


Associations Between Masculine Norms and Health-Care Utilization in Highly Religious, Heterosexual Men

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Abstract

The purpose of this study was to use focus groups to explore married men's avoidance of health-care utilization. Five focus groups of 8 to 10 married, heterosexual, male participants ($N = 44$) were conducted and analyzed using grounded theory methods. Several important themes emerged connected to how masculine norms were associated with health-care utilization at several domains including at the organizational level (*perceptions of doctors*), interpersonal level (*past family context* and *current family context*), and individual level (*illness severity*, *money concerns*). These themes were all connected with the societal theme of *masculine norms*, where men's reasons for health-care utilization (or underutilization) seemed in large part to emerge because of their perceptions of male gender roles. Implications for married men's health-care utilization and health prevention education will be discussed.

Keywords

masculine norms, qualitative focus group, health-care utilization, ecological theory

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A number of studies demonstrate the large gender disparities in health status in the United States, with men at a higher risk for mortality and morbidity (Vaidya, Partha, & Karmakar, 2012). One of the mechanisms that has received attention as to *why* this disparity exists—besides greater engagement in risky behavior (Courtenay, McCreary, & Merighi, 2002)—is because men use less preventive health-care services and do not seek immediate treatment for many health problems (Courtenay, 2000a; Vaidya et al., 2012). This behavior is often attributed to commonly held beliefs about traditional male gender roles, especially men's hesitance or reluctance to seek medical care (Courtenay, 2000b; Farrimond, 2012; Lee & Owens, 2002a, 2002b). Social constructionists suggest there is a range of masculine norms that differentially influence male behavior depending on the situation or on variables such as social class, occupation (Galdas, Cheater, & Marshall, 2005; Wenger, 2011), racial or ethnic differences (Garfield, Isacco, & Rogers, 2008), or age (Peak & Gast, 2014).

Despite the focus on masculinity as one of the primary reasons for health-care avoidance or underuse (Cranshaw, 2007), others scholars have proposed a more complex interpretation, specifically, the *pluralization* of masculinities, for

example, that masculinity plays out differently for mental and physical health (Connell, 2000; Galdas, 2009; Jarret, Bellamy, & Adeyemi, 2007) and the *feminization* of health care—being a “female and passive recipient of medical treatment” is valued less than being “male, resilient, and independent” (Lee & Frayn, 2008). Although these frameworks do argue for a more cautious approach to ascribing masculinity as the main cause for health-care underutilization, still it focuses only on the societal force interface on an individual level—there is less consideration given to the relationship with other levels of health behavior frameworks, for example, the interpersonal and organizational domains of the ecological framework (Sallis, Owen, &

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Fisher, 2008). Not only do other domains warrant attention but it is also worth considering how they might connect with the notion of idealized masculinity. The present study sought to identify what themes emerged related to masculine norms and health-care utilization specifically applied to mainly young and married heterosexual men.

Literature Review

Ecological Models of Health Behavior

Understanding why people engage in health-promoting or health-damaging behaviors has been of interest for nearly 70 years (e.g., Lewin & Cartwright, 1951). Several ecological, or hierarchical, models have been developed that examine categories of influences, from Bronfenbrenner's (1979) micro-, meso-, and exo-environment approach to McLeroy, Bibeau, Steckler, and Glanz (1988) five sources of influence (intrapersonal, interpersonal, institutional, community, and policy). Some models have been adapted to include global health behaviors and others have been adapted for specific categories of behaviors (see Sallis et al., 2008).

Although an ecological model framework has been applied to men and health (as an example, see McCabe, Mellor, Ricciardelli, Mussap, & Hallford, 2016, for an ecological model applied to Australian indigenous men's health), it has not been applied to health-care utilization. Shen-Miller, Isacco, Davies, St. Jean, and Phan (2013) did propose an ecological model to understand men's health but it was specific to men in college. That model identified the macrosystemic factors (culture and society), exosystemic factors (media, policies, laws), mesosystemic factors (interactions with everyday people in their life), and finally, microsystemic factors (families, friends, romantic partners). Despite the potential impact of using this model, it has not been tested or specifically applied to health-care utilization (just general health), nor has research investigated how men perceive these various levels, and how masculinity operates at each level. Although untested in health-care utilization, this is an important line of inquiry, as men who adhere to more restrictive ideals of masculinity are at greater risk for significantly worse health outcomes (O'Neil & Crasper, 2011); also, typically men seek health services less or later than women (Seidler, Dawes, Rice, Oliffe, & Dhillon, 2016). Understanding men's health-care utilization from an ecological perspective across multiple domains and levels allows for more tailored health promotion strategies that can guide prevention, education, and intervention specifically for those men who may identify with more traditional gender roles.

Masculine Gender Norms

What is it about being male that can have a negative impact on a man's health (Evans, Blye, Oliffe, & Gregory,

2011)? The conventional answer is that traditional beliefs about being male are detrimental to a man's health. If a man is in the 18–64 age group and not experiencing a serious health event or does not have a vigilant spouse (Gast & Peak, 2011), he is also not likely to have a regular health provider or annual wellness exam. Even if truly sick or in pain, a man is likely to delay seeking health care which may be related to the socialization men receive about what it means to be male (Bonhomme, 2007; Galdas et al., 2005; Gast & Peak, 2011). Commonly held beliefs by men about masculinity are frequently blamed for health attitudes that can have negative consequences for men's health (Williams, 2008) even if it is not apparent why those beliefs are so compelling (Courtenay, 2000b). Masculinity is often seen as static and constant yet recent research has acknowledged health behaviors associated with masculinity can change over time, context, and environment (Griffith, Gilbert, Bruce, & Thorpe, 2015).

