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## **Qualitative Research in Psychology**

**‘I don’t want to let myself down or the charity down’: Men’s accounts of using various interventions to reduce smoking and alcohol consumption.**

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## **Abstract**

Men are less likely to seek medical help than women, and are more likely to adopt unhealthy practices. This study investigated men's constructions of alcohol and tobacco cessation interventions in relation to dominant masculine identities. Focus groups and interviews with twelve male university students were analysed using an eclectic approach informed by discursive psychology and Foucauldian discourse analysis. Findings suggested that interventions encouraging competition amongst friends were constructed as favourable, and autonomy and control were central to men's accounts. While men presented their behaviour change as intentional, their accounts revealed a tendency to conceal this from others, suggesting a negative influence of peer pressure. However, participants who had raised money for charity whilst abstaining described this process as rewarding and acting as a 'buffer' to legitimise their healthy behaviour when socialising with other men. Implications for health providers and policy makers are discussed.

**Keywords:** Masculinity; Alcohol; Smoking; Charity; Cessation; Discourse Analysis

## 1. Introduction

Across Europe, women generally live longer and adopt healthier lifestyles than men (Office for National Statistics, 2015; White, 2011; Crimmins, Kim and Solé-Auró, 2010; Courtenay, 2009). In the United Kingdom (UK), not only are men more likely to drink alcohol and smoke tobacco than women but their consumption rates are higher (Health and Social Care Information Centre (HSCIC), 2015a and 2015b). This, in turn, translates to higher rates of illness and mortality amongst men (Office for National Statistics (ONS), 2016). In 2013, for adults over the age of 35, there were almost twice as many male alcohol related deaths than female (4332 and 2260). Also, 21% of all adult male deaths during that time were smoking related, compared to 13% of all female deaths (HSCIC, 2015b).

Studies have shown how men procrastinate about seeking medical help (Menierre, 2015; Jeffries and Grogan, 2012; ONS, 2012; Galdas, 2009) and construct health in terms of stoicism and strength (Sloan, Gough and Conner, 2010). Connell's (1977; 1987) seminal works used the term 'hegemonic masculinity' to refer to the dominant hierarchical identity of manliness that is closely associated with these attributes that are embedded cultural practices. These behaviours can be reinforced by health professionals when their practice is influenced by stereotyped assumptions about masculinity (Seymour-Smith, Wetherell and Phoenix, 2002) resulting in different treatment pathways based on gender (Pattyn, Verhaeghe and Bracke, 2015).

In the age of the internet and smartphone technology, direct access to health interventions is now more accessible than ever and can be used to support a variety of health choices such as increasing exercise, smoking cessation, losing weight and

reducing alcohol consumption. In 2012, approximately 400 smartphone applications were available for smoking cessation and the 51 most popular applications were being downloaded between 310,800 and 1,248,000 times per month globally (Abroms, Westmaas, Bontemps-Jones, Ramani and Mellerson, 2013). Users of health applications also include a significant amount of people who had not previously considered seeking professional help (BinDhim, McGeechan and Trevena, 2014). Mobile applications therefore, appear to be a growing platform to support increased participation.

However, the efficacy of some app-based approaches have been questioned; there is often a lack of rigour in the development of mobile applications (Held and Halva's, 2016) and in one study, real-time tracking of alcohol consumption appeared to trigger competitive drinking amongst male participants (Gajecki, Berman, Indinavir, Rosendahl and Andersson, 2014). Risk taking behaviour has been associated with hegemonic masculinity (Iwamoto, Corbin, Lejuez and MacPherson, 2014; Santamariña-Rubio, Pérez, Olabarria, and Novoa, 2014; King, Semlyen, Tai, Killaspy, Osborn, Popelyuk and Nazareth, 2008) and may account for these effects. It is important to note that risk taking behaviour is also common in 'subordinated' masculine identities (Crossley, 2002; Good, Schopp, Thomson, Hathaway, Sanford-Martens, Mazurek and Mintz, 2006). Studies involving focus group data shows the reinforcing nature of discourse amongst men and how risks are minimised such as with smoking whilst the act of smoking (or drinking alcohol) is constructed as being 'care-free' and youthful (Gough, Fry, Grogan and Conner, 2009; deVisser and Smith, 2007).

Despite these concerns, a nuanced understanding of gender may provide opportunities to present evidence-based approaches in ways that are deemed more

favourable amongst men in order to support the need to address the gendered health inequality. Recent examples of some other (non-smartphone) approaches include 'Dryathalon', an intervention developed by Cancer Research UK (Marrins, 2014) and 'Sober for October' (SFO) (MacMillan Cancer Support, UK). Dryathalon runs during January every year where participants are encouraged to form teams and compete with peers to raise the most sponsorship money for abstaining from alcohol. SFO uses a similar competitive approach but where individuals rather than teams participate in an abstinence based fundraising initiative during the month of October. Both approaches use the traditionally masculine quality of competition amongst peers (Sloan, Gough and Conner, 2010) to encourage alcohol abstinence and appear to offer a more physically interactive intervention than smartphone applications, which may support those who wish to take more private approach to reducing their alcohol (White, Kavanagh, Stallman, Klein, Kay-Lambkin, Proudfoot, Drennan, Connor, Baker, Hines and Young, 2010) and tobacco use (Abroms, Westmaas, Bontemps-Jones, Ramani and Mellerson, 2013).

