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Masculinity and Men's Participation in Colorectal Cancer Screening

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Colorectal cancer (CRC) is a common cancer and an ideal target for early detection and prevention through screening. The Australian National Bowel Cancer Screening Program currently provides free testing to Australians at 5-year age intervals between the ages of 50 and 65. Despite the effectiveness of screening, participation in the program is suboptimal, with men participating at a significantly lower rate than women. Men's reluctance to use health services and seek help for health problems is a common concern across Western cultures, often attributed to "traditional" masculine traits such as stoicism, strength, and independence. In this qualitative study we interviewed 35 older men (50 to 74 years) who had been invited to screen for CRC through participation in a randomized controlled trial, and explored the extent to which the men's discussions of screening for CRC were consistent with theories of masculinity. Using theoretical thematic analysis we identified that men drew on discourses of responsibility, risk, rationality, and control in discussing their views of screening for CRC, demonstrating an interconnection between discourses of hegemonic masculinity and dominant discourses of neoliberalism.

Keywords: masculinity, colorectal cancer, screening, neoliberalism

Men have a shorter life expectancy than women (Barford, Dorling, Davey Smith, & Shaw, 2006; Salomon et al., 2012) and are reportedly reluctant to use health services or seek help for health problems (Boman & Walker, 2010). Likewise, men have a higher lifetime probability of being diagnosed with an invasive cancer than women (Jemal, Siegel, Xu, & Ward, 2010), yet they are less likely than women to use preventative health care services such as cancer screening (Davis, Buchanan, Katz, & Green, 2012). This is the case with many cancers, including colorectal cancer (CRC).

CRC is the third most commonly diagnosed cancer in men (Jemal et al., 2011). Chances of survival increase dramatically with early detection; early detection is therefore critical to improving health outcomes (Hewitson, Glasziou, Watson, Towler, & Irwig, 2008). Early detection of precancerous abnormalities in the colon

is also advantageous because it facilitates earlier medical intervention, therefore preventing the progression to CRC altogether (Australian Institute of Health and Welfare, 2013). National screening programs for CRC have been introduced in many countries and have demonstrated success in reducing mortality (Autier et al., 2013). The Australian National Bowel Cancer Screening Program (NBCSP) currently provides free testing using a fecal occult blood test (FOBT) to Australians at 5-year age intervals between 50 and 65 years. A FOBT tests for minute traces of blood in a sample of feces, which is an indication of CRC risk (although blood can be a result of other factors; thus a positive screen for blood would lead to further diagnostic evaluation such as a colonoscopy). Despite the effectiveness of FOBT screening, participation in the NBCSP is suboptimal, with men participating at a significantly lower rate than women (Australian Institute of Health and Welfare, 2013; Ward et al., 2011). This finding is well replicated in the international research literature (Ananthakrishnan, Schellhase, Sparapani, Laud, & Neuner, 2007; Frederiksen, Jørgensen, Brasso, Holten, & Osler, 2010; von Wagner et al., 2011).

The underutilization of health services such as cancer screening places men at a disadvantage (Davis et al., 2012). This lack of engagement in prohealth behavior can be understood through the exploration of how men's psychology is influenced or shaped by the social construction of gender. One possible explanation is that "traditional" masculine traits such as stoicism, strength, and independence act as a deterrent to help seeking among men (Courtenay, 2000; Galdas, Cheater, & Marshall, 2005). Underpinning this view is the notion of hegemonic masculinity. Developed in the 1980s this theoretical concept proposes a hierarchical notion of masculinity in which men are required to position themselves

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against an idealized version of what it means to be a man (Connell & Messerschmidt, 2005). The increasing popularity of the investigation of hegemonic masculinity across a range of disciplines saw its application in the 1990s to exploring men's health-related behavior, an approach that continues today (Buckley & Tuama, 2010; Chapple, Ziebland, & McPherson, 2004; Courtenay, 2004; Galdas et al., 2005; George & Fleming, 2004).

A seminal work in this area is that of Courtenay (2000), who drew on social constructionist and feminist perspectives to propose a relational theory of men's health. Courtenay argued that differences in health-related behavior between men and women were due to men demonstrating dominant ideals of manhood that were defined by their society. Men, he argued, must "adhere to cultural definitions of masculine beliefs and behaviors and actively reject what is feminine" (Courtenay, 2000, p. 1397). In Western cultures this means adhering to a cultural definition of masculinity connected with unhealthy beliefs and behaviors, such as increased risk taking and dismissing health needs to legitimize themselves as the "stronger" sex (Courtenay, 2000).

The relationship between masculinity and health has been in explored in both qualitative and quantitative research. In a recent study of measures of masculinity (Masculine Gender Role Stress Scale [MGRSS; Eisler et al., 1988], Male Role Norms Scale [MRNS; Thompson & Pleck, 1986], Extended Personal Attributes Questionnaire; Spence & Helmreich, 1978) and health behaviors, aspects of masculinity measured by the MGRS and MRN predicted lower levels of positive health behaviors and higher levels of negative health behaviors in men and in women, with a stronger relationship for men (Sloan, Conner, & Gough, 2014). An Australian study found conformity to dominant masculine norms to be associated with men consuming less fiber and fruit (Mahalik, Levi-Minzi, & Walker, 2007). Qualitative studies also have supported the relationship between masculinity and men's health behavior (de Visser & McDonnell, 2013; Rivera-Ramos & Buki, 2011).

The notion of hegemonic masculinity has offered a useful explanatory framework for understanding men's reluctance to seek help and participate in preventative health care. However, there has been a tendency with the evolution of the concept toward essentializing and homogenizing the character of men, and an evolving view of masculinity "not just as a type, but as a negative type" (Connell & Messerschmidt, 2005, p. 840). This is reflected in the view that men are disinterested in or ignorant about their health and victims of their own behavior (Emslie & Hunt, 2009; Smith, Braunack-Mayer, Wittert, & Warin, 2008) as a result of adhering to traditional masculine norms (Mahalik, Levi-Minzi, & Walker, 2007). A further critique of research into hegemonic masculinity and men's health behavior is that it fails to account for the fact that men can and do attend to their health (Calasanti, Pietilä, Ojala, & King, 2013; Sloan, Gough, & Conner, 2010; Smith et al., 2008).

Connell and Messerschmidt (2005) explored the various critiques of hegemonic masculinity and outlined aspects of the theory that could be maintained, those that could be rejected, and those that could be reformulated so that the concept was reflective of research findings and addressed the critiques. In particular, they rejected the usages of the concept that "imply a fixed character type, or an assemblage of toxic traits" (Connell & Messerschmidt, 2005, p. 854), instead viewing hegemonic masculinity as having a

number of both positive and negative configurations. Furthermore, hegemonic masculinity can be understood in terms of multiplicities of gendered identities, with gendered behavior conceptualized as "doing gender" in contemporaneous contexts (Calasanti et al., 2013). This provides a more nuanced understanding of the relationship between gender and health behaviors.

