

Working Men's Constructions of Visiting the Doctor

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James R. Mahalik¹ and Faedra R. Backus Dagirmanjian² 

Abstract

To understand influences on medical help seeking in men from traditionally masculine occupations, semistructured interviews with 12 men employed in manual and industrial labor were conducted. The semistructured interview format explored participant men's understanding and experiences of annual exams and medical help seeking, their own and others' reactions to seeking medical help, and influences on their own care and understanding of what it means to seek medical care. Utilizing consensual qualitative research methodology, five domains emerged: *Social norms around medical care*, *managing threat*, *getting medical help is gendered*, *work-related influences*, and *pragmatic contributors to medical help seeking*. Results extended the literature by situating men's understanding of physician visits within a gendered and social context, and highlighting the influence of work and coworkers, where messages are often contradictory and inconsistent about medical help seeking. Future research should examine additional contextual factors influencing men's attitudes toward seeking health care, including race, culture, and sexual orientation, as well as seek to develop and evaluate interventions that promote men's utilization of medical services.

Keywords

physician visits, men's health, gender, masculinity

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There is substantial support for the long-standing stereotype that men tend to avoid seeing the doctor (Farrimond, 2012; Pinkhasov et al., 2010). Men are about a quarter as likely as women to have seen a physician over a 1-year period, half as likely over a 2-year period, and three times less likely during the past 5 years (Agency for Healthcare Research and Quality, 2012; Blackwell & Villarroya, 2016). This avoidance of physician visits is consequential, as it is understood as contributing to men dying at higher rates than women for 14 of the 15 leading causes of death in the United States (Arias, Anderson, Kung, Murphy, & Kochanek, 2003; Courtenay, 2000; NCHS, 2014).

Research examining U.S. samples about why men do not go to the doctor documents an array of reasons including not having time, not having insurance, and being uncomfortable with what they may find out (American Heart Association, 2015; Brahmabhatt & Parekattil, 2016). From a gendered perspective, seeking help for health concerns is usually cast as contrary to masculine norms (Courtenay, 2000). For example, asking for help for a physical problem from an expert in a situation in which

you are not in control is viewed as incongruent with being self-reliant, physically tough, and in control (Addis & Mahalik, 2003).

Hegemonic masculinities incorporate rejecting help as a way to assert masculinity (Sabo & Gordon, 1995). Acting "like a man" means to downplay self-care and health needs to portray males as the "stronger" gender (Bunton & Crawshaw, 2002; Connell, 1995; Courtenay, 2000). There is substantial support for this idea with research documenting that traditional masculinity predicts help-seeking behaviors and attitudes in men (e.g., Himmelstein & Sanchez, 2016a; Mahalik, Burns, & Syzdek, 2007; Seidler, Dawes, Rice, Oliffe, & Dhillon, 2016).

¹Boston College, Chestnut Hill, MA, USA

²Pace University Counseling Center, New York, NY, USA

Corresponding Author:

James R. Mahalik, Boston College, Campion Hall 312, Chestnut Hill, MA 02467, USA.

Email: Mahalik@bc.edu



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An extension of this line of thinking is that men's reluctance to visit doctors is part of managing threats to manhood status that seeking care may entail. The Precarious Manhood model (Bosson & Vandello, 2011; Vandello & Bosson, 2013) posits that men must carefully watch out for "social transgressions and shortcomings" that might jeopardize their manhood status (Bosson & Vandello, 2011, p. 28). Since "seeking professional help is itself a socially risky act given that men risk being seen as less manly for such behavior" (Vandello & Bosson, 2013, p. 106), men would be more likely to take some type of action (e.g., display courage through "toughing out" the problem), rather than to seek help. Thus, needing help for a health concern may be considered a masculine transgression, such that rejecting care becomes a way to reestablish manhood.

Another framework that addresses the social context of men's help seeking is the social norms theory (Berkowitz, 2003; Sieverding, Mattered, & Ciccarello, 2010). This model frames the act of getting help for medical issues as affected by two types of social influence. Subjective norms are information communicated to a person about what is expected or approved by important others. Descriptive norms are the behaviors of others that a person observes. Applied to medical help seeking, important others such as family members may communicate expectations to men about medical help seeking (i.e., subjective norms), and men will see—or not see—family members, coworkers, and male friends utilizing medical services (i.e., descriptive norms). Research supports that social norms influence health practices, generally (see Berkowitz, 2003), as well as specific men's health behaviors including physician visits (Mahalik & Burns, 2011; Mahalik et al., 2007) and cancer screenings (Sieverding et al., 2010). For example, both subjective norms assessed with items such as "My 'partner,' 'family,' 'most people I consider important,' respectively, think(s), I should undergo a cancer screening" and descriptive norms assessed by items such as "What do you think is the percentage of 'men your age' as well as 'men among your circle of friends and acquaintances' who regularly attend cancer screening examinations?" (Sieverding et al., 2010, p. 74) explained significant unique variance in men's cancer screenings.