This gendered approach has been explored in other areas of health to increase participation. Ellis, Collin, Hurley, Davenport, Burns and Hickie (2013) found that when using internet mental health self-help resources men in their study showed a preference for action based advice more than any other advice options.

Recent focus has also been devoted to men's health through the charity Movember where men are encouraged to grow facial hair during November with the aim of raising money and awareness for mental health issues and various cancer campaigns (Robertson, Bagnall and Walker, 2015). Research by Robertson et al. (2015) has assessed the impact of this initiative and they emphasise the role of discourse in

shaping opportunities for men to talk positively about issues such as mental health and prostate cancer health needs.

### **1.1. Study Aims**

This timely study aims to understand how various alcohol and tobacco reduction interventions (see Table 1) are constructed by men when speaking with other men. Conversations amongst men offer a valuable and natural setting for constructions and indeed co-constructions to be explored in detail (Robertson, 2007). Discussions will explore the various aspects of each intervention; whether it be an individualised smartphone application, a team based competition or a traditional smoking cessation support group. Analysis will then focus on masculine qualities such as competition and autonomy and will explore what features can facilitate or limit their use in everyday settings.

This research aims (a) to explore the ways men constructed their participation in a variety of health initiatives, particularly those that relate to attributes of hegemonic masculinity. (b) To explore how men negotiate their involvement in particular interventions when discussing them with other men.

## **2. Method**

### **2.1. Design**

This exploratory qualitative study used focus groups and individual interviews where a semi-structured framework provided opportunities and time for participants to speak freely (Morgan, 1997; King and Horrocks, 2010). The combination of individual and group discussions enabled a wider range of discourses to be obtained as language is often constructed dependant on context (White, 1994). Also, a semi-structured format helped to facilitate ‘gender talk’ between men as it is often found that a directive

approach can help instigate conversations that men are less likely to have without being prompted (Morgan, 1997; Kitzinger, 2005; Speer, 2008). Two focus groups included more natural dialogue and ‘taken for granted’ assumptions due to participants already being known to each other (Agar and MacDonald, 1995).

## **2.2. Participants**

A small sample of twelve male post-graduate students were recruited from the Greater Manchester area. Their ages ranged from 23 to 45. Eight participants were recruited by purposive sampling at [blinded for review] University’s campus and four were recruited through the researcher’s own networks. All participants had consumed alcohol within four weeks of the study (see Table 2), ten regularly consumed five consecutive drinks and six intended to reduce their drinking levels; five participants had smoked a cigarette in the six months prior to the study.

Three focus groups (each involving three participants) and three individual interviews were conducted by the first author and sessions lasted between 50 and 85 minutes (see Table 1).

As participants were drawn from a restricted sample of men, it was assumed that the discourses produced did not represent a heterogeneous group of men’s attitudes to masculinity. Some qualitative studies have previously controlled for this issue using Connell’s four male sub-scales (Robertson, 2006), however, it was decided that the administration of a psychometric measure such as the Male Role Norm Scale (Thompson and Pleck, 1986) would be counterproductive to establishing a comfortable environment for participants.

## **2.3. Materials/apparatus**

A smoking and alcohol screening questionnaire established individuals' current levels of use and was based on Stages of Change research (DiClemente, Prochaska, Fairhurst, Velicer, Rossi and Velasquez, 1991; Velicer, Fava, Prochaska, Abrams, Emmons and Pierce, 1995; Laforge, Maddock, and Rossi, 1998).

Sessions were audio recorded and then transcribed using ExpressScribe software (<http://www.nch.com.au/scribe/>). The transcription style was adapted from techniques developed by Jefferson (2004) and is referred to as 'Jefferson-lite' (Parker, 2005).

A series of pictures depicting various cessation interventions were used during each session (see Table 1). These included new approaches (smartphone applications, SFO and Dryathalon), well known sources of support and some lesser known options. Some could easily be related to the attributes of hegemonic masculinity, such as 'cold turkey' (relating to inner strength) and some represented more of a challenge such as smoking cessation support groups (where sharing feelings is encouraged).

These were projected onto a screen to instigate discussion amongst participants.

## **2.4. Procedure**

Prior to each session, informed consent was obtained and participant's rights to withdraw were explained. Refreshments were provided for participants but no incentives or payments were given. The sessions began with participants assigning themselves a pseudonym that was used for the duration of the session.

Each semi-structured session aimed to provide equal time to discuss each intervention and involved. A general plan of pre-determined questions was used and the group or individual was asked, if they felt comfortable to share personal experience of the

interventions depicted on the images shown, giving specific examples where possible (based on the design developed by Merton, Fiske and Kendall, 1990).

At the end of each session, participants were thanked, debriefed and provided with supplementary information about local support available for smoking and alcohol cessation. They were also provided with researcher details so they could request further information about the study at a later date.

## **2.5. Ethical issues**

Ethical approval was obtained from the [blinded for review] Ethics Committee to ensure that the research adhered to ethical guidelines set out by the British Psychological Society (British Psychological Society, 2014).

In addition to participants giving informed consent and using pseudonyms during the study, the issue of shared disclosure was considered for working with groups. This was managed at the start of each focus group by agreeing anonymity between participants.

Participants were also given the right to withdraw their data following the completion of the session. Audio recordings were deleted following transcription.

