (Morse and Richards 2002, p. 74). Once all the focus groups were completed, all authors reread the transcripts and separately identified the common themes they observed across interviews. A more detailed analysis was then undertaken by RO using the 'constant comparative method' (Strauss and Corbin 1990, 1997). This is an iterative process of identifying themes from the text and ascribing relevant text to that theme. This process results in a number of themes that are organised into a coding framework (assisted in this instance by the use of NVivo 2). RO then further examined the major themes by undertaking a *horizontal analysis* (or cross-group analysis) as well as a *vertical analysis* (or individual case analysis) (Miles and Huberman 1994). The exploration of novel areas in interview, together with this process of analysis generated a number of substantive areas for analysis. This article explores just one of these major themes to emerge from this study. Others, for example the impact of ill-health on men's identities (O'Brien *et al.* 2007) and the relationship between masculinity and help-seeking (O'Brien *et al.* 2005) have been explored elsewhere.

Summary of findings

The data capture the experiences both of men who felt pressured to engage in potentially health-damaging behaviours in order to appear masculine and of those who felt freer to embrace salutogenic health practices. The diversity within the sample also allowed some exploration of how men re-negotiated their masculinity and health in response to critical events over the lifecourse or in relation to their perceptions of age-appropriate behaviours.

Prioritising masculinity over health: examples of competitive drinking

Participants most frequently linked masculinity and health in their descriptions of health-related behaviours, for example by describing a 'macho beer drinking kind of culture' (Sean, 47, Student Group), which appeared to be recognisable to most participants across groups and a wide age range. However, this practice (or at least participant's *presentation* of their adherence to this accepted practice within group discussions) appeared to be most prevalent among younger participants.

The drinking 'regimes' that were described appeared to be less about the consumption of alcohol *per se* and more about the enactment of a particular kind of masculinity. One participant described his drinking in terms of a masculine career.

He described how his ability to 'handle his drink' provided him with an identity he felt was desirable and earned him a particular status among his peers:

Why do I go out and drink competitively with my friends? I don't know why... We started it at sixteen years old. Let's see who can drink the most... That trend has carried on through all of our sort of drinking lives basically. It's like 'let's go out and we're going to drink twenty five pints each and the first person to be sick'...that's it... My other circle (of younger friends) it's 'Colm's a drinker'... I feel as though people are watching me and I've got to do so much you know (for them to say) 'oh Colm can handle his drink'... I feel if I don't I'm letting them down (laughs).

Colm, 32, Gas Worker's Group

A group of younger participants (who elsewhere in the discussion had emphasised how health conscious they were with regard to diet) also described how their regular binge drinking was viewed as a 'masculinity competition' that enabled them to construct an informal hierarchy of masculinities ('pussy' vs 'the main man') in their group:

Rajiv (22): It's like there's a bit of competition involved there, who's going to drink the most and still stand up.

Sam (21): Without puking.

Rajiv: Like Vikram got a lot of abuse off folk for being feeble... After a few drinks he was away with the fairies.

RO: What would it say about you if you couldn't drink much?

Rajiv: You're weak.

Sam: You're a pussy. If you're more tolerant, you're the main man.

Asian Men's Group

It was clear that this group of participants felt that there was considerable pressure to engage in heavy drinking to avoid being exposed as 'weak' (synonymous with being 'less of a man') and to avoid the kind of censure to which Vikram had been subjected.

Accounts given by participants who wished to avoid engaging in such behaviours were revealing of the very real pressures some felt to reject salutogenic health practices in order to appear masculine. Weight loss was a common reason that men provided for making changes to a long-established pattern of heavy drinking. The men who seemed to find it relatively easy to replace their old routine ('ten pints (then)... Now I sit there with my diet coke' (Howie, 31, Slimming Group)) were exceptional. Many described considerable social pressure from peers to abandon their new regime. As one participant said: 'it starts off when you're young. You go to the boozers with your pals and it's a habit you get into. It's hard to get out of it' (Jake, 33, Slimming Group). A participant in another group suggested that his masculinity was repeatedly challenged when he chose to avoid drinking heavily: 'you can get a certain amount of stick for... saying no to going out drinking and for turning down options, ... you get a *lot* of stick for that' (Paul, 30, Health Change Group). His solution was to give up alcohol in the short term to enable him to achieve his weight loss goal. Once he had reached a weight he considered to be healthier, he described how he used 'healthy eating' and exercise to balance his heavy drinking. He believed this 'balance' allowed him to continue to 'drink

whatever I want'. He described this as the 'ying and yang of fitness'. This also enabled him to 'balance' his desire for a healthier body with his need to appear acceptably masculine to his peers.

