


“Take a Spoonful of Concrete and Harden the **** up!”: How British Men in Hong Kong Talk About Health and Illness

American Journal of Men's Health
Volume 13(1): 1–13
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DOI: 10.1177/1557988319829334
journals.sagepub.com/home/jmh


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Abstract

The present study draws on semistructured focus group discussions conducted with British men living in Hong Kong to examine how men's constructions of masculinity influence health behavior and attitudes. Twenty-eight men aged 21–51 years were divided into groups based on age (≤ 35 years and ≥ 36 years); length of residence ranged from 2 to 20 years. Discussions were analyzed using open-ended thematic analysis. Following intensive analysis of the transcripts, four subthemes were identified and analyzed in greater detail: (a) health talk; (b) help-seeking behavior; (c) health risk; and (d) health motivations. Findings suggest a widespread endorsement of a hegemonic view of masculinity among men in the present study. Men expressed reluctance in seeking help for illness, regardless of age, particularly when experiencing symptoms of ill-health that were deemed to be “minor.” However, help seeking was embraced when it was perceived to impact masculinity, for example, when potentially related to sexual performance or function. While men in the present study were sometimes dismissive of health advice provided by family, they were more open and responsive to seeking help upon the advice of male friends. Findings are further discussed with reference to the relationships between masculinities and health; implications for health are discussed.

Keywords

gender, masculinity, health behavior, help-seeking behavior, men's health, qualitative

Received July 25, 2018; revised January 12, 2019; accepted January 15, 2019

In the past two decades, more attention has been paid to masculinity and men's health, and with good reason. Men around the globe have higher mortality and morbidity across all leading diseases (White et al., 2014), with women now outliving men by an average of 5 years (Rochelle, Yeung, Bond, & Li, 2015). Explanations for this gender gap in mortality and morbidity have focused on men's poor health-seeking behavior and how this impedes their health (Courtenay, 2011; Yousaf, Grunfeld, & Hunter, 2015). National figures have reported that men experience higher rates of injury and illness, take more risks with their health, and demonstrate an apparent reluctance to access health services (Office for National Statistics, 2012). The World Health Organization (WHO) recently set up a commission to examine social effects on health, and gender issues feature prominently in drivers for social change (Solar & Irwin, 2010). The fact that global governments and organizations are addressing and

examining the subject of gender issues demonstrates the importance that is being placed on the potential impact that these issues can have upon health. Research in the past few years pointing to the gender gap in life expectancy (Rochelle et al., 2015; White et al., 2014) only serves to further emphasize the importance of the issue.

From a theoretical perspective, hegemonic masculinity occupies its dominant position in gender relations, functioning to subordinate other forms of masculinities and femininities (OliFFE, Kelly, Bottorff, Johnson, & Wong, 2011). Hegemonic masculinity is the dominant

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ideology of masculinity for men across the world, idealizing power and control along with other qualities such as self-reliance and stoicism; it is expressed through behaviors such as sexual dominance, risk-taking, and physical and emotional strength (Calasanti, Pietilä, Ojala, & King, 2013; Jeffries & Grogan, 2012; Oliffe et al., 2018). Complicit masculinity has been described as compliance with dominant forms of hegemonic masculinity. According to Connell and Messerschmidt (2005), complicit masculinity sustains hegemony by enacting traditional Western social practices that position men as strong and independent and as providers. Connell's seminal work on men and masculinities has been applied to understanding men's behavior, including health behavior, and, as such, masculinity has increasingly been conceptualized as a health risk for men (Courtenay, 2011). Hegemonic constructions of masculinity have been attributed to men's engagement in risk-taking behavior as well as their reluctance to engage in health-enhancing activities (Dolan, 2014; Teo, Ng, Booth, & White, 2016).

However, this conceptualization of masculinity has not been without criticism, which has led to greater recognition of the diversity and fluidity of masculinities, and the coexistence of differing ideologies of masculinity (Levant & Wong, 2017; Thompson & Bennett, 2017). It is being acknowledged that there is not one universal masculinity but many masculinities that coexist among men in different societies, contexts, and cultures.

Social norms are defined as shared expectations about how members of a group should behave. Social norms have been reported to influence health behaviors, such as alcohol and tobacco consumption and dietary habits (Allmark, Grogan, & Jeffries, 2018). Male gender identity emerges from social interaction through a range of gendered practices that men engage in (Levant & Wimer, 2014; Yousaf et al., 2015), and, as such, gender role orientation has been identified as playing an important role in health behavior (Caroli & Weber-Baghdiguian, 2016). Findings in the literature support the notion that women pay more attention to their health than men do (Ek, 2015). Women are reported to value their health more than men do, with health matters identified as more salient among women (Caroli & Weber-Baghdiguian, 2016). Women have also been reported to positively influence the health practices of men through their nurturing behavior (Courtenay, 2011); this behavior is reported to be a compensatory measure for men's disregard in looking after their own health (Bottorff, Oliffe, Kelly, & Chambers, 2012). These social norm practices reportedly contribute in part to the fact that married men live longer than single men, not to mention the significantly shortened life expectancy of widowed men (Liu, Waite, & Shen, 2016).