It is likely that men's experiences with medical help seeking also vary as a function of the type of medical help being sought. For example, how a man reacts to an annual physical exam may be different than how he reacts to getting medical help when involved in an accident. Men might be reluctant to get an annual checkup because they are feeling fine and do not see a reason to go, whereas seeking medical help after an accident may activate other concerns. In terms of threat to manhood status, an annual checkup may reveal physical deficiencies or factors that

threaten a man's sense of himself as powerful and in control. Seeking help for an injury on the job may also be viewed as threat to lose status with coworkers if he does not just "walk it off." From the social norms perspective, annual exams are something men are more likely to schedule if important others communicate that it is expected and he sees other men getting an annual exam. He may experience social norms as leading him to avoid medical help seeking if important others on his job site communicate that he should tough out injuries and he does not observe other men leaving the work site for injuries.

How a man's job setting contributes to his experience of seeking medical help is an important question to address. For example, men are more often employed in jobs with more physical dangers such as the construction trades or other jobs that require physical labor (Bureau of Labor Statistics, 1998). Understanding the experiences of medical help seeking from men who work in physical labor may be particularly helpful, as these men tend to be more traditionally masculine (Levant & Richmond, 2007) and engage in more health risks (Choi, Redman, Terrell, Pohl, & Duffy, 2012). Given that research has largely overlooked this group of men whose perspective on medical help seeking has not been explored, a consensual qualitative research design (CQR; Hill, Thompson, & Williams, 1997) may be an ideal approach to constructing such an understanding. The CQR methodology takes an inductive approach to understanding phenomena by organizing participants' responses to interviews into larger domains, and categories within those domains, to give voice to participants' experiences. The purpose of this study is to use a CQR methodology to explore the constructions of medical help seeking from men employed in physical labor.

Method

Recruitment and Description of Participants

Participant men were recruited through newspaper advertisement in a large metropolitan area in the northeast United States. The ad described interest in interviewing men working in manual or industrial labor (e.g., factory workers, construction) between the ages of 21 and 70 years for a research study about men's health. The ad stated that participants would complete short questionnaires and a 1.5- to 2-hr interview about their health behaviors but that there were no physical exams or medical procedures. Selected participants were compensated \$150 for their time and travel.

Twelve men participated in the study ranging in age from 23 to 59 years ($M = 40.42$ years, $SD = 9.70$). Most were Caucasian ($n = 7$, 58%, African American = 3, 25%,

Table 1. Semistructured Interview Guide for Medical Help Seeking.

1. Answering on a scale from 1 = *Never*, 2 = *Rarely*, 3 = *Sometimes*, 4 = *Often*, 5 = *Usually*, or 6 = *Always*, how often do you get an annual physical exam?
2. What comes to mind when you think of people getting an annual physical exam from a doctor?
3. Research shows that men are less likely to have seen a physician in the past year than women. Why do you think that is?
4. Your answer to that question was _____ (e.g., rarely), what do you mean by _____ (e.g., rarely)?
5. You said that you got an annual exam _____. Tell me a little about the people in your life who also get annual exams and seek medical care _____ (e.g., rarely). People in your family? Friends? Coworkers? Neighbors? People on TV and the media? Anyone else?
6. Who are the people in your life who (*opposite answer*) get annual exams or medical care? (e.g., "usually" is the opposite of "rarely," "always" of "never," etc.; see the six choices on the Likert items for this.)
7. How did you come to be more (your answer) than (opposite answer)? [If participants have trouble answering, ask "Which people or experiences were most influential to you being more (your answer) than (opposite answer)?"]
8. What would people's reactions be if you changed in terms of getting an annual exam or medical care? [If you don't get information on both positive and negative reactions and why they would react this way, then ask, "Who would react positively to you if you got physical exam more/less often?" "Why would they react positively?" "How would you feel if they reacted positively?" "Anyone else?"; and "Who would react negatively to you if you got a physical exam more/less?" "Why would they react negatively?" "How would you feel if they reacted negatively?" "Anyone else?"]

[For Question 8, if they answered "Never or Rarely" in response to Question 1, then only ask them "More." If they answered "Sometimes or Often," ask them both "More" and "Less." If they answered "Usually or Always," ask them only "Less."]

