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DISCIPLINE OF PSYCHOLOGY – MASTERS RESEARCH PROJECT

A social constructionist study of masculinity and its effects on health seeking behaviours among men who are at risk of cardiovascular disease

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Plagiarism declaration

I pledge that the work done is my own work and that nothing has been copied or not referenced. It is being submitted in partial fulfilment of the requirements for the Degree of Masters of Social Sciences in the Discipline of Psychology, University of KwaZulu-Natal, Howard campus. It has not been submitted before for any degree or examination in this or any other university. I have used the American Psychological Association (APA) conventions for citation and referencing

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Abstract

In a world that has gender constructions, the masculine and the feminine, these gender constructions are used to highlight differences, and from this emerges differences in power that has an important effect on the phenomenon of health (Hollway, 1984). Males, as opposed to females, have lower life expectancies, which has been associated with a higher level of risk behaviours as well as a lower level of health seeking behaviours (Connell, 1995; Will H Courtenay, 2000; J kahn, 2009). The prevalence of cardiovascular disease is something of concern, as approached by Seedat (2000), which showed the indiscriminate nature of cardiovascular disease amongst males regardless of race. The way in which masculinity is constructed has been seen to emanate from multiple constructions including work roles, and thus the changing work climate is something that, in conjunction with cardiovascular disease, needs to be explored in order to see how, and if, there has been indeed a negative effect (Connell, 1995). The combination of masculinity and cardiovascular diseases is something that needs to be explored in relation to construction. The results of this effect can then be subsequently used to design interventions to either slow down the degradation or seek to create an equilibrium in order to minimise harm.

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Chapter 1: Introduction

The effects of gender in the salient social world have been well documented on both sides of the gender line, be it masculinity or femininity. This study will be exploring the male gender as well as sex, in particular the social construction of masculinity in relation to health. The reason for the exploration of masculinity is to understand masculinity in a changing context that has evolved and undergone a metamorphosis since the start of the understanding and exploration of gender in the form of masculinity. The salient masculinity can be understood to be a hybrid of that from the past, and that from the current time (Jewkes et al., 2015). This is an interesting area as it allows for exploration into constructs that are central to masculine understanding; that of a males job in relation to their health (Connell, 1995).

The particular health issue that is being looked at is that of cardiovascular disease, with a particular focus on hypertension sufferers, as this has a high prevalence in males. Males also have a shorter life expectancy as well as having a higher chance to suffer from a severe or fatal incident (Courtney, 2000).

The experience of how the male constructs masculinity within the context of the changing job environment could alter the way in which masculinity is perceived by another male, as well as a female, in their social context. The repercussions of this could lead to an understanding of the change in masculinity over time, with particular focus on the working environment. Implications for this could fall into health behaviour change interventions to deal with the low death age, and the higher chronic conditions seen amongst males throughout the world.

The way in which males are constructing health has both seen a vast change due to the change in locus of masculinity with job change, but at the same time has remained the same due to the salience of masculine constructs based on historical contexts. As such in reflexivity of the data collection stage, there had to be a change in analytical methodology from a discursive analysis, to one of a social construction, taking on thematic analysis through a process of mixed methodologies which allows for multiple qualitative insights into the phenomenon to deliver a more in-depth exploration (Wigginton & Lee, 2014).

Chapter 2: Literature Review

Introduction

Cardiovascular disease is a great health concern in modern day society. Its reach can be felt as both one of the most prevalent chronic illnesses, as well as a leader in mortality statistics (Massyn et al., 2014). As a key, yet overlooked health problem in the world, this condition is currently overshadowed by other world health epidemics such as HIV/AIDS. The oversight of key chronic conditions in South Africa can easily be seen in the electronic health record that is being used in South Africa which is called TIER.Net. This e-health system does not include non-communicable diseases, such as cardiovascular disease, but only communicable diseases like HIV/AIDS and the health related focus areas surrounding these communicable diseases, such as maternal health (Osler et al., 2014). As a key chronic condition identified by the world health organisation, there is a legitimate reason for further study of cardiovascular disease. As the subject of cardiovascular disease is an important one, there is a lot of literature on the subject that engages the causes, results and relating factors. The topical subject of gender has thus been covered in relation to the burden of this disease, with a keen focus on the feminine subject, due to an increase in interest in the feminist movement (Clarke & Olesen, 2013). In turn the masculine response to cardiovascular disease is an important subject to study as the disease can have behaviour change effects related to lifestyle due to popular methods to deal with it. These methods include change in diet, increased exercise and medication (Perk et al., 2012; Rose, 1981a). The effects of all three in relation to masculinity through a social constructionist paradigm will allow for the effects of the disease to be explored in relation to the social construction of masculinity. With this exploration, a duality of understanding will emerge to understand how the disease affects masculinity and in turn how masculinity affects areas around cardiovascular disease, such as treatment and living with this chronic condition.

When exploring health seeking behaviours, it is important to understand what these are. A health seeking behaviour is one whereby a perception of illness, disease or hurt triggers a reaction to take remedial steps in order to the problem. This is done through steps or stages where the person or persons seek a strategy or treatment to combat the illness, disease, or hurt (Ahmed, Adams, Chowdhury, & Bhuiya, 2000; Otwombe et al., 2015). What is important to understand in the context of social construction is that health seeking behaviour is a three-part endeavour with a trigger, an action to seek help, and an outcome from seeking help such as a

strategy. The concept of help seeking is an action, whereby one seeks help for their perceived problem. The importance of a social constructive paradigm here is that all of these three parts can are constructions meaning that health seeking is extremely fluid and reliant on social constructions to be present in order to be triggered. In order for someone to engage in health seeking behaviour they would first need to perceive that they have an illness, disease or other hurt. The perception of these ailments is then needed to move towards a state of action to trigger the behaviour. With males the barrier to this trigger is blocked by social constructions of masculinity whereby males seeking help is seen as a weakness, an affront to masculinity.

Cardiovascular disease is a class of diseases related to either the heart or the blood vessels. There are many types of cardiovascular disease including stroke, hypertension, and heart failure (*Global atlas on cardiovascular disease prevention and control*, 2011). Cardiovascular disease is one of the leading causes of death in the world, with the diseases not being racially or geographically located. There are many types of cardiovascular disease with multiple risk factors including: Age, Sex, Physical Activity, Diet, Tabaco or Pollution, and sleep.

Discourse

Before delving into the problem, and the literature surrounding it, a stance must be taken on understanding the basic constructs in the research. The research paradigm that this paper will be running from will be that of social constructionism. This needs to be explored prior to any other literature review to give an understanding of the background of the research used, as well as the way in which the research will be structured and expanded on.

Social constructionism is a paradigm in which meaning is seen to be constructed rather than having innate properties, and these constructions are based on inter-personal shared meaning (Noss & Clayson, 2015a, 2015b). The concept of social constructionism is that learning is core in the process of understanding the world, and everything that is understood is learned – with learning taking place in a social environment. This shares some understanding that learning takes place within a social and culturally salient context, which is a theory popularised by Vygotsky and is currently seen as one of the foundations of learning and developmental psychology (Daniels, 2014). As learning, and thus knowledge, derived from this learning, is located within a social inter-personal paradigm, it is then relevant that everything learned is specific to that socio-cultural understanding. While it may be possible to have a similar understanding that is intra-socio-cultural, these are still located within the

socio-cultural locality and are not the same when explored cross the socio-cultural divide. The emphasis on experience ,and that these experiences the person has, gain meaning from socially located learning and understanding, and this meaning is shared as well as co-created during a social interaction (Burr, 1995a).

Social constructionism places emphasis on shared meaning, and the dialogical process of understanding and constructing. In this way meaning is created when two, or more, people share an experience and have the same understanding of the meaning (Burr, 1995a). An example that can be used is that of a wooden table. A wooden table in the Western perspective is a piece of furniture that is used for placing objects on and is constructed of wood. This is known due to the western upbringing where the construction of a table and its uses are shared inter-personally. Now if a person had never had the shared experience of a table but had known wood to be a fuel source through their interpersonal experiences, they would interpret the table as a fuel source and not as furniture. While this crude example of constructionism is a very basic one, the principles can be applied to more advanced and abstract concepts like that of masculinity – as it is in this paper. This is when the construction is taken out of the solid and physical world, into that of mentality and meaning that cannot be isolated from social context.

The concept of social construction happens in the form of language, as well as gestures. Through the consistent dialog between two or more people understanding is created and shared. One of the theories that best explains the process of that is of dialogism. This is explored by Bakhtin in literature where meaning is created between partiers whereby words have inherent meaning in them which is created due to social, cultural and political context that the world has experienced (Roth, 2014). This system of understanding presumes that both parties have a shared understanding or concept of meaning, and this meaning is translated in a dialectical process, from one person to another. If there is no shared meaning then there can be no shared understanding, and the dialog between persons breaks and the meaning is lost, with no transfer of knowledge or understanding (Bakhtin, 2010). While the dialogue that is focused on with Bakhtin (2010) is usually that of literature, it can be translocated into the spoken word to understand the systems of shared meaning. The concept of shared meaning is one that is central to discourse analysis (Donnellon, Gray, & Bougon, 1986; Noss & Clayson, 2015b). Going forward in the research the emphasis on shared meaning and understanding is one that will be recreated and explored multiple times. This is due to the nature of shared meaning within the different methods of data collection, either

through individual interviews or focus groups. The concept of shared meaning then takes on different systems, either through a single one on one interaction, where shared meaning can be constructed between two people, or in a focus group where shared meaning is split not only between participants and researcher, but also between participants themselves, thus creating a three-way multi-directional shared construction.

The problem

This work is exploring a problem that is a conglomeration of multiple known problems in the world at the moment and will address them as separate entities, as well as a singular problem. The salient problems to be addressed are: the effects of masculinity on health, and the resultant result of an increase of male risk behaviour, as well as a decrease of male health seeking behaviour, and the potentially deadly affect cardiovascular disease has on the population – especially males.

Male health seeking behaviour has long been seen as a being less common and accepted than female health seeking, which results in an outcome whereby males do not seek help. It has been hypothesised that the reason behind this is due to gender role violations which happen when men, who are supposed to be seen as strong and as such within the standard masculine paradigm, and in relation seeking help would be seen to be weak or feminine. A consequence of these gender role violations has been seen to be more severe for males than females, as males are meant to show strength, both physically and mentally, but in not doing so, are showing negative masculine attributes that are associated with femininity, which is seeking help. This is thus seen as a weakness and a threat to a males' masculinity (Omar Yousaf, Aneka Popat, & Myra S. Hunter, 2015a). This creates gender conflicts as males are perceived as displaying female characteristics. The display of feminine characteristics is seen as extremely anti-masculine and is avoided even at the detriment of the male's health. While the male is not only suffering physically from the elements, which in this case is cardiovascular disease potentially not being controlled, they are also suffering mentally due to the internal gender conflicts which can be seen as a level of cognitive dissonance (Yousaf et al., 2015a).

Males as a subgroup have known differences when compared to females in conjunction to health seeking behaviour. Males tend to not be the main sex that accesses healthcare, with healthcare being predominately accessed by females (Paul M. Galdas, Francine Cheater, & Paul Marshall, 2005). This healthcare access is across multiple types of health seeking, as well as ailments. The type of healthcare that is being accessed does not have an effect on how

males access it, whether it is to heal an ailment or for preventative measure, males do not tend to access healthcare as frequently as females (Paul M. Galdas et al., 2005; Yousaf et al., 2015a). The result of this in conjunction to cardiovascular disease is that a manageable chronic condition is left unchecked, untreated, and as such, can cause death as an outcome, although treatment is available for management of the set of conditions.

With the first hurdle of males' access and seeking of healthcare explored, the second hurdle is that of adherence to healthcare. It has been shown that males, when compared to females, do not adhere to healthcare too as great an extent (Paul M. Galdas et al., 2005; Kagan, Faibel, Ben-Arie, Granevitze, & Rapoport, 2007; Yousaf et al., 2015a). This is then resultant in a recursion of the disease or ailment, and in the case of this paper – cardiovascular disease, which when treated, can result in a normal lifespan, as well as a normal quality of life; but left untreated can easily kill (Groeneveld, Proper, van der Beek, Hildebrandt, & van Mechelen, 2010; Seedat, 2000). Examples of health seeking behaviour in cardiovascular disease has been explored in the United Kingdom (Rose, 1981b). This study sought to understand health seeking behaviour in relation to heart attacks in males. This was explored cross culturally as a way to understand masculinity. The reasoning for this is the construction of masculinity is by nature, socially based, and the effect of culture may have an influence on the construction and maintenance of masculinity through a dual dialectical process. The study explored male health seeking and health experiences around having a heart attack. The result of the study showed that males did not actively engage in immediate health seeking behaviour after or during heart attacks. The theme that this study highlighted was that males felt that seeking help without prompt, would mean that they were not adhering to masculine constructions of being physically strong, and as such delayed health seeking or only sought out health care when promoted by a female. The prompting by a female allowed for a transference of responsibility of the male's health from themselves, to the female, and as such would mean that the male is not embracing the feminine trait of seeking help but adhering to an outside influence as part of social interaction. The result of this is that masculine construction is not put into a negative situation, but saved due to the female influence.

Cardiovascular disease is one of the biggest killers in the world, and in specific to the context this is written in – South Africa. This has been shown by the world health organization through successive reports where cardiovascular disease is on the list of top 10 chronic conditions, as well as the top 10 causes of mortality by chronic conditions (Massyn et al., 2014; Seedat, 2000). The latest statistics show that cardiovascular disease occupies 10% of

the percentage of deaths by chronic conditions in sub-Saharan Africa, making it a real problem to worry about (Seedat, 2000). The problem is further compounded due to cardiovascular disease being known as the silent killer due to the potential of being afflicted and unknown due to lack of symptoms (Massyn et al., 2014; Seedat, 2000) When understanding males' health seeking behaviour and adherence to treatment in the case of cardiovascular disease, the exploration of masculinity can help shed some light on the problem, and the experiences of those dealing with cardiovascular disease. The exploration can be done using a discursive analysis in order to understand how those effected construct their choices and feelings in relation to masculinity, with an outcome of both an understanding of the interactions between masculinity, health seeking behaviour, medication adherence and those suffering from cardiovascular disease (Buchbinder, 2010; Will H Courtenay, 2000; Seedat, 2000). Ultimately this understanding can be further expanded into interventions and behaviour change strategies to help decrease mortality ratios and increase life expectancies for those that are affected by this disease.

Sex Comparison in Health

Males and females have historically been explored in separated research and programmatic outputs when related to health. This can be seen on a basal level in the World Health Organizations stats for Sub-Saharan Africa where males and females are normally disaggregated to show the burden of disease as separate entities. This is once again seen in HIV and AIDS research where males and females have different emphases placed on the volume of research. While there is reasoning and scope for separation in males and females for demographic reasons, the increased focus on females as opposed to males due to, in part, easier access to the female population through their health seeking behaviour, has caused an uneven exploration of the sexes.

The differences in male and female health have been noted throughout many studies across multiple burden of diseases. A good example can be seen in the vast amount of work that is done in Southern Africa in regard to HIV and AIDS. This work shows the trend that females show, in relation to HIV and AIDS, generally have higher infection levels. This is clearly seen in the HIV study done across the universities of South Africa, where females had a higher infection rate than males (Colvin, Kelly, Connelly, & Parker, 2010). The same research done by Colvin et al (2010) showed that males were engaging in more sexually risky behaviour with a higher number of multiple sexual partners, which puts the males at a higher

risk than females for contracting HIV/AIDS. This difference would seem to then suggest that it is females that should be explored, and this is what has happened. While this type of additional female exploration has been a focus, especially in South Africa, this has left males not having a focus community, outside of the key population research of men who have sex with men.

Having differences in research across the sexes has left a vacuum of inequality between males and females with regards to being a researched population. While there are valid reasons for this, further studying into males needs to be expanded on and explored in-depth to allow for better outcomes that research can help direct.