It seemed particularly difficult for the men whose identity rested on being perceived as a 'drinker' to sustain a more moderate level of drinking. Younger participants, like Paul, appeared to prioritise their masculinity over their health.

The challenges presented to men who embraced salutogenic practices

Participants who identified themselves as highly motivated with regard to their own health and fitness were typically a minority within a group that did not share the same zeal. One participant described how he had devised a 'challenge for himself' to follow an intensive exercise program and eat a low-fat diet (even though he was in the normal weight range when embarking on this) (Ross, 30, Health Change Group). However, others in the group seemed to find this behaviour challenging; another group member implied that men who engaged in regular physical activity when they 'did not need to exercise or worry about their diet' (i.e. if they were thought to be a normal weight) were less masculine than men who showed little regard for their bodies. Ross clearly felt a need to defend his interest in building a body he felt happier in (viewed as 'vanity' by his peers):

Steve (29): (Describing a gym) Some guys are just looking looking looking in the mirror...

Ross (29): (Interrupts) No you see I agree with you.

Steve: ... all the time. It is just a total narcissism just looking at yourself like that. Most of the sports that you do ... you're not automatically spending time in front of a mirror.....

RO: But why shouldn't you?

Steve: Yeah but it's just narcissistic. You know you're looking after yourself and that's fine.

Ross: I mean I've looked in the mirror but I don't go about going (pretends to admire himself in the mirror).

Health Change Group

The majority of the participants in the Health Change Group shared a common interest in engaging in sports such as football or running. However, there was the suggestion that participating in these activities had less to do with the health and appearance of their bodies and more to do with being seen to engage in a key practice of masculinity; competition with other men. While Ross clearly had felt able to continue with his routine regardless of how his peers viewed it, he was required to provide the group with an assurance that he was not involved in any practices that would jeopardise his own, or the group's, sense of masculine identity.

It is easy to see why enthusiasm for such healthy practices could wane, even for highly motivated men, in the face of such challenges from peers. Participants emphasised how important it was for them to be 'seen' to be engaged with, or indeed rejecting of, health-related behaviours depending on what was deemed to be 'acceptably' masculine within their peer groups. As one stated: 'you don't want to

feel ostracised' (Jake, 33, Slimming Group). When discussing the acceptability of certain behaviours among men, another said:

It becomes the thing to do for that group. As I was saying earlier on... in a certain environment it becomes the thing to do to go to a sports club, to eat the right kind of food, to take care of your health. It's acceptable for men in some walks of life to be quite fastidious about what they eat and what they do. In other areas you're just sort of looked on as some kind of fruitcake for fussing about it too much.

Liam, 43, Mental Health Group

One man described how the same behaviour might take on different meanings in different social contexts depending on the kind of masculine practices privileged within particular groups. He described instances where he had felt he was being ridiculed by other men if he expressed a concern about the shape of his body or if he was seen to be actively monitoring his diet:

I watched what I was eating and that wasn't a problem for me. I didn't give a shit what anyone thought. They used to laugh at me eating my All Bran. I didn't care.

Nathan, 34, Slimming Group

However, despite such challenges from his peers Nathan felt able to seek support from another male group who had similar goals with regard to weight loss and healthy eating. Similarly, Jake described the camaraderie of belonging to such a group:

The patter's good. There's a couple of old guys in there. You'd just wet yourself just listening to them. Hearing the way they carry on... They've been coming since the year dot.

Jake, 33, Slimming Group

Membership of this group enabled participants to share a common goal with other men within an environment that had been negotiated as 'male'. This appeared to help them to deal with other social encounters in which their concern about food might be constructed as 'feminine' and therefore challenging to their identities as men.