Within this formulation, the pursuit of hegemonic masculinity can lead men to adopt risky behaviors and fail to undertake health-promoting activities, but it can also lead to an increased focus on health in contexts in which maintaining good health strengthens claims to manhood (Calasanti et al., 2013). For example, O'Brien, Hunt, and Hart (2005) conducted focus groups with a diversity of men in Scotland to explore their experience of help seeking in relation to the practice of masculinity. Although there was widespread endorsement of the view that men are reluctant to seek help, there were two contexts in which consulting for health problems was seen as preserving rather than threatening masculinity. The first involved firefighters, who identified help-seeking and preventative health as important in ensuring they could maintain their health and keep their jobs. The second involved seeking help for sexual health problems. Furthermore, men were identified as restoring their masculinity through help-seeking in the context of having an illness, where a diagnosis legitimates the inability to fulfill masculine roles such as working and providing for a family. In an editorial for the special issue on men's health and masculinity for *Health Psychology*, Gough (2013) identified a theme cutting across the articles in the issue "concerning how masculine 'capital' can function to both constrain and open up healthy practices" (p. 1).

Recent research exploring men's health behavior also has highlighted the importance of individual responsibility and control in contemporary discourses of health (Farrimond, 2012). These discourses are prominent where neoliberal governmental rationality dominates the governance of health care, where the essence of governance is an economic logic that reconceptualizes social behavior along economic lines. Through this reconceptualization the individual becomes "an entrepreneur of his or her self" (Rose, 1999, p. 142), an active citizen who takes personal responsibility for managing and maintaining health through the advice of experts. In a study exploring laymen's understandings of health and well-being, Robertson (2006) identified a tension in the men's discussions between the masculine imperative of indifference to health and encouraging risk taking, and the moral imperative in late modernity to take personal responsibility for health and minimize risks. Within the context of a health conscious and consumer-driven culture, men are provided with "new opportunities for constructing autonomous, rational and controlled masculine identities" (Calasanti et al., 2013, p. 22). Thus Sloan et al. (2010) argued that research into masculinity and men's health behavior needed to consider "how men are increasingly engaging with cultural injunctions to 'be healthy'" (p. 784).

Drawing on contemporary research into hegemonic masculinity, in this paper we explore the ways in which men's discussions of CRC screening relate to theories of masculinity. We were particularly interested to explore the ways in which discourses of hegemonic masculinity sat alongside other dominant discourses such as those of neoliberalism, and the effect of this on the way in which men made decisions and took actions in relation to screening for CRC. Current research into gender and screening for CRC has

explored gender differences in screening rates (Javanparast et al., 2010; von Wagner et al., 2011; Wallace & Suzuki, 2012) and beliefs, knowledge, and attitudes toward screening (Davis et al., 2012; Friedemann-Sanchez, Griffin & Partin, 2007; Molina-Barceló, Salas Trejo, Peiró-Pérez, & Málaga López, 2011; Ritvo et al., 2013; Winterich et al., 2011; Wong et al., 2013). These studies provide some insight into why men may decide not to screen for CRC.

Only two studies have addressed the issue of screening for CRC in relation to theorizing around masculinities. Christy, Mosher, and Rawl (2014) drew on prior research and theories of men's attitudes to CRC screening to propose a conceptual framework that integrates men's health and masculinity theories. The framework hypothesizes four masculinity norms to be associated with CRC screening, namely risk-taking, self-reliance, avoidance of femininity, and heterosexual self-presentation. Thompson, Reeder, and Abel (2012) interviewed New Zealand men and women about their knowledge of and attitudes toward CRC screening programs. They identified a stereotypical "macho image" discourse in relation to men's screening decisions, but also highlighted the heterogeneity of men where different performances of masculinities were presented. As Thompson et al. (2012) pointed out, issues of gender, and in particular masculinities, have been underexplored in relation to screening for CRC. Addressing this gap will add depth to our understanding of men's CRC screening behavior and improve knowledge and understanding about men's health behavior more broadly.

Method

Design

The study reported here formed the qualitative follow-up to a population-based randomized controlled trial (RCT) aiming to increase the participation of Australian men in CRC screening through the development of targeted, gender-specific invitations (Duncan et al., 2013). Participants in the RCT were invited to complete a FOBT and post it back to the researchers. Following the intervention a subsample of men were invited to participate in one-on-one telephone interviews. The aim of the qualitative study was to explore in depth men's attitudes toward and experiences of screening for CRC.

Participants

Written invitations to participate in the telephone interview were mailed to 2,092 men who had previously been invited to screen as part of the trial. The men were given information about the qualitative study and asked to contact the researchers if they were interested in taking part. A total of 164 men agreed to be contacted about being interviewed, and purposive sampling (Grbich, 1999) was used to select participants for the interviews. Participants were sampled on a selection matrix that included group assignment (the group they were allocated to in the RCT) and age group (50–54, 55–59, 60–64, 65–69, 70–74 years).

An attempt was made to include equal numbers of men who had completed the study FOBT and those who had not. Efforts were made to interview every man responding to the invitation who had not completed his FOBT, as this group was much more difficult to

recruit. Interviews with men who had completed the FOBT (from whom a surplus of offers was received) were conducted until data saturation among this group was achieved. Through this process 39 men were interviewed. Twenty of these had returned their FOBT and 19 had not. However, while men's participation in the study FOBT was used to classify them, many of the men who did not participate in the RCT made this decision because they were already up-to-date with bowel screening; thus, very few can actually be considered "nonscreeners." Furthermore, an additional four men had subsequently completed their study FOBT after being contacted about participating in an interview. This information was only discovered during the interviews, and no further nonscreeners were available to be contacted for interview. With the sample consisting predominantly of men who had at some stage screened for CRC, and only four who had not, the decision was made to focus the analysis on the men ($n = 35$) who had screened. As Sloan et al. (2010) pointed out, in addition to understanding unhealthy masculine positions, it is also important to explore how masculinity is constructed in the context of those men who do engage in healthy practices.

Procedure

The University of Adelaide Human Research Ethics Committee granted ethics approval for the trial, including the qualitative component. Participants were assured of their confidentiality and that no identifying information would be presented in any outcomes of the study. They also were assured that they could refuse to answer questions or withdraw from the study at any time without prejudice. The interviews were conducted by one of the authors (Clare McGuiness [CM]) who was a project officer on the RCT. The interviews were conducted over the phone between June and August 2013.

The interviews were semistructured, and the interview schedule began with an open-ended question about how and why the men decided to participate or not participate in screening for CRC. They also were asked to discuss pros and cons of screening, effectiveness of screening, using the FOBT, cancer risk, current health, the influence of others, and any information they may have read or heard about screening for CRC. Participants were encouraged to express their own views and describe their experiences. Two pilot interviews were conducted and the interview schedule minimally refined on the basis of these interviews. The pilot interviews were included in the analysis.

The interviews were approximately 30 min in length and were audiotaped and transcribed verbatim. In addition the interviewer took notes during each interview of salient responses to the interview questions. This allowed the interviewer to come back to these points to gather further information where necessary without interrupting the flow of conversation. The research team also reviewed these notes over the course of the study to identify whether the interviews were eliciting in-depth information about men's screening decisions. For example, after reading through the interview notes of early interviews we decided that greater depth of information could be elicited by referencing what other men had said and asking participants to comment on the relevance of this to their personal experience.

Analysis

The interviews were analyzed using theoretical thematic analysis (Braun & Clarke, 2006), where the development of themes was driven by a theoretical interest in the concept of hegemonic masculinity (Connell & Messerschmidt, 2005). Theoretical thematic analysis is understood as a “contextualist” method situated between the “two poles of essentialism and constructionism” (Braun & Clarke, 2006, p. 81). It involves focusing on both the ways in which individuals make meaning of their experiences as well as the ways in which the broader social context, in this case hegemonic masculinity, delimits those meanings. In addition, we explored the intersection of hegemonic masculinity and neoliberal governmental rationality (governmentality), as discussed in the introduction.