Hegemonic Masculinity

When looking at the construction of masculinity the formative process of hegemonic masculinity needs to be explored. The reasoning behind this is due to the way in which masculinity is created through the social interacts and shared understanding, but also the way in which males position themselves within this discursive environment of masculinity. Before delving any deeper it should be noted that masculinity is not seen as a fixed variable, but rather one that is constantly being shaped and changed through social interaction and is therefore a social construction that is moulded (Arxer, 2011). As the construction of masculinity is not fixed but is a social dialectical construction of understanding and experience, it can be then understood that there is no static version of masculinity. Masculinity is rather something that is created out of shared understanding. This understanding may then differ between races, cultures and social standings (Arxer, 2011). The outcome of this is that masculinity can be understood as being different or similar depending on contextual situations including chrono-spherical positioning.

Hegemonic masculinity has been explored by Connell (1987) and was seen to be explored not as a universal truth as to what creates a man, but rather as a representation of the social norms at the time. This can be further explored as "not a fixed character type, always and everywhere the same. It is, rather, the masculinity that occupies the hegemonic position in a given pattern of gender relations, a position always contestable" (R Connell, 1987b, p. 205). The construction of the masculinity of males is normally phrased as being between males, thus at the exclusion of female influence. This has been argued by both Connell (1987) and Arxer (2011) as being incorrect. They argue that the correct way to understand this construction would be amongst males and amongst females. This gives agency to the female

sex whom is also part of the culture and society in which masculinity is a social construction, and as such would have an influence on it even if not directly through a challenge action. The inclusion of the feminine input into the construction of masculinity is a more realistic approach to understanding the construction, as the effect of influences that are enacted from the outside of the in-group, cannot be discounted regardless of the level to which the influences have power within the given situation. This argues for a more inclusive concept of social construction where multiple influences intertwine to co-create meaning. From this level of argument, one is able to discern that masculinity is deeply entrenched within the fabric of human interaction. While this may not be consciously done, it is still a part of social interaction and the co-construction that follows there-after.

In many settings around the world, males and masculinity are seen as a dominant system. This is no exception in the workplace, where masculine discourse has been dominant (Berdahl, Cooper, Glick, Livingston, & Williams, 2018; Rumens, 2017). The reason for masculine dominance in the workplace environment is that masculine discourse, as a core construction, revolves around dominance (Berdahl et al., 2018). This dominance is projected to females, and femininity, as well as other males and therefore a core standard of interpersonal interaction within the masculine construct. Within this, there are hierarchical systems which rank masculinity levels, with the dominance of masculinity over other constructions or displays of either masculinity or femininity giving higher prestige (Berdahl et al., 2018). The prototypicality of males in relation to their display of masculinity in the workplace is thus shown as being tough, taking risks, aggressive, taking charge or being a leader. With these traits in place, the cycle of masculine domination within the workplace creates a cyclical rhythm with those displaying the desired traits dominating those that do not, and in turn maintaining that level of hegemonic masculinity within the workplace.

Precarious masculinity is something that is salient in relation to prototypical masculine constructions within the workplace and is a reason for the cyclical re-enforcement. The construction of masculinity, while being pervasive, is somewhat fragile as it is easy to lose your level or status, and hard to gain or maintain that status as this requires constant effort (Berdahl et al., 2018; Dozier, 2017). As masculinity has to be constantly constructed and negotiated within the salient paradigm, there creates a level of stress and conflict within the workplace. Males are required, in order to maintain their status, to continually enact their masculine construct, and are worried about their loss of status which can happen easily, as

well as the effort and energy it takes to maintain the current levels. This in turn creates an internal level of psychological stress which is perpetuated within the workplace environment where masculinity is so salient and dominant.

In order for females to conform and entwine within the workplace, there has even been seen to have masculinity appropriate through a female hybrid masculinity which allows for a co-construction of masculinity within the female sex (Dozier, 2017). This is in part a co-construction and re-creation of the hegemonic masculine discourse which is generally seen to be salient within the workplace (Berdahl et al., 2018). From this a conflict between the masculine norms, which exist in the working environment, clash with the feminine constructions which exist both outside of the work environment and within smaller sections of workplace ingroups.

With the structure of masculinity in the workplace, and the understanding of how it creates levels of stress due to a continuation of cyclical effort and maintenance, there is now the further issue of how stress is dealt within the workplace. Stress in the workplace is a major problem in today's workforce, with the stress not simply being located within the workplace, but having an effect on other parts of life (Langille, 2017). It has been found that workplace stress if very prevalent, with a study showing that 76% of persons within the workplace feel burnt out at least once a week (Langille, 2017). Another reason for workplace stress, especially in relation to males is due to the change in workplace structure and organisational design (Cooper, 2006). As the world economy has seen a change from predominately blue-collar workers, and now a flow of jobs being white collar, this has changed the whole structure of the working environment. A special note on this is that masculine constructions were very salient and easy to discern within a blue collar environment, as masculinity and the linkage of expression and physique could be physically seen, as well as being constructed as intertwined as the psychological constructs of masculinity were a direct expression of a physical construct where dominance is physical (Berdahl et al., 2018; Cooper, 2006). The workplace shift to white collar work, and the structure of organisations that encourages co-operations and intergroup melding, place additional stress on the masculine construction which has been relevant through the workplace prior.

As a result of the shift in workplace, masculinity as a construction is having to change. While there is pervasive masculinity, the form and level of acceptability has its own ebb and flow.

Resulting from this, are males who are having to alter their construction of masculinity, and thus have multiple constructions that must be maintained which causes stress. The addition of workplace pressures cause more stress to be added, resulting in a masculine construction that has mental pressure to both maintain a masculine construction, as well as deal with the workplace stress (Berdahl et al., 2018; Cooper, 2006). This creates a level of cognitive dissonance and conflict of masculine constructions, having to deal with the workplace stress or illness while at the same time maintaining the masculine construction, as it is easily lost. Within this contextual construction, masculinity is fighting to stay relevant and pervasive, while at the same time causing discomfort at be maintained.

Masculinity as Physical and Emotional Strength

Masculinity, while different across many different cultures and classes, has been historically linked to, the male physique. Examples of this can be seen through historical accounts and art, where the male figure is portrayed as being physically strong and muscular. The reasoning behind this has been explored and a causal link has been argued between male physique and their role in society. Examples of masculine physique and the masculine role in society has been shown throughout history. The start of the masculine physique is shown in the hunter/gatherer society where a muscular physique enabled males to better hunt. As the female role of gathering was less physically tasking or demanding on bulk muscle tone, they did not have an emphasis on muscular tone/physique (R Connell, 1995). We can see emphasis on muscular tone as the masculine physique in both Greek and Roman history where males dominated roles that required physical strength such as being a soldier, and females were relegated to tasks that did not require as intense muscular work. This commonality throughout history where masculinity is portrayed as a muscular physique, and directly linked to the experience of being muscular is one that has been perpetuated throughout the ages. Other examples include jobs where males, and masculinity, were exemplified (Barrett, 1996; L. A. Krefting & Berger, 1979; Simpson, 2004). These jobs were prominent even up to the 1970's, where after that there was a change in discourse in understanding biological sex, gender and its relation in society. This change was that of the movement for equality between males and females in all facets of life, including in the workplace. While the movement was relatively slow, and is still happening today (Hareli, Klang, & Hess, 2008; L. A. Krefting & Berger, 1979), examples of this can be seen through the rise in the feminist movement, workplace equality, as well as equal rights, all bridging the traditional divide between male and female. The slow pace to which gender equality between

males and females is that, while the nature of the working world and job seeker market have changed, the bias towards male workers, as well as male management, is still strong (Hareli et al., 2008). In regard to this current gender bias in the workplace, and the switch of males from physical jobs to mental based ones', there has been a push for females to be seen on the same level of social status as males. This creates confusion in the construction of masculinity, as prior to this, masculinity was measured by the work that was done and the direct comparison to your working colleagues who were also constructing the same systems of understanding for masculinity, allowing for direct intra-group comparison. With the change in this, and the locale and scope of the work, it can be seen that there is confusion as to how to construct salient masculinity for both those working traditionally masculine jobs, as well as those working within the new paradigm of jobs.

Females challenging, and being peers with males in their places of work, also has an effect on masculinity due to the historic nature of male/female working environments (L. A. Krefting & Berger, 1979; Simpson, 2004). Prior to the gender equality shift, females were not in the traditional male workspace, and if they were in a workspace it was one that was subservient to males or one that was seen as 'female work'. This shift in construction allow for males and females to interact on level playing fields, meaning that there is intra-group comparison, where males and females which form part of a social group, previously the inter-group comparison was split between the males and females due to each being in their own salient social grouping (Tajfel, 2010). The change to inter-group comparison now means that males, and as a result the construct of masculinity, are now incorporated within a salient social grouping that is inclusive of females, and their resultant construct of femininity. Through this there will be constant negotiation as to the fundamental construct of masculinity for males as during the construction that happens within salient groups in the workplace the masculinity that used to exist in male dominated jobs can no longer be completely salient – this is due to sharing the space with females. due to this a new construction needs to be created and co-exist within the grouping that is both male and female, as well as having to change and be adapted due to the typing of work changing from physical to mental based work. This creates confusion as to how to co-construct masculinity, and as a result this creates fractured masculinity constructs that are not salient in all social settings. Without this salience, and constant fluidity there is internal conflict within the males as to their identity, which in turn has an impact on their help seeking behaviour (Connell, 1995; J kahn, 2009; S Robertson & Williams, 2010).

While masculinity is not only created by the perception of physique, physique is a construct that is used to define one's masculinity. The more muscle or muscle tone that a person had was historically linked to their masculine role within society. This results in one's meta-stereotype of one's self, and the stereotyping of others being based on the historical link between masculinity and physique. The result of which has been perpetuated to the salient times, with examples of masculinity still being linked to physique which include clashes of masculinity, which portray one's masculinity with pastimes such as fighting or doing other physical activity in athletics.

The association of physique and emotional strength has been noted, whereby males are expected to be as emotionally strong as they are physically. This creates a link between the emotional and physical state of males whereby males are expected to be unemotional, aggressive and dispassionate (Montes, 2013). This link is therefore part of the intertwined nature of a male's physique and their emotional state. Through the elements of males' physiques, emotions and their sexuality, the construct of masculinity has a systematic linkage of intertwined outcomes (Jeleniewski Seidler, 2007). A male construction with the focus on physical strength is thus reflected in their emotional strength, and just as a male was supposed to be physically strong for the work that was traditionally carried out, so to should their emotions reflect this. An example of this during the earlier hunter/gatherer phase, would be that the male was responsible to kill the game, and as such their emotional construction would reflect that of a hunter – showing no remorse or outward emotion to their prey. This hegemonic masculine trait has thus been part of the construction that leads back to one of the earliest masculine constructions based on the physical body, with emotions reflecting the physique; strong and maintaining the aura of strength.

Masculinity as Sex

The difference between sex and gender is one that has been explored by multiple authors, but is generally defined as sex being a biological binary, a person is either biologically male or female with difference in genitalia and other biological markers, and gender being something that is more fluid and not being directly linked to biological, thus allowing for a more fluid change between the previous static genders (Elder, 2015; Nagy Jacklin & Baker, 1993). It is noteworthy that this does not include the third sex, of intersex, which is not discussed here. The usage of biology to justify the construct of gender, as well as reject genders elasticity by trying to create it as a static entity, is one that is slowly changing, but still a pervasive

discourse. This is done by associating constructions of biology with prescribed behaviours and norms that are seen as socially acceptable, as is seen in the construction of masculinity. Examples of this are seen heavily in the male sex discourse where males are seen to be biologically pre-disposed to have sex, and it is within their right to enact this biological role, as not doing so would deny a base construct of male genetics, and as such justifies displays of masculinity that are seen as biological in origin (Meyer, 2013; Willig, 1998). This is an important point to explore, as this is where some of the locus of power that is created through the masculine construction is located. If one is biologically included to do something, it conveys a legitimacy to one's actions, which further perpetuates historical masculine constructions.

With the usage of biology as a salient discourse to understand masculinity, and gender construction as a whole, it can be used to justify thought and actions as being biological in nature. When an action is biological in nature, it is seen as natural and ratified as being part of who someone is. Things that are perceived as natural are easily ratified as being just and part of the way in which things work, so altering or questioning them is seen as taboo and makes them very immovable when it comes to change. Changing something that is seen as natural means that one would have to question the natural construct, and biology itself. The result of this are justified actions relating back to masculinity being part of the natural word, based on the sex of males, and as such should not be questioned, and does not need to be defended (R Connell, 1987a; Meyer, 2013; Willig, 1998).

It is notable that there is a difference between masculinity as sex and masculinity as physical and emotional strength. When the discourse of masculinity as sex is salient, there is an emphasis on biology. While biologically and evolutionally there may be a link between sex and physique, this link would fall into the sex discourse. The masculinity as physical and emotional strength discourse however is focused on the construct of the masculine body, and not its biological origins.

The Change

The potential change in masculinity constructs was not something that was originally designated for this study, but was something that needed to be kept in mind. This is explored by Connell (2012) who looks at the change in society and job type, as well as its effect on masculinity constructs. The question posed is then: is the construct of masculinity one that is stagnant and based on the traditional male as the hunter in an evolutionary context; male as

the physically strong sex, and male jobs reflecting these perceived truths. Examples of this historically would be males as builders, males as farmers, and males as soldiers. All of the for-mentioned jobs being heavily reliant on physical strength as the main characteristic in completing the job, and having a resultant associated to male physique. This male physique is muscular, and as such the muscular façade of the male has traditionally been associated to a masculine male. This association has been part of the masculine social construct that has crossed cultures, and as such is represented in a similar way regardless of society (Connell, 1995; Raewyn Connell, 2012). This means that masculinity has been seen as physique, or rather tied to physique across multiple cultures and societies. There are exceptions to this, but by way of a general rule this seems to be historically true. This makes masculine construction one of a few anomalies that transcends culture and society based on what is normally described as a primal or evolutionary construct – as males are commonly understood to be the strong, muscular protectors or hunters.

With general understanding of masculinity being similar across culture there is a shared understanding that is very salient in South Africa today. The reasoning for this is the vast mix of culture that is present within South Africa, with eleven different languages and many cultures represented (Statistics-South-Africa, 2011). If there is, or is not, a shared understanding the racial differences or similarities, regarding culture, integration could have an influence on this. The resultant understanding would explore how South African men understand masculinity as opposed to just Caucasian men, or Black African men. This cross-cultural understanding that has been historically present, could represent one of the few shared understandings that hinges together the historical patriarch societies of the world.

The change in constructions of masculinity due to the salience of societal restructuring in gender and gender roles, coupled with the high levels of cardiovascular disease, and ways in which this disease manifests, as well as the side effects of the drugs that have a potential effect of constructions of masculinity is something that needs focus. This change can throw males into a state of cognitive dissonance as they could be unable to adjust, and the adjustment can create a negative social and subsequent personal consequence – as well as the current negative consequences that are associated with masculinity and cardiovascular disease, such as the lack of help seeking behaviour (Wicklund & Brehm, 2013)

Chapter 3: Aim and Rationale

There has been much research that segregates sex and health, but this is normally done on a level that does not delve into the depths of social construction. Examples of this can be seen throughout health research published by transnational bodies, such as the world health organization which disaggregates health by sex, namely male and female. The bodies of research that cover the disaggregation by sex, while useful as a descriptive, does not fully explore the effects that gender, as opposed to sex, has on the issues around health. This is especially relevant with males ,and masculine constructions, whom are historically known to be take more risks and to have less health seeking behaviour than females (Galdar, 2010; Paul M Galdas, Francine Cheater, & Paul Marshall, 2005; Omar Yousaf, Aneka Popat, & Myra S Hunter, 2015b). Thus, the aim of the research can be seen to fit into the following areas:

- How males with cardiovascular disease understand and construct masculinity
- If there is a difference between constructs of masculinity within the males
- If cardiovascular disease appears in their construction of masculinity
- How cardiovascular disease effects masculinity constructions
- If working type and environment plays a role in the construction of masculinity

The purpose and final result of the research has potential far reaching results in the areas of Health Promotion and Communication based interventions for males with cardiovascular disease in the workplace. Males being targeted in the workplace will allow for a wide range of traditionally missed males to be reached as traditionally males represent a large proportion of the workforce in South Africa (Statistics-South-Africa, 2011). If these males could be targeted and have direct interventions that work within the masculine construction, and by understanding the masculine constructs that effect the understanding and interaction with cardiovascular disease – there may be a chance to reduce the number of fatalities and increase quality of life for those affected.