Scholars have identified masculine gender scripts, or the specific cognitions, emotions, and behaviors that are based on socially accepted and promoted norms of masculinity (Helgeson & Lepore, 1997, 2004). These masculine norms appear to promote disinterest in health-care seeking for men although the range of response to the demands of the male role paradigm also needs to be acknowledged (Addis & Mahalik, 2003) and the reasoning underlying the span of response should be explored. Masculinity is not just one idea and some masculinity constructs can have positive effects on health behaviors (Levant & Wimer, 2014). One acceptable reason that allows a man to seek health care that is congruent with traditional masculinity is that it is associated with being a good provider for one's family, a motivation that may also be used to promote positive health habits generally (Peak & Gast, 2014; Umberson & Montez, 2010). Concern about a health problem that causes pain or affects normal functioning, such as the ability to work, is another justification connected to the good provider role (Wenger, 2011). A different motivator that encourages health seeking for men is concern about the detrimental impact of a family history of illness such as heart disease or cancer (Reed, 2013). These varying reasons and manifestations of masculine gender norms need to be untangled to better understand where health promotion and education can be targeted and improved.

Doctor Avoidance and Health-Care Utilization

It is not just avoidance of health seeking for physical health concerns, men seek help less often than do women for mental health challenges (Seidler et al., 2016) and substance abuse problems as well (Addis & Mahalik, 2003; Galdas et al., 2005). Women generally engage in more health prevention and promotion activities whereas

men often appear to consider health promotion and prevention as unacceptable masculine behavior (Courtenay, 2000a; Giorgianni, Porche, Willims, Matope, & Leonard, 2013; Williams, 2008). The importance of appropriately *demonstrating* masculinity cannot be overstated (Kimmel, 2018) and for some men that means avoiding health care (Courtenay, 2000a,b; O'Brien, Hunt, & Hart, 2005). Adherence to personal behavior choices related to masculine beliefs may be a key contributor to men's typically lower life expectancy and higher rates of morbidity (Courtenay, 2000b; International Longevity Center Workshop, 2004).

The Present Study

Although a majority of studies report that masculinity ideals and socialization are a major reason why men avoid medical care, there may be more nuanced explanations of men's health-care avoidance behaviors in other domains that are related. Ignoring some of these more nuanced reasons means that health-care providers and educators may not be appealing to men in the most effective ways. The purpose of the present study is to investigate these nuances using focus groups of heterosexual married men. This study was guided by the following research questions:

RQ1: What do heterosexual married men say are reasons why they avoid health-care utilization (e.g., going to the doctor or other health-care encounters)?

RQ2: How does masculinity operate at different levels to inform why married men do or do not go to the doctor?

Methods

Sample

A total of 44 heterosexual married men participated in the five focus groups (See Table 1 for full demographic information). Participant ages ranged from 21 to 82, with a mean age of 32 and a median age of 27.5. Nearly 30% ($n = 13$) of participants reported to have been married less than a year, 30% ($n = 13$) reported married between 1 and 5 years, 18% ($n = 8$) reported married between 6 and 10 years, 14% ($n = 6$) reported married between 11 and 20 years, and the remaining 9% ($n = 4$) reported to have been married 21 years or more. In terms of employment, 41% ($n = 18$) were employed part-time, 45% ($n = 20$) employed full time, 11% ($n = 5$) unemployed, and one participant was retired. Of the 44 participants, 11% ($n = 5$) were enrolled in school part-time, 52% ($n = 23$) full time, and the remaining 36% ($n = 16$) were not enrolled in school. All participants completed

high school, 45% ($n = 20$) reported some college, 23% ($n = 10$) completed a bachelor's degree, and eight completed some type of postcollege degree. Two participants were Asian, 90% ($n = 40$) White/non-Hispanic, one reported to be Navajo and Black, and one reported to be Hispanic. In terms of religious affiliation, the majority (82%) reported affiliation with The Church of Jesus Christ of Latter-day Saints (Mormons). Only two men reported a previous marriage; both were in a second marriage. More than half of the men ($n = 25$) reported their wives currently worked. The sample was considered highly religious since the Pew Research Center has reported that

more than four out of five Mormons (82%) say religion is very important to them, compared with 56% of the general public and nearly seven-in-ten Mormons (69%) exhibit high levels of religious commitment, saying religion is very important in their lives *and* that they pray every day *and* that they attend religious services at least once a week (Pew Research Center, 2012, p. 36).

Procedure

Focus group methodology was used to collect data for the study which took place in northern Utah. There were five groups that ranged from 8 to 10 male participants. All participants were married and heterosexual as the focus groups were part of a larger study concerning the impact of wives on health decision-making of their male spouses. To obtain the volunteer sample, printed flyers and digital displays were posted in various buildings on a university campus, at multiple businesses, employment centers, on social media, and at a senior center. Participants were paid \$20 and provided parking validation. University IRB approval was obtained prior to data collection (protocol #5266). A semistructured discussion guide to ascertain how participants viewed health, illness, health-care seeking, spousal influence on health behaviors, and strategies to preserve masculine capital was developed and pilot tested. The purpose of the pilot test was to help clarify the questions used and to determine the effectiveness of the proposed discussion guide. The pilot test also allowed the moderator to refine his interviewing skills prior to conducting the focus groups (data collected during the pilot test were not used for final data analysis). The research team also met to discuss whether the questions were effectively related to the research aims. A male graduate student trained in focus group methodology moderated the focus groups. Focus groups were audio- and videotaped and ranged between 1-1/2 and 2-1/2 hr. All focus groups were held in a conference room on the university campus. For the purposes of this study, only responses to the following question were used for analysis: "some people say that men avoid going to the doctors or reporting their

Table 1. Demographic Information ($N = 44$).