Asian American = 1, 8%, biracial = 1, 8%), single ($n = 6$, 50%, married = 3, 25%, separated = 2, 16%, divorced = 1, 8%), and had a high school education ($n = 5$, 41%, not finished high school = 1, 8%, some college = 4, 32%, college graduate = 1, 8%). Half reported not having children ($n = 6$, 50%, 2 = one child 16%, 2 = two children, 16%, 2 = three children, 16%) and all described themselves as heterosexual. The participants reported having worked on average 10.25 months ($SD = 2.34$) out of the past 12 months, earning on average \$41,417 ($SD = 15.22$), in jobs including those of construction worker, contractor, deleader, forklift operator, laborer, landscaper, mail handler, mason, paint contractor, screen printer, truck driver, and warehouse worker. All but one of the men reported having medical insurance.

Procedure

Screening and interview protocol. Approximately 50 men responded to the advertisement within a 3-day period. The lead author conducted phone interviews with interested persons until 12 participant men were scheduled. Inclusion criteria include being male, between the ages of 21 and 70 years, working primarily in manual or industrial labor positions, having worked for at least 6 months during the previous year, and being English speaking. Exclusion criteria included a psychiatric diagnosis for a psychotic disorder or having received a medical diagnosis that requires lifestyle changes (e.g., diabetes). This study was approved by the Boston College Institutional Review Board (approval no. 06.038).

The lead author met individually with participant men in his university office where he reviewed the procedures of the study, encouraged questions about the study,

obtained written informed consent, completed other paperwork for payment, and then conducted the semistructured interview. The interview explored men's constructions of eight health behaviors (i.e., medical help seeking, alcohol use, seatbelt use, physical violence, tobacco use, exercise, diet, and help seeking for feeling depressed or sad). For this study, the data concerning medical help seeking through their responses to seven questions were examined. Sample questions from the interview included: "What comes to mind when you think of people getting an annual physical exam from a doctor?" and "Research shows that men are less likely to have seen a physician in the last year than women. Why do you think that is?" (see Table 1 for interview guide).

Sectioning transcripts and coding into domains. All material was transcribed verbatim removing identifying information and analyzed using CQR methods (Hill et al., 1997; Hill et al., 2005). In the first step, five graduate students in psychology (4 women, 1 man) worked in rotating teams of three raters reaching consensus about when a new topic started. This was marked in the transcript and these sections were used to identify domains. To code domains (i.e., what general topic was addressed in the section), the rotating teams of three raters independently read each section and identified a domain label (e.g., "Social norms around medical care"). The team of raters then discussed the domain labels until consensus was reached. The team then met to collapse similar domains into more inclusive domain labels.

Identifying core ideas. Transcripts were then organized into domains identifying the general topic in a section, and a new set of graduate students (1 woman, 4 men) read

Table 2. Domains, Categories, and Frequencies for Men's Seeking Medical Care.

Domain	Category	Frequency
Social norms around medical care	Descriptive norms	Typical (8)
	Subjective norms	Variant (7)
Managing threat	Must cross a threshold	Variant (7)
	Fear of learning something bad	Typical (7)
	Don't want to draw attention to self	Variant (5)
	Relief to know things are okay	Variant (3)
Getting medical help is gendered	Men tough things out	Typical (9)
	Women need more medical care	Variant (6)
	Men don't want to know	Variant (5)
	Normative for women to seek medical care	Variant (4)
Work-related influences	Can't miss work	Variant (5)
	Checkup needed for work	Variant (3)
Pragmatic contributors to medical help seeking	Positive view of annual checkup	Typical (9)
	Age	Typical (8)
	Experience with physicians and medical setting	Variant (6)
	Family history	Variant (5)
	Cost/insurance	Variant (5)

Note. $N = 12$.

the transcripts to audit each domain and abstract core ideas from the transcripts. Core ideas are succinct summary statements of the content within each domain across cases that capture "the participant's perspective and explicit meaning" (Hill et al., 2005, p. 200). The five raters independently read transcripts organized by domain and constructed core ideas for each passage. The team then discussed the core ideas, examining a variety of ways to understand the content and word the core ideas, until consensus was reached on the most accurate and concise phrases for participants' ideas. In this way, the team generated a consensual classification of core ideas for each domain across all cases (See Table 2).

Cross-analysis. After meeting and reaching consensus on core ideas for each of the 12 cases on each of the domains, raters developed categories from the core ideas that best represented specific themes within the larger domain. Each rater organized core ideas for each domain into categories (themes). The group then met weekly and argued to consensus on the wording and meaning of the categories as well as the placement of each core idea into a category. This stage of the process was iterative, in that as categories were created and modified, the core ideas that had been placed within them were reevaluated and placed accordingly, sometimes into a newly constructed category. This process yielded a categorization for each core idea and the corresponding participant remarks.

Audit. To check the domains and cross-analysis, the first author examined all data organized by domains and themes reviewing the wording of domains and themes and the accuracy of rater categorization. The

auditor discussed suggestions with the leader of the research raters (the second author in this study) concerning reclassification of some content and revisions to some of the categories.