The discussions also included, albeit to a lesser extent, some accounts of peer groups that encouraged men to have an open regard for their health with regard to diet or activity (including the Fire Fighter's Group, Asian Men's Group, Gay Men's Group, Prostate Cancer Group and the GP's Group). The group of fire fighters were probably the most notable for their shared interest in achieving healthy and fit bodies. The fire fighters described a culture where they were actively encouraged to 'swap recipes' and compare notes about the physical activities they did to maintain their fitness (see also O'Brien *et al.* 2005). Although some acknowledged that there were men in the fire service who were less interested in fitness and would 'slag you for coming into the gym; "what do you want to do that for?"' (Denny, 26, Fire Fighters Group), it was clear that their immediate team shared a common belief that care and concern about their health 'should' be integral to their identity as men and as fire fighters.

Linking masculinities, health and place: the 'West of Scotland man'

The subject of Scotland's poor record of health, viewed by many participants as 'the worst...in the world' (Chris, 30, Fire Fighter's Group), was raised

spontaneously in the majority of groups. Participants expressed a mix of horror, disgust and amusement in discussions of the excesses of the 'junk food diet' (particularly the deep-fried Mars Bar) and other poor lifestyle 'choices' they had observed in Glasgow. A number of participants believed that the unhealthy practices and inequalities that were perceived to be inherent in Glaswegian culture were compounded for men by pressures to live up to the 'macho' image of the male Glaswegian or the 'West of Scotland man'. Participants' constructions of masculinity in the West of Scotland predominantly presented images of working-class Glaswegian men (as opposed to descriptions of their own masculinity or of the masculinities of men they knew). One of the presentations of the 'West of Scotland man' included:

The average Scottish Man is overweight, he smokes, he's no' got a car. (citing a headline in local paper, *The Evening Times*) they had a cigarette hanging out of his mouth lying there with a poke of chips.

Sam, 34, Mental Health Group

A number of participants cited examples that exaggerated the 'legendary' toughness of Glaswegian masculinities. Some older participants alluded to violent masculine practices relating to male territory in Glasgow as exhibited through the 'gang warfare' of the 'razor years (1950's)...(where) you couldn't go out in certain streets because you...were afraid they (other men) would (attack) you' (Bill, 62, Unemployed and Retired Men's Group). Other participants connected the enactment of this kind of 'tough' masculinity to the heavily industrialised city that Glasgow once was, where 'men used to do tough physical labour' (Sean, 47, Student Group). Younger participants who had grown up expecting to do these kinds of jobs (predominantly in the Youth, Student and Gas Worker's Group) did appear to retain an idea that a particular kind of masculinity was exalted in their culture: 'if...you're dead hard, you're masculine' (Colm, 32, Gas Worker's Group).

Many of the younger men who identified themselves as 'working class' felt that the decline in heavy industries in Glasgow presented them with fewer opportunities to engage in practices that enabled them to enact a masculine toughness they perceived to be desirable in Glasgow. Some (particularly the younger men) suggested that by engaging in certain health-related behaviours, such as excessive drinking or being seen to flagrantly flout dietary guidelines, men could continue to construct and demonstrate masculinities that many felt were exalted in the social world they inhabited.

A query remains as to whether these data relating to men's constructions of masculinities merely reflect cultural ideals held by men in Glasgow and the West of Scotland or if the practices men describe are representative of ideals of masculinity in other regions in Britain. It is likely that the stoicism and toughness that participants often perceived to be 'Scottish' could also be interpreted as 'Irish', 'Welsh', 'Northern' depending on the social context and time of the interview (Balarajan and McDowall 1988, Scanlon *et al.* 2006).

Masculinity and health-related beliefs and practices across time and the lifecourse: prospects for change?

As well as references to masculinities that were socially located in specific parts of the West of Scotland there were also references to wider culturally held notions of

masculinity which were perceived by some participants to be undergoing change. Some participants described how they felt men still had the option to construct their masculinity along traditional lines but felt that they would be considered 'stupid' if they did so given the perceived consequences for their health:

We are in a changing world . . . I don't think men are as masculine. They're not as stupid to be masculine now as they were twenty years ago, thirty years ago, where it would have been a death sentence.