Demographic	<i>N</i>	Percentage (%)
Age		
20–29	25	57
30–39	14	32
40–49	1	2
50–59	1	2
60–69	2	5
80–89	1	2
Length of marriage		
Less than 1 year	13	30
1–5 years	13	30
6–10 years	8	18
11–20 years	6	14
21+ years	4	9
Employment status		
Employed part-time	18	41
Employed full time	20	45
Unemployed	5	11
Retired	1	2
Student status		
Enrolled in school part-time	5	11
Enrolled in school full time	23	52
Not enrolled in school	16	36
Highest level of education completed		
High school graduate	6	14
Some college (associates degree, voc., etc.)	20	45
College graduate (bachelor's degree)	10	23
Postcollege graduate (master's degree, PhD)	8	18
Race		
Asian	2	5
White	40	91
Other	2	5
Ethnicity		
Hispanic/Latino	2	5
Non-Hispanic/Latino	40	91
Did not respond	2	5
Religious affiliation		
Baptist	1	2
Catholic	1	2
The Church of Jesus Christ of Latter-day Saints	36	82
Muslim	1	2
Presbyterian	1	2
No religious affiliation	4	9
Have you been previously married?		
No	42	95
Yes	2	5
Number of marriages		
1	41	85
2	2	5
Left answer blank	1	2
Does your current wife work for an income?		
Yes	25	57
No	19	43
Highest level of education your current wife has completed		
Some high school or less	1	2
High school graduate	11	25
Some college (associate degree, voc., etc.)	16	36
College graduate (bachelor's degree)	15	34
Postcollege graduate (master's degree, PhD)	1	2

Note. Due to rounding, totals may not equal 100.

illness. Is this true for you? Why or why not?"; several follow-up questions and prompts to continue discussion on the topic were also included.

Analytic Plan

A grounded theory approach was used to analyze the data meaning an inductive approach was used in order to identify themes that described the phenomena of married men's health-seeking behaviors (Saldana & Omasta, 2018). Data were transcribed by one of the authors and initially analyzed using the discussion guide questions as semantic themes (Maguir & Delahunt, 2017). Further analysis used a latent approach that examined themes at multiple levels. Once these themes were identified, they were organized and given labels related to and informed by ecological theory. In addition, the authors compared themes by frequency and content to gauge the weight a theme should be given; if a discrepancy occurred among the researchers, the theme was reanalyzed until agreement was reached.

Trustworthiness of the results was determined as outlined by Tolley, Ulin, Mack, and Succop (2016), and includes credibility, dependability, confirmability, and transferability. Credibility of the data was established with the research team looking at outliers in the data (e.g., men who do actively and regularly seek out health care) and also comparing thematic results to the existing literature on how men utilize health care. Unexpected results were noted and included as part of the analysis. Dependability of the data was established through offsetting the bias of any one researcher. For example, the research team was multidisciplinary—marriage and family therapist, public health, and social work—which helped to view the data from multiple perspectives and offset disciplinary bias. The coding team was also diverse in terms of gender. In addition, each team member analyzed the data separately before creating the final codebook. Confirmability was enhanced by an audit trail that included the raw data, a codebook with both final and subcodes, research instruments, field notes, and protocols, all stored in a secure cloud server. In addition, participant feedback was collected at the conclusion of each focus group both orally and in writing. At the conclusion of a group this feedback was shared with the participants who were then asked if clarifications and additional information was needed. Any clarification or additions were added to the transcripts. Only one participant shared comments in writing, though all were given the opportunity to do so. Finally, transferability of the findings is in the context of the sample, which was heterosexual male, mostly young, and connected to the Church of Jesus Christ of Latter-day Saints, a fairly traditional religious group.

Overview of Results

At the societal level *masculine norms* emerged as the primary motivator for men's avoidance of seeking health-care services. Men reflected on how they are supposed to be tough, push through pain, and not go see the doctor. At the organizational level, two themes reflected men's view of the health-care system—*negative perceptions of doctors* and *positive perceptions of doctors*—and addressed if men saw doctors' expertise as helpful. At the interpersonal level, *past family context* revealed important contextual information about men's past experience growing up in their families. The second interpersonal-level category was *current family context*, which included important subthemes such as money concerns, how men balanced urgency with their financial situation, and finally, how they viewed their responsibility to provide for their family. Finally, at the individual level, a theme emerged that reflected the severity of illness and how it served to justify men's health-care utilization. The societal level of masculine norms seemed to permeate and influence all other levels, from organizational (perceptions of the health-care system) to the individual level (illness severity).

Societal Level

Masculine Norms

Masculine norms, or men's adoption of what they perceived to be the idealized male behavior, seemed to be exhibited by all participants. This was seen as the overarching theme that influenced the rest of the domains/levels. This theme included language such as "men don't go to the doctor," "push through pain," and "men avoid going to the doctor" in fulfillment of what they perceived to be societal expectations of them as men. One participant put it this way [FG 2, age 25, married 3 years]:

Bleeding, yeah, super glue it you know. Why go to the doctor when you know, you can fix it yourself, kind of thing. So, that's kind of mentality that I was raised with, you know, and for a lot of the people that I know, it's pretty similar. You know, just, you know, men avoid going to the doctor. I'm not sick... if it's not broken, why fix it.

Other men signaled their avoidance of going to the doctor: "I go when necessary. I don't just go to go. If it's important enough that I feel it's important, I go" (FG 4, age 39, married 14 years), and "I avoid going to the doctor as much as I can... unless I absolutely have to" (FG 5, age 42, married 13 years).