The propensity for men to engage in particular types of masculine behaviors is recognized to be influenced and constrained by factors such as social class and ethnicity (de Visser & McDonnell, 2013; Dolan, 2014). Implicit in explanations of men's health is the view that men often do not take personal responsibility for their health (Dolan, 2014). Although hegemonic masculinity is more often associated with health-impeding behaviors, resulting in much of the earlier masculinity and health behavior research examining behaviors such as substance misuse, with a particular focus on alcohol consumption (de Visser & McDonnell, 2013; Iwamoto, Corbin, Lejuez, & MacPherson, 2014), there is also evidence that some behaviors can have potential benefits to men's health, such as engagement and participation in sports (Hunt et al., 2014). Qualitative studies of masculinity and men's health behavior have examined healthy masculinities and the way that men frame their health differently from women (Sloan, Gough, & Conner, 2010). Studies have also examined men's dietary behavior and barriers to healthy eating (Mellor, Connaughton, McCabe, & Tatangelo, 2017), with findings from one review indicating that men's persistent adherence to hegemonic masculinities and men's perception of diets as feminized has led to the belief that "real men don't diet" (Gough, 2007). While the WHO recently revealed that men engage in more physical activity than women (WHO, 2013), studies report that men often feel the need to justify their engagement in health-enhancing behaviors (Allmark et al., 2018). A recent review of factors associated with delays in both medical and psychological help seeking identified reluctance to express emotions and concern about health as a prominent barrier to help seeking among men (Yousaf et al., 2015). Age differences have been identified in perceived threats to masculinity; younger men are reported to experience a greater perceived threat to their masculinity in the advent of ill health compared to older men, with illness being viewed as weakness and a threat to masculine capital (Thompson & Bennett, 2017). Pride has also been reported in men's health behavior, the pride of maintaining good health independently, without assistance from doctors (Harvey & Alston, 2011). Finding ways to encourage men from a younger age to develop healthy masculine identities is of interest to health psychologists, as well as being important for the potential benefits to health.

Qualitative research can be used to complement quantitative research on men's health by adding texture to and elaborating on the often complex ways in which men navigate taking care of their health through a lens of masculinity (Allmark et al., 2018; Dolan, 2014; Oliffe et al., 2018). Little is known about the health of British men overseas (Rochelle, 2019a). Hong Kong is an eclectic mix of East and West, resulting from its time as a British

colony where it enjoyed relative autonomy until 1997 when Hong Kong became a Special Administrative Region of China. Since this time, China's grip on Hong Kong has become increasingly influential (French, 2017). How has this increasingly pervasive Chinese influence impacted on the behavior of British expatriate men in Hong Kong? Using a qualitative approach, the present study explores how British expat men in Hong Kong talk about their health and illness behavior, exploring the narrative of men's health using focus group discussions among British men living and working in Hong Kong. Findings explore how men's constructions of masculinity influence health-seeking behavior and attitudes toward health. Focus group discussions described here form part of a larger, mixed-methods study examining constructions of masculinity and health-seeking behavior among men in Hong Kong.

Methodology

Focus Group Discussions

The focus group discussions presented here form part of a larger mixed-methods study examining constructions of masculinity and health behavior among a cross-cultural sample of men in Hong Kong (Rochelle, 2019a, 2019b). A total of 28 men were recruited to the present study, with ages ranging from 21 to 51 years. As Caucasian men are a relatively small and hard-to-reach group in Hong Kong, men were recruited by a variety of different means, including posting notices on online forums, social media sites, and local expatriate groups online, and applying snowballing sampling. Men were initially invited to complete a quantitative questionnaire examining masculinity and health behavior before being asked if they were interested in further discussing their health behavior in a focus group. Initially focus groups were planned for three different age groups (<35 years, 35–54 years, and ≥55 years). However, no men aged 55 and over agreed to participate in the focus group discussions. This resulted in focus groups with younger (≤35 years) and midlife (≥36 years) men only. An older Caucasian community in Hong Kong is relatively rare; it is common for expats to retire to their home countries once they are nearing retirement, which may go some way to explain the struggle to recruit older Caucasian men to the study. Participants were divided into groups by age: It was hoped that grouping men by age could help to facilitate discussion and generate interaction among participants who may have had similar life experiences or issues.

Four focus groups were conducted in total, with seven men in each group, and two focus groups per age group. Focus group discussions were structured around 16 questions concerning men's health and health behavior,

followed by discussion of these questions among the men, which allowed for natural discussion among the men themselves with minimal input from the facilitator. The focus group schedule was crafted based on previous literature and broadly covered questions and probes related to men's health behavior and approaches to help seeking. The schedule included items such as "Do you discuss your health with others?"; "When was the last time you consulted a health professional?"; "When you get symptoms, such as a sore throat or a runny nose, what would you do?"; "Have you ever delayed seeking treatment?"; "In what ways do you attempt to maintain your health?"; "What motivates you to become healthier?" All four focus group discussions covered the same questions, although participants had the freedom to introduce topics of personal interest and relevance that were not included in the schedule. All focus group discussions were conducted in English in a room at the academic institution of the researcher. The duration of the discussions ranged from around 60 to 120 min; all discussions were audio-recorded and later transcribed verbatim by the author. All audio recordings were deleted following completion of the transcriptions. The author was single-handedly responsible for the conduct of the focus groups as moderator and later transcribed the audio recordings; as such, no other individuals had access to the transcripts.