Results

Five broad coding domains were identified from analysis of the content of the interviews. Consistent with CQR studies (Hill et al., 1997; Hill et al., 2005), the results were organized around the domains with the frequencies of categories (i.e., specific themes emerging from the core ideas within each domain) presented in Table 1. Categories were described using Hill et al.'s (2005) labels of *general*, *typical*, *variant*, and *rare* to reflect how frequently they occurred. General indicates all or all but one of the participants identified the category (i.e., 11–12 participants in this study). The labels typical and variant indicate categories identified by more than half of the participants (7–10) and more than one participant up to half of the participants (2–6), respectively. Rare indicates that the category was identified by one participant, and this were not included in the findings.

Social Norms Around Medical Care

The first domain reflected two types of influence that other persons had on men's medical help seeking. These types of influences are captured in the two categories Descriptive Norms and Subjective Norms, namely, whether men's going to the physician was influenced by what they observed others doing (i.e., descriptive norms)

and the expectations that important others communicated to them about physician visits (i.e., subjective norms).

Descriptive norms. Participants were very aware of how men at their work sites, and among family and friends responded to situations that might involve medical help seeking. Often their observations focused on other men refusing or delaying medical care. For example, M says that “guys that I work with” avoid medical care. TK reports how a man at his work site with a history of heart problems was complaining about shortness of breath.

I said go sit down, go lay down, go right here, sit down here or lay down here, don't go too far, I'm going to go call the nurse right now I don't care what you're saying. And he's like no, no, I, this is fine, I'll just, I'll take another nitro and I'll be fine.

MN relates how his older brother tends to avoid medical care when in need. He describes,

A doctor at [Name of Hospital] said you know, you're ignoring this it's only going to get worse. And he's got a hip problem, so they're both telling him, hip surgery and lower back problems. And he just, ignores those doctors

The influence of descriptive norms was also mentioned in terms of promoting help seeking. Some participants observed other men regularly using physician visits to keep themselves healthy. For example, TK says about a friend,

TK: He's the kind of guy who goes to the dentist every three months to get his teeth cleaned, gets his colonoscopy when he's supposed to, gets, goes to the doctor, his regular doctor yearly. Gets extra tests at his own expense just to be on the safe side. Just a very, very . . .

INT: He's using all available services.

TK: Yes, yes, very smart.

Subjective norms. In this second category, participant men were also aware of how expectations from important others, particularly family members, contributed to their medical help seeking. For example, in following up with TK about why he always goes for an annual exam, he says, “Because my wife insists (laughs). That's the bottom line, because we have the insurance, I'm getting the physical. Plain and simple, she wants to make sure I'm healthy.” Similarly, T identifies his wife's expectation that he gets medical care as the main reason he goes to the doctor saying, “Cause of my wife. I know it's good for me, I know I should do it, but the reason I do it is because of my wife. I don't know if I would otherwise.”

In an interaction with the interviewer, SR identifies his father as an important influence on his medical help seeking.

INT: You're a young guy, why do you go to the doctor every year?

SR: I don't know, just, I don't know cause of my father, it's good thing to do, keep your weight and, you know, just get checked out.

INT: You were saying because of your father?

SR: Yeah, he said it's a good thing to do, get checked out, you know, just like, a seasonal or yearly physical.

Managing Threat

In the second domain, men described experiences around threat that were connected to getting, or contemplating, medical help seeking. These experiences focused on their own reactions and judgments as well as being aware of how others may react to them in these situations.

Must cross a threshold. In the first category of this domain, participant men tended to believe that the need for medical care had to cross a certain level of severity for it to be legitimate. They described certain injuries as meeting that threshold and others as not. T points to this threshold line but also is specific about injuries that justify medical care. He says,

It's almost like, well, if you can keep working, then it's not bad enough to go. Can you keep working? Yeah? Then you don't need to go. The only . . . exceptions are like if you get something in your eyes, that you can't just rinse out.

The idea about still being able to work was repeated by other participants. CJ says, “Yeah, I mean people were pissed, cause I mean, all you do was just tear off your nail, throw a bandaid on it and, go to work.” Even when a boss at the work site says to get the injury treated, men would not seek help, as the injury did not cross their own personal threshold justifying care. T illustrates when he says,

I was putting together some boards. And nail gun shot through, hit a knot, came out the side and ripped through the tip of my pinky. Ripped it wide open. I didn't cry. I gave a yell. But that was it. My boss came over and said, you need to go to the hospital. I said no, taped it up, I mean it bled for quite a while, but. . . .

Fear of learning something bad. The second category in the Managing Threat domain emphasizes that avoiding medical care was one way to manage the anxiety that accompanied the possibility of bad news that might come from a physician. For B, this strategy makes sense because “maybe you don't want to hear that you have cancer, or you have AIDS or have a sexually transmitted disease, you just don't want to know. It's better to not know.” MH shared

this anxiety related to his own death when he says, “Yeah, especially if it’s well, if it’s, if it’s if you don’t have too long to live yeah, I think. I don’t think, I don’t want to know.”

