


THE PROBLEM OF MASCULINITY FOR MALE HEALTH

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Abstract:

Men's health has historically received little attention in terms of consultation, planning, strategy development or project implementation, but in recent years there has been an increased focus on gender in the context of men's health. Whilst in the past the focus on gender and health in Ireland has tended to be synonymous with women's health, the significance of gendered health practices (particularly gendered patterns of help-seeking) have more recently come to the forefront in the context of men. Men's reluctance to seek help and use health services is a concern across most Western cultures. Some commentary has suggested that men are victims of their own behaviour and the concept of masculinity. When forming a male-specific policy, health service providers and policy makers need to take men's self-monitoring behaviour into account, when attempting to engage men within the health system. This paper forms part of a wider study into men's health and focuses on masculinity as a potential problem in the socialisation of men.


Keywords: *male health; masculinity; male help-seeking*

EL PROBLEMA DE LA MASCULINIDAD PARA LA SALUD DE LOS HOMBRES

Resumen:

La salud de los hombres ha recibido históricamente poca atención en términos de consulta, planificación, desarrollo de estrategias o implementación de proyectos, pero en los últimos años ha habido un mayor enfoque de género en el contexto de la salud masculina. Mientras en el pasado el enfoque de género y salud en Irlanda ha tendido a ser sinónimo de salud femenina, la importancia de las prácticas de salud de género (en particular los patrones de género en la búsqueda de ayuda) han llegado más recientemente a la vanguardia en el contexto masculino. La renuencia de los hombres a buscar ayuda y utilizar los servicios de salud es una preocupación en la mayoría de culturas occidentales. Algún comentario ha sugerido que los hombres son víctimas de su propio comportamiento y del concepto de masculinidad. Al establecer una política específicamente masculina, los proveedores de servicios de salud y los políticos deben tener en cuenta la conducta masculina de autoseguimiento cuando se intenta involucrarles en el sistema de salud. Este artículo forma parte de un estudio mayor de la salud del hombre y se centra en la masculinidad como problema potencial en la socialización de los hombres.

Palabras clave: *salud masculina; masculinidad; búsqueda masculina de ayuda*

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1. Introduction

The profile of men's health has been raised internationally in recent years through a number of key mechanisms. Against a backdrop of a growing awareness of particular issues relating to men's health is an emerging international men's health movement (Johnston et al. 2008). A number of important international developments have resulted in a raised profile surrounding men's health in recent years. At an international level, the first World Congress on Men's Health was held in Vienna in 2001, and there have been a number of national and international conferences on men's health in Australia, the United States of America, Asia and Europe –including Ireland– (Richardson and Carroll 2009).

Other international initiatives in recent years include the launch of the International Society for Men's Health, the commencement of an International Men's Health Week, the launch of the European Men's Health Forum and the introduction of three academic journals devoted to men's health: *The International Journal of Men's Health*, *The Journal of Men's Health and Gender*, and *The American Journal of Men's Health* (Richardson and Carroll 2009). In 2004, the European Men's Health Forum launched a report that provided, for the first time, a comprehensive overview of statistics on men's health across Europe (White and Cash 2004). There has also been an increased focus by the World Health Organisation on gender mainstreaming in relation to health (Richardson and Carroll 2009).

The upsurge of interest and activity around men's health at international level has also been mirrored in Ireland. In recent years, there has been a growing awareness, and indeed concern, about the burden of ill-health experienced by men in Ireland, where men die, on average, approximately five years younger than women do, and have higher death rates than women for most of the leading causes of death and at all ages (Richardson and Carroll, 2008).