Finally, a participant [FG 4, age 23, married 4 months] reflected on the tolerance of pain and avoidance of going to the doctor:

I'd say that I avoid going to the doctor, at all costs. You know, I believe that the body can take care of itself, and that, and, you can take me to the doctor when I pass out. Actually, last semester, I was doing a lot of running and it was hurting my shins a lot, and they'd get worse, and they'd get worse, and they'd get worse, and my wife kept telling me, "You need to go to the doctor and get it taken care of." "No, no. I'm not going to the doctor; I'm not going to the doctor." And eventually, it got to the point where I couldn't even stand up; I'd get out of bed and I couldn't even stand up, because it's, it's, I had just pushed myself so hard, so bad, that I go to the doctor and then I'd be super frustrated at the doctor because I'd just sit there and they would just rub this steroid on my shins and then tell me to go home. Well this is a waste of my time. I don't like this. So I will avoid going to the doctor at all costs. It's, I don't know, my pride that allows me to do so but I feel like...

Organizational Level

Perceptions of the Health-Care System

The organizational factors the men described were related to their perceptions of the health-care system, specifically how helpful or knowledgeable doctors are or are not. These resulting themes related only to the medical profession—not other organizational themes. The first subcategory, *negative perceptions of doctors*, mostly revolved around doctors using multiple or inconsistent diagnoses, telling the men what they might have already known (and charging for it), or just treating obvious symptoms. The second subcategory, *positive perceptions of doctors*, emerged as a counterpoint to that narrative and promoted health-care utilization.

Negative perception of doctors. This subtheme of the organizational level reflected men seeing doctors as unhelpful and essentially not worth the time. One participant (FG 1, 29 years old, married 7 years) said it this way: "Well, I'm in the Army National Guard, and army doctors are the worst. They just give you pills for every symptom you tell them you have and I can do that going to the pharmacy, so what's the point."

Another participant (FG 3, age 35, married 3 years) put it this way:

Yep, ah, I don't like it 'cause they'll diagnose you for one thing. The next thing you do, you'll have to come back and they don't diagnose you for the same... they'll diagnose you for something else, and you were just there, yesterday. "Oh yeah, you had this." OK...but now you come in with different symptoms. "Oh, now you have this." "What happened to this?" "Oh, you didn't have that. Now you have this." So it's just... to me, if it... it's a game that they play. I don't... in my thinking, it is, because, let's say, you're diagnosed with this, or

you're diagnosed with this... send you on your way, and then...if the symptoms worsen, you have to come back...they don't tell you straight out front what. What could be the situation, or what it could be leading into, they just tell you, "Hey, okay, here's a couple of pills. Call us in the morning if it gets worse, come back in to ER." So that's why I don't go to doctors, unless I'm definitely dying of an illness, I don't go.

Finally, another participant (FG 3, age 30, married 3 months) reflected on his experience with a doctor:

One day they tell you a different symptom, and another day, another symptom. I...before going to doctors, I search, I Google it, because I know my symptoms, I search what kind of treatment I should get for these symptoms, and I go to one doctor, get his or her advice, comments, and I'm going to another doctor to compare what they say, to see if they match, and at that time I can follow, if they are not matching, I can go to the third doctor. So I'm very skeptical to going to a doctor, so, I don't, I can't, I don't ask them like for 100%.

Positive perception of doctors. Despite the fact that the research questions were focused on why men did *not* seek a doctor, there were times that men discussed how helpful they viewed those encounters. This observation is noted because it is important in qualitative research to identify negative cases, or narratives that may not fit the overall pattern of the data (Charmaz, 2014). An individual (FG 2, age 35, married 11 years) reflected on his view of going to the doctor:

I would rather go to the doctor. If there is something suspicious going on, I would definitely go to the doctor. If I want to seek a specialist, I would definitely go and see... it's the same with my wife, too.

Another participant (FG 5, age 22, married 10 months) reflected on the ease of going to the doctor to get better quicker than on his own,

I actually, it's very easy for me to go to the doctor now just because I'm not very patient, and I know that what the doctor has is gonna help me overcome my illness a lot faster than not dealing with it.

Finally, an individual (FG 4, age 26, married 1.5 years) recalled his experience of how helpful his doctor was and how he would rather go, especially with ease and relatively low cost because of having insurance:

Real quick, my wife and I pay out the nose for amazing health insurance, and I am getting to the point where I am actually okay going to the doctor. I'm willing to drop \$50 to go ahead and you know...do full blood work and do all this, go ahead and see if I have any type of cancers...you know... anything flowing through my system. I'm willing to do that

for \$50. I'm like, "Yeah, I'm okay with that." It's just afterwards, I'm just like, okay, so I've gone ahead and done this and my insurance covers X and so forth, but if I had no insurance I would honestly wait until I passed out on the side of the road before I was able to go.

Interpersonal Level

Past Family Context

Past family context emerged as an important interpersonal-level factor that also influenced men's relationship with masculine norms and avoidance of physician encounters. The men in this study relayed how their family of origin experiences seemed to not only reinforce masculine norms but also, in some cases, encouraged going to the doctor. One participant (FG 1, age 24, married 2 years) stated:

I don't think it came from my wife, I think it came from my family. We grew up... I grew up in a really small town, and so... I split my head open, used a butterfly bandage, or super glue... that's what we use...was like, "We could have went to the doctor..." but you know 20-30 minutes later I'm bleeding, my head's bleeding. It's not...that's just how we did things, and we never went to the doctor, and so I feel the same way. I'm like, well, what's the point. I've done other things... I'm fine. I guess if I had health care it would be different. That's the big thing... it's like not having the financial means of doing it.

Another participant (FG 2, age 27, married 9 months) stated

I think that one other thing he mentioned was, well, one, how you were raised, but I think that ties into if you have a family history of something. So if you know that a lot of people in your family have something, then anything that looks like it might be possibly be related to something.

A participant (FG 3, age 23, married 3 months),

Again, I used to not like doctors at all, um, but my sister passed away like a year ago, just over that. I've been in a hospital maybe twice since, and it's never been for me. I probably will never go to the hospital again, unless I'm unconscious and taken there against my will, kind of deal.