Some men described that anxiety about negative medical news actually led to them canceling medical appointments. For example,

MH: Exactly, cause I used to always cancel my appointments. Just put it off.

INT: So you’d have an appointment, and days are getting closer, days are getting closer, what are you thinking and feeling?

MH: Anxiety level tends to go up and I just say, nah, I don’t feel like going, sometimes I might not be feeling good, and might think that, you know, something might be wrong.

Don’t want to draw attention to self. About half of the participant men described minimizing problems because they were uncomfortable with other people’s reactions. For example, TK says in response to a potential medical concern, “I don’t want to bother people, I’ll be fine, I’ll go call my doctor after I get off work and, I’ll be fine. I don’t want to make a spectacle.”

MN describes having his vision affected by an accident at work but trying to downplay it because “I felt a little foolish that I got myself in the situation.” He described what he did to avoid this discomfort created by his needing help in this way:

I couldn’t see, but I lied to him, but I said I can see a little bit. It was blurred vision, I wasn’t completely, you know, blacked out. So I started driving and I had a tough time driving, but I drive like a mile or two, pull over, wash out my eye a little bit and drive. But I, I didn’t bring it to their attention. Otherwise they would have driven me home, my car, someone else gets a ride. I was just trying to keep it as low-key as possible.

Relief to know things are okay. In contrast to the second category in this domain, *fear of learning something bad*, that described men’s avoidance of medical care to reduce their own anxiety, a smaller portion of the participants described using medical services to help them feel less anxious. For example, BK says, “I’m glad I went, and that there’s nothing else to deal with . . . I feel relief by that.” Similarly, SR describes going to the doctor as it made him less anxious when he says,

And also, it’s good for your, you know, positive, your well-being, you know, ok, yeah, everything’s alright, you know. A good kind of insurance. Yeah, I mean, it’s not going to kill you a couple hours out of a year to go to the doctor’s office and get that checked out.

Getting Medical Help Is Gendered

In the third domain, participants situated medical help seeking as a gendered event. They discussed men’s responses to needing medical attention and how women are gendered as weaker and in need of medical services. In discussing the gendered nature of medical help seeking, participant men constructed men as needing to be tough and women’s higher utilization of health care as evidence of their weakness.

Men tough things out. This category was the most frequently occurring in the domain and reflected participant men’s construction of masculinity to include refusing care to be masculine through the expression of toughness. T illustrated this in describing an accident at the work site and the reactions of coworkers to it.

T: He did it with a nail gun double shot, and he nailed two of his fingers together. He pulled the nail out. Now these are barbed nails [yeah]. But he took a pair of pliers [and he went backwards]. And, put his fingers underneath, where there was I think it was a steel i-beam, and just kept pulling, until he got the nail out, and it tore the hell out of his fingers. And he duck taped ’em. Never made a sound.

INT: Were you the only person who saw this?

T: No everybody did.

INT: And what was the general reaction and responses?

T: You’re nuts! Just that he was, he was the man, he was the boss, cause that was, that’s tough. You know, that’s tough.

He elaborated on this issue by contrasting tough working men with babies and little girls. He says, “Then you’ve got the other situation where somebody gets a little tiny scratch and they want to go see the doctor. And, they’re babies, go get an office job, if you’re worried about a paper cut get an office job,” concluding that getting help for most injuries mean “you’re acting like a little girl . . . to [be a little girl], yeah, it’s an insult.”

Women need more medical care. In this category, participant men constructed women as needing more medical care because of being frailer due to their physiology. For example, in response to a question about why women were more likely to go to the doctor than men, SR says, “They’re more sensitive I’d say. . . . It’s just natural, they have more things to take care of, you know,” and CJ suggests “I think women have a whole lot more to worry about.”

Other participants elaborated on this topic by describing other presenting issues that drive women’s need for medical care. For example, B says, “Well, cause women have more problems, with their period, you know, the

gynecologist stuff, so it seems that they're at the doctor's more anyways, so while I'm here I might as well get a physical."

Men don't want to know. In discussing the category *fear of learning something bad*, men discussed a general threat that could come from going to the doctor. In this category, participants discussed men's reluctance to learn bad news from the physician as there were gender specific threats to their sense of self and status as men. For example,

MN: If you take the same scenario, man and woman, with the same potential problem, I think a man would rather not know about it, and a woman would rather know about it and then deal with it.

INT: Sure. Why would a man rather not know about it?

MN: Again, what's the word I'm looking for, you find out you're not infallible, you're not a man. You're not indestructible kind of thing. I think that's more upsetting to a man than it is a woman.