2. Why are men a specific health concern?

The gap in life expectancy is particularly striking between young men and young women. A more careful examination of aggregated data also reveals substantial differences between different categories of men, particularly in relation to socio-economic status and so, e.g. if compared to men in the highest occupational classes, men from the lower occupational classes have poorer health outcomes and experience significantly higher mortality rates (McEvoy and Richardson 2004). Indeed, despite unprecedented economic prosperity during the 1990s, men in Ireland are living only marginally longer (0.3 years) than the average man in the European Union, and it is also well recognised internationally that men are often reluctant to seek help and continue to present (too) late in the course of an illness (Richardson and Carroll 2008).

Whilst in the past the focus on gender and health in Ireland has tended to be synonymous with women's health (Richardson and Smith 2011), the significance of gendered health practices (particularly gendered patterns of help-seeking) have, more recently, come to the forefront in the context of men (Richardson and Carroll 2009). This reflects more deep-rooted and widespread changes that have occurred in gender relations. The increased attention to men's ill-health coupled with significant changes and challenges to more traditional roles and to men's sense of place in Irish society, provide an important backdrop to the development of men's health at a policy level in Ireland, amid the growing concern in Western countries in recent times about the burden of ill-health specifically encountered by men (Morgan et al. 2008).

In Ireland, as in other developed countries, the challenge to the position of men in gender relations has resulted in important changes in work practices, more “democratic family structures” (Richardson and Carroll 2009) and the continued blurring between more traditional male and female roles. The Irish Department of Health and Children argue there has been a rise in the level of interest and activity in the area of men's health in Ireland over the past decade that has revolved around research, advocacy work and a variety of grass-roots work in both the statutory and voluntary sectors (Morgan et al. 2008).

The World Health Organisation's globally recognised definition of health argues that health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (Saracci 1997). Whether men's health should be largely concerned with the functioning and diseases of uniquely male organs, such as the prostate, penis and testes, and related sexual health concerns, or whether it should be a response to the lower life expectancy and higher rates of many health problems and risk factors for men in society is often asked (Gregory et al. 2006). It is argued that a male health issue is one that appears from various physiological, psychological, social, cultural or environmental factors to have a definite impact on boys or men and/or necessitates male-specific actions to achieve an enhancement in health or well-being, at either an individual or a population level (Wilkins 2009).

3. Is men's behaviour and attitude (masculinity) towards health a reason for lower life expectancy?

White and Cash (2004) found in relation to men's health in Western Europe that even though overall health is improving for many conditions, there are still noticeable inequalities both between countries and between men and women. There are clear gender and gender-related differences in population health needs. Men have a distinct and universal disadvantage in all the major disease states that affect both genders. They have a higher rate of incidence for the majority of cancers than women and a higher rate of death across a wide range of major illnesses (White and Cash 2004). The increased attention on men's ill-health together with significant changes and challenges to more traditional male roles and to men's sense of place in Irish society, provide an important back drop to the development of men's health at a policy level in Ireland (Richardson and Carroll 2009).

Men's reluctance to seek help and use health services is a concern across most Western cultures (Galdas et al. 2005). Some commentary has suggested that men are victims of their own behaviour (Courtenay 2000a, 2000b; Peate 2004). When forming a male-specific policy, health service providers and policy makers need to take men's self-monitoring behaviour into account, when attempting to engage men within the health system (Elliott and Popay 2000; Smith 2007). To provide a more persuasive men's health policy argument in Australia, and to facilitate a broader conceptualisation of what men's health constitutes, male consumer viewpoints are considered when describing men's health (Smith 2007). Specific empirical data on male lay perspectives of health and well-being have however largely remained absent in research on men's health (Robertson 2006). This has been a contributing factor that has stalled the development and implementation of men's health policy in Australia (Lumb 2003).

The differences in help-seeking by males may be better explained as reflections of well-established cultural barriers to men's expression of emotions (Brody 2000). Despite an emphasis on different men's health problems, all men without exception, had problems in accessing mainstream medical services (Kierans et al. 2007). Explanations presented to Robertson (2003), by male participants have stressed that males did not want to waste the doctor's time; that males did not have the time; and that going to the doctor was not something that men do.

