ILKKA PIETILÄ

Between Rocks and Hard Places

Ideological dilemmas in men's talk about health and gender

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ACADEMIC DISSERTATION
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UNIVERSITY OF TAMPERE

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University of Tampere, School of Public Health
Finland

Supervised by
Professor Marja Jylhä
University of Tampere
Docent Pauliina Aarva
University of Tampere

Reviewed by
Professor Jeff Hearn
Swedish School of Economics, Helsinki
University of Linköping, Sweden
Docent Ossi Rahkonen
University of Helsinki

Distribution
Bookshop TAJU
P.O. Box 617
33014 University of Tampere
Finland

Tel. +358 3 3551 6055
Fax +358 3 3551 7685
taju@uta.fi
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Juha Siro

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Sirpa Randell

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To the memory of my grandfathers Eino and Jorma

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According to a Chinese proverb, 'nothing is as important as gardening – and even that isn't always so important'. Getting one's hands dirty with soil may not be crucial for life and happiness, but it certainly eased my mind during my thesis work, especially when making the late amendments to the manuscript. To relax in between work hours, I often took a pause in the garden. While weeding and raking I also enjoyed following the 'research work' of our children – Pihla, Markus and Tom – as they posed, often complex, questions on various topics and explored both big and little life issues. These moments reminded me that there will be plenty to wonder and learn even after the doctoral thesis. To my dear wife Pia, I am deeply grateful for the quiet evenings at home, and especially for times in the garden, when I was able to voice my thoughts out loud, contemplate the problems of writing and receive her personal support as she listened and encouraged me, and gave her sharp-sighted observations and alternate perspectives, particularly on my interpretations of the interviews. Thank you, Pia, for sharing your life with me in the past and in the future.

In Nokia, June 2008

Ilkka Pietilä

SUMMARY

ILKKA PIETILÄ

BETWEEN ROCKS AND HARD PLACES. IDEOLOGICAL DILEMMAS IN MEN'S TALK ABOUT HEALTH AND GENDER.

The starting point of this study is the claim, often expressed in research on men's health, that the traditional models of masculinity, or hegemonic masculinity, conflict with healthy lifestyles and taking care of one's own health. In health research, the assumed conflict has been used as an explanation for men's unhealthier behaviours and lower life-expectancy. Thus, masculinity has been conceptualised as a system of norms and attitudes leading men to risk-taking activities and trivialising of health information. In recent years several, mostly European, researchers have questioned the one-dimensional view of masculinity and health, emphasising two major changes in their interrelations. First, the studies have referred to the changing ideals and flexibility of masculinities in contemporary men's gender-identification. The current cultural models of manhood involve contradictory elements which, according to several empirical studies, lead to negotiations between 'old' and 'new' masculinities for the contextual definitions of maleness. A second major change has been the growing valuation of health. Qualitative studies have shown that modern men are increasingly interested in health issues and enter into negotiations over gendered meanings related to health in diverse interactive situations. The traditional image of men resisting health awareness and healthy lifestyles may thus no longer be a central component of 'hegemonic masculinity'.

The potential conflict between masculinity and health-awareness may be conceptualised as an *ideological dilemma* (Billig et al. 1988). Both masculinity and healthiness of lifestyle are seen as normative and ideological expectations guiding individual action. This study approaches the apparent conflict between masculinity and healthiness from a critical, discursive and research material-based perspective by exploring constructions of masculinity and healthiness as well as their interrelations via thematic interviews with Finnish paper mill workers. Both healthiness and masculinity are understood as sets of discourses, involving conflicting and contrary themes and reproduced and challenged in interaction as part of participants' contextual identity work. The general aim of this study is to analyse the contrary and conflicting themes contained in situational constructions of gender and healthiness in men's interview talk: how the potential tensions, conflicts and dilemmas are presented, negotiated and resolved in interactive situations. The empirical material of the study consists of 14 personal interviews and six focus groups with 23 male, mostly blue collar workers from the paper industry. The interviews are approached from the discourse analytic perspective and, methodologically, the study draws from the tradition of discursive psychology.

The theoretical and methodological approaches of the study are presented in Chapters 1–3. The empirical section begins from Chapter 4 with analysis of the argumentation used by the interviewees to justify their self-ratings of health. The chapter explores the ways in which men define health in the interview context, interpret the causalities of health and illness, and

discuss the potential conflicts involved in assessing their personal health. Chapter 5 examines how health information is discussed in men's interviews, with special attention on how critique is expressed towards health information. It analyses the ways in which the contents and role of health information are interpreted in relation to healthy lifestyle choices, as well as the ideological and contrary themes incorporated in these interpretations. Furthermore, the chapter explores how gendered discourses emerge in health information related discussions. Chapter 6 approaches men's health from a non-individual perspective: the focus of the chapter is on how the gender gap in life-expectancy is explained and, accordingly, on which premises 'men's health' as a social phenomenon is constructed in the interviews. Chapter 7 analyses how healthiness and gendered features are discussed when considering the four central health-related behaviours: physical exercise, diet, alcohol and smoking. Chapter 8 examines how the interviewees evaluate their health-related behaviours as a whole, and how they justify the healthiness of their lifestyle despite certain unhealthy 'transgressions'. In addition, guarding of the 'masculine self' is explored in talk about healthy lifestyles. Chapter 9 summarises the results and presents the conclusions made.

The central characteristics of this interview material turned out to be the men's attempts to present their own lifestyles as healthy, i.e. asserting certain *lifestyle compliance*, and the aspiration to present themselves as rational, health-aware and responsible citizens. The essential discursive practice was to emphasise moderation as the guiding principle of healthy choices. The discourse of healthiness was dominant particularly in those interview contexts where the participants' own personal lives, health and health-related choices were discussed. Other kinds of health-related interpretations, e.g. critical views on health promotion, were most frequently expressed in non-personal contexts. Traditional descriptions of men, including gender relationships and differences, were similarly mainly brought forward in contexts where the accounts were not directly linked to the speaker himself. Both the critical views on health promotion and the gendered interpretations of health were, however, often softened. In my interpretation, this reflects the central position of healthiness and egalitarianism in the Finnish society: it seems inappropriate to express strict views on either theme, particularly to an outside interviewer. In the analyses of the interview materials, systematic differences were also found between the personal interviews and the focus group discussions: the personal interviews were characterised by emphasis of the healthiness of one's own lifestyles and caution in gender-related descriptions, whereas in focus groups there emerged more critical views on e.g. health education but also more traditional conceptions of the relationship between gender and health.

Detailed analysis of the interview materials demonstrated the interview talk about health and gender to incorporate several kinds of contrary interpretations, and that negotiation of these interpretations is a profound element of men's health-related thinking. On the basis of this study it may also be concluded that these working class men have adopted the central messages and discourses of health promotion and health education. The discourse of healthiness dominated the interviews over 'Real Man' interpretations. Thus the idea of conflict between masculinity and healthy lifestyle turns out to be a black-and-white interpretation, which fails to reach the diversity and contextual variability of men's health-related thinking. The study rather gives reason to believe that health-awareness is gradually becoming one of the central ideals of masculinity and thus a component of today's hegemonic masculinity.

TIIVISTELMÄ

ILKKA PIETILÄ

BETWEEN ROCKS AND HARD PLACES. IDEOLOGICAL DILEMMAS IN MEN'S TALK ABOUT HEALTH AND GENDER.

Tutkimuksen lähtökohtana on miesten terveyttä koskevassa tutkimuksessa usein esitetty väite, jonka mukaan perinteinen miehen malli, tai hegemoninen maskuliinisuus, ovat ristiriidassa terveydestä huolehtimisen ja terveellisten elintapojen kanssa. Terveystutkimuksessa tätä oletettua ristiriitaa on usein käytetty selityksenä miesten epäterveellisille elintavoille ja miesten alhaisemmalle eliniälle. Maskuliinisuus on siis ymmärretty normien ja asenteiden järjestelmänä, joka johtaa miehet riskinottoon ja terveystiedon vähättelyyn. Viime vuosina useat, erityisesti eurooppalaiset, tutkijat ovat kyseenalaistaneet yksipuolisen näkemyksen maskuliinisuudesta ja terveydestä ja korostaneet kahta merkittävää muutosta näiden välisessä suhteessa. Tutkimuksissa on yhtäältä viitattu muutoksiin maskuliinisuuksien malleissa sekä nykymiesten itsemäärittelyn joustavuuteen. Nykyiset miehisyyden kulttuuriset mallit sisältävät ristiriitaisia elementtejä, jotka useiden empiiristen tutkimusten mukaan johtavat neuvotteluun uusien ja vanhojen ideaalien välillä miehisyyden tilannekohtaisissa määrittelyissä. Toinen merkittävä muutos on terveyden arvostuksen kasvu. Laadullisissa tutkimuksissa on todettu, että nykymiehet ovat kasvavassa määrin kiinnostuneita terveysasioista ja käyvät terveyteen liittyvistä sukupuolittuneista merkityksistä neuvottelua erilaisissa vuorovaikutustilanteissa. Perinteinen näkemys miehistä terveystietoisuuden ja terveellisten elintapojen vastustajina ei välttämättä enää ole keskeinen osa 'hegemonista maskuliinisuutta'.

Maskuliinisuuden ja terveystietoisuuden välistä potentiaalista konfliktia voidaan tarkastella *ideologisen dilemman* (Billig ym. 1988) käsitteen avulla. Sekä maskuliinisuus että elintapojen terveellisyys nähdään tällöin normatiivisina ja ideologisina yksilön toimintaa ohjaavina odotuksina. Tämä tutkimus lähestyy oletettua maskuliinisuuden ja terveellisyyden välistä ristiriitaa kriittisestä, diskursiivisesta ja aineistolähtöisestä näkökulmasta ja tarkastelee maskuliinisuuden ja terveellisyyden rakentumista sekä niiden keskinäisiä suhteita suomalaisten paperimiesten teemahaastatteluissa. Maskuliinisuus ja terveellisyys ymmärretään ristiriitaisia ja vastakkaisia teemoja sisältävinä diskursseina, joita uusinnetaan ja haastetaan vuorovaikutuksessa osana osallistujien tilannekohtaista identiteettityötä. Tutkimuksen yleisenä tavoitteena on analysoida sukupuolen ja terveellisyyden konstruktioihin sisältyviä ristiriitaisia teemoja miesten haastattelupuheessa: miten mahdolliset jännitteet, ristiriidat ja dilemmat esitetään, millaista neuvottelua niistä käydään ja miten ne ratkaistaan vuorovaikutustilanteessa. Tutkimuksen empiirinen aineisto koostuu paperiteollisuuden miestyöntekijöiden 14 yksilöhaastattelusta ja 6 fokusryhmäkeskustelusta, joissa oli yhteensä 23 osallistujaa. Haastattelupuhetta tarkastellaan diskurssianalyysin keinoin ja tutkimus sijoittuu menetelmällisesti ns. diskursiivisen sosiaalipsykologian traditioon.

Tutkimuksen teoreettiset ja metodologiset lähtökohdat esitellään luvuissa 1–3. Empiirinen osuus alkaa luvusta 4 jossa analysoidaan haastateltavien itsearvioitua terveyttä koskevaa argumentaatiota. Luvussa tarkastellaan miten miehet määrittelevät terveyttä haastattelutilanteessa, tulkitsevat terveyden ja sairauden syy-seuraussuhteita sekä käsittelevät oman terveyden arvioin-

tiin potentiaalisesti sisältyviä ristiriitaisia ajatuksia. Luku 5 keskittyy terveysinformaation käsittelyyn miesten haastatteluissa, erityisesti terveystietoa kohtaan esitettyyn kritiikkiin. Luvussa tarkastellaan miten terveystiedon sisältöä ja merkitystä arvioidaan suhteessa terveellisiä elintapoja koskeviin valintoihin sekä näihin tulkintoihin sisältyviä ideologisia ja ristiriitaisia teemoja. Lisäksi luvussa tutkitaan terveystiedon pohdinnoissa esiintyviä sukupuolittuneita diskursseja. Luku 6 lähestyy miesten terveyttä ei-yksilöllisestä näkökulmasta: luvussa keskitytään haastateltavien elinajanodotteen sukupuolierolle antamiin selityksiin sekä millaisille ennakko-oletuksille 'miesten terveys' yhteiskunnallisena ilmiönä haastatteluissa rakentuu. Luvussa 7 tutkitaan millaisina terveellisyys ja sukupuoli näyttäytyvät neljästä keskeisimmästä terveystavasta (liikunta, ravitsemus, alkoholinkäyttö ja tupakointi) keskusteltaessa. Luvussa 8 analysoidaan millä tavoin haastateltavat arvioivat elintapojaan kokonaisuutena ja perustelevat niiden terveellisyyttä tietyistä epäterveellisistä poikkeuksista huolimatta. Lisäksi tarkastellaan 'maskuliinisen minän' puolustamista elintavoista puhuttaessa. Luku 9 kokoaa analyysien tulokset ja niiden pohjalta tehdyt päätelmät.

Miesten haastatteluaineiston keskeiseksi piirteeksi osoittautuivat miesten pyrkimys esittää omat elintapansa terveellisiksi, eräänlaisen *elämäntapa-komplianssin* toteennäyttäminen, ja pyrkimys esiintyä haastattelutilanteessa rationaalisena, terveystietoisena ja vastuuntuntoisena kansalaisena. Olennainen diskursiivinen käytäntö oli kohtuullisuuden korostaminen terveysvalintoja ohjaavana periaatteena. Terveellisyysdiskurssi hallitsi erityisesti niissä haastattelukonteksteissa, joissa keskustelu kosketteli haastateltavien henkilökohtaista elämää, terveyttä ja terveyteen liittyviä valintoja. Muunlaisia terveyteen liittyviä tulkintoja, esimerkiksi kriittisiä näkemyksiä terveyden edistämisestä, esitettiin useimmin ei-henkilökohtaisissa konteksteissa. Myös perinteisiä kuvauksia miehistä, ja sukupuolten välisistä suhteista ja eroavaisuuksista, esitettiin pääosin niissä tilanteissa, joissa kuvaukset eivät liittyneet suoraan puhujaan itseensä. Sekä terveyden edistämistä koskevia kriittisiä näkemyksiä että terveyteen liittyviä sukupuolittuneita tulkintoja kuitenkin usein pehmenneltiin. Tulkintani mukaan tämä kuvastaa sekä terveellisyyden että sukupuolten välisen tasa-arvon keskeistä asemaa suomalaisessa yhteiskunnassa: kummastakaan aiheesta ei ole soveliasta esittää jyrkkiä näkemyksiä, varsinkaan ulkopuoliselle haastattelijalle. Haastatteluaineistojen analyyseissä todettiin myös systemaattisia eroja yksilöhaastatteluiden ja ryhmäkeskustelujen välillä: yksilöhaastatteluille oli leimallista omien elintapojen terveellisyyden korostaminen ja sukupuolta koskevien kuvausten varovaisuus kun taas ryhmäkeskusteluissa esiintyi enemmän myös kriittisiä näkemyksiä mm. terveyskasvatuksesta ja perinteisempiä näkemyksiä sukupuolen ja terveyden välisistä suhteista.

Haastatteluaineistojen yksityiskohtainen analyysi toi esiin, että terveyttä ja sukupuolta koskeva haastattelupuhe sisältää monenlaisia vastakkaisia tulkintoja joista käytävä neuvottelu on olennainen osa miesten terveyttä koskevaa ajattelua. Tutkimuksen perusteella voidaan myös todeta, että haastattelemani työväenluokkaiset miehet ovat omaksuneet terveyden edistämisen ja terveyskasvatuksen keskeiset sanomat ja diskurssit. Terveellisyysdiskurssi hallitsi haastatteluita perinteisten 'tosimiestulkintojen' sijasta. Näin ajatus maskuliinisuuden ja terveellisen elämäntavan välisestä ristiriidasta osoittautuu yksioikoiseksi tulkinnaksi, joka ei tavoita miesten terveysajattelun moninaisuutta ja kontekstuaalista vaihtelevuutta. Tutkimus antaa pikemminkin syyn olettaa, että terveystietoisuudesta on hiljalleen muotoutumassa olennainen osa miehisyyden keskeisiä ideaaleja, osa tämän päivän hegemonista maskuliinisuutta.

CONTENTS

INTRODUCTION

The starting point for this study is the claim, made often in men's health research, of traditional (or hegemonic) masculinity being in conflict with health-awareness and healthy lifestyle. Culturally dominant ideals of manhood, hegemonic masculinity (Connell 1995), have been used to explain men's unhealthier practices which, in turn, are found in epidemiological studies to be among the most important reasons for men's lower life-expectancy compared to women. This study approaches the apparent conflict between masculinity and healthiness from a critical, discursive, research material -based perspective by exploring constructions of masculinity and healthiness as well as their contextual interrelations in thematic interviews with Finnish paper mill workers. Both 'healthiness' and 'masculinity' are understood as sets of discourses, involving contrary themes and conflicting ideas, which are reproduced and negotiated in interaction as part of interactants' contextual identity work.

Within sociological studies on gender and health, men's health has become a distinct research area during the past three decades. Based on the work of feminist scholars from the 1960s and 1970s, both masculinity and femininity became subjects of critical scrutiny. The essentialist views of gender as static dual divisions were replaced by a more flexible understanding of genders as culturally embedded and thus constantly changing categories. This gave rise to studies on men, masculinities and men's health in the 1970s and 1980s that started to explore cultural constructions of masculinity and its links to men's health. The major reason for the interest in men's health was the wide gender gap in life-expectancy and men's premature mortality in industrialised countries, which were, to a large extent, explained by men's more unhealthy behaviours compared to women. Since early studies on men's health, men's more frequent smoking, drinking and involvement in many other risky behaviours have been linked with the male socialisation and cultural ideals and norms related to manhood and masculinity. Consequently, in the studies on men's health, especially in those focused on men's health-related behaviour, it has been commonplace to claim that the traditional forms of masculinity, or hegemonic masculinity, are in conflict with a healthy life-style, thus resulting in men's unhealthy behaviours. Masculinity has therefore often been claimed to be one of the most significant 'risk factors' for men's health (e.g., Harrison et al. 1989; Kimmel 1995; Möller-Leimkühler 2003). A great deal of men's health studies have been characterised by *pathologisation of the masculine*, a perspective which has dominated the research area for three decades.

Despite analyses by many leading theorists of research on men that have explored recent changes in cultural expectations related to manhood in Western societies and pointed to the existence of multiple forms of masculinity (e.g., Carrigan et al. 1985; Connell 1987; 1995; Kimmel 1995; Messner 1997), a few scholars have *reconsidered the role of masculinity in men's health-related practices and thinking*. For decades, men's health research has been dominated by a view of (hegemonic) masculinity being something that leads men to unhealthy lifestyles, and pathologisation of the masculine, without contemplating the elsewhere discussed changes in the ideals of manhood. Furthermore, the majority of research has not critically considered the adequacy of the concepts of hegemonic or traditional masculinity in explaining men's health. In several studies, 'hegemonic' masculinity is perpetually used as an equivalent to 'traditional' masculinity, making an implicit assumption that contemporary men still live in accordance with the same norms and ideals as their grandfathers did. These writings bypass some crucial questions in studies of men's health: is traditional masculinity still hegemonic? Does (modern) hegemonic masculinity still oppose healthy ways of living?

The aforementioned assumptions seem unjustifiable when mirrored with survey studies among males in many countries. Regardless of the fact that men, on average, have unhealthier habits compared to women, numerous studies have shown that men's health-related behaviours and practices have turned into a significantly healthier direction over the last few decades (e.g., Helakorpi et al. 2007). In particular, many men are both well-aware of their health and actively take care of themselves by avoiding unhealthy practices and by being involved in health-promoting ones. It is therefore worth asking three vital questions. First, as the idea of avoiding effeminate behaviours has been the bedrock of *masculinity-being-in-conflict-with-health* thinking, is it really so that health and healthy lifestyle are still strictly associated with femininity in Finnish culture today? Secondly, is femininity equally associated with all different sides of healthy lifestyle or are some health-promoting activities more feminine (unmasculine) compared to some others? And thirdly, following from the previous question, does potential femininity of 'healthiness' lead men to resist everything that is associated with it? Is health awareness still generally something that only women 'fuss about' and that 'real men' categorically reject?

In the 30-year history of men's health studies, dominated by US scholars, the role of singular dominating, hegemonic masculinity in men's illness has largely been taken for granted. Recently, several British researchers have challenged the one-dimensional view of masculinity and health by referring to increased awareness of health among populations (e.g., Watson 2000; Robertson 2003a; 2003b; De Souza & Ciclitira 2005; De Visser & Smith 2006; Robertson 2006). These writings

have pointed to constantly increasing valuation of health in Western societies, a phenomenon that has been an important research subject in the sociology of health and illness, conceptualised as 'healthism' (Crawford 1980), and 'healthicisation' (Conrad 1994) of everyday life. As health has gained more and more space in public debates, become a consumer good used in marketing various products, and a subject of major community campaigns for promoting healthy lifestyle among populations, health-awareness has become a salient normative system in Western societies (e.g., Douglas 1990; Lupton 1993; Bunton & Burrows 1995; Lupton 1995; Petersen & Lupton 1996). Normativity of healthiness of lifestyle results in people being held accountable for their health and health-related actions in interaction (Radley & Billig 1996). Taking this into account, it is important to note that health-awareness nowadays sets expectations for asserting responsible and decent (male) identities. The interpretation here is that this has led men to face a potential dilemma between traditional norms related to masculinity on the one hand and to healthiness on the other hand.

> Given that health is often associated with that which is feminine, that part of asserting male identity involves expressing a lack of concern with health issues. Yet the idea of 'health' today carries moral connotations and identifying yourself as a 'good citizen' means also showing at least some concern with your health. Men may therefore face a dilemma in having to balance these two contradictory demands: a dilemma between 'don't care' and 'should care'. (Robertson 2003a, 112.)

According to the idea of dominant discourse of masculinity being in conflict with health awareness, and that an essential feature of a modern 'good citizen' is to take responsibility for one's own health, men must face a dilemma between two dominant social expectations in considering health-related choices and assessing their own lifestyle. This conflict may also be conceptualised, in Billig et al. (1988) terms, as an *ideological dilemma*, deriving from normative conceptualisations of hegemonic masculinity, claimed to oppose health-awareness, and healthism, emphasising individual responsibility for health through the adoption of a healthy lifestyle, a dilemma between 'don't care' and 'should care' (Robertson 2003a).

In discussing ideological dilemmas of everyday life, Billig et al. (1988) make an important distinction between 'formal ideological theories' and the 'lived ideology' of ordinary life (ibid., 25–27). The former refers to ideology as a system of political, religious or philosophical thinking, and the latter to informal common sense as a society's way of life involving values and beliefs that have their roots in formal ideologies. The 'lived ideology' comprises contrary themes and conflicting ideas

that 'continually give rise to discussion, argumentation and dilemmas' (ibid., 6). Hence, by pointing to ideological features of hegemonic masculinity and 'healthism', my interest is not in formal ideological theories but, instead, in 'lived ideologies' of masculinity and healthiness that are puzzled over from contrary discourses constructing their objects (Parker 1992).

The general aim of this study is to analyse contrary and conflicting themes involved in situational constructions of gender and healthiness in men's interview talk; that is, how the potential tensions, conflicts and dilemmas are represented, negotiated and resolved in interaction. The thread of this study is to shed light on how both masculinity and healthiness contain conflicting and ideological themes requiring discussion and argumentation and are thus potentially dilemmatic constructions of themselves and – in some cases – in relation to each other. The study draws on recent sociological and social-psychological discursively oriented research on how masculinity (e.g., Cameron 1997; Edley & Wetherell 1997; Gough & Edwards 1998; Wetherell & Edley 1999; Willott & Griffin 1997; 1999) and healthiness of lifestyle (Backett 1992a; 1992b; Mullen 1992, Lupton & Chapman 1995; Lupton & Tulloch 2002a; 2002b) are negotiated in interaction. The study approaches men's health from the perspective of *Critical Studies on Men*, which seek to present 'critical, explicitly gendered accounts, descriptions and explanations of men in their social contexts and contextualisations' (Hearn & Pringle 2006, 5; cf. Lohan 2007).

The first chapter of this study discusses the ways in which the concept of masculinity, and related concepts 'hegemonic' and 'traditional' masculinity, have been utilised in some influential writings on men's health. By reviewing selected texts, I want to demonstrate the ascendant ways of conceptualising men's lives and their health as well as the variations and inconsistencies in the use of the concept(s). In the chapter, I claim that research on men's health has largely been founded on pathologisation of the masculine, seized upon the 'unhealthy' masculinities and, consequently, neglected alternative views of studying men and their health. The second chapter continues the themes related to healthiness and gender that were initially discussed in the introduction. It goes further in contemplating healthiness and gender in terms of ideological (normativity), dilemmatic (contrary themes), and negotiative (contextuality) aspects involved in both concepts. Ideology, contrary themes and contextual, negotiated constructions are the key concepts of the study that the empirical analyses are rooted in. The third chapter introduces the specified research questions, research materials and methodology of the study.

The fourth chapter starts the empirical analysis by exploring argumentation that the interviewees' use in justifying their self-ratings of health. The chapter analyses the ways in which men define health in the interview context, interpret

causalities of health and illness, and discuss potential conflicting ideas involved in assessing personal health. The fifth chapter is focused on how health information is discussed in men's interviews. It analyses the ways in which contents and role of information are interpreted in relation to choices of healthy lifestyle as well as ideological and contrary themes incorporated in these interpretations. Furthermore, the chapter explores gendered discourses involved in the discussion of health information. The sixth chapter approaches men's health from a non-individual perspective: the focus of the chapter is on how the gender gap in life-expectancy is explained and negotiated and, accordingly, on which premises 'men's health' as a social phenomenon is constructed in interviews. The seventh chapter is aimed at analysing how healthiness and gendered features are discussed when considering four central health-related behaviours: physical exercise, diet, alcohol and smoking. The eighth chapter, in turn, analyses how the interviewees evaluate their health-related behaviours as a whole and justify that their lifestyle is generally healthy despite certain unhealthy 'transgressions'. The ninth chapter summarises the results and presents the conclusions made on the basis of them. The primary interest is in identifying the locations of the 'conflict' between masculinity and healthiness: what are the specific health-related topics and contexts where the conflict is represented and negotiated?

The primary theoretical interest of the study is in critical scrutiny of key theories of men's health, that have dominated the research subject for the past three decades, and their adequacy in analysing men's health in the current Finnish society. Based on empirical analyses of men's interviews, the study is aimed at adjusting theories of masculinity and health-awareness to correspond to the lives of modern men. Alongside this, the study approaches Finnish men's health-related thinking to gain knowledge that may be utilised in the promotion of men's health. Implications of the study for men's health research and men's health promotion are discussed in the conclusions of the study.

1 THE CONCEPT OF MASCULINITY IN STUDIES ON MEN'S HEALTH

In studies on men's health, especially in those focused on men's health-related behaviour, masculinity has often been mentioned as one of the most significant 'risk factors' for men's health. Empirically, this idea is based on the notion that men engage in health-damaging behaviours more often and health-promoting activities less frequently than women. It is assumed that men's unhealthy behaviours stem from cultural expectations defining manhood that are often referred to as 'masculinity'. Despite how frequently the concept of masculinity is used as an upper-level concept for explaining culturally embedded practices and behaviours, it is not always clear what is actually meant by the concept and its variations such as 'traditional masculinity' and 'hegemonic masculinity' in men's health research. Furthermore, since contents of these concepts are not always opened up to readers, their links to men's health behaviours, and men's thinking, attitudes and motivation as well, too often stay vague. The third deficiency in the use of the concept of masculinity in men's health research is that assumptions related to masculinity often tend to be static bypassing changes in cultural ideals related to manhood as well as changes in men's health-related behaviours. In the same way, speaking about traditional or hegemonic masculinity tends to create an illusionary unity between different groups of men and leaves aside differences between men in terms of (national) cultural backgrounds, social class, ethnicity, age and so forth.

In this section I briefly analyse some texts often cited in studies on men's health in order to review how the 'cultural male' has been conceptualised when accounting men's morbidity, mortality and unhealthy behaviours for men's (supposedly) shared cultural values and attitudes. My intention is not to make an extensive and thorough analysis or critique of concepts such as 'traditional masculinity', 'hegemonic masculinity' or 'male sex role' as there exists a large body of literature on these conceptual developments within the broad range of research on men and masculinities (e.g. Carrigan, Connell & Lee 1985; Hearn 2004; Connell & Messerschmidt 2005). My aim, instead, is to outline some developments in the conceptual basis of how men's health has been explained over the past three decades in men's health studies. Particular attention is paid to the assumed conflict between masculinity and health-awareness and the deficiencies in how these central concepts have been used in describing the conflict.

Health behaviour and men's lower life-expectancy

Men's lower life expectancy compared to that of women is a worldwide phenomenon (Mathers et al. 2001) even though men have had most of the social determinants of health (such as employment, income, education, etc.) in their favour (Meryn & Jadad 2001). In Finland, men's life-expectancy at birth was around 76 years and women's 82 years, respectively, in 2005, resulting in a gender difference of 6 years (WHO 2007). Life-expectancy of Finnish men has gradually increased over the last few decades. Although the increase of life-expectancy has concerned both genders, men's life-expectancy has grown quicker compared to women's and the gender gap in life-expectancy has thus diminished gradually (Lahelma et al. 2003). However, Martikainen, Valkonen and Martelin (2001) found out that although life-expectancy increased between the years 1971–1995 in all social classes, it did not increase equally. Among non-manual men, the increase was 5.1 years while among manual workers the change was 3.8 years. A clear majority of the increase of male life-expectancy was attributable to a decrease in mortality from cardiovascular diseases, especially ischemic heart disease, and all cancers.

Three decades ago, Waldron (1976) estimated that three-quarters of the gender difference in life-expectancy can be accounted for by 'sex-role related behaviours' which contribute to the greater mortality of men. Whether or not behaviours like smoking, drinking and high-fat eating habits are gendered or 'sex-role related', it has been shown that men's more unhealthy habits partially explain gender differences in life-expectancy (e.g., Verbrugge 1989; Waldron 1995). In Finland, men's higher mortality has, to a large extent, been explained by gender differences in smoking and alcohol consumption (Martelin & Valkonen 1996; Mäkelä 1998; Martelin et al. 2002). In 2006, alcohol-related causes were the most frequent cause of death among the Finnish working-aged population resulting in 1654 deaths, with clear male dominance (1300 males vs. 354 females) (Tilastokeskus 2007). In addition, concerning road accidents, men's share of annual deaths was 74% in 2005 (Tilastokeskus 2005). Finnish suicide rates are among the highest in the world with a clear gendered bias; around 75% of suicides are committed by men (Lönnqvist 2005).

The Finnish follow-up studies, implemented by the *Finnish National Institute of Health*, have shown that Finnish men's health-related lifestyle choices are unhealthier compared to women. Men smoke cigarettes and drink alcohol more often than women, have a less-healthy diet, and practise less leisure time physical exercise compared to women. In addition, men report fewer attempts to change their unfavourable health habits and their knowledge of national health promotion

programmes is worse than women's. In the national surveys, the male respondents also more frequently reported that their family members have advised them to make changes to their health habits while female respondents reported having had advice from physicians and nurses more often, which is explained by women's more frequent use of health care services. (Helakorpi et al. 2007.)

The gender differences in health-related lifestyle cannot be unequivocally attributed to men's lack of knowledge of health issues. It has recently been concluded that the Finnish population has widely accepted key messages of health promotion (Aarva & Pasanen 2005; Aarva et al. 2005). While lay understanding of causalities related to health acknowledges the importance of healthy lifestyles, the health-related choices are bound to complex cultural and social processes and practices in every-day life (Backett 1992a; 1992b; Backett & Davison 1995; Williams et al. 1995). This notion has led researchers to analyse cultural norms, expectations and practices involved in men's lives, which have often been explored under the concept of 'masculinity'. It has therefore become commonplace to claim that traditional forms of masculinity, or 'hegemonic' masculinity, are in conflict with healthy lifestyles. This notion suggests that these forms of masculinity involve such norms and practices that make men resist advice on healthy lifestyles and engage in health-damaging activities. Therefore, masculinity has been seen as a barrier to men's healthy lifestyle choices and as a reason why men, as a group, are not motivated to (or are even resistant to) change their lifestyle independently from health-related knowledge (cf. Bunton et al. 1991). This has led to a general *pathologisation of masculinity* in men's health research.

Origins of pathologisation of the masculine

The epidemiological transition in Western Europe resulted in the replacement of infectious diseases as a major cause of death, particularly after World War II. Cardio-vascular diseases emerged as the salient cause of death throughout Western Europe and the United States in the 1950s and '60s. Cardio-vascular diseases also explained the rising gender difference in mortality; men suffered significantly more often from heart diseases compared to women. This led medical researchers to study men's vulnerability to cardio-vascular diseases from the 1960s onwards. As Riska (2000) has described, in addition to men's unhealthy behaviours that explained the uneven prevalence of cardio-vascular diseases, some researchers started to consider larger behavioural patters among men that would both have explanatory power for men's more unhealthy behaviours and their susceptibility to heart diseases through concealing emotions and stress. Based on empirical research on behaviours and

mortality, US medical researchers defined a coronary prone behavioural pattern called 'Type A' offering a diagnostic tool for identification of a person with a high risk of cardio-vascular diseases. Although the settings of the studies did not originally focus on men but covered both genders, it soon became obvious that the 'Type A' behavioural pattern primarily concerned men. The 'Type A' behavioural pattern consisted of characteristics typical of white American middle-class men:

> (1) an intense, sustained drive to achieve self-selected but usually poorly defined goals, (2) profound inclination and eagerness to compete, (3) persistent desire for recognition and advancement, (4) continuous involvement in multiple and diverse functions constantly subject to time restrictions (deadlines), (5) habitual propensity to accelerate the rate of execution of many physical and mental functions and (6) extraordinary mental and physical alertness. (Friedman & Rosenman 1959, cited by Riska 2000, 1667.)

Consequently, as Riska (2000) noted, by the early 1960s there was a shift from external causes of disease and directly health-linked behaviours to inner characteristics of the male: 'the medical gaze turned to men's "interior" – their selves and their masculinity – and a new risk factor was discovered' (ibid., 1666). Conceptualising men's 'interior' as a risk factor of cardio-vascular disease meant the first step in the 'medicalisation of traditional masculinity' (ibid.). The 'Type A' behavioural pattern was followed by 'Type A personality', a psychological model describing a coronary prone person, in the late 1960s. As Riska (2000) observes, both diagnostic and social categories began to lose their position as explanatory models for heart disease in the 1990s. Despite this, the pathologisation and medicalisation of masculinity continued and became a thread in the majority of research on men's health[1].

[1] In her later article on the use of concepts of the 'Type A man' and 'hardy man' in stress research, Riska (2002) claims that 'hardiness' demedicalised and legitimised the 'core values of traditional masculinity' that the Type A man had earlier medicalised. Although not disagreeing with her notion as such, there is, in my view, a conceptual confusion in Riska's conclusion. As the 'hardiness' offered a means for interpreting traditional male characteristics as factors protecting men from stress, it thus *depathologisised* rather than demedicalised those characteristics of the male. In my interpretation a new category of the 'hardy man' continued to have the same essentially *medicalised* framework for conceptualising masculinity as the 'Type A men', merely representing a 'healthy' exception within the 'unhealthy' generalisation.

Concepts of the pathologisised cultural male: from the 'male sex role' to 'hegemonic masculinity'

While pointing to medicalisation of traditional masculinity, Riska (2000) rightly observes that the early studies on men's health did not approach the topic as a gendered issue. Only the rise of gendered studies on men in the 1980s brought up the 'lethal character of traditional masculinity' (ibid., 1672) as a research topic and treated men's health as a truly gendered phenomenon. Since the 1960s gender (or sex) had been a routine variable in epidemiological studies. However, as Sabo and Gordon (1995, 3) note, in the first stage, researchers followed a basic *add and stir* approach, which 'treated gender as just another variable for identifying health patterns and risk factors'. In other words, whilst gender was brought up as an entity in research, its cultural boundaries were not considered, problematised and questioned. With the rise of critical studies on men, on the basis of the work of feminist scholars' in the 1960s and 1970s, there gradually emerged another perspective to gender where gender was elevated from a background variable to a distinguished topic of research. This latter perspective could, adapting Sabo and Gordon's formulation, be called a *shaken, not stirred* approach, where genders and their cultural constructions have been subjected to critical scrutiny while simultaneously acknowledging distinctive features of the cultural constructions relating to masculinity and femininity. Accordingly, 'shaking' of the gender, and problematising it as a category, has led to a widely shared conclusion that instead of one femininity and masculinity, there are different masculinities and femininities within every culture.

In early studies on men's health, men's high mortality was largely attributed to the *male sex role*. James Harrison (1978), for instance, in his article *Warning: the male sex role may be dangerous to your health*, used this term to denote the expectations for men, which explained men's unhealthier behaviours, aggressiveness, risk-taking etc. all resulting in men's premature death. Notably used in the singular, the male sex role is a concept without space for alternative models of masculinity. Harrison grounds his ideas about the contents of the male sex role on Brannon's (1976) characterisations of key dimensions of 'stereotyped male role behaviour', articulated in four phrases:

1. No Sissy Stuff: the need to be different from women.
2. The Big Wheel: the need to be superior to others.
3. The Sturdy Oak: the need to be independent and self-reliant.
4. Give 'Em Hell: the need to be more powerful than others, through violence if necessary.

(Brannon 1976, cited by Harrison 1978, 68.)

Brannon's characterisations have been influential in studies on men's health. The four dimensions have been often referred to as a crystallisation of the 'core' of the stereotyped traditional masculinity and its negative impacts on health in several later studies (e.g. Harrison et al. 1989, 297; Sabo & Gordon 1995, 6; Messner 1997, 37; Nicholas 2000, 30). Although Harrison (1978) points out that it is difficult to define the exact contents of the male sex role due to its 'elusive quality and the apparent contradictions within it' and refers to Brannon's work as highlighting the 'stereotyped' male role behaviour (ibid., 67–68), his interpretative framework of the male sex role and men's health solely relies on Brannon's formulations. The basic idea of the impact of the male sex role to men's health is based on rigid normative expectations for men's behaviour resulting in men's dilemmatic position between basic psychological needs essentially the same for both men and women ('need to be known and to know, to be depended upon and to depend, to be loved and to love, and to find purpose and meaning in life'), on one hand, and fulfilment of the gendered expectations, on the other.

> The socially prescribed male role … requires men to be non-communicative, competitive and non-giving, inexpressive, and to evaluate life success in terms of external achievements rather than personal and interpersonal fulfillment. All men are caught in a double bind. If a man fulfills the prescribed role requirements, his basic human needs go wanting; if these needs are met, he may be considered, or consider himself, unmanly. … Attempts to fulfill the role requirements result in anxiety, emotional difficulty, a sense of failure, compensatory behavior which is potentially dangerous and destructive, and stress which results in physical illness and premature death. (Harrison 1978, 68–70.)

The direct impacts of stress, arising from a constant struggle to compete and pressures from evaluating 'life success in terms of external achievements' (most clearly articulated in the 'Type A man'), on men's health has gradually become a side-track in the main-stream men's health studies. Instead, 'compensatory masculine behaviours' have gained growing interest among researchers since the 1980s, which may be partly accounted for by the emergence of 'healthism' (Crawford 1980) or 'health-lifestylism' (Riska 2000) in health research in the 1970s and 1980s. Compensatory masculine behaviours, to which the male sex role gave a basement, included health-threatening behaviours such as smoking, drinking, violence, reckless car-driving and other forms of risk-taking, interpreted as strategies for maintaining and strengthening male status. In men's health research, health-related behaviours have become an overwhelmingly dominating topic of research in recent decades while biogenetic explanations for gender difference in mortality have stood down.

In the 1980s, a shift in terminology emerged: the male sex role was gradually replaced by *masculinity* or *hegemonic masculinity* in studies on men. In their influential writing in the mid-1980s, Carrigan, Connell and Lee (1985) further developed the concept of *hegemonic masculinity*, originally introduced by Robert Connell in his essay *Men's bodies* written in 1979 (reprinted in Connell 1983), as a critique to male sex role theory. The authors perceived the role theory as too static and rigid to describe the changing ideals of manhood and normative masculinity, and thus having a tendency to result in the 'false universalization of men' and their experiences (Messner 1997, 40–41). Hegemonic masculinity proposed, instead, a model of multiple masculinities and power relations within society and pointed to constant struggles between dominant and subordinated forms of being a man. The hegemonic form of masculinity referred to the dominant views of ideal manhood but acknowledged existence of other forms of masculinity. The concept has been further developed, particularly in Robert Connell's later writings (e.g. 1987; 1995), and become the key concept in studies on men. Since the 1980s the concept has been used in numerous studies for conceptualising historical formulations, ideals and dominating conceptions of manhood (for a review, see Connell & Messerschmidt 2005).

Despite the change in terminology, a great proportion of studies on men's health from the 1980s onwards have continued to account for men's lower life-expectancy through explanations of men's unhealthy habits based upon one unitary form of, either hegemonic or traditional, masculinity. Ten years after his previous article on the male sex role and men's health, James Harrison wrote, in collaboration with James Chin and Thomas Ficarrotto (Harrison et al. 1989), another article where terminology was adjusted to meet the new requirements. The new article, called *Warning: masculinity may be dangerous to your health*, followed the same logic as the earlier work in that, first, men's unhealthy habits were attributed to masculinity which in turn, secondly, was conceptualised on the basis of Brannon's (1976) four phrases characterising the core of male sex role. In addition to replacement of the key term, the article offered very little new about boundaries of men's health compared to the earlier writing and can thus be seen as a plain terminological update of what he had written ten years before.

Since the 1980s it has become commonplace to explain men's vulnerability to chronic illness and premature death as the 'cost of masculinity' (Messner 1997) and conceptualise masculinity as a 'risk factor' for men's health.

> Most of the leading causes of death among men are the result of men's behaviors – gendered behaviors that leave men more vulnerable to certain illnesses and not

> others. Masculinity is among the more significant risk factors associated with men's illness. … But masculinity is not only a risk factor in disease etiology but it is also among the most significant barriers to men developing a consciousness about health and illness. 'Real men' don't get sick, and when they do, as we all do, real men don't complain about it, and they don't seek help until the entire system begins to shut down. (Kimmel 1995, vii–viii.)

In the *second terminological* wave of studies on men's health, which emerged after the male sex role literature, *masculinity* has notably often been used in the singular, despite the simultaneous notion of multiple masculinities. Most often 'masculinity' was used as a concept referring to norms and practices that make (some) men resist advice on healthy lifestyles and, on the other hand, engage in health-damaging activities (such as excessive drinking, speeding, unhealthy diet etc.). Another recurrent theme in analyses of masculinity and health is men's claimed reluctance to seek help in case of physical or mental problems. As Kimmel pointed out in the quotation above, 'real men' do not get sick but when they do, they do not (and are not supposed to) complain about it. Similarly, Möller-Leimkühler (2003) discusses men's coping strategies with psychological strain and concludes that 'traditional masculinity is a key risk factor for male vulnerability promoting maladaptive coping strategies such as emotional unexpressiveness, reluctance to seek help, or alcohol abuse' (ibid., 1). Both authors pay attention to how 'masculinity' forms a set of norms and expectations that lead men to engage in harmful behaviours and, on the other hand, ignore activities promoting health. From this perspective, then, it is warranted to call such a set of norms as one of the most significant 'risk factors' for men's health.