Ethical approval was granted by City University of Hong Kong Ethics Committee (Ref: 157413). Prior to their involvement, men were provided with participant information sheets detailing information about the study. Prior to each focus group, participants' rights to withdraw were clearly explained. Participants provided informed consent and the issue of shared disclosure was addressed at the start of each focus group by agreeing on anonymity among participants and providing each participant with a pseudonym. All focus group discussions were conducted in a room at the academic institution of the researcher. At the end of the focus groups discussions, participants were thanked and debriefed. The debriefing included more detailed information about the study as a whole, including the mixed-methods approach used, and how the focus group discussions could help add greater depth to the study findings. More information was also provided to participants on how the findings would be used for publication. Finally, men were provided with contact details of the researcher, so that participants could request further information at a later date, if necessary.

It should be pointed out that the moderator was female. Previous studies have noted the potential relevance of gender on data collection. For example, it has been suggested that the presence of a female interviewer may facilitate men to talk about issues (Lyons & Willott, 1999; Sloan et al., 2010). However, it has also been suggested that the presence of a woman may be

inhibitory in the context of male camaraderie (Gough, 1998). The moderator of the current study chose to take on this role; she (author) is a health psychologist with previous experience of conducting qualitative research and of conducting focus groups. The moderator also had prior experience of conducting research with men and, as such, felt she was best placed and fully equipped to take on and handle the role. The moderator was also from the United Kingdom and, as such, English was her first language and thus for practical reasons she felt best placed to lead the focus groups in a Chinese context. The moderator encouraged participants to discuss previous and current life experiences, sought specific examples from participants, and clarified unclear details in the interviews. In the present study, the men seemed to have no problem with freely discussing their health issues and practices, some personal, some less so, in the presence of a female moderator. For example, men felt comfortable enough to discuss their genital health: "I had a lump just around my nuts . . . I had a talk with my friends" (Y4, 26 years), genital help-seeking behavior: "The ultrasound scanning my balls . . . I'm just lying there with two women (doctors) groping my balls" (Y2, 29 years), their sexual performance: "We're all stallions!!" (M11, 47 years), and other risky behavior: "There's certain drugs I used to do when I was younger" (M6, 48 years) in the presence of the moderator, all potentially awkward subject matter to discuss in the presence of an unknown female. However, men in the present study often needed no prompting to freely discuss these issues among one another, demonstrating how the presence of a female moderator did not inhibit the discourse between men in the present study.

Analysis

Following initial transcription, all transcripts were read and reread by the author while simultaneously listening to the audio recording of the focus group discussions. All focus group discussions were listened to once again immediately prior to analysis in order to become reacquainted with the data and to conduct one final check for any mistakes in the transcription on the eve of the final analysis. All audio recordings were deleted following completion of the analysis. Methods of analysis used were drawn from interpretive description, whereby analytic approaches from a range of qualitative traditions were adapted and applied to inductively gain insights into men's health-related behavior (Olliffe et al., 2018; Thorne, 2016). Focus group data were read and analyzed on a line-by-line basis, and notes were made regarding interpretations and development of preliminary codes with the purpose of organizing the data. Using constant comparison techniques, interview

data were then compared within and across the focus group interviews; data were then able to be allocated descriptive codes (Strauss & Corbin, 1998). Numerous descriptive codes were initially derived from line-by-line coding. For example, the sentence "man the f**k up" was coded as "toughen up." Earlier on in the analysis process, a broader range of codes were used, some of which were combined as the data were reassigned, with overlap noted with some double coding. Descriptive codes were then subjected to constant comparison techniques until the codes started to form more analytic categories that described similar phenomena. Second-level coding then focused on making connections between codes and reassembling codes into themes to form more precise and holistic explanation of the phenomena (Strauss & Corbin, 1998). Analytical techniques used were both selective and functional, with the main aim being to generate themes for analysis (Willott & Griffin, 1997). The present study was particularly interested in how masculinity is constructed in the context of health behavior through the accounts of British men living and working in Hong Kong. Four themes were identified and analyzed in more detail: (a) health talk; (b) help-seeking behavior; (c) health risk; and (d) health motivations.

Findings

The sample consisted of Caucasian men aged 21–51 years living in Hong Kong. Men were recruited through a variety of different methods, including posting notices in online expatriate forums in Hong Kong and in an expatriate newsletter distributed among the Hong Kong expat community; snowball sampling was also applied. Three focus group discussions involving 28 White British men were conducted. All participants were born in the United Kingdom, in England, Ireland, Scotland, or Wales. One participant was unemployed; all other participants were in full-time, paid employment, living and working in Hong Kong. Years of residence in Hong Kong ranged from 2 to 20 years. All participants described themselves as heterosexual, and the majority (79%) of participants were married. Men were divided into groups based on age (≤ 35 years and > 36 years); it was hoped that grouping men by age would help facilitate discussion and generate interaction if participants had shared similar experiences. Eighty-six per cent had attained a high school or college-level qualification, while 14% attained a university-level qualification. Further details can be found in Table 1.