Chapter 4: Methodology

Research Design

This project approach to the investigation into the effect of cardiovascular disease on masculine constructions, was done from a qualitative research paradigm, in particular using a social constructionist stance (Finlay & Gough, 2008; Terre Blanche, Durrheim, & Painter, 2009). The method of analysis was initially that of discourse analysis but changed as the project progressed to be reflexive of the data that was emerging, so as a result was a mixed analysis method of both discourse analysis with a thematic component. The usage of the mixed methods approach of thematic analysis coupled with discourse analysis will be centred around using thematic analysis to explore themes which emerge from the data, and discourse analysis to explore the construction within the themes (Wigginton & Lee, 2014). The foundation of the qualitative paradigm is that everything is contextually related, subjective by nature, and a part of the natural human experience (Babbie & Mouton, 2005a). In this qualitative paradigm, the aim of the research is to gain an understanding of these subjective experiences and explore them within the context that they are located. Without the contexts, the understanding of the subjectivity will be lost, as the context is a place whereby the subjectivity is grounded, and centrally located (Babbie & Mouton, 2005a). The reason this approach has been chosen is due to the nature of the understanding of masculinity within the given context of working males whom have cardiovascular disease. This specific context and exploration of language, and themes within the language will allow for a critical investigation of the ways in which language is used to construct meaning in an inter-personal setting and give a critical understanding. The usage of the critical understanding is done in order to explore the way in which the construction of meaning is taking place in an unbiased way, without the status-quo being seen as the norm, and thereby accepted as the norm (Wilbraham, 2004). The usage of a qualitative paradigm further allows for a rich descriptive understanding of the context and events that surround the research, giving further understanding to how things are socially constructed, as the construction does not happen in isolation of context.

Sample

For the purpose of this research, a purposive and convenience sample was used in conjunction with snowball sampling. This is often done in qualitative research due to the nature of gaining a sample that falls within the categories required (Babbie & Mouton, 2005a; Kelly, 2009). Purposive sampling is sampling methodology whereby participants are selected

based on certain criteria which is relevant when answering the research question (Terre Blanche, Durrheim, & Painter, 2008). The reason behind the purposive sampling is to gain access to those whom meet the basic sampling criteria. Convenience sampling can be defined as the use of able and willing participants whom are available to be part of the research as opposed to a randomized sample that is often used in quantitative research, which randomly selects participants (Terre Blanche et al., 2008). The reasoning behind using the convenience sampling in this research was due to the availability and willingness of anyone whom fulfilled the criteria being willing to participate in the research. Without these two things the discourse that would emerge could be a forced one due to outside pressure of unwillingness on participants to fully envelop themselves within the research. Snowball sampling is when a participant is gained through a system of referrals from another participant or key stakeholders within the research. Just like a snowball rolling down a hill, the momentum in recruitment is gained through participants knowing others whom may possibly be willing to participate as well as meeting all the criteria (Terre Blanche et al., 2008)

In this research project, there were two data collection methodologies used, the first being a focus group and the second being individual interviews. The usage of both methodologies gives differing perspectives, with focus groups being more socially bound and expecting to elicit more socially stereotypical rhetoric from within the salient in-group, and individual interviews to gain a deeper understanding of a single individuals experiences (Kelly, 2009). In this particular research project, a single focus group was conducted alongside three individual interviews. There was no cross recruitment from those whom were in the focus groups, to those who were part of the individual interviews. All persons who were part of the study were males whom had a cardiovascular disease, with almost all of them identifying as having high blood pressure with the remainder having a different form of cardiovascular diseases. The sample was drawn from a large corporate business that is centrally located within the greater Durban area of Kwa-Zulu Natal, South Africa. The reason a large corporate company was chosen was due to the way in which changing job patterns can have an effect on the constructions of masculinity (Connell, 1995). The difference in white collar and blue-collar jobs is also visible from within the sample selected, as the business that the sample was recruited from, had both of these two job types. The participants in the study were all above the age of 18, and no age cap was included in the study. The minimum age of 18 was chosen as this is the minimum age of consent, as well as being the minimum age at which persons are hired at the company (Crozby, 2007). All of the males recruited were still of working age,

meaning they had not hit the retirement age of 65 at the company. The following table highlights the participants' participation in the focus groups and individual interviews:

Participant	**Participated in Focus Group**	**Participated in Individual Interviews**
Participant A	x	
Participant B	x	
Participant C	x	
Participant D	x	
Participant E		x
Participant F		x
Participant G		x

Recruitment

Participants were recruited from within the business at one of their office sites. This was done firstly by placing advertisements at the resident medical centre (See Appendix I). Permission was obtained to place these advertisements from the head of the workplace health company that is contracted to run the workplace health system on the campus. It was in consultation with the head of the workplace health company that the advertisements were placed within the clinic environment, with approval from the company that the sample was being recruited from, as well as the workplace wellness company. The reasoning for this is that the males whom had cardiovascular diseases would come to the clinic for check-ups and to get their medication within the month that the research was to take place. Within the company, each of the employees whom have a cardiovascular disease have regular check-ups to make sure that they are doing well, or to determine if they need further referral. The head of the health facility stated that the month of the research was a month where most of her patients would come into the clinic, and thus would be able to see the advertisements. The nurses at the health facility were also instructed to inform those whom were having a check-up of the advertisements in order to ensure that everyone that would qualify, had exposure to the advertisements. This was done in order to gain as much exposure as possible, as with previous experience gaining access to males to talk about masculinity is not easy.

The researcher had great difficulty in gaining a large enough pool of participants to conduct the research with only the advertisements, despite all the efforts from those working at the health facility. To combat this, the snowballing sampling method was used. Participants were

asked to contact other males with cardiovascular disease within the company and inform them of the research, as well as ask them if they would like to be part of the research. Those participants who had contacted the researcher had a follow-up call in order to ascertain what date and time would be best. Once a mutually agreed-upon time was recognised the times for the focus group and individual interviews were booked with the participants, as well as confirming and getting approval for these sessions and times with the company they were based at. The reason for making a time with the company was to allow for the participants to be involved in the research without affecting the work that the participants were doing. The company obliged and allowed the participants to be part of the research without having a negative effect on perceived performance, as well as offering spaces to run the focus groups and individual interviews. The recruitment took place near the end of the year in order to minimise the impact that taking time out of their schedules would have on their workload and productivity. This was ascertained through consultation with the participants whom were amongst the first to contact the researcher, as well as the management of the company.

There was no reward or incentive offered to the participants by way of cash or voucher. Instead, a light snack and drinks were provided in order to compensate for the time that the participants were giving, as well as a gesture of thanks for participating. The reward was not revealed to the participants prior to the focus groups or individual interviews. This was not revealed in order that the incentive did not cause participation for monetary gain, and to not increase participation in order to gain access to free refreshments. The refreshments were basic so that these themselves did not cause the participants to gain a disproportional amount from participating in the research.

There was no requirement from the company that was used for the sample, or the workplace wellness company that aided in the sampling. The researcher was under no obligation to release any results or information that would be counter to the rights of the participants. All of the effort of both companies involved was done purely due to good will, with no incentives or obligations placed on either the participants or the researcher.

Data Collection

The data collection was done with two types of qualitative methods. These were focus groups, as well as individual interviews. Both data collections methods were used in order to have a varied localised setting, which included salient group constructions in the focus group

versus a one on one construction in an individual interview, with social forces of intergroup construction not being salient on a physical representation level.

The focus groups and the individual interviews had a different interview schedule due to the researcher wanting to maintain similar themes, which can be seen as sub-headings within the schedules, while exploring different potential constructions within the different settings. Additional types of questions were avoided in the focus group which could potentially harm or cause discrimination post the focus group, thus protecting the participants rights.

Focus Group

A focus group, with a semi-structured interview schedule, was used to investigate the participants' general understanding and attitudes towards masculinity in relation to cardiovascular disease. The focus group was used as a tool for the qualitative research as it allows the researcher to gain access to participants in a group, thus allowing a co-construction of understanding that can be shared amongst the participants, as well as the exploration of this socially bound construction within the salient social structure that it is located in (Babbie & Mouton, 2005a). In a focus group, each of the participants is part of the group, and has a say in the group's construction through their own diverse opinions, thoughts and interactions. This means that new meaning and understanding can be constructed in the group setting that the researcher may not have had access to outside of this setting (Babbie & Mouton, 2005a). In the context of this research, the focus group was used to discuss the construction of masculinity in relation to a disease – cardiovascular disease. This was done in a group to gain the group's understanding of what it means to be a male and to have a cardiovascular disease, as well as what having a cardiovascular disease means to be a male. These two questions seem very similar, and are in fact inversions of each other. The reason for this is the dialectical relationship between the chronic cardiovascular disease on masculinity, and masculinity on the disease. In order to gain this level of interaction the interview schedule was designed to be fairly non-directive and as such only constructed on general concepts about the participants' perceptions of masculinity and cardiovascular disease within the group context. The focus group schedule was designed by the researcher in relation to the literature found on the topic of masculinity in relation to cardiovascular disease, as well as the aims of the research (See Appendix II).

The focus group was held in an off-duty station within the corporate office and plant setting. The off-duty station was booked a week in advance so there would be no disruptions and no

breaches of confidentiality. No non-participants were inconvenienced as the off-duty station that was used, would not be in use at the time of the focus group, because the focus group was run during the day and the off-duty station is only used by the night staff at night. The focus group was comprised of four males and ran for a total time of fifty-one minutes and twenty six seconds. All the participants in the focus group were white males. This was not due to the focus group design, but rather due to the sampling method having limitations. It is noted that this could cause bias within the research.

Prior to running of the focus group, participants were given information sheets which explained the purpose of the research as well as fully informing them of their role in said research (see Appendix III). Participants kept a copy of this information sheet. Participants were subsequently asked to sign a consent form which outlined their rights and responsibilities in regards to the research that was being conducted (See Appendix IV). A further consent to be recorded sheet was signed by the participants that gave permission for the use of the audio report (see Appendix V). The signing of both the consent and audio consent form provided tangible evidence that the participants were willing to be part of the study, and did so knowing the nature of the research. Participants were allowed to withdraw consent at any time during the study, with no participants enacting this right.

Confidentiality is an important aspect to be discussed in relation to focus groups. This is due to the fact that focus groups are comprised of multiple individuals, who are each autonomous and, as such, cannot be controlled. Confidentially disclosed information that happens due to the research in a focus group setting is thus vitally important (Kelly, 2009; Terre Blanche et al., 2009). As each person in the focus group is an autonomous individual, the confidentiality of information shared by participants cannot be guaranteed. This means that the researcher could not guarantee that all participants are treated with respect and that the views are not shared outside the focus group setting. This concept is especially salient within this research due to the sensitive nature of the topic being covered. Even though the topics that were being discussed were kept general, participants could share personal information relating to their experiences of masculinity and cardiovascular disease. In order to minimise any potential damage to the participants, the researcher informed the participants about the risks associated with confidentiality, and implored that all participants kept everything that was discussed confidential. The participants were also instructed that if they did not feel comfortable, or felt uneasy, they did not have to answer a question or partake in that particular topical area. The participants were also asked to sign a confidentiality pledge which requested that the

participants kept what was being discussed in the focus group confidential, and did not share this with others outside of the research process (see Appendix VI). In an attempt to further gain confidentiality, the participants were offered the use of a pseudonym rather than their own in the focus group session. While the participants were offered this, they chose to use their own names during the focus group, as they had friendly relationships with other people in the focus group and wished to share their experience with these people. The participants were further assured that the names would not appear on any transcripts or within the research, instead the pseudonym would be used, and the transcripts would be stored securely both in digital and hardcopy form.

Individual Interviews

Three individual interviews were conducted for this research. The reason the individual interviews were used was to gain a second dimension of understanding about masculinity in relation to cardiovascular disease through in-depth personal understanding in the one on one setting (Kelly, 2009; Terre Blanche et al., 2009). One of the first things that can be noted for the need for the individual interviews is the difference in setting between them and the focus group. The individual interviews are in a participant or researcher environment and lack the outside influence of peers or other participants. As a result, there are no potential problems with the confidentiality that can occur within the focus group setting. Without having the issue of confidentiality conflict, the more personal understanding of the participants' masculinity experiences in relation to cardiovascular disease can be explored, and as a result give a different dimension to the constructions that are involved. It is worth noting that the social setting is still present as the researcher them self is still in the room, and while not part of the direct peer group, is still within the social setting co-creating discourse. The interviews were done via a semi-structured interview schedule that was different from the one used in the focus group (See Appendix VIII).

The semi-structured interview schedule was used to the gain insight into the participants' perceptions and construction, through having some structured and continuous themes while having the flexibility to pursue any interesting constructions that may arise during the interview. This allows for the natural progression and construction of masculinity in relation to cardiovascular disease to happen at the participants. None of the participants who were involved in the interviews were involved in the focus group. The reason for this was due to the time constraints of the participants. The participants who were involved in the interviews

were either a mid or senior management level and as such were perceived to have an increase in time pressure, thus resulting in no time where more than one of them could be present to be part of a focus group. The three individual interviews were conducted on the same day, at varying times of the day in order to accommodate the participants' schedules. The location of the individual interviews was at an off-duty station. This off-duty station was booked out for the duration of the interviews, and had a sign on the door stating that interviews are in programme, please do not disturb. The interview with participant G was not held in the off-duty station but in his office. This was at his request in order to accommodate his schedule. Some of the participants were in a high management level, and were unable to give large quantities of time, which meant that the interviews were substantially shorter than would be ideally liked.

Participant	**Length**	**Designation**	**Race**
Participant E	27 Minutes	Middle Management	White
Participant F	22 Minutes	Middle Management	Indian
Participant G	13 Minutes	Upper Management	Indian

The interviews that were conducted ranged from as short as thirteen minutes for the participant in upper management, to 27 minutes for the participant in middle management (See table above). The race was mixed, with one of the participants being identified as white, and the other two Indians. The interview participants, like the focus group participants, were given an information sheet prior to the interviews being conducted. These interview information sheets informed the participants of their role in the study, and the purpose of the research (See Appendix VIII). As such, the participants were fully informed of the research prior to engaging in it, knew of their rights and responsibilities, as well as knowing that their identity would remain fully confidential and that participation was fully voluntary – they could withdraw at any time should they wish. Much like the focus group, the participants were asked to sign an informed consent form (See Appendix IX), as well as a consent to record form (See Appendix X). The consent form was used to gain permission to be part of the research. as well as discuss the content of the interviews. The consent to record form was signed in order to gain consent from the participants to be recorded and later have the interview transcribed. No participant refused to sign either of the forms or wished to

withdraw from the study. The participants of the interviews were also assured that their information, both digital and paper based, would be stored securely. The participants were also told that none of their identifying information would form part of the research, and their real identities would be replaced by a pseudonym. The reason for this was to give the participants the anonymity that is required due to the sensitive nature of the discussion, so they will not be prejudiced in the future. Any identifying information that would otherwise lead to the participants' real identity being uncovered was subsequently changed in order to ensure the continued anonymity.

It is worth noting that the upper management interview was very short, and this was due to a dynamic between the participant and the researcher, as well as time constraints on his side. The interviews were scheduled around the workload of the individual being interviewed, and as such time limits and constraints were enforced to not interfere with the participants workload and to not cause a potential negative consequence. While the business allowed for the research to be conducted, it did not allow for special time to be taken for the research to be conduct. The outcome of this was that participants used their free time to schedule in the interviews, and this coupled with the participants mood for that day, which potentially aligned with workload of other work factors, could influence the interview.

Data Analysis

The transcripts of both the focus group and the individual interviews were analysed by a mixed method of discourse analysis, as well as thematic analysis. The reason for this mixed methods approach was to explore the discourse that emerged from the focus groups and interviews while at the same time allowing for grouping of themes that went off of traditional discourse tracks (Wigginton & Lee, 2014). Prior to the analysis, the focus group and the individual interviews were transcribed by the researcher using a simplified Jeffersonian method of transcription (see Appendix XI). The reason for the simplified Jeffersonian method was to gain a deeper insight into the usage of the spoken language in understanding the way in which the constructions are created, and verbalised. The simplified version was used in order to have a balance between gaining insight into language construction and accessibility of the full method, which becomes hard to understand to anyone without experience using it or direct access to the coding sheet.