What is problematic in the constant references to 'masculinity' is that they tend to create the same kind of 'false universalization' (Messner 1997) of men and men's lives as what was earlier criticised in the male sex role literature. The research has largely brushed aside the fact that *not all men* are continuously involved in risky behaviours, *not all men* resist advice on healthy lifestyles and *not all men* hide their pain and are reluctant to seek help for their illnesses. As De Visser and Smith (2006, 686) point out, 'not all men engage in … unhealthy behaviours, and men may engage in some risky behaviours but not others'. Regardless of the notion of multiple masculinities, 'unhealthy masculinity' has dominated men's health research and been the terminological tool for depicting a cultural pathogen causing heightened mortality and illness among men.

The focus on 'unhealthy masculinity' has been rooted on outside-in notions that, statistically, men on average die younger than women, engage more often in unhealthy behaviours and engage less often in health-promoting activities. Explanations for

gender differences have led the researchers to treat 'unhealthy masculinity' as a statistically prevailing generalised feature of men; otherwise, the 'lethal character' of masculinity could not explain men's lower life-expectancy. Consequently, in studies explaining these gender differences in health in terms of masculinity, the attributes of normative masculinity follow, to a large extent, the same characterisations as in the earlier writings of the male sex role.

Avoidance of femininity as a bedrock of masculinity

As in the previous quotation from Kimmel (1995), the norms and expectations involved in 'masculinity' define the ways in which 'real men' are supposed to act, differentiating 'real men' from 'other men'. The idea of norms defining preferable, ideal, and sometimes dominating ways of being a man, e.g. in relation to health, is most clearly expressed in the concept of *hegemonic masculinity*.

> A key element of 'hegemonic' masculinities is a direct rejection of bodily maintenance and self-care in order to assert masculinity. To 'be' or act like a man is to show a lack of concern for care of the self such as dietary regimen or aesthetic enhancement. (Bunton & Crawshaw 2002, 192.)

Here, norms related to masculinity, which define how 'real men' are supposed to act, are located within the boundaries of 'hegemonic masculinity'. The notion of hegemony points to the idea that while there are several different forms of masculinity available for men's self-identification, the dominant ideals of manhood support 'rejection of bodily maintenance and self-care'. To 'be or act like a man' follows the logic of how 'real men' are supposed to act, making a distinction between those men who fit the expectations and those who do not. In this context, hegemony thus refers to power relations where some ways of being a man are valued higher than others. However, it is striking how 'hegemonic masculinity' used in men's studies comes close – or is even coterminous – to the male sex role or *traditional masculinity*, a concept also widely utilised in men's health research.

The ideals of manhood associated with hegemonic masculinity are often similar with those attached to 'traditional masculinity', another concept often used for depicting men's normative health-related behaviours, values and attitudes. Traditional masculinity, as a concept, emphasises historical stability of dominating ideals of manhood though acknowledging the possibility of change. A central difference between the concepts is that traditional masculinity locates the formation of ideals of manhood to long-standing historical processes and traditions while hegemonic

masculinity is, conceptually, more flexible in terms of the time dimension of social change. Therefore, 'traditional' ideals and attributes of masculinity are more easily explicated compared to relative flexibility of constantly contested 'hegemonic' views.

> The traditional male gender-role, as defined and reinforced within the public realm, is characterised by attributes such as striving for power and dominance, aggressiveness, courage, independency, efficiency, rationality, competitiveness, success, activity, control and invulnerability. … Traditional masculinity is sharply outlined against attributes being socially defined as feminine. (Möller-Leimkühler 2003, 3.)

Möller-Leimkühler lists some attributes that are related to the 'traditional male gender-role' in order to illustrate how many of the characteristics of traditional masculinity are in conflict with coping strategies promoting health. She claims that the constant struggle for power, aggressiveness and ideas of invulnerability lead to 'maladaptive coping strategies' (mentioning emotional non-expressiveness, reluctance to seek help, and alcohol abuse) as well as ignorance of other potential coping strategies that are in conflict with the traditional attributes of masculinity. At the end of the quotation, Möller-Leimkühler gives her explanation for why traditional masculinity is in conflict with health-promoting coping strategies. In her view, 'traditional masculinity is sharply outlined against attributes being socially defined as feminine' resulting in avoidance of activities and practices holding feminine attributes. This way 'traditional' and 'hegemonic' masculinities are both based on two basic distinctions between 1) 'real' versus 'other' men (masculine vs. un-masculine) and 2) men and women (masculine vs. feminine). William Courtnenay (2000a) discusses the masculine/ feminine distinction in the context of hegemonic masculinity and its influences on health.

> Rejecting what is constructed as feminine is essential for demonstrating hegemonic masculinity in a sexist and gender-dichotomous society. … Health care utilisation and positive health beliefs or behaviours are … socially constructed as forms of idealised femininity …. They are, therefore, potentially feminising influences that the men must oppose. … Rejecting health behaviours that are socially constructed as feminine, embracing risk and demonstrating fearlessness are readily accessible means of enacting masculinity. (Courtenay 2000a, 1389–1391.)

Describing the rejection of (everything) 'what is constructed as feminine' as a vital part of demonstrating hegemonic masculinity reminds one of the key characteristics of the male sex role from Brannon's (1976) study discussed above. 'No Sissy Stuff',

the need to be different from women, was one of the core qualities mentioned in relation to the male sex role. Attachment of the qualities of the abandoned male sex role to 'hegemonic masculinity' in the current (Western) society is a question of major importance in the research on men's health: has anything really changed in conceptualisations of the cultural male ideals during the past 30 years of men's health research? As concluded above, the research on men's health to date has underlined the significant influence of traditional ideals of masculinity on men's health, especially through health-damaging behaviours. Based on critical reading of influential writings on men's health, I argue that from the mid-1970s till mid-2000s noticably little has changed in the ways in which, first, masculinity has been conceptualised and, secondly, how its role in men's health has been interpreted. This brings up another vital question: why have the changes in the content of masculinity, as a concept, been such minor, superficial corrections of terminology, within a period of 30 years?

Limitations of the canon of 'pathological' masculinity

In reading the texts about the 'lethal character of masculinity', I recurrently wondered why such a big share of all the literature on the subject is devoted to negative impacts of 'bad masculinity' to men's health when statistics from many countries actually show a gradually diminishing gender gap in several health-related indicators. As I suggested above, one potential reason for clinging, even fixation, to one invariable conceptualisation of masculinity, which has made basically no difference between the concepts of the male sex role, traditional masculinity and hegemonic masculinity, may draw on the subject of research. As men still die younger than women throughout the industrialised world, the phenomenon easily calls for a negative interpretation and, consequently, pathologisation of masculinity. In other words, it could be argued that the subject of research – men's lower life-expectancy – itself sets negative presuppositions for factors (masculinity) claimed to explain it (cf. Pietilä & Rytkönen 2006, 26).

On the other hand, a one-dimensional view on masculinity and health may be partly explained by the historical linkage of (critical) studies on men and masculinities with feminist research[2] which has explored gendered inequalities and male subordination over women in Western societies. Themes like men's

[2] There are obviously also tensions and differences between feminist theory and research on men and masculinities as recently reviewed, for instance, by Robinson (2003) and McCarry (2007). It is also worth noting that not all research on men is rooted in critical views on gender. As Hearn (2004) points out, at worst 'Men's studies' are anti-feminist.

aggressiveness and violence, unequal division of domestic work, gendered inequalities in the labour market and many others linked with women's oppression have underlined negative outcomes of the patriarchal order and paid attention to the cultural grounds of the reproduction of power relations. In conceptualisations of the cultural male, the emphasis has thus often been on repressive features related to masculinity. Whilst not wanting to deny any of these forms of gendered oppression, their institutionalised structures, nor their cultural backgrounds, I argue that the interrelationship between feminism and studies on men may have also resulted in narrowed perspectives on men's health. Negative forms of masculinity, i.e. the 'pathological masculinity', have continued to dominate conceptualisations of social origins of men's health-related attitudes, behaviours and practices.

Within research on men's health, dominated by the notions of 'unhealthy masculinity', 'healthy' masculinities have remained marginalised, which is somehow ironic from the point of view of efforts to improve men's health. Until recently, few researchers had paid attention to men's habits that are positive to their health. As Roos and Wandel (2006) emphasise, in health research masculinity is 'often simplified and viewed as a barrier and problem whereas potentially positive aspects are seldom discussed'. One additional reason for the domination of 'bad masculinity' in research on men's health may be found in the methodologies used. A big share of men's health research has explored men's lifestyle choices at the macro population level showing men's active engagement in health damaging behaviours and investigated the determinants of these behaviours (e.g., Courtenay 1998; 2000a; 2000b; Courtenay & Keeling 2000) and/or prevalence of diseases typical to men (see Sabo 2005). These statistical/ epidemiological studies have centred on lifestyle factors and often used 'masculinity' (or merely male sex) as a background variable that has often not been operationalised as a subject of empirical research. As Möller-Leimkühler (2002, 1) encapsulates, 'many studies which call themselves gender-specific reduce the term to quantitative differences in research variables'. This has in many cases resulted in imbalance between empirical findings and their interpretation; the statistical variations have been interpreted with a concept which has no similar empirical basis as the subjects of empirical research. 'Masculinity' has been taken into research from outside of empiricism as a concept which 'everybody knows', often without questioning relevance of this, basically commonsense, theorising. As Watson (2000) points out, explanations of gender differences in health have largely drawn on gender stereotypes that the researchers, as members of a given society and culture, are not free from.

Consequently, there are three major problems in restricting conceptualisations of masculinity to one 'hegemonic' view in researching men's health. First, it tends to

treat men and masculinity as a singular concept and leaves other (presumably non-hegemonic) forms at the periphery. As a consequence, a large portion of men's health research lacks variety in its conceptualisations of masculinity as well as health-related attitudes and practices of men of different social groups in different circumstances. It seems that many studies on men's health tend to reproduce 'false universalization of men' (Messner 1997, 40–41) and their ideas of and practices related to health.

> While generally speaking the influence of a particular 'masculinist' ideology is seen to offer a sophisticated and socially grounded explanation for the present state of men's health, much more work needs to be done to analyse the relationship between the commonalities shared by men, and the differences in their specific circumstances. To put it differently, masculinity needs to be explored in terms of how it is played out under different social circumstances by different groups or categories of men. (White 2002, 273.)

Another shortcoming of the perspective of 'singular hegemonic masculinity' is that it bypasses changes in ideals of manhood and maintains an ahistorical and static view of immutable masculinity. Change of men and masculinities has been a constant topic in research on men (e.g. Kimmel 1987; Rutherford 1988; Brittan 1989; Messner 1993; Segal 1993; Messner 1997). Deindustrialisation, structural unemployment, changes in family-structures, women's larger involvement in paid work outside home etc. have challenged the traditional male role of a family breadwinner in many societies, which has been concluded to cause problems for men in defining their roles[3]. Due to societal changes:

> 'a higher and higher proportion of young males today see that the image of the male family breadwinner is increasingly unattainable for them. It's actually getting harder and harder for a young male to figure out how to *be* a man. (Messner 1997, xiv, emphasis original.)

Changes in the labour-market have often been referred to as a salient cause of problems for men's self-understanding, particularly due to the collapse of men's sole right as the provider for the family. Consequently, negotiation of the provider role has been a topic of several studies during the past decade (e.g., Willott & Griffin 1997; 1999; Riley 2003). Despite notions of changing roles of men and changing ideals of masculinity, this has so far generally been poorly taken into account in men's health

[3] These themes have recently been topics of several studies in post-socialist Russia, where particularly rapid and large social changes have had impacts on men's roles in society as well as their health and well-being (see Rotkirch 2000; Ashwin & Lytkina 2004; Kay & Kostenko 2006; Pietilä & Rytkönen 2006; 2008).

studies. As Henwood, Gill and McLean (2002, 182) note, there is a case for stressing 'the importance of linking changing expectations and representations of men to issues of men's health and well-being'.

Thirdly, the focus on masculinity as a cultural pathogen obscures important changes in men's health-related attitudes and practices and tends to treat them similarly as unchanging objects. Although men's health-related practices have become significantly healthier in many respects in recent years, the majority of men's health research over the past three decades has not paid attention to these changes but has instead continued to approach masculinity as a general 'threat-number-one' to men's health. Whilst many men undoubtedly engage in risky behaviours and perceive these behaviours as truly masculine, an increasing number of men are more and more interested in health topics in all industrialised countries. Regardless of this, men's growing health-awareness has not gained researchers' interest until recently. Since 2000, several researchers have pointed out that, together with changes to men's roles and identities, men's health-related ideas and practices have changed, too. Continuing to label 'hegemonic' masculinity with characteristics of 'traditional' masculinity does not, therefore, give a full picture of men and health.

Towards a third wave of men's health research – is traditional still hegemonic?

As I have suggested above, a large portion of men's health studies over past three decades has been more or less stagnant in maintaining uniform ideas of 'hegemonic' masculinity as its core theoretical tool in researching men's health. The 'unhealthy masculinity', with its primary characteristic of neglecting health issues, has been treated as the statistically prevailing ideal of manhood thus having explanatory power for men's risky behaviours. This approach tends to focus upon one form of masculinity and leaves others at the margin. While doing so, the canon of 'unhealthy masculinity' may actually contain even fallacious conceptions of how health and taking care of health are interrelated with ideals of 'what it is to be a man', i.e. masculinity. McMahon (1993) interestingly discusses psychologism in literature on masculinity and notes that often there seems to be a circular argumentation regarding men's behaviour and masculinity: while the concept of (hegemonic or traditional) masculinity is often conceptualised in terms of, or at least with references to, men's (unhealthy, risky) behaviours, the concept itself has, in a circular argument, been used as an explanation, or even excuse, for these behaviours. It may thus be argued that, by basing its analyses on circular deduction, the canon of pathological masculinity has

not detected and analysed important changes in masculinities and men's health but has tended to reproduce its own constitutive assumptions about the subjects.

Adherence to one conception of hegemonic masculinity, characterised by and large by traditional features of manhood, may not fit well with contemporary ideals regarding masculinity and health. Together with the large amount of literature on changing masculinities, several researchers, most often British, have challenged the one-dimensional view of masculinity and health by referring to increased awareness of health among men (e.g., Watson 2000; Robertson 2003a; 2003b; De Souza & Ciclitira 2005; De Visser & Smith 2006; Robertson 2006). Notions of men's increased interest of health issues and multiple ideals of manhood lead to a requirement to adjust phrasing of questions within men's health studies to contexts of research for taking multiplicities seriously. As Henwood, Gill and McLean (2002, 186) have observed, recent studies of men's health and male embodiment, what I would call the third wave of men's health studies, 'argue against any attempt to provide a singular impression of what it might mean for men today to possess a "male psychology"'.

> Rather they seek to build up, through detailed theoretical examination and empirical investigation, a more complex and contradictory picture of men's embodied thoughts and feelings, and of what this might tell us about men's psychologies as a sociocultural and sociopsychological issue (ibid., 186).

The previous citation includes several important implications for men's health research. First, it is required that studies should be based on strong linkage of empirical findings to relevant theory of both lay conceptions of health, particularly those of men, and the interplay of different ideals of masculinity. It may well be claimed that a significant part of previous men's health research has been rather atheoretical in reporting empirical findings without linking them with theoretical developments regarding, among others, changing masculinities. That this may (and is even supposed to) result in a more contradictory picture of men's ideas about gender and health, should not be thought to lead to a fragmentation of theory. On the contrary, a contradictory picture of men's thinking about health opens a more realistic perspective on the subject since human thinking is contradictory and dilemmatic by nature (Billig 1996).

A complex picture of men's thinking also concerns different men's opposing ideas about health. There is a need to investigate health-related ideas and perceptions of men from different social groups to avoid an overly simplistic view of men as a falsely unitary group. As White (2002, 273) suggests, masculinities need to be explored in terms of how they are 'played out under different social circumstances by different groups or categories of men'. In addition, as Gough and Conner (2006) note, future

research should gain more understanding of '*how* ideals of masculinity are enacted by *individual* men situated within *particular* social and health contexts' (ibid., 388, emphases original). This calls for another perspective to contextuality. In addition to contextualising research in terms of particular groups of men and their particular circumstances, contextualisation also concerns situational circumstances related to carrying out research with men.

Regarding neglected aspects in men's health research, Watson (2000, 2) has rightly pointed out that 'what is striking is the absence of knowledge grounded in the everyday experiences of men themselves'. O'Doherty Jensen and Holm (1999) similarly observe in the context of food choices that studies focusing on men's own ideas, viewpoints and accounts are rare. Taken that research on men's health has largely been dominated by (US) epidemiology, survey data and quantitative methodologies, gaining a more complex and contradictory, rich in nuances, vivid and, consequently, a more realistic picture of men's ideas about gender and health requires the adoption of a qualitative analysis of men's own conceptions.

Researching men's conceptions of health and masculinity as 'sociocultural and sociopsychological issues' (Henwood et al. 2002) necessitates contradictory aspects of thinking to be interpreted in their cultural contexts. Aiming to take culture seriously yet avoiding cultural reductionism, critical studies on men's health focus on diversity in 'how masculinity and health operate in daily lives between men – and by the same men in relation to different health practices – and by relating this diversity to the broader social and economic milieu' (Lohan 2007, 498). A necessary cultural entity, that should be addressed when studying men's health in contemporary Western societies, is heightened health-awareness of the population and the moral obligations related to it. As several authors have pointed out, not only has men's interest in health issues increased, but so has the 'moral imperative of healthiness' (Backett 1992a) in men's understandings of health and healthy lifestyle as well (Watson 2000; Robertson 2003a; 2003b; 2006; Roos & Wandel 2006). The moral obligation to continuously take care of one's health and live in accordance to advice of healthiness plays a significant role in men's understanding of health nowadays. While there are also culturally shared 'traditional' views of men being disinterested in health issues, modern men may face an ideological dilemma between two contradictory and normative demands, one suggesting that men 'don't care' and another that they 'should care' about and for their health (Robertson 2003a). In interaction, this dilemma leads to the *negotiation of traditional and new ideals, norms and obligations related to masculinity and health through their (re)conceptualisations and (re)interpretations as well as argumentation for or against different choices.*

> It is clear that stereotyping men as not wanting to take responsibility for their health and of consistently delaying in seeking help from health professionals and services cannot be sustained. However, it became apparent from the men surveyed, that caring for their health and wellbeing and engaging with health services needs to be legitimised or explained in some way. (Robertson 2003a, 113.)

The quotation above is one of just a few examples of studies that have approached men's negotiations between new and traditional images of masculinity in the context of health (see also De Souza & Ciclitira 2005; De Visser & Smith 2006)[4]. It has become clear from these studies that it is far too simplistic to assume that men have only opposing attitudes towards health and that men's health-related thinking is characterised by a one-dimensional 'hegemonic' stand. In fact, Robertson (2006) has recently noted that there is not only a tension between 'don't care' and 'should care'. In addition to this, his interview material included negotiations on, and balancing of, control and release 'in order to achieve or maintain "healthy" hegemonic, male citizenship' (ibid., 185).

> [I]t is not just caring too much about health that puts hegemonic identity at risk. Not to take enough care with one's health, particularly through indulging in excess, also moves one away from hegemonic ideals. It suggests irresponsibility and lack of control, which then becomes representative of transgressive (male) behaviour… (Robertson 2006, 184.)

It is interesting to note that while some researchers have rightly called for analyses of men's 'gender transgressive' behaviours (Henwood et al. 2002) that overstep traditional norms (such as consumption of various health products), some empirical analyses actually show how 'traditional' behaviours and attitudes may be interpreted as gender transgressive due to the irresponsibility and irrationality they represent. This leads to two important conclusions. Firstly, describing 'hegemonic' masculinity in terms of traditional values, a view which has reigned over men's health research, is a stagnated over-simplification of modern men's health-related thinking. In other words, *traditional is not necessarily hegemonic in men's ideas about health*. Secondly, contemporary ideals of masculinity (potentially even hegemonic masculinity) may well be based on notions that counteract traditional values. This suggests that *traditional values may even be in conflict with hegemonic ones*, in case we conceptualise

[4] There have also been published a few studies, which have empirically approached negotiations of masculinities in contexts of specific diseases, such as depression (Emslie et al. 2006), prostate cancer (Chapple & Ziebland 2002) and other prostate problems (Cameron & Bernardes 1998), testicular cancer (Gordon 1995), multiple sclerosis (Kohler Riessman 2003), and chronic illness, in general (Charmaz 1995).

'hegemonic' values to be the currently dominating ideals of masculinity without mixing them up with 'traditional' ones.

In this chapter I have reviewed some influential writings of men's health research published within the past 30 years and discussed the ways in which the concept of masculinity and its different formulations have been utilised in explanations for men's lower life-expectancy and particularly for men's unhealthy lifestyles. I have claimed that, until recently, the research area has been dominated by a fixed and confusingly lopsided conception of masculinity and its relation to men's health-related choices, which has formed an unquestioned canon of pathologisised masculinity and maintained a view of masculinity as a cultural pathogen for men's illness and premature death. These studies have not critically scrutinised their own constitutive assumptions concerning concepts they have routinely used in explanations for men's health. 'Hegemonic' and 'traditional' masculinities have (similarly as the earlier prevailing concept of 'male sex role') stayed vague due to a lack of specification of how these concepts are situated in men's everyday lives. Despite frequently repeated notions about masculinity being the most significant 'risk factor' for men's health (e.g., Harrison et al. 1989; Kimmel 1995) and being in conflict with healthy lifestyle, noticably few studies have been conducted both analysing how this conflict emerges in men's everyday lives and elaborating theory on masculinity and health from an empirical basis. Only over the past ten years or so, has there emerged studies that have acknowledged another side of masculinities – those that are not in conflict with a healthy life. Recent research has also pointed to dilemmatic and negotiated character of men's health-related thinking where old 'traditional' values and ideals clash with new moral imperatives regarding an individual's obligations to maintain and improve his health.

One of the key challenges for men's health research is to replace the old essentialist conceptualisations of masculinity and create theory of how the old and new values and ideals interact in men's conceptions of health. Jonathan Watson has framed tasks for future research as follows:

> There is a need to move beyond the fragmented definitions of men's health, and especially the role of masculinity, that currently dominate the admittedly sporadic and tetchy debate around the subject. This requires both a more assured engagement with relevant theory and substantial empirical investigation. The challenge is to discern whether and how masculinity and health operate within daily lives. (Watson 2000, 36.)

In line with Watson, the starting point of the study in hand is to base the analysis of empirical interview material on solid theoretical ground. Approaching men's

conceptions of health, healthiness and the role of masculinity from the perspective of discursive cultural studies requires that the opposites of traditional views of masculinity – men's health-awareness and prevailing discourses of healthiness – are subjected to investigation as well. Accordingly, the topic of this research might not be 'whether and how masculinity and health operate within daily lives', as Watson put it, but, instead, *how different discourses of masculinity and healthiness operate within men's talk about health and gender in the context of interviews.*

2 IDEOLOGICAL AND CONFLICTING THEMES IN MASCULINITY AND HEALTHINESS

Approaching the claimed conflict between masculinity and healthiness as a potential *ideological dilemma* (Billig et al. 1988) between two sets of norms, or two hegemonic discourses, requires consideration of ideological aspects and contrary themes related to both concepts. This is because the notion of conflict between masculinity and a healthy way of life easily leads to an over-simplified idea of 'masculinity' being a single, unitary model of manhood colliding with a similarly consistent, single way of thinking about health and illness, and practices related to them. Research on masculinities and lay understandings of health and illness has, however, shown that both themes involve contradictory elements that are discussed and negotiated, among others, in interaction. Ideological features related to both masculinity and healthiness, in turn, constitute normative expectations of people's identity work when talking about health and gender in interaction, in an interview, for instance. As this study analyses men's interpretations of gender and healthiness on the basis of interviews, in this chapter, I discuss ideological and conflicting themes of masculinity and healthiness, and their effects upon interview talk.

Ideology in discourses of masculinity and healthiness

Billig et al. (1988), when discussing ideological dilemmas in modern societies, make an important distinction between 'formal ideological theories' and the 'lived ideology' of ordinary life, as was noted in the Introduction. While formal ideological theories refer to ideology as a system of political religious or philosophical thinking, the lived ideology comprises the informal common sense, which combines and reproduces different parts of intellectual ideology that are transformed into everyday ideology. As the authors note, ideology is a particularly difficult concept, lacking clear and precise definition. In its broadest sense, lived ideology as a set of values and beliefs characteristic to a given society comes close to the concept of *culture* in articulating what is considered appropriate and valuable, deprecated and condemnable, and thus defining morality within a particular society. Consequently, concepts of culture and lived ideology are similar in that they 'both seek to describe the social patterning of everyday thinking' (ibid., 28) through which the world is experienced.

According to Fairclough (1992), ideologies are particular constructions of reality which are built into 'various dimensions of the forms/ meanings of discursive practices, and which contribute to the production, reproduction or transformation of relations of domination' (ibid., 87). Discursive struggle for domination lead some discourses to gain a hegemonic position in relation to others, to become naturalised and achieve a status of common sense. In reaching for a dominating position, the discourses refer to other discourses by reproducing, challenging and opposing them (cf. Parker 1992). Wetherell and Edley (1999, 352) note that hegemony is thus 'a relative position in a struggle for taken-for-grantedness'.

> [Hegemony] is best understood not as something separate from ideology, but as a *state* or *condition* of ideology. All ideology works by making what is partial or conditional seem as normal, natural and inevitable. A state of hegemony exists when a particular cultural understanding or practice comes close to achieving that aim; when it becomes widely taken for granted or common sense. (Edley 2001a, 137.)

Hegemonic discourses shaping gender and health have been approached in research from both perspectives of formal ideological theories and lived ideology. Healthism (Crawford 1980), itself, has been conceptualised as an ideology, a conscious political choice, where 'victim-blaming' shifts the responsibility for health from government to individuals (Crawford 1977). This equates healthism with formal ideology by emphasising that the ideas are produced by professional thinkers (Billig et al. 1988) as a particular political strategy. Healthism has also been interpreted to reflect neo-liberal ideology in its overt individualism and market-orientation (e.g. Crawford 2006; Crashaw 2007). Hegemonic masculinity, in turn, has often been conceptualised as a strategy for maintaining the patriarchal gender order and advantaged men's power over women and marginalised men (e.g., Kimmel 1994), reproduced by, for instance, priests, journalists, advertisers, politicians, psychiatrists, designers, playwrights, film makers, actors, novelists, musicians, activists, academics, coaches and sportsmen (Donaldson 1993). Men are thus both agents and objects of hegemony: '"Men" are both *formed in* men's hegemony (or a hegemonic gender order), and *form* that hegemony' (Hearn 2004, 61, emphases original).

In contemporary Western societies, gender and health are subjects of continuous public debate and therefore discussed, among others, in political arenas. Hardly a day goes by without health issues being discussed in media, parliament and municipal councils involving considerations of ideological choices and viewpoints: how should equality in health be assessed and promoted? How should individual responsibility for health be considered? What is the role of government at both national and local

levels in protecting and improving public health? Gender and gender (in)equality are similarly topics of public and political debates today. The feminist movements have challenged the patriarchal gender order and men's privileges since the late 1960s (about men's movements, see Messner 1997; Jokinen 1999, 30–40). Therefore, gender equality in several spheres of life is widely and continuously discussed in various arenas of social life thus challenging traditional images of manhood and reformulating ideals of men's lives and masculinities. Fatherhood, men's role in domestic reproduction, men's positions in the labour market and many other issues related to gender equality and constructions of masculinity are daily topics of public debate. These debates also regularly highlight the 'core' ideological issue involved in health and gender; i.e. power that certain groups have over others, which result in the unequal distribution of health, freedom of choice, independence and, generally, physical, mental and social well-being.

The analyses of the 'lived ideology' have explored how hegemonic discourse of 'life-stylism' (Riska 2000) is negotiated in lay understandings of origins of health and illness (e.g. Davison et al. 1991; Davison et al. 1992; Lupton & Tulloch 2002a; 2002b) and how hegemonic masculinity is challenged by counter-discourses of gender equality and alternate masculinities in men's contextual identity work in interaction (e.g., Edley & Wetherell 1997; Gough 2001; Wetherell & Edley 1999). These studies have pointed to ideological aspects of hegemonic discourses of health and gender in three major respects: in power that is reproduced in discourse, in normative definitions of masculinity and healthiness, and in moral obligations structuring people's self-presentation in interaction arising from these normative definitions. In addition to the ideological aspects, the studies have also shown how hegemonic discourses are constantly challenged and thus involve contrary themes. In the following, I will discuss these features of discourses of masculinity and health with a focus on how they take shape in lived ideology of everyday life.

Ideology, hegemony, men and masculinity

Within gender studies, one of the constant topics has been the *change of men and masculinities*, which has largely been approached from the perspective of power relations between men and women. The rise of feminist studies in the 1960s started critical analyses of the patriarchal gender order and challenged the 'naturalised' privileged position of men in relation to women. Feminist research aimed at revealing gendered practices in different areas of social life (e.g., labour market, education, politics and family) in order to manifest women's oppressed position and gendered

structural inequalities. Discovering gender practices and questioning mundane 'gender-neutral' concepts like citizenship, has since assumed to have provided us with 'the emancipatory potential of gendered subjectivity, which applies to both men and women' (Prokhovnik 1998). The idea of emancipatory potential has been linked with the notion that, whilst men as a group are in privileged positions in almost all fields of social life, not all individual men engage in the subordination of women, and may even be oppressed themselves for this reason. The issue of whether men change in their relation to gendered oppression of women is an *ideological issue*.

> Whether or not men change, which men are most likely to change, whether or not this makes a difference to the customary privileges and authority of men, is an ideological and social as much as a personal issue, an ideological and social struggle, as much as a personal and interpersonal struggle. (Segal 1993, 638.)

The gendered inequalities were, for a long time, attributed to differing 'sex-roles' between men and women and to men's and women's early socialisation, an idea largely derived from Parsonsian functionalism. As I noted in Chapter 1, in the 1980s there was a shift in terminology in gender studies from 'male sex role' to 'masculinities' and new theory was developed. This was initiated by the notion that, as Segal (1993, 627) observes, it has always been possible to detect competing forms of being male, and competing masculinities. Rather than being a consistent and homogeneous group with similar conceptions, positions and motivations, men are diverse both individually and as members of different groups. 'Sex role' was therefore thought to give an over-simplified and too static picture of men as a homogenous group.

On the coat-tails of feminist and women's studies in the 1960s and 1970s there emerged a growing interest in research on men and different forms of masculinity[1]. The notion of men being an internally heterogeneous group in terms of power they had over other men and simultaneously a homogeneous group in terms of power they had over women, led to the formulation of the concept of hegemonic masculinity. Hegemonic masculinity was, from the beginning of its emergence in the early 1980s (Connell 1983; Carrigan et al. 1985), used as a concept for depicting sets of widely shared cultural beliefs and expectations related to men. Its basic idea was that while there are multiple forms of being male and that men differ from each other in many important respects in their values, motives and ideals of life, some of these ideals are

[1] Unpacking gender-neutral concepts and making gendered practices, interpretations and definitions visible is the core issue in critical gender research. Since their emergence as a new field of enquiry, studies on men and masculinities has shared the basic premises with feminist research 'describing hierarchies of dominance, relationally defined gender, and multiple and interactive axes of social oppression'. (Gardiner 2005, 47, cf. Wetherell & Griffin 1991.)

more powerful than others and dominate public images and shared understandings of what it is to be a man.

Hegemonic masculinity is *par excellence* a concept about power. It refers to men's power over women and other men (such as homosexuals, ethnic minorities, men of lower classes etc) who do not have power (e.g. Pyke 1996; Garlick 2003). Hegemony was originally a concept the Italian sociologist Antonio Gramsci used in his *Prison notebooks* (1971) to describe how groups of people in power and the ruling class establish and maintain their powerful position in society. In the context of masculinity, the 'ruling class' has often been claimed to consist of white, middle-class, early middle-aged, heterosexual men. As Kimmel (1994, 125) suggests, hegemonic masculinity is the image of masculinity of those men who hold power, equating manhood thus with being strong, successful, capable, reliable, and in control.

When discussing power relations between men and women, and between different groups of men, the power has referred, in the first place, to concrete power some men have over other men and women in a number of arenas of social life, where men in power make decisions in the labour market, education, politics as well as in domestic life on reproduction and so on. But in addition to concrete power in the meaning of decision-making, men in power possess positions to make and control definitions of masculinities. Due to this power over definitions of masculinities, as Kimmel (1994) notes, all masculinities are not equally valued in society. It is important, however, to bear in mind that hegemony is not a stable state, but a continuous process. As Donaldson (1993) outlines:

> The ability to impose a definition of the situation, to set the terms in which events are understood and issues discussed, to formulate ideals and define morality is an essential part of this process. Hegemony involves persuasion of the greater part of the population, particularly through the media, and the organization of social institutions in ways that appear "natural", "ordinary", "normal". (Donaldson 1993, 645.)

As Donaldson notes, media is one the most important institutions in legitimising hegemonic views. The remarkable role of media and other institutions in maintaining hegemony stems from their ability to articulate experiences, fantasies and perspectives. (Ibid.) Opinions and interpretations of opinion leaders have a major influence on public views on gender regime because their voice is easily heard and, most often, respected. The dominant gender beliefs have significance in social life because they are widely shared and *institutionalised* in many ways, e.g. in the media, government policy and normative images of the family (Ridgeway & Correll 2004, 513).

Hegemonic masculinity is a concept, which has been used in numerous studies in diverse cultural contexts over the past two decades and has, in addition to its usefulness in describing societal level struggles for dominant images of manhood, obviously met criticism as well. 'Existence' and ontological status[2] of hegemonic masculinity have been questioned with focus upon questions concerning the locations of such a 'thing' in society: e.g., *where* it can be found and identified, *who* are those who 'own', define and maintain it, *what* is its exact contents in a given time and place, *how* its dominating position is reproduced, and so forth. Robert Connell and James Messerschmidt (2005) have recently reviewed this critique with the aim of reformulating the concept to meet the new theoretical challenges. Within their review, Connell and Messerschmidt summarise the concept and its origins in the mid-1980s.

> Hegemonic masculinity was distinguished from other masculinities, especially subordinated masculinities. Hegemonic masculinity was not assumed to be normal in the statistical sense; only a minority of men might enact it. But it was certainly normative. It embodied the currently most honored way of being a man, it required all other men to position themselves in relation to it, and it ideologically legitimated the global subordination of women to men. (Connell & Messerschmidt 2005, 832.)

In their article, Connell and Messerschmidt suggest several ideas about how the concept should be reformulated, and things that should be kept in mind when using the concept. What should be retained, despite reformulations, is the normative character of hegemonic masculinity: 'certain masculinities are more socially central, or more associated with authority and social power, than others', thus presuming the subordination of non-hegemonic masculinities (ibid., 846).

Interestingly, in the new formulations of the concept, hegemonic masculinity is not centrally grounded in the idea of the subordination of women to men, while it still presumes a hierarchical order of different forms of masculinity. In fact, the authors state (ibid., 846–847) that the earlier formulation, which 'attempted to locate all masculinities (and all femininities) in terms of a single pattern of power, the "global dominance" of men over women' is nowadays 'clearly inadequate to our understanding of relations among groups of men and forms of masculinity and of women's relations with dominant masculinities'. Despite this major change in one of the central characteristics of the concept of hegemonic masculinity, its contents have

[2] The status of 'hegemonic masculinity' has also been questioned from epistemological perspectives, i.e. how texts reflect its 'existence' and how researchers read and interpret 'hegemony' in their data, see Speer 2001a; 2001b. This perspective will be further discussed in Chapter 3.

not changed in an ideological sense. As an ideal form of being a man, it still assumes normative power of these ideals structuring men's understandings of themselves. This has its effects on individual men's lives because dominant ideas relating to gender, or 'gender beliefs', are consensual in that virtually every member of a culture is aware of them and likely expects that most others hold these beliefs.

> Therefore, as individuals enter public settings that require them to define themselves in relation to others, their default expectation is that others will treat them according to hegemonic gender beliefs. In this way, these hegemonic beliefs act as the implicit rules of the gender game in public contexts. (Ridgeway & Correll 2004, 513).

Being aware of hegemonic views does not, of course, necessarily refer to conscious and rational consideration of expectations related to gender. As members of a given culture, we are able to follow the 'rules of the gender game' even without active contemplation of the rules. Due to ideological and normative expectations involved in the 'rules', definitions of masculinity lead to negotiations between 'hegemonic' and 'alternate' versions, and between different versions of 'hegemonic' and 'alternate' masculinities: as Connell (1995, 181) points out, different forms of masculinity are not internally coherent: 'hegemonic and complicit masculinities are no more monolithic than are subordinated and marginalised masculinities'.

Challenges for hegemonic ideals of masculinity: 'masculinity in crisis'

As noted in the Chapter 1, and in the section above, change of men and masculinities has been a constant topic in research on men (e.g. Kimmel 1987; Rutherford 1988; Brittan 1989; Donaldson 1993; Messner 1993; Segal 1993; Messner 1997). Research on changing ideals of manhood has, among others, tracked particular historical periods when dominant images of masculinity have been subjected to substantial challenges, resulting in a 'crisis' of masculinity (Kimmel 1987), and their effects on gender relations and ideals of manhood. Despite the importance of such historical analyses, it has been noted that 'any such crisis is the latest in a long line of such episodes' (Edley & Wetherell 1997, 203). As Kimmel (1987, 121) has observed, the notion that men are *today* confused about 'what it means to be a "real man" – that masculinity is in "crisis" – has become a cultural commonplace'. Literature on the 'crisis of masculinity' thus markedly illustrates that masculinity is in a somewhat continuous state of 'crisis'. In addition, the notion of 'crisis' dominates the discussion

on men and masculinities even though the exact nature of the 'crisis' has not been clearly explicated.

> Although there is by no means agreement about the exact nature of this 'crisis' … there is a widely felt sense that the contemporary period marks a decisive point in terms of thinking about established cultural understandings of the masculine and about the possibilities for reshaping male identities on the basis of radically new conceptions of the person. (Petersen 1998, 19.)

Several studies have linked the 'crisis' of masculinity to structural changes in society (e.g., Kimmel 1987; Segal 1993; Messner 1997), especially in the labour market, that have reshaped gender relations, manifesting the idea that changes in masculinities take place in close relation to changes in femininity and women's positions in society. That men and women, masculinities and femininities, are relational concepts results in a reciprocal process of change.

Regarding the labour market, one of the most commonly noted changes has been the diminution of traditionally male sectors of labour, such as heavy industries and other manual work, and an increase in more 'gender-neutral' forms of work, such as information technology, as well as overall computerisation in all spheres of work. Rapidly increased automation of industrial production has created structural unemployment in many traditionally male sectors of labour. At the same time, women's participation in paid work has become more common, which has reshaped conventional gendered ideas regarding division of labour and home-work. Conventional ideas of house-wives and male breadwinners are far from being matters-of-course in modern, at least middle-class, families.

Another central process behind the transformation of masculinities is the rise of women's movements and feminism in Western societies since the 1970s. As discussed in the previous section, women's movements have effectively questioned male dominance in many fields of social life and promoted gender equality. This has had partially similar influences on reformulation of masculinities as deindustrialisation and other structural changes in the labour market due to questioning of 'self-evident' male dominance and thus traditional ideas of manhood. Importantly, however, feminist movements have also affected men's lives outside the labour market, most visibly in men's participation in domestic work and parenting, which have often been claimed to be even more important changes both regarding men's self-understanding and gender relations than those relating to labour. 'New fathers' and the changing of fatherhood have been topics gaining increasing interest among researchers of men and masculinities (e.g., Messner 1993, 725–728; Edley & Wetherell 1999; Huttunen 1999).

Men's increased interest and participation in parenting and domestic work, traditionally regarded as purely feminine areas, have brought out new qualities of a modern man, i.e. 'softer', more sensitive and more emotional styles of masculinity. The emergence of the 'New Man' has been considered to form a major challenge for the 'Traditional Man' (Messner 1993), due to new qualities being seen to conflict with traditional characteristics of the masculine, and this tension has resulted in the emergence of the 'Retributive Man' (Rutherford 1988).

> Today the flux of meaning around masculinity has produced a 'debate' between them. The representation of different masculinities has produced two idealised images that correspond to the repressed and the public meanings of masculinity: … the New Man and the Retributive Man respectively. (Rutherford 1988, 28.)

In the late 1980s when Jonathan Rutherford published his article on two idealised images of masculinity, the New Man may still have been a repressed form of masculinity. Therefore, he described the New Man to be an 'expression of the repressed body of masculinity' and a 'fraught and uneven attempt to express masculine emotional and sexual life' being a response to the structural social changes and feminism (ibid., 32). The Retributive Man, in turn, represented 'the struggle to reassert a traditional masculinity, a tough independent authority' as a counterforce to egalitarian values and gender equality (ibid., 28).

The notion of 'new' masculinities has led to analyses of how the 'new' discourses of masculinity have challenged the 'old' ones in various contexts on social interaction, both in private and institutionalised communications. From the point of view of men's health, a relatively new important field of enquiry has been the analyses of how various discourses of masculinity and health occur in media, which is one of the most important institutions and arenas where the discursive struggle for hegemony takes place. While some studies have reported that the newspaper articles on men's health tend to locate health strictly within feminine and women's arenas (Lyons & Willott 1999), men's lifestyle magazines establish new arenas for discussions on men and masculinities. An especially interesting example of this is *Men's Health* magazine, which is among the first magazines combining the traditional non-masculine topic of health with male readership. Due to its challenging new perspective (the interrelation between masculinity and health) the magazine has gained interest among researchers resulting in several analyses of how masculinities are (re)produced and how 'old' and 'new' discourses are negotiated within a health-context (e.g., Toerien & Durrheim 2001; Stibbe 2004; Parasecoli 2005; Crashaw 2007)[3].

[3] For similar analyses on men's health issues in other lifestyle magazines, see Bunton & Crashaw 2002, and Benwell 2004, and in newspapers, Gough 2006; 2007.