## **2.6. Discourse analysis**

Social constructionist approaches informed the methods used in this study where language is recognised as being action oriented rather than simply descriptive or referential (Parker, 2015, Wood and Kroger, 2000). Within this approach, masculinity is viewed as something conferred on men by other men through discourse and defined in terms of status (Buchbinder, 1994). Language also draws on social structures and context and is therefore both a product and producer of discourse (Billig, 1991).

Similarly, health behaviour, as a social practice is constructed through language and interaction (Willig, 2015). It has been argued that this leads to an eclectic analytical approach (Jeffries and Grogan, 2012; Seymour-Smith, Wetherell and Phoenix, 2002; Wetherell and Edley, 1999) informed by Discursive Psychology (Potter and Wetherell, 1987 and 2001) and Foucauldian discourse analysis (Parker, 2015; Willig, 2013). This seeks to recognise the discursive features of rhetoric activity used in conversation, for example, justifications, extreme case formulations (such as using a worst case example to explain reasoning) and issues of consensus between group members. Consideration was also then given to how the discourses drew on existing ways-of-being and meaning available to us.

The discursive process followed the three-stage structure outlined by Willig (2015). Stage one involved the first author transcribing and reading the recordings to familiarise himself with the dialogue. Stage two involved coding to locate central themes; this took place after each interview or focus group and discussion with the second author was used to verify all discourses against transcripts. Stage three (analysis) took place once all discourses had been agreed between first and second authors and involved all three authors examining how respondents constructed accounts and the rhetoric activity used in conversation (Potter, 1996:146). The importance of context was recognised and that individuals express themselves differently dependant on the settings and who they are speaking to. It is assumed that these issues contribute directly to the production of the specific version of discourse that is produced and that a multitude of different versions can be created because of this.

Foucauldian analysis followed the six-stage process provided by Willig (2015), based broadly on the work of Parker (2014), (identify discursive constructs, locate

discourses, action orientation, positioning, practice and subjectivity). The relationship between language and subjectivity focused on the men and masculinity. Discursive constructions are therefore embedded within and informed by a culturally sensitive historical context (Wetherell, 1998; Edley, 2001), for example, competition, power and patriarchy. This, in turn results in some discourses being more readily available and indeed hegemonic (Gramsci, 1971), therefore of value in analysing. Also, care was taken to ensure that the relationship between text and macro-issues such as the operation of power and ideology could be justified and did not represent an analyst led commentary.

## **2.7. Reflexive Analysis**

The interviewer/facilitator (first author) was a 36-year-old male, moderate drinker and occasional smoker. He recognised that his attitudes and views played a part in the data collection and analysis; thus, he sought to ensure that participants felt comfortable and could share their views freely without feeling influenced. He avoided disclosing his personal opinions, choosing instead to neutrally ask open questions and facilitate dialogue between group members.

The first author kept a reflexive diary during the completion of this study which helped to recognise the impact of his interactions with participants and avoid analyst-led interpretations whilst still seeking to relate participants' constructions to macro-issues in society (Foucault, 1980). This diary highlighted consensus in one interview between a participant and himself (who both identify as openly gay), which seemed to facilitate discussion. This occurrence only happened in one interview and showed how different discourses are available to men dependant on context, and the importance of reflexivity on the part of researchers. The fact that discourses were agreed across a

research team consisting of two men and one woman, who all had slightly different experiences of health promotion, and research in this area, was a strength of the study, and we would encourage others to utilise teams whose experiences vary in future work.

### 3. Results

The following analysis is structured around the core emerging discourses that emerged from men's responses to the different interventions presented. These included control, autonomy, economics/finances, taking action, competition, fitting in and legitimacy. Words presented in bold refer to text selected for analysis.

#### 3.1. Control, "I can stop when I want to"

The issue of control clearly emerged in how men constructed interventions; in the following extract, Eric and Dev discussing the value of using SFO to abstain from drinking:

Extract 1: Eric and Dev (focus group 1)

Eric: Yeah (.) I used to work with a company that **worked with** (0.5) **erm offenders** who had alcohol issues and I think that that's interesting because (.) what you gain from that in that sense, to prove that you can stop if you want but after a lot of these times like you say, in the short term=

Dev: =they go back to it

Eric: yeah, like I don't know where, whether that is a positive thing, **proving** you can stop for a period of time if you want.

Dev: mmmm

Eric: and then that can **reinforce** the fact that further down the line=

Dev: =that's what I mean

Eric: that you've **always** got in your mind[

Dev: [I can stop when I want to

Eric: [I can stop when I want to

Eric uses his work experience in rehabilitation services to explain how stopping for even a short period of time increases self-efficacy for change. This counters Dev's critique about going back to drinking after October; such a criticism could be used as a reason not to participate at all. Eric uses a well-known phrase to jointly construct agreement with Dev about the value of abstaining, even for a short period of time. This exchange opens up the possibility of considering an intervention like SFO; which is an intervention that could easily be criticised for not, on the face of it, providing a clear long-term solution to addressing one's drinking. Self-control is therefore used as a positive quality for participating in cessation interventions.

Steve, constructs self-control in terms of responsibility and his personal identity when discussing interventions like SFO and Dryathalon:

Extract 2: Steve (interview 2)

Steve: Yes, but in life, (0.5) and this I think makes the difference, (0.5) I want to be **responsible** for whatever I do (.) So if I get a goal, (.) I want to know that this happened because of **me** and not because of your support or other guys. If I quit smoking I want to know that I did that because I can do that and because it is my decision and it is not because other people don't **allow**: me to smoke, know what I mean?