None of the men participating in the focus group discussions reported any major health problems. The men seemed happy to divulge details of the trials and tribulations of their personal health with other men in the focus

Table 1. Participant Sociodemographic Details.

| Pseudonym | Age (years) | Education | Marital status | Occupation | Hong Kong residence (years) | Place of birth |
|-----------|-------------|-------------|----------------|------------------------|-----------------------------|----------------|
| Y1 (FG1) | 26 | University | Married | Kindergarten teacher | 3 | England |
| Y2 (FG1) | 29 | College | Married | Kindergarten teacher | 3 | Scotland |
| Y3 (FG1) | 29 | College | Married | Managing Director | 8 | England |
| Y4 (FG1) | 26 | College | Single | Construction | 2 | England |
| Y5 (FG1) | 30 | College | Married | Kindergarten teacher | 4 | Scotland |
| Y6 (FG1) | 21 | College | Single | Construction | 2 | Wales |
| Y7 (FG1) | 25 | University | Single | Teacher | 2 | England |
| Y8 (FG2) | 34 | College | Married | Manager | 7 | England |
| Y9 (FG2) | 32 | University | Married | Manager | 5 | England |
| Y10 (FG2) | 24 | College | Single | Construction | 2 | England |
| Y11 (FG2) | 31 | College | Married | Manager | 5 | England |
| Y12 (FG2) | 27 | College | Single | Teacher | 3 | England |
| Y13 (FG2) | 27 | College | Married | Teacher | 4 | England |
| Y14 (FG2) | 25 | College | Single | Construction | 3 | England |
| M1 (FG3) | 43 | High school | Married | Construction manager | 19 | England |
| M2 (FG3) | 37 | College | Married | Manager | 17 | Ireland |
| M3 (FG3) | 39 | High school | Married | Recruitment consultant | 3 | England |
| M4 (FG3) | 46 | University | Married | Business owner | 9 | England |
| M5 (FG3) | 43 | High school | Married | Personal trainer | 20 | England |
| M6 (FG3) | 48 | College | Married | Manager | 18 | England |
| M7 (FG3) | 42 | College | Married | Manager | 16 | England |
| M8 (FG4) | 38 | College | Married | Manager | 13 | England |
| M9 (FG4) | 51 | High school | Married | Business owner | 19 | Scotland |
| M10 (FG4) | 44 | College | Married | Manager | 14 | England |
| M11 (FG4) | 47 | College | Married | Business owner | 12 | England |
| M12 (FG4) | 39 | College | Married | Manager | 9 | England |
| M13 (FG4) | 40 | College | Married | Construction | 14 | England |
| M14 (FG4) | 42 | College | Married | Manager | 10 | England |

group, despite not being familiar with one another, for example, detailing issues of finding lumps on their testicles or the inconvenience of hemorrhoids. However, while the men were keen to discuss their health with other men, many were explicit in their reluctance to share their health concerns with their wives or partners. Analysis is structured around the core emerging themes that emerged from the data. Findings presented examine men's attitudes toward health and how this influences help-seeking behavior; findings also discuss men's engagement in health-enhancing behavior and the motivations behind this behavior. The men interviewed drew on a range of discourses that constructed men as strong and independent. Men commonly ignored symptoms of ill-health and constructed a discourse of not needing help from a doctor; wives and partners were constructed as nagging and overreacting to ill-health. Regardless of age, evidence of men's reproduction and endorsement of a traditional hegemonic construction of masculinity are clear from the discourses presented.

Health Talk

Men differed in how much they discussed their health and health issues with others; while some men were happy to share, others were less forthcoming. Most men discussed their general health with friends, although there were variations in the information shared. Men had different motivations for wanting (or not wanting) to discuss their health with others; they also talked of approaching the discussion of health differently depending on who they were talking to. Some of the variations in approaches used were constructed as differences in "men's" and "women's" health problems. Differences were also observed in whether men were talking with their friends, family, or work colleagues:

Facilitator: Do you discuss your health with others?

M5 (43 years): I discuss basic fitness stuff, you know how to lose weight, how to get fit and healthy . . . all that kind of stuff. If there was anything seriously wrong it'd be with my mates I would discuss it with more than anyone else.

M3 (39 years): I had a bad case of piles [hemorrhoids] one time, I was telling everyone about them. . . . It's a problem that I think a lot of men have so you don't mind talking about it. . . . But I work with a load of girls, so I would never say "Alright girls, I've got piles so I'm going down the doctors." I'd just say "I'm going to the doctors." Whereas to the lads I'd say "I'm going down the doctors to get some cream again, them piles are doing my nut in."

Some men talked of engaging in superficial health talk, for example, in relation to general health and fitness, while others talked of not wanting to discuss their health; in general, the men talked of gaining comfort from consulting friends about health problems. Although some men expressed reluctance in discussing their health with others, this was generally related to whether or not the health issue was constructed as "personal" or "serious," in which case some men mentioned they may not wish to disclose their situation. The value of another's opinion was clearly acknowledged by most men, regardless of whether this advice was from a close friend or a family member. However, while some men confessed to divulging all health issues with their partners, others talked of avoiding, wherever possible, discussion of their own health issues with wives or partners. Motivations behind this behavior varied; while some men talked of sharing even minor ailments with their other halves in the hope of extra attention, others confessed to avoiding the discussion of ill-health altogether to avoid being nagged, or in the words of Y1 because "she [wife] just gives me grief." M5 talked of "annoying" his wife with discussion of his healthy behavior with the intention of seeking praise or impressing his wife with his improved fitness, specifying how he would mention good behavior to his wife in order to receive praise "in a haven't I done good way."

Facilitator: Do you discuss your health with your wife/partner?

Y1 (26 years): I try not to, she just gives me grief!

M5 (43 years): I annoy my wife telling her how great I am, my fitness level is getting better, I'm looking better in the shower. Haha . . . so basically yeah I tell my Mrs, sort of in a "haven't I done good" way.

M1 talked intently of only sharing with his partner when there is "nothing wrong," not wanting to disclose his situation "if it was something serious." When asked to clarify, he shared a recent incident when he discovered a lump on his testicle; he constructed this as a "serious" health situation and explained how he explicitly avoided telling his wife "because she'll just worry," thus demonstrating diversity in health information shared, who this information is shared with, and the motivations behind

this. This behavior could perhaps be motivated by not wanting to be perceived by others as being weak or vulnerable, or in the case of M1, he didn't want his wife to "worry."