Rossi (1992) argues that men are socialised to hide their vulnerability and have a propensity to regard themselves as invulnerable to health concerns and injuries. Men have less knowledge of basic health information and are consequently less likely to engage in health promoting behaviours. This sense of invulnerability is evidenced in Ireland, where only 38% of men (aged 18 and over) report always adhering to the speed limit when driving, while 15% and 52% of men do not always wear seat belts, while travelling in the front or back of a car respectively (Richardson 2004). Further demonstrating men's attitude toward risk is that while 56% of men report "using sunscreen infrequently", men aged 18-29 and less educated men are more likely to expose their skin to the harmful effects of the sun (Richardson 2004).

Gender therefore, has a crucial bearing on men's health. How men perceive themselves as "masculine" impacts on the value they place on their health and how they manage their health within the healthcare system (Richardson 2004). White and Johnson (2000) argue that men who engage in health damaging or risky behaviours often do so to "prove their masculinity to others". Cultural expectations about masculinity shape the experience of boys as they grow up. Most at risk are the "boys who don't talk" (Kindlon et al. 2000). They become "ashamed of being ashamed and try to stop feeling anything". This makes them seem invulnerable, even to themselves (Levant and Pollack 1995).

The excess of non-fatal and fatal incidents among boys is part of a pattern of poor motor and cognitive regulation in the developing male, leading to an ill-judgment of risk (Levant and Pollack 1995). In adolescence, the nature of risk taking may change and lead to dangerous experiments with drugs and alcohol or to violence against self and others. The suicide rate in young men is several times higher than in young women and has risen alarmingly from the late 1970's (McClure 2000). The health outcomes of young men in Canada offer an alarming snapshot: young men are 3 times more likely to die from accidental death than young women; 4 times more likely to die from suicide; and half as likely to seek out health care services (Evans et al. 2011). For example in Nova Scotia, Canada, male youth (12-24 years of age) constitute over 50% of the youth population, however, health care contacts for male youth are almost half that of female youth. When boys do access health care, they are twice as likely to visit emergency rooms for injury/poisoning, and are three times more likely to die from accidental injury, including motor vehicle accidents (Evans et al. 2011).

Masculinity can be defined as the actions, attitudes and values that clearly identify someone as being a man (Courtenay 2000a). Connell (1987 p10) defines it as “a social construction, dependent on a specific historical time, culture and locale”. Such a definition captures the complexity of men’s lives, which “like all lives, are always individual, always particular and inexhaustibly various” (Frank 1993, p. 5), and moves away from the essentialist notion that a relatively stable or unitary masculine essence exists that defines men and differentiates them from a feminine essence that defines women (Petersen 1998). In addition, within any given society, there can exist a hierarchy of masculinities with an idealised version being dominant or hegemonic (Connell 1995).

Masculinity ideologies are belief systems about what it means to be a man, and the degree to which a man endorses and internalises his culture’s values and norms about masculinity (Addis and Mahalik 2003; Mansfield et al. 2003). In Western cultures, contemporary hegemonic masculinity is associated with being white, heterosexual and middle class, and possessing stereotypical masculine traits of assertiveness, dominance, control, physical strength and emotional restraint (Evans et al. 2011). As a result, many men experience subordination and marginalisation as a consequence of not measuring up to the ideal standard against which all men are judged (Evans et al. 2011).

Gender role socialisation has a clear impact on both the physical and mental help-seeking behaviour of men (Addis and Mahalik 2003). When a boy is taught the masculine ideology that real men do not show emotion and do not ask for help, it influences how he will view help-seeking acts and behaviours in the future. Connell (1993) suggests that only a small percentage of men actually can and do measure up to a hegemonic version of masculinity. This has significance in relation to men’s health practises, particularly for boys and men who jeopardise their health striving to demonstrate this ideal (Evans et al. 2011). When men then encounter health issues later in life, they may be less likely to admit their problems and seek help for them (Mansfield et al. 2003).