For Steve, self-determination is constructed in opposition to authority; to this extent, abstinence interventions are a challenge to autonomy. This important issue relates to the broader themes in masculinity research where independence represents strength, constructed through the media as not needing help from others (Gough, 2006). Interventions that prescribe certain behaviours (such as abstinence for a month) may therefore be viewed negatively as a threat to self-control.

### 3.2. Autonomy, “When someone, say, is telling you”

In relation to cessation of both drinking and smoking, men constructed formal external support (such as group facilitators) as being a challenge to autonomy. Here, Matt discusses support groups and autonomy:

Extract 3: Matt (interview 1)

Matt: When you got people there who are in the **similar situation** to you, (0.5) that can you know, (.) that’s part of the, (0.5) a lot of things I’ve, you know big thing for me is when someone, say, is **telling you** to stop drinking and they’re not a drinker? or have never really had any problems with it, I think people find it really: hard to relate it to someone who hasn’t been in that position before. You know! who doesn’t know how hard it is or how down it gets you (..) So if you get a group of people round there, sat with you who have all had the **same experiences** as you, (.) who know how hard it is, who don’t, who you don’t feel, not saying people do but you might not feel like they’re being **judged** as much.

Nigel: Yeah.

Matt: And kind of **looked down on**.

Matt constructed mutual support as coming from those in a '**similar situation**' rather than an outsider '**telling you**', therefore challenging your autonomy. These discourses are evident in other areas of health interventions where men take control of their own support groups (Seymour-Smith, 2008) and retain their autonomy, personal identity and power by creating an environment that is equal, without hierarchy, judgment or professional facilitation. In terms of behaviour change, this has real implications for groups of men working together. Matt is explicit about the need for a social contract between group members with shared leadership. Not only does this emphasise autonomy but also 'community' and the possibility of men supporting each other to make positive health decisions in supportive situations.

This 'autonomy' discourse is also used by Howard when discussing his experience of reading a self-help book about smoking:

Extract 4: Howard (focus group 2)

Howard: I think it's **garbage**, (laughs) it's just the problem is that it's **someone's own philosophy** at the end of the day so therefore: it's based on **their** attitudes and their change. I don't think it's generally applicable! The fact that it's made as much money as he has made off it kind of diminishes it a bit for me. I don't like the idea of someone **making money** off something like that, (0.5) even though obviously: they've got a right to sort: of you know, >spend money on a product< but at the same time (0.5) I think it's **tripe**!

Howard constructs this book as a threat to autonomy, even though it is written by someone who has personal experience rather than professional experience of giving up smoking. To some extent, this represents a slightly different issue than that

presented by Matt. On further exploration, the construction of the book being ‘tripe’ may relate to how men are traditionally out of practice with ‘emotion-talk’ (Edley, 2001:195) and viewing it as a challenge to autonomy or traditional discourses. Worthlessness is further suggested through the word ‘**garbage**’, the origins of which lie in North American language, helping to relate the issue to American ‘self-help’ therapy culture (Füredi, 2003), a traditional threat to masculinity.

Also, by drawing on capitalist structures (the financialisation of behaviour change), Howard suggests that the author’s desire to make money is greater than to help others. These arguments are seen in society, with health care becoming privatised amidst criticisms that corporations and big businesses are favoured at the expense of citizens (Giroux, 2011). In Howard’s group discussion, he positions support for the self-help book as representing naivety, and being ‘taken advantage of’ would be a threat to self, indeed masculinity.

### **3.3. Economics/finances, “It’s kind of getting money”**

Economic discourses were frequently used by participants, particularly in discussing mobile phone applications. In the following extract, Duncan, Dave and Izzy discuss the value of a money saving tracker on a stop smoking smartphone application:

Extract 5: Duncan, Dave and Izzy (focus group 3)

Duncan: I would like to know what sort of **money I have saved**, so I would actually think that was quite a useful app.

Dave: It is pretty expensive isn’t it? I haven’t smoked for so long, I bought a packet of 10 cigs and it was over a fiver!

Nigel: Yeah, yeah, yeah

Duncan: I find it quite **shocking** how much, (0.5) well you can pay 10 quid for 20 and if you are 20 a day=

Izzy: =I've not used that but I have used the kind of **financial: benefits** thing as I >travelled some time ago< and: the time that I quit over was probably about three weeks' worth of travelling in China at the time.

Duncan constructed the money saving tracker favourably as opposed to government interventions which he presents as a threat to autonomy. Both approaches seek to make smoking less attractive however the former emphasises financial benefits to the individual whereas the latter emphasises increased taxation (Action on Smoking and Health, 2016). This threat to autonomy is strong and helps to show that interventions for men may have most success when they encourage autonomy by encouraging participants to make specific selections or choices and monitor the consequences of these.

In the group discussion, Izzy presented a further example of success through autonomous money saving efforts; this further supports Duncan's point that autonomy as opposed to external enforcement is a favoured option for men choosing to stop smoking.