Studies on masculinities in media represent research addressed to cultural changes in diverse ideals of masculinity. The idea of hegemony emphasises a contestable and ideological character of such definitions within culture, where alternative forms of masculinities constantly challenge dominant definitions of manhood which, in turn, result in the reformulation of ideals. Hegemony is, therefore, not a state of stable and fixed conceptions but, rather, a point of comparison which alternative discursive practices are positioned to. Media is one of the institutionalised contexts where the struggle for hegemony takes place. At the same time, different discourses of masculinity are also interpreted and reproduced in other social contexts such as daily conversations. Masculinities are products of culture where people both reproduce masculinities and live by them. As Billig et al. (1988) note using Moscovici's (1984) term, 'the thinking society' is about interaction between individuals and society/culture where neither social basis of thinking nor individuals' interpretations should be ignored. This perspective on the reproduction of masculinities has been conducted in several studies on how masculinities are discussed, interpreted and negotiated in interaction, which I will review in the next section.

Negotiation of masculine identities and positions

From the point of view of everyday interaction, gender is not something that 'is' but something people 'do' within that interaction. As West and Zimmermann (1987) claim, 'doing gender' is an everyday process where people use their cultural knowledge and beliefs about what it is to be a man or a woman, representing normative expectations for situational categorisations. An essential past of 'doing gender' is differentiating 'us' from diverse groups of 'others' (West & Zimmermann 1987; West & Fenstermaker 1995). Edley and Wetherell (1997, 208) crystallise this 'definition by difference' by concluding that 'we define ourselves negatively, in terms of being different from somebody else. Those who are not "us" define who "we" are.' It has often been claimed that the most important 'others' to true masculinity are women and homosexuals. This 'basic' differentiation in defining masculine identities is of major importance in analysing masculinities since, as Donaldson (1993) points out, 'heterosexuality and homophobia are the bedrock of hegemonic masculinity'. Steve Garlick (2003) claims that the basis for this is in our idea of gender as strictly dualistic which maintains the existence of two oppositional sexes.

> Studies of men and masculinities routinely refer to gay men, along with women, as constituting the most significant "others" of hegemonic masculinity. Homosexuality is rightly seen as disrupting conventional ideas about what it is to

> "be a man". Yet because the existence of two *oppositional* sexes – male and female – is taken as given, this specifically *heterosexual* relationship, which grounds modern ideas about gender, is often overlooked. … Although it is generally recognized that masculinity and femininity are relational concepts – that is, to be masculine is to be *not* feminine and vice versa – little time has been spent inquiring into the specific nature of this relation. (Garlick 2003, 158, emphases original.)

In addition to women and homosexual men, hegemonic masculinities have been defined as opposite to non-white men, non-native-born men, non-professional men (see Hearn & Collinson 1994) or men otherwise not fitting the traditional ideals of manhood, such as those called 'sissies' or 'wimps'. Understandably, the latter labels do not carry such clear criteria for their use as in the case of ethnic or sexual minorities, for instance. Therefore, use of such labels is a much more complex issue incorporating subtle interpretations and meaning-making in the contexts where these, traditionally, non-masculine characteristics are used in producing identities. As there are, however, alternative views of masculinity challenging the dominant definitions, there are also new 'others' to those of traditional definitions. In other words, those men defining themselves as opposite to 'sissies' or 'wimps' may equally be called 'machos' or 'male chauvinists' by those holding alternative standpoints. This highlights the diversity of ideals attributed to masculinity and suggests that mere analysis of distinctions made by differentiating 'us' from 'them' does not, as such, provide us with a detailed picture of identity work in interaction (Edley & Wetherell 1997). Those distanced in identity work do not necessarily represent socially identifiable groups but are formed on the basis of *different values, attitudes, appearance and other qualities attached to people who act as 'others' for the contextual purposes of interaction*.

Among the first studies approaching contextual identity work from a detailed discursive perspective, Edley's and Wetherell's study (1997) is an interesting example of how masculine identities are constructed in interviews and how contrary themes and ideological dilemmas are negotiated within the constructions. Their study was aimed at analysing how traditional and modern ideals of masculinity, conceptualised in Rutherford's (1988) terms of the 'retributive man' and the 'new man', were negotiated in 17–18 year old boys' interviews, conducted in a school in the UK. The interviews consisted of group discussions of a subordinated group of boys who did not belong to a group of rugby-playing 'hard lads' dominating the school environment. As the distinction of boys into two categories was noticeable for the whole data collection period, the authors became interested in identity work of the members of a subordinated group and focused the analyses on 'the interviewees' efforts to construct alternative, counter-hegemonic identities for themselves' (Edley & Wetherell 1997,

208). From the point of view of differentiation, the group dynamics in the school embodies an interesting case where the Other is male which does not, therefore, allow the identity work to be based on a male-female distinction. Accordingly, the analyses demonstrate the nuances of how male-male group distinctions operate in an interactional context.

The study interestingly shows how traditional images of manhood, to a large extent, structure but do not determine identity work in interaction. When constructing their gender identity, one of the powerful ideological dilemmas, that the study participants considered in interviews, related to tensions between descriptions of the self as not being a 'macho' man, on the one hand, and avoiding effeminate positions ('wimps' and 'sissies'), on the other. This tension was articulated by the authors as a notion of 'I am a man, but not *that* type of man' (Edley & Wetherell 1997, 209, emphasis original). The participants used two different strategies for managing this position. On the one hand, they distanced themselves from beer-drinking, chasing girls, fighting and other 'macho' behaviours describing these activities as 'stupid rather than cool, pathetic rather than hard' (ibid., 210) representing a distinction between old-fashioned, chauvinistic, machismo masculinity and more egalitarian, liberal modern man. On the other hand, as mere withdrawal from these stereotypically masculine behaviours would potentially lead them to a threatened position of 'wimps', the participants also referred to traditionally masculine characteristics when describing themselves, such as having self-control and strength of character. From this perspective, 'macho' behaviours were considered to be evidence of rugby-players' shortcomings as men: 'the real hard men are those who do not need to dive on each other in an attempt to prove their masculinity' (ibid., 214). The study illustrates the diversity of elements used in identity work where attributes attached to different groups of men are selectively utilised for differing purposes in interaction. It also demonstrates that while the qualities of 'New man' were used as resistance to 'macho' characteristics, the more common strategy for displaying the masculine self involved 'buying back into values embodied within a more traditional definition of masculinity' (ibid., 203).

In another study, Wetherell and Edley (1999) analysed the same topic from a different perspective. The study was oriented to explore how 'men position themselves in relation to conventional notions of the masculine' (ibid., 335). On the basis of interviews with men of different age and occupational backgrounds, they identified three 'psycho-discursive practices' through which the men constructed themselves as masculine and negotiated qualities related to it. The authors called the first strategy *heroic positions* which come closest to the conventional idea of masculinity aligning the self with courageousness, physical toughness, being in control, taking challenges etc. This was, however, quite a rare practice of positioning in their interview material.

The most common pattern was *ordinary positions* where the traditional attributes of masculinity were described as stereotypes while the self was constructed as ordinary, normal, moderate and average, thus taking distance from 'extreme' forms of masculinity. The third pattern of discursive practices, *rebellious positions*, appears superficially as resistance to traditional ideas of masculinity. Here the self is defined in terms of unconventionality and discursive practices involve the flouting of social expectations manifested in the interviewees' accounts of being prepared to cry, support their wives, act as the primary caretaker of children, doing knitting and cooking, being dressed in unconventional ways and so forth. The authors, however, point out that these examples of rejecting conventional gendered ideas represent highly privatised and individualised rebellion rather than a political strategy: 'what is being celebrated in this discourse is not so much knitting, cooking and crying per se, but the courage, strength and determination of these men *as men* to engage in these potentially demeaning activities (ibid., 350, emphasis original). The analysis of discursive practices thus delineate that 'a simple dichotomy between resistant and complicit practices is not sufficiently subtle to capture the complex production of gendered selves that occurs in men's talk' (Wetherell & Edley 1999, 346–347). Furthermore, they also demonstrate that even 'rebellious' stands to traditional images are constructed in close connection to the conventional ideas and even operate on the same bases with them.

> [P]aradoxically, one could say that sometimes one of the most effective ways of being hegemonic, or being a 'man', may be to demonstrate one's distance from hegemonic masculinity. Perhaps what is most hegemonic is to be non-hegemonic! – an independent man who knows his own mind and who can 'see through' social expectations. (Wetherell & Edley 1999, 351.)

Men's self-presentational practices obviously vary depending, among others, on the topic of interviews. Sarah Riley's (2003) study on men's talk about provision and Willott and Griffin's (1997) analyses of men's interpretations of effects of unemployment on their masculine identity demonstrate contexts where men easily defend their conventional roles as breadwinners of the family. It might be argued that the traditional images of masculinity are evoked by the concrete and traditionally strongly male-associated topic, where central building blocks of the masculine self are under scrutiny and potentially threatened. Despite this, these studies also highlight another important feature in modern men's orientations in constructing gender. As noted in several studies, constructions of masculinity often include management of the potential threat of being seen as a sexist which results in in-advance replies to

potential counterarguments. This is because gender equality has become a valued characteristic of a modern person and 'a cultural truism or commonplace … an argument of principle which stands beyond question' (Edley & Wetherell 2001, 447, emphasis removed.)

In interaction, endorsement of equality leads to reducing 'hearability' of sexism (Riley 2001) as well as other strategies to avoid 'extreme' stands to gender and gender equality. As Edley and Wetherell (2001) and Riley (2001) have demonstrated, one additional means to express egalitarian ideas is to take distance from feminists and radical feminist thinking, which may be considered to represent fanatical positions to gender and thus potentially counter-effective ideas of 'true' equality. Representation of egalitarianism thus requires a two-sided management of ideological pressures towards constructions of masculinity and gender, in general. As Gough (2001, 183) suggests, 'a particular feature of doing masculinity in contemporary society concerns suppression, whether of masculine vices (such as aggression towards 'feminist' colleagues or partners) or politically correct sentiment (such as pro-feminist ideas in the presence of old mates), that is, "biting your tongue"'. Keeping balance between the extreme stands in identity work requires locating oneself somewhere in-between traditional masculinity and radical pro-feminist thinking.

The review of previous studies on the contextual construction of masculinity suggests three major conclusions. The studies presented here clearly demonstrate that talking about masculinity and constructing a masculine self in an interactional context is a highly ideological and moral enterprise with strong normative expectations structuring and setting limits for gendered positions available for situational identity work. Secondly, while the literature on men and masculinities and gender relations have generally suggested that ideological features of gender stem from power relations between men and women as well as different groups of men, the discursive studies highlight another perspective to ideology in interaction, which emphasises the importance of the struggle between 'old' and 'new' values and discourses in self-presentation. The ideologically dilemmatic positions between the 'extreme' stands to gender result in negotiating one's own location within these discourses in order to provide the self with the best of both worlds. Thirdly, the studies demonstrate that the mere notion of differentiation between men and women, and between certain groups of men in constructing masculinities is not sufficient to effectively analyse gender in contemporary Western societies which requires more detailed analyses of discursive practices adopted in positioning the self according to situational requirements.

Ideology, health and healthiness

> Health as an aim is inseparable from what people conceive the 'good life' to be – *health is ideological* (Radley 1994, 205).

Many of the recent writings and public debates relating to ideological characteristics of health and healthiness in Western societies have their roots in medicalisation critique. In the beginning of the 1970s, several researchers started to consider medicine as a means of social control alongside traditional normative systems of religion and law (e.g. Zola 1972). As Lupton (1997) has observed, in the 1970s and 1980s medicalisation critique was largely characterised by two dominant perspectives: one of feminism and another pointing to class hierarchy of society, mainly deriving from the Marxist tradition of sociology. Feminist critics of medicalisation viewed the medical profession and medicine as a largely patriarchal institution which maintained gender inequality by controlling women's lives and bodies by, for instance, medicalising pregnancy and childbirth that were earlier not medical concerns. From the perspective of class, medicalisation was equally criticised as a means of keeping control over the working class and other socio-economically disadvantaged groups, and thus maintaining the social hierarchies and social status quo by 'possessing the exclusive right to define and treat illness, thereby subordinating the opinions and knowledges of lay people' (Lupton 1997, 96).

Having the 'exclusive right' to define illness, medicine extended its sphere to cover issues that were previously not considered to be medical. As Conrad (1992, 209–210) points out, in its literal sense, medicalisation means 'to make medical' and thus describes 'a process by which non-medical problems become defined and treated as medical problems, usually in terms of illnesses or disorders'. Several forms of deviant behaviour and 'natural life processes' have gradually become subjects of medicalisation, as Conrad further suggests.

> Examples of medicalized deviance include: madness, alcoholism, homosexuality, opiate addiction, hyperactivity and learning disabilities in children, eating problems from overeating (obesity) to undereating (anorexia), child abuse, compulsive gambling, infertility, and transexualism, among others. Natural life processes that have become medicalized include sexuality, childbirth, child development, menstrual discomfort (PMS), menopause, aging, and death. (Conrad 1992, 213.)

These ideologically-driven characteristics of medicalisation, expressed among others in medicalisation critique, are very similar to notions of hegemonic masculinity as an ideological construct in two major respects. First, both concepts of medicalisation

and hegemonic masculinity have been conceptualised in ideological terms due to concrete power and control that men in dominating positions and medical professions have over other groups of people, i.e. women and subordinated groups of men, and lay people, particularly women and subordinated classes. Secondly, medicalisation and hegemonic masculinity have been approached as ideological concepts because the advantaged groups (men, medical profession) are thought to have the power to define situations, or in Donaldson's (1993, 645) words, to 'set the terms in which events are understood and issues discussed, to formulate ideals and define morality'. The long list of behaviours and processes of human life that have been increasingly conceptualised in medical terms, provided by Conrad, highlights the large extent of social phenomena over which medicine has the power to define terms, and even ideals and morality.

David Armstrong (1995) has used the term 'surveillance medicine' to depict an important change in medical thinking and practice during the twentieth century. While earlier medicine had been focused on curing diseases, ailments and symptoms of an individual patient, surveillance medicine turned the 'medical gaze' to observe seemingly healthy populations. This was caused by epidemiological transition in Western societies where chronic diseases replaced acute life-threatening infectious diseases, accompanied with an increase in life-expectancy and an ageing population, which marked a significant change in medical practice and disease prevention (Nettleton 1995, 11–13). The perspective of prevention was fostered by the development of socio-medical surveys and other quantitative methodologies, which offered new tools for examining large numbers of people instead of a single patient and uncovering numerous associations between health and illness. Simultaneously, there was an important change in medical thinking concerning health and illness:

> A symptom or sign for Hospital Medicine was produced by the lesion and consequently could be used to infer the existence and exact nature of the disease. Surveillance Medicine takes these discrete elements of symptom, sign and disease and subsumes them under a more general category of 'factor' that points to, though does not necessarily produce, some future illness. Such inherent contingency is embraced by the novel and pivotal medical concept of *risk*. It is no longer the symptom or sign pointing tantalisingly at the hidden pathological truth of disease, but the risk factor opening up a space of future illness potential. (Armstrong 1995, 400, emphasis original.)

Surveillance medicine thus *problematised the normal* by noting that, from the perspective of examination of risk factors, no-one was truly healthy due to the possibility of future disease. The basic concern of interest for surveillance medicine

was not anymore the illness per se, but the 'semi-pathological pre-illness at-risk state' (ibid., 401). Accordingly, the target group of surveillance medicine was not just patients anymore, but basically everyone: 'the patient was inseparable from the person because all persons were becoming patients' (ibid., 397).

The rise of surveillance medicine gave basis for prevention of non-communicable diseases which is a constitutive part of contemporary research and practice within public health and health promotion. Epidemiological transition brought chronic diseases into the focus of medicine and prevention of these diseases gained a legitimate and politically reasoned position in health promotion. That the preventive perspective started to dominate medical thinking also brought people's lifestyle and behaviours into the centre of health promotion research and practice due to several behavioural factors being found to be associated with chronic diseases. This, in turn, resulted in increasing efforts to encourage people to adopt healthier lifestyle habits, and avoid unhealthy behaviours, which were mainly implemented through large health education campaigns organised in most European countries since the 1970s.

Enlargement of preventive measures addressed to populations through health education campaigns reshaped the earlier medicalisation critique. The criticism towards ideological features and exercise of power were no longer directed primarily at medicine in the context of health care but covered a larger sphere of activities and actors of public health. Health education and health promotion practice were criticised for their focus on changing individual behaviour instead of paying attention to structural, material and social surroundings where the behaviours take place. Robert Crawford (1977) was among the first who discussed the ideological features of the overly individualised approach of public health policies in the United States. He connected the individualised approach to increased costs of American health care in the 1970s and saw the 'ideology of victim blaming' as a response to a 'cost crisis' aimed at reducing the costs by shifting the responsibility for health from government to individuals. According to Crawford (ibid., 670), the victim blaming ideology helped to 'justify shifting the burden of costs back to users' of health care by taking a moral stand to promote responsibility for one's illness: 'If you are responsible for your illness, you should be responsible for your bill as well.' Crawford regarded health education and economic sanctions as a means to enlighten and reinforce individuals' sense of responsibility for health, which was assumed to result in a decrease in health care utilisation. These activities had clear political and ideological purposes.

> Similar ideologies of individual responsibility have always been popular among providers and academics trying to justify inequality in the utilization of medical services. During the period of rapid health sector expansion, higher morbidity

> and mortality rates for the poor and minorities were explained by emphasizing lifestyle habits, especially their health and utilization behaviour. … Structural barriers, such as provider resistance or unavailability of services, were rarely mentioned. … Previously, the poor were blamed for not using medical services enough, for relying too much on their own resources, and for undue suspicion of modern medicine. Now they are blamed for relying too much on admittedly ineffective medical services and not enough on their own resources. (Crawford 1977, 670.)

The quotation above highlights the highly politicised nature of critique towards public health policies where health education, among others, was seen as a means to control the disadvantaged groups, direct their behaviours to fit the aims of public policies and, simultaneously, to maintain social inequalities. This theme has remained as one of the central topics within the critique towards individualised approaches to health promotion. It has often been claimed that the individualistic perspective represents a political agenda, where reluctance to make structural changes for reducing inequalities in society is an ideological choice (e.g., Hayes 1992; Shaw, M. 2002).

In another influential article, Crawford (1980) continued the discussions initiated in the previous one (Crawford 1977) in order to provide 'a more in-depth and broader examination of the structure' of the ideology of individual responsibility for health. While the former article was 'aimed more at elaborating the instrumental or functional uses of the ideology' the following article comprised an 'attempt to identify some of the concepts and suppositions of the new health consciousness'. (Crawford 1980, 367.) In this article, Crawford developed a concept of 'healthism', which has since been one of the most utilised concepts within sociological studies of health and illness. Healthism refers to a culturally dominant idea where responsibility for health is increasingly put onto the individual through his/ her health-related behaviours and practices that are aimed to modify 'with or without therapeutic help'. While the disease etiology may be complex, 'healthism treats individual behavior, attitudes, and emotions as the relevant symptoms needing attention'. Even though 'healthists' acknowledge that the origins of unhealthy practices may be societal and cultural, solutions to health problems are seen to lie 'within the realm of individual choice'. As an ideology, healthism promotes health awareness, personal control and change. (Crawford 1980, 368.)

As Crawford's article (1980) approached healthism as a socio-cultural phenomenon, the ideology was not so firmly attached to certain groups of people or professions as it was in the previous article (Crawford 1977), which emphasised power held by medical professions and policy-makers. Instead, the focus in discussions of ideology was more on the moral implications that the ideology of individual responsibility for

health had for people in their everyday lives, and on the notion of blame for illness. While Crawford notes that self-responsibility itself does not necessarily equal blame, he claims that healthism, as an ideology, brings the blame front-stage.

> As an ideology … which focuses so exclusively on behavior, motivation, and emotional state, and as an ideology of self-improvement which insists that change and health derive from individual choices, poor health is most likely to be seen as deriving from individual failings. (Crawford 1980, 378.)

The thread going through Crawford's writing is that health is an increasingly ideological and moral issue. The ideological nature of healthism clearly derives from the notion of power that either the medical profession or dominating ideas of origins of health and illness have over interpretations of people's inner states and daily practices[4]. Simultaneously, since health and illness are conceptualised in terms of individual behaviours and choices, they become not only subjects of ideological debate but also of moral judgement. As Bergmann (1998, 284) suggests, the notion of possibility of choice is 'the presupposition for the attribution of responsibility. Once [the people] are equipped with this capability of choice, they may be held responsible for their doings.' Regarding moral attiributions attached to health, Crawford (1980) also points out that healthism has led to 'elevating health to a super value, a metaphor for all that is good in life' which, in later terminology, indicates that healthism has gained a position of a *hegemonic discourse* with an extension to concern not only physical or mental health but 'good life' in general. As Karisto et al. (1993, 187) conclude, health has become 'a kind of super-value or a common sieve prism of well-being' used to value an increasing number of things in everyday life. Consequently, if something is good for health, 'it is beneficial to the whole well-being of an individual, by definition (ibid., 187).

Peter Conrad (1994) used the concept of 'healthicization' to describe a process complementary to medicalisation. Healthicization comes close to Crawford's notion of 'healthism' in Western societies, but articulates more explicitly the interconnections between medicalisation and the societal processes leading to increasing valuation and the moral dimension of health. While medicalisation opens up utilisation of medical terminology and interpretations regarding social problems, healthicization leads to interpreting possible social determinants of medical problems (especially

[4] Vaskilampi (1981, 193), for instance captures this as follows: 'In health education, medical professionals define the values and norms of behaviour: that which is healthy is good, and that which is unhealthy is bad. Thus the medical profession is an agent of social control in everyday life.'

health-related behaviours) in moral terms: 'one turns the moral into the medical; the other turns health into the moral' (Conrad 1994, 387).

The notion of 'super value' of health reshapes how power is seen to be involved in healthism and the medicalisation of everyday life. While the medicalisation critique largely approached the medical profession as an agent of social control, 'ideology of healthism' emphasises another angle of power, that of self-governance. The Foucauldian perspective to power, which underlines the non-coercive and non-repressive strategies of power that exist alongside the repressive control of the ruling class over lower classes, has often been adopted when interpreting the ways in which normativity and morality involved in healthism work in everyday life (see Lupton 1995). In addition to 'normalisation', healthism also provides people with strategies for 'practices of the self' (Lupton 1997). From this perspective, it is worth noting that individual responsibility for health resonates with many other central values of Western cultures.

> [H]ealth is a moral discourse, an opportunity to reaffirm shared values of a culture, a way to express what it means to be a moral person. … Self-control, self-discipline, self-denial, and will power may be attempted not only *in order to achieve* health; they may constitute the symbolic substance, the implicit meaning of the pursuit of health. It is possible to say that health is thought about in terms of self-control. It is equally possible that the concept of self-control is 'thought' through the medium of health. (Crawford 1984, 76–77.)

Some authors have suggested (e.g., Conrad 1992) that one reason for the heightening position of health within a social system of values is increased secularisation of Western societies. As religion has lost its sole right to define morality, healthism becomes a new moral code for identifying and decoupling 'good' from 'bad' life, acceptable from blamed acts, decent citizens from sinners. Førde (1998, 1158) rightly notes that in an age where health is 'worshipped as the principal life value', adoption of the moral imperative follows the same characteristics as in religious communities: 'individuals tend to be valued according to their adherence to recommendations'. Following Crawford's quotation above suggests, however, that it is not necessarily so that healthism itself sets the norms and morality but that health itself acts as an arena for reaffirming central values of culture regarding the morality of an individual. Health, therefore, represents a 'medium' for interpreting morality. In sum, due to its position as a 'super value' within contemporary Western societies and its connotations with several other central values, such as rationality and self-control, the 'moral imperative of healthiness' (Backett 1992a) is central to modern people's self-understanding as a moral person and good, responsible citizen.

'Risk discourse' and contrary themes of lifestyle and health

In recent decades, risk has become one of the key concepts of health research and health promotion. Risk factors of various diseases and public perceptions of them have become a focal point in medical and health promotion literature which is, however, a relatively new phenomenon in the history of medicine. As reported by Skolbekken (1995), there emerged a 'risk epidemic' in medical journals between 1967 and 1991. Based on searches in *MEDLINE* and a selection of medical journals, it was revealed that both the number and share of 'risk-articles' (articles containing 'risk(s)' in the title and/ or abstract) have increased dramatically during the period covered by the study. The trend is continuing: more than 50% of all registered 'risk-articles' were published in the last five years of investigation. As the word risk has several meanings and synonyms, one possible explanation for the results could be a change in the terminology used over the period. Additional searches for the terms 'hazards', 'dangers' and 'uncertainties' did not, however, show significant changes in the number and share of articles published containing these concepts. Accordingly, Skolbekken concludes that the dramatic increase in the use of the term risk has not been due to a change in terminology. As causes for an increased focus on risks (as well as hazards, dangers etc.), Skolbekken mentions developments in computer technology and probability statistics, as well as a shift in medical thinking and ideological assumptions of public health research. By the ideological backgrounds of risk epidemic he refers to health promotion: 'for various health promotion strategies the identification and estimation of risk factors have been regarded as basic knowledge and a major path on the road to improved health' (Skolbekken 1995, 298).

The concept of risk and its use in public discourse have received much attention among researchers since the early 1990s. The content of 'risk' has changed over decades as Mary Douglas (1990) has shown. Originally, the concept was introduced in the context of gambling, meaning the neutral probability of an either positive or negative event occurring, i.e. gains or losses in the game. Over time, the concept has come to be used in many other contexts of social life. Simultaneously, the content of 'risk' has narrowed to mean probability for the occurrence of a negative, unpleasant and undesired event. Any risk is nowadays negative (Lupton 1993). Winning in a lottery is not described as risk. Recently, risk has become a synonym for threat and danger: high risk means a lot of danger (Douglas 1990).

The concept of risk fits well with the individualistic consumer cultures enabling an individual, at least ostensibly, to self-assess the seriousness of a potential health hazard. Continuous assessments of threats and their likelihoods is a constitutive part of life in contemporary 'risk societies' (Beck 1990; Giddens 1991). Despite rapidly

increasing use of the concept, it is used inconsistently in health promotion research and practice (Hayes 1992; Skolbekken 1995), often without analysing assumptions of human behaviour and society. With reference to health, the concept of risk has many differing contents. The difference between a 'risk factor' and risk as likelihood has diminished even in scientific terminology. Nowadays, lack of physical exercise and smoking are often called 'health risks' instead of 'risk factors of disease'. Instead of calling them factors increasing the risks of developing certain diseases, these well-known risk factors of diseases are often considered as threats to health as a whole. Comparing concepts of 'disease risk' and 'health risk' clearly illustrates the imbalance in terminology. Disease risk refers to a known prevalence or incidence of a disease in a certain population, based on statistical association between risk factors and (clinically) observed outcomes. Health risk, instead, is far from exact and seems to refer generally to things which are – or are expected to be (potential risks for health) – in association with diseases and, thus, threats to health.

Knowledge of potential dangers is tightly linked to risk: if connections with health are not known, the subject cannot assess potential threats related to their behaviour, environment etc. Often things may become a threat to health if certain other factors pertain or processes take place. This further widens the assessment of the actuality of potential threats. A risk related to a concrete thing, action, incidence or choice may still be controllable. This is especially the case when the likelihood of an undesired outcome is connected only to that very issue in hand and actualises in a short period. It is far more difficult to consider such actions or incidences where several factors intertwine simultaneously and which the individual is not even aware of. It is a lot easier to choose a slalom slope fitting the abilities of the skier, weather conditions etc. than to assess long-term health outcomes of alcohol drinking or diet. The potential health threats that people have to consider in life differ in many respects, i.e., in the time period in which the threat may occur and in what chances the individual has to influence the situation if the illness has occurred.

Risk is originally an expert concept from epidemiology that an individual may find difficult to conceive of in their everyday life. That is mainly due to the variety of threats to our health around us and the complexity of aetiology of many diseases. In considering the extent of information produced by epidemiology, and public perceptions of this information, several studies have taken cardio-vascular diseases as an example of large numbers of risk factors that should be taken into account for avoiding illness. As van de Vathorst and Alvarez-Dardet (2000) point out, consideration of 218 reported risk factors for heart attack is difficult even for trained cardiologists. This notion leads the authors to pose an important question: would lay people really avoid 218 things in their lives just for one organ?

Skolbekken (1995) concludes that risk factors of epidemiological research too easily become implicit causal factors of diseases, which is in conflict with principles of good academic research.

> Risk factors do in many cases serve as causal hypotheses, a status, which is frequently stretched beyond the rules of good science, when these hypotheses are treated as if they were already verified. … Having gained this causal status, rightly or not, makes the risk factors subjects to treatment. They become diseases to be cured. (Skolbekken 1995, 299.)

Skolbekken's previous extract contains important notions about dilemmatic aspects included in information about health. Avoiding hundreds of things in life for the sake of health is impossible. On the other hand, some of these risk factors may receive a completely new status as equivalent to disease themselves. This tendency is clearly seen in the use of expressions like 'treatment of nicotine addiction' or 'obesity is a new public health problem'. Even if one does not consider the medicalisation of every-day life, potential social control, and other political aspects involved in current health promotion discourse, the risk discourse obviously has significant influence on the lives of people in contemporary Western societies.

Today, people receive information on health from many sources, where media is one of the most important. Health promotion campaigns aimed at marketing healthy lifestyles utilise media and have to struggle, then, with messages from competing sources (Lupton 1995; Gwyn 2002; Randolph & Viswanath 2004). On the other hand, journalists themselves produce and publish a lot of material on health using officials, researchers, representatives of commercial companies and NGOs as sources of information (e.g., Lupton 2004; Shaw 2004). In Finland, according to retrospective studies, health keeps being one of the highest valued things in people's lives. Accordingly, health is an issue that sells and may, thus, be utilized in advertising (Lumme-Sandt & Aarva 2005). From a critical point of view, health and well-being 'tips' are now a perennial feature of an approach to health which has become not only overwhelmingly individualistic but also increasingly consumerist: health is something the individual purchases (Shaw, M. 2002). The health information available for citizens mostly originates from health education campaigns, health journalism, the internet, advertising and public debate on health and health care. In addition, people receive health information when they come into contact with health professionals, such as doctors and nurses.

An 'epidemic' of risk information, an increase of diverse advice for healthy lifestyles and a multiplicity of sources of health information may result in contradictory views

of the healthiness or un-healthiness of behaviours or other health-related 'factors' which, in turn, produces problems or even dilemmas for interpreting information. The problems become even more complicated when taking into account the moral aspects that are inevitably included in the information. In their theoretically valuable article, Frankel, Davison and Davey Smith (1991) summarised results from the South Wales Heart study and suggested new perspectives in the research of risk behaviours. On the basis of previous research they conclude that since poor compliance to lifestyle advice has been regarded as a major problem in health education interventions, the key concern in the health education research has been to discover why people fail to adopt the practices advocated by the health educators and practitioners in primary health care. They further point out that a standard answer to this incompliance is to consider people's beliefs and behaviour as irrational, although this answer may be oversimplified. Instead of simply attributing resistance to or neglect of health education messages to irrationality, researchers should understand the viewpoints of those whose behaviour they seek to change. This is especially important in considering lay people's 'knowledge' about health and illness. The authors suggest, as one of their general observations from several studies, that public perceptions of health risks are the outcomes of a process called 'lay epidemiology', which:

> refers to a scheme in which individuals interpret health risks through the routine observation and discussion of cases of illness and death in personal networks and the public arena, as well as from formal and informal evidence arising from other sources, such as television and magazines (Frankel et al. 1991, 428).

The concept of lay epidemiology thus interestingly illustrates how 'health beliefs' is in fact a continuous process of interpreting and combining information coming from diverse sources and contrasting, or 'testing', information with personal and socially shared experiences. Truthfulness and adaptability of information is therefore assessed by mirroring it with other, possibly contrary, pieces of advice regarding healthiness. Studies on lay people's ideas of health and illness have demonstrated that people interpret probabilities of illness differently depending on how concrete and 'close' the threats are perceived to be. Generally, people may well be aware of the potential negative outcomes of smoking, excessive alcohol drinking etc. from formal sources as well as personal and shared experience. Despite this, the researchers maintain that:

> where the individual risk is so small or long term that its assessment is beyond the experience of the individual, or where the changes required to reduce the apparent risk have social, personal or economic effects, different considerations apply (Frankel et al. 1991, 428).

The authors thus note that the temporal dimensions of health threats play an important role in 'risk' perceptions accompanied with the notion that concrete dangers are easier to comprehend compared with other, more abstract threats[5]. In addition, they point out that despite the potential health threats involved in environments or practices of everyday life, several of them include positive aspects for people as well, which are therefore also considered when thinking of possible changes in lifestyle, for instance. Several unhealthy practices (such as smoking and drinking) produce pleasure for people and may be, in some contexts, socially beneficial as well. In addition, as Lupton and Tulloch (2002a) have recently shown, some forms of 'risk behaviours' may be tempting to people specifically due to potential dangers involved in them, which thus offer feelings of power and being in control for people engaged in these activities. In another article (Davison et al. 1992), the authors further conclude that different disorders and diseases also tend to have different public images in terms of the likelihood of self-infliction by the sufferers:

> Diabetes, for example, along with some cancers, brain haemorrhage, and many common infectious diseases generally stand at the 'least fault' end of the spectrum. Sexually transmitted diseases, cirrhosis of the liver and lung cancer are more strongly associated with a personal contribution towards cause from the sufferer. The category 'accident' exists to give cultural order to sudden, violent physical damage and while the concept is defined in terms of the victim's lack of influence over the event, a complex explanatory procedure often re-introduces some measures of blame and fault. (Davison et al. 1992, 678.)

The previous quotations give reasons for two important features of public interpretations of 'health risks'. First, different health threats, whether they concern behavioural or environmental determinants, have differing statuses in terms of the extent to which their health-effects are agreed. While health-effects of certain behaviours, for instance, may be widely accepted and agreed, this does not apply equally to all behaviours which, in turn, results in the individual negotiating these effects by comparing official with unofficial information and, further, with personal experiences. Secondly, as noted, different diseases also vary in terms of their moral dimension regarding the responsibility attached to sufferers and perceived self-infliction of diseases or accidents. This also highlights that individual responsibility is differently interpreted in terms of different activities that the individuals perform which, in cases of illness, become assessed as 'causes' of disease. The latter quotation

[5] Some studies have also shown that people tend to underestimate the impact of common risks (such as heart disease and diabetes) and to overestimate uncommon events (such as death by murder or being struck by lightning) (Stewart et al. 2004).

thus suggests that the most well-known 'risk-behaviours' of certain diseases, such as smoking, extensive alcohol use, lack of exercise etc, are more easily subjected to moral judgements compared to some other activities, such as driving a car or playing football or ice hockey, independent of the 'risks' involved in them. In other words, the health-related behaviours and choices are hierarchical in two different senses, both in terms of their perceived (un-)healthiness and moral appropriateness.

Despite the fact that lay epidemiology acknowledges and interprets a multiplicity of health-related factors, an important finding from studies on lay explanations of health and illness has been the notion of people's tendency to conceptualise causes of health and illness in terms of health-related behaviours. Mildred Blaxter's work (1997) on lay conceptions of reasons for health inequalities exemplifies this. In her article she demonstrates, on the basis of large surveys, how people with different social backgrounds explain health and illness largely by health behaviours and individual choices, instead of social and structural causes. The participants in the study expressed the idea that the responsibility for one's health rests with the individual. Structural inequalities were not prominent topics in lay presentations. A paradoxical finding from the study was that structural conditions were least considered among those respondents most likely to be exposed to disadvantageous environments. Alongside this general tendency of emphasising individual behaviours, there was, however, variation in explanations depending on the question context in the surveys. Contexts addressing health from a general perspective, asking respondents for explanations for *people's* good or bad health, easily elicited behavioural explanations. Contrary to this, in explanations for the respondents' *personal* health, the behavioural causes were less frequently invoked. Blaxter (1997) concludes that general emphasis of individual health-related practices in lay conceptions of causes for health and illness are likely to be an outcome of extensive health promotion activities over recent decades and the currently dominating idea of 'healthism' in Western cultures. Both are probable reasons for why people easily express individualised ideas that they assume the interviewers are expecting from them in surveys and other forms of interviews.

Although increased health awareness amongst populations have usually been taken as a success of health promotion activities, it is also important to note that increased awareness of risks may also create anxiety in people. Terrorist attacks and other dramatic events, new incurable infectious diseases, disasters and catastrophes, reported in news media every day, may well produce uncalled-for anxiety in the population (cf. Razum et al. 2003). As Petrie and Wessely (2002) point out, media's increased coverage of health topics is among the plausible reasons why people generally feel increasingly vulnerable, which is visible in many people's tendency to interpret every-day symptoms, such as head-ache and fatigue, as signs of disease or ill-health.

People's tendency to increasingly react in a negative manner to diverse symptoms has been reported as far back as 20 years ago. Barsky (1988) used the term 'health paradox' to describe a paradoxical tendency in the United States: while the health of the nation had objectively improved dramatically over past decades, the surveys reported people's growing dissatisfaction with their personal health accompanied with increasing use of medical services. Barsky attributed this, in addition to epidemiological transition, to heightened health awareness of the population, commercialisation of health, and medicalisation of everyday life. All this presumably results in people's expanding, even over-reacted, alertness with their bodily processes and lowered threshold to interpret symptoms as signs of disease. Equally important is that extensive information about risks may also create an unrealistic illusion of absolute controllability of human life where potential threats are manageable and thus avoidable. As Barsky (ibid., 417) notes, 'illness seems all the more disturbing because we think it need not have happened at all'.

> Health … includes many other dimensions than just absence of disease. The problem is that an extensive and dogmatic healthy lifestyle easily grows into general risk aversion and risk intolerance, which in turn may harm some of those other elements of the expanded health concept. A growing intolerance to risks and uncertainty is hardly the best basis for self-realisation and coping as long as uncertainty, unpredictability and risk are an inherent part of any human life that is worth living. (Førde 1998, 1157.)

On the basis of this section, three major conclusions are suggested. First, the 'risk epidemic', an expansion of knowledge of a variety of 'risk factors' associated with health, has both increased people's awareness of determinants of their personal health and hampered interpretations due to the mass of diverse information coming from multiple sources. This easily leads to scepticism among the lay public since contradictory messages undermine credibility of all health information. Secondly, 'healthism', in terms of discourse of healthiness[6], may be considered as a hegemonic discourse dominating the views on health in contemporary Western societies which even over-emphasises individual choices and healthy lifestyles as key determinants of health. Thirdly, as a consequence of dominating individualised discourses of health, the moral connotations of health have increased, which has resulted in a

[6] In this study, I use the term discourse of healthiness to refer to healthism as a discursive construct. Other conceptualisations, such as 'risk discourse' (Lupton 1993), with its reference to avoidance of threats, does not adequately fit in a study focused on interactive construction of healthiness, since these constructions not only concern avoidance of risks but also other aspects of health and healthiness, such as one's own current state of health.

strengthening of expectations towards individual responsibility for health through healthy lifestyles.

Managing moral imperatives and contrary themes of healthiness in interaction

Bunton and Burrows (1995) have discussed health promotion in relation to consumer culture in post-modern societies. Their basic idea is that health promotion has emerged within contemporary consumer culture and is centrally concerned with influencing patterns of consumer choice. In promoting lifestyle choices supposedly conducive to health and attempting to minimise preventable conditions, health promotion has changed expectations for and roles of people in relation to health from passive receivers of curative medicine to active promoters of their own health. Discussing Parsons' well-known theory of the sick role, the authors suggest that along with the *sick role* of modern societies there has emerged a *health role* in post-modern societies. The central idea of Parsons' (1951; 1958) sick role was that in return for being relieved from fulfilling normal duties at work for the duration of their temporary incapacity, the sick are obliged to attempt to get better and to seek expert assistance and comply with the recommended treatment regime. In contemporary post-modern societies, in turn, the responsibilities of people have grown from complying with the sick role obligations in episodic states of sickness to continuous involvement in professional interventions concerning not just the sick but general healthy populations as well.

> The contemporary citizen is increasingly attributed with responsibilities to ceaselessly maintain and improve her or his own health by using a whole range of measures. To do this she or he is increasingly expected to take note of and act upon the recommendations of a whole range of 'experts' and 'advisers' located in a range of *diffuse* institutional and cultural sites. (Bunton & Burrows 1995, 208; emphasis original.)

The idea of the 'health role' and obligations related to it include two major critical issues. First, in relation to Parsonsian sick role theory, an individual's obligation to seek help and comply with recommended treatments arose from the fact that sickness had relieved him/ her from normal duties. The individual was, then, expected to 'compensate' for this by complying with treatment. In the 'health role', in turn, the immediate 'benefits' the individual receives from *lifestyle compliance* are much more obscure. Another difference in these two roles is in the identity of those setting the obligations. For the sick, it is the doctor, at the first stage, who gives the treatment and advice as well as follows the compliancy of the patient. In the post-modern

health role, instead, the instructor or controller is often faceless and nameless. As Bunton and Burrows (ibid.) claim, the 'experts' and advisers are 'located in a range of diffuse institutional and cultural sites' but identifying them is, however, much more complex than in the case of the sick role. Both these notions highlight, in fact, the central characteristics of the health role as a moral rather than functional category. Irrespective of the benefits for expressing 'lifestyle compliance', and who it is presented to, healthiness is a matter of high importance for people today.

As noted above, in the context of choices related to lifestyle, the concept of risk includes a moral dimension (Douglas 1990). People who are aware of risks but do not act in accordance with advice aimed at reducing risks, may be accused of acting irresponsibly. 'Risk-taking' is, thus, an individual choice that has consequences in respect of an individual's position in the community. In cases where an individual does not follow the norms regarding risk awareness, non-conformity may be seen as violating the norms of the community. As Lupton (1993) notes, acting against advice on healthy lifestyles may be taken to reflect an individual's lack of will-power, moral weakness, venality and laziness. Simultaneously, it is important to keep in mind that various risks differ in their social acceptability: smoking is often considered as a sign of conscious indifference to health, while diving is thought to be a fashionable and exciting hobby. Accordingly, moral aspects involved in different types of 'risk-behaviours' do not have similar normativity regarding their social acceptability.

Moral obligations to contrary themes of healthiness result in negotiations in interaction which have been analysed in several studies among lay people[7] (e.g. Calnan & Williams 1991; Backett 1992a; 1992b; Mullen 1992; Conrad 1994; Sachs 1996). When talking about health and considering healthiness of their daily practices, people also consider acceptability of these practices and behaviours in moral terms. The primary reason for this is the notion that health is a moral issue to the extent that discussions of health almost inevitably involve considerations of responsibility, especially when considering behaviours and practices. This moral talk articulates qualities of the speaker: the pursuit of health is the pursuit of moral personhood (Crawford 1994). Thus, in interaction, people do not merely express their 'health beliefs' or other opinions to each other as fixed inner attitudes; they also make claims about themselves.

> They also construct their state of health as part of ongoing identity in relation to others, as something vital to the conduct of everyday life. This means that

[7] Due to widespread information of health, the ontological status of the category of 'lay' people may well be questioned, as Ian Shaw (2002) has demonstrated. As my interest in this study is not in interrelations between 'expert' and 'lay' knowledges of health, I use here the term lay people when referring to people who do not deal with health issues on a professional basis.