M1 (43 years): I've got nothing wrong with me at the moment, but if I had something wrong then I wouldn't tell my wife. . . if it was a little thing then I'd tell the Mrs, but not if it was something serious.

M4 (46 years): I tell my wife about everything, even all the small niggly stuff that I wouldn't bore my mates with. I'd tell my wife about it because, you know, I want a bit of extra attention . . . get the dinner cooked for me. Hahaha . . . a bit of TLC.

Some men intentionally shared information when dealing with minor health complaints in order to gain some benefit, for example, in order to get advice from friends or, in the case of M4, that "bit of extra attention" from his wife or "the dinner cooked for me." This construction of stereotypical heteronormative gendered norms was interesting and clear in its intent among the men: Women were constructed as caregivers and nurturers, whose role it is to care, worry, and nag. However, when men perceived their situation to be more "personal" or "serious," reluctance was demonstrated in terms of who to share with and what information to share.

Help-Seeking Behavior

Men expressed a reluctance to seek medical help, particularly for minor illnesses and symptoms, constructing a discourse of men "getting on with things" and "not wanting to kick up a fuss" over minor illnesses and symptoms. When asked about the last time they consulted a medical practitioner, regardless of age (and if they could actually remember), the men interviewed confessed to very rarely seeking consultation with a practitioner; seeing a general practitioner (GP) was constructed as a waste of time. However, while all men dismissed the idea of seeking help for what were perceived to be "minor" symptoms, some men talked of not hesitating to seek help for something deemed to need "specialist" help. Consulting a doctor was perceived as a last resort for many of the men, with some explicitly saying they would never see a doctor for minor symptoms. The attitude of the men was very much that when experiencing minor symptoms, one should just "get on with it" (M2). Visiting the doctor was framed as pointless; M4 legitimized this avoidance behavior, explaining: "I just don't think that they [GP] know much more than your average intelligent person."

Facilitator: When was the last time you consulted a health practitioner?

Y5 (30 years): Jesus! I cannot remember, a long time.

M4 (46 years): I actually can't see any circumstance when I'd go. I have very little faith in, you know, doctors knowing more than me or you do about general stuff. . . . Now if it's something special that's wrong with me, then yes, I would definitely go and see a specialist.

None of the men in the study had recently consulted a GP; indeed, some could not recall the last time they sought medical help. Some of the younger men were more forthright in their assertions of what action should be taken when experiencing minor symptoms with hints of hegemonic bravado, the implications of which are clear: Men should "live through it" (M14), or "have a hot toddy or something like that" (Y2) when confronted with minor symptoms of ill-health.

Facilitator: If you get a symptom like a sore throat or a runny nose, what would you do?

Y4 (26 years): Take a spoonful of concrete and harden the **** up!

Y2 (29 years): Have a hot toddy or something like that, d'you know what I mean?

M1 (43 years): Jesus! I would never ever go to the doctor for a cold.

Men were constructed as often ignoring health problems, particularly those perceived to be "minor," and waiting for them to recover without medical help. Y1 described delaying seeking help for an ingrowing toenail until it got infected and he couldn't walk, framing the symptoms as minor because it was "just" an ingrowing toenail and therefore not deserving of attention until his discomfort became too much. This same attitude was often extended to more ambiguous symptoms; Y6 talked of potentially waiting as long as a month if he had a lump, sharing how he would only do something about it if it "didn't go away." The men talked of consciously delaying seeking medical help, because "you give everything a few days" (M3). Women's approach to health on the other hand was framed by men in terms of worry, which had implications for men's disclosure of health information:

Facilitator: Have you ever delayed seeking help when unwell?

Y1 (26 years): Yeah, I mean it was just for an ingrowing toenail but I actually couldn't walk on it.

M1 (43 years): Yes, when I found a lump on my balls. I went to see the doctor about it and stuff, but I didn't tell my wife because she'll just worry. She still doesn't know now

because she'll just worry. She worries too much, she's a great worrier is my wife. No, she knows nothing about it.

M3 (39 years): Give it a few days, I mean you give everything a few days.

Facilitator: Would you seek help if prompted by a close family member?

Y1 (26 years): It would probably put more urgency on me to do it if someone else told me to do it then yeah. I mean normally I'd just sit it out and wait and see what happens but yeah if someone else says "go" then....

M6 (48 years): It would have an influence but erm no, I wouldn't because I'm pretty stubborn me. On the other hand, if my mates said to me "Look you should really get that checked out" then it would influence me and I'd probably get it checked out.

M4 (46 years): It's easier to just go [home]. . . . I think we'd rather just go back [home] and lick our wounds you know and just get better that way.

From the discourse, it can be seen that younger men were more responsive to encouragement from family members: "Sometimes it takes a loved one to say . . . before you actually do something about it" (Y4), while others considered taking care of one's health an individual responsibility: "You shouldn't have to wait for someone to say" (Y10). M4 talked of men being "stubborn" as an explanation for not listening to health advice from family members, that men were more open to seeking help upon advice from friends "because there's more of a push," describing that "men are just built that way" as his explanation for why men are more responsive to the advice of other men over and above that of family members and loved ones when unwell. Showing an air of self-reliance, the men engaged in a discourse of pride and avoidance, with M4 explaining how it was "easier" to "just go back home and lick our wounds" when unwell than seek medical help. Using a striking metaphor to position men as strong and independent, illness is constructed as weakness, with a discourse of men not wanting to overreact to minor ailments and positioning themselves as strong.