Nathan, 34, Slimming Group

Participants considered men who continued to resist alternative ways of constructing their masculinity to be a 'dying breed'. One group described such men as belonging to the 'old school' of masculinity (Fire Fighter's Group). One younger man felt that some images of masculinity that men had once aspired to were now considered to be 'dated'. He describes how contemporary images of men and masculinity might encourage a 'new breed' of men who embrace a different way of enacting masculinity through their engagement with more 'positive' health-related behaviours:

If you look at . . . John Wayne and his big beer gut. Yeah people like John Wayne right; big hard men. They're not exactly the most healthiest men. They weren't exactly you know prime . . . physically fit specimens. Whereas now if you look at the kind of guys that are (role) models and stuff all of them practically have a six pack . . . They're all exercising like mad! You never heard of John Wayne exercising. I think that younger people are wanting to be more like them (newer role models) and they kind of see the older stereotypes of maleness as being . . . a bit dated . . . So with these new role models come the way to look like that which is to go down to the gym . . .

Debu, 22, Student Group

There was some indication that certain health behaviours, such as smoking and drinking to excess, had been strongly associated with these 'outdated' notions of masculinity. One group were particularly scornful of the idea that smoking could continue to be perceived as 'macho' because the men who had embodied this kind of masculinity were now viewed as 'extinct':

(Following a discussion about the advertisement of smokers and how smokers are often depicted as sexually attractive).

Doug (47): Are you talking about Marlborough Man?

Keiron (36): No! That dinosaur? No thanks . . . Marlborough Man has lung cancer.

Rob (25): Well maybe in the past smoking (was) seen as a pretty masculine thing.

Gay Men's Group

Although John Wayne and Marlborough Man appeared to represent an archetypal masculinity for those who mentioned them, it was one that was associated with ill health; 'Marlborough Man has lung cancer' (Keiron, 36, Gay Men's Group). It was acknowledged that smoking and heavy drinking 'still went on' and continued to be associated with masculinity for some (particularly for alcohol). However, one participant believed that many men would now prioritise their health over the need to appear masculine by engaging in known high-risk behaviours: 'I don't think you get it the same . . . I think more and more (men) are becoming aware that you need to look after yourself' (Denny, 26, Fire Fighter's Group).

Most older participants also reflected on how their views on masculinity and health had changed over the lifecourse. Some pinpointed the start of working life as having a positive effect on their health practices. For several men, adult responsibilities that came with working, owning their own home or starting a family, with all of the accompanying money pressures, was also the need to 'grow out' of the health-related excesses they associated with youth. The Slimming group equated heavy drinking with demonstrating masculinity in their youth but described how they felt that it was no longer appropriate:

Howie (31): There's the going out and putting twenty pints down your neck every Friday, Saturday and Sunday night.

Nathan (34): Aye. Until you mature.

Howie: Aye. But some people never mature obviously you know things like that or the boy racer thing.

Slimming Group

There was a strong suggestion that men whose health-related beliefs and practices indicated that they had 'never mature (d)' because they continued to 'behave like an eighteen year old' regardless of family or work commitments, were frowned upon by some participants (Howie, 31, Slimming Group). One participant expressed anger at men who he perceived as being able to hang on to their 'hunter gatherers' attitude' (and related behaviours) unchallenged as they aged:

When you're a daft laddy you drink all weekend and you do all the things that you're meant to do as a teenager . . . Then you grow up and you realise well that was then, this is now. I don't want that anymore . . . You might get married. Life moves on. But a lot of people . . . (have) this . . . hunter gatherers' attitude. They get on my nerves. They get on my nerves because they're not being realistic. They're not being honest with themselves.

Nathan, 34, Slimming Group

Several participants appeared to share the expectation that men should place less emphasis on the need to appear masculine as they aged. One described how he felt there was less pressure to enact a particular kind of masculinity as an older man:

I think it's a stage you get through in life. I mean I took my trade in the North Sea on an oil platform for five or six years and one of the guys I know he still calls me tiger, you know the North Sea Tiger that was me back in the seventies, eighties and it boosts your ego I suppose but I think it's when you're in your thirties and your twenties and thirties you want to be macho that is the way you are.