Kimmel (1994, p. 120) describes masculinity as “...a constantly changing collection of meanings constructed through our relationships with ourselves, with each other and with our world. Manhood is neither static nor timeless; it is historical. Manhood is not the manifestation of an inner essence; it is socially constructed. Manhood does not bubble up to consciousness from a biological makeup, it is created in culture. Manhood means different things at different times to different people. We come to know what it means to be a man in our culture by setting our definitions in opposition to a set of ‘others’ - racial minorities, sexual minorities, and above all, women”.

Masculinity is conceptualised as an action performed in social interaction (West and Zimmerman, 1987). Different types of masculinity are hypothesised to be available, and individuals enact a particular type through their behaviour (Johnston and Morrison 2007). It is also conceptualised however, that masculinity is fluid and capable of being renegotiated (Wetherell and Edley 1999). The same individual may therefore enact different forms of masculinity across situations in which different social expectations exist. According to Connell (2005), one dominant paradigm of masculinity exists within a culture, termed hegemonic masculinity.

Namely, Connell (2005) conceptualised hegemonic masculinity as a configuration of practises that are currently valued in a particular society and which are enacted socially. Hegemonic masculinity in Western society characterises men as powerful, self-reliant, inexpressive, heterosexual, successful and competitive (Levant and Pollack 1995). This conceptualisation influences the socialisation of men in Western culture from childhood (Shepard 2002) and functions as an archetype of what a man “is” and “does” (Kraemer 2000).

It is important to understand that men’s health behaviours are embedded in, and likely influenced by, the social context in which they live. From a social psychological framework, perceptions of normative group behaviours, also called descriptive norms, function to guide behaviour, by providing information about “normal” behaviour in social environments and constrain behaviour by indicating what behaviours are deviant or off-limits (Cialdini and Trost 1999). Cialdini (1993) argues that people are influenced by their observations of others because the “social proof” these descriptive norms provide saves time and cognitive effort, while giving guidance about behaviour that is likely to be effective. Applied to men’s health behaviours, perceptions of others’ health practises may provide information about how individual men should act, or not act, in terms of the health behaviours they adopt.

From an early age, parental responses to children are more accepting of emotion in girls than boys (Pollack 1995). In their early years, boys are taught to “suck it up” because “boys don’t cry” and that

showing emotion or vulnerability will have them labelled “weak”, a “sissy”, or a “girl” (Hamilton 2006). Socialisation into what is considered to be masculine ultimately focuses on a separation from what is considered feminine (Pollack 1995). Increasingly, men participate in “risky” practises that cause them hardship and pain, illustrating the way in which gender operates within an informal but powerful ideology of gender difference (Connell 2005). Whilst the traditional hegemonic masculine role is sometimes mocked in the mass media (Addis and Cohane 2005) or presented as problematic, such references concurrently maintain its dominance (Connell 2005).

The tendency for many men to engage in high risk practises (e.g. excessive use of alcohol, high speed driving, etc.), while avoiding preventative care, delaying treatment, and ignoring health information and physician recommendations, can be interpreted as practises of masculinity, which in turn, contribute to poor health outcomes for men (Taylor et al., 1998; Courtenay 2000a; Gibson and Denner 2000). That said, in most health analyses that have conceptualised “men as gendered”, little attention has been given to the ordinary, everyday practises that constitute masculinity (Frank 1993, 1997) and their effect on individuals and diverse cohorts of men.

Restrictive emotionality has been found to be a strong predictor of psychological distress for men in clinical and non-clinical samples (Cournoyer and Mahalik 1995; Good et al. 1995). Shepard (2002) proposes a connection between restrictive emotionality and a pattern of depressive symptoms characterised by a negative state of mind, and specifically self-dislike, feelings of failure, guilt and pessimism. None of these findings should be unexpected because masculine ideology is inescapably associated with cognitive distress (Mahalik 1999).