Finally, a participant (FG 4, age 28, married 4 years) described his experience in a rural town:

I was raised in kind of a small town, country town, you know, farm town, and you know, you got sick you toughed it out, you got hurt, put a band aid on it, you know, and keep working, until you absolutely can't. You know, like last year, I had my knee surgery. I couldn't walk; my leg was stuck in

a bent position. There was no other option, but that's like the first time I've been to the doctor since I can remember.

Current Family Context

Analogous to past family context, current family context was an important interpersonal factor relating to experiences, perceptions, and behaviors associated with being in their own family.

Money concerns. In the first subcategory, *money concerns*, participants described their current family's financial situation and how money factors in as an important reason for not going to the doctor. A participant (FG 2, age 35, married 11 years) explained it this way:

I have to tough this out, whatever. And then I had a kidney stone one time and that was the most pain that I've ever had, and I was sitting there trying to tough it out the best I could, for hours, and like finally I had to break down, and my wife's like, "Just go to the hospital you stubborn..." you know. And I was like, "Fine, take me, I'm going to die." I didn't, I really didn't know what was going on. I felt like an idiot afterwards. They told me it was a kidney stone, and I thought, "Am I a pansy?" you know, because I should have been able to take that. And so we got the bill from that, and I thought, "Really? I'm never going again. Never! I don't care how much pain it is." You know.

A participant (FG 3, age 25, married 4 years):

It's definitely financial. I know...My wife will call me a cheap bastard, but... I hate going to the doctor. I really do, and, it's like [others] said, unless it's like something where I can't control it, I'm not going to go and it's primarily because of money. I can't handle how expensive it is, and the hoops they make you jump through? I think it's completely insane...and insurance is a joke...so I hate it.

A participant (FG 5, age 26, married 3 years) talked about his family budget as a reason for not going to the doctor:

The reason I don't go is that I just don't feel it's in the budget. I don't want to pay the doctor. I don't want to pay for whatever, X-ray, you know, blood tests. I just feel like, you know, I'll get over whatever it is, but it's like the negative consequences in the past, like with my broken ankle, but I just feel like I don't want to pay the money, so I don't go.

A participant (FG 1, age 24, married 2 years) reflected on his overall avoidance of going to the doctor, while still able to recognize when it is a good time to go:

I don't like to go, mostly 'cause I just don't want to spend the money. If I feel like I can just get over it, I hate spending

money on something like that. But sometimes, I... it depends on how sick I am. If I realize, like, maybe if I have strep throat of something, and if I just go, get the prescription for the... penicillin, or whatever it is, I'll be feeling better in just a couple of days, whereas I don't know how long it will take me to just kind of wait get over it, but if it's just a regular cold, or something, I won't want to go in.

Providing for the family. Providing for the family was also regarded as an important reason why some men avoid going to the doctor. Men commented that going to the doctor takes away from their ability to be at work and make money which they saw as an essential role and justified their avoidance of seeking health care. A participant (FG 2, age 37, married 7 years) said:

In our world culture, men have the biggest responsibility of taking care of their families, to provide for their wife and kids, so I was always told that men, they need to stay healthy and they have the responsibility to save some money, like insurance, and insurance for everybody. So that needs to be there, and he needs to be staying healthy, but it's not meaning that when you have a cold or fever that we go to a doctor, or cut your finger you need to go to the doctor.

A participant (FG 5, age 39, married 16 years) reflected on how money is a concern and his role as the one earning money, "I think, finances is a big thing and just the worry of, you know, if I go to the doctor and they find something whose going to earn the money and keep things going."

Finally, a participant (FG 2, age 35, married 11 years) stated:

Yeah. I agree with that because I...I was never one to go to the doctor, and then after having kids and a wife, and things of that nature, the financial situation starts to play into it. If I go, then that's taking away from something that I could be providing for my wife and kids. Why would I put my needs above theirs, and so it's like I have to be a man.

Individual Level

Severity of Illness/Pain

The theme of *severity of illness* was seen as an important individual factor that, although related to masculine norms, also enabled men to seek health-care services because of the severity or degree of physical pain. Severity of illness seemed to break through masculine norms to justify going to the doctor, especially, if this was after experiencing pain and enduring it, so that they could still be seen as masculine. A participant (FG 4, age 36, married 13 years) stated, "I'll watch something and it's really got to be fairly debilitating before I'll be like, 'All

right, I'll go in and see if they can tell me the exact same thing I came up with.”

Additionally, a participant (FG 3, age 31, married 9 years) reflected on his choice to go see a doctor based on the degree of his physical health concern:

So, I'm not worried about going in, so, if it doesn't seem imminent, or it doesn't seem like something I can't fix on my own, or that will fix itself, there's really no need to go see the doctor because there's plenty of stuff out there to help you get over it. But if it seems my life is being threatened or my arm is broken, and it probably won't ever set right again, you know, then I would consider going, but other than that, I'm not going to go pay anybody to tell me what I already know—it's messed up.

Discussion

General Findings

This study sought to identify themes related to masculine norms and health-care-seeking behavior in traditional, heterosexual married men. Scholars have argued for more research that investigates the interplay of several factors from multiple domains and levels, and how they operate in tandem (Sallis et al., 2008). This study aligns with Shen-Miller et al. (2013) model, but for health-care utilization. The resulting themes were all influenced and informed by masculine norms, which emerged as the overarching approach and orientation to doctor-seeking behavior, and permeates through to the organizational, interpersonal, and individual levels. Illness or physical health concern severity seemed to be what most men identified as a legitimate reason to see a doctor, after they endured or experienced a significant amount of pain. Identification of these themes has important implications for health-care prevention, intervention, and education.