The second extract is from an individual interview where Steve discusses the same mobile phone application:

Extract 6: Steve (interview 2)

Steve: Well I just think this is a bit more useful (0.5) because it gives you a lot of information and it is more **practical** (0.5) so nowadays everyone is so: **obsessed about money** and how I am going to get money or save:

money or how I'm going to get about that in any case, so giving information about how you save money by quitting smoking is something useful (0.5) and it is like motivation to go on. So yes (0.5) again it is about the motivation, in this case it **gives you the motivation** to start and go on as well (0.5) it keeps you aware all the time.

The transactional aspects of economics are used here to construct money as valuable, tangible, '**practical**' and necessary. Steve's construction refers to social economic concerns and to some extent, the transactional construction places motivation as an external commodity, one that is provided by the intervention, assessed on its 'value for money'.

In examining these extracts, economic power appears to be of relevance when exploring masculinity (Connell, 1987) and indeed health. The present extracts show how this construction can be of value for men making positive health choices.

### 3.4. Taking action, "Made the decision"

An 'action' orientated discourse was employed by most of the men to construct change as something that was decided upon, then quickly enacted. These discourses typically appeared when discussing the idea of going 'cold turkey' (here defined as the enforced acceptance of cravings) but were also used when talking about nicotine replacement, as in Matt's extract where he describes his favoured approach:

Extract 7: Matt (interview 1)

Matt: For me it would be the more immediate solution (.) just (..) like an e-cigarette (..) If it's reducing >you know< the **immediate damage** or anything like that you know? (..) it's **better for the people around you**, then that (0.5) to me would be the way to go at first but then (..) oh,

I would: say I was (.) if I >had to kind of < **pigeon hole** that (0.5) then:

I'd say that was the best, the e-cigarettes because it gives the **most results in the quickest amount** of time you know?

Here, action is constructed as something that prevents '**immediate damage**'. It is further supported by using a rhetorical strategy known as systematic vagueness (Edwards and Potter, 1992:162). This refers to how providing vague, global detail (by presenting the use of e-cigarettes as being '**better for the people around you**') makes it difficult to refute. However, on closer examination, the inference in Matt's comment is that e-cigarette's are better than all the other smoking cessation options for '**the people around you**'; and this is not the case, in fact, e-cigarettes are more likely to be perceived as antisocial than some of the other options as their use is regularly prohibited in indoor public places.

Matt's discourse uses its 'replacement' properties to construct change as something quick, action based and requiring physical rather than cognitive intervention. He overtly positions and '**pigeon hole's**' himself in that discourse, making it easier for him to speak from this stance and project the benefits of this approach as producing '**most results in the quickest amount**' of time.

Here Eric discusses stopping smoking without support:

Extract 8: Eric (focus group 1)

Eric: I'd built up this day waiting for it but it was also just a **personal thing** so I'd made the decision to stop without making (0.5) erm (0.5) for want of a better word, a bit of a **fanfare** about it. Doing that, I just kind of **sloped off** into the shadows and that was it.

Eric positioned the act of abstinence as being autonomous, constructing change as being '**just a personal thing**', implemented without '**fanfare**'. This employment of an 'action orientated' discourse is traditionally associated to masculinity, for example, in sport, 'Just Do It', a phrase developed by Nike Inc. sport brand embodies this 'taking action' discourse. From a feminist perspective, this phrase constructs sport and action as hegemonically masculine (Dworkin and Messner, 2002). In terms of behaviour change, it is easy to see how this approach may be favoured by men, especially when talking with other men.

### 3.5. Competition, "that competitive edge"

A competitive discourse was used by men in this study; group discussions enabled hierarchy and subject positioning to be explored in depth. This can be shown through the following example, where Howard and Dave discuss the competitive elements of Dryathalon:

Extract 9: Howard and Dave (focus group 2)

Howard: I must lack that **competitive edge** because I don't think it would do anything for me

Dave: really?

Howard: I think I actually just lack that competitive=

Dave: =what about **badges**?

Howard: (laughs) well badges!

Dave: yeah get: a badge: (laughs)

Howard: mm (laughs) I just don't think it'd do it, I don't know. >It wouldn't make me do it any harder I suppose<, I **wouldn't be worried about losing**

Dave: You're not a competitive person?

Howard: Nah (.) **maybe my friends are just losers** so I don't have to beat them (laughs)

This interaction gave rise to competitive discourses that appear to be implicitly understood between the men involved. By positioning himself against the dominant hegemonic norm of competing, Howard faces the ideological dilemma (Billig, Condor, Edwards, Gane, Middleton and Radley, 1988) of reconciling this deviation with the traditional roles of masculinity. He negotiates this by projecting his deviation assertively, whilst, also by positioning himself hierarchically above his own peer group, portraying them as '**losers**'. This positioning both mocks them and guards against Dave's questioning about status.

Dave defends his own identity and the challenge that Howard presents by questioning Howard's transgression (see Edley, 2001:195) with a humorous exchange about '**badges**' (a reference to childhood sporting achievement, rewarded with a badge) that further utilises a competitive and hierarchical discourse. The implications of this competitive discourse for behaviour change amongst men relates to how it may not only risk rejection by some men but also reinforce unhelpful stereotypes about masculinity. The present example shows an unsupportive and defensive exchange between Dave and Howard that is unlikely to enable successful behaviour change.

### 3.6. Fitting in, "I don't like standing out if I can help it"

Discourses of ‘fitting in’ were used by men, particularly with reference to socialising. Avoiding alcohol in social situations was often described as problematic. Here, Matt discusses how he would feel about drinking alcohol free lager in public:

Extract 11: Matt (interview 1)

Matt: I: (0.5) would choose that over standing there with anything else (0.5) like a glass of water or: >something like that< just coz it would look a bit:

Interviewer: coz’ it would look a bit?