Men are considered to be stoical about illness and reluctant to seek help (Hodgetts and Chamberlain 2002). Men in the USA are more likely than women to adopt beliefs and behaviours that increase their risks, and are less likely to engage in behaviours that are linked with health and longevity (Courtenay 2000b). There are a number of interesting observations relating to the pattern of help-seeking and health service utilisation by men. These include that the initial approach by men for seeking help for health-related issues tends to be indirect; men tend to view their partners and friends as a primary resource for help (Smith et al. 2006). Rickwood et al. (2005) studied Australian youth and found that only 6% of men who had sought professional psychological help claimed they were not influenced to do so by others; one third claimed they would not have sought help without the influence of others, and almost 75% reported that they were influenced by more than one source. Steel et al. (2006) also found that social support increased the likelihood of more allied health consultations, suggesting that confidantes encourage sufferers to seek professional psychological support.

Dominant masculine cultures and values may negatively affect the patterns of illness and men’s experiences and behaviour (Seymour-Smith et al. 2002). Stoicism and suppression of emotion for example, are values often associated with masculine gender role socialisation (Lee and Owens 2002). Health promoting and coping behaviours are aligned with constructs related to traditional femininity (caring) and masculinity (stoicism), and health practices and behaviours may be understood as activities by which society constructs its understanding of self and gender (Saltonstall 1993). Men are, therefore, influenced by cultural stereotypes to ignore screening and preventive health care, and to delay help-seeking for symptoms (Smith et al. 2006).

Because health-promoting behaviours are linked with femininity, and risk-taking health behaviours are linked with masculinity, men’s alignment with masculine ideals is theorised to contribute to the health disparity between men and women (Evans et al. 2011). Courtenay (2000a) illustrates the risk associated with masculinity by suggesting that men who fall short of achieving idealised masculinity feel stigmatised or marginalised and respond through socio-culturally-defined compensating behaviours that place them at high risk of injury and illness. Courtenay (2000b) adds that men will often prefer to face risk and physical discomfort rather than be associated with traits perceived to be feminine, such as vulnerability, dependence and weakness. Because illness is furthermore associated with weakness and vulnerability, men’s perception of illness and their reluctance to seek treatment is understood as the avoidance of femininity or perceived emasculating behaviours (Evans et al. 2011).

Mahalik et al. (2007) argue the link between normative behaviour and one’s own behaviour is illustrated when a man perceives that his male friends are trying to quit smoking and, believing this to be normative behaviour, attempts to do the same. A man may form his perception of what is normative health care practice based on his recollection that his father never went to the doctor. This perception of normative

self-care for male family members, in turn, is likely to contribute to his reluctance to seek medical care. By contrast, if he observes men in his family prioritising health through exercise, a healthy diet, and not drinking or smoking, he should be more likely to adopt these behaviours himself (Mahalik et al. 2007). Perkins (2003) argues that men who may observe an action-hero who does not get medical attention after a bloody fight, or men in burger commercials eating “man-sized” triple cheeseburgers might conclude that these are normative health behaviours for men. If perceived as normative, men should be more likely to adopt those health behaviours, thus contributing to the problem of the “macho man” idea.

Mahalik et al. (2007) state that masculinity and perceptions of other men's health behaviours predict participants' own health behaviours. The study also shows that as men adopt traditional masculine ideals, they may be adopting health practices reflecting those ideals that put their health at risk. Perceptions of other men's health behaviours may be communicating “social proof” about health behaviours, and thus potentially guiding their own health behaviours. Health promotion efforts could be based on these results. These authors also addresses constructions of masculinity, where cognitive interventions could aim at modifying men's masculine-related cognitive schemas that interfere with healthy behaviours.