Masculine norms emerged as the overarching theme—in fact, at every level this appeared as a dominant organizing orientation to health-care utilization. It also reflects men's socialization about what it means to be male while highlighting independence, stoicism, and self-reliance (Bonhomme, 2007; Galdas et al., 2005; Gast & Peak, 2011). From an early age, men receive direct and indirect messages about how they should think, feel, and behave. These masculine gender scripts (Burns & Mahalik, 2007) affect many aspects of health and health behavior, particularly engagement in risky behaviors such as alcohol use, dangerous physical stunts, avoiding health care, and physical fighting (Addis & Mahalik, 2003). Avoiding doctors specifically is something that men not only encourage other men to do directly but also indirectly because it demonstrates how tough they are (*proves* their masculinity; Kimmel, 2018). This study suggests that this

overall masculine orientation influences—for good or ill—other levels of men's health-care-seeking behavior.

At the organizational level it appears that perceptions of doctors played a key role in whether men chose to go to the doctor or not—again influenced by masculine gender scripts. Although some research has reported that some men trust their doctor and perceive their physician as treating them well (Sandman, Simantov, & An, 2000)—other research relates that, overall, men do not trust the medical profession (Khullar, 2018). The latter view is reflected in this study, with some men reporting that they felt the doctor was incompetent, prescribing different pills for every symptom or changing diagnoses, and others skeptical of the doctor's ability to select the right treatment. At the core of these perceptions is that the men *felt they knew better*—again reflecting masculine scripts about their own abilities or knowledge. This belief may augment the argument that going to the doctor is useless because the doctor will not be helpful anyway. Participant perceptions were mixed with some stating that they trust their physician's expertise and knowledge, would rather know for sure what is going on, and that if insurance covered their visit, they might as well get a full workup.

At the interpersonal level, other important themes were found. First, past family context largely reinforced masculine norms. Several men reported that members of their own families did not go to the doctor and reinforced the “toughing it out and keep going” mentality. These comments reflect that past family context plays a big role in how men act out their masculinity in health-care utilization behavior (Peak & Gast, 2014). Second, perhaps even more influential than past family context, is men's current family context as part of a marital dyad. Several important subthemes—money concerns and providing for the family—seemed to be acceptable reasons for married men not to seek health care. These ideas are important for several reasons, for example, from the male perspective, the overall cost of visiting the doctor is perceived as a barrier to accessing health services which may explain why married men, especially those that are uninsured, delay or forego health-care utilization (Sandman et al., 2000)—they weigh the anticipated benefit against the financial cost. This deliberation and debate likely results in men seeking health care well after symptoms show up because they are put off by the financial strain that might occur (either based on actual past experiences or anticipated ones). In addition, economic concerns combined with negative perceptions of doctors and their helpfulness may tip the scales in favor of not seeking health care. Future research should map the onset of illness with men's cognitive decision-making about seeking health care (and the length of time it takes).

In addition, these married men stated that providing for their family was an important factor in avoiding going to the doctor. They saw their financial provider role as central to their identity, and that taking time off from work to see a physician takes money away from their family. Although some research indicates that the provider role actually helps men choose to utilize health-care services so that they can go back to work quicker (O'Brien et al., 2005), interestingly, these study findings are in direct contrast. Possibly both money concerns and the provider role operate as justification to avoid seeking health care—again in line with masculine gender scripts—and that married men ignore, downplay their symptoms, or are just being stubborn. These may also be legitimate reasons that weigh heavily on them as they choose to put family financial needs above their own health concerns especially if their health suffers because of that sacrifice. Regardless of the reason, this study highlights nuances that warrant further exploration.

Finally, at the individual level, the theme of illness severity/pain may also support a decision to delay utilizing health care until a medical crisis occurs even if that delay exacerbates the health problem and makes treatment more expensive (Sandman et al., 2000). It is at this point that a man may choose to seek health care but only after the pain has persisted or intensified to substantiate that he is “tough” and “can handle pain.” Only after that substantiation that he is masculine, is the decision to seek health care acceptable. The delay may also reflect a connection to the other levels—*societal level* of masculine scripts and being tough, *organizational level* of distrust of doctors, and *interpersonal level* of the current family context (money concerns and providing for the family). These findings illustrate the complexity and gradations of a man’s point of view about his decision to seek health care—and has important implications for health prevention, education, and intervention.

Implications for Prevention, Education, and Intervention

Scholars have called for health education and promotion programs that consider masculine gender scripts in program planning (Gast & Peak, 2011) yet progress in that direction has been slow. This study demonstrates that masculine norms influence and operate at multiple levels of health-care-seeking behavior, and that health education and prevention programs should address these concerns at all three levels.

Masculinity at the societal level may be unable to be changed or addressed, at least until the intergenerational transmission of masculine ideals subsides or is modified. At the organizational level, doctors and health-care providers could address the distrust of their profession in

several ways. First, a feedback system could help male patients express their concerns, report their symptoms, and their experiences with a doctor following their visit. This feedback could utilize an online portal on which men rate and reflect on their experience. Some medical settings emphasize “male-friendly” approaches by adjusting their language and reframing health-care utilization (such as “consultation” or “team meeting”) as a way to focus on men’s strengths rather than deficits (Brooks, 2010; Isacco, Talovic, Chromik, & Yallum, 2013). Men may underreport, not disclose all of their symptoms, or minimize them, in their interactions with physicians and this phenomenon could be addressed directly with male patients to preemptively let them know they are not less masculine for disclosing symptoms or pain.

At the interpersonal level of current family context (cannot change past family experience), health-care providers should explicitly address possible financial concerns or any potential delay in returning to work. There are a number of existing ways to address money issues including financing or payment plans, and itemizing specific costs up front. In addition, health-care providers could ask about potential family support. As noted by Courtenay (2011), family support can improve men’s compliance with physician recommendations and follow-up care. If family support is not available, men can be encouraged to find alternative support sources and to reach out to those sources although they may need to be reminded that asking for help is not a weakness.