Both the focus group and the individual interviews were analysed using discourse analysis and thematic analysis. Discourse analysis is a social constructionist research methodology

and has been defined as using language to show meaning without a discourse, also known as a system of statements, which are made during conversation in order to construct meaning, objectives and achieve goals (Parker, 1992). The usage of thematic analysis was to group discourses into themes, which ran across the focus group and interviews, which may not have been discursively similar but had overarching themes.

Validity, Reliability and Generalisability

The normal scientific rigour that exists within research that relies on the three research principles of validity, reliability and generalisability are not relevant within the constructionist paradigm, as the research will not meet any of these criteria due to differences in epistemology. This thus means that different systems are needed in qualitative research, in specific a constructivist stance, which relies on the usage and understanding of constructions within language to generate findings, and as such does not seek to be valid, reliable or generalisable. Instead, an alternative is offered of credibility, dependability, confirmability, transferability and trustworthiness (Babbie & Mouton, 2005a). In order to maintain the scientific rigour these different systems need to be explored in relation to the research.

The concept of credibility is one whereby inferences that are made from the data are representative of the responses from the participants in the research, as well as being credible (Babbie & Mouton, 2005b). Within this research, credibility was gained by using a system of triangulation. This system is done whereby different methods of collecting data are used – such as individual interviews and focus groups. As the findings of the focus group and interviews were very different, this difference needed to be explored. The result being that the participants were of different cadres, thus showing differences between focus groups and individual interviews with some similarities between them. In order to maximise credibility and make sure that inferences explored are indeed the most valid inferences that can be explored and interpreted from the data, a discussion session was held with peers who were in the same field of research in order to ascertain if the inferences were plausible and within the normal realm of understanding.

Dependability is seen to be research that would yield similar results, if conducted again in a similar context with participants who were similar to those in the original research (Babbie & Mouton, 2005b). In the case of this study, in order to gain dependable data, the research was carried out within the recommended good practice standards of qualitative research, as well as limiting bias which is discussed within the reflexivity section.

Confirmability is seen to be the extent to which the results of this research, produced by a single researcher, are seen to be accurate and correct by other researchers. Within this research, in order to create a level of confirmability, the research was recorded giving a detailed account of the processes that were followed as well as a thought pattern as to why things were done certain ways. Once again, other researchers were consulted in order to confirm if the research and outcomes there-of were within the norm.

Due to the small number of participants in this research, it would be impossible to create any generalisable findings within a qualitative sense – no sample size requirements would be met, the power statistic would be too low, thus there would be no generalisability. As there can be no generalisability, the construct of transferability can be used. (L. Krefting, 1991; Shenton, 2004). The concept of transferability is one whereby the research can be transferred, or replicated, to another setting. This is done through provision of details and accurate descriptions of the research process, as well as in-depth descriptions of the context of the research. This includes the socio-economic climate as well as current salient norms within the sample that exist during the research. Through the use of careful justification as well as explanation of findings and methodological choices, other researchers and peers will be able to make informed judgements about the quality of the research, and deduce if it is transferrable (Shenton, 2004; Terre Blanche et al., 2009). The final thought as to if the research is transferable is given to the reader, as they best know their context, as well as if this research could be transferred to their context. In order to try give the reader the best possible chance of making that informed decision and choice, enough information must be provided so the reader can see if this is possible. Within this research it can be seen that language construct would limit this to English speaking scenarios, and the subtleties within the colloquial English that exists within South Africa may also have another effect that needs to be accounted for.

Reflexivity

The concept of reflexivity is one whereby the researcher is able to reflect on the research process, and how this could have an impact of the research as a whole (Barry, Britten, Barbar, Bradley, & Stevenson, 1999; Koch A & Harrington, 1998). The usage of reflexivity gives a researcher a space in which to acknowledge their interactions and influences in the result of the research, and the changes to the research and why these occurred (Finlay & Gough, 2008). Reflexivity is particularly prominent in qualitative research due to the intrinsic nature

of subjectivity that exists in the paradigm, as well as the effects of the researcher's presence causing an effect on the social construction. The researcher being in the same area is seen as a participant in the construction, as they, regardless of willingness, form part of the construction due to being present. Their presence in the room means that the participants have an interaction, or lack thereof, with the researcher which changes the way in which the discourse is constructed. This is due to the researcher not acting in isolation, as everything is part of the construction, including the way in which the researcher interacts and the environment, both of which offer social clues to shared construction.

The power dynamic that existed due to age and gender, and as a combination thereof, was also in play during the interviews and focus group. Most of the males who participated in the study were in their late 30s to mid-40s, with some participants being older. This created a power dynamic as the researcher conducting the focus group and interviews was, at the time, in his mid-20s, which is lower in age than that of the participants. This creates a difference in power between the participants and the researcher which then skewed the power in favour of the older males. Age being a determinant in power has been seen throughout cultures and is present within the salient situation.

Another power dynamic that exited can be seen and is quoted very often in social psychology and research ethics, is that of researcher positioning. This is seen most commonly in the Milgram shock experiment. This experiment showed that the positioning of a researcher in a research context can have an effect on the results, and lead to a change in the construction that the participants in the research take (Miller, 2014). The result of the research and subsequent analysis update is that people are more obedient to those that they perceive to have more power than themselves, and as a result change their discursive construction – amongst other things – to fall inline within the obedience framework and not be seen to be within the same discursive construction as the person in authority. This is a prime example of the power that a researcher has over the participants which can result in a social desirability effect in conjunction with the obedience effect that existed within the Milgram shock experiment. The social desirability effect is one that is independent of the obedience effect shown by Milgram but is linked by way out outcome, that the participants alter their constructions. This effect is when participants answer questions in a way in which they perceive would be best suited to the current social situation to gain the best social outcome, be it enforcing in-group norms to maintain salience or to cause outgroup alienation to increase in-group status (Berry, 2015; Preiss, Mejzlíková, Rudá, Krámský, & Pitáková,

2015). The social desirability effect isn't necessarily a negative aspect in qualitative research as this is expected, especially in the social constructionist paradigm whereby meaning is constructed based on the salient situation which takes into account the socio-economic status, and the Chrono-geological which has an effect on popular salient power dynamics including gender, race, age, and economic status (Elder, 2015).

The interviews and focus group are a core component of this research, but their systemic location is a cause for potential bias. This can happen due to the co-construction of multi-system influence on the participants through the work, researcher, and individual interaction within the salient research setting. This is mentioned due to the levels of interaction across the participants with special mention of the shorter interview from the senior manager. The power dynamic within the interaction was heavily favoured to the participants side, as the meeting was in their office where their centre of power is located, as one's office is a show of status and power. With this in mind, it made the interaction of the researcher attempting to direct the interview and stay in control via usage of the semi-structured guide harder. This should be taken into account while understanding the interactions of the interviews and focus groups.

The final piece of reflexivity that needs to be mentioned is that of the environment that existed in the interview and focus group settings. The focus group and interviews that took place were at the workplace of the participants in an, especially private, room that was still within the working environment. This has an effect on the power dynamic as the participants were at a power advantage to the researcher as they were in the environment in which they worked and the researcher was a guest in it (Morgan, 1997). The person who is seen to 'own' the space is the one in power, and this can be seen to be the participants as the space is within their work environment. In order to attempt to mitigate this effect the researcher attempted to claim the space by arriving before the participants and inviting them in, and then directing them to their seats. This in itself has the opposite effect that has been spoken about prior which is that of the effect of power that a researcher has in obedience, but for the sake of control this was chosen as opposed to allowing the participants to claim the space.

Taking into account the aforementioned effects is important when looking at the analysis, and discussion thereafter. The influences that exist within the research have an effect on the output of the focus group and interviews, as well as the way in which the research matter is interacted with, and integrated post-data collection phase. While the researcher has attempted

to be as objective as possible and continuously allowing for reflexivity within the analysis component, it cannot be done without a level of subjective experience and understanding being ingrained within the final research output and understanding thereof. Through the exercise of reflexivity, the researcher is able to reflect on their ingrained biases and view their effects on the research, and with this knowledge in mind, is able to retrospectively rework the analysis and outcomes without the initial level of unfiltered construction that would normally exist within the default research. Through the recognition of the limitations within the analysis process that is inherent within salient construction understandings the final findings can be understood and interpreted by the reader within context. This context will give a further level of understanding of the salient forces that interact to form the final findings, and the inherent biases therein.

It is also worth noting that Constructivists approaches are generally critical in the way in which they approach the systems. This means that constructs are critically analysed, including power, as well as salient systems within society – of which masculinity undercuts both of these. This level of critical thinking may have consequences, being overly critical of systems and processes can cause a change in the way in which data is analysed and findings reported. This needs to be taken into account, the level of critical thinking that is normally inherent in the constructivist approach may be having an effect, and instead of mitigating this rather having an understanding of this effect and the context, will give insight into the way in which the salient constructions are being created in the findings.

To give a final understanding of the biases therein, the researcher was strongly attempting to be unbiased and allow for multiple possible constructions to co-exist within a single thought. When this was not possible or potential bias could be identified by the researcher, this was noted, and the data was re-looked at with input from alternative research sources, as well as allowing for a small length of time to pass which allowed for a change in frame of mind. With this done, the hope was that inherent bias can be reduced, and in instances when it cannot, whether covert or over, this is noted within the findings.

Chapter 5: Results

Masculinity as Physical and Emotional Strength

The usage of masculinity as physical and emotional strength is one that is used throughout the interviews and the focus group. The basis of this discourse is that, males, and as such their associated masculinity are a product of their physical self – their physique. This has a history in the work that males do, which was historically manual labour. As a result of this work, males have historically been muscular. As a result of this, muscular physique has been interlinked with work and masculinity – an intertwined and casual relationship that has persisted through time. There has been a shift in the way in which the world has viewed work, with white collar work gaining increasing popularity. With this increase in popularity of white-collar work, there has been a decline in male physique levels in relation to muscular tone, as men have moved to computers and away from the outdoor physical work. This change has seen a cognitive dissonance experience in males, being unsure if masculinity and physique are still linked and how to construct this in the new working environment.

When exploring the examples of masculinity as physical and emotional strength, it is important to note the difference between male and female when it comes to physique. Is it presumed that the female physique is delicate, weak, and often more associated with sickness than that to the male physique. This creates a stark contrast between male and female when the exploration of masculinity and the discourse of physique enables a comparison between the sexes. The male is normally seen as strong, virile and healthy, whereas the female is seen to embrace the feminine physique attributes that contrast masculine, being meek, weak and feeble – enabling sickness to take hold and persist. This is further reflected in the emotional strength with transcends the physical, whereby the male's emotional strength is a reflection of their physique. A male is expected to be strong and steadfast in their emotional health, as this directly relates to their physical health. Should a male show emotional weakness, it would be a further output of their physical station.

The concept of masculinity in the western world, which has subsequently transferred and been assimilated within South Africa due to Globalisation, is seen strongly when it comes to expression of feelings. Examples of this are things like feeling emotions, or pain and then expressing this out aloud. During the focus group, thoughts about expression of emotion in relation to masculinity, as well as relating to the participants' cardiovascular disease, were explored.

The focus group was discussing the difference between males and females within the workplace, and how the different sexes handle stress. While the question was directed at sexes the discussion led towards gender constructions as the difference between biological sex and constructed gender roles.

Focus Group

1 **Participant A:** We just bottle these things [in]
2 **Participant C**: [We] do bottle it up (.)
3 **Participant A**: We bottle it up until we don't realise the damage that we do
4 **Participant B**: Everyone thinks you are a [wissie]
5 **Group**: [Ya]
6 **Participant B**: When you want to go and cry (.)
7 **Participant A**: But you find with a woman they are so easy because I guess they have the time for that (..)
8 **Participant D**: Ya (.) they talk about [it]
9 **Participant A**: [Which is it]
10 **Participant D**: It gives them an outlet

The first participant who speaks in line 1, states that males as a whole bottle things up. This means that males do not express their emotions and in turn they lack the cathartic release that is associated with expression of emotion. This sentiment is once again echoed by Participant C in line 2, agreeing with this statement. The lack of expression of emotion and feelings is typical of the discourse of masculinity as physical and emotional strength, as part of the physique is to maintain the standard masculine façade of being strong. When a male expresses emotion or pain, they are breaking that concept of strength as a physical feature, displaying weakness. This display of weakness showing that the lack of physical physique to maintain the masculinity construction, as people who are not in peak physical condition are seen to be weak, and weak people tend to get sick or express being sick more.

While the initial construct of masculinity is constructed in lines 1 and 2, it is challenged by the same participant who initially engaged with the discourse. Participant A (Line 3) subsequently states that "We don't realise the damage we do" which is a direct challenge to the masculine discourse previously constructed. The participant is showing that while the understanding of the masculine physique is there, it is damaging to continue it. This is a recognition of the construction, and then how this construction can cause damage. Further to

that, the participants explore the social issues around expressing emotions (Lines 4-6) whereby if one expresses their emotions they are called a “wissie” (Line 4) which is a slang term used to describe someone who expresses to much emotion and is seen as physically weak. This type of person is usually synonymous with being bullied and rejected from the dominated masculine discourse. As a result of this, being associated with, or being that type of male would make one a social outcast.

The masculine construction of not showing emotion is compared to that of feminine whereby “woman they are so easy because I guess they have the time for that (..)” (Line 7). This is a contrast from the previous exploration of masculinity causing harm due to non-expression of emotion (Line 2-3) where now the difference between masculinity and femininity are explored and the discourse of masculinity is glorified over that of femininity. This is shown by females having an easier way out, as they are able to express their emotions, with a follow-up explanation of why they are able to do this being that the females have time for it. With this explanation, it is showing that females have free time, but males do not. In the masculine construction of masculinity as physical and emotional strength, and ultimately an expression of historical working environment, the comment of woman having time is direct comparison of males working and providing for their families, whereas woman not having the same responsibilities and as such have time and are able to express their emotions. By creating this direct comparison, it is enabling the masculine discourse to be salient within the situation and thereby giving the males an advantage of the females through the creation of a favourable discourse. This is done directly after a challenge to the masculine discourse through the exploration of expressions of emotions and how not doing so can cause damage to males. This contrast shows that the masculine discourse of masculinity as physical and emotional strength is strong, and while it can be challenged to a certain degree, it is very pervasive.

Participant D (Line 10) states that females have talking as an outlet. This is the final exploration of catharsis via expression of emotion. Once again, a contrast is made between masculinity and femininity, with the usage of the world “them” to create a clear definition between males and females. The definition is a form of creating or showing difference, with then shows that females have an outlet for their emotions which is contrasted by males who don’t. This difference both calls into question the nature of masculinity as physical and emotional strength, due to males not having that direct outlet as females do, but at the same

time glorifies it as not having that outlet, showing a male as tough, resilient and strong which all positive attributes of the discourse of masculinity as physical and emotional strength are.

Masculinity as Sex

The discourse of masculinity as sex is set within the biological origins and seemingly has an evolutionary backing. The premise of this discourse construction is that males are biologically programmed and created, as such masculinity is an express of the sex of male. This discourse is used when biological or historical understandings of male and female roles are evoked, normally due to biological origins. These biological origins are historically based on the roles of males and females, with males being the masculine providers and females being subservient and meeting the needs of males. This is seen to be biologically enshrined in the makeup of the sexes, and such is one that is not normally challenged and is constructed by discourse often to validate the way things are currently and block potential change.

In the following focus group, the participants were discussing the reasoning for hypertension. Prior to the extract the males were having a discussion about if one's job, or one's genes, or a combination of both were involved in males having hypertension. Following this, a challenge was raised by participant C that women were now moving into, historically, male dominated jobs.

The focus group was exploring the working world, and the roles of the different sexes in it. The participants had begun to discuss how females are now involved in historically male jobs.