Governmentality here refers to the connection between government and thought, where government includes “all endeavors to shape, guide, direct the conduct of others” and “the ways in which one might be urged and educated . . . to govern oneself” (Rose, 1999, p.3). Central to the operation of governmentality are *discourses*, defined as “practices that systematically form the objects of which they speak” (Foucault, 1972, p. 49). Discourses shape what can be said and thought about an object, they have effects for the speaker and writer, and they are embedded in power relations with political effects (Borrell, 2008).

Following the approach outlined by Braun and Clarke (2006) the analysis process proceeded as follows. One of the authors (Candice Oster), who was not part of the RCT, undertook the initial analysis of the interviews. Familiarization with the data involved each of the interviews being read through twice, and codes identified. The codes were developed to reflect the content of the interviews, for example a comment about doing the FOBT was coded “procedure.” The codes were then collated into potential themes, in which a theme “captures something important about the data in relation to the research question, and represents some level of *patterned* response or meaning within the data set” (Braun & Clarke, 2006, p. 82, italics in original). The interviewer (CM) reviewed these themes and it was agreed that the themes reflected her written impressions of the interviews as they were undertaken. The online qualitative data analysis software Dedoose (Version 4.3.86, 2012) was used to manage the data and coding process, and to collate data relevant to each code.

The next stage involved interpretive analysis, in which a number of questions were asked of the themes in relation to the theoretical framework of hegemonic masculinity: “What does this theme mean?”; “What assumptions underpin it?”; “What are the implications of this theme?”; “What conditions may have given rise to it?”; and “Why do people talk about this thing [CRC screening] in this particular way (as opposed to other ways)?” (Braun & Clarke, 2006, p. 94). Through this questioning process and reading of the literature on hegemonic masculinity and neoliberalism, and through a consultative process involving discussion among all authors, a thematic map of the analysis was generated and the themes were defined and named. In this final stage the “overall story the different themes reveal about the topic” (Braun & Clarke, 2006, p. 94) was identified, including the discourses that underpin the themes.

Results

As discussed previously, the participants included in this analysis ($n = 35$) had all screened for CRC at some stage, either through the RCT ($n = 24$) and/or previously through the national screening program or their general practitioners (GPs; $n = 29$). With the general understanding, both within the CRC literature and health literature more broadly, that men are reluctant to seek help for health problems or undergo preventative screening, the focus in this analysis is on why these men do attend to their health and the implications of this for their masculinity. In what follows we describe six themes, namely (a) neoliberalism and preventative health care; (b) responsibility, masculinity, and CRC screening; (c) risk, masculinity, and CRC screening; (d) rationality, masculinity, and CRC screening; (e) control, masculinity, and CRC screening; and (f) comparison to others. Underpinning these themes is the intersection of four discourses, namely responsibility, risk, rationality, and control, through which neoliberal governmentality operates.

To preserve their anonymity only limited information about the participating men is included alongside the quotations, including their age range and screening status (the letter *S* refers to those who underwent screening through the RCT; *PS* refers to those who underwent screening for CRC in the past).

Neoliberalism and Preventative Health Care

As discussed earlier, neoliberalism is the central mode by which health care is governed in contemporary western democratic societies, such as Australia (Benoit, Zadoroznyj, Hallgrimsdottir, Treloar, & Taylor, 2010; Broom, Meurk, Adams, & Sibbritt, 2012; Carey, Riley & Crammond, 2012). Neoliberalism emerged in the 1980s as a challenge to the welfare state and the high levels of public expenditure and taxation required to sustain this form of governance. Neoliberalism as a political theory emphasizes the role of the economic market rather than government intervention to address the “ills of social and economic life” (Rose & Miller, 2010, p. 295). The neoliberal approach to health care is “characterized by reduced governmental responsibility for service delivery and greater involvement of the individual in their own care” (Henderson, 2007, p. 84). Individuals are expected to govern themselves and achieve positive health outcomes in accordance with the information and advice of experts (Deleuze, 1999).

Discourses of risk, responsibility, rationality, and control are central discourses through which neoliberalism operates. Key features of neoliberalism are self-governance through personal choice (Rose, 1999; Rose & Miller, 2010), and the responsabilization of rational, active citizens who are expected take personal responsibility for their well-being and self-manage any risks to their health (Liebenberg, Ungar, & Ikeda, 2013). One way in which neoliberal citizens can self-manage health risks is to undertake preventative health care, and this was evident in this study by the men’s preventative health orientation. By this we mean that the men articulated the importance of self-managing their health through undertaking a range of preventative measures, including screening for CRC.

Having a preventative health orientation was an important consideration in the men’s discussions about their decision to screen for CRC. References to the importance of taking preventative action included statements such as: “I certainly see a lot of posi-

tives to [CRC screening] as I would do to anything in relation to preventative, you know, an early diagnostic and early warning all that sort of stuff" (S, PS, 55–59); "prevention's better than cure" (S, PS, 50–54); and "if you detect it from the first, if it's early then you probably can avoid it but if you leave it, leave it, leave it and then it's too late. That's why the checks are good" (PS, 70–74).

Nineteen out of the 35 interviewees described preventative health care in general as being important to them. This involved activities such as regular health checks with a GP, with 14 men stating that they went to their GPs on an annual basis for health checks such as cholesterol and prostate screening. Other activities included regular exercise, healthy eating habits, dieting to lose weight, and taking dietary supplements; for example, "My wife and I are active in our retirement, we cycle a lot and we keep healthy" (S, PS, 65–69). Screening for CRC through the national screening program or the GP was identified as being incorporated into this broader program of illness prevention:

I've now actually gotten myself into the habit with my GP that every year we do a number of standard tests which include a bowel screen and a prostate check as well, and regular bloods and all that sort of stuff. (S, PS, 55–59)

The adoption of a preventative health orientation, including screening for CRC, suggests a transformation of masculinity at the contact between discourses of neoliberalism and hegemonic masculinity. In particular, the men's discussions suggest a transformation of the traditionally masculine traits of irresponsibility, risk taking, rationality, and control, which are discussed in the following.

Responsibility, Masculinity, and CRC Screening

Within the traditional, hegemonic notion of masculinity men are viewed as irresponsible when it comes to their own health and reluctant to engage in preventative health behaviors (Courtenay, 2003). Not seeking help for health problems or engaging in preventative health care is a means by which "men actively reconstruct a dominant masculinity that positions men as unconcerned about their health and as more powerful, more resilient and less vulnerable than women" (Richardson, 2010, p. 420). By contrast, the men in our study engaged in preventative health care described earlier, underpinned by the importance of taking personal responsibility for their health and demonstrating their adoption of neoliberal governmentality. As discussed earlier *responsibilization*, understood as the "self-management of risk by the autonomous individual" (Liebenberg et al., 2013, p. 3), is a key feature of neoliberalism. By taking responsibility for one's own health, individuals can demonstrate that they are good neoliberal citizens (Rose, 1999).