> the accounts that are given of health and illness are more than a disclosing of a supposed internal attitude. In offering views, people are also making claims about themselves as worthy individuals, as more or less 'fit' participants in the activities of the social world. (Radley & Billig 1996, 221.)

Due to contrary and contradictory themes involved in discourses of health, making claims about ourselves 'as more or less "fit" participants' of society is not a simple task. The potentiality of moral judgements relating to individual responsibility leads to 'face-threat' in talking about health (Jolanki 2004), especially in the context of an interview with a health researcher, who is easily assumed to expect 'right answers' from those interviewed (Blaxter 1990). Contrary themes of healthiness lead to negotiation of different aspects of health and healthiness as well as causalities related to health and illness. While discourse of healthiness, involving representation of a responsible, rational healthy citizen, may well be a dominating way to construct events, practices and identities, negotiation of contrary themes also activates other discourses that challenge the dominating ones, as Crossley (2002), among others, has shown on the basis of focus group discussions. In her study, resistance and 'rebellion' positions were adopted when valued moral states of health were considered 'wearing' and 'over-bearing' which led the participants to assert ' their own psychological independence and autonomy over and against what are perceived as "imposing" cultural restrictions' (ibid., 1482). Ideas such as 'life would be pretty dull without risk' and 'risk is part of your life' (Lupton & Tulloch 2002a; 2002b) might be interpreted either as discursive resistance of health promotion activities and discourse of healthiness, emphasis of autonomy, or even representation of 'anti-health ideology' (Karisto et al. 1993). Regardless of how these responses are interpreted, they show that lay understanding of causalities and determinants of health and illness involve critical tones, despite frequently expressed compliance with healthy lifestyles.

3 QUESTIONS, DATA, AND METHODOLOGY OF THE STUDY

In this chapter, I formulate the specified research questions on the basis of previous literature reviews. The empirical part of this study is based on thematic *personal interviews* and *focus group discussions* with male paper mill workers from the Pirkanmaa region of Finland. In the chapter, I introduce the research material and rationale for the chosen sampling strategy (selection of interviewees and types of data), describe the interviewing process and briefly discuss interaction within the interviews in regard to methodological considerations relating to specific characteristics of interviewing men about health. In addition, I introduce the methodological approach and analytic process of the study.

Aims and questions of the study

On the basis of the review in the previous chapter, it may be summarised that both masculinity and healthiness involve ideological themes, are structured by certain hegemonic discourses and raise normative expectations for how people talk about them thus exposing individuals to moral judgements about their conceptions and actions. Despite this, both of them possess inconsistencies and contrary themes that need to be solved in interaction. Different contexts actualise different aspects of masculinity and health and these contrary themes need to be puzzled over to create a more or less consistent form enabling construction of consistent selves in interaction. As gender and healthiness are ideological issues, involving normative expectations for language use, interview talk about the subjects is thus a potentially face-threatening, moral concern.

Contrary themes, and counter-discourses that challenge the hegemonic ones, are especially important to consider as they incorporate ideological aspects that people have to consider in their daily lives. A common occasion in which this consideration takes place is conversation or, as a specific form of face-to-face interaction, such as an interview. Analysing conflicts *between* and *within* constructions of masculinity and healthiness on the basis of interviews requires a detailed analysis of rhetorical practices that people use in managing contrary themes involved in both subjects in order to represent identities that correspond with the contextual requirements for representation of healthiness and masculinity.

As both masculinity and healthiness are constructions of several competing discourses, they inevitably include contrary themes that potentially lead to dilemmatic

situations in discussing the topics and self-presentations in interaction. It is, however, necessary to keep in mind that *not all dilemmas are ideological* in nature. If we subscribe to an idea of a dilemma being 'a situation that requires a choice between options that are or seem equally unfavourable or mutually exclusive' or 'a problem that seems to defy a satisfactory solution' (http://www.thefreedictionary.com/dilemma), we may easily conceive conditions where equally unfavourable or mutually exclusive options exist but are not bound to ideological or normative choices. On the other hand, it is equally important to note that *not all conflicts are dilemmatic*. For these reasons, the analyses of this study are aimed at identifying ideological, contrary and conflicting themes in men's interview talk without prior assumption of all of them being ideological dilemmas.

The general aim of this study is to analyse ideological, contrary and conflicting themes involved in situational constructions of gender and healthiness in men's interview talk and how the potential tensions, conflicts and dilemmas are represented, negotiated and resolved in interaction. The study has, therefore, a dual primary aim. On the one hand, it is aimed at identifying contrary themes, and potential ideological dilemmas, related to healthy lifestyles and masculinity occurring in men's interview talk. The conflicting themes may concern both interrelation between masculinity and healthy lifestyles and contrary themes involved in both of them separately. On the other hand, the study focuses on discursive practices utilised for resolving these conflicts and contextual variation in them. Analysis of discursive practices is aimed at shedding light on cultural resources in use when the participants display certain versions of masculinity, or of the healthy citizen, in an interview context. In my interpretation, ideological themes, conflicting ideas and discursive practices used in managing conflicts form the essential elements of the 'lived ideology' (Billig et al. 1988) of masculinity and healthiness.

The primary aims of the study are divided into four research questions and tasks of analysis. The first task of the study is to *identify different conflicts related to healthiness, masculinity and their interrelations, and contextual variations related to them*: are there topics that are particularly 'conflict-prone' (e.g., certain behaviours) compared to others subjects? The second task relates to situational management of conflicts and ideological dilemmas: *how are the potential conflicts which emerge in interviews negotiated and what kind of discursive practices are used for resolving the dilemmas*? Conflicts which emerge in an interview are not always expressed explicitly. On the contrary, it may even be assumed that the more value-laden expectations attached to the topic of an interview are, the less visible the signs of conflict become. Therefore, in identifying potential conflicts and dilemmas, the material is read in detail paying attention to subtle signs of disagreement and disharmony. The third

task is to *outline to the extent to which different aspects of health and healthiness are interpreted in gendered terms in different contexts*: do all behaviours, practices and ideas attached to health have similar gendered characteristics in discourse, and if not, how do they differ from each other? One of the constitutive assumptions of the study is that talking about health and gender in an interview context is not merely about information transmission from the side of the participants but also about construction of the speaking self. Therefore, the fourth task is to *outline how self-presentation is regulated by contexts and issues under consideration*: are health, taking care of health and masculinity discussed differently in different contexts? One particularly interesting topic is the potential differences in personal and non-personal contexts: are aforementioned topics discussed differently when considered in a framework of a person's own life compared to other frameworks concerning other people or 'people in general'? The research questions of the study are mutually intertwined in many ways. Therefore, analyses of all research questions are incorporated in thematic analyses in each chapter.

Why study paper mill workers?

Participants were chosen among paper mill workers for practical reasons related to data collection as well as ensuring relative homogeneity of the material. Initially, my idea in collecting interview material was to discuss health issues with 'ordinary Finnish men' for analysing men's perspectives on health and gender. When considering strategies for identifying and recruiting these 'ordinary Finns' for interviews, it soon became obvious that an 'average' Finnish man is a concept that may not have an equal in real life. Getting some idea of 'ordinary Finns' and their ideas about health and gender would, even in the best case, be about making conclusions on the basis 'average' responses, an approach, which does not fit the logic of this type of research. Furthermore, gaining variation in terms of the participants' social status, education, income and so forth would have required increasing the number of participants significantly which, in turn, would have made a through analysis of the data impossible. It was therefore decided that the interviewees should be selected from an occupational group with no large variation in their education, occupational status and income. The paper mill workers offered an applicable occupational group to the study due to their relative homogeneity.

Another reason for interviewing paper mill workers was theoretical. Several studies have shown that there are large variations between manual and non-manual workers within the Finnish population in both their average life-expectancy (Martikainen et al. 2001) and health-related lifestyles (Helakorpi et al. 2007) resulting in manual

workers worse overall health status. Therefore, paper mill workers were chosen to be the primary target group of the study as representatives of manual workers. Accordingly, the data of this study represents a 'purposive' rather than a representative sample (Silverman 2000). It is therefore evident that the material cannot be taken to represent the Finnish male population. However, it is plausible to assume that the material, with limitations generally taken into account in qualitative methodologies, may well be taken to represent Finnish male working-class culture.

Paper mill workers as an occupational group

In the Finnish labour market, paper mill workers form an interesting group, particularly in terms of their relatively high wages compared to their generally low level of education. According to wage statistics from 2006, within all sectors of industry the highest annual wages were in the paper sector in personnel groups of workers, technical staff and clerical officials, where the workers' average annual salary reached 42.609 euros (Palkkatilastokatsaus 2006). According to a representative survey among the members of the Finnish Paper Workers' Union (Mustonen and Savaja 2005), the educational level of paper workers has increased substantially over the past 20 years. Despite this, around a fifth of them still do not have any vocational training, and less than 10% of them have college or university level education. The younger (those under 30 years of age) workers are significantly better educated compared to their older peers.

The paper industry is a male-dominated sector. Less than one fifth of the members of the Finnish Paper Workers' Union are women whose share has constantly decreased over the past two decades. The personnel are also ageing: the average age of the members of the Union has increased by 4 years from 1984 to 2004. (Mustonen & Savaja 2005.) The paper sector is also characterised by a high unionisation level and relatively long and permanent employment. Almost all workers of the sector are members of the Paper Workers' Union. The share of temporary employment, among the working respondents of the survey, was around 12%. Women were more likely to have temporary employment than men: while 86% of the working male respondents had a permanent job, only 63% of their female colleagues were in the same position. About 60% of the respondents of the survey had been members of the Paper Workers' Union for more than 19 years. (Mustonen & Savaja 2005.)

The work in the paper industry concentrates on shift work: only a quarter of the respondents of the survey had day-work (Mustonen & Savaja 2005). It has been noted that, by international standards, there are a lot of absences due to illness and

accidents in the Finnish paper industry, amounting to 6,5% of total working hours, even though occupational accidents are not included in the number (Finnish Forest Industries Yearbook 2007, 29). It has also been found that illness-related absences are about 20% higher in three-shift work compared to day-work (Paperiteollisuus 2006, 73). Frequencies of sick-leaves are basically the only statistical data available regarding paper mill workers' health status. From the perspective of the study in hand, it is unfortunate that there are also no larger studies on the health behaviour of the paper mill workers as an occupational group.

In sum, paper mill workers form a typical male-dominated group of blue-collar industrial workers with the exception of relatively high wages. It may also be claimed that paper workers' professional identity is strong compared to many other sectors due to a high unionisation level and the well-established position of the Paper Workers' Union in the Finnish labour market. The paper mill workers represent a blue-collar, working class group of industrial workers (Ammattiluokitus 2001).

Interview materials of the study

I started the interview process in summer 2002 by conducting 2 pilot interviews with men in Helsinki. The interviews were carried out to test the preliminary interviews guide, creating research questions as well as gaining experience in interviewing. After analysing the pilot interviews, and considering the selection of interviewees, I contacted the staff administration of one paper mill in order to conduct focus group discussions with the male employees of the company. The staff administration had a positive attitude to my research project, and the company nominated a contact person for arranging the interviews and providing me with information I needed regarding, among others, the personnel of the company. At a later stage, when I started to plan the personal interviews, I contacted people responsible for occupational safety in two other paper companies, who then assisted me in organising the interviews.

The six focus groups were conducted among staff of one paper mill in the Pirkanmaa region of central Finland between January and February, 2003. Altogether, 23 men aged 23–55 years (mean 36.8 years) participated in the discussion meetings, 3–6 men in each meeting. Eight of the participants were clerical employees from office staff while the rest were blue-collar workers having different assignments in the paper production process. The groups were formed on the basis of age: two groups consisted of participants under 30 years, two groups consisted of participants aged between 30 and 45, and the remaining two groups consisted of participants over 45 years of age. The 14 personal interviews were conducted in two other paper

mills in the Pirkanmaa region in April 2004. The age range of participants was 27–57 years (mean 44.4 years). Originally, my aim was to recruit participants of personal interviews following the same division of age groups as in the focus groups. However, recruiting younger participants turned out to be more difficult than I expected. The age structure of the two latter companies was older than in the first company, which resulted in difficulties to find younger participants. In addition, it may be that the older workers were more interested in the topic of health compared to the younger ones. As participation in the personal interviews was conducted outside of working hours, the higher interest of the older workers may explain their slight over-representation in the personal interviews.

Participants were selected from the companies' registers on the basis of age, after which the contact person of the company contacted them by mailing them a letter. In the focus groups, the contact person was from personnel administration of the company whereas in the personal interviews the recruitment was arranged by the occupational nurses of the companies. The letter sent to potential participants included information about the purpose, themes and procedure of meetings. Confidentiality of discussion was emphasised and the participants were told that their anonymity would be guaranteed at all stages of analysis. The willing participants agreed on a time for interview with the contact persons from companies and not directly with me. Focus groups were arranged in meeting rooms of the company whereas the personal interviews were conducted in the occupational health care units. Participation in the focus groups and personal interviews was voluntary. In the focus groups, the participants were paid their normal salary for the time spent at the meeting. In personal interviews, the participants were not paid for the time they spent in the interviews but used their out-of-work time voluntarily for participating in the interviews.

In the beginning of each interview I described the transcription process and repeated that their identity would not be revealed in the transcribed material. I also asked for the participants' permission to tape-record the discussions. None of the participants refused the tape-recording and therefore all meetings were tape-recorded and transcribed for analysis. The average length of the focus groups was about 45 minutes and transcribed material consisted of 108 pages (Arial 11, 1.5 spacing) while personal interviews lasted 57 minutes, on average, and consisted of 274 pages of transcribed notes. In extracts of the interviews presented in this study, participants are marked with codes and years of birth. In cases when the interactants use names when addressing other participants, these have been replaced with pseudonyms.

The focus group meetings started with a brief introduction of the aims of my research project where the participants had an opportunity to ask questions about

the project. After that, I asked the participants to make a joint list of factors which threaten Finnish men's health. Each participant mentioned one or more factors which I wrote down onto a clip chart. The factors suggested by the participants varied from lifestyle choices to structural social conditions and further to war and terrorism[1]. The conversation started with a free discussion on the listed factors. In most cases the conversation started by considering health-related issues in general and then moved on to the effects of particular factors. Themes of the discussions included: how to avoid these health threats, do the participants think that people have enough information and knowledge about the listed factors, why do people engage in harmful behaviours and what things they consider relevant for changing lifestyle factors. Other themes, such as gender differences in health and ageing, were discussed, too. A thematic framework of discussion was relatively free for allowing spontaneous conversation.

The personal interviews started, after an introduction of the project, with a similar type of listing of health-related factors as in the focus groups. There were, however, some important differences in the preparation of lists. In the personal interviews I asked the participants to individually write down some health-related issues that may affect health either positively or negatively[2]. Thus, the lists from personal interviews were not that tightly focused on health threats as in the focus groups. It was noted that the factors may not necessarily concern the interviewee himself but rather may generally represent issues that have something to do with health. After the lists were completed, I asked the participants to return to the list, consider the factors again from the point of view of their own life and mark each factor with a plus or minus in accordance with whether they see the effect of the factors as positive or negative to their own personal health.

In the first three personal interviews, I asked the participants to come up with ten factors that affect men's health. It quickly turned out, however, that the participants had difficulties in preparing the lists and it took time for them to list more than five factors. In addition, the completed lists only mentioned different lifestyle factors. As my aim in preparing the lists was to orientate the participants to the themes of the interviews and then use the lists to initiate a discussion on concrete health-related topics, I found the overly individual and behavioural oriented lists problematic for conducting the interviews. Therefore, during the rest of the interviews, I prepared lists with five ready made factors (work, smoking, genes, traffic, and human relations)

1 The complete lists of health-threatening factors from each group discussion are provided in Annex 1.

2 The complete lists of health-related factors from each personal interview are provided in Annex 2.

which I asked the participants to add to. In this way I was able to gain broader topics for discussions. It also turned out that the interviewees found it difficult to consider the impacts of traffic and traffic safety in their own personal lives, and therefore I did not ask them to mark traffic with a plus or minus. As mentioned, the aim of the lists was to orientate the participants with topics of discussion and initiate conversation from the topics they had chosen themselves. Furthermore, I was interested in hearing the reasoning of how they made the conclusions about whether a single factor was positive or negative to their health.

After completing the interviews, I noticed that the participants had a tendency to assess the meanings of the factors in a very positive way. Out of 105 +/– assessments, the share of positive assessments was 79% making the proportion of negative assessments only 21%. The share of positive assessments within each list, and thus each participant, ranged from 50 to 100 percent; not a single interviewee had more minuses compared to plusses in his list of health-related factors. There were four participants who marked all the factors they had written with a plus, and half of all the participants had more than three-quarters of their factors marked with a plus. In my view, this is an important notion since it clearly shows, as we shall see later on in the analysis part, how the participants of my interviews tended to see their own life and lifestyle as healthy and health-promoting rather than unhealthy and health-deteriorating.

After completion of the lists, we discussed each factor in turns and I asked the participants to give some reasons as to why they assessed the factors the way they did. Then I asked them about their present state of health and asked them to specify if they had some diseases or traumas that either hampered their daily living or that they were concerned with. In all other respects the themes of personal interviews were the same as in the focus groups.

When starting the collection of interviews, the questions of this study were largely unspecified. This had an effect on the interviews. When reading them at the analysis phase, I was in some cases dissatisfied with my own actions in the course of an interview concerning episodes where I did not pose certain specifying questions that would have been necessary for interpreting men's accounts. This issue of research material including 'incomplete' episodes, which hamper making interpretations, is obviously a frequently occurring problem in research settings where the people are interviewed just once. Conducting several interviews with the same men would have produced different types of data regarding, for instance, mutual feelings of trust between the interviewer and the participants.

The length and extent of interviews might be regarded as a limitation for some of the conclusions made on the basis of analyses. I had certain time limits for conducting

the interviews since several of the participants agreed to take part in interviews only after they were told that the interview would not exceed one hour. Also, as participation in the focus group discussions were considered as paid working time by the employee, the paper mill, we agreed that the interviews should be conducted within one hour. It may therefore be that longer and more extensive interviews might have resulted in wider variations of accounts.

Personal interviews and focus groups as two types of data

One-to-one personal interviews and focus groups yield different types of research material. As Alasuutari (1995) points out, in answering the researcher's questions about their own lives, the interviewees concentrate on their own thoughts and how their ideas possibly differ from people or groups around them. In group interaction, in turn, the discussion typically turns to 'what is common to the individuals concerned as group members, whereas individual differences and subjective, personal feelings will often be filtered out'. While in face-to-face interviews people may describe the group(s) they belong to, and its culture, in group situation that culture is actually present in 'the terms, concepts, perceptions and structures of argumentation within which the group operates and thinks as a cultural group'. (Alasuutari 1995, 92.) Wilkinson (1998) points to negotiative features of group interaction, which she sees to be an interesting and fruitful, but all too often underused and underreported, source of data.

> In a focus group, people are confronted with the need to make collective sense of their individual experiences and beliefs. This collective sense-making involves sharing information, pooling experiences and comparing and contrasting them, negotiating divergent ideas and experiences, expressing agreement as well as disagreement with other participants, asking questions that challenge or which seek clarification, and providing answers that elaborate, justify or defend the speaker's views. (Wilkinson 1998, 338.)

A crucial characteristic of the focus group material is thus the negotiative manner in which research participants collaboratively turn the personal into the collective, the individual into the social, and search for 'collective sense' of events and phenomena. This way, the researcher may observe the shared, cultural 'rules' of sense-making, the rules that are important resources of our thinking both individually and collectively. The collective meaning-making also offers valuable information to a researcher because the group situation encourages people to problematise and (re)consider

issues that would remain un-discussed in other settings as they are often self-evident (Alasuutari 1995, 94). Accordingly, the focus groups help to explicate 'blind areas' of our shared reality, commonsense, and cultural assumptions that form the resources of everyday thinking.

Taken that focus groups offer a rich set of interactive data to a researcher, some researchers (Kitzinger 1994; Wilkinson 1998) have noted how surprisingly few studies made on the basis of focus group material have really analysed and reported interaction between the participants (and the researcher as well) in an interview context. This may be taken as a failure since the lack of analysis of the interaction loses some of the key characteristics of the data, as discussed above. Wendy Duggleby (2005) notes, on the basis of a review of empirical focus group studies, that there are two different strategies for analysing and reporting group interaction data, which can be found in observations documented in researcher's field notes and in transcripts of focus groups. The first strategy, descriptive analysis, suggests paying attention to observations in field notes and transcripts and reporting the findings by describing the interactions in a detailed way which, in turn, facilitates the reader with understanding of these interactions. Another strategy relies on incorporating interactive elements of data into the transcripts which requires detailed data excerpts. Whichever style the researcher chooses to analyse the interaction in the data, one should maintain congruency in the chosen methodological approach, reporting style and purpose of the study. Duggleby (ibid.) also notes that 'theoretical sensitivity' is a concept which may assist in choosing the ways to report the findings from focus groups. The data, and the findings from it, should be given a theoretical meaning and conceptualisation which, in turn, is reflected in the writing of the findings. Theoretical sensitivity leads to consideration of the theoretical relevance of the findings and thus the modes in which interactive features of the data are reported: 'if group interaction data are relevant to the findings, they should be reported using detailed data excerpts from transcripts and field notes' (ibid., 838).

The reason for collecting two types of data for the purposes of this study was to gain different perspectives. As gender and health may well be examples of issues that are not easily discussed in interview settings due to their 'self-evident' nature (cf. Alasuutari 1995, 94), especially in the case of working-age men without specific health problems, the idea was to use two sets of data to increase variation of the data. In addition, one of the assumptions before the start of data collection was that men's accounts of health and gender might be different in personal and group contexts. Therefore, together with increasing variation of these accounts, collecting two types of data was also used to explore possible differences between the two data sets.

In the analysis of the data I used both paper transcripts and original audiotapes of interviews. I also utilised observations from field notes that I wrote throughout the data collection phase. In presenting quotations from interview material, I have used a rather detailed format where interaction is incorporated into excerpts from material. The transcription notation is provided at the end of this chapter. The description of the interaction is, however, mainly done on the basis of audiotapes since my field notes did not cover the non-verbal communications between the participants and myself or other similar elements that might have had a role in reading the transcripts. However, even without detailed reports from each interview, the field notes helped me to recall some specific moments and interactions within them. Before going into the methodology used in the analysis it is therefore necessary to outline some important characteristics of the interviews and, as part of this, consider special characteristics of interviewing men.

Interviewing men about health

In recent years, a few empirical studies have explored gendered features in interviewing men by analysing difficulties and potential conflicts in interviews with men (Williams & Heikes 1993; Brown 2001; Schwalbe & Wolkomir 2001; 2002; Pini 2005). The studies have investigated, among others, the significance of the researcher's/ interviewer's gender in conducting interviews. Discussing gender in relation to interviews with men is important for two major reasons that concern the interview process, in general, as well as the theme of the interviews, in particular. First, as the study deals with potentially conflicting issues of masculinity and health, it is worth considering how men perceive the interview situation and the interaction with a researcher. Secondly, as I myself carried out all the interviews that are used as material for this study, it is important to consider my own (gendered) role in conducting interviews.

In their methodologically valuable article on interviewing men, Schwalbe and Wolkomir (2001, see also Schwalbe & Wolkomir 2002) discuss the ways in which masculine identities are reproduced in an interview situation, which is a specific form of interaction involving both opportunities for and threats to the masculine self. They divide the threats into two layers. First, the baseline threat is built into any interview where an interviewer, an outside stranger, controls the interaction, sets the agenda, asks the questions, directs the flow of talk and may put elements of manly self-portrayal into doubt. Secondly, other threats can arise from the contents of an interview, from questions that might expose the masculine self as illusory.

> Questions calling for answers that put control, autonomy, or rationality into doubt, if only implicitly, may be experienced as threatening. The threat may be heightened if it seems that the interviewer is interested in gender since this increases the salience of the participant's identity as a man. Surplus threat can also arise because of the interviewer's identity. (Schwalbe & Wolkomir 2001, 91.)

The potential threats related to topics discussed and/or the interviewer's identity are not necessarily consciously perceived, as Schwalbe and Wolkomir (2001) emphasise. Interviewees' reactions to such threats are also more likely to be a matter of 'self-presentational habit' than conscious strategy. The extent to which the participants consciously perceive or react to potential threats to masculine identities is, according to the authors, beside the point. What really matters is 'the interviewer's awareness of the threat potential, alertness for problems arising because of this threat, and ability to respond in a way that makes the interview successful' (ibid., 92). The authors, then, go on with detailed analysis of potential problems and threats and give their suggestions as to how one deals with them in the context of an interview. The problems and strategies they discuss are 1) the struggle for control in an interview, 2) non-disclosure of emotions, 3) exaggerating rationality, autonomy, and control and 4) bonding ploys. The bonding ploys are expressions that emerge when the parties of an interview hesitate to give explicit views on the topic of discussion but appeal to shared knowledge of the researcher and the participants (e.g., 'you know what I mean').

Schwalbe's and Wolkomir's (2001) notions of potential threats to masculine identities and strategies for resolving them in an interview give practical tools for researchers interviewing men. In addition, they also provide researchers involved in analysis of interview talk with conceptual and analytical frameworks for articulating conflicts that emerge in interviews. Often, these conflicts are not undisguised cracks in communication but, instead, appear in subtle expressions of disagreement, silences or attempts to avoid certain topics of discussion. Therefore, in presenting an analysis of my interview data (Chapters 4–8), I will utilise Schwalbe's and Wolkomir's findings in discussing some parts of interviews including conflicts between participants or participants and the researcher.

Men may perceive certain topics of interview as including potential threats to their masculine identities. If we take note of findings from previous studies suggesting that care for health is socially constructed as a women's issue or 'a form of idealised femininity' (Courtenay 2000a), it could be assumed that health may well be a topic of interview that male participants approach with caution. Sally Brown's (2001) study on men's interview talk about health supports this view. She compared interview materials from two separate studies, one with 17 men (aged 48–65 years) without

any specific health problems and another with 24 men (aged 41–85 years) who had experienced a heart attack within the previous two years. In the analysis, it turned out that men with an experience of heart attack were much more willing to talk about their health in detail and at length, whereas with healthy men 'it was sometimes a struggle to get them to talk for half an hour' (ibid., 192). In general, she concludes, 'men are not used to talking about their health, as it is not normally part of their day to day discourse'. Brown also found that men tended to see health as 'women's business' in both samples.

> It may be that where health is women's business, a part of a female discourse, men who do not have any health problems do not need to think about it. When men have health issues thrust upon them by virtue of suffering a heart attack, it is still women's business but it also becomes part of male discourse. (Brown 2001, 193.)

The issue of healthy people finding health as non-concrete and abstract and thus a subject difficult to consider, may not necessarily be a gendered issue at all, as indicated by some previous studies (e.g., Cornwell 1984; Calnan & Williams 1991; Lawton 2002). Probably a more gendered finding from Brown's study is her conclusion on differences between the two samples: 'Men do not wish to seem vulnerable and therefore … in Project Two it was acceptable because a serious and recognised health event had happened' (ibid., 193). Regardless of whether these issues are gendered features in interview talk or not, Brown's findings have important implications for analysis of interviews with men at least in two respects. First, men with no health problems may not find health as a familiar subject of conversation. Secondly, health may be seen as 'women's business' which may result in potential threat to their masculine identities in an interview.

As noted above, I tried to keep the interviews informal and attempted to approach the topics conversationally rather than as a formal 'interview'. My previous experience of two pilot interviews (conducted in 2002) as well as focus groups (conducted in 2003) was that men found it somehow difficult to start to discuss 'health', presumably because they themselves were mainly healthy, suffered from no diseases or major health-related difficulties or constraints in their lives and had therefore, arguably, a limited vocabulary for discussing 'health' as a rather abstract concept. For this reason I decided to start the interviews with a list of health-related issues to familiarise the participants with the topics. This may have had both positive and negative effects on the interviews. While it may well be argued that this kind of listing emphasises the researcher's control over the interviewing situation, and leads the participants to seek answers that they presume the researcher is expecting from them, it may also be

claimed that this kind of approach gave the interviewees the opportunity to 'collect their thoughts' before the actual start of the interview.

In most interviews (both the focus groups and personal interviews) the atmosphere was guarded and a bit distant in the beginning. As the interviews progressed, all of the focus groups and the majority of the personal interviews became more relaxed and conversational. In the focus groups, there were some very talkative participants who actively manoeuvred the discussion and lightened the interaction by using humour. Nonetheless, some focus group participants and some interviewees remained distant for the whole duration of the interview. Although I had introduced the aim of the interview as a discussion of health-related topics in general, instead of an 'interrogation' of the participants about their own lifestyles, I had strong feeling that some of the interviewees were constantly alert when talking about their own lives. In some cases, although they were rare, I even felt some kind of hostility from the interviewees. This was most clearly expressed when the participants discussed health-related information and advice on healthy lifestyles. When talking about the topic, some of them used irony in questioning the relevance of health information and expressed their critical views by looking at me as if I was to blame for unreliable information. In my view, these cases indicate that some of the interviewees associated my position as a researcher from the School of Public Health with health education practitioners: it is possible that for some of them I was one of the 'health terrorists' who control and restrict people's lives. This is of vital importance when interpreting the findings, since the interview data are always a collaborative project of both the interviewer and the participants. The way in which the participants interpret the interviewer's position inevitably structures the interaction, both in terms of the kinds of responses the participants assume the interviewer is expecting from them and what kind of positions the interview context creates with the participants. As Holstein and Gubrium (1997, 122) note, 'the interview respondents … continuously monitor who they are in relation to the person questioning them'.

The interviewer's gender has been a topic in several methodological studies focusing on the interaction between the interviewer and the interviewee (e.g., Williams & Heikes 1993; Pini 2005). However, gender is only one dimension of the interviewer's identity and other issues, such as education, social class, ethnicity, and age also play their part. Therefore, in both conducting and analysing interviews, attention needs to be paid not only to the gendered identities of the researcher and the participants but also to other characteristics attached to their identities. From the very beginning of the analysis I realised that my position as a health researcher was one of the most important situational factors influencing the interaction. To talk to a researcher from

the School of Public Health is a rather specific context which differs a lot from many other daily conversational contexts.

Methodological approach of the study

Discourse analysis has been one of the central methodological approaches from the beginning of linguistically oriented methodological developments in the social sciences (e.g., Alasuutari 1995; Gough & McFadden 2001; Swann 2002). There has, however, emerged a gradual disintegration in discourse analysis, which is currently considered more of an 'umbrella term' (e.g. Edley 2001b) for systematic analysis of language and its use in interaction, rather than a distinctive and coherent method for analysing language. Despite divergences between different forms of discursive studies, these approaches have their roots in social constructionism. Accordingly, all discursive approaches share the view of language as not only reflecting various phenomena of social life but also as constructing objects. In other words, language does not merely reflect physical and social reality outside of it but also reproduces it.

As Wetherell (1998) points out, it has become common-place to distinguish between two or more styles of discourse analysis, where the distinction is usually made between approaches of ethnomethodological and conversation analysis (CA) and critical discourse analysis (CDA) deriving from post-structuralist or Foucauldian traditions. This division is, to a large extent, based on differing views of the relationship between 'texts' analysed and 'other' reality outside of it[3] and, accordingly, differing evaluative criteria for 'good' and 'bad' discourse analysis. Debates around different approaches to discursive studies have mainly concerned the status of material in research and the level of empiricism in drawing conclusions based on materials (see Schegloff 1997; 1998; Wetherell 1998; Billig 1999a; 1999b; Schegloff 1999). The key question has been to what extent the material is interpreted merely in terms of its internal logic without references to outside-the-text reality and concepts that have not emerged in the text where the conversation analytical tradition has favoured more strict empiricism compared to CDA and a more 'technical analysis' of data (Speer 2001a).

The tension between different forms of discourse analysis stems from the paradoxical fact that, as Edley and Wetherell (1999, 182) note, people are both the products and producers of discourse, 'the masters and the slaves of language', constrained and enabled by language. The two main perspectives to analysing data,

[3] The concept of 'text' is often used to refer to transcribed interviews and other written materials which, however, is just one definition of text. Parker (1992, 6), for instance, offers a far broader definition: 'Texts are delimited tissues of meaning reproduced in *any* form that can be given an interpretative gloss' (emphasis original).

often called 'top-down' and 'bottom-up' approaches, focus on different sides of the paradox. The research within the 'top-down camp', adopted in CDA, is most often interested in issues like power and ideology or other institutionalised discourses and approach texts by analysing how different broader discourses take place and the effect in people's talk or other texts, highlighting the 'slave' relation of people to language. The 'bottom-up' perspective typical to CA emphasises the 'master' side of people as producers of discourse. Here, attention is paid to the 'action orientation' (Heritage 1984) in discourse, i.e., how social order is constituted intersubjectively and interactively.

This study is methodologically based on discursive psychology in the sense that Margaret Wetherell and Nigel Edley have used the concept in their series of articles on contextual definitions of masculinities during the past ten years (Edley & Wetherell 1997; Wetherell 1998; Edley & Wetherell 1999; Wetherell & Edley 1999; Edley & Wetherell 2001, also Edley 2001b). The authors' aim in the large project on masculinities was to develop 'a critical discursive psychology of masculinity' (Wetherell & Edley 1999, 337) and a new methodological orientation as part of it. In their studies, the focus is not on *what* are the different types of masculinity involved in negotiations of the masculine self but, rather, *how* men use alternate forms of masculinity for constructing the self in interaction. In the new methodological orientation the aim was to link the macro-perspective to discourse ('top-down' approach) with detailed 'fine-grain' micro analysis of practices that participants use in meaning-making and identity work in interaction ('bottom-up' approach).

The approach is based on the social constructionist perspective on the self and identity which differs from traditional psychological theories. Instead of seeing the self as one, self-contained, unique personality with individual motivation and cognition, the social constructionist perspective treats selves as 'being *accomplished* in the course of interactions; reconstructed from moment to moment within specific discursive and rhetorical contexts, and *distributed* across social contexts' (Edley & Wetherell 1997, 205, emphasis original). The authors' aim to integrate 'macro' and 'micro' perspectives in the analysis was based on the idea that 'an adequate discursive psychology needs a more eclectic base' (Wetherell & Edley 1999, 338).

> When people speak, their talk reflects not only the local pragmatics of that particular conversational context, but also much broader or more global patterns in collective sense-making and understanding. It would seem appropriate, therefore, to adopt a similarly two-sided analytical approach … (Wetherell & Edley 1999, 338).

In relating this general perspective to the substance of their research, construction of masculine identities, the authors specified their methodological perspective.

> [W]e look at, not only the ways in which men are positioned by a ready-made or historically given set of discourses or interpretative repertoires, but also at the ways in which these cultural resources are manipulated and exploited within particular rhetorical or micro-political contexts. (Edley & Wetherell 1997, 206.)

From the point of view of identity work in interaction, it is worth noting that specific discursive and rhetorical contexts do not only enable people in the identity work but also involve constraints for it. Cultural norms, knowledge and shared beliefs set rules and limits for contextual definitions, thus reflecting 'broader patterns in collective sense-making and understanding' (Wetherell & Edley 1999, 338). As Radley and Billig (1996, 227) note regarding ideological features of health, 'health beliefs are ideological in that they are sustained within a wider social discourse that shapes not just how individuals think, but how they feel they ought to think'. Contextuality of self and identity does not, thus, mean that their reproduction is a haphazard and vague process without any coherence: although a specific context may allow different identities it does not allow just any definition or description of self. This leads to analysing 'discursive strategies involved in negotiating membership of gender categories' (Wetherell & Edley 1999, 335). These negotiations, and flexible use of discursive practices, demonstrate how people use, i.e. adopt, contrast and challenge, shared cultural resources in construction of identities within particular local settings.

Within my study, linking 'macro' and 'micro' perspectives relates to the notion of hegemonic discourses regarding both masculinity and healthiness. As concluded above, the claimed conflict between masculinity and healthiness may be conceptualised as an ideological dilemma between two dominant discourses concerning (hegemonic) masculinity and healthiness. While acknowledging the existence of these 'macro' discourses of masculinity and healthiness in current Finnish culture, I do not want to restrict the analyses to interplay between these two. As both macro-discourses, though probably being dominant, are far from being the *only* ways to understand ideals of manhood or healthy ways of life, they are both subjected to counter-claims and counter-discourses which results in situational negotiation of contents of both concepts as well as their interrelations in an interview context. Therefore, my attempt is to focus on micro-level use of discursive strategies and subject positions for resolving tensions and ideological dilemmas both within and between the macro-discourses.

The debate between the two (or more) camps within discursive studies has also been reflected, among others, in the studies on men and masculinities. Conversation analysts have criticised the use of concepts like hegemonic masculinity since they are concepts 'outside the text', which should be the only layer of reality on which the researcher bases his/ her conclusions in discourse analytic work (Speer 2001a). Their criticism has pointed to the fact that when the researcher assumes the existence of 'it-ness', 'an object-like status' of hegemonic masculinity (Speer 2001b), then this leads the researchers to take its ontological status for granted, which biases the analyses. While I generally agree with Speer's notion of the importance of avoiding overly strict assumptions of 'it-ness' of *any* of the concepts used in research, I do not consider it useful or even possible to avoid use of such central concepts in making discourse analysis for two reasons.

First, as Edley (2001a) points out, a researcher is always to some extent dependent on what (s)he knows about the objects of research beforehand, both as a researcher and as a member of society. Cameron (1997) similarly suggests that analysis of data is never done without preconceptions and a researcher can never be absolutely non-selective in his/her observations. As she further concludes, avoiding certain expectations may be particularly difficult when the object concerns gender, which is one of the constituents of social life. For a researcher, conceptualising the topics and questions of research, and making interpretations of data, would be difficult, if not impossible, without previous notions of the 'existence' of 'hegemonic masculinity', 'ideology', 'discourse' etc. This is because these types of key concepts play a central role in theories of men and masculinity. As Silverman (1991, 26–27) states, the researchers should try 'not to replicate but explicate commonsense', which requires adopting both theoretical knowledge from outside the limits of commonsense and mundane knowledge of topics under consideration regarding, for instance, qualities of masculinity that are valued within the culture at hand. As interview material typically involves a significant amount of implicit information, explication of the implicit necessitates interpretations made on the basis of knowledge relating to 'reality' outside the text.

Secondly, full reliance on the research material representing 'reality' as such renders it impossible to make interpretations of the significance of the research findings. All scientific research presupposes that the findings have some broader importance outside the limits of the material used in analysis. Alasuutari (1995, 156) claims that the idea of empirical generalisation should be reserved for surveys only. What is, however, of more importance is 'how the researcher demonstrates that the analysis *relates* to things *beyond* the material at hand' (emphases original) and thus apportions the findings to the relevant theory. In my view, this necessitates, among

others, heightening the level of abstraction, at which the findings are considered, to a level which exceeds that of 'text'. While the study participants hardly use concepts like 'hegemonic masculinity', 'imperative of healthiness' or 'ideological dilemma', they surely have some clue of these ideas even if they were not explicitly expressed during the interview. This means that the informants share the knowledge with researchers, at least to some extent, while not using the same terminology. That the researcher did not elevate his/ her findings from the level of everyday discourse would make it impossible to relate the analyses to any things beyond the material.

In identifying conflicts, contradictions and dilemmas in talk, one should not only pay attention to actively and explicitly articulated conflicts and their discursive management (such as argumentation, persuasion etc.) but also consider other ways in which potential conflicts and contrary themes are discussed in an interview setting. This requires, among others, that attention is paid to subtle and implicit cracks and breaches in the participant's talk and in interaction with the interviewer, which may reflect a tension between different versions of reality. This is particularly important when a study approaches potentially ideological and moral phenomena, such as gender and health. As Bergmann (1998, 280–281) observes, morality is 'such a common and intrinsic quality of everyday social interaction that it is usually invisible to us'.

> [S]eemingly neutral and innocent expressions may in the course of an interaction acquire a moral meaning and may be treated in a moral frame of reference. … Obviously, moral is omnipresent in everyday life; it is so deeply intertwined with everyday discourse that the interlocutors hardly ever recognize their doings as moral business. (Bergmann 1998, 281.)

This is especially the case in notions of hegemonic discourses. Some ways of understanding the world and people's lives in it are culturally dominant or hegemonic and 'can assume the status of facts, taken for granted as true or accurate descriptions of the world' (Edley 2001b, 190). As Jolanki (2004, 488) remarks, the 'commonplaces' play an important part in interaction, which implies that not just anything can be said about health or oneself in a certain culture: 'This is because some things are considered accountable, natural and self-evident, while others are not.' This also leads to analysing accounts which naturalise events, accounts which do not question or challenge the ways of understanding what they represent. Similarly important is to consider non-commented views and positions and to ask not only what is said in the text but also what is lacking: what is not said, commented on or even mentioned.

Analysis of potential (ideological) conflicts and dilemmas as well as discursive practices used in managing them, requires detailed analysis of discursive tools

and practices involved in the interaction. Interpreting the meanings attached to conflicts and discursive practices in negotiating them requires, however, that the language is set to wider social contexts instead of focusing only on the 'micro'-level of interaction as an ahistorical communication between the participants. Analysis of negotiations on different and potentially competing definitions and explanations necessitates taking into account sometimes hidden, but still existing, counter-claims and counterarguments.

> The meaning of discourse used in an argumentative context must be examined in terms of the contest between criticism and justification. Therefore, to understand the meaning of a sentence or whole discourse in an argumentative context, one should not examine merely the words within that discourse or the images in the speaker's mind at the moment of utterance. One should also consider the positions which are being criticized, or against which a justification is being mounted. Without knowing these counter-positions, the argumentative meaning will be lost. (Billig 1996, 121.)

Following Billig's thinking, it might even be argued that the emergence of argumentation itself highlights the existence of conflict. As the dominant views hold the position of the common-place, the views that do not have such an unchallengeable status are the ones which necessitate justification and argumentation. In this way, a rhetorical approach to text adds to analysis by making ideological, moral and challenged views visible.

The primary interest of this study is not in how the interviewees discuss gender and health in an interview as individual persons. Rather, I approach interviewees as representatives of Finnish, male working class culture, who use different cultural resources in constructing objects such as masculinity and health in an interview context. When offering views, contrasting them with others and challenging some descriptions the point is not whether the participants endorse or prefer certain discursive practices but that they know and are able to use them. From an individual point of view, we may approach participants' accounts as portrayals of verbal competence in different discourses of masculinity and health (cf. De Visser & Smith 2006). The notion of verbal competence addresses the very idea of the study: being able to use differing discursive practices highlights participants' knowledge of *varying cultural resources* in use when displaying certain versions of masculinity, or of the healthy citizen, in an interview context.