Other men described the threat as learning about a loss of their competencies as men. SM related men's anxieties about learning negative medical news as "They don't like to be out of the action, they don't want to know that they have something majorly wrong with them. They figure they'll be limited in some capacity, they won't be able to continue with full activities."

Normative for women to seek medical care. Whereas the earlier category focused on women needing more care because they are viewed as more vulnerable, the final category in this domain reflects how men constructed seeking medical care as something typical of women and thus as normative for them to seek medical care. For example, B says,

B: I don't really know. My mother's always at the doctor she always has ailments, she's always doing something, she's always there, my girlfriend's always there.

INT: Mostly women that you know, seem to all kind of be.

B: Yeah, all the women in my life are always at the doctor's. MH agrees and recounts women in his life seeking regular medical care, but the medical care of men in his life is largely hidden to him.

INT: Where do your friends fall in that? So, your friend the cop, and the carpenter, and the engineer, where do they fall in terms of like doctor's visits and stuff like that?

MH: Um, the carpenter, I don't know, how do, how do you, that was, I [never] hear him say that I went to

a doctor. Engineer? Likewise. The police officer, I don't know.

Work-Related Influences

Work has been discussed across a number of categories in other domains. However, participants in the fourth domain also constructed unique requirements connected to work that intersected with their utilization of medical care. Interestingly, the two categories in this domain press men in opposite directions both to not seek care in order to work and get paid and to get medical checkups in order to be allowed to work.

Can't miss work. This category reflected the very practical consideration of not being able to miss work because of not getting paid and being under deadlines to complete work. For example, B describes the experience of a friend of his at work. He says, "He needed the money he couldn't miss work, you know, he wasn't in a position to miss days. . . . You know, I'll be behind on my bills, you know what I mean guys are just going for that paycheck every week, you know."

Other men reported the pressure of being under deadlines, so missing work would cause problems for them. After an accident, the doctor told MN to take a few days off, but he went back to work the next day. The interviewer asked:

INT: And the thinking behind that was?

MN: Well, I was trying, I was, it turns out I did something stupid. I was trying to make the deadline for the inspection so it wouldn't get pushed back, cause everything on a job has a time element.

Similarly, TG says that when people at his job site saw a large cut on his leg from an accident with the shears, they told him, "You gotta get a tetanus shot and everything." However, he felt that finishing work took priority over that concern, saying, "You know you get cuts on hands and bruises, you gotta work, you gotta work, gotta finish the job, so."

Checkup needed for work. Several men described that the decision to get regular medical checkups were taken out of their hands because they were required to have one for work. This led to conscientiousness about physicals as long as they were at a job that required one. For example, CJ said,

I don't feel as though there's nothing wrong with me I don't, you know, it's just for upcoming jobs it's basically because I have to in order to stay working. . . . A lot of companies want up to date physicals, you know. Similarly, MN describes that "I've gone through a period of time

where I've done [went for annual physicals] that because my job required it."

Pragmatic Contributors to Medical Help Seeking

The last domain describes other common factors that participant men viewed as contributing to their seeking care. The six categories include a positive view of annual checkups, aging, experiences with physicians, family history, and issues concerning cost of care and insurance.

Positive view of annual checkup. This was the most frequently occurring category in the domain. Nine of the 12 participants described prevention-focused checkups in a positive light. Most of them said this succinctly as if their short responses indicated that this was an obvious, commonsense thing. For example, in response to the question "What comes to mind when you think of someone getting a doctor's exam?" SM says, "It's a good thing, yeah. Preventative medicine." M, P, T, BK, and SR all have similar assessments. Respectively, they say, "I think it's a good idea, a very good idea"; "Oh, that's good, you better go!"; "It's a good idea (laughs)"; "I think it's a good thing"; and "Routine, you know, it's just something that you should do every year, I think everyone should get it done."

Unlike expectations of negative reactions from coworkers about seeking medical attention, participant men talked about checkups with a certain matter-of-factness that seems outside of criticism from others. For example, when the interviewer asked:

INT: Do you ever say like, ah, I came back from the doctor the other day, or blah blah blah, do they have any reactions to that, positive or negative?

MH: No, because, I said, I don't know I just tell them I went to just do my annual check-up, and that's that.

Age. Eight of the 12 men discussed how age had changed their understanding of medical help seeking. For example, BK said, "Especially the older that you get, you don't heal like when you were younger." Similarly, MN reflects,

But I've also been on the other end of the stick where I didn't see a doctor for many years cause I didn't have to and I felt, you know I felt good, I felt like I was in good shape. As you get older I think you change, you always try to do something preventative.