Matt: yeah exactly! but then again that’s just my: personal preferences coming in there >you know?< (0.5) but for me it would have the added **incentive** of just looking a bit more (0.5) kind of (0.5) I’m not (urm) (.) I’m quite an **introvert** (0.5) I don’t like standing out if I can help it.

He goes on to say:

Matt: It just looks like a regular beer doesn’t it! You **can’t tell** either way unless you look closer at it. Even less so if you >pour a couple into a pint glass< and **no one would know** the difference.

Traditional constructions of masculinity and drinking contribute to Matt’s unease with the idea of drinking water in a public house. In this construction, deviating from expected behaviours equates to vulnerability. This awareness of social norms leads Matt to a position where it is easier to become complicit with hegemony by wanting to fit-in. He negotiates these situations by covertly drinking non-alcoholic drinks; a strategy that makes the process of change an isolating one and restricts his ability to openly make choices based on health.

Duncan faced a similar situation to Matt. Here he describes how Sober For October helped him to drink alcohol free beer in a public house:

Extract 12: Duncan (focus group 3)

Duncan: I think irrespective of what you are drinking (0.5) you are noticing that you are **not on the same level** as someone else (..) I think that's (.) a bit of a downer (0.5) it can! be.

Nigel: and did it make it difficult when (0.5) say: if someone gets a round in?

Duncan: (..) In what respect? What: do you mean?

Nigel: Like (0.5) if they get a round and then you asked them to get a Becks Blue or a Kalibar?

Duncan: No: it didn't! (..) because: I think at the time: they were all in support: of the idea that I was **doing a month off**

Nigel: right okay=

Duncan: =So yeah: (0.5) if I wasn't **on Sober for October** and just said 'get me a Becks Blue' I think maybe: they would be quite **shocked**.

Participation was constructed as an active task that Duncan was '**doing**' during the month of October. This resonates with Farrimond's (2011) work which shows that men's health can often be defined through this approach, for example, sport. Duncan is better able than Matt (in the previous example) to 'fit-in' and negotiate this social situation by using an intervention that also provides legitimacy to his behaviour;

something which gains the support of his peers. Without this, he describes that ‘change’ would have been met with shock by his friends.

### 3.7. Legitimacy, “doing it for a good cause”

Fundraising for charity provided a legitimate reason for men to abstain from drinking. A win/win analogy was used to refer to how participants felt about what they were doing for themselves and others. Here, Duncan talks more about his experience of SFO:

Extract 15: Duncan focus group 3)

Duncan: I think it aids: it somewhat (.) if you know you are **doing it for a good cause?** it assists you and gives you a bit of a backing when you are feeling **weak** (.) at moments, you think ‘oh well you know I don’t want to **let myself down or the charity down**’!

Duncan constructs ‘strength’ as ‘abstinence’ and he describes weakness as ‘giving in’ to alcohol. Again, this uses an ‘active’ discourse to describe this behaviour but he also describes a real sense of responsibility that is uncommon in other interventions. It also reverses the traditional masculine concept and externalises the issue of giving up drinking, doing it for some other cause means that conversations about ‘self’ are avoided.

In the extract, Duncan says ‘**Let myself down or the charity down**’ with a comedic tone reminiscent of the BBC TV characters Alan Partridge (played by Steve Coogan) and Dave Smashie (Harry Enfield), both being parodies of radio disc jockeys, known for their platitudes (Høglo, 2014). This cultural reference appears to serve as a protective measure guarding against potential criticism from others during the conversation, possibly for being earnest or worthy.

Josh, in an individual interview, gave his experience of Movember (a group of men in his workplace growing facial hair for charity):

Extract 16: Josh (interview 3)

Josh: sponsorship is an amazing feeling, even if it is five pounds because that is (0.5) psychologically (0.5) **that encouragement is amazing**.  
Not that you need to be encouraged to grow a moustache.

Here, he constructs participation in terms of achievement; like Duncan, reinforced by knowing he is helping others. As with Duncan's drinking in a public house, Josh refers to how the environment can either facilitate or restrict behaviour. In Josh's case, the latter, as shown when he talks about the workplace with male colleagues:

Josh: It became a joke in this office of twenty five men and then a lot of people couldn't grow them and they were seen as being **less of a man** than=

Nigel: =of course=

Josh: =and it became a very **macho horrible environment** (0.5) I just couldn't wait for November to end.

The male environment appears to construct achievement as dominance, creating a '**horrible environment**' with some considered '**less of a man**' than others. Josh positions himself against this construction despite his superior moustache and his words give rise to the historical oppression of marginalised masculinities or to anyone who deviates from the hegemonic norm. Josh's feelings about this event make it unlikely that he would feel

encouraged about attending again in this same environment; and this example highlights how, even in legitimate situations for behaviour change, other constructions and discourses can sit uncomfortably together.