Callum, 52, Prostate Cancer Group

There was perhaps less incentive for older men who had remained single to challenge their behaviours or beliefs about masculinity. One man who had separated from his wife described his heavy drinking and said 'if an eighteen year old is doing it, I can do it' (Colm, 32, Gas Worker's Group). He viewed his lifestyle, which predominantly involved heavy drinking, as an escape from the responsibilities and monotony of married life and a way of preserving his youth; he was doing what a single man 'should' do. Another man in the same group who had recently divorced and described how much he enjoyed being single also felt that the reason why one of his friends was 'on at him' about his health practices (particularly heavy drinking) was 'probably (because) he's married and settled down' (Angus, 41, Gas Worker's Group).

However, as the majority of participants neared middle age, health and longevity became a much more central concern to them; 'you tend to consider health issues more . . . as you get a bit older' (Sean, 47, Student). One participant was approaching his father's age at death and this had caused him to reflect on what he believed was the cause of his death (heavy drinking). He discusses how the need to alter his own drinking habits had preoccupied him as he grew older:

When I was in my twenties I was a real headcase . . . Health didn't come into it. But now as I've got older I'm beginning to think about heart trouble . . . That's what my father got . . . So I'm beginning to think maybe I should cut back on the drink. But a big part of cutting back on drink is only because of the beer belly, which develops in later years . . . That's health for me at the moment; beer belly.

Aidan, 35, Student Group

Aidan seemed to be aware that the prevention of heart trouble might require a general overhaul of his approach to health, but the beer belly was the thing to tackle 'at the moment'. Signs of ageing appeared to act as a visual reminder that their bodies might require greater care as they got older. As one participant stated: 'health is more immediate (now) . . . There (are) more things dropping off you and things sagging' (Aidan, 35, Student Group).

However, those who had experienced serious health problems found it necessary to make more drastic changes to their behaviours. For one participant, being weighed at the doctor's had 'scared the shite out of me and that was it. The diet started basically the following week' (Jake, 33, Slimming Group). As the risks of being morbidly obese had been made clear to him, he felt he had no choice but to take action:

It's half by choice (and) half I need to lose weight. I've (got) three kids. If I don't lose weight I won't see them going to college or whatever they decide to do with their life. It's a simple choice - do I want to live or do I pack up?

Jake, 33, Slimming Group

Similarly, one of the youngest participants to suffer a health scare described how discovering a tumour (which proved to be non-cancerous) had 'woken him up' and prompted him to re-evaluate his diet and levels of physical activity:

Before Christmas I found out that I had . . . a tumourous growth in my back . . . That changed things for me and since then I've been . . . into healthy stuff and I'm eating fruit and all that stuff . . . It's just the shock. It's not life threatening, (but) it woke me up.

Vikram, 21, Asian Men's Group

Another man expressed similar fears after experiencing chest pains at the age of 31. Having resisted change for so long, the prospect that his lifestyle could kill him became a reality. He spoke about his motivation to change for the sake of his daughter:

The thing that's most encouraging me is (that) my daughter's twelve years old. I want to live to see her being nineteen, twenty. I want to live to see her get married and (have) children . . . When I had chest pains I should have really done it then. But unfortunately . . . (with) people saying 'you've got to watch what you're doing now' and I've never been one to go on advice that other people give, it pushed (me) in the opposite light.

Colm, 32, Gas Worker's Group

Colm had earlier described how he had almost been initiated into practising masculinity in a particular way through the 'rites of passage' he had shared with

his cousin and he seemed reluctant to relinquish the behaviours he associated with being ‘manly’. However, following his own health scare and that of his cousin, he seemed to recognise that the lifestyle he viewed as being symbolic of his status as a man may have contributed to them both becoming ill. He described how he had begun to make a concerted effort to cut down on drinking and ‘eat healthier’ and ‘I’m back playing football again’ (Colm, 32, Gas Worker’s Group).