This sense of one's health vulnerability changing with age was true even for men who were fairly young. For example, M says,

I mean it's, I just turned 30 now, and health problems that even though I wouldn't call them problems are just starting to come up now. Taking medication for my acid reflux. And plus cholesterol is like right underneath what I should be concerned.

Experience with physicians and medical setting. Participant men related experiences that made them feel connected to, or alienated from, their physicians and the medical setting. On the positive side, several related experiences of liking the doctor who saw them because the interaction felt supportive. For example, T relates,

My doctor's pretty good she's, has been after me to quit smoking, but she doesn't raise the threats of throwing the black lung pictures up on the wall or anything like that . . . she's given me suggestions which are actually helping.

Similarly, M liked his doctor, which led him to be more engaged in the visit. He also valued how his physician developed specific expertise in issues for Black men. M says,

M: Cause he's a good man, kinda laid back but not too laid back, he'll tell me what I need to hear. He reinforced me, telling me I'm in pretty healthy shape which is good to hear, and he likes that I ask a lot of questions. . . . He's pretty good at answering questions.

INT: What are his answers like, that they seem to be like good at?

M: They reflect that he's had a special training, special seminars, and interacting with low-income males, Black males, cause he's familiar with those things that threaten my group most of all.

Other experiences led men to feel resentful and disengage from medical care. For example, B related,

They were trying to draw blood from me, and the bastard just kept missing the vein, and I was lying there and they, oh, well just one more time, one more time, one more time, it took them like forever to draw blood and I just, that was it. From that always stuck in my mind. I just want no part of it.

Waiting for the physician was also discussed as an experience of disrespect and powerlessness. For example, M says, "The waiting part is the most annoying part," with BK supporting this asking, "Why would they say 1 o'clock if they really mean 1:15 or 1:30?" When P discussed going to the physician for something that was making him anxious, he felt both powerless in having to wait for a long time and upset about the lack of support patients received in practical terms such as having available parking. He relates,

Made me sit for 5 and a half hours. Cause I was ready to go, you know what I got two parking tickets, 40, and 40. So I gotta move it from one place I moved it, now [Name of Hospital] is tough to park. After I got the ticket I said God-damn-it!

Family history. Participant men also recognized that their family history of medical concerns was a legitimate reason to be more proactive about annual exams. For example, TK reports, "Well I mean I'm pretty healthy, but, I had a colonoscopy done three years ago, because my younger brother died from colon cancer among other things, so my doctor said well, you should go to a colonoscopy." Similarly, T sees this as a priority given his family's history of heart disease. He says,

My dad has had two heart attacks, his brother died of a heart attack. So that's something I worry about when I go. Is there going to be something wrong with my heart. Like I said so far, so good, but that's my worry.

Cost/insurance. The final category in this domain reflects men's understanding that having insurance means that one is able to get health care. Because work can be irregular for men in physical labor, sometimes the participant men would not have insurance. This put an obstacle in the way of going to the physician, whereas having health insurance opens the door to care. For example, when asked why he only goes to the doctor periodically, BK reports,

BK: Because of insurance.

INT: Yeah, yeah. But if you had insurance you would go?

BK: Oh absolutely all the time, it would be like a 10,000 mile check-up on the car.

He elaborates that "I got a friend who works sometimes that doesn't work enough to have the insurance, and he might not go, only if it's like an emergency." In B's words, "It's easy to go when you have health insurance too though."

Discussion

The findings support previous research that practical (e.g., not having insurance) and psychological reasons (e.g., fear of learning bad news) contribute to men's avoidance of physician visits (American Heart Association, 2015; Brahmhatt & Parekatil, 2016). Results also indicated several factors that promoted medical help seeking, including important others' expectations as well as work policies that require annual exams. Beyond identifying a taxonomy of factors that inhibit or promote medical help seeking, the study provided evidence that understanding men's constructions

of physician visits should be understood within a gendered and social context. Specifically, masculinity norms, particularly physical toughness, were salient for men as they discussed medical help seeking (Addis & Mahalik, 2003; Courtenay, 2000; Himmelstein & Sanchez, 2016b; Mahalik et al., 2007; Seidler et al., 2016). Rejecting help asserted or confirmed their masculinity (Sabo & Gordon, 1995) as well as aided their construction of men in physical labor as stronger than women and other men who do not work in physical labor (Bunton & Crawshaw, 2002; Connell, 1995; Courtenay, 2000).

The experience of psychological threat was a prominent theme in the findings in terms of both the general psychological discomfort (e.g., not wanting to hear bad news) and rejecting health services as a way to avoid threat to manhood status. Participants seemed vigilant about losing status with their masculine peers and viewed seeking help with ambivalence even if directed to by a boss on the job. Instead, they tended to tough out injuries to get the job done rather than risk being called "soft," a "bitch," or a "baby." As such, many of the findings supported tenets of the precarious manhood model (Bosson & Vandello, 2011; Vandello & Bosson, 2013).