Focus Group

1. **Participant C:** With the woman now (.) they moving more into the industry (.) the
2. heavy industry (.) into that type of world
3. **Participant A:** Yes (.) hmm
4. **Participant C:** and, maybe monitor someone like [Name Redacted for Privacy] (.)
5. she is a fitter here (.) and she is working in a ma (.) what we call a (.) ah (.) ah (.)
6. mans environment (.) you know (.) you never had woman in the industry (.) monitor
7. them as well (.) she how [Name Redacted] gets on (.) there is a lot of woman moving
8. into heavy industry (.) see how they go (.) see if they (.) they have a change in their
9. lives as well

The first point of deviance from the traditional discourse of masculinity as sex, is the acceptance of females within the work environment. The focus group consisted of males who were doing physical labour as part of their daily working routine, and as such would be the one's who would be invested in the masculinity as sex discourse. The reasoning for this is due to the foundation of the discourse, as the construction is historically embedded within the masculine role in society, where strength and physical prowess was valued and within the masculine domain. The males within the focus group recognised that the females are moving into the traditionally masculine constructed roles within the workplace, and society. This can be seen in line 1, whereby the participant mentions the fact that females are coming into the workplace. He uses the words "heavy industry" in line 2 to show the type of work. The wording of heavy industry is one which constructs the type of work being done within a masculine domain, with this being done through the use of the word "heavy" implying that the industry is not just general industry but heavy. Through this, the understanding is that the type of industry is industrial and requires strength. The implication is that "heavy industry" is one were males typically work due to the nature of the work. This highlight is done to differentiate the type of work being done, with emphasis on the feminine moving into the masculine role.

The participants within the focus group then move on to exploring the female role within the traditional masculine construction of physically dominated work. They do this by exploring and questioning of a female would have differing effects of workplace stressors on their health. This is started in line 6 and extends through to line 9. The participants are acknowledging that the traditional masculine job is changing, with females moving into roles which are traditionally masculine by discourse. This first acknowledgement of the change in roles is seen in line 6 where the participant states that the female is coming into a "man's environment". It can be seen that this is something that is new, as in line 6 the participant states that "you never had woman in the industry". This entrenches that the workplace structure of these participants is male dominated and constructed to be masculine. The ownership of the workplace by males is created through the usage of "the industry" meaning that the industry that the males are working in is seen to be understood as one that is owned by males. This is done through othering, whereby the feminine is excluded from ownership of "the industry" by stating that women were not present there. This creates a separation from females and the masculine workplace, and thus shows masculine ownership. The acceptance of females moving into the traditional masculine jobs is acknowledge again in lines 7 and 8

whereby the participant states “there are a lot of women moving into heavy industry”. This shows a level of acceptance that there is a change in the workplace, and the males have recognised that the construction of masculinity as part of the job is going to change with women moving into that type of job.

So, while the construction of masculinity as sex is being constructed and negotiated, the males within the focus group are exploring the difference between males and females, masculine and feminine within the health seeking, and health in general, work environment. The males within the focus group had been discussing the effects of one’s own work environment on their health, with specific focus on cardiovascular disease. Through the introduction of woman in the workplace the males are seeking to make a comparison as to if the effects of workplace stress are felt differently by males and females, and if the effects on their health differ. The exploration starts in line 8 where the participant states “see how they go”. This was in the context of understanding if there is indeed a difference between males and female’s health outcomes, but within the same work context. The exploration of this shows that the males are thinking about health outcomes, and are, at a base level, exploring health seeking differences within gender constructions. In this construction the males are stating that their work, and therefore a construction of masculinity, is one of the reasons for their cardiovascular disease. With the introduction of females into the workplace, the construction of masculinity as being part of one’s own work, and sex, is being challenged. Within this challenge the males are exploring differences within sexes, and it’s this exploration of difference where comparisons can be made to be negative or positive. This point of comparison could either confirm or deny a construction of masculinity that enables a normalisation of cardiovascular disease as due to work stress, that one gender handles this stress better, or that the masculine construction with the workplace is no longer a strict masculine one, but a new hybrid due to the introduction of females.

Male Health Seeking

Male health seeking behaviour is one thing that is well researched and shows that males do not typically seek help. The effects of masculinity on health seeking behaviour, in particular, relation to cardiovascular disease, is being explored in this research. What has been seen in other countries outside of South Africa, is that masculinity has resulted in males not seeking help. With cardiovascular disease there have been case studies showing males not seeking

help for up to three days after a heart attack, and not changing their lifestyle the entire time in order to maintain their machismo appearance.

The following extract is from a male who works in the finance department, and explores health seeking behaviour and adherence to medication. The reason for this extract being chosen is due to the way in which health seeking behaviour is explored – being externalised, as well as being seen as a problem for females.

The interview was a discussion around medication. Previously the participant was describing how he found out about his cardiovascular disease and had previously mentioned that he sought help due to his wife's persistence.

Individual Interview 2

1. **Researcher**: Have you missed any days of medication (…)
2. **Participant**: hmmmm (.) I may have missed a day or two but not like (..) just dropped
3. it (.) because I've got an alarm at home (.) that is my wife (.) and she makes sure that
4. before I leave home and (.) have you taken your medication (.) and I can't leave home
5. without it (..) ah (.) I felt no side effects (.) nothing since then (…) I do have one of
6. those testing machines at home (.) I check (.) every now and then (.) and it seems to
7. be fine (..) ah (.) what (.) I was wanting to do was (.) drop the medication (.) for a
8. while (.) and then monitor the blood pressure (.) but uh (.) my wife would not let me
9. do that (.) because when the doctor actually spoke to her (.) us (.) she got frightened
10. by it (.) when he spoke to us about hypertension (.) she got frightened and she ensure
11. that (.) I am on my medication all the time

The participant in this extract seeks to externalise health seeking behaviour as outside of a masculine construction, and as such being masculine, is having a feminine person be in control of one's health seeking and adherence behaviour.

The external placement of health seeking behaviour can firstly be seen on line 3 when the participant is taking about adherence to his medication schedule. In Line 3, the participant places the emphasis of adherence on his wife, the feminine, and constructs this as the reason for his adherence. This is shown whereby "I've got this alarm at home (.) that is my wife". This construction means that the person who is responsible for the health seeking and adherence to medication behaviour is not in fact the person who can have serious negative consequences for not adhering – the male participant – but rather his feminine wife. The

construction takes away the masculine response to health seeking as one that is within a masculine discourse and constructs the discourse of health seeking to be one of a feminine nature. The masculine discourse in this construction thus relies on the feminine for the health seeking – and constructs it that males are not health seeking or an adherence gender but are complicit in it due to feminine interaction. As such, health seeking behaviour is not the responsibility of the male in this construction but externalise to be something that the female is required to worry about for the male. Externalisation of responsibility is thus created whereby the masculine construction is complicate in seeking help, but only due to the external pressure that is there due to the female and feminine input. The usage of the metaphor of the participants wife as an alarm clock further exemplifies this as an alarm clock is there to provide constant and continuous reminder for a task, and takes the onus of remembering about the task from the person who is reliant on the alarm clock. This metaphor further shows how the masculine construction is removing the emphasis of health seeking behaviour away from the male, and towards the participants' wife.

The same participant explores adherence and health seeking later on, in the same extract, in Lines 7-9 whereby he was contemplating ceasing the usage his medication and monitoring his blood pressure using a home kit. The participant will then see if the medication is working, or if he is able to regulate his blood pressure on his own. This shows the masculine construction of health seeking behaviour moving towards some level of self-reliance and moving against the need of aids, which in this case would be his chronic medication. The participant takes many pauses during this construction, showing that he is nervous or contemplating this idea. The reasoning for this could be due to construction in a social context with another male, and in order to not look weak as per the masculine discourse of physique whereby taking medication would show that there is something wrong within one's body, and thus you would appear weak due to physical ailment. Through the construction of wanting to attempt to stop taking the medication, the participant is showing that they do not wish to continue with their health seeking behaviour, even if it is externalised and embodied within their wife. In Lines 8-9 the participant then constructs the reasoning behind not continuing with their idea of stopping adherence to the medication and observing if it made any difference. The reasoning behind this was that the participant stated their wife would not let them. The participant said that "my wife would not let me". This once again externalises the onus on health seeking behaviour and continued adherence from the male and shifts it to his wife. The exemplification of health seeking shifted to the feminine and away from the

masculine is once again salient within the dialog created. With this construction the male is able to not lose social standing which comes due to a reduction in physique due to ailment and adherence to medication, by removing the adherence from themselves and placing the onus on their wife who is a famine figure, the opposite of the masculine construction that the participant is co-creating.

Masculinity as health seeking behaviour is often conceptualised as masculinity and not seeking help. This is a combined discourse that arouse of the discourse of masculinity as physical and emotional strength whereby male's masculinity was tied to their bodies, and being unhealthy results in a perceived change in one's body with a negative outlook as being sick means weakness. In the extract below the participant is expressing their belief about health seeking and sharing health information.

Prior to this extract the participant was discussing the differences between males and females when it comes to experiencing health problems. This follow-up question was to gain an understanding of how the participant created health seeking discourse in relation to sex gender.

Individual Interview 3:

1. **Interviewer:** Do you think that men do not talk about their health problems as much
2. **Participant:** No (.) they don't (.) they don't (.) men are ah (.) different (.) ah (.) men
3. are more to themselves (.) I manage it or I (.) ah (.) loose it
4. **Interviewer**: Ok
5. **Participant**: Men don't open discuss (.) ah (.) I don't openly discuss my personal life
6. (..)wife is aware of problems I have (.) ah (..) my doctor is obviously aware of the
7. problems I have (.) and the specialist (..) but if someone wants to discuss their
8. personal health with me (.) or ask me (.) or some sort (.) it's none of their business (.)
9. I am managing it well (.) I worry about myself (.) you worry about yourself (..) do you
10. have nothing you want to talk about that (..) do you want to discuss me (.) ah aaha (..)

In the extract above the participant can be seen to be constructing masculinity using the masculinity as physical and emotional strength discourse. This is shown in Lines 2 and 3 where the participant states that he manages his health problems, and that is prefaced by stating that males are "More to themselves" in Line 3. By doing this the participant is constructing the base of the health seeking behaviour that males are known for, their lack of

health seeking behaviour. In Lines 2-3 the participant states that men keep their problems and ailments to themselves. This is typical masculine health seeking behaviour whereby males do not share their health problems with anyone. Further into the discussion the participant states, in Lines 5 that "Men don't discuss (.) ah (.) I don't openly discuss my personal life". This statement is first constructed by using men as a generic term. The reasoning for this is to start with a reference point to which the participant can make a comparison. From this reference point the constructed discourse can be back-referenced to create a level of validity. The usage of starting with the comparison of the generic male allows for a build-up and justification to happen for usage later during the conversation.

Once the participant had set up his discourse through the use of a generic masculine example, the participant was then able to construct a person approach to the conversation. This can be seen in Lines 5 whereby the participant states that they do not openly discuss their personal life. The result of this is, at face value, that the participant does not discuss their person life. With the preface of males not discussing their personal lives, this allows for a masculine deductive discourse to exist – males do not share their personal life, I do not share my personal life, therefore I am male and masculine. Through this deductive reasoning the participant is able to construct a masculine discourse around the reason they do not talk about their health. The discourse is then constructed that health seeking behaviour, which in this case is not 'opening up' is not masculine. This is because males do not do it, and as such, if males do not do it, it is not masculine – resulting in the health seeking behaviour of talking about problems not being engaged.

The construct of males not seeking help from others by discussing and engaging with the problem on a social level is seen further in Lines 7-9. In Lines 7-8 the participant states that if someone would like to have a discussion or talk about their problems, in this case health related problems, to or about the participant it is "none of their business". This denotes that the participant constructs that his, or any other male's health problems, are not to be discussed or explored amongst other groups of males. The health problems are to be internalised, as discussing these would not be masculine as per the masculinity as physical and emotional strength discourse. In Line 9 the participant moves to be defensive and states that "I am managing it well (.) I worry about myself (.) you worry about yourself (..)". This shows that the participant does not wish to engage in conversation or social engagement around the areas of health with other men, and states that he will take control of his own health issues and that other males should do the same. Further in Lines 9-10 the participant

states that asking about or engaging in conversation around a person's health is a negative thing. This is shown in his statement of" "do you have nothing you want to talk about that (..) do you want to discuss me (.)". In this statement it can be seen that asking about or of another male's health is indicative of having nothing else to talk about. This is seen as a negative and implies that the male does not have any salient points of conversation and as such is filling time enquiring about the persons health. Wanting to do so, and the distain that is created through the construction in Lines 9-10, shows that enquiries about one's health is not a strong masculine construct, and as such would be seen to be constructing an anti-masculine discourse – going against what masculine discourses existed within the salient construction. The construction shows that masculine discourse is not congruent with health seeking behaviour other than the internal intra-personal understanding – as soon as it needs to be explored outside one's self with others it becomes un-masculine. What is interesting to note is that in Lines 6-7 is that the participant shares a list of persons who are aware of his health problems. The list includes his wife, doctor, and specialist. This shows that sharing health information and having a health discussion can happen when needed with those who are deemed to be acceptable. In this instance it is his wife, who will embody femininity which will allow for a discussion and social exploration without having a break any masculine construction as the feminine construction created by the wife and her health seeking behaviour and needs will override any negative social influence created through the masculine construct of masculinity as physical and emotional strength. The second group of persons that the participant is able to discuss health and health seeking with is medical professionals, the doctor and the specialist. This shows that masculine construction is allowed to be flexible within certain situations, with salient interactions such as to a person who is not engaged in a masculine to masculine construction or special circumstances whereby the masculine construction is allowed to wain such as interactions with medical professionals.

Masculinity as an expression of work

Masculinity as an expression of one's work was a theme and subsequent discourse that emerged during the research process. Much like masculinity as physical and emotional strength, the construction of masculinity was linked to one's work – but this time it was the act of working and its subsequent roles and responsibility, as opposed the physical outcome of a change in physique.

In the following extract, difference in work pressure are explored as to reasoning behind perceived reasoning of cardiovascular disease within males.

The event that occurred before this extract was a discussion around the participants work situation, including how he thought that his cardiovascular disease was related to his working environment.

Focus Group:

1. **Researcher**: Do you think there is a difference in job pressure that results in
2. cardiovascular disease
3. **Participant A**: It is a different environment (.) a totally different environment as
4. [Redacted] will tell you (..) when a breakdown (.) you have fifteen minutes to find the
5. problem

The focus group discussion around the reasoning of how they came to gain cardiovascular diseases in relation to one's work was explored in the focus group. Lines 1-2 the research asked the question, if difference in job pressure result in stress and thus are attributed to cardiovascular disease. The participant answers in Line 3 that the environments that people work under are different and expands on this in Lines 4 and 5 whereby he shows that time pressure is a reason that there is pressure. The usage of pressure in one's job environment is constructed to show a difference, a contrast, between the traditionally defined masculine jobs that the participants are doing, and other jobs that are done which may not be seen as highly traditionally masculine – jobs that do not require brawn. In this case the job contrast is created by showing the high level of stress created from their physical job, with the participants repeating that the environment that they work in is different to other working environments. This repetition on Line 3 is then added to on Line 4, whereby the participant seeks affirmation from another participant by way of referencing the other participant in his argument that the job they do is different, and if there is any question about that more than a single person can corroboration this. The reason this is constructed with corroboration included is to remove any doubt or suspicion that what the participant is saying is not true and adds to the credibility of the argument. The participant then expands on the type of work that they do in Lines 4-5. The type of work, when paraphrased, is one that is highly demanding of one's time, expertise and as such results in stress. This can be seen whereby a time limit is given for when their work needs to be done, and as a result will result in stress. The construction as a whole is done in order to separate the work that the participants do

from any other type of work, and as such is part of their expression of masculinity. They construct the work to be highly stressful, and as such one that is inseparable from their masculine construction – the co-creation is harmonised together with work and masculine construction being the same.

The extract below was in conjunction with the participant talking about his work-related life affecting his health, with special focus on his cardiovascular disease. He had previously stated that the cardiovascular disease was a result of the work stress he was under due to workload pressures, and organisational structure.

Individual Interview 1:

1. **Participant**: I can deal with anything (.) in eight hours (.) but after that (..) I leave it
2. (.) it's not mine (.) haha (.) haha (.) hahaha (.) haha (.)
3. **Interviewer**: I can understand that (.)
4. **Participant**: Ya (.) no (.) it's (.) I think (.) men (..) it's almost like a burden thing (.)
5. that they have to carry (.) ah (.) they owe it to (.) prove (.) get results (.) results (.)
6. driven (.) carry the burden of everybody (.) you know (.) and those are the kind of
7. things that just (.) mount up (.) and they (.) you know (.) you don't separate what is
8. yours (.) then (.) the mix is not right

In Induvial Interview 1, the participant explores their health in relation to work. This exploration is both of themselves and their perception of the masculine role within work, and this masculine role as a base expression of masculinity.