#### **4. Discussion**

Men are more likely to adopt unhealthy practices than women and are less likely to seek help or support to improve their health, and this study aimed to understand how various alcohol and tobacco reduction interventions are constructed by men when speaking with other men through analysis of discussions between 12 male university students. Discursive analysis suggested that autonomy and control were central to men's accounts and interventions encouraging competition amongst friends were constructed as favourable. While men presented their behaviour change as intentional, their accounts revealed a tendency to conceal this from others, suggesting a negative influence of peer pressure. However, participants who had raised money for charity whilst abstaining described this process as rewarding and acting as a 'buffer' to legitimise their healthy behaviour when socialising with other men in drinking environments. These issues are discussed in turn with reference to the interventions that are also critically reviewed.

It is also interesting to note how some differences arose in discussing alcohol and tobacco cessation. Generally, men talked about drinking in social terms as opposed to giving up smoking, where its addictive nature was emphasised. Substitutes and 'replacements' featured in discussions about both drinking and smoking, whether it be with an alcohol free beer or nicotine replacement, but again, the social side was emphasised for alcohol and addictive qualities for tobacco.

In group discussions, SFO was often referred to as a 'stop/start' approach, where individuals abstain for a month but then revert back to normal drinking levels. One participant raised a criticism that this may promote unhealthy attitudes towards drinking, far better to encourage 'self-control' by drinking in moderation. The prescribed nature of the SFO intervention (predetermined as being during October) was also criticised as being chosen possibly just because October rhymed with 'sober' and was therefore constructed as a challenge to autonomy. Support groups and self-help books were constructed in an equivalent way; men described these as an external force that limited freedom of choice and expression. These findings highlight the need for caution when designing interventions for men; and studies relating to alcohol recovery groups have shown the importance of this (Livingston, Baker, Jobber and Atkins, 2011) and how rehabilitative services do not always get it right (Ashby, Horrocks and Kelly, 2011). Interestingly, Dryathlon was favoured by some participants based on the timing of the intervention, January (traditionally a time to renew health improvement efforts). It was therefore constructed as a helpful tool that also supported greater social interaction through physical activity rather than a challenge to autonomy.

Smartphone technology may be considered to be a platform that supports autonomy as it uses a more individualised approach. One participant described that he could privately use it when in the company of others. This approach, although favoured by men in this study does appear to have the disadvantage of making the process of becoming healthier a solitary one which could be problematic if men took this to mean 'solving the problems on my own' when it would be beneficial to seek support from others (Jeffries and Grogan, 2012; Robertson, 2003). 'Legitimacy' proved to be a key finding within this study that enabled greater support between men when

making positive health choices. The next section considers 'legitimacy' with reference to an economic discourse.

### **Economics, trade-off and legitimacy**

The favourability of interventions that emphasised financial benefits may not be a surprise as these discourses can easily be related to societal traditions associating masculinity with economic power (Connell, 1993; Mumby, 1998). Neo-liberal political discourse further reinforces the financial benefits of health initiatives in our society, for example increasing taxation of unhealthy products such as sugar, smoking and alcohol (Gortmaker, Swinburn, Levy, Carter, Mabry, Finegood, Huang, Marsh and Moodie, 2011; Sheron, Chilcott, Matthews, Challoner and Thomas, 2014).

Health researchers have observed men's use of economic discourses in terms of how they refer to trading-off different behaviours against each other. This occurs when a non-masculine behaviour becomes legitimised due to accrued masculine capital as a result of certain behaviours or achievements typically related to hegemonic masculinity (de Vissier and Smith, 2006; 2007). In focus groups, young men ranked pictures of male models as being more masculine when depicted in sporting contexts rather than acting in a traditional 'model' pose. The authors suggested the idea of 'man points' being scored for perceived sporting behaviour. They also present the example of David Beckham wearing a sarong; here, a well-known footballer in a 'model' pose and is considered by the group as being masculine due to his football achievements (de Vissier and Smith 2007; de Vissier Smith and McDonnell, 2009). This concept may help to explain how healthy practices amongst men can be constrained or facilitated. In studies by de Vissier and Smith (2007) and de Vissier, Smith and McDonnell (2009), this process was applied to alcohol abstinence contexts; in one specific example a case-study of a hockey captain who could

legitimise his non-drinking by, what de Vissier and Smith (2006) refer to as scoring ‘man-points’ by his athletic achievement and status. This raises the notion that competence in one thing that is masculine, can compensate for another behaviour.

Relating this back to charity initiatives, the results of the present study suggest that charitable interventions may also act in an equivalent way; accruing ‘man-points’ by doing ‘good’ for others. In other areas of health research, men have described similar altruistic intentions, notably, during the life transition of fatherhood, where men increase their desire to modify behaviour for the sake of others (Bortoff, Radsma, Kelly & Oliffe, 2009; Kerr, Capaldi, Owen, Wiesner and Pears, 2011). Although none of the men in this study referenced fatherhood in their accounts, and they were not questioned about their parental status, this could be a valuable area of further exploration.