For example, one participant stated that being healthy is "a responsibility we all have" (S, 50–54). Another stated, when discussing his "regular 12 month appointment . . . for prostate and test the cholesterol and other kinds of things that you need to know about, [that] I look after myself as far as that situation's concerned" (S, PS, 55–59). One participant (English was his second language) discussed the need to screen in terms of being responsible (staying safe) as follows:

But I need to [screen]. One thing is very clear, I need to do . . . I don't have any choice. I think everyone, I mean in this part of this stage of

their life, we need to do. And we don't have any options. We need to do. Being in the safe way. (PS, 55–59)

Other comments included, "Well it's good to look after your own life, we have to keep checking on everything" (PS, 70–74); "I believe that if I don't do something for myself, I can't expect everybody to nursemaid me through life" (S, PS, 65–69).

For some men taking responsibility was also about responsibility to others. This included statements such as, "Apart from being very good for the person when it's detected, it's also very good as a community to . . . maximize the effectiveness while minimizing the cost of health" (PS, 65–69). Thus the men were able to construct themselves as responsible neoliberal citizens through screening for CRC. Taking responsibility for health within neoliberalism involves managing risk. This also was discussed by the participants, and is explored below in relation to risk and hegemonic masculinity.

Risk, Masculinity, and CRC Screening

The concept of risk has been extensively discussed as a defining feature of late modern societies. Theorists such as Beck (1992) and Giddens (1991) were particularly influential in this debate and argued that the modern world was experienced as a threatening place filled with a wide range of risks (understood as "bad") that needed to be managed. Yet as researchers such as Lupton and Tulloch (2002) identified in a study of risk perceptions, the understanding of risk as negative and to be managed and avoided was not ubiquitous; instead some of their participants discussed the importance of risk taking. This is certainly the case in much of the research exploring hegemonic masculinity in which men are traditionally understood to be risk takers, and where engaging in risky activities is central to proving their strength and differentiating themselves from the feminine (Christy et al., 2014). Such risk taking extends to a lack of interest in risk management through prohealth behaviors such as cancer screening.

Recent research has explored risk and masculinity in relation to CRC screening and suggested that "The risk-taking masculinity norm, along with other masculinity norms, may be inversely related to CRC screening due to a lack of perceived risk of CRC" (Christy et al., 2014, p. 58). The men in our study both undertook screening and articulated an at-risk subject position (i.e., they identified themselves as being at-risk of being diagnosed with CRC or other health problems). Perceptions of risk in relation to masculinity are contextual and individually interpreted. Richardson (2010), for example, in his interviews with Irish men between 18 and 71 years, found that the need to preserve and protect one's health "seemed to be mediated by a heightened awareness among men, as they got older, that health was not a bottomless reservoir, and needed to be managed and maintained through appropriate health behaviors" (p. 424).

The men in our study were all between 50 and 74 years. As with Richardson's (2010) findings, getting older signified a self-reported change in the men's perceptions about their vulnerability: "you never used to think about stuff like that [illness]. You were going to live for the rest of your life" (S, PS, 50–54). This can be seen in the following discussion.

Participant [I thought] I should do this [screen for CRC]. But I think that's mainly to do with age.

Interviewer So you don't think you would have when you were younger?

Participant Oh, definitely not. No. . . . I mean, as I get older of course, anything can strike me. I realize this. (S, PS, 70–74)

Thus ageing signified a shift in their masculinity from not caring about their health and feeling like they were going to live forever, to taking preventative action to ensure their longevity:

This is all related to being very conscious of the age that I'm at and, you know, yeah, I can't move as quickly as I used to. And so therefore you just need to be cognizant of that and take preventative steps to ensure that your longevity continues. (S, PS, 55–59)

Another aspect of ageing that led to the men viewing themselves as being at risk was being in a community of older people who are experiencing cancer and other health problems. This created an awareness of their vulnerability to health problems.

In addition to age, and often associated with ageing, health problems affected the men's perceptions of being at-risk and influenced their decision to undergo screening. For example, some men had decided to screen because they had noticed symptoms that could be indicative of CRC: "I'd had a bit of blood in my [stool], so that really prompted me to do it [test for CRC]" (PS, 50–54). For another, the influence of his diagnosis of prostate cancer highlighted the importance of screening for CRC to "clear cancer in the bowel area at least" (S, PS, 60–64).

General awareness of cancer and cancer risk also influenced men's decisions to screen for CRC. When there was a family history of bowel and other cancers the men were more likely to view themselves as being at-risk and hence undergo screening. In addition, knowing other people with cancer and an increased societal awareness of cancer also supported men's views that they are at-risk of cancer, and that screening is necessary to decrease risk. This at-risk subject position led the men to decide to "do something proactive about it" (S, PS, 50–59) and undergo screening. Screening is therefore a mechanism of self-governance by which the men manage perceived risks to their health in accordance with information about CRC and other age-related risks.

Rationality, Masculinity, and CRC Screening

Within neoliberalism, individuals are "increasingly required to invest in prudent strategies for risk management in order to maintain their own well-being" (Crawshaw, 2007, p. 1609). The men articulated this prudentialism in relation to their self-reported change in risk perception with ageing: "You know I was of an age where it's prudent to keep an eye out for these [health problems]" (PS, 65–69). Such prudentialism was associated with rationality, expressed in terms of the decision to screen for CRC being a sensible decision. Their discussions demonstrated the way in which the traditionally masculine trait of rationality has been transformed in relation to their decision to screen for CRC.

When articulating their reasons for screening (and for many of the men who had not screened within the RCT, the reasons why they should continue to screen on a regular basis), screening for colorectal cancer was described as a sensible decision to address CRC risk.

I think as a reasonably intelligent and literate man, the importance of not sweeping these things under the rug and sort of going ahead with the, with what needs to be done so, it's just sort of a, I should imagine a sensible decision to proceed with it. (PS, 60–64)

The view that screening is a sensible decision was articulated in terms of the pros and cons of screening. One of the main pros of screening for CRC through the RCT and through the national screening program was that the tests are free and can be done at home. Furthermore, the FOBT was viewed as a noninvasive screening method when compared to other methods of CRC screening such as a colonoscopy, "One is slightly less intrusive than the other, so that's the basis of going along with the [FOBT], it's the easy option" (PS, 65–69). The FOBT also was considered to be low risk and effective. Within this context it made sense for the men to take action and do the test. Being sensible and deciding to screen for CRC was also discussed in terms of the screening process of the FOBT, which was predominantly described as easy ("a piece of cake"; S, 60–64) and worth any unpleasantness associated with collecting stool samples, "For a lot of people it's, what's the word, it's not a very nice thing to do yourself but it's got to be done" (S, PS, 70–74).

By representing the decision to screen for CRC as sensible, the men were able to represent themselves as rational men investing in their health and their future, "So I mean at the moment we're still paying for [the test through private health insurance] but I still think it's one of the best investments I ever do" (S, 60–64). Being sensible and screening for CRC was analogous to servicing a car, "if you have something wrong in the car you leave it it's going to get worse" (PS, 70–74). One of the men who had not returned his FOBT for the RCT described his decision as "stupid really on reflection because your health is major" (PS, 55–59). This construction of screening as a sensible decision, and of men who screen as being sensible and investing in their future, is consistent with the view of individuals as rational actors in a neoliberal form of market governance (Esposito & Perez, 2014).