Discussion and conclusion

The data presented here support findings reported elsewhere which suggest that the adoption of particular health-related behaviours, for example the ‘competitive drinking’ described here (see also Lemle and Mishkind 1989, de Visser and Smith 2006, 2007, Emslie *et al.* in press) may be understood as a way of ‘doing gender’ (Saltonstall 1993, Williams 2000). Men who, for complex reasons, persisted in engaging in potentially health-damaging behaviours in order to construct their masculinities clearly present the greatest challenge for healthcare providers and those working in health promotion. Less is known about the circumstances that encourage men to re-think performances of masculinity that have potentially detrimental health effects. However, the data presented here suggest that ageing, illness and fatherhood were some of the experiences that prompted men who may have previously prioritised a particular construction of masculinity to re-evaluate their health practices.

It was rare, in the context of these all-male discussions at least, for younger men in particular to critically examine their views on hegemonic masculinity and reflect on how these may have interfered with engaging in recommended health practices unless this met with their group’s collective representation of masculine identity. Some of the data presented here suggest, in line with other findings, that for young men ‘male peer group networks are one of the most oppressive arenas for the production and regulation of masculinities’ (Haywood and Mac an Ghail 1996, p. 54). There was a suggestion, reminiscent of Foucault’s model of the panopticon (Foucault 1995), that some men monitored and corrected their behaviours without active social pressure because they had learnt to view their masculinity and masculinising practices through the eyes of other men. As these and possibly other processes could clearly affect men’s willingness to engage in certain health-related practices, it seems particularly urgent to gain further insights into how men’s masculinities are policed and negotiated through everyday interactions (Kehily and Nayak 1997).

Many men felt there was continual pressure to present themselves in conversation with other men as ‘uncaring’ about their health in conversation with other men. Taken at face value such data would seem to lend weight to arguments that men can appear to be ‘indifferent and resistant’ (DoH 1993) to health promotion messages. However, Robertson (2003) has highlighted the need to be cautious when interpreting men’s representations of their health. He argues that how men actually behave may differ from how they *say* they behave. It is important to highlight that participants in this study presented accounts of their health-related beliefs and practices for the consumption, and sometimes approval, of other men in their group. The accounts therefore included: (1) the group’s collective constructions of masculinities with reference to what was acceptable practice within their group and beyond (e.g. accepted practice in the West of Scotland and wider culturally held

notions of masculinity) and (2) men's reflections on their actual practices (past and present). While we do not doubt the very real pressures that men in our study described, we acknowledge that there is a need to be critical when reporting men's accounts of their 'poor' health practices.

However, this study is rare in capturing experiences of men whose sense of masculinity and membership of their peer group *depended* on them demonstrating their concern about their health by engaging in 'healthy' practices. It appeared that the groups of men who were united in either conforming to (e.g. the Youth Group) or rejecting traditional 'masculine' behaviours (e.g. the Fire Fighter's Group) had much in common. All were motivated to align themselves to the kind of masculinity that was valorised by their peers in order to avoid feeling 'ostracised'. It is rare to find accounts of men's health which include men who do not conform to traditional notions of masculinity or men who have previously conformed but subsequently found it necessary to depart from those at particular times in their lives (Carrigan *et al.* 1987, Courtenay 2000). Those who had felt ostracised by their peers (e.g. the Slimming Group) described seeking out other social groups where their behaviour was viewed positively and could be re-negotiated as 'male'. Similar findings that relate to the influence of peer group social norms in shaping individual behaviour have been discussed elsewhere (Berkowitz 2003, Courtenay 2004). However, these accounts rarely consider the positive influence that social norms may have on men's health-related behaviours.