Analytic process

From the very start of the study, I met three constitutive challenges for defining the relationship between research questions and empirical analysis, regarding the claimed conflict between masculinity and healthy lifestyles. First, health and healthiness are generally rather abstract concepts – especially for people without chronic or other long-lasting diseases (cf. Lawton 2002) – whose meanings are thus very much context-bound. Even if some conceptualisations of health and healthiness were interpreted as being in conflict with certain constructions of masculinity, there might be others that were not regarded as being contradictory with idealised masculinity. Secondly, reading 'masculinity' is an equally challenging task as the one related to healthiness: contextual constructions related to ideals of manhood and situational self-presentations of male speakers are far from being stable and coherent 'attitudes' throughout interviews, which undermines the assumption that a certain form of masculinity 'found' in the material would consistently be in conflict with healthiness. And finally, it was obvious that the potential conflict between masculinity and health would hardly emerge in any 'clear' form in the material, and even if it did, there would surely emerge other contexts where those interpretations were challenged. Considering interpretations of 'masculinities' or 'healthiness' is important in the case of interview materials, where interaction is typically full of contradictory accounts, hesitations, incomplete sentences, non-verbal expressions (laughing, sighs etc.) as well as many other ways of indirect communication. Therefore, it is necessary to consider how masculinity and healthiness are 'read' in interview transcripts.

There are two basic heuristic models to read masculinity in text. One approach of reading masculinity suggests basing the interpretations on previous research. In this approach, different representations or models of masculinity are identified on the grounds of definitions and descriptions introduced in scientific literature that set the 'criteria' for different forms of masculinity. It is thus assumed that on the basis of a theory of masculinities, it is possible to identify different typologies of masculinity (hegemonic, subordinated, alternate etc.) as well as norms, values and practices related to them. However, it has been claimed that this kind of interpretation of masculinities in data leads much too easily to an oversimplified picture of the variety of negotiations related to gender as well as too rigid a view of these categories (Wetherell & Edley 1999). In addition, basing analyses on ready-made assumptions may support reproduction of such versions of 'hegemonic masculinity' that may not have empirical grounds for its existence as, in my view, is the case in the 'canon of pathogenic masculinity' discussed in Chapter 1.

Another way to read masculinity in interaction is to take a data-based approach, which does not build the analysis on assumptions of typologies of masculinity from previous research but, instead, looks for discursive means and practices of how masculinity is constructed in given interaction. Discursively oriented social psychological studies have approached definitions of masculinity as contextual negotiations and analysed the ways in which men position themselves in relation to different forms of masculinity, as reviewed earlier. The interest is not in identifying different types of masculinity that the interviewed men belong to or wish to belong to. Instead, the focus of analysis is on what kind of discursive strategies the men use to 'puzzle over' their identities in the negotiation of different ideology-laden characteristics of the masculine self and how they resolve ideological dilemmas (Billig et al. 1988) related to it. Instead of distinctive norms involved in different notions of the masculine, the normative expectations are seen as discursive practices that the participants use as cultural resources of meaning-making (Wetherell & Edley 1999, 353). As was reviewed in the previous chapter, there has recently emerged a growing body of ethnographic literature on how masculinity is 'done' in interaction (Edley & Wetherell 1997; Willott & Griffin 1997; Gough 1998; Gough & Edwards 1998; Edley & Wetherell 1999; Wetherell & Edley 1999; Willott & Griffin 1999; Speer & Potter 2000; Edley & Wetherell 2001; Gough 2001; Riley 2001; Speer 2001a; Riley 2003).

As noted earlier, a fundamental part of 'doing gender' is differentiation between 'us' and 'others' (West & Zimmermann 1987, West & Fenstermaker 1995). It has been suggested that self-identification through group categorisation is an essential characteristic of our 'tribal mind' (Berreby 2005). It was also noted, however, that in interaction, the 'others' (such as women, homosexuals, ethnic minorities, 'sissies' or 'wimps') are not always defined in clear and explicit ways. Analysing the 'doing' of gender on the basis of differentiations between 'us' and 'them' is a useful method for reading constructions of 'proper' male identities. However, one should pay attention not only to groups of people that the speakers align themselves with or distance themselves from but also to conceptions, ways of thinking and practices that are either endorsed or rejected. This has been interestingly demonstrated in analyses of negotiations between 'new' and 'old' masculinities (e.g. Edley & Wetherell 1997; Wetherell & Edley 1999).

Reading 'healthiness' in interview talk is not an unequivocal task either. Health and healthiness are generally rather amorphous concepts whose concrete meanings are bound to contexts where they are discussed. Health itself is a concept with many different dimensions and meanings (e.g., Herzlich 1973; Williams 1983). Health-related behaviours, activities and choices, in particular, are entwined with many cultural practices and values and therefore represent many other aspects of good

or bad life, joy or sin, and control and release, in addition to their health-related dimensions. Thus it is not self-evident that all activities that are generally regarded as being 'health-related' in health promotion research and practice are considered equally 'health-related' by the public. In addition, resistance and scepticism are important elements of lay understanding of health, which need to be taken into account in reading 'healthiness'.

From the perspective of how 'healthy selves' are displayed in interaction, it is of major importance to explore how healthy identities are constructed in contexts of different health-related aspects of life. It is also assumed that constructions of healthy selves use, at least in some contexts, similar practices of 'definition by difference' as the concept of gender. As Robert Crawford (1994) has noted, constructions of healthy selves are often based on notions of 'unhealthy others' as their negative building blocks. Simultaneously, analysis requires exploring *which* and *how* health-related ideas and practices are distanced or approached as part of participants' constructions of 'me', 'us' and 'them' in interaction.

As the 'pathological' nature of masculinity has mainly been attached to men's unhealthier habits in the previous research on men's health, this study is largely focused on men's interview talk about healthy lifestyles. Due to abstract contents of health and healthy lifestyles, the topic is approached from different perspectives that form the five chapters of the empirical part of the study. Chapter 4 starts the analyses by exploring men's conceptions of personal health and contrary themes related to assessments of health. As the existence of 'healthy' lifestyles is deeply rooted on information and knowledge about possible health effects of certain living habits, Chapter 5 analyses ideological and conflicting themes in men's interpretations of health information and its significance in the formation of healthy lifestyles. Chapter 6 approaches 'men's health' as a social phenomenon and explores explanations and argumentation that the men offer for men's lower life-expectancy. Chapter 7 focuses on four behaviours that are widely acknowledged as bedrocks of healthy lifestyles, both in health promotion literature and lay accounts of healthy lifestyles. The behaviours are analysed in terms of agreement of their healthiness/ unhealthiness and gendered attributions attached to them. Chapter 8 studies how healthiness of personal lifestyles is assessed and constructed in interview speech.

After formulating the basic structure of the study, I first outlined the basic thematic structures in the participants' talk about each topic of discussion. After having this general picture of concepts and ideas that the participants used when discussing each topic, I started to look for interview episodes that were not in line with the general picture; those that were either in contradiction with other parts of interviews or involved different argumentative elements and negotiation on importance of

different views and arguments. I had two reasons for using systematic search for exceptional cases. First, in my view, those episodes which involved negotiations on views and argumentation highlighted the normative and ideological nature of the topics: that the participants needed to consider the views they expressed, either implicitly or explicitly, demonstrates that it is not a matter-of-course how the topics are described in an interview. In this sense, the exceptional cases are fruitful for further theory-building. As Potter and Wetherell (1987, 170) note, 'cases that lie outside the explanatory framework of a theory are almost always more informative than those that lie within, and often dredge up important problems'. The second reason for searching for exceptional cases was methodological, relating to validation of the research findings. As has been suggested by Peräkylä (1990, 191; 1997, 210–212) and Silverman (2000, 180–184), systematic search of 'exceptional' or 'deviant' cases force the researcher to reconsider his/her theory and adjust it to cover the exceptional cases as well which, simultaneously increases the validity of the interpretations made. Power (2004) has demonstrated in her case study how interviewees may give even drastically contradictory accounts on topics of discussion, which necessitates the researcher to explore the interviewee's 'logic of practice' in expressing the contradictory ideas. Alasuutari (1995, 146) similarly notes that the phenomena under analysis should be described and explained at such a level of abstraction that they can be thought to apply to all individual cases.

The theoretical debates surrounding discourse analysis have led to a plurality of evaluative criteria for differentiating 'good' from 'bad' discourse analysis. As Wetherell (1998, 387) notes, 'it seems unlikely that any single set of evaluative criteria will prove sufficient'. Probably due to this, there are a growing number of text books and articles (e.g., Ahern 1999; Finlay 2002; Mauthner & Doucet 2003; Pyett 2003) discussing the reliability and validity of qualitative research. Due to a lack of water-tight evaluative criteria, qualitative studies, in general, are easily criticised for their inability to make generalisations and also for their subjectiveness in interpretating data. The 'personal' inevitably affects the research process in choosing the topics, methods, and forms of analysis as well as conclusions made on the basis of analyses. Possible affects of 'the personal', and thus the researcher's possibly biased interpretations may, however, be diminished through reflexivity and transparency. As Gough and McFadden (2001, 19) suggest, it is recommended that the researcher makes visible his/her position in the study setting and interpretations (reflexivity) and describes the procedures and interpretations in detail (transparency), both of which make it possible for a reader to make his/her own assessment of the relevance of findings and interpretations.

In her much cited article, Wilkinson (1988) considers three types of reflexivity, 'personal', 'functional' and 'disciplinary' reflexivity in the context of feminist

psychology. Personal reflexivity refers to a researcher's own identity with his/ her own life history, interests and values. Within the positivist epistemology, such personal issues have easily been seen as threats to objectivity leading to biases in doing research. However, within an 'alternative epistemology, which emphasises the social construction of multiple realities and takes reflexivity seriously, they [personal interests, values etc.] may be seen both as central to and as a resource which informs one's research' (Wilkinson 1988, 494). Functional reflexivity, in turn, entails 'continuous, critical examination of the practice/process of research to reveal its assumptions, values, and biases' (ibid., 495) whose presentation in study reports follow the principle of 'transparency'. Disciplinary reflexivity means that the representatives of certain disciplines or subdisciplines should be aware of the paradigmatic nature of making research and locate its methods, findings and interpretations to the prevailing paradigm and theories, simultaneously relating them to other paradigms. The latter comes close to the requirement of being congruent in theory, maintaining 'theoretical sensitivity' (Duggleby 2005), when interpreting research findings.

In addition to interpretations made in analysing the data, the researcher's role is inevitably central in data collection as well, especially in interviewing people. This easily evokes the issue of prompting or provoking questions addressed to informants, which arise from the researcher's own preconceptions and may thus be thought to result in accounts that the interviewees had not, otherwise, expressed spontaneously. From this perspective, it may be argued that the researcher has taken a too active role in the interview producing biased results that may have not occurred without his/her influence. From the perspective of 'active interviewing' (Holstein & Gubrium 1995; 1997), which emphasises that knowledge and meanings are always collaborative constructions of both the interviewer and interviewee, the issue of prompting questions is somewhat irrelevant. In the 'active' view of the interview, the aim of interviewing is not to get the respondents to reveal what they 'really' think as 'vessels of answers'. Instead, their interpretative capabilities 'must be activated, stimulated and cultivated' (Holstein & Gubrium 1997, 122) for approaching cultural resources in use in interaction.

> This is not to say that active interviewers merely coax their respondents into preferred answers to their questions. Rather, they converse with respondents in such a way that alternate considerations are brought into play. They may suggest orientations to, and linkages between, diverse aspects of respondents' experience, adumbrating – even inviting – interpretations that make use of particular resources, connections and outlooks. … The objective is not to dictate interpretation, but to provide an environment conducive to the production of the range and complexity

> of meanings that address relevant issues, and not be confined by predetermined agendas. (Holstein & Gubrium 1997, 122–123.)

From this perspective, it could also be argued that the way in which interviewees respond to provocative or 'prompting' questions reveals the existence of those cultural phenomena that the questions refer to. In case the interviewees are able to give corresponding answers underlines that the issues discussed are part of the social reality they live in, even in cases where the interviewees themselves do not agree with the views offered by the researcher. Considering how the interviewee would have expressed their ideas without the researcher's influence becomes thus meaningless. Analysing active interviews necessitates, however, that the interaction between the interviewer and interviewees is described in detail and contextualised, as discussed above.

Different strategies of reflexivity are all utilised for providing the reader with conditions of how the study was conducted and thus rendering it possible for a reader to evaluate the validity of the research process and for evaluating the relevance of explanations offered about phenomena under analysis. Being informed about the study process makes it possible for the reader to contextualise the findings and explanations of the study. As Alasuutari (1995) suggests, this also locates demands of objectivity, representativity and generalisability into a new position.

> If all readers of a study can recognize a phenomenon from the description presented, then generalizability is not a problem; the only issue of interest is the relevance of the explanation offered for that phenomenon (Alasuutari 1995, 145).

Transcription notation

IP	Researcher
P(-57)	Participant (year of birth in brackets)
underlining	speaker emphasises some word(s)
italics	speaker speaks especially quietly
(.)	short pause
(1)	length of pause in seconds
:	speaker attenuates the previous sound
[	square bracket indicates at what point speakers overlap
()	transcriber's or researcher's descriptions or comments
(...)	data deliberately omitted

4 VULNERABLE BODY AND HEALTHY SELF – NEGOTIATIONS ON PERSONAL HEALTH

The first chapter of empirical analyses of the study considers how men conceptualise health in an interview. It focuses on analysing the ideological aspects of health, potential conflicting ideas and contrary themes involved in talking about personal health and discursive practices utilised for resolving conflicting themes. For this purpose I analyse the interview episodes where participants of the interviews assess their present health and, in particular, on the argumentation they use when justifying why they consider their health to be 'good', 'average' or 'poor'.[1]

All interview excerpts analysed in this chapter are from personal interviews, where the participants' own assessment of their health was the first question addressed in order to stimulate discussions about health. A clear majority of the interviewees regarded their health as either good (10/14) or fairly good (3/14). Only one participant said that he does not consider himself healthy (this exception will be discussed at the end of the chapter). From the very beginning I noticed that the interviewees did not merely express assessments about their own current state of health (good, average, bad) but also elaborated upon the assessments (I think my health is quite good, because…). A plain answer to a question such as 'How would your evaluate your present health?' never seemed to be enough (cf. Jylhä 1994) which, in turn, led me to analyse these argumentations more closely. In analysing them, I found that a clear majority of the reasoning involved in the answers could be divided into three groups. In most cases, (good) health was justified by the *absence of disease or ailments*. The participants also referred to their *physical ability and activeness* as an indicator of good health. Finally, *outcomes from health check-ups and medical examinations* were offered as justifications for the participants' assessments of health. All these themes will be analysed in detail in this chapter.

[1] Self-rated health has attracted much interest among researchers over past decades, particularly due to results from epidemiological studies in the 1980s where self-evaluated health was found to predict mortality even better than clinical examinations (for a review, see Idler & Benyamini 1997). This has led the researchers to study the dimensions of health that are considered when people give their assessments of health (e.g. Krause & Jay 1994; Manderbacka 1998). In this study, I do not analyse the material from this perspective, but focus on contrary themes and dilemmatic aspects involved in contextual negotiations of health in an interview (cf. Jylhä 1994).

To be 'non-unhealthy' and potential threats inside the self

The first group of explanations, *health as absence of disease*, is an essential part of our thinking about health. Especially for people who consider themselves to be healthy (as the majority of the interviewees did), health is often a relatively abstract concept (Lawton 2003). Health is a matter-of-course for most of us until something (such as illness or accident) forces us to reconsider it. In these cases, health is conceptualised by illness: health is something we have when there are no diseases or other disabling limitations impeding our everyday activities. As van Hooft (1997, 27) puts it, 'insofar as we are living our lives more or less successfully, our health is not an issue for us, and is not directly experienced as a state of our being' (cf. Calnan & Williams 1991). Due to health being defined on the basis of its counterpoint, the essential nature of health remains abstract and vague. When health is not 'directly experienced as a state of our being', it is significantly more difficult to conceptualise compared to illness. This fundamentally lays the foundations for contrary themes related to health: although health is something that is highly valued and something that people pursue, even in its most concrete and illustrative definition (as in the absence of disease), health is conceptualised negatively in terms of loss rather than achievement.

The division between the absence of disease and illness is not, of course, a simple and catch-all way for defining present health. One aspect of the abstractness of health relates to temporal dimensions involved in assessments of health. The first excerpt of this chapter illustrates how health is not a constant and stable issue which a participant could easily measure. Instead, the assessment is negotiated and puzzled over using several elements including temporal assessments.

Excerpt 4.1.

(Part 1.)

T1: Well (.) I really think that it's (health) (.) pretty good. (1) That is, I think that (.) last (3) last, well er spring (.) if I only remember right (very slowly), I that Leena (occupational health nurse) would know it better of course (1) so (.) in the health check-up the blood (.) blood pressure (.) the lower one was up. And it was monitored (.) oh yes (1) through spring and then last summer when I was (1) I was standing in this day job for seven weeks then I, shop steward (.) well (.) now then they monitored the effect of day work (.) 'cos I was doing three shifts all the time.
IP: Yeah.
T1: However (.) Well it evened out! (...)

(Part 2.)

T1: I've been in finishing off for (1) this is the fifth year (.) *must be* (.) I was earlier on transport, in the transport of the firm, but when it petered out (.) I went onto finishing and (.) At that time (.) there's been trouble with arrhythmia there in the ticker for several years.
IP: Ahah.
T1: Well they were examined then in spring at the time (3) five years back (.) and then when from Hatanpää (health centre in Tampere) it was the mon-, monitoring equipment, I didn't have to go to any exhaustion tests any more that (.) just the monitoring device it was and of course they took all manner of tests, blood tests (speaks fast) and all that well (.) well. Then when the doctor says to me (.) that I have this smaller than normal tendency to arrhythmia (IP: Aye) the:y stopped! There was these, these feelings (speaks fast) (.) there have been later (.) a bit every single has (.) that (.) the ticker does like a somersault there (IP: Aye) something funny (.) well they are, ev- (.) we've talked about them (.) one and another have (them) (.) But by and large otherwise I don't, you know (.) I feel (.) my own (.) state of health (.) nn.. (.) *you could* say fairly good..

(Part 3.)

IP: Oh yes.
T1: ..good, that (1) swimming in a hole in the ice after sauna didn't (.) I had no such feelings that (.) (IP: Aha.) *that it would be* (.) made weak or anything else that (.) sometimes something like (2) when I get up fast like, we:ll and (.) then sometimes at home in the sauna well (.) well there's been such a feeling *th*at it's as if it would be better to sit still. And I've just thought that, well, every so often a man's circulation does them (.) tricks (IP: Yes.) and when it's nothing like recurring (.) that the day after tomorrow again and (.) it's just at times (IP: mmm) it happens rarely so I've thought it (.) that (.) things like that happen to people (.) all sorts of things and (.) (IP: ahah) Even if they've checked you get no certainty that what's causing it.
IP: Aha, ri[ght
T1: [I've put it down to them.
IP: Aye.
T1: But then like mostly I think it's pretty good. (T1:1, born 1955.)

In the excerpt, assessment of health is, to a large extent, constructed on the basis of measurements of potential disease. In the participant's long consideration of his own health, it is obvious that health cannot be assessed as unequivocally good because of the fact that the participant has twice been monitored by the occupational health care unit due to heightened blood pressure and arrhythmia. Therefore, the examinations have to be taken into account in assessing health, which results in a detailed contemplation of physical ailments as well as a monitoring process. Both the participant's heightened blood pressure and arrhythmia have disappeared without any medical treatment which is, especially in the case of blood pressure, evidenced by the measurement of results. Even despite the disappearance of signs of a threatening disease, the account reflects uncertainty as to how a person can make a rating on

his health in these circumstances. This provokes a problematic situation for the speaker: on the one hand, he has no clear current symptoms of actual disease and he could therefore be assessed to be a healthy person. On the other hand, however, previous heart ailments give reason to be concerned for health and make it difficult to consider health entirely good. This is one example of the temporal aspects involved in assessing health: although the participant considers his *current* state of health to be good, former heart problems that have occurred approximately one year before cause uncertainties about the state of his health. Due to these uncertainties, assessment of health requires good argumentation which is to be analysed in detail in the following. I have divided the previous long excerpt into three phases, each of which represents different ways of argumentation.

At the very beginning of the excerpt, the participant states that his health is 'pretty good'. He then goes on to represent uncertainties included in his assessment by describing heightened blood pressure and arrhythmia as well as examinations related to them. After these detailed deliberations he (at the end of Part 2) concludes that his health is 'by and large otherwise (.) you could say fairly good'. Between these conclusions, argumentation in Parts 1 and 2 is largely based on descriptions of medical examinations of heart ailments. Before the conclusion of his state of health at the end of Part 2, he still compares his heart ailments with those experienced by other people. Based on conversations with other people he suggests that 'a bit every single' and 'one and another' have similar 'funny' feelings. Interpretation of these 'funny' feelings in the heart is likely based on the deduction that since several other people around the speaker have experienced similar feelings, they cannot be distinctively deviant ailments requiring special attention and concern. In this part of the reasoning, the argumentation moves from being a medical assessment of ailments to that of 'lay epidemiology', where personal experiences are positioned with wider social surroundings. From here to the end of the extract, the argumentation is based on similar observations from the social environment.

In the second part of the extract, the speaker discusses in a notably detailed way the tests and examinations carried out for him. The account reflects purpose to interpret the results from tests in a positive light. In the beginning of Part 2, the participant emphasises that despite the monitoring device he did not 'have to go to any exhaustion tests any more' and uses superficial and softening expressions when describing the tests: '*just* the monitoring device it was and *of course* they took all manner of tests, blood tests and *all that*'. The speaker distinguishes and distances exhaustion tests from other tests and monitoring. Expressions like 'just' the monitoring device and 'of course' the blood tests and 'all that' refer to routine procedures in health care that are also carried out for those who are not actually ill. The exhaustion test, in

turn, represents a rather more intensive examination which involves a more serious suspicion of disease.

In Part 3, the argumentation is based on generalised observations from social surroundings due to insufficiency of the medical argumentation to offer rhetorically convincing evidence for complete exclusion of a threat arising from potential hidden disease. The participant discusses the relationship of these two types of argumentation by pointing out that people have different ailments that cannot always be sufficiently explained even on the basis of medical examinations. Since the examinations that the participant went through have not provided a distinct explanation for the symptoms experienced, the symptoms are positioned with the wider context of the social environment and human life. In this argumentation, the uncomfortable feelings in the heart are not regarded as signs of disease because:

1. the ailments do not hamper and restrict normal life and are not, thus, serious
   ('I had no such feelings that it would be, made weak or anything else'),
2. the ailments belong to the normal functioning of the body
   ('every so often a man's circulation does them, tricks'),
3. the ailments do not recur often or regularly
   ('it's nothing like recurring (..) it happens rarely'),
4. many other people have similar ailments
   ('they are, ev-, we've talked about them, one and another have [them]').

The previous extract highlights how health and illness are not strictly separate states but both conceptually and experientially intertwined. As Billig et al. (1988, 89) note, if 'good health' was merely defined by the absence of disease, then there would be very few people who could define themselves as completely healthy. This is because most people have something 'wrong', regarding their health, most of the time. Therefore, it can be concluded that 'health and illness are not … discrete states from which one moves in a unitary fashion, but are interdependent terms of experience' (ibid., 89). In case of illness, or potential disease as in the previous extract, the *health – illness* division easily results in negotiation between the sick body and the healthy self, especially when illness can be located in a specific part of the body as above (heart ailments). These ailments of certain parts of the body act as unhealthy exceptions of the healthy self, and are, thus, distanced from the self ('there's been trouble.. in the ticker'). The trouble is not in me, but there, in the ticker.

Billig et al. (1988, 88) claim that the *body – self* distinction is an important division because the body is an individual aspect of life while the self is a part of social life. In illness, the sick body is often withdrawn from social life which turns the consequences of individual illness into the social self. Therefore, in the case of illness, conditions of health and illness as well as their relationship need to be redefined, 'often through the maximization of what (people) can do freely and the minimization of what they are forced to limit themselves to do' (ibid., 88). It is important to note, however, that these type of accounts are not limited only to experienced conditions, ailments and symptoms that have led to the diagnosis of a specific disease and, accordingly, to limitations of participation in social life (through sick-leaves etc.). The mere foreboding of disease, which has moved the individual from a state of unquestioned health to a field of uncertainties and to belong to a group of those examined, results in the need to justify healthiness of the self. The variety of arguments used is wide, as presented above. It is therefore warranted to claim that the central dilemmatic issue the participant is negotiating in the excerpt is the obscurity of the status of a 'healthy person'.

The temporal dimensions of health are not, however, limited to consideration of the past in relation to the present. The same consideration applies to the future in relation to the past and present, which I see as a fundamental part of all negotiation about healthiness of the self. These temporal dimensions of health are analysed further within the two other groups of argumentation for good health.

'Measuring' health by tests of physical ability and performance of exercise

In relation to assessments of one's own health, many of the participants (8/14) took functional ability (e.g. ability to work), good physical condition or regular physical exercise as indicators of good health. The central role of the functional ability in self-evaluations of health has been documented in several previous studies (e.g. Barsky et al. 1992; Jylhä et al. 1998; Benyamini et al. 2003). Functional capacity and good physical condition were in many cases used together with the notion of absence of disease: in cases where there were no signs of illness (symptoms, ailments, and diseases), good physical condition and an ability to manage daily tasks, especially at work, were referred to as secondary arguments that concretise perceived good health. However, similarly as in the case of absence of disease, good physical condition may need some additional evidence as in the following excerpt.

Excerpt 4.2.

K4: Now at the moment (.) in my own opinion it's (health) entirely good that there's *nothing* (health problems) there (.) Anyway you're taking exercise (.) in moderation and (IP: mm) (.) so that (2) now (.) nothing (.) there's nothing particular, anyway, at the moment.
IP: Aha.
K4: (.) In my opinion, I have gon- (.) I have gone on all sorts of courses to keep us in good shape and others, from here (the company), we have been (IP: mm) it's been more than once so that (.) I know that it's sort of (.) and ther-, it showed (.) a pretty good condition. (K4:1, born 1956.)

In the beginning of the excerpt the assessment of 'entirely good' health is largely based on the absence of problems related to health ('there's nothing particular, anyway'). In the latter part of the argumentation, he refers to courses of physical exercise, organised by the company he is working for, and to the results of the physical capacity tests carried out during the course[2]. Rhetorical cogency of the argument relies on tests being made by outside professionals, which makes the evaluation objective and not dependant on the speaker's own assessment. Therefore, it can be claimed that the test itself showed that the speaker was in 'pretty good condition'. The test of physical capacity embodies the same type of facts-based knowledge as the previously analysed medical tests in Excerpt 4.1 and was used for concretising good physical condition which, in turn, was presented as a sign of good health. Again, the problem for representing good health is rooted in the abstractness of health which, rhetorically, requires a concrete anchor point. Otherwise the speaker might have faced a disrupting question including implicit counterargument: 'What do you mean by good physical condition? Why do you think you are in such good shape?' Reference to measurable and comparable tests eliminates these potential counterarguments.

The ability to have physical exercise and results from tests may be taken as reflections of good present physical condition and health. Another way of reading the excerpt suggests, however, that mentioning physical exercise is rhetorically convincing in other ways, too. The participant's comment 'anyway you're taking exercise in moderation' may also be read as an indication of an active healthy lifestyle which, in turn, can be taken as a sign of good health. According to Manderbacka (1998), in self-evaluations health is often conceptualised as action and in terms of healthiness of lifestyle. In case one's own lifestyle is regarded as 'healthy', health itself may be concluded to be good, at least in the absence of serious medical conditions. The latter interpretation differs from the previous one in its orientation of the future;

[2] By the 'courses to keep us in good shape' the participant refers to courses the companies organise for their employees in order to maintain and improve the employees' health and prevent chronic diseases, usually known as Activities for maintaining work ability (in Finnish, TYKY-toiminta).

physical activity is not depicted as a sign of the current state of the body or mind, but as action which is expected to result in good future conditions (cf. Krause & Jay 1994).

The latter discursive practice of presenting physical exercise as an indication of healthy lifestyle and, thus, as an indicator of health, leads to two theoretically interesting notions. Firstly, health is not merely something that 'is' but also something that one 'does' (cf. Saltonstall 1993). Secondly, 'doing' health is not merely something that one does but also something that *one is supposed to do*, and includes normative obligations for not only representing good present health but also acting for good future health. Earlier in the chapter it was concluded that, for healthy people, it is the abstractness of health which leads to attempts to concretise the claims made about one's own health by various tests or functional ability that both represent a more or less measurable indicator of one's physical condition. The moral obligation to actively act for future health (Bunton & Burrows 1995; Lupton 1995) requires measurability of 'doing' the same way.

Excerpt 4.3.

IP: How do you feel about your own health at the moment?
K2: Well, (1) I do feel, that I am (.) almost in better shape than (.) a few years ago, that about (1) I've done more of that exercise now here (.) let's say about (3) what would it be (1) at least almost ten years has.. (.) I went on this (.) this fitness holiday week at Peurunka. (1) It was around ninety-six that would be the first one. (1) That's how it started, when I saw that (laughter) (1) I wasn't in that good shape that I thought I was (.) shape, that well (IP:mm) (2) Then I've done those Pirkan kierros[3] (.) rounds partly, and this year I actually skiied it so that (1) I've been rowing and cycling so (2) And I've cycled to work, in summer I've got (1) 15 kilometres there and back that (1) (IP: Ahah) journey to work well.. (.) That gives me a nice daily.. (laughs) And this (.) job is also the sort that I (.) am (.) on the tele jobs, so (.) I have to go round the factory steps quite a lot in the course of the day so that (1) (IP: OK). So like (.) exercise as you go and then of course at home (.) I (.) I have this (2) collecting (.) wood because I do my heating with this central boiler with wood so I (2) so I get that (.) starting with chopping the wood (laughs) (IP: yes) I get all kinds of exercise. (K2:1, born 1956.)

There are several interesting issues in the excerpt concerning health and physical exercise. In the account, physical ability and exercise are not represented only as co-evidence for good health but, also as direct indicators of health. In other words, in the excerpt *to be healthy is to be in good physical condition* and the reason for why the interviewee concludes his health to be better compared to a couple of years ago is that

[3] Pirkan kierros is a chain of four fitness sport events (Pirkka Ski Race, Pirkka Cycling, Pirkka Rowing and Pirkka Jogging) organised annually in the Pirkanmaa region.

he has had physical exercise on a more regular basis. The reason for starting a more active exercise was a test of physical capacity that the participant had gone through.

What is, however, most interesting in the excerpt is how the rest of the excerpt is devoted to the representation of all types of physical exercise that the participant does regularly (skiing, rowing, cycling) accompanied with other physical activities beneficial to maintaining physical ability (walking stairs at work and chopping firewood at home). The long list of different physical activities is also accompanied with emphasis on the regularity of activities ('daily', 'in the course of the day') as well as the numeric representation of cycling ('15 kilometres' a day). What is a notable difference between this excerpt and the previous Excerpt 4.2 is that in the latter physical exercise and activities are not taken merely as concretising the speaker's good physical condition but there is also a clear future orientation in talk. By giving a list of various physical activities the participant represents how actively he works on his health. Active 'doing' of health is thus assumed to result in good future health.

Abstractness of health forces an assessment of health to be based on concrete and, preferably, measurable and comparable states of being and doing. Definitions of and argumentation for health are often based on the absence of illness, which helps display the healthy self. In illness, in turn, the relationship between health and illness needs to be reconsidered, often 'through the maximization of what they can do freely and the minimization of what they are forced to limit themselves to do'. (Billig et al. 1988, 88.) The next extract is an interesting example of 'maximisations' and 'minimisations' of different activities in a person's everyday life. The participant in the interview is 68-years old man with severe asthma[4].

Excerpt 4.4.

IP: Now has the doctor given you many other instructions about how to live and how (.) how you should stay heal[thy?
PI2: [Aye:! In-deed (very loud voice) and (.) I went there (1) to that place of Hengitysliitto (Pulmonary Association) (1) a kind of, kind of (1) afternoon's training. (IP: mmm) There in Laakso (.) and there I was and there was how to do exercises like and (IP: Uhuh) and all the rest (1) and there they told you that, there was like a doctor and (1) a keep-fit nurse and, and..
IP: And did you get them done?
PI2: We:ll, sometimes just a little (loud voice) and then that (IP: Aye) that, but (1) but let's say that I've been keen on exercise a:ll my life but (1) now it's that 'cos (1) I can't really you know (1) you know manage in wintertime but let's say that in summer, well you know (1) on the bike it goes (.) pretty (.) pretty nicely. (IP: Aye.) So (.) so that to get there. But walking (.) walking is now, and used to be, really I couldn't get from one end of the room to the other but (.) but well (1) on the bike I have

[4] This interview is another of two pilot interviews I made in Helsinki before starting the actual data collection. The interviewee is a pensioner who has not worked in the paper industry.

(.) so like now (2) Three years ago I had (.) three years ago well (2) they diagnosed sort of (1) a tumour here (.) in the lung and (.) it was operated on but it was(.) something from a former (2) pneumonia, a scar
IP: A:[hah I see[
PI2: [So they [they were (.) they were benign. (IP: Uhuh.) So there was nothing (.) nothing and (1) and yes I really well, the operation went ve:ry well and so did the recovery from it and (.) And then I started going on the bike (2) after the middle of May and then it was and (1) and then I went for the final check-, the doctor was a bit put out that I shouldn't have been on the bike (faster).
IP: Aha[h
PI2: [I did more than 2000 kilometres that sum[mer!
IP: [Good heavens![(laughter)
PI2: [on the bike
so that it didn't (.) that it went pretty nicely (.) but let's say that last summer I only went a thousand kilome[tres
IP: [I: se[e.
PI2: [tha[t it was..
IP: [yes well (.) that's not exactly a sma[ll amount either
PI2: [Yes so it was and (.) yes and summer before last I went mo-, more than (.) more than a thousand.
IP: ay[e.
PI2: [so that it was (.) that now I've gone (.) I haven't gone that much 'cos (.) it was just 'cos this [asthma] it's been *such a thing* that in its active phase you know (.)
IP: Uh[uh.
PI2: [So I haven't (1) really felt like tearing myself that (PI2:2–3, born 1934.)

In my interpretation, a thread running through the excerpt is the speaker's attempt to separate the partly sick body from the generally healthy and capable self who has been 'keen to exercise all (his) life'. Although he acknowledges the difficulties he has had in managing the daily tasks (walking between the rooms), he minimises these difficulties by maximising other activities, out of which cycling is the most evident indicator of physical ability. An interesting feature of maximisation is numeracy involved in descriptions which, again, makes the claims of physical ability more convincing through measurability and objectivity of numeric information.

What seems to initiate the calculation of activity is the interviewee's notion of how the doctor in the post-operation check-up had been 'a bit put out' with the patient's cycling. After that the interviewee tells me about how he cycled 'more than 2000 kilometres that summer' indicating that the doctor's concern was not in order and that he was not able to see the 'true' condition of the patient. Since he does not, however, criticise or estimate the doctor's professional skills and knowledge, acting against a doctor's recommendation implicitly constructs an *exceptional patient* who, against the doctor's expectations, had recovered from an operation to the extent where he is able to act without functional limitations and achieve results that are hard to gain even for younger people. The achievement is further emphasised with

a 'modest' notion that last summer he 'only went a thousand kilometres' which I, again, acknowledge by disagreeing with his understatement.

The previous excerpt was an interesting example of 'minimisations' and 'maximisations' that people use as discursive strategies for coping with threatening identities of the sick. Reinterpreting functional capacity, on the one hand, and limitations of capacity, on the other, may be especially important for men.

> Helplessness is the worst thing a man can imagine. A man may even show his feelings, but he must not be incapable. Even when he is sick, he should be able to act. (Honkasalo 1995, 198.)

In line with what Honkasalo mentioned, the interviewee of the previous excerpt did basically all he could for representing a sick-but-still-capable self. Even when describing the latest time, when his asthma has caused him more troubles than before, the reason for not continuing cycling is formulated as his own decision: 'So I haven't really felt like tearing myself (by cycling)'. Regardless of illness limiting the activities in his life, the interviewee guards his agency and freedom to make choices.

'Measuring' health by medical tests

As noted at the beginning of the chapter, absence of illness or symptoms was the dominant argument for considering one's own health to be good. These assessments involved several dilemmatic aspects concerning, among others, temporal dimensions of health. 'Current' state of health is constructed, and due to contradictory elements negotiated, on the basis of previous 'health history' by considering the significance of former ailments. Significance of the formerly occurred ailments, symptoms and diagnosed diseases requires thorough contemplation due to the obviousness that all ailments are not equally dangerous to health. Common colds or well-recovered small fractures in adolescence, for instance, do not substantially affect the current state of one's health. In case the previous ailments do not offer a point of comparison for assessing current health, medical tests form a basis for arguing for or against the absence of disease. In the excerpt below, the participant uses medical tests as an argument for justifying his own health self-assessment.