Control, Masculinity, and CRC Screening

In addition to being a sensible means of addressing CRC risk, the decision to screen for CRC also was presented as a means for participants to take control of their health and health care decision making, "It's [health] something that I need to take charge of" (S, 50–54). Being in control is another traditionally masculine trait that has been transformed in the men's discussions of CRC screening. Traditionally, men are viewed as being in control, particularly in terms of having bodily control such as not crying or otherwise indicating pain, and making independent choices (Calasanti et al., 2013). Although help-seeking has been identified as threatening men's sense of control over their well-being (Kaye, Crittenden, & Charland, 2008), our participants discussed help-seeking (in this case for health care and screening) as a way of taking control of their health. This is a reflective of a shift in neoliberalism from the passivity of patient treatment to active clients who are in control of their health and health care decisions (Liebenberg et al., 2013).

The importance of being in control was seen in participants' discussion of the influence of others on their decision making, in which screening was largely described as an independent choice and not influenced by others. When discussing screening as a personal decision the men described the process as being "all about

me . . . by doing the testing it's not gonna harm me by doing it, it's only gonna enhance my life hopefully" (S, PS, 50–54). As one man put it, rather than being a decision that other people make for him, "it's more the case of making sure I'm on top of the changes in my body" (S, PS, 55–59). Another man stated: "if other people talk to me about various different things I certainly listen, but it doesn't really influence me one way or another" (S, PS, 65–69).

Although the men were generally quite adamant that the decision to screen was made independently of others, the decision occasionally involved some influence from partners/spouses and health professionals. This was usually in relation to the initial introduction to the notion of screening by a doctor or a spouse.

Well several years ago my doctor suggested that I just get screened for bowel cancer on a yearly basis, just as a purely precautionary measure because this is probably coming up to the danger period when I was sort of over 50, and so I've been getting it done ever since. (S, PS, 55–59)

Ultimately, however, the participants noted that advice was listened to only if the person giving the advice was considered knowledgeable (particularly GPs), with the final decision being in the participant's control. This demonstrates how the participants are operating within neoliberal governmentality as autonomous and self-governing in accordance with the information and advice of experts.

The importance of taking and being in control was also seen in participants' discussion of how they would, did, or should respond to the test results. For some men the negative result they received from the test (negative for blood in the stool) provided them with a feeling of relief and that they are clear of CRC risk, at least until the next test is due. When discussing the possibility of a positive result (positive for blood) the men expressed the view that they would take control and "deal with it." "I've got to deal with this. Let's get this underway, dealt with and then we'll go to the next step. That's how I think I would have handled it" (PS, 65–69). Furthermore, they expressed the view that it is important "to know either way" (S, PS, 70–74) so they could take active steps and be in control of the outcome.

As Kemshall (2010) discussed, "to be prudential, one has to have an agentic, nonfatalistic attitude to the future . . . in effect, believe in one's power to choose and self-efficacy" (p. 1253). Previous research into men's health behavior has identified "macho fatalistic risk taking" (Skovdal et al., 2011, p. 8) as a barrier to men's use of health services. The men in this study viewed themselves as agentic and in control; by contrast, they viewed other men who choose not to screen as risk takers who gamble irresponsibly with their health. This is discussed further in the following section.

Comparison to Others

The performance of their masculinity through the discourses of responsibility, risk, rationality, and control was most evident when the men compared their behaviors or decisions to those of other men. The men were often surprised to hear that the rate of uptake of screening for CRC by men is so low (32.5% in the Australian national screening program; Australian Institute of Health and Welfare, 2013), particularly given the at-risk age group and the fact that the FOBT is free, easy, and sent to their home. To explain

the discrepancy between their decision to screen and other men's decision not to screen, these other men were described as irresponsible, afraid, and failing to take proactive action with regard to their health. Within neoliberal governmentality, individuals who behave in a way that puts them at risk can be ranked as bad, whereas those who take responsibility for managing risk are ranked as good (LeBesco, 2011). This type of moral judgment was evident in the men's discussion of nonscreeners.

In the following quote the participant makes an analogy to Russian roulette, a dangerous game of chance, in the decision not to screen.

But obviously there's a real issue out there with males. . . . It's like a game of Russian roulette sort of. . . . And then they wonder why when it's too far down the track, you know? They should have done something sooner. (S, PS, 55–59)

The view that other men are afraid to find out the results of the test can be seen in the following quote.

And so I think they're frightened of the result, might be bad, so they just kind of like, I mean I probably would have been like that years ago. I think I'd have been "I don't want to know if it's bad." So yeah, some people go along, men a bit . . . more so like that than women I think. (S, 65–69)

In addition, men who choose not to screen for CRC were described as stoic and not proactive about their health.

And I mean there's probably hundreds of thousands of people . . . that couldn't be bothered. . . . Especially men. And I know, you know, me being a man, I suppose I don't adopt that [view]. . . . You know it's "go to the doctor," "No, I'm all right. I'm right." That's what men are like. (S, PS, 50–54)

As these quotes suggest, the men situate themselves as different to these other men.

These descriptions of other men are reflective of the general societal view of men as irresponsible, stoic, and not caring about their health discussed in the literature. This can also be seen in discussions about how to get these other men to participate in screening. In particular, they were seen as needing confrontational messages and "shock" tactics (S, PS, 55–59) rather than detailed, informational messages:

So what they need to do is make it a bit more "blokesy," an ad that's got a grab to it. . . . I mean they're too much into the facts and figures as far as the thing's [advertising] concerned and not enough into what's going to captivate blokes to say, "Hey I need to look into this a bit more." (S, PS, 55–59)

The term *bloke* is an Australian term for a *macho* man. Such a macho attitude to health care was articulated in a negative way by the participants, indicating their adoption of neoliberal governmentality through the importance of taking personal responsibility to self-manage the risks to their health. By contrasting their decisions to those of irresponsible risk takers, the men were able to establish themselves good neoliberal citizens.

Discussion

This study supports existing research into the psychology of men's health that reports that men can and do attend to their health (Calasanti

et al., 2013; Gough, 2013; Sloan et al., 2010; Smith et al., 2008). The men in this study participated in screening for CRC, either through the RCT or through previous screening programs, and many of them can be described as having a preventative health orientation, including annual visits to the GP, healthy eating, and exercise. This is in contrast to the common understanding that men (at least in Western cultures) typically engage in risky behavior, do not attend to their health care needs, and refuse participation in health prevention programs (Courtenay, 2000). Previous research on men and CRC screening supports the traditional view of men as stoic and failing to take care of their health (Molina-Barceló et al., 2011; Thompson et al., 2012). Our findings reflect the predominance of screeners self-selecting to participate in the interviews. Despite this limitation, however, the study offers an important insight into the views of men who do take part in health prevention programs.

As discussed elsewhere (Dolan & Coe, 2011; Robertson, 2006; Thompson et al., 2012), being concerned with health and well-being does not mean the abandonment of hegemonic masculinity. Instead, the findings of this study demonstrate how the men discussed screening for CRC in terms of masculine ideals of risk, rationality, and control, reformulating these ideals in relation to health care by drawing on contemporary neoliberal discourses of the informed, responsible health consumer. Within this cultural context, control over health and taking responsibility for health care have emerged as new hegemonic ideals by which men are able to “do gender” in relation to health (Robertson, 2006), or in fact as ways of enacting traditional masculine ideals such as independence and control (Sloan et al., 2010). In particular, the men described themselves as being at-risk (rather than risk-takers), and as sensible and responsible men who take control of their health. This was in contrast to other (nonscreening) men who were viewed as irresponsible risk takers who were fearful of the test results and who would regret their decision not to screen. Thus the men were able to construct themselves as good neoliberal citizens, while still maintaining their masculinity.