At the individual level the Men’s Center Approach (MCA; Davies, Shen-Miller, & Isacco, 2010) and framework on “possible masculinities” can be helpful, in that it may help men set goals for their own individual behaviors and identities based on what they want to be in the future, what men require to meet developmental needs, and what they can provide to their communities (Davies et al., 2010).

Limitations

Although these findings add to the literature base, they should be considered in light of their limitations. First, the majority of the sample were Caucasian, heterosexual, married, and members of a fairly traditional religious faith, so the results cannot be generalized to all men. Certainly, men’s reports of their perception and experience of health-care utilization might function differently in terms of ethnicity, sexual orientation, relationship status, age, and religious practices. In addition, the focus group format may have influenced participant responses especially their willingness to be truthful. Participants might have felt pressured to join in with what others are saying in a “group think” mentality, and not as likely to express ideas perceived as different. The interview protocol tried to address this to some degree as the

interviewer made sure to ask for contradicting views or opinions. Also, men self-selected to participate, so their reported experiences could be different from those unwilling to take part in a focus group interview.

Conclusion

These results help address the need to identify how married men's health-care utilization behaviors interface and interplay across societal, organizational, interpersonal, and individual levels. The theme of masculine norms operates at several levels that influence how men perceive and connect with the health-care system. Married men's past and current family experiences reinforce masculine scripts and provide "legitimate" reasons to delay health-care utilization. Finally, individual responses to illness severity and pain play a double role—as masculine indicators and to legitimize physician visits. These findings highlight the complexity and nuances to be considered when designing health programming specifically for married men.

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References

- Addis, M., & Mahalik, J. (2003). Men, masculinity, and the contexts of help seeking. *American Psychologist, 58*(1), 5–14. doi:10.1037/0003-066X.58.1.5
- Bonhomme, J. (2007). Men's health: Key to healthier women, children, and communities. *American Journal of Men's Health, 1*(4), 335–338. doi:10.1177/1557988306297261
- Bronfenbrenner, U. (1979). *The ecology of human development* (pp. 1–64). Cambridge, MA: Harvard University Press.
- Brooks, G. R. (2010). *Beyond the crisis of masculinity: A trans-theoretical model for male-friendly therapy*. Washington, DC: American Psychological Association.
- Burns, S., & Mahalik, J. (2007). Understanding how masculine gender scripts may contribute to men's adjustment following treatment for prostate cancer. *American Journal of Men's Health, 1*(4), 250–261. doi:10.1177/1557988306293380.
- Charmaz, K. (2014). *Constructing grounded theory* (2nd ed.). Thousand Oaks, CA: Sage Publication.
- Connell, R. W. (2000). *The men and the boys*. Cambridge: Polity Press.
- Courtenay, W. (2000a). Constructions of masculinity and their influence on men's wellbeing: A theory of gender and health. *Social Science and Medicine, 50*, 1385–1401.
- Courtenay, W. (2000b). Engendering health: A social constructionist examination of men's health beliefs and behaviors. *Psychology of Men and Masculinity, 1*(1), 4–15.
- Courtenay, W. (2011). *Dying to be men*. New York, NY: Routledge.
- Courtenay, W., McCreary, D., & Merighi, J. (2002). Gender and ethnic differences in health beliefs and behaviors. *Journal of Health Psychology, 7*(3), 218–231.
- Cranshaw, P. (2007). Governing the healthy male citizen: Men, masculinity and popular health in Men's Health magazine. *Social Science and Medicine, 65*(8), 1606–1618. doi:10.1016/j.socscimed.2007.05.026
- Davies, J. A., Shen-Miller, D. S., & Isacco, A. (2010). The men's center approach to addressing the health crisis of college men. *Professional Psychology and Practice, 41*, 347–354.
- Evans, J., Blye, F., 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. doi:10.1016/j.jomh.2010.09.227
- Farrimond, H. (2012). Beyond the caveman: Rethinking masculinity in relation to men's help-seeking. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine, 16*(2), 208–225. doi:10.1177/1363459311403943
- Galdas, P. M. (2009). Men, masculinity and help-seeking. In A. Broom & P. Tovey (Eds.), *Men's health: Body, identity and social context* (pp. 63–82). London: John Wiley & Sons.
- Galdas, P., Cheater, F., & Marshall, P. (2005). Men and health help-seeking behavior literature review. *Journal of Advanced Nursing, 49*(6), 616–623. doi:10.1111/j.1365-2648.2004.03331.x
- Garfield, C., Isacco, A., & Rogers, T. (2008). A review of men's health and masculinity. *American Journal of Lifestyle Medicine, 2*(6), 474–487. doi:10.1177/1559827608323213.
- Gast, J., & Peak, T. (2011). "It used to be that if it weren't broken or bleeding profusely, I would never go to the doctor": Men, masculinity, and health. *American Journal of Men's Health, 5*(4), 318–331. doi:10.1177/1557988310377926.
- Giorgianni, S. J., Porche, D., Willims, S., Matope, J., & Leonard, B. (2013). Developing the discipline and practice of comprehensive men's health. *American Journal of Men's Health, 7*(4), 342–349. doi:10.1177/1557988313478649.
- Griffith, D. M., Gilbert, K. L., Bruce, M. A., & Thorpe, R. J., Jr. (2016). Masculinity in men's health: Barrier or portal to healthcare? In J. J. Heidelbaugh (Ed.), *Men's health in primary care* (pp. 19–31). Switzerland: Springer.
- Helgeson, V. S., & Lepore, S. J. (1997). Men's adjustment to prostate cancer: The role of agency and unmitigated agency. *Sex Roles, 37*, 251–266.
- Helgeson, V. S., & Lepore, S. J. (2004). Quality of life following prostate cancer: The role of agency and unmitigated agency. *Journal of Applied Social Psychology, 34*, 2559–2585. doi:10.1111/j.1559-1816.2004.tb01992.x