The construction starts with the participant stating that they are able to "deal with anything (.) in eight hours" (Line 1). This construction is centred around the participant being able to be handle anything within their work day. The usage of eight hours in Line 1 shows that the participant is constructing the workday, which is done by referencing eight hours. The reference of eight hours is how long the average South African work day is, 8am to 5pm with a single hour for lunch resulting in a workday being eight hours. The participant then continues to state that once they are finished work, other problems related to work are not his to worry about. This is shown in Lines 1-2 where the participant states "but after that (..) I leave it (.) it's not mine (.)". This construction shows that the participant has separated their work life from their personal life. This is the foundation of the conversation, and subsequently the participant begins to explore more into the work-life separation and the

effects it has on masculine construction, as well as health and health seeking related behaviours.

After the participant had spoken about his boundaries in Lines 1 and 2, the participant begins constructing a separate discourse in Lines 4 to 8. The participant begins the discourse in Line 4 exploring masculine constructions in the workplace. The participant states that males have "a burden thing (.)" (Line 4). This burden is explored in Lines 5 and 6 where the participant states that males have a burden in the workplace whereby they have to prove themselves in work, and they are beholden onto others to maintain this masculine discourse. This can be seen in Line 5 where the participant states "they owe it to (.) prove". By owing it prove the masculine discourse, the language usage of the word 'owe' shows that there is almost a contractual obligation that has to be filled. The word 'owe' is used to denote when there is pay or give someone something. In this case the transaction that is happening is the males are required to maintain a certain construction, which in this case is to prove themselves by getting results, and in exchange they will get or maintain the masculine construction. The objected that is 'owe[d]' in this construction is that of results. In this specific context as referenced, the participant believes that the discourse is constructed around the work environment, and in Line 5 and 6 around getting results and being results driven. In this context this construction at work is centred around outputs. The masculine discourse and construction for a male, is not only about being physically fit as per the masculine as physique discourse but have now moved to one's output of work. This is where the change in working environment from one that required a strong and robust physique moved to one where results are no longer necessarily measured in muscle and physicality but can be measured in creations. The construction of creations can be measured in output, so what the employee creates – either solely or within a group. This output can be physical or intellectual, to include ideas and constructs that move beyond physically creating something as was the masculine role historically. Through the change in the historical masculine role in the work environment, to that of a mentally related one as is the case with the participant, the requirement to have an output still remains. The participant thus has linked the masculine construction and expectation of the construction to their masculinity and the masculinity of others.

The usage of "carry the burden" in Line 6 is another example of masculinity construction carrying over from masculinity as physical and emotional strength to that of the salient construction of masculinity that is not solely reliant on physique. The metaphor is constructed

to centre around strength, as a burden is something that is heavy, and carrying is a physical act. Although this metaphor in the salient construction is a total shift from physicality to an emotional and intellectual construction, as in this example the participant is not talking about carrying a physical burden but rather an emotional one due to the requirements he has at work. This shows that the participant is experiencing stress at their workplace, which in conjunction with the prior examples of being results driven, shows that the stress of the work environment is a burden that he feels he needs to carry. The carrying of the burden is thus part of the masculine construction which is directly related to work. The construction of masculinity relies on this to happen, and not engaging with it will result in the construction not being for filled.

The participant in this extract, after his exploration of what masculine construction dictates to in the work environment, explores the effect of these on one's health. In Lines 6 to 8, the participant starts to unpack the reasoning behind what it means to have all of these constructions and the impact of such. In Lines 6 and 7, the participant states "those are the kind of things that just (.) mount up (.)". This is said in relation to the previous constructions of being results driven, and how it is a burden. The participant is not introspectively commenting on the accumulation of the required masculine constructions. As is alluded to in the sentence, the requirements to maintain the masculine construction place stress on the participant, and males in general, thus resulting in "mount[ing] up" of things. The meaning of this is that once the effects accumulate, they become a cumulative construction that causes and places stress on those constructing the salient masculine discourse. In Lines 7 and 8, the participant states "you don't separate what is yours (.) then (.) the mix is not right". In this sentence, the participant is exploring what happens if one accumulates all these salient constructions at a single time. As is shown in the sentence, the participant wants to separate what he is his, so what he believes, and sift out what is not his, so what the participant does not construct or is required to accumulate in order to construct the masculine discourse. The usage of the phrase, "the mix is not right" shows that the participant is constructing a way to understand limits and boundaries of masculine constructions and the effect it has. The usage of the phrase is done to understand that the construction is a 'mix' whereby it's a co-creation from a multitude of interactions and inter-personal interactions. The use of the phrase shows that if one does not balance the construction of what is masculine with the practical applications of constructing masculinity at the expense of the persons health and wellbeing. The participant here is highlighting that there needs to be that balance, while at the same time

constructing a masculine discourse of emotional ownership for one's self and not sharing or accepting other persons emotional or other problems. This is done through not isolating the metaphor and use of the wording 'not yours'. Through the use of vague statements, the participant is enabling the active and passive participants in the conversation to interpret the statement in a way in which will best maximise the construction. This is done by holding onto the perceived masculine construction of responsibilities of a male while at the same time trying to engage that these constructions may be to one's detriment.

Masculinity and Stress

The concept masculinity and stress are one theme that emerged during the research. This theme is centralised around the stress that a man faces, which revolve around the construction of masculinity in relation to social roles both work and home. The concepts of stress, and its relation to health, in particular with regard to cardiovascular disease as is the focus in this research, is something that is explored in both the focus groups as well as the individual interviews. During the data collection there was a large amount of introspection from the participants when it came to the cause of their cardiovascular disease, with many participants finding a causal link between their stress as well as they cardiovascular disease, as well as the subsequent management of this disease in relation to management of their stress.

The first step that was taken to understanding masculinity as stress was explored in Individual Interview 1. This participant was exploring how men are driven and forced to have a lot of responsibility.

Prior to the interview transcribed, the participant was describing the responsibility he has in a dual environment, both at his home environment as well as his work environment. The participant was visually unsettled during this section of the interview and expressed that this was something that had a negative effect on him which resulted in him having to take time off.

Individual Interview 1:

1. **Participant**: I think men have this (.) it's almost like a burden thing they have to
2. carry(.) where they (.) they (.) ah (.) they owe it to PROVE or (.) get results (.) results
3. (.) results driven (..) um (.) carry the burden of everyone (.) you know (..) and those
4. are the kind of things that just mount up (..) and they (.) if you don't separate what is
5. yours (.) and you don't get to finish what is yours (.) then the mix is not right (.) men

6. carry a lot (..) they do

In the text above it can be seen the participant is constructing masculinity as inseparable from stress, and that this stress can have a negative detriment. The start of the participants speed identifies the males as the subject of the conversion in Line 1. This creates a concrete understanding that males or the construct of masculinity in rom the word "men" are the subject which is going to be explored. Through the use of the word men, it shows that this this construct is being created to include multiple males, as the plural for man is being used. From this it shows that the masculine construct is being explored not as his own personal feels but what he feels is applicable to those experiencing masculinity. This is echoed later in Line 3 where the participant used the word "everyone" to show that this is not something that is unique to his situation but applies to all those within the masculine construct.

The participant subsequently moves on to describe how there is something which affects all those who experience and construct masculinity and this having to get results or prove themselves, which in this case is in the workplace. The participant describes that there is a need to get result or prove ones' self, but furthermore this is a "burden thing they have to carry" as shown in Lines 1 and 2. This usage of the word burden shows that this is not something that is positive, but rather negative. The construct is that the masculinity requires that this burden be placed, and as Line 2 shows, "carried. Through the usage of the word "carried" in Line two, there is a link to masculinity as physical and emotional strength, as carrying is a very. This is further emphasised by the usage of the word "burden" in Line 1 which denotes something heavy. In this context the combination of the two harps back to carrying of something heavy, which is a masculine trait that is construct in conjunction to physique. The usage of this link to an emotional understanding of "burden" then directly links to how one's constructs understandings of emotion in a term that is both relevant to masculine physique but also to stress. The amount of stress is explored in Line 3 with the use of the word "everyone". This shows that the masculine construct, and the construct of it, is moving towards understanding masculinity as being something that is constructed and enacted by males but encompasses of gender constructs. In this case the male and female are in direct contrast as the male has to "carry" the "burden" for "everyone". This construction positions the male as having responsibility which is heavy as denoted by the word "burden". The heaviness is not in the literal term, but rather in the figurative emotional term. This means that in the masculine construct males are expected to act a certain way, and in instance

with the workplace setting they are expected to prove themselves to be worthy, and to get results.

With the masculine construction meaning having to prove ones' self, and thereby stress is created, the participant in Line 3 and 4 further adds another dimension of the results of all this stress by stating, "those are the kind of things that just mount up (..)". The construction of this sentence shows that the addition of pressure leads to stress. The usage of the word "mount up" shows that every additional piece of responsibility that is created through co-creation of a masculine discourse, by itself is not a problem, but the joining of all these creates the problem. At the end of the sentence the participant takes a slightly than longer pause. This addition of the pause is due to contemplation. The participant is taking slightly longer to think about the sentence that they have just constructed – thus adding emphasis to this point. The added emphasis in this particular sentence is there to show, and thus highlight, the movement away from the general masculine construct whereby males are biologically and historically strong and have been doing so throughout history as providers and protectors of the family. With the addition of the emphasis the participant is showing that there is added thought to breaking away from that traditional construct and exploring the generally less constructed discourse of masculine health. This breakaway can create a level of cognitive dissonance whereby the salient discourse is in contrast with those previously construct. The addition of the pause allows for quick contemplation of this, and to show a break away from the general discourse.

In Line 5 and 6, the participant further explores the level of stress that males face due to the construction of the masculine discourse. The participant states that "men carry a lot", and suffixes it by "(..) they do". The first part of the sentence is a repetition of Line 1 and 2, with the usage of the word "carry" and the general sentiment of having a weight that males are forced to carry. This repetition shows emphasis on the level of the construction. The usage of a repetition is done to further emphasis something that has already been stated, which allows the participant to show that this construction is something that they believe to be important. The reason to show importance is that this is both breaking from the general masculine discourse of masculinity as physical and emotional strength whereby the male is the provider and is expected to bear these responsibilities and at the same time adhere to this construction by showing that he is not weak or breaking from the discourse. The first part of this final construct is the breaking from the masculine discourse of masculinity as physical and emotional strength. By simply mention that males struggle, it suggests that there is hardship

and a possibility to fail. This is in direct contrast with the masculine discourse of masculinity as physical and emotional strength, and historically males have been conquerors, providers and done physical work. The participant is exploring an additional component outside this construction that is centred around physique, and that is emotion and dealing with something in the world outside the physical world. This can be seen through the mix metaphorical construction of assigning emotions a physical characteristic such as being 'heavy'. This allows for something that is not dealt with in a general masculine construction have relevance, while at the same time not breaking from the masculine discourse. This type of metaphorical construction of masculinity allows for a glimpse at emotion while still having the façade of the salient masculine construction of masculinity as physical and emotional strength.

The use of masculinity and emotional understanding construction in respect to health behaviour shows how emotional issues are not dealt with correctly and may have an issue on health.

The individual interview transcript that is to follow was conducted in the interviewees office which must be noted. The participant was a senior member of the organisation and as such had time restraints. This reflects in the short replies with a lack of depth in description.

Individual Interview 3:

Interviewer: So could you tell me about (.) when you were first diagnosed with
hypertension
Participant: In about ninety (..) ninety (..) about nineteen ninety nine (.)
Interviewer: and how did it happen (.) what was the situation around it
Participant: It happened most (.) work pressures (.) mostly work pressures (.) work very
long hours (.) very minimal sleep
Interviewer: So (.) how did you find out about it (.) that you had hypertension
Participant: Headaches (.) headaches all the time
Interviewer: [headaches]
Participant: Get to the doctors and then (..) second opinions (.) and then the same (.) I
did a twenty four hour cycle test (.) they stuck something to my arm and to my waist (.)
and then they diagnosed me (.) definitely hypertensive (..) and then I had to take chronic
medication
Interviewer: Have you been taking your chronic medication since your first diagnosis

15. **Participant:** Yes
16. **Interviewer:** Has it been the same medication the entire way through
17. **Participant:** No (.) it has changed somewhat (..) it used to be [inaudible] (.) and then went to taric one sixty (.) some generic brand (.) ya (.) double dose of the normal stuff

The participant 3 was in a management position in the company that was hosting the researcher, and as such would generally expect to be the enacting stereotypical masculine discourse under the social psychology of leadership whereby leaders are stereotypical of the group that they represent, which in this case is persons who do physical labour as the profession (). This would thus lean into the participant to be what the literature would suggest is a stereotypical male with the masculine construction of masculinity as physical and emotional strength. This is previous explored, but the start of the interview was participant 3 had a dual construction of masculinity as physical and emotional strength, as well as the construction of masculinity as stress. When asked about the participants diagnosis, in Lines 5 and 6 the participant states that the reason for the hypertension was due to work pressure. The participant then emphasis this by repeating the sentiment, that the cause was 'mostly work pressure'. The participant then expands on this work pressure, stating that due to work pressure he had to work 'very long hours' and that he got 'very minimal sleep'. The participant uses the repetition in Line 5 to emphasis the amount or level of the pressure due to work. The construction of the pressure was stated and directed directly at work. While the participant may have had other pressures in his life, the constructions direct stating of the source of the pressure as work shows that the participant constructs the cause of the pressure as something that they are involved in within their life, but something that is external to them. This results in the externalisation of the problem and removes the physical weakness aspect which is constructed during the discourse of masculinity as physical and emotional strength. This is further echoed through the addition of physical manifestation of stress, caused by work, in the participants life which was the reduction in sleep, and the long work hours which would result in a physical and, or, mental fatigue.

The discourse of masculinity as physical and emotional strength is explored in the same interview, a few lines later whereby the participant seeks out a second opinion. This is seen in Line 10 where the participant goes to a doctor, and then seeks a second opinion. This is seen as stereotypical health seeking behaviour for males, as sickness is generally seen as weakness through historical constructions of physique as masculinity, whereby without a strong and healthy physique the male would not be able to support himself and his family due to not

being able to work. The reason that a second opinion is needed is due to a denial of sickness, the denial of constructed and self-perceived weakness which may lower one's social standing within a general masculine construction. The participant stating that they sought a second opinion shows that they did not believe the first medical opinion given or did not want to believe it. As such, they turned to a second medical professional in order to either ascertain if there was indeed a problem, or if they were not afflicted as they hoped. In Lines 11 and 12, the participant further goes on to explain the testing methodology used. The reasoning for this is to further entrench the construction of masculinity as physical and emotional strength as they had everything possible done to check the diagnosis as proof that there was something wrong with them. This, in effect, is showing that the participant was seeking further proof that they were indeed sick, which is a direct reflection of the construction described for the seeking of a second opinion with a medical professional.

Chapter 6: Discussion

The construction of this research document began with a base understanding of masculinity in relation to historical constructions of masculinity, as well as how they have been explored within different situations and contexts throughout the world. The specific focus of the previous research and theory discussed was euro-centric, which may have had differences in implications and constructions within the salient situation that this research was conducted – within a developing nation, South Africa. The aim of this research was to understand masculinity in relation to males in a work environment, whom suffered from cardiovascular diseases. The research aimed to both confirm if the related research and theories were applicable to the salient situation, as well as to gain a new body of knowledge in relation to the masculine construction with health seeking behaviour within the pre-defined context of this research.

Multiple types of masculinity constructs have been discussed in the research conducted, including masculinity as physical and emotional strength, sex, male health seeking, masculinity as an expression of work, and masculinity as stress. Each of these constructions were explored to understand how, if at all, South African males with cardiovascular disease within a working environment would construct masculinity. The exploration of the experiences of these males within their working environment can now be explored in relation to other research that has been done, as to include ways in which to improve health systems and health seeking in the males in order to gain a potentially better health outcome.