Theoretical work on masculinities in the last decade has emphasised the importance of exploring the dynamic ways in which male identities are negotiated (Hearn and Morgan 1990, Morgan 1992, Brod and Kaufman 1994, Connell 1995). The findings presented here raise questions about how men of different ages, life stages and differing experiences construct their masculinity in relation to their health. A number of participants described 'growing out' of the worst excesses of masculinity that they associated with their youth and appeared critical of those who had not followed suit. Others have also suggested that there are widely held lay beliefs about the kind of behaviours considered appropriate at different stages of the lifecourse (Backett *et al.* 1994, Backett and Davison 1995). Some men who presented themselves as reluctant to health promotion guidance described how fatherhood was the only event that had encouraged them to adapt their lifestyle. This corresponds with other data that suggest that fatherhood might be beneficial to men's health (Bartlett 2004). The obligations of a father-child relationship and a committed partnership have been viewed as 'replacing the more 'chaotic' character of singledom, particularly for men' (Backett and Davison 1995). Our data lend support to arguments that a life-course approach might be particularly illuminating in understanding men's health (Arber and Cooper 2000, Lohan 2007).

The data also raise interesting questions with regard to the negotiation of masculinity and health-related behaviour in light of social change. Writers who have discussed the 'crisis of masculinity' have examined the critical events that they believe have led to the emergence of new masculinities (Kimmel 1987, MacInnes 2001, Beynon 2002). However, few have explored the contradictions and challenges these co-existing models of masculinities present to men or how these 'new' ways of articulating masculinity have impacted on men's health.

Crawshaw's analysis of the magazine *Men's Health* highlights the ways in which this medium departs from traditional constructions of masculinity and health (in constructing the male reader as 'interested in managing their own health and

engaging in an ongoing body project' (Crawshaw 2007, p. 1616)). However, clearly men like Ross (Health Change Group) who have an interest in engaging with such practices still live with challenges from other men who fear they are taking 'too much' interest in their body. Other writers have commented that the muscular body can simultaneously be viewed positively as a symbol of masculine attainment and as a source of suspicion as 'anything less than functional physicality (is) suspect' (Klein 1995). However, in different social contexts such pursuits may be viewed positively, as was the case with the gay men's group (Fawkner and McMurray 2002). In the Fire Fighter's Group work on the body was related to notions of masculine responsibility that echoed the way some participants had referred to their masculine responsibilities as 'breadwinner' (see also O'Brien *et al.* 2005). Mishkind and colleagues have suggested that:

Men arrange themselves along a continuum, from unconcerned with body at one end to extremely concerned at the other. This conceptualization may help predict the type and degree of behaviour in which individuals engage to change their physical appearance and come closer to the masculine ideal

(Mishkind *et al.* 1987).

However, it is clear from this study that the 'masculine ideal' may be understood by men to be related to appearance or to ideals about appropriate social practice for men depending on what is considered most important in their social group or in the light of circumstances thrust upon them (such as a serious threat to their health (O'Brien *et al.* 2007)).

Participants appeared sensitive to changes in the way in which gendered images of smoking have been presented (Elliot 2008). Although smoking was described as having been an important means of expressing a particular kind of masculinity in the past, many men expressed strong views regarding the 'death' of the image of the macho smoker. Other researchers have highlighted how the 'morass of complex gendered imagery surrounding smoking' has become increasingly feminised (Hunt *et al.* 2004, p. 247). Some of the men in this study certainly reject the idea of smoking as a masculine practice forcefully. However, there were many others, such as the Youth Group, in which smoking from a young age (in this case from the age of nine or 10) was a sign of masculine toughness and presented as a badge of honour to others in their group.

Courtenay has expressed the hope that social change might create a climate where 'men will begin to see... that following good health habits can be manly as well as lifesaving' (Courtenay 2004, p. 276). In this study, 'healthy' behaviours (e.g. healthy diet and regular physical activity) were constructed as both manly and lifesaving within particular contexts where this was permissible (e.g. the Fire Fighters Group). Many who showed awareness of changes at a cultural level described the practical constraints they continued to feel in everyday life to behave in traditionally masculine ways, particularly with regard to diet (see Gough and Conner 2006, Gough 2007). Further research might provide a more detailed examination of the social circumstances and characteristics of those men who appear able to embrace the idea that a concern with men's health is 'manly'. However, there is a need to explore the inequalities between men that currently mean that only *some* are free to embrace 'new' ways of articulating their masculinity which bring health benefits while others feel pressured to continue engaging in practices of masculinity that are likely to be harmful to their health.

Note

1. Paraphrasing a participant from this study and Leishman and Dalziel 2003.

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