Another area where the notion of doing gender in contemporaneous contexts is of particular relevance to screening for CRC is the relationship between ageing, health, and masculinity. The men in our study ranged in age from 50 to 74 years. According to Connell and Messerschmidt (2005), masculinities are “configurations of practice that are constructed, unfold, and change through time” (p. 852). Thus we can expect that older men would draw on different hegemonic masculinities than they may have done when younger; in fact the men themselves discussed this shift toward an increased focus on taking control over and being responsible for their health as they aged. According to Tannenbaum and Frank (2011), by “engaging in proactive behavior to improve their health, men show that they can still be in control” (p. 247; see also Backett & Davison, 1995; Calasanti et al., 2013; Gibbs, 2008; Grzywacz et al., 2012; Oliffe, 2009; Sloan et al., 2010; Smith, Braunack-Mayer, Wittert, & Warin, 2007). Engaging in screening for CRC is therefore a way for older men to reinterpret masculinities and provides them with an opportunity “for constructing autonomous, rational and controlled masculine identities” (Calasanti et al., 2013, p. 22). For the men in this study, getting older led to the emergence of an at-risk subject position, in which the men described themselves as being at increased risk of health problem as they age. This necessitated a reconstruction of their masculinity; presenting themselves as being sensible, responsible, and in control were the central tenets by which they achieved this.

As discussed previously, there is increasing recognition of the heterogeneity of masculinity (Connell & Messerschmidt, 2005). However, the men in our study were fairly homogenous in the ways in which they discussed screening for CRC and other health behaviors. This is likely due to the self-selection of men who are supportive of participating in health care activities, such as screening for CRC, into the study. However, the study does demonstrate heterogeneity by discussing men who do attend to their health in contrast to the general view that men are predominantly risk takers who do not seek help or participate in preventative health care. Future research exploring CRC screening and masculinity in a greater diversity of men (e.g., ethnicity, class, age) would be useful. For example, Farrimond (2012) questioned whether taking control and being an “action man” in relation to help-seeking “may be a role only afforded to those middle-class men with the time, money and social status to ‘take control’ of their health” (p. 222).

Current debates within men’s health promotion, including screening for cancers such as CRC, tend to focus on the negative effects of hegemonic masculine traits on men’s behavior (Molina-Barceló et al., 2011; Smith, 2007). Yet as this study demonstrated, masculinity is not necessarily defined by health-damaging traits. Although masculine traits such as stoicism and risk taking do influence men in their decision not to screen for CRC (as demonstrated by Thompson et al., 2012, see also Molina-Barceló et al., 2011), men can and do attend to their health, including making the decision to screen for CRC, without undermining or negating their masculinity. This study offers an important insight into the relationship between masculinity, neoliberalism, and screening for CRC, namely the role of discourses of responsibility, risk, rationality, and control in allowing the participating men to maintain their masculine identities while screening for CRC. Incorporating such an understanding of masculinity into men’s health promotion more generally is crucial for advancing policy and practice (Smith, 2007; Smith et al., 2008). Screening programs, too, may benefit from an understanding of the heterogeneity of men as they enact masculinity in relation to screening for CRC (Thompson et al., 2012).

References

- Ananthakrishnan, A. N., Schellhase, K. G., Sparapani, R. A., Laud, P. W., & Neuner, J. M. (2007). Disparities in colon cancer screening in the Medicare population. *Archives of Internal Medicine*, 167, 258–264. <http://dx.doi.org/10.1001/archinte.167.3.258>
- Australian Institute of Health and Welfare. (2013). *National bowel cancer screening program monitoring report: July 2011–June 2012* (Cancer series no. 75, Cat. no. 71). Canberra, Australia: Author.
- Autier, P., Ouakrim, D. A., Malvezzi, M., Bleiberg, H., Jenkins, M., Boniol, K., & Negri, D. (2013, September). *Trends in colorectal cancer mortality and screening activities in European countries*. Paper presented at the European Cancer Congress, Amsterdam, The Netherlands.
- Backett, K. C., & Davison, C. (1995). Lifecourse and lifestyle: The social and cultural location of health behaviours. *Social Science & Medicine*, 40, 629–638. [http://dx.doi.org/10.1016/0277-9536\(95\)80007-7](http://dx.doi.org/10.1016/0277-9536(95)80007-7)
- Barford, A., Dorling, D., Davey Smith, G., & Shaw, M. (2006). Life expectancy: Women now on top everywhere. *British Medical Journal*, 332, 808. <http://dx.doi.org/10.1136/bmj.332.7545.808>
- Beck, U. (1992). *Risk society: Towards a new modernity*. London, England: Sage.
- Benoit, C., Zadoroznyj, M., Hallgrimsdottir, H., Treloar, A., & Taylor, K. (2010). Medical dominance and neoliberalisation in maternal care provi-