While this research was qualitative in nature, and as such does not have null or alternative hypotheses, it does have some questions to which the research sought to understand. These questions are as follows:

- How sales with cardiovascular disease understand and construct masculinity
- If there is a difference between constructs of masculinity within the males
- If cardiovascular disease appears in their construction of masculinity
- How cardiovascular disease affects masculinity constructions
- If working type and environment plays a role in the construction of masculinity
- If working role affects the construction of masculinity in relation to cardiovascular disease

The reasoning for understanding these questions in relation to the research conducted is thus explored in the discussion, using findings from the results section and applying them to the reasoning for the research. Once this is done, problems and limitations can be explored within this context and then practical implications explored.

Gender in the workplace is an extremely salient topic that has been explored before, and has been very current within the contemporary socio-economic setting where females in the workplace are common, although a pay and leadership differential does exist (Oaxaca & Ransom, 1999). As such, masculinity has taken a backseat, while in research has begun to focus on creating equality through female upliftment in the workplace and as such, research has moved away from understanding this complex evolution of masculinity in the workplace as work roles have changed over time. With this background of why masculinity has not been explored, this research has sought to understand masculinity within the workplace, to denote any changes that have occurred and understand the discourse used to construct masculinity in the workplace, as well as to understand masculinity in relation to cardiovascular disease, which is one of the most prominent health problems in Southern Africa.

The centre of this research encompasses the experiences of males and their construction, and co-construction of masculinity. In this endeavour, five main concepts were explored in the results section of this research. These five main concepts within the research were created from a combination of discourses that were in the literature, as well as being directed by what was most salient within the given narratives and constructions. These concepts allowed for

masculinity to be explored from different contexts and perspectives but aligned under a single banner of similarity. The concepts that were discussed within the results section are:

- Masculinity as physical and emotional strength
- Masculinity as sex
- Male health seeking
- Masculinity as an expression of work
- Masculinity and stress

One of the most complex problems dealt with in this research involved the categorisation of the discourses, as the discourses constructed often overlapped across the five aforementioned concept areas list. In order to combat this, the results discuss the constructs within the aforementioned concepts, as well as link them back to other discourses and concept areas. As discourses are complex and compound constructions – being created inter-personally and existing within a given contact - they were bound to conflict and to be intertwined with one another (Burr, 1995b). While this may cause a complex problem, and as to how to unpack these can be intricate, it can be argued that this is the best way to understand them – within their given complex situation. The reasoning for this is that a complex system needs to be understood in context and with the relations understood in order to maintain the level of efficacy that is required for vigorous research. As a result of this, the systems explored were done within one another, allowing for compound discourses to emerge, which shows that there can be multiple salient discourses running within a single dialectical conversional thread.

One of the most important aspects of this research, which was an unintended outcome, was the exploration of the compound discourses and how they run into one another. Examples of this can be seen throughout the body of the research and in the results section whereby participants start using a single discourse and then re-orientate their discourse for a new one. This is done with or without a contradiction but allows for a single stream of salient dialog to proceed in the flowing constructed conversation. The way in which discourses change and adapt attempts to give and sustain credibility through the participants' dialogs and allows for the exploration of multiple truths – that is that not one single discourse is a universal truth within the participants' constructs but rather a compound and complex intertwining of unique and individual discourses compounding into a single coherent and systematic construction. The reason that this is so important is it breaks down the barriers between the unique

discourses which advocate a dominant salient construction and aids in understanding how a discourse is a combination of multiple, sometimes unrelated and opposing, discourses. With this knowledge in hand salient systems can be understood instead of just singular isolated discourses.

With this new knowledge of compound and intertwined discourses, new ways of which understanding can be co-created and subsequently reconstructed can be used to create interventions. This is crucial in combatting the high incidence of cardiovascular disease within South Africa, and with particular focus on that of persons within the workplace. Once an understanding of these compound discourses is understood and interrogated, the influence of something as complex as masculinity can be meshed into an intervention to gain a wholistic understanding allowing for masculinity to be integrated into the change system. This integration will allow something as complex as masculinity and masculine discourses to be part of the intervention, working alongside it, as opposed to being ignored or simply seen as a nuisance variable to be pushed aside in favour of a different focus. The addition of understanding multiple integrated discourses will also allow for a combination approach to not a single discursive understanding and intervention, but rather one that approaches the conglomeration of discourses within their given contexts and allows for an expanded intervention to give precedent for intertwined and amalgamated change systemic approaches.

One of the first, and most important questions that this research set out to understand, was how males within the working environment, understood and constructed masculinity. The base concept of this question seems simple, but during this research the ultimate answer to this question became a lot more complex. When initially exploring the concept of individual discourses, the research was set to find the discourses in isolation. Within this isolation the discourses could be explored, and as a result of this the question of how discourses were understood and constructed would be explored. As mentioned previously, the discourses were all intertwined, and did not exist within isolated instances. With this in mind, all the aforementioned discourses were explored with the males during the focus group – regardless of being interwoven with one another. The males did use and construct multiple discourses during both the individual interviews and focus group.

The first part of the question was how the males understood masculinity, followed by how the males constructed masculinity. When delving into how males understood masculinity, it can be seen from the results that this varied by person. During the research there was a wide

variety of understanding of the construct of masculinity. There were extremes where males expressed strict adherence to masculinity as physical and emotional strength discourse, and where the male sex discourse was dominant. In these instances, the traditional male discourses did not deviate from the literature but were text-book typical, where the male constructed a negative outlook on health seeking and a reluctance to accept their own health problems. While this discourse was prevalent, it was overshadowed by the multifaceted constructions of combined discourses and the exploration of those thereof. For most of the participants, the focus group and interviews allowed for an exploration into meanings behind the discourses that were being constructed. This was exposed the most in the focus group, whereby during the co-creation, the participants engaged in unpacking and understanding the default masculine discourses which were emerging. This was not expected as masculine discourses were expected to be deeply ingrained and salient within the blue collar workers, upon which the focus group was comprised. The participants in the focus group engaged in actively questioning the constructions of masculinity as they were raised in relation to both work life, as well as gender roles and masculinity. This questioning thereafter allowed for masculinity constructs to be altered outside of what the literature was expecting. During the literature review, the constructs of masculinity for blue collar workers was seen to be based on, and around, the male sex discourse and masculinity as physical and emotional strength (R Connell, 1995; J. Kahn, 2007; Verdonk, Seesing, & de Rijk, 2010). While those discourses were present within the focus group, what was unique was the level of interaction with them on a conscious level. This was done by the participants questioning the discourses and attempting to understand why they were constructed a certain way, as well as ways in which to test them. An example of this was when, against general masculine discourses, a participant broke down and cried during the interview. This goes against the discourse of masculinity as physical and emotional strength, which was theorised to be extremely salient within the blue collar, physical workers, but the level of comfort and engagement to console the crying male that the other employees offered was contradictory to what was theorised. This is against the masculinity as physical and emotional strength discourse where crying is seen as a sign of weakness and results in a reduction of masculine qualities and subsequently a reduction in social standing. However, this was not the case, as all of the males broke the construction that was expected of them from the literature and attended to the crying male. This shows that the discourses within that space were fluid and open to criticism and re-construction. This knowledge is part of the useful knowledge gained about how males understands masculinity. From the focus groups and interviews it is observed that fluid

understanding incorporates multiple well known and documented discourses, while at the same time allowing for flexibility within these discourses. With future interventions and research in mind, understanding of how the salience of discourses work, and how this can be integrated into a behaviour change intervention, may create a new systemic change solution to work within male dominated settings, where masculinity is a restrictive construction inhibiting and retarding health seeking behaviour.

The second part of the question is: how do males create, and by default co-create, the different discourses that were examined in the literature. The first step is to understand that not all discourses appear evenly, with some being more popular due to chrono-social-economic conditions. With that knowledge, the explorations in this research was done to gain an understanding of which discourses were still salient within the given context of males in their working environment. The differences in discourse usage are heavily dependent on the salient conditions, and as such the literature that was reviewed gave an insight into how the discourses are constructed and the meaning behind them, but their popularity and usage would then differ from what was previously published. A lot of the research done on masculinity and masculine discourses has its' history firmly within the bounds of chronological location (R. W. Connell & Messerschmidt, 2005; Moynihan, 1998). It was theorised that the blue collar workers would continue to exhibit the standard masculine discourses that were present in history, whereas the white collar workers were an unknown. They could have possibly become the new standard for masculinity due to a change in the nature of the working environment with a shift from work and pay for males, moving from the blue to white collar environment. This change in working environment thus offers a new systemic understanding platform in which to explore within the current socio-economic chromosphere.

The study sought to understand masculinity within the aforementioned constraints and the results of this were not what was in the literature. From the literature, it would have seemed that masculinity previously had strong systemic ingraining due to the type of work that males did – which was specifically related to physical work and labour. This would then mean, historically, that blue collar workers would inherit this understanding of masculinity and white-collar workers would either seek to work within this construct or seek to make their own. The research found that the discourses were all present at some time during the focus group or individual interviews, but these discourses were a mixture, with dominance of a constructed discourse rising and waning very rapidly. This was seen most prominently in the

group setting of the focus group with traditional blue-collar workers whom were expected to fall within the construct of masculinity as physical and emotional strength. While the males did use this construction, they also heavily broke the construction during the breakdown when a participant cried and expressed his fears and feelings to the group. The group did not shun or belittle the participant, as would be expected from the masculinity as physical and emotional strength discourse where showing emotion and vulnerability is seen as negative, but rather embraced the participant and allowed him a space to explore his feelings and gave encouragement.

Exploring the white-collar working environment brought into contrast the differences between white and blue collar workers in masculine constructions. The exploration of the differences in construction between the two types of workers was part of the study questions. The transition between white and blue collar workers as the main income working type in the western world has raised questions regarding how masculinity will translate between the shift in jobs (Pringle, 2005; Simpson, 2004). This study has both blue- and white-collar workers and was thus able to make a comparison. The comparison was not a clear-cut exemplar as to the change of masculinity, but rather further ratification that the constructions of masculinity are freely constructed and deconstructed depending on the salient situation. In the individual interviews with the participant worked in white collar jobs, the constructions were just as fluid as those who worked in blue collar roles. Each of the participants actively transitioned between discourses, continuously letting no discourses remain salient through the entire interview, showing the fluidity and non-normalised systemic changing of constructs. There was a single exception in the interviews which was a male who mainly used the masculinity as physical and emotional strength discourse throughout his interview. He used this construction as justification for his actions, and displayed the stereotypical constructions associated with masculine health seek and maintenance behaviour – those that are placing health seeking and health in general as the role of a female and admitting to a lack of perfect health as something that a male should not be doing.

The third question that was asked was that of cardiovascular disease in males, namely how do males experience this. The experiences of cardiovascular disease in males, according to the literature, revolved around accessing and maintaining health behaviours which include changes in lifestyle, maintenance of medication and awareness as well as understanding of the problem (W. H. Courtenay, 2000; S. Robertson, Sheikh, & Moore, 2010). Of the participants that were interviewed and those in the focus group, all identified as having some

sort of cardiovascular disease. From this we can explore how the men experienced it. One of the first constructional differences that was seen in the discourse, was the difference between those who were afraid of it versus those who were not. Of those participants who were scared of the disease, there was no common discursive construction that presented itself in all of the interviews or focus group. The participant whose constructions did now show overt fear to the cardiovascular disease was the participant whose discourse was mainly masculinity as physical and emotional strength. This is congruent with the generalisation of the discourse where masculinity is linked to physique, and acknowledgement of any sort of weakness, including illness, means an acknowledgement of a reduced physical standing, and as such a reduction in masculinity. The other males in both the focus group and the individual interviews had a mixed construction of their cardiovascular disease. With the males in the focus group there was a general consensus that it was something to be afraid of, and something that needed to be managed. The males were concerned that without management and health seeking and maintenance behaviour, their lives would be forfeit before their natural end, and as such were engaged in health seeking behaviour in order to maintain a healthy lifestyle which included the usage of medication to control the disease. Through ownership of the disease the males were also owning the process and result thereof. This was seen through the maintenance constructions, where the males spoke about seeking help from within the company, as the company has onsite nursing staff who are equipped to handle health seeking, as well as through the usage of private doctors. The usage of onsite personnel to handle and help maintain the health of those males who identified as having cardiovascular disease is one that is in contrast with masculinity as physical and emotional strength discourse. One of the reasons for this is that masculinity and one's job are closely linked and gaining access to healthcare in that discourse is seen as non-masculine, and the discourse being primarily created due to a history of working, as well as being physically fit – accessing healthcare at the workplace would be counter to everything that the masculinity as physical and emotional strength discourse is constructed from, historically. The knowledge that males who would historically have fallen into the most masculine roles in society, as they are working in a skilled physical career, now break the construction that would have historically been theirs to maintain, demonstrating the salience and changing of discursive constructions. As a result of this, interventions can take advantage of this current renegotiation of constructions around masculinity and help shape the reconstruction to one which has better health seeking and adherence outcomes for males, where there is no conflict

between those ideologies and their identity as a male in society. This once again falls into the effect of fluid discourses that have been seen as a main theme throughout the research.

The fourth question that was to be answered was: how does cardiovascular disease affect the constructions of masculinity? This question was created based on the literature which concluded that masculinity was historically based on masculine physique, and physique was intertwined with one's job and health status, and thus the discursive construction of masculinity as physical and emotional strength was born (Barrett, 1996; Kohler Riessman, 2003; Moynihan, 1998). The effect of having that level of health, and subsequent potential change in physique, could have impacted on the way that males construct masculinity in order to better maintain a level of masculine presence, while having the cardiovascular disease. With this information in mind, males would not seek help. Seeking help would mean admitting that they were physically less able than they were prior to having the cardiovascular diseases, and as a result of this would not seek help or discuss their health problems. Reasoning for this is that admitting that they need help, or that their body has an ailment which could affect physique or physical fitness, would mean that they are losing social prestige and identity, as masculinity has been so historically tied to physique.

With this historical and literature understanding of what was expected to be constructed in mind, the exploration of how cardiovascular disease was constructed in the salient context of this research can now be explored. When constructing masculinity, it seems that the cardiovascular disease played a role in how masculine discourses were constructed, and this differed between those in the focus group, and between each participant within the individual interviews. In the focus group, the males had a very fluid construction of masculinity in relation to their cardiovascular disease. They were very open to talk about it and were worried about the disease killing them. The males talking freely in a group about how they are scared for their lives as cardiovascular disease can kill them, as well as how they have sought help and maintained their medication regiment in order to keep the cardiovascular disease controlled was not expected. Discussions of that nature were not explored in the literature, as these males were going against the normative discursive constructions of masculinity by exploring their feelings and behaviour towards the disease as well as providing support to one another around the disease, where social exclusion was expected from the literature. The opposite effect was however true, with the males offering support to one another and giving a discursive understanding as to feeling similar emotions and ratifying feelings around the disease. During the individual interviews there was a different sentiment

and masculine construction to that of the focus group. The males in these interviews differed with regards to masculine construction around the cardiovascular disease, with some taking a very traditional masculinity as physical and emotional strength discourse, while others explored multiple discourses showing once again the fluidity of discourses. Constructions of masculinity in relation to the cardiovascular disease were different with all the individual interview participants, but the threat of cardiovascular disease as being deadly and something to worry about was expressed by all but one participant, who placed the onus of worrying on his wife, as he felt that the feminine should worry about health.

Chapter 7: Conclusion

The aim of this study was to gain an understanding of masculine discourse constructions with males who had cardiovascular disease within the workplace, and thereby add additional knowledge to the spheres of masculinity within the workplace and masculinity in relation to cardiovascular disease with a final aim of improving health outcomes for males. In order to achieve these aims, a qualitative study was used to gain an understanding of experiences of males with cardiovascular disease, and discourse analysis was used as the method of analysis to explore masculine discourses within the salient contexts in which the participants found themselves.