For a man who constructs a healthy diet to mean “eating like a girl”, cognitive techniques such as history review (e.g. his father's unhealthy eating led to weight gain, back problems, and heart disease) and exploring the logic of behaviour change (e.g. “eating better will lead to doing better at work and having more energy for my family”) might be useful in modifying his personal constructs to promote a healthier diet (e.g. “I don't want to have the health problems my father had. I want to be energetic at work and home, and having a healthy diet can help with these concerns”). Such interventions would be a logical extension of the finding that men' constructions of masculinity are significant predictors of health behaviours (Mahalik et al. 2007).

4. Final remark

This paper examined the key role of the concept of masculinity as a predictor of men's physical and mental health behaviour, with its associated beliefs of stoicism and invulnerability as key aspects of being a man. Men are often characterised as unwilling to ask for help when they experience problems in living. Popular stereotypes portray men as avoiding seeking needed help from professionals. This has huge consequences for how medical services can be best accessed by men.

References

- Addis, M. E., & Cohane, G. H. (2005). Social scientific paradigms of masculinity and their implications for research and practise in men's health. *Journal of Clinical Psychology*, 61(6), 633-647.
- Addis, M. E., & Mahalik, J. R. (2003). Men, masculinity, and the contexts of help seeking. *American Psychologist*, 58(1), 5-14.
- Brody, L. R. (2000). The socialization of gender differences in emotional expression: display rules, infant temperament, and differentiation. In A. H. Fischer (Ed.), *Gender and emotion: social psychological perspectives* (pp. 24-47). New York: Cambridge University Press.
- Cialdini, R. B. (1993). *Influence: science and practice*. 3rd ed. New York: Harper Collins.
- Cialdini, R. B., & Trost, M. R. (1998). Social influence: social norms, conformity, and compliance. In D. Gilbert, S. Fiske, & G. Lindzey (Eds.), *The handbook of Social Psychology* (pp. 151-192). Boston: McGraw-Hill.
- Connell, R. W. (2005). Globalization, imperialism, and masculinities. In M. Kimmel, J. Hearn, & R. W. Connell (Eds.), *Handbook of studies on men & masculinities* (pp. 71-89). Thousand Oaks, CA: Sage.
- Connell, R. W. (1987). *Gender and power: society, the person, and sexual politics*. Palo alto, CA: Stanford University Press.
- Cournoyer, R. J., & Mahalik, J. R. (1995). Cross-sectional study of gender role conflict examining college-aged and middle-aged men. *Journal of Counselling Psychology*, 42(1), 11-19.
- Courtenay, W. H. (2000). Constructions of masculinity and their influence on men's well-being: a theory of gender and health. *Social Science & Medicine*, 50(10), 1385-1401.
- Courtenay, W. H. (2000). Engendering health: a social constructionist examination of men's health beliefs and behaviours. *Psychology of Men & Masculinity*, 1(1), 4-15.