- sion: The evidence from Canada and Australia. *Social Science & Medicine*, 71, 475–481. <http://dx.doi.org/10.1016/j.socscimed.2010.04.005>
- Boman, E. K. O., & Walker, G. A. (2010). Predictors of men's health care utilization. *Psychology of Men & Masculinity*, 11, 113–122. <http://dx.doi.org/10.1037/a0018461>
- Borrell, J. (2008). A thematic analysis identifying concepts of problem gambling agency: With preliminary exploration of discourses in selected industry and research documents. *Journal of Gambling Issues*, 22, 195–218. <http://dx.doi.org/10.4309/jgi.2008.22.4>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77–101. <http://dx.doi.org/10.1191/1478088706qp0630a>
- Broom, A., Meurk, C., Adams, J., & Sibbritt, D. (2012). My health, my responsibility? Complementary medicine and self (health) care. *Journal of Sociology*. Advance online publication. <http://dx.doi.org/10.1177/1440783312467098>
- Buckley, J., & Tuama, S. O. (2010). "I send the wife to the doctor"—Men's behaviour as health consumers. *International Journal of Consumer Studies*, 34, 587–595. <http://dx.doi.org/10.1111/j.1470-6431.2010.00908.x>
- Calasanti, T., Pietilä, I., Ojala, H., & King, N. (2013). Men, bodily control, and health behaviors: The importance of age. *Health Psychology*, 32, 15–23. <http://dx.doi.org/10.1037/a0029300>
- Carey, G., Riley, T., & Crammond, B. (2012). The Australian government's "social inclusion agenda": The intersection between public health and social policy. *Critical Public Health*, 22, 47–59. <http://dx.doi.org/10.1080/09581596.2011.559535>
- Chapple, A., Ziebland, S., & McPherson, A. (2004). Qualitative study of men's perceptions of why treatment delays occur in the UK for those with testicular cancer. *The British Journal of General Practice*, 54, 25–32.
- Christy, S. M., Mosher, C. E., & Rawl, S. M. (2014). Integrating men's health and masculinity theories to explain colorectal cancer screening behavior. *American Journal of Men's Health*, 8, 54–65. <http://dx.doi.org/10.1177/1557988313492171>
- Connell, R. W., & Messerschmidt, J. W. (2005). Hegemonic masculinity: Rethinking the concept. *Gender & Society*, 19, 829–859. <http://dx.doi.org/10.1177/0891243205278639>
- Courtenay, W. H. (2000). Constructions of masculinity and their influence on men's well-being: A theory of gender and health. *Social Science & Medicine*, 50, 1385–1401. [http://dx.doi.org/10.1016/S0277-9536\(99\)00390-1](http://dx.doi.org/10.1016/S0277-9536(99)00390-1)
- Courtenay, W. H. (2003). Key determinants of the health and well-being of men and boys. *International Journal of Men's Health*, 2, 1–30. <http://dx.doi.org/10.3149/jmh.0201.1>
- Courtenay, W. (2004). Making health manly: Social marketing and men's health. *Journal of Men's Health & Gender*, 1(2–3), 275–276. <http://dx.doi.org/10.1016/j.jmhg.2004.07.027>
- Crawshaw, P. (2007). Governing the healthy male citizen: Men, masculinity and popular health in *Men's Health* magazine. *Social Science & Medicine*, 65, 1606–1618. <http://dx.doi.org/10.1016/j.socscimed.2007.05.026>
- Davis, J. L., Buchanan, K. L., Katz, R. V., & Green, B. L. (2012). Gender differences in cancer screening beliefs, behaviors, and willingness to participate: Implications for health promotion. *American Journal of Men's Health*, 6, 211–217. <http://dx.doi.org/10.1177/1557988311425853>
- Dedoose. (2012). *Web application for managing, analyzing, and presenting qualitative and mixed method data, Version 4.3.86 (Computer software)*. Los Angeles, CA: SocioCultural Research Consultants. Retrieved from <http://www.dedoose.com>
- Deleuze, G. (1999). *Foucault*. London, England: Continuum.
- de Visser, R. O., & McDonnell, E. J. (2013). "Man points": Masculine capital and young men's health. *Health Psychology*, 32, 5–14. <http://dx.doi.org/10.1037/a0029045>
- Dolan, A., & Coe, C. (2011). Men, masculine identities and childbirth. *Sociology of Health & Illness*, 33, 1019–1034. <http://dx.doi.org/10.1111/j.1467-9566.2011.01349.x>
- Duncan, A., Zajac, I., Flight, I., Stewart, B. J., Wilson, C., & Turnbull, D. (2013). Comparison of mailed invitation strategies to improve fecal occult blood test participation in men: Protocol for a randomized controlled trial. *Trials*, 14, 239. <http://dx.doi.org/10.1186/1745-6215-14-239>
- Eisler, R. M., & Skidmore, J. R. (1987). Masculine gender role stress. *Scale development and component factors in the appraisal of stressful situations. Behavior Modification*, 11, 123–136. <http://dx.doi.org/10.1177/01454455870112001>
- Emslie, C., & Hunt, K. (2009). Men, masculinities and heart disease: A systematic review of the qualitative literature. *Current Sociology*, 57, 155–191. <http://dx.doi.org/10.1177/0011392108099161>
- Esposito, L., & Perez, F. M. (2014). Neoliberalism and the commodification of mental health. *Humanity & Society*. Advance online publication. <http://dx.doi.org/10.1177/0160597614544958>
- Farrimond, H. (2012). Beyond the caveman: Rethinking masculinity in relation to men's help-seeking. *Health*, 16, 208–225. <http://dx.doi.org/10.1177/1363459311403943>
- Foucault, M. (1972). *The archaeology of knowledge*. London, England: Routledge.
- Frederiksen, B. L., Jørgensen, T., Brasso, K., Holten, I., & Osler, M. (2010). Socioeconomic position and participation in colorectal cancer screening. *British Journal of Cancer*, 103, 1496–1501. <http://dx.doi.org/10.1038/sj.bjc.6605962>
- Friedemann-Sánchez, G., Griffin, J. M., & Partin, M. R. (2007). Gender differences in colorectal cancer screening barriers and information needs. *Health Expectations*, 10, 148–160. <http://dx.doi.org/10.1111/j.1369-7625.2006.00430.x>
- Galdas, P. M., Cheater, F., & Marshall, P. (2005). Men and health help-seeking behaviour: Literature review. *Journal of Advanced Nursing*, 49, 616–623. <http://dx.doi.org/10.1111/j.1365-2648.2004.03331.x>
- George, A., & Fleming, P. (2004). Factors affecting men's help-seeking in the early detection of prostate cancer: Implications for health promotion. *Journal of Men's Health & Gender*, 1, 345–352. <http://dx.doi.org/10.1016/j.jmhg.2004.10.009>
- Gibbs, L. (2008). Men and chronic arthritis: Does age make men more likely to use self-management services? *Generations*, 32, 78–81.
- Giddens, A. (1991). *Modernity and self-identity*. Cambridge, England: Polity.
- Gough, B. (2013). The psychology of men's health: Maximizing masculine capital. *Health Psychology*, 32, 1–4. <http://dx.doi.org/10.1037/a0030424>
- Grbich, C. (1999). *Qualitative research in health: An introduction*. New South Wales, Australia: Allen and Unwin.
- Grzywacz, J. G., Stoller, E. P., Brewer-Lowry, A. N., Bell, R. A., Quandt, S. A., & Arcury, T. A. (2012). Gender and health lifestyle: An in-depth exploration of self-care activities in later life. *Health Education & Behavior*, 39, 332–340. <http://dx.doi.org/10.1177/1090198111405195>
- Henderson, J. (2007). The National Mental Health Strategy: Redefining promotion and prevention in mental health? *Australian Journal of Primary Health*, 13, 77–84. <http://dx.doi.org/10.1071/PY07041>
- Hewitson, P., Glasziou, P., Watson, E., Towler, B., & Irwig, L. (2008). Cochrane systematic review of colorectal cancer screening using the fecal occult blood test (hemoccult): An update. *The American Journal of Gastroenterology*, 103, 1541–1549. <http://dx.doi.org/10.1111/j.1572-0241.2008.01875.x>
- Javanparast, S., Ward, P. R., Cole, S., Gill, T., Matt, M. A., Aylward, P., . . . Young, G. (2010). A cross-sectional analysis of participation in National Bowel Cancer Screening Program in Adelaide by age, gender and geographical location of residence. *Australasian Medical Journal*, 1, 141–146. <http://dx.doi.org/10.4066/AMJ.2010.198>