- International Longevity Center Workshop. (2004). *Promoting men's health: Addressing barriers to healthy lifestyle & preventive health care*. New York, NY: International Longevity Center.
- Isacco, A., Talovic, E., Chromik, L., & Yallum, N. (2013). Addressing men's mental health through a strength-based approach. In J. M. Rippe (Ed.), *Lifestyle medicine* (2nd ed.). Boca Raton, FL: CRC Press.
- Jarrett, N., Bellamy, C., & Adeyemi, B. (2007). Men's health help-seeking and implications for practice. *American Journal of Health Studies*, 22(2), 88–95.
- Khullar, D. (2018). The largest health disparity we don't talk about. *New York Times* Retrieved from 30 May, 2018.
- Kimmel, M. (2018). *Healing from hate: How young men get into – and out of – violent extremism*. Oakland, CA: University of California Press.
- Lee, C., & Owens, R. G. (2002a). Issues for a psychology of men's health. *Journal of Health Psychology*, 7(3), 209–217. doi:10.1177/1359105302007003215
- Lee, C., & Owens, R. G. (2002b). *The psychology of men's health*. Buckingham: Open University Press.
- Lee, E., & Frayn, E. (2008). The 'feminisation' of health. In D. Wainwright (Ed.), *A sociology of health* (pp. 115–133). London, Thousand Oaks, New Delhi: Sage Publications.
- Levant, R. F., & Wimer, D. J. (2014). Masculinity constructs as protective buffers and risk factors for men's health. *American Journal of Men's Health*, 8(2), 110–120. doi:10.1177/1557988313494408
- Lewin, K., & Cartwright, D. (1951). *Field theory in social science*. New York, NY: Harper.
- Maguire, M., & Delahunt, B. (2017). Doing thematic analysis: A practical, step-by-step guide for learning and teaching scholars. *All Ireland Journal of Teaching and Learning in Higher Education*, 8, 3351–3365.
- McCabe, M. P., Mellor, D., Ricciardelli, L. A., Mussap, A. J., & Hallford, D. J. (2016). Ecological model of Australian indigenous men's health. *American Journal of Men's Health*, 10(6), NP63–NP70. doi:10.1177/1557988315583086
- McLeroy, K. R., Bibeau, D., Steckler, A., & Glanz, K. (1988). An ecological perspective on health promotion programs. *Health Education Quarterly*, 15(4), 351–377.
- O'Brien, R., Hunt, K., & Hart, G. (2005). 'It's caveman stuff, but that is to a certain extent how guys still operate': Men's accounts of masculinity and help seeking. *Social Science & Medicine*, 61(3), 503–516. doi:10.1016/j.socscimed.2004.12.008
- O'Neil, J., & Crasper, B. (2011). Using the psychology of men and gender role conflict theory to promote comprehensive service delivery for college men: A call to action. In J. Laker & T. Davis (Eds.), *Masculinities in higher education: Theoretical and practical considerations* (pp. 15–49). New York, NY: Routledge.
- Peak, T., & Gast, J. (2014). Aging men's health-related behavior. *Sage Open*, 4(4), 1–10. doi:10.1177/2158244014558044
- Pew Research Center. (2012). *Mormons in America: Certain in their beliefs, uncertain of their place in society*. Washington, DC: The Pew Forum on Religion and Public Life.
- Reed, K. (2013). Beyond hegemonic masculinity: The role of family genetic history in men's accounts of health. *Sociology*, 47(5), 906–920. doi:10.1177/0038038513494505
- Saldana, J., & Omasta, M. (2018). *Qualitative research: Analyzing life*. Los Angeles: Sage Publications.
- Sallis, J. F., Owen, N., & Fisher, E. B. (2008). Ecological models of health behavior. In K. Glanz, B. K. Rimer & K. Viswanath (Eds.), *Health behavior and health education: Theory, research, and practice* (pp. 465–485). San Francisco, CA: John Wiley & Sons.
- Sandman, D., Simantov, E., & An, C. (2000). *Out of touch: American men and the health care system*. New York, NY: Commonwealth Fund.
- Seidler, Z. E., Dawes, A. J., Rice, S. M., Oliffe, J. L., & Dhillon, H. M. (2016). The role of masculinity in men's help-seeking for depression: A systematic review. *Clinical Psychology Review*, 49, 106–118. doi:10.1016/j.cpr.2016.09.002
- Shen-Miller, D. S., Isacco, A., Davies, J. A., St. Jean, M., & Phan, J. L. (2013). The men's center approach: Ecological interventions for college men's health. *Journal of Counseling & Development*, 91(4), 499–507. doi:10.1002/j.1556-6676.2013.00123.x
- Tolley, E. E., Ulin, P. R., Mack, N., & Succop, S. M. (2016). *Qualitative methods in public health: A field guide for researchers* (2nd ed.). San Francisco, CA: John Wiley & Sons.
- Umberson, D., & Montez, J. (2010). Social relationships and health: A flashpoint for health policy. *Journal of Health and Social Behavior*, 51(1_suppl), S54–S66. doi:10.1177/0022146510383501
- Vaidya, V., Partha, G., & Karmakar, M. (2012). Gender differences in utilization of preventive care services in the United States. *Journal of Women's Health*, 21(2), 140–145. doi:10.1089/jwh.2011.2876
- Wenger, L. M. (2011). Beyond ballistics: Expanding our conceptualization of men's health-related help seeking. *American Journal of Men's Health*, 5(6), 488–499. doi:10.1177/1557988311409022
- Williams, D. R. (2008). The health of men: Structured inequalities and opportunities. *American Journal of Public Health*, 98(Supplement_1), S150–S157.