Men talked of how fear or worry would prompt them to seek help for health problems they would otherwise ignore or delay seeking help for, implying that feelings of vulnerability also impact men's help seeking and motivate behavior change. It is interesting that while the men talked of discussing their health with other men, some men were more reluctant to share ambiguous symptoms with their loved ones, positioning themselves as strong and stronger than their partners in not wanting to expose their vulnerabilities, as well as potentially being

influenced by wanting to avoid worrying their loved ones, taking a practical stance of “find out what’s happening first” (M2). When M5 broached the topic of breast cancer among men, M2 was clear:

M2 (37 years): This is the sort of thing I’d definitely want to share with my friends. This is the sort of problem I’d tell my mates first without actually telling my Mrs. Anything you’re not sure if it’s serious, I would get it checked out first then mention it. You don’t want to worry them [wife]. I’d find out what’s happening first then mention it but I would share with my mates definitely to get advice and stuff.

M13 (40 years): It’s quite simple with me, if it’s serious enough, you know it’s worrying me slightly, just the slightest bit of worry, I mean it’s fear. It’s fear that drives you to see a doctor.

M1 (43 years): Yeah I mean honestly, joking aside, I’m terrified to go to the doctors in case there’s something wrong with me. That’s why I don’t want to go for a medical.

M3 (39 years): Yeah I’d go along with that. I think that’s . . . yeah . . . universal among men. You only avoid going through fear for a certain amount of time then if it [illness] didn’t wear out or die off you’d probably go [see doctor]. . . . I wouldn’t hesitate.

Facilitator: How about if you had symptoms that were less obvious, such as a lump. What would you do?

Y6 (21 years): It depends how paranoid you are about it. . . . I’d leave it and watch it, I think. For about a month at least. . . . If it got bigger or didn’t go away I’d do something about it.

Y2 (29 years): Happened to me a few weeks ago with my balls. I mean yeah I told the Mrs. straight away and I spoke to a few of my close mates and they said to go get it checked out.

M1 and Y2 both experienced the same symptoms on the same part of the body, and both immediately sought help when finding a lump on their testicles. However, while both men experienced similar symptoms and sought prompt medical advice, Y2 immediately told his wife when he found the lump, while M2 did not share the news with his wife; indeed, his wife remains unaware of his condition. Some men also admitted that they delayed seeking health care because of fear of finding out: “Honestly, joking aside I’m terrified to go to the doctors” (M1), implicating the role of fear and vulnerability in delaying seeking help. The role of fear was interesting and contradictory: On the one hand, fear was a motivator prompting some men to seek help for unknown symptoms; however, for others,

fear proved to be a deciding factor in keeping men away from the doctors.

Health Risk

The discourse between younger men when discussing health risk is interesting. Y5, at the age of 30 years considered himself too young to be more conscious of his health. When questioned about when his health would matter more, to the dismay of the rest of the table of men involved in the discussion, he pinpoints later life (“I’ve still got around 20 years at least”). This implies that Y5 sees his age as protection against ill-health and that he still has “quota” for his acknowledged unhealthy behavior, such as daily consumption of junk food because “it doesn’t matter yet.” Age is constructed as protection against his current engagement in risky health behavior, with Y5 believing he is still too young for his behavior to impact on his health. The men had a clear understanding of their health risks and acknowledged and discussed the ways in which they put their health at risk.

Facilitator: In what ways do you think you put your health at risk?

Y5 (30 years): Oh I’m too young for that, I’d say . . . even if I eat McDonalds everyday, which I do, it doesn’t matter yet.

Y3 (29 years): Yeah it does.

Y5 (30 years): Nah it doesn’t matter yet because I’ve still got around 20 years at least.

Facilitator: When do you think it will matter for you?

Y5 (30 years): In 20 years when I feel like I’m on the decline . . . I’d say I’m feeling ok at the moment, I’m feeling the same, I’m not feeling any worse.

Y4 (26 years): So you’re just going to wait for it to feel worse before you actually do something about it?

Y5 (30 years): Yeah probably aye like when I’m in my forties.

Health risks were framed as related to lifestyle and associated with being a man (“If I have a drink with the boys . . . my diet goes out the window”), lending support to men’s endorsement of hegemonic constructions of masculinity. Y4 talked of how age was a factor in concern for health explaining how when young, “you just wanna have fun and having fun means going out and drinking, smoking and taking drugs.” By implication, being healthy is framed as not fun, while unhealthy behavior, such as drinking and smoking, is framed as fun:

Y4 (26 years): To be honest though, when you're our age you just don't really . . . well I was going to say care about your health, but you just wanna have fun, and having fun means going out drinking beer, smoking.

M5 (43 years): I'm trying to give up smoking . . . yeah I drink excessively. My diet is pretty good but erm you know if I have a drink with the boys. . . . Basically my diet goes shockingly bad when I have a drink.