From the results it can be seen that the masculine discourses which have been present in history and the literature, are still there and relevant today. Those masculinities highlighted included the male sex discourse, masculinity as physical and emotional strength, as well as some themes which emerged during the research which were not explored within the traditional realm of discourses, including male health seeking behaviour, masculinity in the working environment and masculinity with stress (Arrington, 2008; Christy, Mosher, Rawl, & Haggstrom, 2017; Raewyn Connell, 2012; Sloan, Gough, & Conner, 2010). The usage of discourses was something which was explored in-depth, with specific interest in the fluidity of the discourses which was not expected, especially with the contradictions that were created during the fluidity. The findings showed that the males in this study were constantly cycling through discourses in order to construct and co-construct their experiences. These constructions were sometimes in conflict with one another, such as using a masculinity as physical and emotional strength discourse which has emphasis on strength of body, and moments later acknowledging the cardiovascular disease and the potential for harm that currently exist. From the literature, it would seem that these two constructions are in opposition, but it seems a new discourse is being constructed whereby physique, and the emphasis on physical condition of the body, can co-exist with worry about one's physique and physical health being affected by cardiovascular disease, and the handling of it thereafter. The findings therefore acknowledge that discourses are changing and evolving with the society as a whole, and that literature will need to be continually updated to accommodate how discourses are being constructed with the given socio-economic and chrono systems.

The results that were found were confounding to what was expected with regards to the literature discussed. When looking at the masculine discourses, historically the males who

were most invested in the masculine discourses were the males with physical jobs, which are now known as blue collar jobs (Connell, 2012). With the change in working environments, with males moving from blue collar jobs to that of white collar, and the pay also changing to favour those in white collar jobs, the case of masculinity being linked to one's physique needed to be explored. With the exploration came outcomes which were not expected, as the males who were in physically demanding jobs, and would be classed as blue-collar workers, were actively questioning the role of masculinity within their context. This was done by including females in their questioning about the relation of their work role to the cardiovascular disease, how work affects it, and how it is constructed within the work environment. From this the males broke away from the typical norm of masculinity, where the masculine is what separates males from females, and by actively trying to see if there was indeed a difference subtly undermining this contrast that masculinity creates.

The health promotion outcome of the research has been extremely valuable. From understanding that masculinity is currently going through a change in construction, whereby males are able to question it, and make non-negative comparisons, health change could be initiated. A health change initiative could be done to target the way in which males use their masculinity to construct health seeking and maintenance as a positive, instead of a negative as has been done historically. The usage of the fluidity of masculine discourse could also be maximised in order to introduce new pro-health seeking and maintenance behaviours. Through acknowledging the fluidity of the discourse, introduction to reshaping and reconstructing through introduction of alternative discursive systems could lead to acceptance of new discourses in the current state of fluidity.

Finally, there is room for further research into the construction of masculinity with working men who are experiencing different types of health problems. This study was limited to males' experiences with cardiovascular disease, which is very specific in potential health outcomes and drug control side effects. As such the reactions to this potentially fatal disease could be part of the reason that the constructions were so fluid. Exploration into other diseases that exist, which are also life threatening, that can be controlled differently, or into diseases that are not life threating, may potentially show how fear plays a role in the construction of masculinity, and if different disease can show a similar fluidity in construction and a willingness to alter or question salient historical constructions.

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Appendix I: Recruitment Poster

Participants wanted for a psychology study

Looking for both male students to be part of a study exploring masculinity in relation to health seeking behaviour. Must be over 18,. The focus group will run for approximately 1.5 hours.

For more information contact Chris Hamlyn:

Chris Hamlyn: Chris@hamlynfamily.com	Chris Hamlyn: Chris@hamlynfamily.com	Chris Hamlyn: Chris@hamlynfamily.com	Chris Hamlyn: Chris@hamlynfamily.com	Chris Hamlyn: Chris@hamlynfamily.com	Chris Hamlyn: Chris@hamlynfamily.com	Chris Hamlyn: Chris@hamlynfamily.com	Chris Hamlyn: Chris@hamlynfamily.com

Appendix II:Focus Group Schedule

General

1. What does health mean as a

a. Man

b. Working at ….

2. How important is health

a. To men

b. To their wives / girlfriends

c. To their families

d. To their friends

3. Do men and women have different approaches to seeking help

a. In what way are they different

b. How are they similar

4. Do men and women have different ways in keeping healthy

a. In what way are they different

b. How are they similar

5. Has there been a change in the way men see

a. Health

b. Seeking help

c. Taking medication

Body

1. How important is a mans body is his health

a. How does he show health

2. What about a mans body shows that he is healthy or sick

3. Would you sacrifice medication or seeking help to keep a ‘healthy body’

Sex

1. How important is sex in being healthy

a. Why?

2. What about sex makes you healthy?

3. What would happen if you could not have sex?

Access

1. How hard is it to get health care

a. Where do you go

b. What do you have to do

c. Constraints

i. Time

ii. Money

iii. Stigma

2. What is the experience of accessing health care

a. Does it cater to men

b. What would make it more male friendly

3. Why do you access health care

a. Does someone influence you

b. Do you choose to yourself

Appendix III: Info Sheet for Focus Group

Information Sheet: Focus Groups

Thank you for agreeing to participate in this focus group. This sheet is intended to provide you with information about this study and your role in it. **To agree to participate in this study, you must be above 18 years of age.**

My name is Christopher Hamlyn. I am postgraduate students at UKZN (Howard). As part of my degrees, I am conducting research on how males construct their relationship with healthcare and high blood pressure. I would like to know how having high blood pressure affects you, and how being a man effects seeking help and understanding this affliction. By researching this topic, I hope to gain a better understanding of how masculinity can effect health in males with high blood pressure.

The focus group process

The focus group will last about 2 hours. In this focus group the researcher will ask you questions about being a man, having high blood pressure and seeking help. This research is investigating your attitudes, opinions and knowledge so there is no right or wrong answers and you are encouraged to express yourself freely and informally. You also have no obligation to answer any questions you don't want to. Your participation in this focus group is voluntary and you will not be forced to participate. You are also free to leave the study at any time if you wish without worry about reprisal or any negative implications.

Recording the discussion

A tape recorder will be used to record the focus group discussion, so that we can pay attention to the details of what each participant says and then be able to access what was said at a later stage.

Confidentiality

Your identity will be kept confidential in this process by using your pseudonym. This pseudonym will be used in the discussion in the focus group, and in the transcriptions of the discussion, and also in the final research project. Your real name will never be mentioned in the research. Because you are in a group setting, you will be asked to sign a confidentiality pledge stating that everything said in the focus group will be kept confidential. By promising to keep what is discussed in the focus group confidential you are agreeing not to reveal the identity of anyone in the group or what was said by them to anyone outside the group. You will also be asked to choose to use a fake name (pseudonym) during the discussion to make sure your personal details are not revealed to other participants.

However, please be advised that we cannot guarantee confidentiality even if a pledge is signed. For this reason, you will not be asked to discuss any personal questions, but will instead be asked general questions about what other students do and think. It is also recommended that you do not disclose any sensitive information about yourself when taking part in this focus group discussion.

What happens after this focus group?

After the discussion, we will take the recordings and transcribe the information into a written form. In this process we will still refer to you by your pseudonym. The transcriptions will then be analyzed and a report will be written. This report will be used a Masters dissertation. It will be examined by at least two staff members in the Discipline of Psychology.

This data is made available to my supervisor, and may be used in a presentation or a published article. Your name will not be mentioned, as you will be referred to by a pseudonym.

Storage of project data

The transcriptions of the discussions will be kept for future research purposes. They will be stored for five years in a locked cabinet in my supervisor's office, as will any other materials

relating to this research. Once this five year period is finished the data shall be erased. To keep your identity confidential, all data will be stored separately from information which links it to your actual name.

Possible interviews

After participating in the focus group, you may be asked to participate in a separate, personal interview as well. If you would like to do this, you will receive details of this process.

Anything else?

If you have any questions you would like to ask us, you are welcome to contact me by either calling me on 0828557343 or emailing F1veClaw@gmail.com. If you have any questions you may also contact our supervisor, Kay Govender , on 0312607616 or email him at govenderk2@ukzn.ac.za. If you have any complaints about this study you may contact Phume Xumba on the Humanities and Social Science Research Ethics Committee via phone (031) 260 3587 or email ximbap@ukzn.ac.za.

Thank you for your time and participation, it is most appreciated. I hope this is an interesting and rewarding experience for you.

Appendix IV: Consent Focus Group

Consent Form – Focus Group

I hereby agree to participate in this study on the study of effects of masculinity of health seeking and maintaining behaviour in men with high blood pressure. I have had an opportunity to read and understand the information sheet given to me.

The purpose of the study has been explained to me. I understand what is expected of me in terms of my participation in this study and the time commitment I am making to participate in this study.

I understand that my participation is voluntary and I know that I may withdraw from the study at any point, without negative consequences.

I understand that there is a limit to confidentiality in a focus group setting as the researcher cannot guarantee that the other participants will adhere to the conditions of the confidentiality pledge.

I understand that my data will be stored securely for five years and used for future research. I understand that measures will be taken to ensure that my identity is protected and my participation in this research will be completely confidential in this regard. I understand that no identifying information about myself will be published.

_____ _____

Signature of Participant Date

Appendix V: Consent Audi Recording Focus Group

Consent for use of recordings – Focus Group

I hereby give permission for audio recordings of this discussion to be used as data in this research project. I understand that measures will be taken to ensure that my identity is protected and my participation in this research will be completely confidential in this regard.

I understand that this data will be kept for up to five years, and after that point will be erased.

_____ _____

Signature of Participant Date

Appendix VI: Confidentiality Pledge

Confidentiality Pledge: Focus Groups

I have consented to participate in this study on how males construct their relationship with healthcare and high blood pressure. As part of my commitment to participate in this study I hereby agree to keep everything that happens in this focus group confidential. This means that I agree not to talk about any of the issues that were discussed to anyone outside of the focus group or divulge the identities of any of my fellow participants.

I understand that every member of this focus group has the right to respect and privacy. I further understand that while the researcher has no control over my actions, if I break my promise of confidentiality that this may have damaging effects on my fellow participants and research in this field.

I understand that it is important for this research that I, as well as my fellow participants, feel comfortable to express ourselves without fear of any negative consequences. I hereby agree to keep this confidential because I am aware that if I do not, my fellow participants may be harmed by my actions.

_____ _____

Signature of participant Date

Appendix VII: Interview Schedule

Interview Schedule

General

1. Do you have a medical problem at the moment (High blood pressure)?
    a. What do you know about it
    b. How does it affect you as a man
    c. Is this different to how it would effect a woman
2. Do men and women see health differently
    a. How
    b. Does this affect you
3. Do you feel like worrying about health is equal in the genders
    a. Who worries more
4. Do you take the medication
    a. Why / why not
    b. What would stop you
    c. What would make you start
    d. What do others think about it
5. Why do you seek help
    a. What is important for you
6. Do you think seeking help is getting easier
    a. Why / Why not

Body

1. How does high blood pressure effect your body
    a. What are the effects
2. How do you manage the effects
    a. What do you do
    b. Why do you do it
3. How would a healthy mans body look
4. How would a sick mans body look

Sex

1. How important is sex to health
    a. Can you not have sex and still be healthy
2. Does high blood pressure effect sexual activity
    a. How do you deal with this
    b. What are the repercussions

Access

1. How easy is it for you to get access to health
    a. Where do you go
    b. How do you get there
    c. Is it expensive
2. What is the experience like
    a. How were you treated as a man
3. Do you think there is a gender bias at medical institutions
    a. Who is favoured
    b. Why

Appendix VIII: Info sheet for Interviews

Information Sheet: Interview

Thank you for agreeing to participate in this interview. This sheet is intended to provide you with information about this study and your role in it. **To agree to participate in this study, you must be above 18 years of age.**

My name is Christopher Hamlyn. I am postgraduate students at UKZN (Howard). As part of my degrees, I am conducting research on how males construct their relationship with healthcare and high blood pressure. I would like to know how having high blood pressure affects you, and how being a man effects seeking help and understanding this affliction. By researching this topic, I hope to gain a better understanding of how masculinity can affect health in males with high blood pressure.

The interview process

The interview will last about 2 hours. In this interview the researcher will ask you questions about being a man, having high blood pressure and seeking help. This research is investigating your attitudes, opinions and knowledge so there is no right or wrong answers and you are encouraged to express yourself freely and informally. You also have no obligation to answer any questions you don't want to. Your participation in this interview is voluntary and you will not be forced to participate. You are also free to leave the study at any time if you wish without worry about reprisal or any negative implications.

Recording the discussion

A tape recorder will be used to record the interview discussion, so that we can pay attention to the details of what each participant says and then be able to access what was said at a later stage.

Confidentiality

Your identity will be kept confidential in this process by using your pseudonym. This pseudonym will be used in the discussion in the interview, and in the transcriptions of the discussion, and also in the final research project. Your real name will never be mentioned in the research.

What happens after this interview?

After the discussion, we will take the recordings and transcribe the information into a written form. In this process we will still refer to you by your pseudonym. The transcriptions will then be analyzed and a report will be written. This report will be used a Masters dissertation. It will be examined by at least two staff members in the Discipline of Psychology.

This data is made available to my supervisor, and may be used in a presentation or a published article. Your name will not be mentioned, as you will be referred to by a pseudonym.

Storage of project data

The transcriptions of the discussions will be kept for future research purposes. They will be stored for five years in a locked cabinet in my supervisor's office, as will any other materials relating to this research. Once this five year period is finished the data shall be erased. To keep your identity confidential, all data will be stored separately from information which links it to your actual name.

Anything else?

If you have any questions you would like to ask us, you are welcome to contact me by either calling me on 0828557343 or emailing F1veClaw@gmail.com. If you have any questions you may also contact our supervisor, Kay Govender , on 0312607616 or email him at govenderk2@ukzn.ac.za. If you have any complaints about this study you may contact Phume Xumba on the Humanities and Social Science Research Ethics Committee via phone (031) 260 3587 or email ximbap@ukzn.ac.za.

Thank you for your time and participation, it is most appreciated. I hope this is an interesting and rewarding experience for you.

Appendix IX: Consent Interviews

Consent Form – Interviews

I hereby agree to participate in this study on the study of effects of masculinity of health seeking and maintaining behaviour in men with high blood pressure. I have had an opportunity to read and understand the information sheet given to me.

The purpose of the study has been explained to me. I understand what is expected of me in terms of my participation in this study and the time commitment I am making to participate in this study.

I understand that my participation is voluntary and I know that I may withdraw from the study at any point, without negative consequences.

I understand that there is a limit to confidentiality in a focus group setting as the researcher cannot guarantee that the other participants will adhere to the conditions of the confidentiality pledge.

I understand that my data will be stored securely for five years and used for future research. I understand that measures will be taken to ensure that my identity is protected and my participation in this research will be completely confidential in this regard. I understand that no identifying information about myself will be published.

_____ _____

Signature of Participant Date

Appendix X: Consent Audi Recording Focus Group

Consent for use of recordings – Interviews

I hereby give permission for audio recordings of this discussion to be used as data in this research project. I understand that measures will be taken to ensure that my identity is protected and my participation in this research will be completely confidential in this regard.

I understand that this data will be kept for up to five years, and after that point will be erased.

_____ _____

Signature of Participant Date

Appendix XI: Jeffersonian Transcription

Symbol	Name	Use
[text]	Brackets	Indicates the start and end points of overlapping speech.
=	Equal Sign	Indicates the break and subsequent continuation of a single interrupted utterance.
(# of seconds)	Timed Pause	A number in parentheses indicates the time, in seconds, of a pause in speech.
(.)	Micropause	A brief pause, usually less than 0.2 seconds.
. or ↓	Period or Down Arrow	Indicates falling pitch.
? or ↑	Question Mark or Up Arrow	Indicates rising pitch.
,	Comma	Indicates a temporary rise or fall in intonation.
-	Hyphen	Indicates an abrupt halt or interruption in utterance.
>text<	Greater than / Less than symbols	Indicates that the enclosed speech was delivered more rapidly than usual for the speaker.
<text>	Less than / Greater than symbols	Indicates that the enclosed speech was delivered more slowly than usual for the speaker.
°	Degree symbol	Indicates whisper or reduced volume speech.
ALL CAPS	Capitalized text	Indicates shouted or increased volume speech.

underline	Underlined text	Indicates the speaker is emphasizing or stressing the speech.
:::	Colon(s)	Indicates prolongation of an utterance.
(hhh)		Audible exhalation
? or (.hhh)	High Dot	Audible inhalation
(text)	Parentheses	Speech which is unclear or in doubt in the transcript.
((italic text))	Double Parentheses	Annotation of non-verbal activity.