Excerpt 4.5.

```
IP: Shall we start (.) just, just about how (.) how would you evaluate your
own health at the moment?
T4: Good. I was recently in the 55 years check-up and I'm (.) at least the
blood, blood values were just normal.
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IP: Aye. Was it (check-up) here, at the workplace or how?
T4: Yes, it was here at the workplace. I haven't sort of, in my opinion, any health problems at the moment. (T4:1, born 1949.)

The participant bases his assessment of health on results from a recent health check-up and, in particular, on results of blood tests. Because the check-up did not reveal anything that would have indicated worsened health, and the results of the blood tests were 'just normal', he may conclude that he does not have 'any health problems at the moment'. A medical check-up and blood test, in particular, offer an objective and measurable basis for the claim that there are no health problems, even such hidden problems that might not have been noticed in a 'subjective' evaluation. However, simultaneously, the participant emphasises that the blood tests do not necessarily disclose all potential threats by using an expression 'at least', which can be read as a 'disclaimer' (Hewitt & Stokes 1975) for possible counterarguments about the relevance of the tests in assessing health.

The 'disclaimer' seems realistic because the participant does not specify the type of tests made. As various tests of blood indicate different potential 'health problems', their use in justifying good health might, indeed, be questioned. For example, in case the tests proved the absence of a certain infection, then the test could be used to indicate the absence of disease and, thus, absence of health problems. If, on the contrary, the blood tests refer to cholesterol tests, for instance, then their use as an indicator becomes far more complex. Heightened levels of cholesterol in the blood may not, as such, be regarded as a disease but, instead, as a risk factor for diseases. In the latter case, the tests would be taken as an indicator of future health instead of the current state of health. During the later stage of the same interview, the participant again refers to blood tests in the context of nutrition. Here, the blood tests are not only seen as reflecting health but also healthiness of the participant's lifestyle.

Excerpt 4.6.

IP: Aye (.) Aye and then we get onto the eating bit then you're (.) you're (.) you think your own diet is still pretty (.) pretty good as it is?
T4: Aye, oh yes Pajamäki (the occupation health doctor) (1) when he was looking (2) at those blo-, blood values, well, he says that (.) *that* in his opinion there's no (.) no need to make any (.) changes in the *food* and habits that *they're*..
IP: Like the cholesterol values are?
T4: That was exactly five.
IP: Aye.
T4: I've had it even lower, it's been four-six, four-seven but (.)
IP: Yes.
T4: It was exactly five and then the good cholesterol was one-nine-two that (IP: Aha.) he said it's that high it (.) now was if ADL or HDL, (IP: well) whichever it was but (.) that it was that high (.) that it's just fine and

(IP: aha.) the liver values were (1) twenty-three and that's, I suppose, (3) *now is it* from zero to eighty the (.) (IP: mm) so there's still (.) so I can still afford to take a drink (laughing).
IP: (laughs) Aye. (T4:8, born 1949.)

A noteworthy feature in the excerpt is the detailed manner in which the participant discusses the results of blood tests. The exactness of how he recalls not only the results but their reference values ('now is it from zero to eighty'), too, gives good reason to believe that he has some personal interest in the values. Test results offer, again, an 'objective' basis for making claims about abstract health ('no need to make any changes in the food and habits') as well as about healthiness of lifestyle, even to the extent, where potentially unhealthy habits may be seen as acceptable when considered together with indicators from tests ('so I can still afford to take a drink'). It is also notable that the test results give an opportunity to assess health within a temporal framework. By comparing the latest test results with the previous ones renders it possible to 'monitor' changes in health and make conclusions about the future. Therefore, if Excerpts 4.5 and 4.6 are read together, it may be concluded that discussion of medical tests is one context where temporal dimensions of health assessments become important. Here, good health does not only refer to the current state of health but comprises interpretations about past and future health as well.

From the point of view of ideological aspects involved in health talk, consideration of test results may be seen as references to moral decency and control, to 'wellness as virtue' (Conrad 1994), especially in the context of healthiness of lifestyle. When the excerpt is read from this perspective, it is worth paying attention to the competitive tone of discourse: 'I've had it (cholesterol values) even lower'. As the participant seems to be aware of the reference values of the tests and, thus, knows that his own cholesterol values are below 'risk-values', detailed discussion of test results may be seen as constructions of a healthy, responsible and controlled self. Adelswärd and Sachs (1996) found in their study on nurses' and patients' discussions of cholesterol values in general practice, that for the patients it was of high importance to be under the set numeric limit of risks, even if not fully understanding the meaning of numeric information and variation in test values.

Being on the 'safe side' may also explicitly involve an idea of the self who has 'done it better' compared to some other people. This type of rhetorical use of medical tests is represented in the next excerpt.

Excerpt 4.7.

IP: By the way how (.) I forgot to ask at the time I was asking about how you yourself estimate your health, well, at the time I forgot to ask that

(.) how if you compare er your health to other men of your age (.) well what do you think of your health?
K7: Well (.) I would say that it's well (1) above the average certainly that (.) even if, if you only look at the blood values so (.) that already (.) that alone *so that* (2)
IP: Aha.
K7: *and that* (.) it's *because* the exercise bit is in (.) and that you can also see in the stuff they bring to eat (.) that, well (.) at least it seems to me straight off that that (.) I can already see it in the food (.) which of us, sort of (.) which of us has a body in better co-, condition, *so*.. (entire speech with laughter.) (K7:12, born 1968.)

In the excerpt, blood values form an argumentative basis for claiming that own health is 'above the average certainly'. However, it is also important to note that in the course of argumentation, reference to blood values is not a 'water-tight' evidence for the claim about better health. Although the blood values 'alone' give good reason to assume that his health is better compared to other men of the same age but the claim still necessitates further evidence. This is arguably because it is obvious that such evidence cannot be provided in the context of the interview. Therefore the participant points to other indicators related to blood values (apparently cholesterol values) that may be easily imagined by the interviewer, unhealthy diet and lack of physical exercise, which he then discusses as combined indicators of health. Nutrition and physical exercise may also be interpreted as visible markers of presumed blood values of others. In the argumentation, the 'unhealthy others' (Crawford 1994) who are used as points of comparison for one's own good health are assessed on the basis of individual behavioural factors often associated with 'coronary candidacy' (Davison et al. 1991) and other chronic diseases. This interestingly demonstrates how certain behaviours and exterior features (over-weight, sweating, ruddy face and so forth) have become markers of un-healthiness, especially what comes to other people's health (see Saltonstall 1993; Lupton & Chapman 1995). A healthy appearance, in turn, now testifies to internal, moral goodness (Jutel 2005).

Assessing one's health on the basis of blood values, without specification of which tests are referred to, brings up again the complexity of assessment of one's own health, at least when it comes to rhetoric used to justify the claims about one's own health. In these assessments and argumentation, health and health-related lifestyle choices are intertwined in intricate ways. In the same way, the argumentation is not strictly limited to current health or even to past health, but involves assumptions of future health. It is noteworthy that results from medical tests can be used in both previous 'frames' of health for excluding potential hidden ill-health, on the one hand, as well as arguing for good future health, on the other.

Considering 'blood values' as indicators of health highlights an important cultural transformation in conceptualisations of health. As Adelswärd and Sachs (1996) have demonstrated in their study on nurses' and patients' discussions on cholesterol tests, the tests result in the emergence of a 'grey area' between health and illness. The people with heightened cholesterol levels are treated as ill and needing medical care, even without visible signs of illness or experienced symptoms. More generally, both references to physical exercise and 'blood values' represent how healthy lifestyle, risks related to unhealthy choices as well as measurable signs of potential disease (presumably caused by unhealthy habits) have become an essential part of assessing health itself. As Sachs (1995, 503) puts it, 'the search for health dangers and risks shows how medical technology has been integrated with our thinking about health'. Awareness of health-related risk-factors has in this way become a constitutive part of understanding health.

Healthy self and predisposition to future threats: a case of heredity

Negotiations on individual health involve interpretations of past and present ailments, symptoms and findings of medical tests, which are assessed as grounds for one's current state of health. As we have seen, however, assessments of current health are often not limited to present time alone but include, simultaneously, contemplations of future health. This leads to considerations of health-related lifestyles and findings from medical tests as predictors of future health. Accordingly, different health-related factors of present life and self become indicators of potential predispositions to future ill-health. One factor of this type is heredity, which was mentioned several times in interviews as a determinant of health.

Heredity is a complex thing in assessments of future health. It is simultaneously something which is inside the self and, thus, a part of the self, while at the same time it is something that the person cannot control. What makes assessment of hereditary factors even more complicated is that the self cannot be sure if he/she is carrying 'bad genes' or not, and further, does the 'bad heredity' result in ill-health or not. In the same way that medical tests indicate medically abnormal findings, 'bad genes' locate the individual in a grey area between health and illness. The most obvious difference between 'blood values' and 'bad genes' is a clear future-orientation included in discussions of heredity. The next excerpt is an example of how the role of heredity, as one of the health-related factors, is discussed and negotiated in a focus group. Before the excerpt, we have talked about how people tend to pay more attention to health when they get older. This leads the participants to discuss their own parents and how

they have experienced their parents' ageing as well as health-related problems related to it.

Excerpt 4.8.

P2 (-49): *My* father, well (.) he was a bit over seventy and (.) died well (.) what he had was a brain (.) brain haemorrhage (.) we've that (2) sort of failing in the family (2) so that (1) quite a few of them has had (.) a brain haemorrhage. (.) So it like made me *think a bit* (1). I mean father got a stro- (.) he lost his power of speech and ability to move (1) one hand didn't work at all (.) *so that yes* it mak*es* you think a bit. He lived several years like that and.. (4)
P3 (-54): Now I can remem-, remember very well the (.) how father left us (.) *and in* recent months it's been a lot on the agenda (.) through Mother (1) that (.) if she just could keep on believing that life would go on *like* (3) That's surely one (.) the heredity, too (.) to blame why (1) those heart problems are starting to come (.) for one and another in our family that (2) He was, he lived to a bit over seventy, the old man so.. (3)
P2 (-49): Yes (.) they're quite a long-lived (.) family but it's just those brain haemorrhages that come when they're older (.) so (.) (IP: mm, aha.) There's some weak point up there (.) there in the head in some veins, I suppose there's some kind of a, that's what my brother said when they tested him, well (.) there's some junction that tears like (.) but I suppose it can easily be fixed if there is one (2) and he told me to go (.) to one of those magnetic pictures and (.) If there's a hereditary fault (.) well, they can (.) it's a small matter, I suppose, to fix (it) (.) strengthen the vein, the branch part that (.)
IP: Aye.
P2 (-49): That's (the vein) what makes the difference there. (FG5:6.)

Pointing to exceptions of the generally healthy self, discussed earlier in the chapter, does not necessarily have to be based on direct personal experiences or concern a person's own illness. The accounts in the excerpt may be read as 'narrative reconstructions' (Williams 1984) of chronic illnesses, where a person creates a storyline for his illness in order to make sense of it. Interestingly, the narrative reconstruction can also be made for an illness that emerges repeatedly in the family thus representing a potential future illness of the speaker. When describing ailments and the death of his father, P2 expresses the idea that a brain haemorrhage is a familial disease ('we've that sort of failing in the family') and notes that several family members have had the disease. He says that his father's stroke and later death made him 'think a bit', although he didn't explicitly talk about his own future. P3 continues the same theme in a more explicit way by noting that it is the heredity in his family, among other factors, which is 'to blame' for the 'heart problems which are starting to come' for 'one and other' in his family.

P2's latter account is interesting in how it continues the same theme of discussion but in a different, negotiating way. In my interpretation, P3's comment forces P2 to

reconsider the significance of heredity not only within his family, in general, but in his personal life, in particular. P3's notion of heredity and its influence on the health of members of his family may be interpreted as a claim of hereditary vulnerability being a potential threat for all family members, which places P2 in a threatened position in terms of hereditary predisposition to brain haemorrhage. The last part of P2's account may thus be read as counterarguments to that claim, indicating that despite a familial predisposition to brain haemorrhages, he cannot be seen as being in a particularly vulnerable state where his health would be determined merely by heredity.

In P2's account, there are five counterarguments for hereditary vulnerability. First, despite cases of brain haemorrhages, P2 describes his family as being generally 'quite long-lived' undermining the image of his family as particularly vulnerable to premature death. Secondly, he localises the potential vulnerability of the whole family into one specific and limited part of the body (it's just those brain haemorrhages', 'some weak point up there', 'there in the head in some veins'), which both diminishes the perceived threat and makes the distinction between a potentially sick organ and a generally healthy organism/self. Thirdly, at the same time, he distances himself from the family, starting to refer to it as 'they' ('they're quite a long-lived', 'when they're older'). Fourthly, P2 diminishes the actual threat of a potentially inheritable disease by pointing to possibilities of modern medicine in 'fixing' weak parts of the body. As part of this argumentation, he finally questions the threat by referring to it as a conditional matter: '*If* there's a hereditary fault (.) it's a small matter, I suppose, to fix (it).' Mechanistic terminology used in accounts both distances the (potentially) loosely functioning body-machine from the healthy self and renders it possible to make simple (technical) repairs in the case of malfunctions.

The ageing male body

It has been noted in previous studies on men's ageing that men tend to assess their physical ageing in terms of a decline in functional ability and strength whereas women are typically concerned with their appearance (Hennessy 1989; Julkunen 2003, 90–102). As men's identities are largely constructed on the basis of socially valued achievements such as work, sports and sex (Julkunen 2003, 102), a decline in physical ability clutters co-ordinates by which a man has defined his position in the community (Hänninen 2006, 72). In my interviews, several participants discussed bodily signs of ageing and decline in functional ability in the context of assessing their health. Most of these discussions focused on the ability to work and physical

ability at work. A widely discussed theme was the negative influence of shift work on one's health as well as the demands that hard physical work places on the ageing body. Some participants addressed their ageing in the framework of work by pointing to younger workmates' better physical abilities, which was often taken as an example of a concrete situation where a man recognises his ageing and gradual decline in physical capacity. It is notable, however, that the interview episodes of declines in functional ability by ageing did not concern 'old age' alone, but covered several stages of life from early middle-age to retirement.

During the interviews, men continually pointed to the decline in physical capacity as an issue which forces ageing men to recognise a need to start to improve their health. In these accounts physical condition and ability were typically used as more or less a synonym for health. In a focus group, before the next excerpt, we talked about why women read more health-related magazines compared to men.

Excerpt 4.9.

P6 (-75): I think it's just what Mika (P2) says (.) that what's at the back of somebody's mind is that (2) that (.) for men it's that they see themselves that they are OK "I don't need them" (.) rather I take that Tekniikan Maailma (World of Technology) magazine or something (.) like it that well "I'm fit as a fiddle" or (.) it, this (.) a man has to get a more radical wake-up call so that he's now seriously got to do something. (.)
P2 (-78): Many have (.) they say that (.) many men have still had (1) since they were boys this (1) sports (.) sporty background there and (.) have done and played everything (1) and (.) have such an image of themselves that (.) they can still manage it (.) manage such, a certain performance in sports so (.) That, it might remain for quite a long time (.) before he sees that he can't (.) what the reality really is. (FG2:16.)

In the first part of the excerpt, the participant P6 explains men's disinterest in health magazines by describing men's instrumental understanding of health. In his account, a man is not interested in health issues until he gets 'a more radical wake-up call' after which he seriously has to do something about it. Another participant, P2, continues P6's idea by referring to achievements in sports where 'certain performance in sports' is an indicator of being in good physical condition. In his account, the 'radical wake-up call' is a man's realisation that he cannot manage the same levels of skill and performance in sports than he could earlier in his life. In these two accounts, it is interesting how the opposite of health is not illness or deteriorated health but, instead, a certain physical state where a man sees 'what the reality really is'. In this line of thinking, physical capacity does not only represent one dimension of health but comes close to 'health' as such. Lowered physical ability then becomes an issue which leads men to want to 'do something' for their health. What is also interesting,

however, is that when speaking about the decrease in their physical abilities as an indicator of weakened health, the participants do not talk about men as 'us' but 'them'. Thus it seems that the line of thinking men suggest to be generally true for men may not be completely endorsed on a personal level.

A striking indication of the salience of physical ability in men's 'health culture' was competitiveness, which emerged in many accounts of physical ability. Later in the same interview we continue to discuss the reasons why the majority of men do not take part in exercise programs during the breaks at the company, the 'thresholds' for participating in them[5].

Excerpt 4.10.

P6 (-75): But *there* (.) there's in a certain way, there's the fear that that's when you notice it (.) when you go there (.) that (1) first you might see yourself or others notice what poor shape you're in that you can't stretch this way and that so (1) everybody else can and (.) half way through you yourself start to puff and blow that (.) you can't do it. (FG2:17.)

A competitive tone in accounts of physical capacity was most noticeable when tests of physical exercise or other achievements in sports were discussed. The excerpt above represents another type of 'competition' highlighting the way in which not being able to manage a certain level of performance in a public setting may be interpreted as shameful for a man. While good results in sports or tests of physical exercise may be used to represent a healthy, capable self, inability to perform physical exercise in a public setting forms the other extreme of an incapable, weak, old and unhealthy man.

An unhealthy exception of the healthy rule

In the interviews, most participants assessed their health to be good or relatively good. One of them, however, stated very clearly that he is not healthy. The interviewee's conclusion was not based on medical findings, but on his own interpretations of bodily signs and contemplations of, among other factors, the effects of 27 years of smoking upon his health.

Excerpt 4.11.

IP: If we now set out right from where, I would like to ask you what do you (.) think of your own health at the moment?

[5] This discussion will be analysed in detail in Chapter 7.

T2: Just health as health, that we're not talking (.) let's say like about diseases or anything like that (.) ge:neral keep-fit or (IP: mmm: no) that sort of things, that if I can have hobbies.
IP: Not quite, so would you say that you are healthy?
T2: No.
IP: No?
T2: No.
IP: Yeah. (4) So what kind of (.) ma-, may I ask what sort of trouble or..?
T2: Well (2) the sort of thing that (1) my stomach doesn't work as it ought to for a normal person (1) and well (1) then I have my own suspicions (1) about what has got into my (.) body after twenty-seven years of smoking and..
IP: Ahah.
T2: But, well (.) I'd rather not know about it, what I've got, rather than that I would go to talk to the doctor.
IP: Yeah, yeah.
T2: Waited four and a half years, but I haven't got meself there.
IP: Oh yes (.) OK (.) Ri[ght
T2: [The symptoms all (1) suggest (.) certain things. (1) (IP:mmm) Let's see when I can get myself round to it. (T2:1, born 1958.)

In this exceptional excerpt, there are several important issues that need to be thoroughly considered. In the beginning of the excerpt, different *dimensions of health* are, again, mixed and intertwined, in the same way as discussed above. When I asked him what he thinks about his own health, the interviewee had difficulties outlining the specific contents of the question and tried to concretise it by comparing it to the *absence of disease* ('we're not talking (..) about diseases'), *health-promoting activity* ('general keep-fit'), and *functional ability* ('if I can have hobbies'). Associating 'health' with health-promoting activities simultaneously highlights context-bound presuppositions about what the interviewer wants to know in the interview. A brief negotiation of the contents of 'health' leads to a second interesting point in the interaction. When the interviewee answers the question *Would you say that you are healthy?* with a laconic *No*, the interviewer (me) loses his confidence for a while. After an immediate ascertaining question ('No?') the interviewer seems not to know how to proceed after an apparently unexpected answer, which is seen in a relatively long pause of around 4 seconds. The next specifying question about why the interviewee does not consider himself healthy ('So what kind of (.) may-, may I ask what sort of trouble or..?') is formulated highly hesitantly which, together with preceding lines, suggests two conclusions. In my interpretation, performing a healthy self is such a strong presupposition that acting against this expectation results in confusion and breaches in interaction. In addition, hesitations in formulating a specifying question about the interviewee's presumed disease(s) highlights that while health may easily be brought up to a public matter of consideration, illness is a private and delicate issue.

The previous notions concerned interaction between the interviewer and interviewee regarding the conceptualisation of health and illness. In addition, there are other important things concerning the ways the interviewee considers consequences and his own activity relating to a potential disease. As his thought about himself having a disease is based on his own observations and 'suspicions' of the consequences of smoking he, arguably, seems to encounter an implicit counter-argument of why he has, then, not contacted a doctor, both for clarifying his suspicions and getting treatment to a possible disease. His answer to this potential counter-argument, which is how I read his comment, is interesting in two respects.

> I'd rather not know about it, what I've got, rather than that I would go to talk to the doctor.

The first interesting issue in this account is how he formulates not going to a doctor as his own conscious and rational decision, the same way as the speaker in Excerpt 4.4. This idea represents both autonomy of the speaker, on the one hand, and some sort of responsibility, on the other: claiming that not going to a doctor is his own conscious choice absolves him from the potential blame of being careless with his health, of not being aware of the possible consequences of his own actions. Although the account includes other ways of describing the reasons for not going for a medical check-up, referring to a lack of motivation, will-power and so forth ('I haven't got meself there'), the first formulation underlines his own agency in relation to health. Another crucial notion in the account regards the logic of preferring not to know about potential disease and remaining uncertain about the state of his health. Being uncertain of whether he is suffering from a disease or not is about staying in the 'grey area' between health and illness instead of falling into a state of illness. Taken that several assessments of health analysed in this chapter concerned the contemplation of a border between health and a grey area of potential disease, this exceptional account is, in turn, about negotiating the border between the grey area and illness.

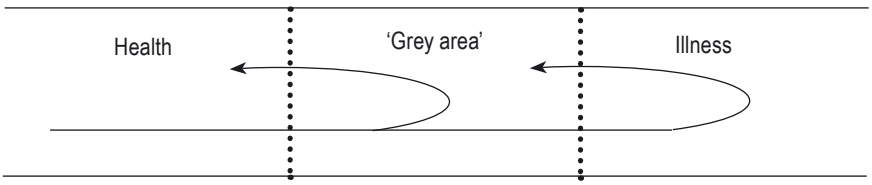

Figure 4.1. Negotiations between health and illness and the 'grey area' between them.

Those of the interviewees who considered themselves to be healthy met difficulties in claiming their health to be entirely good when considering signs of potential illness

arising from medical check-ups or tests, or from previous ailments. In considering this, they had to take the grey area between health and illness into account and aspire to the healthy self by negotiating the probability of potential illness. In Excerpt 4.11, the logic is very similar despite the difference in negotiating the border between the grey area and illness instead of the grey area and health. In the same way, the speaker locates his state of health nearer to health than illness by positioning it next to the grey area instead of illness. 'Suspicions' of disease are therefore a more secure state than a covered chronic disease.

Conclusions

In this chapter I have approached ideological and dilemmatic aspects of health by analysing how conflicting themes related to conceptualisations of health take shape in the context of self-assessments of health. The ideological features of health were most clearly manifested in men's eagerness to assess their health to be good and thus represent a healthy self. Crawford (1984) similarly noted in his interview study that most interviewees started off by saying that they were healthy, which Crawford interprets as reflecting in part a strong moral imperative attached to health and its normality: 'Health clearly represents a status socially recognized and admired and therefore important for our identities' (ibid., 64). The moral imperative of health became particularly noticeable in cases when the participants of interviews were to some extent uncertain of how assured an assessment they could make about their health. Previous diseases, ailments and declines in physical condition hampered making a water-tight rating of good health. Despite these potential doubts, the vast majority of all men assessed their health as good. In interpreting talk about health and the self, Blaxter (1997) made an important conclusion regarding the effects of disease on social identity: 'if one cannot deny the reality of one's own disease, one can at least respond "healthily" to it' (ibid., 756). In this context, Blaxter's notion could be reformulated: *if one cannot deny the previous ailments and other things creating uncertainties in relation to one's current health, one can at least respond 'healthily' to it*.

The dilemmatic aspects of assessing one's own health arose from a profound abstractness of health, which resulted in efforts of concretising health by conceptualising it in terms of more easily observable conditions such as absence of disease, physical activity and functional ability, and outcomes from medical check-ups and tests. Although each of them provides an anchor point for situational conceptualisations of health, the temporal dimensions of health form another axis

for evaluations, which is equally taken into account in assessments. Even in cases where health was conceptualised in a rather concrete way, the temporal dimensions of health complicated the assessments: speaking about current health involved (re)considerations of past and future health as well, which broadened the topic of evaluation. An especially complex feature in assessments of health was the implicit but nevertheless apparent future orientation in considerations of health. This future orientation resulted in assessing health-related behaviours as part of one's health and medical test results as indicators of potential future illness as well as considering their implications for health. Consequently, assessment of current health broadened to cover potential health risks involved in one's own life, ranging from cholesterol levels to heredity and genes.

Medical tests have an important role regarding temporal dimensions involved in self-evaluations of health. From a social and cultural perspective, their recurrent use in talk about health shows how methods of 'surveillance medicine' (Armstrong 1995) have become an essential part of lay people's understanding of health (cf. Sachs 1995, 503). According to Adelswärd and Sachs (1996), assessing personal risk on the basis of results from medical tests (such as cholesterol measurements that they use as an example) causes new difficulties for people in conceptualising health.

> The dilemma arises from the fact that whereas epidemiology speaks of risk as a measured property of a group of people, clinicians as nurses speak of risk as a specific property of an individual. Risk then becomes something that is diagnosed through abstract measurements by clinicians and accordingly something that the patient suffers as a sign of future disease. … This ambiguity results in the creation of a new state of being healthy yet ill; a state that is somewhere between health and disease and that results in the medicalization of people's lives through abstract measurements. (Adelswärd & Sachs 1996, 1185.)

The fact that a heightened cholesterol level is often accounted for by an individual's lifestyle may lead to anxiety and even social isolation as Lisbeth Sachs (1995) has demonstrated in her study among Swedish men who had been monitored for their heightened cholesterol levels. Linking the test results with individual lifestyle choices and locating responsibility for the cause and the cure of health problems in individuals' lifestyle choices represents an ideologically driven paradigm of medical practice, which causes the patients to be held accountable for their conditions. In Sachs' study, the nurses in the clinical practice often did not even consider the possibility that heightened cholesterol levels had resulted from hereditary causes. She concludes that with its narrowed emphasis on lifestyle, medical institutions become institutions of social control (Sachs 1995, 503).

Although talking about personal test results in an interview may pose a moral 'risk' for a speaker as it makes it possible to scrutinise his health-related behaviours, the tests have become such a central part of people's understanding of health that they cannot be neglected (cf. Olin Lauritzen & Sachs 2001). In addition to providing a rhetorically convincing tool for representing a healthy self, they simultaneously offer a means for representing a morally decent, responsible self. Going to medical check-ups and discussing the test results demonstrates a person's interest in and awareness of his health. In this way, a healthy self is not only a presently physically healthy self but involves a commitment to acting for health and being aware of health.

An interesting example of how health awareness and morality are intertwined in the use of various health-related tests is the study on HIV antibody tests by Lupton, McCarthy and Chapman (1995). The researchers aimed their study at understanding why 'low risk' individuals make the decision to have an HIV test. It turned out that in many cases the persons having HIV tests did not expect to have the virus infection, but had a test for reasons other than those advocated in official policy statements. The motives for having the test were not medical but social including pressure from parents or lovers, the wish to give up the use of condoms and the need to display mutuality in a relationship. The authors thus conclude that the test has become a 'cultural icon', which serves as a symbol of commitment and fidelity in relationships 'signifying a proof of renewed purity and bodily integrity' (ibid., 179). In addition to interpersonal motives, the tests form a means for representing broader moral decency: 'the test was also discursively represented as a form of bodily maintenance, a means of protecting one's health, of "doing something" to keep the body in good order' (ibid., 179). In the latter sense, the test may be seen as a symbolic representation of one's sense of responsibility for health, not only within a sexual relationship, but also as a broader value in life.

Use of tests as an indicator of health may be seen to arise from 'positivism of the self' – a concept which Jesse Berrett (1997) has referred to as a 'belief that one's inner resources could (and should) be weighed, measured and tabulated' in order to 'measure "normality" and "adjustment" … and thereby enable one to trace one's exact inner progress in relation to putatively objective standards of valuation' (Berrett 1997, 810). The usefulness of tests relies on their quantified comparability and 'objectiveness', which absolves the individual from potential accusations of 'colouring' his/her conditions. This, of course, relates to a more general phenomenon of rhetorical effectiveness of numbers which, according to Potter, Wetherell and Chitty (1991, 358), is grounded in their apparently neutral non-rhetorical nature and the idea that calculation is 'an impersonal, mechanical routine impermeable to human desires and biases'.

The central dilemmatic position in men's assessments of their health arose, on the one hand, from a need to represent a healthy and capable self in an interview and, on the other hand, from the difficulty to make certain claims regarding abstract and multidimensional health. The use of test results as indicators of health in argumentation dissipates ideological bases of the assessments positioning claims of good health into objectively verifiable medical procedures. Regarding the topic of this study, masculinity and health, it is worth noting that the self-ratings of health did not involve accounts that might have been taken to reflect the conflict between masculinity and personal health. On the contrary, I would say, the men I interviewed expressed interest in, and in some cases, concerns about their personal health. As this was obvious throughout analyses presented in this chapter, I did not see it as necessary to contemplate men's talk about their health from the perspective of masculinity. But can we still make some conclusions concerning masculinity involved in their talk?

Several earlier studies have concluded that male manual workers tend to conceptualise health in functional and instrumental terms, as absence of disease and with focus on physical aptitude and capability (Bourdieu 1984; d'Houtard & Field 1984; Calnan & Williams 1991; Watson 2000). Wandel and Roos (2006) found, on the basis of interviews with three occupational groups, that the themes related to the ageing body, which emerged in the interviews, varied between the occupational groups. While an important theme in the engineers' interviews was keeping the body in shape, the carpenters were most often concerned about decline in physical strength. The drivers did not have any specific theme related to ageing and the body. The findings of this chapter are in line with the previous studies in that manual male workers tend to conceptualise health, body and ageing in terms of functional ability and physical strength, which was reflected in their self-assessments of health. This may be interpreted as a reflection of a certain type of masculine ideal which links abstract but valuable health with concrete and evenly valuable physical strength, functional capacity and the ability to work.

Another feature that could be interpreted as particularly masculine discourse of health was the recurrent use of mechanistic terminology and metaphors relating to the body. Mechanistic discourse may be taken to reflect the central role of technology and machines in men's lives, as Mellström (2004, 369) observes: 'technology and technical skill are constitutive features of what it means to be masculine'. It may also be interpreted to reflect men's general conceptions of their bodies as 'instruments under their control' (Henwood et al. 2002, 182–183), as well as their tendency to 'see the body as a machine' and to 'deal with the mechanics of their bodies – inputs, outputs and effects – rather than emotions and feelings' (Cameron & Bernardes 1998, 682). In my interviews, the human body and health were repeatedly described with

mechanistic expressions, alongside the test results discussed earlier. In talk about the body, there were several metaphors of machines such as 'ticker' or 'pump' regarding heart and different 'failures' of the organism which are 'fixed' when necessary. The healthy body is a 'system which works' properly. One of the participants used an expression of 'when I've got 55 on the clock' when talking about his health and ageing.

Men's frequent discussions of medical tests and tests of physical exercise might also be interpreted as being related to mechanistic thinking about health. Use of measurable quantities such as cholesterol, blood pressure, body-mass index or kilometers of annual skiing act as a means to locate health on a scale representing the functional capacity of the body machine. In this mechanistic discourse, health equates with normal functioning of the body machine whereas disease and ailments are indications of flaws or shortcoming requiring repair with appropriate operations. Using technological terminology when speaking about health and the body could also be seen as a means for articulating thoughts about things that many men are not familiar with and about which they have a limited vocabulary to express their ideas (cf. Brown 2001).

5 IDEOLOGICAL AND CONFLICTING THEMES IN INTERPRETATIONS OF HEALTH INFORMATION

Healthy lifestyle, whether as a concept of health promotion or individual choices in everyday life, is conceptually tightly linked with information based on epidemiological knowledge about diseases and their risk factors. In contemporary Western societies, discussions on health and illness are dominated by medico-epidemiological discourses, which became apparent in the previous chapter. Since interpretation of health information is thus an essential part of lay understandings of health, this chapter focuses on the ways in which health information is discussed in men's interview talk.

At an early stage of analysis, I noticed that the importance of delivering information about health was discussed in contradictory ways in the interviews. In the material, many participants agreed with the importance of health information and no-one expressed ideas of information delivery being completely futile in promoting public health. In general, delivering health information was considered to be important for promoting health. However, participants also concluded that nowadays people in Finland have enough information available about healthy lifestyles and, therefore, health-damaging behaviours cannot be explained by a lack of knowledge. Accordingly, healthiness of lifestyles was depicted in terms of personal choice and motivation instead of sufficiency/ insufficiency of information.

Excerpt 5.1.

P6 (-75): It seems to me that it's more what's in your head. (.) I'm pretty sure (.) nowadays (.) people know (.) what's good for them and what's not. (FG2:4.)

Argumentation discussing what is in an individual's mind ('head') personalises and individualises life-choices. Simultaneously, current delivery health information is positioned as *generally* important yet it only has limited significance in relation to actual decision-making regarding the healthiness of an individual's life. A further reading of expressed views on the role of health information exposed the inclusion of contrary themes and potentially conflicting interpretations. The following excerpt gives an example of these potential conflicts.

Excerpt 5.2.

P3 (-72): But that (2) if we're still talking about (1) about the importance of getting information, so (.) there's certainly no harm in it. And I believe, or I would like to believe that (.) some of it is useful. (FG3:6.)

The excerpt may be interpreted in two, opposite ways. The first suggests that the participant agrees with the importance of health information but, for some reason, hesitates to say it without some critical considerations. The second way to read it suggests that the participant does not believe the delivery of information has any major significance in promoting public health but, again, he hesitates to express his view directly. The latter interpretation considers expressions like 'I believe, or *I would like to* believe' and 'that *some* of it is useful' as softened ways for expressing that very little health information is actually useful. Regardless of interpretation, however, the hesitations and softening expressions show that there are potential conflicts incorporated in the different ways of interpreting the importance of health information.

In the analysis, it turned out that, regardless of the frequency of accounts articulating general acceptance with importance of health information, contentual variation of these positive accounts was notably narrow. I quickly noticed that these accounts represented only slightly varying ways of agreeing with the significance of information about health: 'I think to have that information is useful for many people' was a typical account of this. Therefore, it may be concluded that *positive views on health information need no special consideration or argumentation*. Contrary to this, variation of negative accounts was notably wider. In the context of considering why people engage in health-damaging behaviours despite knowledge about their harmful effects, explanations offered by the participants concerned to a greater extent applicability, exactness and coherence of health information rather than behavioural issues themselves. For this reason, I focused the further analyses on critical accounts of health information.

Betrayal in health information: highly normative but constantly changing knowledge

Constant changeability of knowledge about healthy lifestyles was a recurrent theme in sceptical views on health information in the interviews. Due to its perceived fluidity, health information was often claimed not to offer stable rules one could follow over the life course. The following excerpt is a typical example of this criticism.

Excerpt 5.3.

P3 (-50): What interests me an awful lot (1) for a long time I've been following all (.) sorts of (1) articles and st- (.) studies what's (2) what's being done in the drugs industry there, and then (.) all these others that are doing all the time err about (.) fo-, food and so on, what you ought to eat. (1) They're one thing today and another tomorrow, (.) and then back again to the beginning. (.) Butter was banned for years (.), salt was banned. (.) I've been told to eat, the doctor, salt, 'cos my blood pressure went down too far (2) for twenty-five years I learned to eat salt-free food, I learned to go completely without salt, (1) and then it's just start eating salt again. (.) You learn to do it surprisingly quickly! (2) That is (1) it's just that, when (.) there's (.) this information available, (1) it's (.) coming at you from all sides, full blast (.) if you only want to follow it, (.) (IP: aye) and (.) and at our house (.) me and the wife we really keep up with what's going on nowadays, (.) for example, these changes in food factors, (.) or coming changes and so on (.) and (1) It just goes to show (1) going back to the old or (2) half way there, (1) I mean, (.) today the (1) diet (.) there used to be at school, these (.) comprehensives, when we were in the old type of school well (.) it looks totally different. (.) And in those days it was the only proper way. (1) And now the only proper way is something different (1) that is, (.) no (.) not that (.) they're not correct! (IP: hmm) I mean, (.) it's very hard if you want to stick to something, (.) I'm gonna, (.) now I' m going to (.) will (.) live a really healthy life, (.) then all of a sudden you see that you haven't been living a healthy life at all! (.) (IP: Aye) You're not supposed to use low fat spreads at all, (.) you're supposed to use butter (1) (IP: hmm) because low fat spreads contain all sorts of other things. (.) I mean, this isn't, (.) that's completely, (.) that's completely (2). I mean it-, it would be so nice if you could stick to some-, so that it would be some use. (1) But (.) if you stick to that then the next day you'll hear that you've been doing wrong all the time. (2) (IP: hmm, aye, so it's) That there you go like (1) the father-in-law always said "live a god-fearing life in all of this.." that (general laughter) (2). I think that's well put so whe[n
P2 (-48): [That you get two different kinds of information [coming from all sides all [the time
P3 (-50): [Yes! (.) yes, exactly! (.) [and it changes all the time! (.)
P2 (-48): Yes, that there's no (.) they like give no real basis like (P3-50: *yeah*) that [they change it around and
P3 (-50): [That every researcher invents (.) or finds new ways and (.) brags that 'now that's (bangs fist on the table) the only right way'..
(FG6:9.)

This excerpt includes many key features of tensions and dilemmatic themes involved in interpreting health information. The tone of the speaker's description is notably emotional, even aggressive, and the whole story gives the idea of some kind of a betrayal: even when one tries to live in accordance with given advice, he finally notices that all his efforts were in vain. The 'betrayal' lies in two aspects of health information delivery that the participant points to. First, health information is described as highly normative, setting demands for choices people make in everyday life. The speaker demonstrates his 'compliance' with healthy lifestyles and active efforts to keep track

of the latest advice on healthy lifestyles, especially advice related to nutrition. On the other hand, the 'full blast' of health information including contradictory and fluid advice does not, however, provide the people with exact, consistent and stable understanding of how to live healthily. This results in a conflict between expectations of compliance with given advice, and perceived non-applicability of the information. A notable feature at the end of the excerpt is the collaborative way in which the tension is described by participants P3 and P2, which gives a hint of the somewhat shared 'script' of critique.

The previous excerpt illustrates how strong *normative characteristics* are attached to descriptions of health information setting rules for the right or wrong way of life. This is clearly articulated in expressions as what one 'ought to' eat, how butter and salt were 'banned' for years, how diet taught in school was 'the only proper way' and how new research produces new advice for healthy living claiming that 'that's the only right way' from now on. In addition, the 'right way' of life is also controlled: 'the next day you'll hear that you've been doing wrong all the time'. That the speaker bangs his fist on the table when imitating a researcher, emphasises their utmost authority and power in giving lifestyle directions. This clear-cut distinction between those who give advice and those who should follow it is also expressed in an ironic phrase 'live a god-fearing life' which positions researchers and other authorities as priests representing God's will and ordinary people as congregants trying to follow messages of a sermon. In the excerpt, the dichotomy between right and wrong lifestyles is drastic: when new recommendations replace the old ones, the people are forced to face the realisation that they have not been 'living a healthy life *at all*'.

Despite the manifold depictions of health information as a highly normative body of knowledge setting rules for healthy lifestyles, it remains unclear who or what is the authority which produces information and controls the people. In his speech, the participant points to 'all sorts of articles and studies' being done in the drugs industry and to 'all these others that are doing (research) all the time'. In addition to the drugs industry, researchers and doctors are explicitly mentioned as giving advice about healthy lifestyles while implicit references to media and teachers are made in pointing to 'articles' the participant has been following, and to diet recommendations at school. Nevertheless, it remains unclear who are 'all these others' producing the information and judging the correctness of individuals' lifestyles. In the excerpt, the unidentified 'health authority' advises, directs, orders and even judges individuals but remains impersonal. Hence, obscurity of the doer in the description of delivery of health information emphasises the uncontrollability of information coming from multiple sources. In addition, the excerpt highlights a conflict between general information about health and personal experiences. The participant takes his

personal experience of his doctor recommending an increase in the use of salt as an indication of how health information contains contradictory advice. Amongst the 'full blast' of advice, the doctor is the only real person who may be referred to as a concrete source of information.

Excerpt 5.4.

P1 (-49): And on the other hand, (.) who's to say what's the right ones, (.) really healthy living habits. So that are they, (1.0) what you're always hearing, (.) are they really that good? They're not necessarily, well, (.) there, (.) there are these fads (.) like there's (1) salt and there's sugar, sometimes they're poison, (.) and sometimes again (1) you're supposed (.) to use them (.) the ones (1) that (1) it rather takes the bottom out of, (.) that (.) one year something is (.) y' know it's like (.) very healthy and another year it (.) might be banned and (3) That, (1) I don't know
  if it's [
P2 (-54): [ye[ah
P1 (-49):   [who's to say the last word, what's real[ly health[y?
P2 (-54):   [that   [The latest example of this is this (.) acrylcramiliar in chips, what was it now, er (.)
IP: acrylamid[e
P2 (-54):   [aye!
P3 (-49): Yes, tha-, that was good that, (.) talking about osteoporosis, (.) it was just in the paper, (1) about osteoporosis. (1) That thin people well, (.) they get things like that, but being fat protects you, so (.) a bit contradictory things..
P1 (-49): Aye. (FG5:9.)

The first speaker in the excerpt basically repeats the same concerns as the participant in Excerpt 5.3. After P1's account, another participant P2 turns to another dilemmatic aspect of knowledge about health. He mentions acrylamide as an example of a new threat to health recently reported in the media. Acrylamide content of certain food supplies was big news in Finland not long before the interviews of this study were made, and raised wide public discussion on the safety of foodstuff. Results from a study carried out by Stockholm University, published in spring 2002, showed that several common food supplies contained acrylamide, which may cause cancer. Due to serious concerns the news created among the citizens, publication of the acrylamide study was criticised for seeking publicity without considering its impact on the population. In Finland, the Swedish acrylamide study was called a cautionary example of a poorly planned and organised publication of science news (see Pohjanpalo 2003; Tuomola 2003). With his statement about the acrylamide news, the participant P2 refers to the idea that health research constantly produces new uncertainties that people cannot estimate and control: 'the *latest* example of this is.. acrylamide'.

Perhaps the most interesting part of this excerpt is, however, how P3 continues the theme initiated by P2. He takes osteoporosis as an example of a contrary theme

emerging in health information. In his argumentation, he finds it contradictory that being fat might protect a person from osteoporosis. Presumably, the idea behind this argument is that being fat cannot be said to promote health in relation to osteoporosis when it is, at the same time, widely regarded as a major risk factor for many other diseases. His account may be read as a manifestation of the difficulties people meet in trying to make an overall picture of healthiness from the 'full blast' of health information and in trying to deal with contradictory themes incorporated in it. It represents, again, the dichotomous understanding of healthiness: *either* something is good *or* bad for one's health.

Both excerpts analysed in this section highlight one more important general finding in that the utmost majority of all criticism addressed to health information, particularly regarding the perceived fluidity of the information, concerned nutrition and diet. Cynicism arising from perceived inconsistencies and conflicting aspects of information about healthy food has previously been called one of the main barriers to men's healthy eating habits in a British qualitative study (Gough & Conner 2006). While criticism towards information of healthy diets may be attributed to a 'myriad of information about food risks and food benefits' (Lupton 2005, 460) coming from multiple sources, or the perceived femininity of dieting and being interested in nutritional messages (De Souza & Ciclitira 2005), Gough and Conner (ibid.) interpret the cynicism of persuasive and ideological information about food and health in part as resistance towards the government and media. This may be seen as an emphasis of reason, autonomy and control, some of the traditional characteristics of masculinity (Wetherell and Edley 1999), which lead to discussions of 'irrational forces from external sources' and preserving individual agency (Gough & Conner 2006, 391). The gendered aspects of diet will be discussed later on in this chapter, and more thoroughly in Chapter 7.

Complexity of applying statistical data in an individual's life: am I one of them?

The relationship between epidemiological knowledge and personal life was a theme widely discussed in the interviews. In particular, how general knowledge related to health should be used by individuals was considered in detail.

Excerpt 5.5.

P5 (-75): But then on the other hand (.) there's that much of them you (1) hear about research where now, we:ll for example (deep sigh), what's all this about what's in chips and other things that what-do-you-call-it (1) (IP: Acrylamide.) acrylamide which is (1) er which might you know be bad for your health and (2) (…) Maybe for people it's generally that, that if you

(.) know something (.) that tends to cause something (.) well it's not that sure, if we talk about some (.) small chance in a big number of people, it adds to the likelihood by that and that much, (.) it's not as it's a clear connection, that (.) people (.) necessarily (.) that they should completely (.) abstain from something or (.) otherwise. Not necessarily even cut down like or change your habits. So that you think that it's not (.) so sort of (.) obvious, that it'll happen to me, or anything else that it would affect (1) necessarily. (.)
P1 (-79): And nowadays when there's as much research done on everything, they always seem to find something like (.) just like those chips and all, well (1) that, that they're bad for your health, so you don't take any serious notice a[ny more..
P2 (-78): [Then there's some more research that's the opposite, that they're not dangerous after all [that…
P1 (-79): [Aye. (FG2:5.)

Making statistics-based conclusions on the healthiness of an individual's lifestyle contains obvious complexities. The key problem is crystallised in the sentence in which P5 concludes that 'it's not so.. obvious that it'll happen to me' which points to the complex relation between an individual and groups, single and general, and concrete and theoretical. Just as in Excerpts 5.3 and 5.4, it is notable how fluently the other participants continue discussing the theme initiated by the first speaker. P5 problematises statistics-based information in a relatively detached and dispassionate way, without actually making a stand against information, and he uses many softening expressions like 'not necessarily', which he repeats several times. P1 and P2, in turn, support him and continue to consider the topic making, however, clear conclusions about the problem referring to changeability as well as incoherence and contradictions in the information available. This discussion provides a typical example of one of the discursive practices used to resolve dilemmatic themes related to health information and individual choice. A conclusion on the fluid and contradictory information available is used to resolve complexities relating to the *particular* health issues under consideration by pointing to *general* irrelevance of that information. This type of interpretation easily awakens the 'betrayal' discourse: 'they always seem to find something.. so you don't take any serious notice anymore'. The 'betrayal' discourse is similarly represented in the next excerpt.