### **Competition and activity**

The favourable construction of competitive and activity based interventions such as Dryathlon helped to show the enduring appeal of traditionally hegemonic activities and, rather than oppose these traditional conceptions of masculinity, or indeed attempt to trade different behaviours off against each other, it is felt that carefully planned interventions can combine these issues to support men to make autonomous choices about their health in a supportive environment. Examples of this can be found in health psychology, where numerous studies have shown how male football supporters increased their exercise levels when health programmes were delivered through popular football clubs (Pringle, Zwolinsky, McKenna, Daly-Smith, Robertson and White, 2013; Gray, Hunt, Mutrie, Anderson, Leishman, Dalgarno and Wyke, 2013). This legitimate and safe environment for the men involved in those

studies was also utilised in mental health settings where football metaphor was used during group therapy sessions, for example "playing by the rules" or "left off the pitch" being shown as phrases to engage men in 'emotion talk' (Spandler, Roy and McKeown, 2014). Also, 'Men's Sheds' have helped men overcome issues related to social isolation through providing peer support whilst working on practical projects (Hansji, Wilson and Cordier, 2015). This construction of health as 'action' was observed by Farrimond (2011) in a study showing that men preferred to view themselves as assertive and that their health was something that needed to be 'sorted-out'. Similarly, Seymour-Smith (2008) worked with groups of men undergoing cancer treatment who preferred to define their participation in terms of action rather than support.

### **Future research**

It therefore appears that using traditional notions of masculinity in a gender sensitive way can help to facilitate accepting and supportive environments for healthy practices to be adopted.

It was not intended to generalise findings from this small sample of male postgraduate university students; instead, this study presents how deeply this group of men thought about their behaviour and their personal experiences of masculinity. Future studies could explore these discourses from naturally occurring discussions on-line or in the media. This could also increase the range of male perspectives included.

### **Implications for healthcare**

Within this area, the challenge for policy makers and health care providers remains how best to increase their reach to men whilst avoiding approaches that reinforce

negative gender stereotypes. Although health promotion has traditionally located behaviour change as an individual issue (Robertson and Williams, 2010), there is a real need for societal institutions to take up this challenge due to the socially structured factors influencing men's health. It will be important to promote positive associations between masculine selves and healthy behaviours using a gender-specific approach focus on universal issues affecting all types of masculine identity rather than ones that highlights difference; such as how Movember raises awareness for the prevention of gendered cancer prevention (Oliffe, 2009; Robertson et al. 2015). Reconstructing traditionally feminised issues, such as the courage involved in expressing emotions (Kilmartin, 2005; Gough, 2011) should also be considered, and health professionals should avoid using stereotypes that both homogenise and construct 'men' at the same time, for example 'man up'.

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*Table 1: Interventions*

Intervention	Description
Sober for October	A UK fundraising initiative organised and widely advertised at a national level by Macmillan Cancer Charity. Individuals gather sponsorship to abstain from drinking alcohol during the month of October. The money raised by voluntary participants goes to Macmillan Cancer Charity.
Change4Life Drinks Tracker. Smartphone application to track intake of alcoholic drinks.	An application available for download on iPhone and Android platforms. Individuals can track their own drinking levels in real time and received direct information about the impact of their drinking on their health and finances. Suggestions and advice is also provided to help people reduce their drinking.
NHS Stop Smoking iPhone smartphone application	An application available for download on iPhone and Android platforms. Individuals can track their efforts and progress to stop smoking. Daily motivational messages of support are provided plus instant tips and facts about smoking cessation. The real-time counter displays the minutes, hours and days that an individual has been smoke free, and keeps track of the money saved.
Alan Carr's 'The Easy Way to Stop Smoking' book	A bestselling book on how to give up smoking. Individuals are introduced to ideas about the psychological nature of addiction to tobacco and thinking strategies to manage craving experiences.
Smoking cessation support groups	This intervention was introduced as a group that individuals can self-refer too or be referred to by a health professional. Sessions are facilitated by a health professional and involve up to 10 group members, meeting weekly to discuss strategies that help them quit smoking, share stories and encourage each other.
Drinking alcohol free beer such as Kalibar	Alcohol free beer is often available in public houses and can be drunk as an alternative to alcoholic drinks.
Nicotine replacement such as 'liquid cigarettes' (vaporisers), patches and chewing gum.	Tobacco free substitutes as a way of reducing nicotine intake. These are readily available to purchase and some of which can be obtained with a prescription from a health professional.
'Cold turkey' (doing it on your own without any support.	This was presented to the group as a phrase to open up a dialogue of 'doing it on your own'.

Dryathalon	Dryathalon runs during January every year where participants are encouraged to form teams and compete with peers to raise the most sponsorship money for charity by abstaining from alcohol. Cancer Research UK advertise Dryathlon widely and emphasis the competitive and team focus encouraging groups such as work colleagues to sign up as 'Dryathletes'. A leadership board is continually updated online to create a sense of competition.

*Table 2: Participants*

Pseudonym	Age	Interview or focus group	Had 5+ consecutive drinks the last month?	Intended to reduce their drinking?	Smoked within last 6 months?	Venue	Length (minutes)
Eric	43	FG 1	No	No	No	MMU	85
Dev	24	FG 1	Yes	Yes	No	MMU	“
David	23	FG 1	Yes	No	No	MMU	“
Howard	25	FG 2	Yes	No	Yes	MMU	80
Tom	24	FG 2	Yes	Yes	No	MMU	“
Dave	24	FG 2	Yes	No	No	MMU	“
Duncan	35	FG 3	Yes	Yes	Yes	N	50
Izzy	42	FG 3	Yes	No	No	N	“
Dave	45	FG 3	Yes	No	No	N	“
Matt	31	I 1	Yes	Yes	No	H	50
Steve	25	I 2	No	Yes	Yes	MMU	60
Josh	30	I 3	Yes	Yes	No	H	75

*Note: MMU refers to a room at the university campus, H refers to participant's home, N refers to neutral location (a room at one of the participant's workplace).*