- Elliot, H., & Popay, J. (2000). How are policy makers using evidence? Models of research utilisation and local NHS policy making. *Journal of Epidemiology and Community Health*, 54(6), 461-468.
- Evans, J., Frank, B., Oliffe, J., & Gregory, D. (2011). Health, Illness, Men and Masculinities (HIMM): a theoretical framework for understanding men and their health. *Journal of Men's Health*, 8(1), 7-15.
- Frank, B. (1997). Masculinity meets postmodernism: theorizing the "man-made" man. *Canadian Folklore Canadien*, 19(1), 15-33.
- Frank, B. (1993). The "new men's studies" and feminism: promise or danger? In T. Haddad (Ed.), *Men and masculinities: a critical anthology* (pp. 333-343). Toronto: Canadian Scholars' Press.
- Galdas, P., Cheater, F., & Marshall, P. (2005). Men and health help-seeking behaviour: Literature review. *Journal of Advanced Nursing*, 49(6), 616-623.
- Gibson, M., & Denner, B. (2000). *Men's health report 2000: the MAN model. Pathways to men's health*. Daylesford, VI, Australia: Centre for Advancement of Men's Health.
- Good, G., Robertson, J., O'Neil, J., Fitzgerald, L., Stevens, M., Debord, L., Bartles, K., & Braverman, D. (1995). Male gender role conflict: psychometric issues and relations to psychological distress. *Journal of Counselling Psychology*, 42(1), 3-10.
- Gregory, A., Lowy, M., & Zwar, N., (2006). Men's health and wellbeing: taking up the challenge in Australia. *Medical Journal of Australia*, 185(8), 411.
- Hamilton, M. (2006). *What men don't talk about*. London: Penguin.
- Hodgetts, D., & Chamberlain, K. (2002). The problem with men: working-class men making sense of men's health on television. *Journal of Health Psychology*, 7(3), 269-283.
- Johnston, L., Huggard, P., & Goodyear-Smith, F. A. (2008). Men's health and the health of the nation. *New Zealand Medical Journal*, 121(1287), 69-76.
- Johnston, C., & Morrison, T. (2007). The presentation of masculinity in everyday life: contextual variations in the masculine behaviour of young Irish men. *Sex Roles*, 57(9), 661-674.
- Kierans, C., Robertson, S., & Mair, M. D. (2007). Formal health services in informal settings: findings from the Preston Men's Health Project. *Journal of Men's Health and Gender*, 4(4), 440-447.
- Kimmel, M. (1994). Masculinity as homophobia: fear, shame and silence in the construction of gender identity. In H. Brod & M. Kaufman (Eds.), *Theorizing masculinities* (pp. 119-141). London: Sage.
- Kindlon, D., Thompson, M., & Barker, T. (2000). *Raising cain: protecting the emotional life of boys*. New York: Random House.
- Kraemer, S. (2000). The fragile male. *British Medical Journal*, 321(7276), 1609-1612.
- Lee, C., & Owens, R. G. (2002). Issues for a psychology of men's health. *Journal of Health Psychology*, 7(3), 209-217.
- Levant, R., & Pollack, W. (1995). *A new psychology of men*. New York: Basic Books.
- Lumb, P. (2003). Why is men's health and well-being policy not implemented in Australia? *International Journal of Men's Health*, 2(1), 73-88.
- Mahalik, J. (1999). Incorporating a gender role strain perspective in assessing and treating men's cognitive distortions. *Professional Psychology: Research and Practice*, 30(4), 333-340.
- Mahalik, J., Burns, S., & Syzdek, M. (2007). Masculinity and perceived normative health behaviours as predictors of men's health behaviours. *Social Science and Medicine*, 64(11), 2201-2209.
- Mansfield, A. K., Addis, M. E., & Mahalik, J. R. (2003). Why won't he go to the doctor?: the psychology of men's help seeking. *International Journal of Men's Health*, 2 (2), 93-109.
- McClure, G. M. G. (2000). Changes in suicide in England and Wales, 1960-1997. *British Journal of Psychiatry*, 176(1), 64-67.
- McEvoy, R., & Richardson, N. (2004). *Men's Health in Ireland*. Belfast: The Men's Health Forum in Ireland.
- Morgan, K., McGee, H., Watson, D., Perry, I., Barry, M., Shelley, E., Harrington, J., Molcho, M., Layte, R., Tully, N., van Lente, E., Ward, M., Lutomski, J., Conroy, R., & Brugha, R. (2008). *SLAN 2007: survey of lifestyle, attitudes & nutrition in Ireland: main report*. Dublin: Department of Health and Children.
- Peate, I. (2004). Men's attitudes towards health and the implications for nursing care. *British Journal of Nursing*, 13(9), 540-545.