The findings indicated support for the social norms theory (Berkowitz, 2003; Mahalik & Burns, 2011; Mahalik et al., 2007; Sieverding et al., 2010), as men identified both important others and their observations of other men at their work sites as influential in their medical help seeking. However, these two influences were described as in contradiction to each other, with the subjective norms of important others such as family members communicating that they wanted their husband or son to take care of his health leading him to get medical help. In contrast, what men observed of other men, particularly men held with some regard on the work site, was that they tended to not seek help for problems, making it normative to avoid physician visits. It would be valuable to explore men's reactions to the conflicting expectations around medical help seeking of partners/family members and coworkers/supervisors in future research.

The findings also point to an important distinction made between men's routine, preventive care such as annual physical exams and experiences of injury or illness. Preventive care in the form of annual exams was largely valued by men in the study, even though a part of them felt the visits were unnecessary as they felt fine. Supportive of social norms theory, men described those visits as routine, normative events and had many examples of people who went for annual checkups. Similarly, men viewed going to the doctor more positively as they aged, or if they had a family history with a medical concern, as a normal thing to do.

However, participant men talked about their own experiences of being sick or injured, particularly on the job site, very differently, with seeking health services deeply tied into issues of gender and work. For example, they often described men who got hurt but would not seek care in order to get the job done. Seeking medical help was also gendered when men viewed medical care as normal for women because women were weaker and more vulnerable.

A larger picture of the findings is that men related how they received conflicting and inconsistent messages about approaching medical care. This supports Pleck's (1995) gender role strain model in that, on the one hand, participants recognized the importance of preventive care and seeking medical care when one needs help. Participants were also encouraged to get health care by influential important others, including family members, employers, the medical community, and at their job sites when injured as part of avoiding lawsuits for their employers. However, participants also tended to gender medical treatment as feminine and wanted to live up to a tough masculine ideal that rejected medical care. Participants were anxious about how other men would perceive them if they got treatment for "minor" things (e.g., gashes, losing a fingernail, shooting self with nail gun).

One way to reduce the contradictory and inconsistent messages that men experience related to gender and health would be to help men view medical care as supporting the ability to maintain important masculine roles. For example, instead of suffering longer with problems because being masculine means to tough things out, masculinity could be reconstructed to reflect behaviors that promote being successful in masculine roles such as being strong or able to continue providing for one's family. Supportive of this idea, O'Brien, Hunt, and Hart (2005, p. 503) noted that "help seeking was more quickly embraced when it was perceived as a means to *preserve* or *restore* another, more valued, enactment of masculinity (e.g. working as a firefighter, or maintaining sexual performance or function)".

Several limitations are noted for the study. Although men discussed being influenced by the factors identified, the study did not experimentally test men's reactions to experiences that would inhibit or promote their medical help seeking. Also, utilizing a sample of men from an understudied group with unique health risks and working in the masculine arena of manual and industrialized labor is an important strength of the study. However, generalization of these findings to other groups of men should be made with caution because the intersections among age, gender, race, immigration, language, sexual orientation, class, religion, and other social, political, and personal variables are likely to impact the ways in which men perceive visiting a physician. For example, similar to the findings in this study, Galdas, Cheater, and Marshall (2007) reported that White men were concerned about being seen as weak

when going for medical treatment, whereas they reported that Indian and Pakistani men in their study were more willing to seek treatment as they constructed masculinity as being wise, educated, and responsible for their family and their health. Hammond (2010) notes that African American men have unique medical mistrust about their interactions with the medical community and should receive specific attention from research about their experiences.

Conclusion

Many factors influence one's decisions about seeking medical care. For men, perceptions of help seeking for medical concerns can be highly gendered, making social norms and constructions of masculinity important factors in whether or not they seek care. The majority of men in the study stated positive views of the general idea of going to the doctor for checkups, but experienced a number of barriers to seeking care for themselves. These barriers were multi-dimensional, encompassing social (e.g., how they would be viewed by others), psychological (e.g., finding out they were not well), and pragmatic (e.g., not having insurance) concerns. Participants described having to navigate various societal and interpersonal messages about what it means to be a man and, specifically, to be a man working in manual labor. Often, it was either directly or indirectly communicated that in most scenarios, men should not seek out a doctor because to do so would be incongruent with traditional masculine ideals of toughness, self-reliance, and control. Work policies that mandated annual exams were effective for some men in this group, likely because when the reason for seeking care was placed outside the self, it gave them the opportunity to disown responsibility for the decision. Future research and intervention should continue to focus on how men can retain a sense of self as masculine while also engaging in the medical system in order to preserve their health and longevity.


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ORCID iD

Faedra Dagirmanjian  <https://orcid.org/0000-0003-3694-3564>

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