In terms of alcohol consumption, all men involved in the focus group discussions talked of regularly drinking alcohol. An association was made between alcohol and poor dietary habits, demonstrating an awareness of the impact their behavior can have on their health. Age influenced men's perception of time frame and propensity to engage in particular types of behavior; while Y5 talked of how his behavior of eating McDonalds daily won't yet impact on him healthwise because he's still young, M3 talked of limiting his consumption of convenience food ("I don't even let myself have it once a month now"), suggesting that age plays a role in the perceived impact of health risk behavior. However, while Y5 talked of planning to worry more about his health later in life "in 20 years time . . . like when I'm in my forties," already being 30 years old, 20 years' time would make him 50—meaning he has an unrealistic time frame.

Health Motivations

When discussing motivations to become healthy, the men talked of different factors. All men regardless of age were motivated to a greater or lesser extent by concern with their appearance. Men were motivated to improve their health in order to look good; younger and older men alike were driven by body goals: "I wanna get myself a beach body" (Y6). Some of these motivations were linked to an awareness of age and getting older: "No one wants to be that old guy sat in the corner" (M2). Other men talked of having physically demanding jobs requiring a certain level of fitness, which gave them allowances: "Well I've got such physical work, I don't feel like I need to go to the gym" (Y4). Men with families spoke of how patriarchal responsibilities and changing family makeup had impacted on their behavior and motivated them to become more healthy, wanting to be there for the family "in the long-term" (Y1). Men's relationships with their families were oftentimes presented in relation to their roles as providers:

Y11 (31 years): Yeah but all that changes [drinking, smoking, etc.] when you have a kid though.

Y1 (26 years): Oh God yeah massively. That's one of the things that's made me wanna get back in shape again . . . so

yeah I guess having a baby has motivated me more to get back in shape again and get healthy so I can just try to be there for them.

Facilitator: What motivates you to become more healthy?

Y1 (26 years): Leaving her [daughter] with only one parent so yeah that's a big, big changer for you. Trying to get myself fitter so I can be there for them [wife and daughter] in the long term.

Y3 (29 years): I've got my sister's wedding coming up, and the baby yeah. Maybe the wife would appreciate it a little bit as well if I'm fitter.

M4 (46 years): I think a bit of male ego as well. You know you don't want to look like a big fat lardy arse. You want to look good, you know as you get older, you want to kind of regain your youth a bit.

M2 (37 years): No one wants to be the old bloke sat in the corner.

Older men were conscious of aging and this was a motivating factor in looking after their health. M2's perception of no man wanting "to be the old bloke sat in the corner" is insightful in its revelation of the vulnerability of aging among men and the importance of keeping up appearances in order to avoid being "the old bloke sat in the corner." Men also spoke of wanting their wives to appreciate the benefits of their drive for fitness, while other older men spoke of the role of the "male ego" and the drive to "regain your youth a bit" as they aged, which was constructed as being young and fit because "you don't want to look like a big fat lardy arse" (M4). Conscious of idealized modern-day representations of masculinity, participants valued looking good as a by-product of engaging in healthy behavior.

Discussion

The present study used a qualitative approach to examine how British expatriate men in Hong Kong talk about their health and illness behavior. By exploring men's discourses about their health behavior, we can better understand how discussions of health shape behavior. Findings suggest a widespread endorsement of a hegemonic construction of masculinity among British expat men in Hong Kong. Men in the present study drew upon discourses of dominant hegemonic masculinity (Connell & Messerschmidt, 2005) that constructed men as strong, independent, and reluctant to consult GPs or take advice from loved ones. Illness is constructed as weakness; men constructed a discourse of not wanting to overreact to minor ailments and positioning themselves as strong, reluctant to present themselves

as being overly concerned with their health. On the other hand, women's approach to health was framed in terms of "worry," which lead to some men withholding information about their health situation from their wives or partners because they didn't want them to worry or because they didn't want to be nagged by their partners. Consistent with previous research, men were conscious of idealized modern-day representations of masculinity; participants valued looking good as a by-product and as a result were more motivated to engage in healthy behavior (Olliffe et al., 2018).

Men constructed themselves as strong, resilient, and in control, although they did acknowledge engagement in reckless and risky behavior. On the whole men were of the view that they didn't need to seek help for most ailments. Men were keen not to overreact to what were perceived to be minor illnesses and constructed themselves as resilient and tough, supporting previous research in this area (Jeffries & Grogan, 2012). Consistent with previous findings, men delayed seeking help and framed themselves oftentimes as self-reliant, where illness was constructed as a weakness (Jeffries & Grogan, 2012). Findings revealed the ways that men positioned their behavior and response to illness differently from women; where women were perceived to worry and fuss around illness, men just got on with it.

A clear distinction was made by men in the present study between what were perceived to be "serious" and "minor" symptoms. This is in line with previous research, which has identified that perception of the seriousness of symptoms influences men's decisions to seek help or advice (Grogan, Parlane, & Buckley, 2017). Help-seeking behavior was affected by men's perceptions of whether or not their health situation was perceived as "serious." Although men were keen to avoid seeking medical help for symptoms perceived to be minor, serious symptoms were treated differently. Two men in the present study had found a lump on their testicles, and although only one of the men had shared this information and sought support from his wife, both men had immediately sought medical assistance for what were deemed to be "serious" symptoms of ill-health.