- Perkins, H. (2003). *The social norms approach to preventing school and college age substance abuse: a handbook for educators, counsellors, and clinicians*. San Francisco, CA: Jossey-Bass.
- Petersen, A. (1998). *Unmasking the masculine: "men" and "identify" in a sceptical age*. London: Sage.
- Pollack, W. (1995). No man is an island: toward a new psychoanalytic psychology of men. In R. F. Levant, & W. Pollack (Eds.), *A new psychology of men* (pp. 33-67). New York: Basic Books.
- Richardson, N. (2004). *Getting inside men's health*. Kilkenny, Ireland: Health Promotion Department-South Eastern Health Board.
- Richardson, N., & Smith, J. (2011). National men's health policies in Ireland and Australia: what are the challenges associated with transitioning from development to implementation? *Public Health*, 125(7), 424-432.
- Richardson, N., & Carroll, P. (2008). *National men's health policy 2008-2013: working with men in Ireland to achieve optimum health and wellbeing*. Dublin: Department of Health and Children.
- Richardson, N., & Carroll, P. (2009). Getting men's health onto a policy agenda - charting the development of a National Men's Health Policy in Ireland. *American Journal of Men's Health*, 6(2), 105-113.
- Rickwood, D., Deane, F., Wilson, C., & Ciarrochi, J. (2005). Young people's help-seeking for mental health problems. *Australian e-Journal for the Advancement in Mental Health*, 4(3), 1-34.
- Robertson, S. (2003). Men managing health. *Men's Health Journal*, 2(4), 111-113.
- Robertson, S. (2006). I've been like a coiled spring this last week: embodied masculinity and health. *Sociology of Health and Illness*, 28(4), 433-456.
- Rossi, J. S. (1992). *Stages of change for 15 health risk behaviours in an HMO population*. Paper presented at the 13th Annual Scientific Sessions of the Society of Behavioural Medicine. 15-18 March 1992. New York.
- Saltonstall, R. (1993). Healthy bodies, social bodies: men's and women's concepts and practices of health in everyday life. *Social Science and Medicine*, 36(1), 7-14.
- Saracci, R. (1997). The World Health Organisation needs to reconsider its definition of health. *British Medical Journal*, 314(7091), 1409-1410.
- Seymour-Smith, S., Wetherell, M., & Phoenix, A. (2002). "My wife ordered me to come!": a discursive analysis of doctors' and nurses' accounts of men's use of General Practitioners. *Journal of Health Psychology*, 7(3), 253-267.
- Shepard, D. (2002). A negative state of mind: patterns of depressive symptoms among men with high gender role conflict. *Psychology of Men and Masculinity*, 3(1), 3-8.
- Smith, J. (2007). Addressing men's health policy concerns in Australia: What can be done? *Australia and New Zealand Health Policy*, 4(20), doi:10.1186/1743-8462-4-20.
- Smith, J. A., Braunack-Mayer, A., & Wittert, G. (2006). What do we know about men's help-seeking and health service use? *Medical Journal of Australia*, 184(2), 81-83.
- Steel, Z., McDonald, R., Silove, D., Bauman, A., Sandford, P., Herron, J., & Minas, I. H. (2006). Pathways to the first contact with specialist mental health care. *Australian and New Zealand Journal of Psychiatry*, 40(4), 347-354.
- Taylor, C., Stewart, A., & Parker, R. (1998). Machismo as the barrier to health promotion in Australian males. In T. Laws (Ed.), *Promoting men's health: an essential book for nurses* (pp. 15-30). Melbourne: Ausmed.
- West, C., & Zimmerman, D. H. (1987). Doing gender. *Gender & Society*, 1(2), 125-151.
- Wetherell, M., & Edley, N. (1999). Negotiating hegemonic masculinity: imaginary positions and psycho-discursive practices. *Feminism & Psychology*, 9(3), 335-356.
- White, A. K., & Cash, C. (2004). The state of men's health in Western Europe. *Journal of Men's Health and Gender*, 1(1), 60-66.
- White, A. K., & Johnson, M. (2000). Men making sense of their chest pain - niggles, doubts and denials. *Journal of Clinical Nursing*, 9(4), 534-541.