- Jemal, A., Bray, F., Center, M. M., Ferlay, J., Ward, E., & Forman, D. (2011). Global cancer statistics. *A Cancer Journal for Clinicians*, 61, 69–90.
- Jemal, A., Siegel, R., Xu, J., & Ward, E. (2010). Cancer statistics, 2010. *A Cancer Journal for Clinicians*, 60, 277–300.
- Kaye, L., Crittenden, J., & Charland, J. (2008). Invisible older men: What we know about older men's use of healthcare and social services. *Generations*, 32, 9–14.
- Kemshall, H. (2010). Risk rationalities in contemporary social work policy and practice. *British Journal of Social Work*, 40, 1247–1262. <http://dx.doi.org/10.1093/bjsw/bcp157>
- LeBesco, K. (2011). Neoliberalism, public health, and the moral perils of fatness. *Critical Public Health*, 21, 153–164. <http://dx.doi.org/10.1080/09581596.2010.529422>
- Liebenberg, L., Ungar, M., & Ikeda, J. (2013). Neo-liberalism and responsibilisation in the discourse of social service workers. *British Journal of Social Work*. Advance online publication. <http://dx.doi.org/10.1093/bjsw/bct172>
- Lupton, D., & Tulloch, J. (2002). "Risk is part of your life": Risk epistemologies among a group of Australian. *Sociology*, 36, 317–334. <http://dx.doi.org/10.1177/0038038502036002005>
- Mahalik, J. R., Levi-Minzi, M., & Walker, G. (2007). Masculinity and health behaviors in Australian men. *Psychology of Men & Masculinity*, 8, 240–249. <http://dx.doi.org/10.1037/1524-9220.8.4.240>
- Molina-Barceló, A., Salas Trejo, D., Peiró-Pérez, R., & Málaga López, A. (2011). To participate or not? Giving voice to gender and socio-economic differences in colorectal cancer screening programmes. *European Journal of Cancer Care*, 20, 669–678. <http://dx.doi.org/10.1111/j.1365-2354.2011.01263.x>
- O'Brien, R., Hunt, K., & Hart, G. (2005). "It's caveman stuff, but that is to a certain extent how guys still operate": Men's accounts of masculinity and help seeking. *Social Science & Medicine*, 61, 503–516. <http://dx.doi.org/10.1016/j.socscimed.2004.12.008>
- Oliffe, J. (2009). Health behaviors, prostate cancer, and masculinities. *Men and Masculinities*, 11, 346–366. <http://dx.doi.org/10.1177/1097184X06298777>
- Petersen, A., & Lupton, D. (1996). *The new public health: Health and self in the age of risk*. London, England: Sage.
- Richardson, N. (2010). "The 'buck' stops with me"—Reconciling men's lay conceptualisations of responsibility for health with men's health policy. *Health Sociology Review*, 19, 419–436. <http://dx.doi.org/10.5172/hesr.2010.19.4.419>
- Ritvo, P., Myers, R. E., Paszat, L., Serenity, M., Perez, D. F., & Rabeneck, L. (2013). Gender differences in attitudes impeding colorectal cancer screening. *BMC Public Health*, 13, 500. <http://dx.doi.org/10.1186/1471-2458-13-500>
- Rivera-Ramos, Z. A., & Buki, L. P. (2011). I will no longer be a man! Manliness and prostate cancer screenings among Latino men. *Psychology of Men & Masculinity*, 12, 13–25. <http://dx.doi.org/10.1037/a0020624>
- Robertson, S. (2006). "Not living life in too much of an excess": Lay men understanding health and well-being. *Health*, 10, 175–189. <http://dx.doi.org/10.1177/1363459306061787>
- Rose, N. (1999). *Powers of freedom: Reframing political thought*. Cambridge, England: Cambridge University Press. <http://dx.doi.org/10.1017/CBO9780511488856>
- Rose, N., & Miller, P. (2010). Political power beyond the state: Problematics of government. 1992. *The British Journal of Sociology*, 61(Suppl. 1), 271–303. <http://dx.doi.org/10.1111/j.1468-4446.2009.01247.x>
- Salomon, J. A., Wang, H., Freeman, M. K., Vos, T., Flaxman, A. D., Lopez, A. D., & Murray, C. J. L. (2012). Healthy life expectancy for 187 countries, 1990–2010: A systematic analysis for the global burden disease study 2010. *Lancet*, 380, 2144–2162. [http://dx.doi.org/10.1016/S0140-6736\(12\)61690-0](http://dx.doi.org/10.1016/S0140-6736(12)61690-0)
- Skovdal, M., Campbell, C., Madanhire, C., Mupambireyi, Z., Nyamukapa, C., & Gregson, S. (2011). Masculinity as a barrier to men's use of HIV services in Zimbabwe. *Globalization and Health*, 7, 1–14. <http://dx.doi.org/10.1186/1744-8603-7-13>
- Sloan, C., Conner, M., & Gough, B. (2014). How does masculinity impact on health? A quantitative study of masculinity and health behavior in a sample of UK men and women. *Psychology of Men & Masculinity*. Advance online publication. <http://dx.doi.org/10.1037/a0037261>
- Sloan, C., Gough, B., & Conner, M. (2010). Healthy masculinities? How ostensibly healthy men talk about lifestyle, health and gender. *Psychology & Health*, 25, 783–803. <http://dx.doi.org/10.1080/08870440902883204>
- Smith, J. A. (2007). Beyond masculine stereotypes: Moving men's health promotion forward in Australia. *Health Promotion Journal of Australia*, 18, 20–25. <http://dx.doi.org/10.1071/HE07020>
- Smith, J. A., Braunack-Mayer, A., Wittert, G., & Warin, M. (2007). "I've been independent for so damn long!": Independence, masculinity and aging in a help seeking context. *Journal of Aging Studies*, 21, 325–335. <http://dx.doi.org/10.1016/j.jaging.2007.05.004>
- Smith, J. A., Braunack-Mayer, A., Wittert, G., & Warin, M. (2008). "It's sort of like being a detective": Understanding how Australian men self-monitor their health prior to seeking help. *BMC Health Services Research*, 8, 56. <http://dx.doi.org/10.1186/1472-6963-8-56>
- Spence, J. T., & Helmreich, R. L. (1978). *Masculinity and femininity: Their psychological dimensions, correlates and antecedents*. Austin, TX: University of Texas Press.
- Tannenbaum, C., & Frank, B. (2011). Masculinity and health in late life men. *American Journal of Men's Health*, 5, 243–254. <http://dx.doi.org/10.1177/1557988310384609>
- Thompson, L., Reeder, T., & Abel, G. (2012). I can't get my husband to go and have a colonoscopy: Gender and screening for colorectal cancer. *Health*, 16, 235–249. <http://dx.doi.org/10.1177/1363459311403948>
- Thompson, E. H., & Pleck, J. H. (1986). The structure of male role norms. *American Behavioral Scientist*, 29, 531–543. <http://dx.doi.org/10.1177/000276486029005003>
- von Wagner, C., Baio, G., Raine, R., Snowball, J., Morris, S., Atkin, W., . . . Wardle, J. (2011). Inequalities in participation in an organized national colorectal cancer screening programme: Results from the first 2.6 million invitations in England. *International Journal of Epidemiology*, 40, 712–718. <http://dx.doi.org/10.1093/ije/dyr008>
- Wallace, P. M., & Suzuki, R. (2012). Regional, racial, and gender differences in colorectal cancer screening in middle-aged African-Americans and Whites. *Journal of Cancer Education*, 27, 703–708. <http://dx.doi.org/10.1007/s13187-012-0396-2>
- Ward, P. R., Javanparast, S., Matt, M. A., Martini, A., Tsourtos, G., Cole, S., . . . Young, G. (2011). Equity of colorectal cancer screening: Cross-sectional analysis of National Bowel Cancer Screening Program data for South Australia. *Australian and New Zealand Journal of Public Health*, 35, 61–65. <http://dx.doi.org/10.1111/j.1753-6405.2010.00637.x>
- Winterich, J. A., Quandt, S. A., Grzywacz, J. G., Clark, P., Dignan, M., Stewart, J. H., & Arcury, T. A. (2011). Men's knowledge and beliefs about colorectal cancer and 3 screenings: Education, race, and screening status. *American Journal of Health Behavior*, 35, 525–534. <http://dx.doi.org/10.5993/AJHB.35.5.2>
- Wong, R. K., Wong, M. L., Chan, Y. H., Feng, Z., Wai, C. T., & Yeoh, K. G. (2013). Gender differences in predictors of colorectal cancer screening uptake: A national cross sectional study based on the health belief model. *BMC Public Health*, 13, 677. <http://dx.doi.org/10.1186/1471-2458-13-677>

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