Family and male friends played an important role in encouraging men to access professional help for any health concerns. From the discourse, it was clear that younger men were more responsive to encouragement from family members and while older men were more dismissive of concern or prompting from family members, especially wives, older men were particularly responsive to advice from male friends. Findings revealed that perceived reward also influenced the propensity for men to share health information with their wives or partners. When the sharing of information was perceived to be rewarding in some way, for example, in terms of

gaining more care and attention, the men were more than willing to share their health status. Some men were explicit in their discourse, explaining that sharing their ill-health status would mean getting more "TLC" and "getting the dinner cooked for me," demonstrating evidence of a strong heteronormative discourse among men in the present study. However, in cases where men experienced what they perceived to be "serious" symptoms, they were less forthcoming in sharing their health status with loved ones. This can have important implications—if men do not disclose their health situation to others and are reluctant to seek medical help, they may delay seeking help until a later date, which could have significant implications for their health.

Unhealthy dietary habits, such as consuming junk food and alcohol, were common behaviors embraced by men in the present study. Although, on the whole, family was perceived as a positive influence on men's health, health advice from male friends was often valued over and above the advice of close family members. Men's coping behavior when unwell was framed in terms of a "get on with it" mentality, with many men not being able to remember the last time they consulted a health practitioner. This supports previous findings, which demonstrate British men's endorsement of traditional hegemonic constructions of masculinity and the influences on health attitude and behavior (Dolan, 2014). In the present study, men framed their wives and partners as in need of protection from the worry of their poor health status. Phrases such as "she's a worrier my wife" imply a subtle message alluding to men's emotional strength compared to women, legitimizing their behavior of not sharing their ill-health concerns with their wives and partners.

The role of traditional masculine roles, such as being the provider for the family, encouraged some men in the present study to adopt an anti-stoic approach to their health. These men negotiated their masculinity, whereby they legitimized their nondrinking and nonsmoking and engagement with healthy behavior, by what has been referred to as "man-points" (de Visser & McDonnell, 2013), by their patriarchal achievements as father and leader of the family. This implies that competence in one valued masculine domain can compensate or make up for weaker performance in other valued masculine domains (Allmark et al., 2018). While the current findings provide support for theories suggesting men's health is at risk with greater endorsement of hegemonic masculine norms (Knight et al., 2012), findings also reveal instances where hegemonic discourses motivated men's engagement in healthy behavior. This provides further evidence that health behaviors are shaped by contexts such as age, class, and culture and are in line with recent research supporting a more nuanced approach to the relationship between masculinity and health (Allmark

et al., 2018; Calasanti et al., 2013; Oliffe et al., 2018). Men in the older focus groups discussed being motivated by “the male ego,” not wanting to be perceived as the “old guy,” wanting to “regain their youth” as they aged by engaging in more healthy behavior in order to look good, wanting to look fitter and younger, and engaging in behavior that could be interpreted as men resisting the idea of “being old.” In line with previous findings, older men in the study faced the contradiction between wanting to maintain their youth and their awareness of aging and its impact on their appearance (Calasanti et al., 2013).

Findings revealed that years of residence in Hong Kong had no real influence on health attitude or health behavior for men in the present study; constructions of masculinity were defined in clearly traditional, hegemonic ways, which influenced health behavior in ways echoed in previous research examining the health behavior of British men. The present findings show little similarity to previous findings on the health behavior of Chinese men in Hong Kong. While men in the present study were on the whole more reluctant to listen to the advice of a female family member, Chinese men are reported to be responsive to the worries and health advice of female family members (Rochelle, 2019b). The British expat men in the present study were infrequent visitors to the doctors, whereas previous studies of Chinese men in Hong Kong have not identified such a reluctance to seek medical assistance (Rochelle, 2019b).

The present study is not without its limitations, which must be acknowledged. While the current sample contained a broad age range of men, the sample size was relatively small; in addition to this, the British are a relatively small community within the Hong Kong population. Research with larger, more representative samples are required before the findings could be generalized. Focus groups require men to “perform” masculinity and health in front of others, which may lead to differences between what men say they do in front of other men and what they really do in practice (Farrimond, 2011).

This may occur less in individual interviews, which don’t require men to “perform” in front of their peers. Another point to note is that the moderator of the focus groups was female. Although it can be evidenced from the present findings that the presence of a female moderator did not seem to impact on the way men constructed their masculinities or discussed their health, some studies have observed that the presence of a woman may be inhibitory in the context of male camaraderie in the interview process (Gough, 1998). Meanwhile, other studies have reported that men find it easier to talk with women (Farrimond, 2011).

The present study used a qualitative approach to explore how men’s constructions of masculinity influences their

health behavior and attitudes among a sample of British expatriate men living and working in Hong Kong. Findings suggest that complex challenges are presented for health-care providers in encouraging men to proactively seek help for illness. Men talked of delaying seeking help for health-care issues. This can have potentially serious implications for men in terms of their health and for health-care providers in terms of the potential for increased health-care costs when patients seek care and treatment at later stages of illness. It is important to raise greater awareness among health professionals of the ways in which men position themselves in relation to discourses of masculinity and how men construct their health in relation to their masculinity. It is important for health-care professionals and health-care providers to take care not to reinforce dominant discourses and stereotypes of masculinity, which can have implications for men’s help-seeking behavior in relation to health. Echoing previous research, health promotion must enable the presence of a variety of discourses through which men can feel empowered to take care of their own health (Gough, 2013; Jeffries & Grogan, 2012). This study contributes to the growing literature on men’s health with findings providing support for the argument that constructions of masculinity and masculinity ideologies may be influenced by cultural values. The findings build on the existing body of research between masculinity and health and provide fertile ground for further studies examining the influence of culture on constructions of masculinity.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: The work described in this article was fully supported by a grant from the Early Career Scheme sponsored by the Research Grants Council of Hong Kong (Ref: 157413).

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