Excerpt 5.6.

P3 (-75): That information is too
vague. (.) [Some figures that out of a thousand people a certain
P6 (-75): [And
P3 (-75): number die of this and that[
P6 (-75): [And very likely there a[re
P3 (-75): [So that it doesn't concern you in any way (.) like just directly.

P6 (-75): Probably it's just, there's also the point that (1) if you wanted to live a healthy life (.) you shouldn't do anything, (.) because there's something come in everything (.) that causes something, (.) that this is poisonous and that's poisonous, (.) you can't eat this and you can't eat that and you can't do this and you can't do that. (1) And then you'd just have to (.) sit there, and even that's bad for you, so you'd still have to do something. (FG2:6.)

The argumentation in P6's account is based on an extreme interpretation of advice for healthy lifestyles where living in accordance with given advice is not only impossible but also clearly harmful for one's health. The argumentation uses paradox as a rhetorical storyline that is hard to oppose. Advice on what makes a healthy life is described in highly normative terms with a number of references to instructions restricting the individual's life. What is common between the two latter excerpts above is that the reliability of the statistical information itself is never questioned (such as research methods, biased samples, cultural relevance of studies made abroad etc.). Instead, the criticism focuses on the individual's potential to make exact, universal and watertight conclusions on the basis of evidence available. However, it is worth noting that even when criticising statistics-based information, negative generalisations about research are made with caution. In the latter excerpt, P1 softens his conclusion about the relevance of information for individuals in the middle of his account: 'it doesn't concern you in any way (.) like just directly'. Saying that the information does not concern people in *any way* seems to be a particularly radical view, which needs to be tempered. The obvious problem relates to the interpretion of the relationship between epidemiological knowledge that is based on studies of large groups, and the advice given to individuals. As the statistical data are not questioned as such, and therefore taken as reliable, their application to individuals is the point which provokes the crucial question: am I one of those whom the studies concern? Personal observations offer a means for relating statistical information to individuals.

Resolving dilemmatic positions 1: relating personally observed cases with statistical data

In Excerpts 5.5 and 5.6, the contrary ideas discussed dealt with the difficulties individuals had in trying to make life-choices on the basis of statistical information. As noted above, statistical information is a topic where a more common dilemmatic relation between general information and personal experience is articulated and negotiated. In the earlier examples of Excerpts 5.3 and 5.4, personal experience was involved in accounts but not discussed for commenting on the relevance of statistical information as is the case in the following excerpt.

Excerpt 5.7.

P4 (-64): In a past life I was there (1) on the docks (1) we were building those aluminium tankers and (1) and you know all of a sudden one time this (1) man from Huber Testing came and says to me that (1) don't walk along there 'cos we're doing isotope imaging, and he points like this upwards, there was isotope imaging going on just a short way away. And he only says that (.) it's like roulette, that you either get it or you don't (.) when you've been around that radiation all your life, that (.) there's many who think that just (1) as they say, there's pollution (.) and all the others are polluting and there's coming, (.) there's ozone loss and there's radon coming and all sorts of other things so what's one cigarette to that, (.) it makes no difference! (1) That, (.) you know like (.) that's it a whole lot down (.) it depends on the individual (.) if someone gets (1) a smoking disease (1) for example, (.) or (.) or something else (1) like it, that (.) Well, (2) I've seen both (.) cases, I've seen (.) about alcohol, I've seen this fellah, twenty-eight, he couldn't drink a bottle (.) with his pancreas that bad. (.) Then you can see them (.) them that's (1) always sitting in the boozer (1) fifteen years on the trot and no sign of it anywhere, (.) and then (1) Me own grandparents (1) that is, (.) grand- (.) father especially, (.) he was smoking until he was ninety-eight (1) and that, the way it is, (.) is that (2) personal like, (.) this kind of heredity (.) things like (.) They don't think of them that way, it's just one (.) vice among others. (FG3:11–12.)

In commenting on statistical information, the participant takes up several observations from his own life to illustrate how statistical information does not provide watertight knowledge about health. In his argumentation, on an individual level, 'it's like roulette' whether a person stays healthy or not, which describes health as a more or less random outcome in life. This is due to the fact that there are various health risks, such as radiation, pollution, ozone loss and radon, which makes it impossible to be sure that living in a healthy way would result in a long and healthy life. Furthermore, even with the most well-known risk factors (for example, smoking and drinking) the causalities are not straightforward. In the middle of these uncertainties, one possibility to understand why some people stay healthy is to explain it in terms of personal, inner characteristics: the reasons for health are thus 'personal like, heredity things'.

Explaining health through an individual's biology places causalities of health outside of subject's decisions. Pointing to individual cases where smoking and drinking have not resulted in illness is an additional argument fostering this interpretation. In this argumentation, it is interesting that the participant expresses these views as if they were not his own ('there's *many* who think', 'just as *they* say', '*they* don't think of them that way') but without criticising the views in any way. In other words, he seems to agree with the conceptions of 'those others' but does not take any explicit stand for or against the interpretations he offers. However, the way

he adds his own observations in the middle of opinions of others (‘*I’ve* seen both cases’) gives ground for assuming that the views are shared by the participant as well. From this perspective, accounting for individual heredity, luck and other such factors outside an individual’s control, instead of health-related life-habits, seems to be an interpretation that must be expressed somewhat indirectly. Presumably, due to their political incorrectness, conceptions such as this are easier to express if they are other people’s views. That these ideas do not necessarily represent the speaker’s own opinions is repeated at the end of the excerpt in the context of smoking: ‘they don’t think of them that way, it’s just one vice among others’.

Having the possibility to influence one’s health and, accordingly, having responsibility for one’s health, is a theme loaded with contrary themes. On the one hand, the interviews reflected the Western individualism view with recurrent emphases on a person’s capability and responsibility to manage life-choices. As one participant said, ‘I think up to 95 percent (of health) depends on you’, highlighting the idea that people can – and they should – take care and take the responsibility for their own health. On the other hand, health is a matter with plenty of uncertainties that cannot be controlled, even if a person takes serious note of healthiness of lifestyles.

Excerpt 5.8.

P2 (-78): Yes and it sometimes feels that (.) however well (.) you sleep and eat, even so, (.) there are still these illnesses, so it’s not. (.) There’s still always some such area, (2) a small area where you can’t make any difference. (FG2:4.)

In the first sentence the participant expresses the idea that however well an individual takes care of his health, there is always the possibility of illness. Health does not solely depend on individual choices. Despite the correctness of this realistic idea, the expressed conception remains slightly unsatisfactory for the speaker. In the next sentence he adjusts his view by noting that the area, where one cannot influence health, is small. I read this as an emphasis of personal agency: although there are uncertainties one cannot control, this area is small. Generally, however, it is the individual who holds control over health. Arguably, without this correction, the statement would have sounded too passive and even fatalistic.

Personal observations of health and illness may be interpreted to act as counter-arguments to health information, especially when they represent cases that contradict the core messages of health education. Nonetheless, even when introduced in a critical tone, discussion of personal observations and individual cases may be understood to reflect the difficulties people meet in interpreting the relationship between statistical data and individual lives.

Resolving dilemmatic positions 2: locating epidemiological knowledge in a larger context

The previous examples have highlighted two major topics of criticism towards health information in men's interview talk. First, health information and advice for healthy lifestyles change over time and, therefore, do not offer stable and unambiguous rules for a healthy life. In addition, pieces of information from several sources may contradict each another. At the same time, the previous excerpts have also manifested the moral aspects involved in talking about the healthiness of lifestyles. Information is described as highly normative, indicating that not living in accordance with given advice is morally condemnable. The tension between the complex applicability and normative character of health information results in depictions of some kind of 'betrayal', a discourse – or an interpretative repertoire – included in many of the excerpts analysed above. Another central difficulty in interpreting epidemiological information, and a second topic of criticism, is the problematic relationship between statistical data and individual life. The likelihoods that health information is based on are difficult to interpret in an individual's own life. Uncertainties are, therefore, discussed using personal observations from social surroundings. As noted above, setting abstract percentages into a concrete context and 'testing' knowledge coming from many sources is the key feature of 'lay epidemiology' (Davison et al. 1991; Davison et al. 1992).

Another key feature of lay epidemiology that is involved in men's interviews is that lay conceptions of causes of disease operate with a larger number of determinants of health compared to health information. Health information is typically focused on lifestyle factors, health behaviours, that are only part of all of the factors associated with health and illness. As Frankel, Davison and Davey Smith (1991) point out, lay epidemiology is, in this respect, more realistic than much of the materials used in health education. This leads to a conclusion frequently expressed in the interviews: even if a person could keep track of all information, and live in accordance with it, this *does not guarantee health for an individual*. This is because health is not determined only by lifestyle factors but also by environmental, genetic and social factors that the individual has little or no chance to influence. Therefore, avoiding risk factors may not prevent those chronic and life-threatening diseases that the avoidance of these factors is aimed at: a non-smoker may develop lung cancer, or a marathon runner may die from a heart attack and so forth.

As living in a healthy way cannot guarantee health for an individual, uncertainties involved in information can also be used as counter-arguments for undermining overly strong interpretations of individual responsibility. As we have seen, nutrition and alcohol drinking are often used as examples of behaviours where knowledge of a

healthy way of doing them (healthy diet and 'healthy'/ moderate drinking) is described as inconsistent or even airy-fairy. This type of reasoning may be interpreted in two different ways: either it represents a logical and realistic conception of the role of lifestyles in causalities of health and illness or it is merely a purpose-oriented excuse for a person's own unhealthy habits. In both cases, interpretation of information is based on positioning epidemiological knowledge into a wider context of life. The excerpt below represents an extreme case of the interpretation of causalities of health and illness.

Excerpt 5.9.

P3 (-75): *Or then the conclusion is* that everybody (.) the only (.) sure thing is that everybody's going to die of something! So it's only (.) it depends on you, that you take the risk that you die of one thing or another, *so that*.. (FG2:7.)

Unavoidable death of every human being is an absolute reality that is easy to invoke since the fact itself cannot be denied. Regardless of how the excerpt is read, as either a representation of realism or an excuse, it can hardly be refuted. Nevertheless, even in this type of account, where such absolute facts are involved, the participants still tend to maintain that there are opportunities for individual agency. In the middle of health threats that the individual has no catch-all means to control, individual agency can still be maintained by emphasising matters of choice, as at the end of the excerpt above. Even though death is unavoidable, an individual may, however, make choices between the threats around him.

Negotiating gendered attributes of health information[1]

Health information was discussed in many parts of interviews and these discussions were initiated both by the participants and by me as the interviewer. In the interview guide, I had questions concerning the role of information in avoiding health threats, which have been analysed previously in this chapter. This was not, however, the only context where information was discussed. Discussions on gender differences in health, for instance, were often accompanied with contemplations of the role of information as a possible explanation for gender differences. Many of the men concluded that women are more interested in health issues and read more about it, which was then seen as a cause for women's healthier ways of life. In some cases, this notion was spontaneously suggested by the participants and in some others I asked

[1] An early draft of this section was presented in Pietilä 2006a.

them about the role of information in gender differences. Health information was thus often discussed in gendered contexts.

When reading the interview transcripts from the perspective of gendered accounts, I found it quite surprising that discussion of health information was actually the context which raised the strongest distinctions between men and women of all of the interview topics. After thoroughly analysing the episodes where health information was discussed, I paid attention to the fact that in most cases where strong gendered expressions were used, the episodes concerned either reading about health in public settings (at the work place, for instance) or certain magazines that were considered to have gendered labels.

As noted above, the information discussed in the interviews was not limited to 'official' sources but covered all information coming from many different sources that the participants themselves considered relevant. The men recurrently pointed to 'women's magazines' as an important source of health information, a notion which was often used as an argument for women's wider knowledge and awareness of health issues. It was claimed several times that women are in a better position in relation to health awareness due to the fact that there are so many magazines which include information about health that are primarily targeted at women. This often led to a 'chicken and egg' situation where it was discussed whether women know more about health and are more interested in it because of the magazines directed at them or do the 'women's magazines' include articles about health because of women's 'innate' interest in health. The men also frequently discussed other magazines traditionally thought of as being targeted at male readers. In some cases, the 'men's magazines' (with topics of technology, hunting and sports) were used as points of comparison to women's magazines but not always, at least not directly. In many cases the distinction made between the magazines, or sources of health information in general, were made in implicit ways, as in the next excerpt.

Excerpt 5.10.

IP: *Ay:e*. Well (.) Can you then say (.) that are (.) are women somehow like more interested in health (.) like (.) for example read- er getting to know about information and that (1) compared to men?
T6: (1) *I'm not quite sure but if* (.) wom- (.) women read more magazines, well, most likely they get to know more (.) I don't suppose men read much but (.) well (.) it what I've only thought but it's (.) better just the evening papers.
IP: Hmm
T6: They probably don't have time to read (.) much (.) these other magazines so.. (T6:11, born 1946.)

From the point of view of sources of information, the most interesting part of the previous excerpt is on the last line. After the interviewee considers the idea that women read more magazines and concluded that they 'most likely' get to know more about health, he claims that men typically just read the evening papers. After a short pause he conjectures that men do not have time to read magazines other than the evening papers. Even without knowing what 'these other magazines' are that he refers to, it may be concluded that the other magazines are those that include more information about health. The suggestion that men have less time for reading about health has two possible secondary meanings. First, it can be seen as an excuse for not reading about health. Secondly, by referring to a lack of time the speaker indicates that men are so busy with other, more important things that health is understandably not something a responsible man could spend his time on. Whichever interpretation we choose, it is clear that the speaker indicates that there exists 'those magazines' about health that men 'don't have time to read'.

In the excerpt, the gendered distinction between different sources of health information was made in an implicit way, where 'these other magazines' were not named. In many cases, however, the magazines and reading them were discussed in more explicit ways. Before the next excerpt from a focus group, the group had talked about the causes for men's lower life-expectancy when one of the participants pointed to the role of 'women's magazines' in providing women with information about health. This led me to ask the participants why there are not magazines, which include health issues, for men. As a response, one of the participants noted that there are, in fact, such magazines as *Men's Health*, which have only emerged in Finland within the past five years, while 'women's magazines' have written about health for their readers for decades. After that I return to magazines directed at women.

Excerpt 5.11.

IP: Well (1) Yes but really (.) the way it is (.) aa (.) in a way if you think of it from the point of view of the producers (.) publishers so, well, women seemingly (Lights go out for a moment in the room) well, they're, they're (.) better consumers in that sense so (.) so that they wouldn't (.) those health things wouldn't sell magazines if they didn't (1) have customers (.) that is (.) consumers (.) buyers. So that (1) well, could you somehow say (.) so that (.) in some sense health is a kind of women's thing (.) that women are in some way (.) more interested or more receptive to them (.) to health issues and at least to health information? (.) Is that how it is? (.)
P6 (-75): I think it's just what Mika (P2) says (.) that what's at the back of somebody's mind is that (2) that (.) for men it's that they see themselves that they are OK "I don't need them" (.) rather I take that Tekniikan Maailma magazine or something (.) like it that well "I'm fit as a fiddle" or (.) it, this (.) a man has to get a more radical wake-up call so that he's now seriously got to do something. (.)

P2 (-78): Many have (.) let's say (.) many men have still had (1) since they were boys this (1) sports (.) sporty background there and (.) have done and played everything (1) and (.) have such an image of themselves that (.) they can still manage it (.) manage such, a certain performance in sports so (.) That, it might remain for quite a long time (.) before he sees that he can't (.) what the reality really is.
IP: Aye.
P5 (-75): And it's maybe on th-, on the other hand there's also that it's (.) it's maybe a bit effeminate (.) to read Men's Health and (.) er gabbing on about diet and (.) the re:st of it.. (.) Of course if the other lads are of the same type, it might then be quite (.) natural but it's on (.) yes (1) yes, on average it's maybe not (.) it's maybe a bit (.) it's a bit (1) effeminate when you, you know (.) talk too much about, well (1) they (women) maybe have a bit different (.) different kind of attitude
(.) er (.)[to well-bei[ng.
P2 (-78): [Well (.) [there you see it. You go on a break and say "Anybody going to aerobics tonight?", well (.)(All start laughing) No (.) No way. (.)You'll have plenty of time to yourself after that (.) so.. (FG2:15–16.)

As a response to my rather provocative question, P6 turns the discussion to a more general level about how men do not feel they need information about health ('I don't need them (magazines about health)') but get interested in health only after there has been a reason to ('a man has to get a more radical wake-up call'). This is followed by P2's account which continues P6's idea about men's focus on physical ability as a sign of health and not being interested in health until there is a perceivable decline in ability (this part of the excerpt was analysed previously in Chapter 4). P6 interestingly takes a well-known 'men's magazine', *Tekniikan maailma* (World of Technology) as an example of a publication, which has nothing to do with health, and illustrates, thus, men's general disinterest in health issues. In this example, a 'men's magazine' offers a contrast to 'women's magazines'.

P5, in turn, gets back to the theme of *reading about health* and its gendered attributes. In offering his views, it is striking how P5's account is full of softening expressions ('it's maybe a bit', 'it might be quite'), relativisations ('on average', 'if the other lads are of the same type'), pauses, 'wells' and 'you-knows' that may be read as 'pre-delicate perturbations' (Silverman & Peräkylä 1990; Peräkylä 1995, 293). Although expressed in a highly softened way, his claim is that reading *Men's Health*, 'gabbing on about diet' and talking 'too much about (health)' may be seen as effeminate behaviour. It is interesting how P5 takes reading *Men's Health* magazine as an example of overly 'effeminate' behaviour related to health. In doing so he positions the magazine somewhere in-between the 'men's magazines' and 'women's magazines': although the magazine is addressed to men, it carries certain characteristics that distinguish it from 'true' men's magazines. In this excerpt, the issue which makes the difference between *Men's Health* and other 'true' men's magazines is its focus on health.

What happens after P5's account is an illustrative example of how shared knowledge of the variety of discursive practices is utilised in interaction. As noted above, P5 expressed his ideas in a highly softened way. Another participant of the focus group (P2) goes on to clarify effeminate behaviour in a public setting by portraying an illusory situation where a man goes on a break and asks his work mates if any of them are going to aerobics tonight. The spontaneous laughter, which all the participants take part in, shows that the speaker has succeeded in describing the first speaker's idea in a more graphic and pointed form. While the example he uses ('going to aerobics'), does not directly refer to activities brought up by the first speaker (reading *Men's Health*, gabbing on about diet etc.), his illusory example concretises another feature of P5's account: *in a public setting, a man has to avoid behaviours that may be seen as effeminate*. This idea is fostered by the indication of a potential exclusion of the transgressor of the homosocial order ('you'll have plenty of time to yourself after that'), which even hints at a homophobic interpretation of effeminate behaviour in the company of men.

The focus groups used as research material in this study were made before the personal interviews. In the early analysis of the focus groups I noticed that men made clear-cut distinctions between 'our' and 'their' magazines, i.e. men's and women's magazines. Therefore, I wanted to discuss this topic in the personal interviews more. More specifically, I wanted to explore why those magazines that were considered 'men's magazines' (magazines about technology, sports, hunting etc.) somehow conceptually exclude health as a journalistic topic. One of these discussions is presented in the next excerpt. It starts with my provocative idea of adding health issues into one of the 'traditional' men's magazines, *Tekniikan maailma* (World of Technology), which was, in the interview, clearly the most often mentioned example of magazines addressed to men. Before the excerpt, we had discussed women's magazines publishing health-related articles and, correspondingly, men magazines where health-related topics are rare. In the excerpt, we continue to discuss why there are no articles on health in a popular men's magazine (*Tekniikan Maailma*) and the participant considers this possibility by broadening this contemplation to concern magazines directed at men in general.

Excerpt 5.12.

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IP: Aye. Now how (.) how do you feel know (.) or (.) how do you feel about
the idea that in this Tekniikan Maailma magazine (World of Technology) (.)
if there were to be a health section where there would be like exercise
instructions for a week and, and (.) well (.) er a menu for a week you
know (.)[ how to eat healthily?
K7:     [(laughs) Aye, it doesn't (.) it doesn't really (.) It doesn't
really go with (.) go with the image (.) image of the magazine, that (.)
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really it's more like (1) it's more for (.) them that, I don't know how you would get (fast) (.) how you would get (1) a magazine or publication like that, with you know all, so that it was totally new (.) a new magazine, publication, yes there are for men (.) of course there are fitness magazines just like Bodaus (Bodybuilding) and others (fast), in those there's all sorts about nutrition (.) research on everything (.) all issues (.) "grapefruit loses you weight", "new American research" and all of that like (.) that.. (IP: mmm) So (.) but it shouldn't be just that sort of magazine (.) 'cos (.) that does no:t then (1) cater for more than a certain narrow (.) narrow group (.) and then again that (.) you'd need a bit of everything like (.) to make something that'd you know for everybody. (.) That it you know (.) interested everybody. (.) There would be fishing, hunting, cars (.) technology, everything (.) that what's (.) *then*, what the share of sections is that (.) when there'd be enough for everybody (.) something of their own for everybody and then we'd get something into it that (1) (sigh) it's hard to say (laughs).
IP: Well that's been tried (.) I mean elsewhere (.) purely (.) purely commercial (.) magazines there are (.) coming out [in Finland
K7: [Men's hea[lth
IP: [Men's hea[lth
K7: [Uhuh
IP: mm but (.) a certain concept for this (.) that they try to get (.) these things combined.
K7: *Aye* (.) I (.) would say that (.) I suppose the magazines like that (.) wo-, work (.) let's say that it might go (fast) more on the (1) academic side and on that side, I s-, suppose a working man would not (2) not dare to read it, *not* there (laughs) at his place of *work* (.) that.. (IP: Aye) So my feeling is, at least, that it's a matter of attitude that if you look at it, well (.) (laughing) well then they're that (IP: Aye) [*it's*..
IP: [what is it about it (.) (K7: it..) What's this about daring (.) what does it sort of represent like the magazine?
K7: Well it surely re:presents the, just the same thing, you know (.) the aesthetic *pers*pective (.) that's, it's considered you now that (.) it's sort of a women's thing so (.)
IP: Yes, yes. (K7:17, born 1968.)

In the beginning of the excerpt, it seems that my suggestion is unexpected and even abrupt for the interviewee. He starts to laugh and has some difficulties in expressing his ideas of how the suggestion sounds for him. Nevertheless, after considering the image of the magazine, where health issues do not belong, he starts to consider the possibility of creating a 'totally new' magazine that would combine different topics including health, among others. When I mention that there have emerged such publications combining the things the way the participant suggested, he recognises *Men's Health*[2] as an example of such a magazine. Taken that the 'combination'

[2] Slightly surprisingly for me, *Men's Health* magazine was often taken as an example of a magazine combining men's 'traditional' interests with health issues. However, despite several references to the magazine, none of the interviewees said that they read it themselves. Most of the participants only mentioned that they had seen it in shops.

perspective was suggested by the interviewee himself, it is interesting how he starts to distance himself from the *Men's Health* magazine.

In the excerpt, the *Men's Health* magazine is denied belonging to the speaker's social circles since the magazine, and 'magazines like that' in general, go more 'on the academic side'[3] which is the reason why a working man 'would not dare to read it'. Making a distinction between 'academic' and 'working' men may be read as the speaker's own self-identification as a manual worker. Simultaneously, it also refers to a wider self-identification process at the work place, where conformity of the group is thought to be controlled, too ('it's a matter of attitude that if you look at it [the magazine], well then they're [work mates]..). In other words, he is not only constructing his own stand on reading *Men's Health* but locates this view in a wider context of class relations. The argumentation is further developed when the speaker points to gender as incorporating distinctive attributes that make reading *Men's Health* magazine somehow inappropriate for men of his type. Despite these explicit distinctions between working men, 'academic side' and 'women's thing', the excerpt follows the logic of many previous excerpts in that the opinions expressed are either located as being typical of other people's thinking ('they are'), formulated as non-agentic ('it's considered, you know') or tempered by softening expressions ('it's, sort of, a women's thing').

The excerpt illustrates how a common discursive strategy for masculine self-identification, 'definition by difference', not only utilises women and homosexuals etc. as 'others' and opposites to the normative definition. In the excerpt, distinctions regarding self-identification are made against women and 'academic men' who contrast with blue-collar men. What is even more interesting is that in addition to those groups of people representing concrete 'others', the speaker refers to an 'aesthetic perspective', which he attaches to conventional femininity and what is used as another key argument of why a (working) man does not dare to read it. Thus, it may be concluded that self-identification through 'definition by difference' is a rather complex phenomenon including references not only to groups of people but also references to qualities and characteristics seen as inappropriate to a speaker's own reference group.

Distancing oneself from certain types of magazines, such as *Men's Health*, on the basis of the 'aesthetic perspective' they are claimed to represent, exemplifies a clearly gendered topic, which emerged recurrently in the interviews. The participants explained women's greater interest in reading about health often in terms of women's

[3] Reference to 'academic' audience may arise from the fact that at the time of the interview *Men's Health* magazine was only published in English in Finland. Another reason may be that the primary target group of the magazine is upper middle-class.

orientation to their physical appearance. Together with motherhood, women's interest in their looks was often mentioned as a reason for why women were thought to be more eager to take care of their health and read magazines on health issues[4]. In extreme cases, women's interest in their physical appearance was claimed to reflect women's vanity. References to women's vanity simultaneously, reversely, suggested that men are more serious and do not pay attention to that type of futile information. Associating taking care of physical appearance or even narcissism to femininity is not, of course, a new finding (cf. Aoki 1996), while distancing oneself from beauty is one of the central features in traditional definitions of masculinity (Tiihonen 2004). A rather more interesting finding of this section is that aesthetics is not used here only as a means for making distinctions between men and women, but also between men and other men, between different types of masculinities and, finally, between appropriate and inappropriate readings within certain defined groups of men.

The previous excerpts have intentionally concerned 'men's magazines'. The reason for this was my early finding that men tended to make clear distinctions between men's and women's magazines as noted before. However, it needs to be stressed that not all men in my interviews made such a clear-cut difference between 'our' and 'their' magazines. Some, although few, told me that they read family magazines and nursing magazines that may be considered as women's magazines. Despite this, in those interviews, where the division of magazines into those of men and women was definite, the descriptions of 'women's magazines' might be very stark as in the next excerpt.

Excerpt 5.13.

IP: Yes, it's like we (.) we talked about information and (1) and about men and women so (.) so well (.) I've heard people claim that (1) many men, at least middle-aged men, think this (.) er (.) health information is somehow sissy or (.) or (.) or like (1) er (.) a women's thing (.) like something that women fuss about (.) what do you think about this? (4)
P2 (-75): Well (1) well (1) I guess there is (2) I guess there's some truth in that (.) I suppose there's (1) that sort of things in it (.) and I guess more so with older people (2) more so a:nd (.) a bit (1) there's a kind of embarrassing (.) a kind of embarrassing example sort of (.) when we had (1) I had to take (.) the junior to the child health centre and (2) a friend of mine came by and the missus had to be somewhere (1) So and (1) the missus went out and I said I would take the kid (to the health centre) and then this friend of mine came with us (.), he was (.) about the same age (.) a man of about the same age as me (.) a year (.) well (.) a year younger than me or something (1) so we were at the health centre and there was (.) the junior was with us. And (.) then this friend took (.) the first magazine that came to his hand and it was some kind of (1) it was something like Terveys ja Kauneus (Health and Beauty) or (.) Voi Hyvin (Feel well) or some

[4] These topics will be further discussed in Chapter 6.

magazine like that (.) and he was reading it there and (.) I was sitting beside him with the kid so it was like (.) the older people started to look at us that (.) what the hell kind of a couple is that (everybody bursts out laughter) (.) so I guess that's (still laughing himself) (.)I dunno (.) was it because of (.) was it because of the health magazine or what was about (.) but (.) there was a bit like (.) well (.) yeah (.) older people looked kind of (.) the ways you know (FG1:15.)

Even as my question is quite provocative, the participant's response is unexpectedly strong in describing reading a health magazine as potentially unmanly accompanied with homosexual associations. He also distances himself from the threat of being considered feminine by using the expression 'this friend took the first magazine that came to his hand' which underlines that taking such a magazine was not an intentional choice. This excerpt repeats the same features noted above about distinction-making, but in a highly pronounced fashion. The extreme interpretation of femininity related to 'health magazines', which makes the basis of potential homosexual connotation involved in reading the magazines, is rooted on the social context described in the excerpt. As noted earlier regarding Excerpts 5.11 and 5.13, reading that type of magazine in a public setting is in my view the context which leads to extreme interpretation of characteristics potentially attached to the reader of the magazine. This once again illustrates the claim I made earlier: while reading a 'health magazine' in a private setting might not be a case for telling an anecdote of this type, public settings call for other behavioural expectations. Transgressing the norms involved in a public context lays the actors open to ridicule. However, in this situation the speaker himself is not ridiculed since he tells the story as an anecdote which illustrates a potentially politically incorrect interpretation of reading 'health magazines' that might easily be opposed if told in a serious manner.

It could be claimed that in the previous extract the researcher is prompting the interviewee with a provocative question that results in an account that the interviewee had not expressed spontaneously. On the other hand, the notion that the participants are able to give a corresponding response, join the anecdote and laugh at it, underlines the social nature of knowledge. Spontaneous laughter after the climax of the story, in which all the participants engage, is evidence that they all recognise the ideas expressed and catch the humour based on the tension between different rules of gender-appropriate behaviour, even if they would not endorse such homophobic conceptions themselves. This affiliates other participants with collaborative construction of one version of how masculinity and reading about health may be interpreted.

Conclusions

In this chapter I have analysed men's interpretations of health information from two perspectives. In the first part of the chapter I approached the criticisms attached to health information. The reason for concentrating on criticisms within all accounts of health information was the early notion that while the clear majority of participants of my interviews subscribed to the idea of information transmission being useful for improving public health, expressions of this idea gave little, if any, variation for more thorough analysis. Critical views, instead, were significantly more diverse, colourful and vivid. One potential way to interpret this notable difference between agreeing and questioning accounts of health information is to read positive views, i.e., agreeing that health information is important for public health, as more or less ritualistic responses in a context where the interviewer, as a person leading and controlling the interaction, is easily expected to hold only favourable views about information delivery. By ritualistic responses I refer to the interpretation that positive views on health information may be regarded as those 'correct' answers that the interviewer is thought to expect from participants in this context and that the participants therefore offer him even if they do not fully approve of them.

In the analysis of critical views on health information delivery, there emerged two large topics of criticism. Perceived fluidity of information was criticised on the basis of the notion that changing information coming from many sources does not make it possible to live in accordance with advice of healthy lifestyles. Criticism towards the fluidity of information also highlighted another key feature incorporated in discussions: expectation to take note of given advice was described as highly normative and thus ideological. The conflicting issues of normativity and fluidity of information gave the basis for an idea of 'betrayal' involved in information delivery: while the people are supposed to follow the 'rules', changeability of 'rules' makes this impossible, which was seen as both illogical and unfair. This may be interpreted as an ideological dilemma where the faceless 'health authority' urges and expects the people to live in a healthy way but changes the 'rules' in the course of the game.

Another recurrent topic of criticism was the inadequate applicability of statistical information in individuals' lives. As information about healthy lifestyles is typically based on statistical data dealing with large numbers of people, the advice given may be either relevant or not in the case of each individual person. The dilemma between normative statistics-driven advice and individual lives is founded on the uncertainty of whether 'me' is one of 'them' or not, whether a general rule is applicable in particular cases, which is obviously an unsolvable problem in an individual case. The participants used two main discursive strategies, tightly linked with each other, in

resolving this dilemma. First, they recurrently pointed to personally observed cases, which conflicted with the general statistical information, in order to illustrate that health information does not offer water-tight instructions for how to stay healthy. These accounts included both cases when a person with unhealthy habits had lived a long and healthy life as well as those when a person with notably healthy lifestyle habits has died prematurely. The general conclusion drawn on these observations was that, in the end, health is governed by chance, a notion widely adopted in 'lay epidemiology' (Davison et al. 1991). The second discursive practice used for coping with uncertainty was to position epidemiological knowledge in a larger context. The advice of healthy lifestyles was contextualised by referring to structural, environmental, genetic or other factors affecting health that are not under the control of the individual. The conclusion made on the basis of this contextualisation was that even if a person could keep track of all of the health related information available in various public fora, and live in accordance with it, this does not guarantee health for an individual. As one of the participants said, 'the only sure thing (is) that everybody's going to die of something'.

One important finding of the first section was that the clear majority of all criticism directed at general health information, particularly concerning representations of the fluidity of that information, concerned nutrition and diet. One explanation for this criticism is to see it as a consequence of the 'myriad of information about food risks and food benefits' (Lupton 2005, 460) coming from many sources. Nowadays, food is a topic of major interest in Western societies. Magazines introduce us to exotic new recipes, newspapers have their regular food columns, and cooking programmes on the television are extremely popular. Food and cooking utensils are among the most advertised products. Together with this, as Lupton (2000) notes, hardly a day goes by without a report in the news media either on the linking of a certain food substance with some disease or health risk, or a claim about a foodstuff protecting people from illness or improving their health. Food is also frequently linked with new infectious diseases that gain great interest among the public. Salmonella, listeria, and 'mad cow disease' (BSE) are some examples of new threatening infections that have caused deep concerns about the safety of daily foodstuffs and gained enormous media publicity. In addition to infectious diseases, there are often news reports on links between certain foodstuffs and the prevalence of chronic diseases, such as different types of cancer or cardiovascular diseases. Consequently, several studies have investigated how potential threats of food, introduced by the media (see Lupton 2004), are interpreted by the public (e.g., Shaw 2004; Lupton 2005). Acryl amide, which several participants of this study referred to, is an example of how news reports on food and health are interpreted in the context of everyday life. Considering the multiple ways in which

food is part of everyday life, it is easy to conclude that media coverage on food is purportedly larger than any other health-related issue. In addition to news reports, food is a subject of extensive advertising as well as a topic of journalism, in general. Therefore, it is understandable that in the mass of information there are parts that are, or are perceived to be, contradictory which results in questioning the reliability of the information.

Another perspective on reading men's accounts of health information was that of gender. It turned out that in many contexts reading 'tips' of healthy lifestyles was associated with femininity and, to some extent, distanced from the masculine self. However, one of the features common to excerpts analysed in this chapter was the participants' tendency to use neutral expressions when describing gendered aspects of health awareness. In stating ideas that might be heard as sexist, the participants used several softening discursive strategies, such as relativisations, disclaimers ('I personally do not think that way but..', see Hewitt & Stokes 1975), 'bonding ploys', humour and non-agentic formulations which all distance the speaker from expressed ideas that may engender criticism or counter-arguments. In my view, the need for political correctness arises from the interview context which is, as such, a potentially threatening situation, perhaps particularly threatening in the case of men (Schwalbe & Wolkomir 2001; 2002). Expressing sexist ideas about women, alternative masculinities and the gender order, in general, is seen as inappropriate behaviour in a culture where egalitarian values are respected and widely discussed in public. Therefore, the participants approach these topics cautiously.

Despite this, a conflict between masculinity and healthy lifestyles was reflected in the material, mostly in implicit and subtle forms. It was notable, however, that these conflicting accounts were mainly represented in non-personal contexts, while the personal accounts, i.e. those that might be taken to reflect the speaker's personal stand towards health information and healthy lifestyles, were dominated by the 'health awareness discourse'. In an extreme case, even homophobic attributions were attached to interest in healthy lifestyles that may be interpreted as a reflection of a traditional view of health and care-taking as belonging to women's areas. These were particularly visible in discussing public contexts, where reading about health was associated with femininity and 'fussing' about health. In many cases, the femininity of reading advice for healthy lifestyles was discussed in relation to information on healthy diets, a topic often connected to conventionally feminine interests. This, in turn, gives another perspective to why diet and nutrition were the most often mentioned themes in criticisms of health information. It seems that the nutrition combines two aspects that the men easily distance themselves from: fluid and potentially inconsistent information and perceived femininity of the topic.

Both criticisms of health information and gendered meanings attached to information and its consumption were much more strongly represented in focus groups compared to personal interviews. This gives an idea that while personal interviews may be more highly framed by the health-awareness discourse and expectations of individual responsibility to follow advice of healthy lifestyles, the group discussion opened less individualised contexts where critical views are easier to express or which even calls for more critical views. That the topics of criticism are shared among the participants was notable in the collaborative ways in which dissatisfaction of health information was constructed by the participants.

The participants' criticism towards health information revealed interpretations of health information involving ideological and contrary themes. Regarding the topic of the study, it is important to note that discussions of health information also reflected a potential conflict between masculinity and health awareness. In attaching health information to women and femininity, the participants referred to a traditional discourse linking health with women's areas and femininity. But another central feature of this talk, using softened expressions when giving gendered statements, refers to another discourse. In fact, together with the notion that health information was seen as necessary when talking within individual contexts, delicate tissue of gendered accounts places the masculine self on a thin rope across a gap to face an ideological dilemma. On one side, there is traditional masculine discourse about men not being primarily interested in health and linking it to the women's world. The potential dangers involved in expressing these views is, first, to be seen as an irresponsible subject if one does not properly assert one's own health-awareness and commitment to a healthy life and, secondly, to be heard as having biased and prejudiced, sexist views. On the other side, there is a modern health awareness discourse, which underlines individuals' activity and responsibility for health. What threatens the masculine self from this side is potential femininity, especially if one is claimed to be too enthusiastic in relation to health issues, and judged as being 'fussy about his health'. This dilemma results in cautious positioning of the self within discussions about health.

6 CONSTRUCTIONS OF 'MEN'S HEALTH' IN EXPLAINING THE GENDER GAP IN HEALTH

In Chapter 4, the focus of analysis was upon how men construct individual health in an interview context and on argumentation they used for displaying the 'healthy self' apart from the potentially sick body. As was noted in the analysis, the 'imperative of health' (Crawford 1984; Lupton 1993) is a strong norm which results in a variety of argumentation for the healthiness of an individual speaker. It was also concluded that accounts of individual health did not include direct references to masculinity or being a man. This chapter addresses men's health from a different perspective. Here, the focus is not on the health of an individual man but health of men as a group. The focus is on how 'men's health', as a social phenomenon, is constructed in the interview talk.

In the interview material, 'men's health' was most clearly articulated in contexts where the gender gap in life-expectancy was discussed. In both focus groups and personal interviews I asked the participants to express their views on men's lower life-expectancy compared to that of women. The analysis of the chapter approaches 'men's health' from the perspective of explanations that the participants give for men's lower life-expectancy in Finland. The interest is not, however, in the given explanations themselves but, instead, in the ways in which men are constructed as a group in these accounts as well as in relation to specific health issues that are taken up for consideration. In the analysis, I was particularly interested to see if those explanations included gendered patterns which, in turn, would have made the health-related 'gender-order' visible. Accordingly, I paid special attention to the ways in which 'male' behaviours, activities, ways of thinking etc. were distinguished from 'female' ones, assuming that these 'definitions by difference' may be interpreted as the interviewees' contextual self-identification practices for a masculine identity, which reflect the broader cultural codes of legitimate psycho-discursive practices of self-presentation.

As the question itself made an active distinction between men and women, it is rather obvious that most of the explanations offered were based on gender categories and distinction-making between men and women instead of contemplating men and men's lives independently from women. It might, then, be argued that the analysis gives an overly gendered picture of men's health and also that the use of gender categories in explanations (definition by difference) is an in-built premise

rather than a finding from material. Whilst not wanting to deny the relevance of these arguments in gender research in general, I do not believe that they biased the interpretations in the context of this study. This is because the study is explicitly focused on gendered features of men's interview talk about health and aims at making visible cultural assumptions related to men and masculinity. From the perspective of 'active interviewing' (Holstein & Gubrium 1995), the concern of prompting questions leading to predictable answers is not necessarily considered as a threat to interpretations made on the basis of analysis. As both the interviewer and interviewee actively work in contextual meaning-making, the focus is on analysing how the participants use the common cultural resources and discursive practices in negotiating interpretations. In cases where the discursive practices are recognised by the participants of interaction, then they are a part of our shared social reality. Secondly, we might ask what would be the ideal (or even possible) way of asking questions about men's health (with an emphasis on *men's* health) without formulating the question in such a way that it calls for a distinction between men and women? Since gender is 'one of the primary axes around which social life is organised' (Kimmel 1995, viii) and, simultaneously, a dichotomous and relational concept (e.g., Lotman 1990, 133; Courtenay 2000; Garlick 2003, 158; Gardiner 2005), discussions on men almost inevitably involve comparisons with women.

When reading the interview episodes, I noticed that explanations for gender difference in health were grounded in three different ways:

1. whether there is something specific in women and women's lives that shields them from premature death ('female' factors for women's longer life);
2. whether there is something specific in men and men's lives that makes them vulnerable and results in men's premature death ('male' factors for men's shorter life); and
3. whether there are certain important differences between men and women and their lives that result in gender differences in health (disparity in health-related factors common to both genders).

The ways of considering the role of gender varied in different themes of explanation. In the analysis, I found that the participants' explanations for men's lower life-expectancy dealt with five themes. The first group of explanations concerned *gender differences in the labour market and work* where men's physically harder, more dangerous and more stressful work was seen to deteriorate their health which, in turn, was considered to result in men's higher mortality. In some of these accounts, the women and women's occupations were used as a point of comparison for concretising men's harder work but the explanatory power was concentrated in men's

hard, dangerous and responsible jobs. Secondly, *psychosocial factors* were mentioned as reasons for gender differences in health. These explanations concerned both men and women. Women's greater social contacts and their openness to talk about health problems and other worries were concluded to improve women's health. On the other hand, the 'gloominess' of Finnish men was explained as a factor leading to depression and a lack of social contacts which was thus assumed to have a negative impact on men's health.

Explanations for men's lower life-expectancy were, thirdly, accounted for men's and women's *different attitudes towards bodily signs and help-seeking*. It was frequently concluded that women take care of their health more intensively and keep track of their bodily signs better than men. In the most concrete form this was articulated in men's and women's differing dispositions to seek help in case of bodily ailments. Fourthly, *biological advantages of women*, differs from the previous explanation in that it concerned only women. It was concluded that because women 'preserve life', it is their biology which makes women less vulnerable to illness. However, in the early stage of analysis it become clear that biology was a rather vague category for explaining the differences since it was often combined with notions of boys' and girls' differing socialisation and tended to focus on motherhood as both a physiological and social phenomenon. The fifth theme of argumentation, *differences in health-related lifestyles* was often referred to as a cause for women's higher life-expectancy. Since women's lifestyle choices were described as being healthier than men's, it was concluded that this is one of the reasons why women live longer than men.

The aforementioned themes of argumentation included, however, contrary themes and were, thus, topics of negotiation in the interview context. A closer analysis of these contrary themes in interview talk is therefore addressed in constructions of men's health. As gender is not the only division used in self-identification, I also analysed other distinctions made between the speakers and 'others', i.e. distinctions made on the basis of social status, age, employment, place of living etc. The analysis pays attention to potential ideological and dilemmatic aspects of these constructions and ways in which they are negotiated and resolved in speech.

Hard working men

In discussions of the gender gap in life-expectancy, gender-related differences in the labour market and work were often mentioned as reasons for men's lower life-expectancy, which was accounted for by men's physically and psychologically harder work. Taking into account that, in personal interviews, a clear majority of the

participants saw work as a positive thing for their own health[1], it is interesting that in another, non-individual context, labour was generally interpreted as a threat to men's health. The following excerpt is an example of accounts of this type, focusing on men's physically wearing occupations.

Excerpt 6.1.

IP: Yeah, it is (.) actually that's what I was going to have for the next theme here, those men and women because (1) er, (2) I don't know do you know but in Finland women live about seven years longer than men on average, so that at the moment (.) men's so-called average life expectancy is, so for men it's sev-, less than 75 years and for women almost 82. Er, can you think of anything why this should be so? Why do women live so much longer than men?
P4 (-77): Could it be that, when men are sixty well (.) they start lolling on the sofa and (.) it's sloppy like. And those.. (1) women more, they're always on the go. (3) All sorts going on. Could that be one-?
IP: What else?
P1 (-76): Well the jobs might also have an effect that (.) what sort of work you've done (1) if you've like (2) if a man has in a way done heavier work (.) ever since he was a nipper. And (.) a woman has been, like more studying and (.) in a way had the family life and then working life and that so (2) might it be (unclear) the combined effect there, that (.) a man only lives at work (.) just at work.
IP: Uh-huh.
P3 (-76): Well there's a lot of that substances, like tobacco, alcohol, well that's (2) a lot like (.) when you think, men. And the men surely use quite (.) use much more, when you compare with women. (5) That certainly does something.
P2 (-75): Of course (.) Of course it's not only that (2) not necessarily that (.) or certainly the physical heaviness of the work but then the problem, the problem factors that come in some, some jobs, there's no escaping it (.) no escaping it that men do the kind of, kind of work that where maybe (.) maybe it (.) your body starts without your noticing it to get (.) to get all kinds of, kinds of poison there so that it starts to make itself noticed when you're older.
IP: Do you mean that the heavier the work or, or also (P2: or..) such pollutants or (P2: Well poll.. like..) these others.. (?)
P2 (-75): Or (.) well things like, how should I put it, like for example that you get exposed to all (.) now no, I didn't just mean this heaviness but like messing about with all these solvents and all of that (.) all that (.) that (.) some welders who have to do with and all kinds of asbestos that's around and all of that, suchlike, that (.) that your body's full of shit by the time you retire. So well like for all, all kinds of impur-, impurities and that. (FG1:11–12.)

In the excerpt, men's lower life-expectancy is explained by men's physically harder work and unhealthy work conditions typical to men's occupations accompanied with

[1] This is mainly explained by the fact that most of the participants contrasted impacts of work to health with those of unemployment. It was therefore concluded that work(ing) is always healthier compared to not having a job at all.

other themes that will be discussed later on. The explanation is based on a rather strict categorisation of men's occupations limiting them to physical, manual work, which is generalised to be a threat to (all) men: 'if a man has in a way done heavier work ever since he was a nipper' and 'men do the kind of work that..'. Reducing men's occupations to manual work involving physical and occupational risks forms a basis for explaining men's health in a way, where poisonous conditions and physical hardness of work result in unavoidable deterioration of physical health ('there's no escaping it').

The participants' emphasis on manual work may be interpreted as arising from the context where the accounts take place. The interviews were conducted at the men's work place and the company of work mates easily turns the conversation to topics that the participants mutually experience in their everyday work. In the group of work mates, the men discuss health-related issues that all the workers are probably concerned about in the context of work, such as chemicals used in the paper industry. Simultaneously, the strong emphasis on work and work conditions may be read as a *collective identity-work of manual workers*. The accounts may be seen as an identity-producing narrative created by two participants of the focus group (P1 and P2). In this narrative, the man is engaged in hard physical work from childhood onwards ('ever since he was a nipper') and committed himself to the work to the extent that the work forms the primary content of his life ('the man only lives at work'). The physically hard work and health-damaging work conditions (poisonous chemicals) gradually deteriorate the man's health, which becomes noticeable in later life when the man retires from work ('your body's full of shit by the time you retire'). Taken that the story is produced by two participants of the discussions emphasises the collective character of the narrative.

The importance of work in men's health emerged both in personal interviews and focus groups. However, the strict categorisations used in the accounts were expressed in the clearest forms in focus groups which, in my view, foster the interpretation of the accounts as collective identity-work. A part of this identity-work is the distinction made between men and women, which highlights the gendered characteristics of subject positions adopted collectively in the course of interaction. Descriptions of women's lives and engagement in the labour market were also frequently based on unquestionable, self-explanatory and unchangeable categorisations, the same way as in the case of men's occupations. In the previous excerpt, 'family life' and studying were addressed as women's areas, a notion used to explain why women's lives include various fields compared to men's tight commitment to work. The next excerpt follows the same logic of surprisingly strict categorisations of men's and women's lives, focusing explicitly on male and female occupations.

Excerpt 6.2.

P4 (-64): Women's professions are different by nat-, nature like with these, these (.) private businesses, well, well (.) yes it's (.) pretty clear that if you're a hairdresser, well there you've got certain folks, and the hair gets cut the next month the same way, so that you've got a certain clientele. Then if you're some sort of an excavation contractor or building contractor, which generally is a ma-, fewer women than men, well (.) well you know, one year they build more and then when there's a slump they build nothing at all. And so, well they cut people's hair every month! So that women's jobs are traditionally the sort that, they're different, they're not so prone to (.) stress. Some keeper of a coffee bar or something. (FG3:18.)

The general conclusion in the excerpt is that men's occupations are more stressful which is used as an explanation for gender differences in life-expectancy. The previous excerpt might be read as an example of a certain type of gendered talk operating as a means for male oppression of women in maintaining male power and the patriarchal gender order. Strict categorisations of men's and women's occupations are represented in unproblematised and taken-for-granted ways and fostered with expressions such as 'by nature', 'traditionally' which support the expressed views as the static 'natural' order of things. The women's occupations are described in belittling ways compared to men's responsible 'true' jobs. Despite this, a closer analysis of the speech brings up another ideological side of the account.

Although the conclusions made in the account are relatively hard-hitting and are based on rather crude generalisations, it also includes hints of the speaker being slightly uncertain about appropriate expressions to talk about men's and women's occupations. In starting his account before me and three other participants of the group, he says that 'women's professions are different by nature' making a clear distinction between men's and women's jobs. It is interesting that when continuing, and using a hairdresser as an example of a woman's occupation, he does not specify that he refers to women as hairdressers but expects that it is understandable for all the participants. When finding an example of men's occupations he, suddenly, seems to get a bit uncertain of the appropriate expressions which is seen in faltering expression 'an excavation contractor or building contractor, which generally is a ma-, fewer women than men (involved in those businesses)'. That the speaker corrects his expression about certain professions being 'a man's job' or 'male occupation' by softening it with relativisation ('fewer women than men' involved in those businesses) may be interpreted as a reaction to potential accusations for expressing broad generalisations and prejudiced opinions. Thus, although the general tone of the excerpt may easily be interpreted as being ideological in its belittling notions of women's occupations, another ideological aspect of avoiding to be heard as male-chauvinist is simultaneously present.

From the perspective of identity-work, in turn, the account may be interpreted as a classic example of 'definition by difference', which is used as discursive practice for collective self-identification. Comparisons between men's and women's occupations can be seen as identity-work for all men, not just for those involved in the interaction. Here the main emphasis is not on the physical heaviness of manual work, but on psychological pressures arising from a work loaded with responsibility, which is seen to characterise all men's occupations. At the end of the excerpt, the categorisation of men's and women's occupations leads the speaker to a conclusion concerning the health influences of these differing jobs. On the basis of the description of women's occupations as non-stressful, the speaker implicitly claims that men's occupations cause stress for men, which, in turn, explains men's higher morbidity and mortality.

The claim of men's more stressful jobs may be read as part of identity-work. Stressful work, despite its negative consequences to health, represents the male worker's high commitment to work and responsibility. Work, professional knowledge and experience are traditionally highly valued and respected characteristics and, combined with a provider-role in the family, are important building blocks of masculine identity (see Kimmel & Messner 1989, 219–287). As Hearn and Kolga (2006, 174) chrystallise this, 'men are often defined rather by "what they do" – their paid work in the public sphere – rather than by "who they are"'. Among Finnish studies, Matti Kortteinen (1992) has described wage labour as a 'field of glory' where masculine identities are reproduced and valued on the basis of successfulness in work and labour. Siltala (1994) interprets successfulness in work as just one example of men's wider tendency to continuously hunt for 'scores' in different fields of life. Paul Willis' (1977) classic ethnographic work on working class boys in the UK shows how personal experience and knowledge of manual labour and physical capability in doing 'real work' form the basis of reproduction of working class masculine identities. Willott and Griffin's (1997) study is an interesting example of how cultural expectations of successfulness in labour are negotiated in unemployed men's interviews. Their study shows how unemployment threatens men's self-image and how this threat is discussed and negotiated in interaction. All of the studies mentioned above give reason to conclude that men's tendency to explain gender differences in health through work and labour market differences should not be interpreted merely as arising from the context of interview (work place, work mates) but represents wider cultural expectations related to male occupations and male success at work. From this perspective, talking about work highlights the participants' work-oriented collective self-consciousness where physically hard work fosters working class male identities. Analogously, work-related stress is not exclusively a negative thing: stress caused by work offers a means for positive self-identification as a responsible, hard-working professional.

Gloomy 'Finnish men' ruminate about things and do not seek help

In addition to work-related stress, other psychosocial factors were also a topic frequently referred to in participants' explanations for men's lower life-expectancy. Men were often described as non-expressive, melancholic and gloomy compared to women who were depicted as more positive, open-minded and active in their social relationships. As was noted in the first excerpt of the chapter, 'women (..), they're always on the go. All sorts going on.'

Excerpt 6.3.

P3 (-50): Yes I think that that's one (very fast) (.) factor for why they're (women) like that (.) view of life is totally diff- (.) different from men. (.) (A man) easily blames himself that (1) while women look for the brighter side like (.) of things (1) er (.) if it's that (fast) getting stressed out or some*thing* that you *could* call it.. *I don't know*
IP: Esko, were you saying something about this when you started that 'does he worry'..
P1 (-56): does a Finnish man worry himself into his grave (.)
IP: Aye.
P1 (-56): He starts (.) ruminating about all sorts (1) of things in his head and.. (FG6:11.)

In the same way as the previous excerpts, 'a man' and 'a woman' are group identities that are used in the singular form and as self-explanatory categories for male and female characteristics, dispositions and behaviours and are often used as two extremes. Women's 'view of life' is described as being 'totally' different from that of men: the women 'look for the brighter side of things' while men get stressed and 'ruminate about all sorts of things'. The notion of men 'worrying themselves into his grave' may, again, be read in different ways.

One way of reading this suggests that the participants hold a critical standpoint to shared models of being a man in the Finnish culture where a man 'easily blames himself' for many things that lead to anxiety, stress and mental indisposition. In this interpretation, the critical view on Finnish culture is based on a specific group category (or membership category, see Baker 1997), 'a Finnish man', which is brought up to the discussion by the participant P1. The 'Finnish man' is a concept which operates both as a generalised upper level identity for a certain group of men but, simultaneously, relates expressed views to the Finnish culture. Conceptually, the 'Finnish man' thus refers to culturally shared conceptions of and attributions attached to Finnish men that distinguish them from women, but also from other nationalities. The accounts may, thus, be read as critical consideration of a culture where men are taught to hide their feelings and ruminate about their problems without seeking

outside help, compassion or sympathy. What is unsatisfying in this interpretation is that the presumed critical standpoint actually remains hidden in the excerpt. The gloominess of the 'Finnish man' is neither directly criticised, nor does the speaker actively distance himself from being one of them. The only distancing expression is the way in which the 'Finnish man' is referred to as 'he'. Therefore, it somehow seems that the 'Finnish man' in the excerpt simultaneously represents both 'them' and 'us'.

In my view, the concept of the 'Finnish man' in the excerpt comes close to what Antero Honkasalo (1995) has called the 'character of mythical masculine man', a cultural icon involving traditional features of masculinity in a given culture. Another way of interpreting the excerpt suggests reading the accounts as a negotiation of different forms of masculinity. From this perspective, the mythical masculine man ('Finnish man') acts as an anchor point for considering qualities of a man in contemporary Finnish society; that is, the 'Finnish man' represents a certain culturally identified and well-known *position for negotiating masculine identities*, which is used as a point of comparison in the interview talk. Explicit use of a generalised masculine identity renders it possible to take a stand on shared cultural expectations attached to this traditional position.

In the previous excerpt, negotiation of masculinities did not result in the expression of an explicit standpoint of valuing characteristics attached to the mythical Finnish masculinity. In the next excerpt, the 'Finnish man' is again brought into the discussion within the context of *men's reluctance to seek help*.

Excerpt 6.4.

IP: Yeah (1) some have said that (.) that (1) of those older (.) blokes (the older interviewees) that they (.) that they've noticed that although many start to have about the time they're fifty a bit (.) problems that they didn't have before (.) (K6: mmm) well still (.) er (.) men don't talk a lot [
K6: [n:o (.) it's well
IP: among themselves about things like that.
K6: Especially a Finnish man, well he's so dour that he doesn't (.) like not (.) very much about things like food and others, they are not talked about anyway. (IP: Yeah) It's surely a bit difficult, I suppose, for many (.) talking about yourself and your troubles for Finnish men so (1) it's more like (3) suffer till the end and then when you can't any more then something (.) thinks about something what should be done.
IP: Yeah. But can you say what it is that why talking about those problems is somehow something (1) that doesn't feel right?
K6: I can't say (3) what it is that finally (.) causes it. I know plenty of cases where they've suffered that long that they could hardly get up out of their beds and only then go to the doctor like (.) I don't know what's so difficult about it. Are they scared that it's something worse and (.) I don't know. (K6:7, born 1976.)

The first notable discursive feature in the participant's speech is the use of the subject position of outside observer. In the same way as the previous excerpt, the speaker does not explicitly include himself in the group of 'Finnish men' although, on the other hand, he does not actively distance himself from it either. Throughout the excerpt, the speaker does not make a clear distinction between 'those' 'Finnish men' and himself. On the contrary, the whole excerpt could be read as indicating the speaker's involvement in the group of men he refers to. The 'Finnish man', is depicted as generally taciturn and uncommunicative which results in avoiding discussions about health and lifestyle choices related to health ('food and others'). This is also seen to lead to concealing physical ailments and reluctance to seek help, which the speaker emphasises with reference to the 'many cases' he has personally observed. Only within this context of concrete 'unhealthy choice' of not contacting a doctor in time does the speaker separate himself from the 'many cases' he has observed by saying that he does not know 'what's so difficult' in contacting health care. However, when saying this he does not explicitly criticise this stand.

The excerpt follows the same logic as the previous one in two important respects. First, the use of 'Finnish man' refers to cultural expectations related to masculine behaviour and alludes to a certain cultural determinism in men's help-seeking behaviours. Secondly, consideration of these cultural expectations that lead to potentially health-damaging avoidance of treatments does not result in the speaker's active withdrawal from the ideas expressed. In my interview material, only one participant of a group interview explicitly criticised men's reluctance to seek help. A 26 years old clerical employee mentioned older men's reluctance to seek help and commented it: 'I just don't get it. If there's something wrong, why don't you go to a doctor? What's so difficult about it?' In his account, it is worth noting that he does not actually discuss men as 'us' but criticises other groups of men, 'the older ones', where the age category may partly legitimise the criticism. Regardless of this exception, men's perceived avoidance of contacts with health care was neither explicitly criticised nor distanced in the accounts of the interviewees. This gives reason to assume that reluctance to seek help is among the strongest health-relating attributes attached to masculinity (cf. Moynihan 1998; Möller-Leimkühler 2002; 2003; Galdas et al. 2005).

> The masculine stereotype does not allow help-seeking, even if help is needed and could be available. Already perceiving a need for help would offend traditional role expectations, and admitting this need would be double offence. For the same reasons, help-seeking implies loss of status, loss of control and autonomy, incompetence, dependence and damage of identity. (Möller-Leimkühler 2003, 3).

Möller-Leimkühler (2003) also points out that mental disorders, particularly depression, have traditionally been thought to be something that women suffer from[2]. It is, therefore, interesting get back to Excerpt 6.3 and note how the participant refers to 'Finnish man's' melancholy and asks a rhetorical question of whether a Finnish man worries himself into his grave. Following Möller-Leimkühler's deduction, expressing feelings of depression should, then, pose a double-threat to one's masculine identity, first in terms of vulnerability and weakness and, secondly, in terms of suffering from a 'female problem'. In my view, there are two reasons rendering it possible for the participant to make a claim which might, potentially, cause him a doubly threatening position within a group discussion. In expressing his view as a general property of (all) 'Finnish men', depression is not attached to the speaker personally, or any of the other participants, but to the Finnish culture that positions (all) Finnish men as vulnerable to depression. In addition, it is a well-known fact that the Finnish suicide rates are among the highest in the world, and that the majority of suicides in Finland annually are committed by men: in 2002, 824 suicides of a total number of 1095 (75 %) were committed by men (Lönnqvist 2005). This gives a good objective ground for the speaker to claim that the 'Finnish man', indeed, 'worries himself into his grave'. Accordingly, it is worth considering if depression might not be as stigmatised in Finnish culture, as it might be in other cultures where men's suicide rates are lower.[3]

In the interviews, men's reluctance to seek help was often taken as a contrasting example to women's greater attention to their bodily signs and active care for their own health as in the next interview excerpt.

Excerpt 6.5.

IP: What of that. (.) It was Martti (P2) who first mentioned women's and men's living habits well (.) I don't know that when we were talking about exercise (.) do women in your opinion I mean otherwise have somehow healthier living habits (.) than men? (.)
P2 (-49): Yes in my opinion they think more about it and (.) live (.) in a healthier way than men. (1) Eat more healthily and then they take more care of themselves and (.) if something happens to them they go to the doctor but men don't necessarily go straight away and (1) they stall and stall, just a bit longer here ( ) "let's see" (.) they (women) are more sensitive about taking care of themselves.

[2] In Finland, women have been found to suffer more from depression compared to men. In a representative sample of 6005 persons (≥30 years), depressive disorders were found in 8.3% of women and 4.6% of men (Pirkola et al. 2005).

[3] Mental health was not a specific topic in my interviews, and mental health as well as mental disorders were explicitly mentioned only a few times in the interviews. Therefore, exploring gendered attributes attached to mental health problems cannot be analysed more thoroughly within this study.

P1 (-49): There's (.) there's certainly something pretty big (.) a big difference that women go to the doctor (1) you know more easily (2) and they feel somehow (.) and men certainly do not go. (1)
P2 (-49): Men go when it's like (.) they go in a terrible rush at the last minute when something is really wrong
P1 (-49): *Yes* or then they get take[n (laughing)
P2 (-49): [or get taken! (.) Taken so that.. (laughing)
P3 (-54): That's really quite true that (1) men mostly don't go (.) for all their problems. Mind you there are those that are always running there (2) but most of us don't go until we absolutely have to.
IP: And why would that be (.) why (.) what is it about men that (.) they don't manage to go, go for treatment or to check-, have a check-up of their own condition?(1)
P2 (-49): *They* play down their own complaint and go on and on (inaudible) (.) that if it feels a bit bad then they *think that* "what's of that" (1)
P3 (-54): Would it be like (.) a bit that it's a tradition and (.) a bit a matter of honour that "what the hell am I doing there" (1) in that way that.. (1)
P1 (-49): I:t's bound to be a bit (.) handed down like (1) from somewhere (1) *come* (2) *it's* a bit of a matter of honour that "now I can (1) manage OK without a doctor" (2)
P2 (-49): I suppose you think that "if spirits, tar or sauna don't do the trick, I'm a gonner" (chuckles and others begin to laugh) (FG5:8–9).

The participant P2 takes women's contacts with health care (doctor) as an example of how women are more 'sensitive about taking care of themselves', while the men, in comparison, stay away from health care until 'something happens to them'. The next speaker (P1) agrees that there is a big difference between men and women in going to a doctor and concludes in the end of his account, 'men certainly do not go (to a doctor)'. After this relatively strong and categorical statement, the discussion continues with an interesting collective reproduction of what was called 'men certainly do not go' to a doctor.

The participants P1 and P2 go further by contemplating how men typically delay going to a doctor up to the moment when contact with a health care professional becomes unavoidable. This view is fostered with humorous notions that even in those circumstances, the men do not go spontaneously to a doctor but 'get taken' there[4]. Taking part in the discussion of the excerpt for the first time, P3 agrees with the others by saying that 'that's really quite true that men mostly don't go (to a doctor)

[4] In the original Finnish excerpt, the latter comment 'Taken so that..' by P2, is expressed in a dialect typical to the Ostrobothnia (Pohjanmaa) region of Finland ('vierähän'), which clearly differs from the common dialect of the interview. In the Finnish culture, the Ostrobothnia region has historically been regarded as a geographically located subculture with high violence rates and associated with extremely masculine stereotypes, a theme of many Finnish films, novels, songs, and even academic studies (e.g., Alkio 1894; Ylikangas 1974). Use of Ostrobothnia dialect seems to refer to these ultra-masculine characteristics, which further strengthens the claim brought up.

for all their problems'. With this sentence the participant P3 actually intensifies the conclusions made earlier. Stating that men mostly do not go to a doctor for *all* of their problems, he creates an interesting bipolarity of going to the doctor 'in a terrible rush at the last minute', on the one hand, and 'for all their problems' on the other. This is an example of 'extreme case formulation' (Pomerantz 1986) which is used for making a clear distinction between 'us' and 'them'.

As this type of formulation would require specification of who are those who go to a doctor for all their problems, P3 advances his conclusions with an interesting sentence: 'Mind you there are those that are always running there but most of us don't go until we absolutely have to.' Although this account does not explicitly specify who are those 'running there' all the time, it becomes obvious, however, that those 'others' differ in this respect from 'most of us'. In the first part of the excerpt, the discussion is about differences between men and women while P3's account turns the discussion to the differences between men. The notion that the distinction is not only made between men and women but also between differing groups of men brings up an interpretation of the construction of 'local hegemonic masculinity' (Connell & Messerschmidt 2005), an agreed, shared and valued form of masculinity within this specific group of men. In the excerpt, those men 'running' to a doctor all the time obviously do not act in accordance with traditional – and in this local context potentially dominating – expectations of the masculine and are thus distinguished from 'most of us' who 'don't go until we absolutely have to'. Normative expressions in P3's talk indicate that, in normal cases, men have, and they *should* have, good reasons for going to a doctor.

Starting from my specifying question of why men do not manage to go to treatments or check-ups, the last part of the excerpt focuses on cultural grounds for men's reluctance to seek help. This reluctance is accounted for by 'tradition', which is 'handed down' from generation to generation resulting in 'a matter of honour' of trying to manage without a doctor. It is worth paying attention to the discursive structure of the excerpt where the three participants collectively produce the above summarised storyline, a conversational narrative (see e.g., Fairclough 1992, 149–152), each bringing his own contribution to the story. In this context, the participants locate the views expressed with other men's thinking, use passive formulations and talk about culture, in general, instead of getting directly involved in the views. Despite this, it is striking how similarly the participants describe the things and how uniform the rhetorical tools they use are in underlining their views.

The most notable rhetorical tool for justifying the claims is how all the participants illustrate the collectively produced narrative by referring to imaginary yet descriptive accounts of illusory male speakers as verbalisations of how men think and talk. In

the structure of conversation, the order of illustrations is also interesting: the four references to imaginary accounts of illusory male speakers are brought up in four consecutive conversational turns.

> 'what's of that' (P2)
> 'what the hell am I doing there' (P3)
> 'now I can manage OK without a doctor' (P1)
> 'if spirits, tar or sauna don't do the trick, I'm a gonner' (P2)

Putting words into imaginary male speaker's mouth does not necessarily act here as a means for distancing oneself from expressed views. Rather, it comes down to the fact that, with these references to illusory speakers, the participants consecutively prove that they are not offering merely their own personal conceptions of how Finnish men talk and think. *By referring to imaginary accounts, the speakers illustrate generality of the discourse* which, in turn, is recognised by the other participants who then join the collective meaning-making, one after another. It is also noteworthy that all previous imaginary quotations concern stands to or justifications for not visiting a doctor, instead of the activity of avoiding medical help itself. Therefore, they can be taken as explanatory examples of cultural determination of the expressed way of thinking which, in turn, is illustrated in the imaginary quotations.

The uniformity of accounts as well as the flexible collective production of the narrative where each speaker supports and gives his contribution to the story gives reason to conclude that the views are agreed and shared by the participants to the extent that they do not require specifications or negotiations. In other words, men's reluctance to seek help seems to have a taken-for-granted position and located thus in the 'hard core' of masculinity. The notion that seeking help is not, traditionally, regarded as masculine is expressed in numerous studies world-wide. Antero Honkasalo discusses the conflict of masculinity and help-seeking within the Finnish context:

> A man also avoids the doctor's consultation because it is difficult for him to submit himself to be on the receiving end of what the doctor does and orders. As a patient he is not in control of the situation; he has to obey treatment instructions and submit to the doctor's diagnosis of the state of his body. He must accept the role of object. Therefore men downplay their illnesses, try not to think of them or treat them on the principle that if tar or hard spirits don't do the trick the condition is fatal. (Honkasalo 1995, 190.)

The previous interview excerpt is literally in line with Honkasalo's views, which is most notable in the use of a well-known Finnish proverb brought up by both Honkasalo

and the participants of the interviews: 'if spirits, tar or sauna don't do the trick, I'm a gonner'. In the interview, the proverb acts as the final conclusion of the discussion, a crystallisation of the phenomenon that all the participants recognise and know, which becomes particularly visible in the participants' spontaneous laughter at the end of the excerpt.

Use of such well-known ideas crystallised in a proverb leads one to consider to whom these justifications are directed. A self-evident, but rather facile, interpretation is to assume that the justifications are directed at the interviewer asking the questions, with aim to convince the interviewer that the claims made reflect reality outside the interview context. From the point of view of interaction, the justifications, imaginary quotations and collective production of the narrative may also be interpreted as an interactional group process where the participants show their cultural competence to other participants as well. In interaction, the participants mutually convince each other of their knowledge and skills to master cultural narratives of this type, in general, and a story on men's reluctance to seek help, in particular. Taking part in the consecutive production of the storyline shows cultural competence in discursive practices required in constructing a shared version of the object that 'men certainly do not go to a doctor'.

Biology and motherhood combined with socialisation and healthy lifestyles

In addition to gender differences in the labour market and work, various psychosocial factors, and differing dispositions to seek help, the biological advantages of women were often mentioned as explanations for gender differences in health. The participants introduced various biology-based theories on gender differences. For example, menstruation was seen to lead to regular cleansing of blood which, in turn, was concluded to result in women's better health compared to men. Another participant deducted that men's average higher pulse meant that men, in fact, live a similar length of life in a shorter period of time compared to women. Within rather mystified notions of how 'mother-nature' has planned the difference to be as it is, the most common biology-based explanation for the gender difference was, however, the general notion of certain hormones (e.g., 'reproductive hormones') that protect women from premature death. The hormones, in turn, were in most cases associated with reproduction and motherhood. Women were called 'female parents' who 'preserve life' and whose life is, therefore, *naturally* longer.

When analysing the biology-based explanations, I found the explanations to belong to two major categories. The first line of argumentation consisted of short

and often unexplained theories of internal, bodily processes (hormones etc.) leading to women's longer life compared to men. Very often those explanations were short notions that 'there needs to be something in their (women's) biology'. Another of the explanations, which the majority of the explanations belonged to, focused explicitly on motherhood (although references to 'reproductive hormones' did the same implicitly). Mothers were thought to be the primary care-takers of children, which accounted for primarily by biology, but socialisation was included as well. In these accounts, the meaning of motherhood in women's longer lives was seen, first, as occurring from the natural order of things where women have to live longer to raise their children. The second, and overwhelmingly more common, deduction was to link motherhood with healthy lifestyles as in the next excerpt.

Excerpt 6.6.

K4: I think that when women are generally mothers, maybe they've got more responsibility like (1) for their children's lives which is therefore, well (3) they live more healthily and want to be examples for their (2) heirs or well, children (4) That a mother is always a mother anyway, that (.) fathers are a bit more (.) er (1) not all but generally fa-, a father, fathers a-, are generally inclined to sort of go all to pot, *that's how it is*. So well (.) (fathers are less) committed to that child (.) to bringing up their children than women are so (2) it could be (1) if you suddenly think about it there's something like this in it (6) Of course it is that be-, before it was still err (.) mothers were always at home so she was of course more (.) with those children. That's where (.) the responsibility and all that. (K4:5–6, born 1954.)

In the excerpt, the obviousness of the statement that women take more responsibility for their children and live healthier lives so as to set good examples for their children is crystallised in the notion 'a mother is always a mother anyway'. This is a good example of a 'commonplace' (Billig 1996), a widely shared and agreed argumentation, in that the idea of the sentence is self-explanatory and hard to question or oppose. The word 'mother' is loaded with associations of responsibility, unselfishness and even sacrifice to an extent, which makes it impossible to deny the deductions included in or based on the 'mother is always a mother' argument. The emphasised word 'mother' and the additional word 'anyway' give a hint of a challenge addressed to the listener: would you be able to oppose this? It is, therefore, interesting to pay attention to how the descriptions of fatherhood differ from unquestioned motherhood. It seems that right after an assured notion of motherhood, fatherhood and fathers' roles are more difficult to describe, which is seen in breaks and hesitations: 'fathers are a bit more (.) er (1) not all but generally fa-, a father, fathers are generally inclined to sort of go all to pot'. That fathers 'are generally inclined' to 'go all to pot' arising from fathers'

weaker role in the family life is the only thing he mentions about men's attitudes to health. Generally, the participant attributes women's longer life to motherhood as a particular form of parenthood, where a man/ father has only a minor part.

Despite the rather strict categorisations of men's and women's roles in family life, the excerpt also illustrates the complex ideological features of gender talk. At the end of the excerpt the participant softens his explanations about women's longer life compared to men by expressing a disclaimer (Hewitt & Stokes 1975): 'it could be (the reason for gender difference in health) if you suddenly think about it there's something like this in it'. By this sentence the speaker makes it clear that his views might not be an absolute truth and releases himself from the complete responsibility of the account. Nevertheless, after a long six second break he continues by referring to traditional family roles which I interpret as additional evidence for claims he has made before. These oscillations and hesitations make it clear that expressing conventional views is a delicate issue where a speaker has to take into account potential counter-claims and use a wide range of argumentation.

A dual explanation of combining biology and socialisation in explaining women's longer life by parenthood is, according to Sarah Riley (2003), the strongest combination of arguments for reproducing traditional gender roles. In her study, Riley found British white-collar men explain gender roles in relation to provision through a combination of biology and socialisation. On the one hand, women are positioned in traditional gender roles by referring to biology and 'nature'. On the other hand, the previous view is often combined and fostered by a notion of tradition where women are claimed to be socialised to follow the traditional norms. Both ways of explanation result in conceptualising women's roles and positions as non-agentic and unchangeable. Biology or abstract socialisation cannot be blamed for maintaining the patriarchal order due to notions such as the 'natural order of things' and generational traditions; 'that's the way the things have always been'. Simultaneously, the biology/ socialisation arguments help the speakers to avoid being heard as holding sexist, oppressive and/or male-chauvinist views. In Riley's study, a recurrent discursive structure in the interviewee's argumentation was 'sandwiching', which involved locating counterarguments for potential criticism in the middle of biology/socialisation arguments: e.g., the biology/socialisation argument is used as a cause for traditional roles – though I admit it might not be fair – but that's how things are and have been; biology cannot be changed, can it?

Although explanations for gender differences in health included several different ways in which women's biology shields them from premature death, it is important to note that 1) biology was very often combined with socialisation arguments and that 2) in most cases the references to biology were rather vague and even mystified

in their presumed causalities related to health. Therefore, it seems that biology offers a relatively wide category of explanations for gender differences without the necessity to specify the claims.

Differences in health-related lifestyle choices

Despite the notion that motherhood was often used to explain gender differences in health-related behaviours, healthiness of lifestyles was also discussed in the interviews independently from motherhood. Generally, women were seen to live in a healthier way compared to men. In the discussions of the impact of lifestyle on gender differences in health, the focus was largely on women's healthier choices and not on men's unhealthy behaviours. Women's healthier lifestyles were accounted for by their early socialisation to keep track of their bodily signs and take care of their health, women's less stressful life (especially at work) and the prominence of health information in 'women's magazines' (see Chapter 5), which was seen both as a cause for women's higher health awareness and as the outcome of women's profound and essential interest in health which makes publishing such magazines profitable. In addition to motherhood as a biological category and as a relationship between the mother and her child/ren, women were thought to carry the primary responsibility for the wellbeing of the whole family which, thus, was considered to influence their own lifestyle choices. The ways to conceptualise and explain 'women's healthy lifestyle' mentioned above were expressed in contexts where health-related behaviours were discussed as a whole without dividing them into concrete activities. When talking about lifestyle choices there were, however, some differences in how separate health-related behaviours were explained.

As will be discussed more thoroughly in the next chapter, smoking seemed to be the least 'gendered' behaviour among those investigated within the study at hand. That more women are non-smokers was explained by pregnancy and breast-feeding. The participants told me and other participants stories about their wives and other female acquaintances who had quit smoking while being pregnant for the sake of the unborn child's health. The same explanation was used to explain women's greater inclination to sobriety. Physical exercise and nutrition differed, however, from the two former examples in that the explanations included more gendered features than in the cases of smoking and alcohol. Women's activeness and more reasonable ways to do physical exercise were explained by the social characteristics of the exercise: women's motivation to exercise was thought to be, among others, socially oriented. This was often combined with a notion of women's sociability and openness,

considered to be features of distinctive 'women's psychology' (Gough 1998). Women's greater interest in nutrition was explained by their role in the family as the person primarily responsible for feeding the family.

In explaining differences in health-related behaviours, physical exercise and nutrition also had one common and clearly gendered feature relating to women's motivation to eat healthily and engage in regular physical exercise: both of them were seen to be linked to women's aspiration to take care of their physical appearance and control their weight. The next excerpt gives a rather extreme example of this type of reasoning.

Excerpt 6.7.

P3 (-72): The women, at least outwardly, want to appear then (1) good-looking and beautiful and healthy (.) that (.) so that they keep something (1) they keep the kilos under control and want to show with the makeup and clothes that (.) they're, they're in good shape, whereas a man (.) well you pull overalls on and hair all messed up, let's get some work done! (FG3:15.)

In the excerpt, the women's interest in health is directly linked with physical appearance ([they] 'want to appear (..) good-looking and beautiful and healthy'), which also indicates health, in this female context, to be something instrumental, superficial and not 'real', merely something that women want to look like. The drastic distinction between masculinity and femininity in the excerpt above is based on the idea that while women continuously take care of their looks, for men this is something essentially irrelevant. 'A man' is, in turn, a responsibility-oriented person who does not pay attention to such frivolities but, instead, pulls his 'overalls on and (with his) hair all messed up' directs his energy to useful things: 'let's get some work done!'

Taking care of physical appearance is tightly linked with conventional femininity in Western cultures (Aoki 1996; Grogan & Richards 2002; Tiihonen 2004). This makes it possible to express the claim that women primarily focus on their looks as a fact, which does not require further argumentation. This 'essential' difference between men and women is further strengthened by another culturally shared, gendered 'fact' of men being work-oriented in the first place. In other words, the distinction-making in the account is based on two important building blocks of feminine and masculine identities, i.e. beauty and (certain kinds of) work. These identities are strictly decoupled from each other. Pulling overalls on has a functional purpose and signifies work-orientation which is presented as something profoundly different from women's superficial identity-making by clothing and make-up. 'A man' categorically departs from this with his 'hair all messed up'.

As mentioned above, the previous excerpt was a rather extreme description about women's orientation to physical appearance as the primary cause for their greater health awareness. Nevertheless, pointing to the same idea was a recurrent phenomenon in the interviews, though, in many cases, it was expressed in softer ways. Women's preoccupation with beauty was also negotiated in the interviews, to a certain extent, as the next excerpt shows. The excerpt is part of a discussion on gender differences in health.

Excerpt 6.8.

IP: Mm, now how about do women liv-, live somehow healthier than men, for example? Ca-can that be the explanat[tion (for their higher life-expectancy)?
P3 (-50): [Well at least they take care of their health[more than men
P1 (-56): [Certainly, they certainly live (healthier)
P2 (-48): Yeah, and (1) there are surely such, certain factors that-that (.) that like the attitude (1) to their own lives well it's quite different from (1) men. Of course there are exceptions among men, too, that they have a really good (1) attitude and that but (2) so that if (.) you compare just that how much like (1) women tal-, talk among themselves (2) when you compare how men talk among themselves (P1: is there some difference like?) Abs-, absolutely different (.) way (P3 laughs in the background)
IP: Yeah, well (.) so what (1) if we assume that women like (.) take better care (.) more care of their health well (.) can you say any reasons that what (.) what that might be due to?(3)
P1 (-56): Women's vanity. (P2 has a good laugh)
IP: In what sense?
P1 (-56): They always have to be so nice-looking. (others laugh)
IP: Aha, so it's appearance, this.. (others continue laughing)(2)
P3 (-50): I don' know it's some (1) sort of (.) some osteoporosis has been well known already for ages and (.) that's one that (.) that (1) the mother taught the daughter first off that (.) you should keep yourself fit, and exercise so that you don't find yourself with bone loss (1) and that way (.) it's one of those first things. And then taking ca-, looking after yourself, taking care of your appearance (.) that has certainly been the positive thing (.) although men can always make it negative. (1) But that's it, taking care (.) it's taking care of everything. (1) Like taking care of the family (P1: ye:s, better care of yourself) they feel it, er (IP: Uhuh) (1) it's holistic with the woman that (.) which is not for a man (IP: Uhuh) (P2: if you think that..) Men let the beer belly grow, but women don't. (FG6:17–18.)

In the beginning of the excerpt, the participant P2 attributes women's healthier ways of life to their different 'attitude to life' compared to that of men, concretising his claim with the notion that women talk in different ways with other women compared to the ways in which men talk with other men. When another participant P1 butts in with the question 'is there some difference like?', the potentially rhetorical question makes P2 intensify his claim by saying that women's way of talking is 'absolutely different', strengthening the intransigence of the distinction between men and women.

After P2's account I continue the theme by asking for reasons why women take better care of their health compared to men. It is interesting that there emerged a relatively long pause of three seconds after my question before P1 laconically attributes it to 'women's vanity', which results in collective laughter. In my view, the collective laughter again represents the shared nature of 'knowledge' regarding women's vanity which is – at this stage – not questioned nor challenged but taken for granted. After a pause, participant P3 continues the theme from a slightly different perspective. In his account he contemplates taking care of appearance, among others, as example of *women's overall inclination to caring*: by early socialisation in self-care (e.g. prevention of osteoporosis) girls and women grow up to continuously take care of the health and well-being of their families and themselves. What is interesting in the account, is that while he expresses faint disagreement with taking care of one's appearance ('that has certainly been the positive thing (.) although men can always make it negative'), he actually does not deny the conclusion that women are interested in their looks, and how this is one of the primary reasons for women's more intensive health care regimens. Instead, he actually develops this argument by broadening it to concern 'women's psychology': taking care of 'everything' is due to women's 'holistic' viewpoint of life. In the same way as in previous examples, women's different worldview is attributed to both socialisation and women's innately different thinking.

An interesting phenomenon in the interviews was that the explanations for differences in lifestyle choices focused on things that make women live in healthier ways while reasons for men's unhealthier habits remained largely unexplained. The excerpt below is explicitly focused on women's health awareness.

Excerpt 6.9.

IP: Yes, well, let's (.) let's say, if I ask this way, that, that er (.) when you said that maybe women take better care of their health, so how do they take better care of their health, what does it (.) mean in practice? What is it that women do differently?
P2 (-78): At least it starts from that they really admit to themselves that they're in bad shape. So that's not, for men it's surely that "Well I'm not in such bad shape yet" so (2) If they start putting on a bit of weight, so "oh well that doesn't matter all that much" but.. (2) They only notice it when, at the point when (.) the places are ready for surgery and (1) they have to make like really radical changes (.) that's when, for men, it only gets noticed. (2) That they do-, don't well (2) kno-, or they are aware, but they don't like admit to themselves that they are in poor shape.
P4 (-75): The women's magazines are full of all sorts of hints, that how to make yourself feel more wonderful (.) and (.) all of that and (1) it surely starts from there, the supermarket (.) from the muesli and bran shelf it starts like the (.) search for feeling good, like through the diet and that and (.) all sorts (1) of new things whatever comes, whatever is in the adverts, that there's less fat and that, so I'm sure it's the (2) female

that for the most (.) part of Finnish households surely like fetches and also tries to get her old man like (.) to dissuade from full fat milk and (.) and (.) that heavily salted butter and so on, that (2) And maybe it (.) starts out like, I don't know if it makes any difference, that (1) that women are (.) a lot more involved (.) compared to men (.) more in like this (1) mmm (.) professions where (1) they have to do with (.) health. Nurses, public health nurses (.) they are all these (2) heal-, them that talks about health living habits, so (.) well like (1) that way it's (2) sure to come. (FG2:14–15.)

The beginning of the excerpt is an example of how men's conceptions and attitudes to their health are discussed when considering gender differences in health. It highlights the idea that for men health is somehow instrumental, which is demonstrated by the notion that men 'notice' their bad health only when 'places are ready for surgery and they have to make really radical changes'. P2's account ends with an indirect reference to men's reluctance to seek help for their health problems: 'they are aware, but they don't like admit to themselves that they are in poor shape'. Simultaneously, the beginning of the excerpt illustrates again how 'definition by difference' (Edley & Wetherell 1997) emerges in interaction: the question concerning women is, to a large extent, answered on the basis of the contemplation of men's ideas, conceptions and ways to act.

P4, in turn, turns the discussion back to women. However, he does not actually express his view about what women do differently but, instead, considers reasons for women's healthier habits. He offers three different explanations for why women are more interested in health and live more healthily. The first one concerns *consumer culture*. Women are a target group for magazines 'full of all sorts of hints' related to health and well-being as well as advertisements of healthier new products, which result in women searching for 'feeling good' in 'the muesli and bran shelves' of supermarkets. Secondly, searching for well-being in supermarkets relates to *traditional gender roles*, according to which the woman is primarily responsible for purchasing food and caring for the family-members, trying to dissuade her 'old man' from consuming 'full fat milk and heavily salted butter', among others. Thirdly, he refers to *gendered divisions within the labour market* with the notion that health-related professions involve more women than men.

An interesting theme throughout the discussions of gender differences in health was certain essentialism concerning gender, particularly regarding healthy lifestyles. The gender differences were largely explained by different biological factors (motherhood, hormones etc.) and structural conditions (labour market, socialisation, gender roles) or rather obscure 'innately' different attitudes and conceptions of men and women. A notable phenomenon was also the interviewees' tendency to explain

differences in lifestyle mainly in terms of women's preferences and ideas, instead of explanations relating directly to men's lives.

Conclusions

The interviewees gave several different explanations for gender difference in life-expectancy as demonstrated in this chapter. Some of the explanations concerned only men (things that lower men's life-expectancy), some concerned only women (things that influence or heighten women's life-expectancy) and some concerned both genders. The hard and stressful work of men was claimed to deteriorate men's health while women were seen to have certain biological advantages protecting their health. These were two factors that were separately given as reasons for either men's worse or women's better health. The majority of causes for gender difference concerned both genders. However, it was notable that these explanations reflected a bipolar gender division. While women were thought to be sensible regarding their bodily signs and disposed to seeking outside help when required, reluctance to seek help was without exception seen to bestride men's health-related thinking and behaviour. Women were viewed as having more social contacts while men were viewed as gloomy and uncommunicative. All these gendered characteristics were more or less unquestioned and unchallenged in the interviews and acted as dominating generalisations regarding the genders.

As the focus of this study is on men's health-related behaviours, it is interesting that when giving explanations for gender difference in life-expectancy, the participants tended to attribute the difference to women's healthier lifestyles and not to men's unhealthy lifestyles. In this context the men talked very little about men's health-related choices, particularly *reasons for the unhealthy choices*, discussing, instead, women's higher health awareness and healthier habits resulting in recurrent considerations of motherhood and concerns with appearance as reasons for women's healthier ways of life. Although it was regularly said that men generally live in unhealthy ways, at least compared to women, this was not explained by men's indifference to health, laziness or other motivational terms. Instead, the explanations concerned structural conditions of men's lives (such as the labour market, culture etc.) as well as those factors that contribute to women's abilities and possibilities to take care of and be interested in health. This may, of course, have arisen from the way the question about health differences was formulated. In all 14 personal interviews, I framed the question by referring to women's higher life-expectancy: 'In Finland women live on average seven years longer than men, what do you think is the reason for that?' Five of the six focus groups focused on women's higher life-expectancy and in one of

them the discussion was spontaneously initiated by the participants themselves. The explanations might have been different if the focus was explicitly on men's lower life-expectancy. Nonetheless, this does not fully account for the systematic 'bias' in how the difference was explained. Despite the question being formulated in such a way that the focus was on women's rather than men's health, the participants nevertheless offered men's harder work as one of the primary reasons for men's worse health, thus focusing explicitly on issues structuring men's lives.

In my view, the bias results from the contextual interplay between 'us' and 'them' and negotiations of 'otherness' and 'us-ness' in explanations for gender difference in health. Despite speaking about men 'in general', and recurrently referring to men as a group as 'they', the participants inevitably realised that they were being talked about themselves as members of that category. The group of 'men' is thus interestingly a category including 'them' and 'us', other people and 'me'. In my interpretation, this prevented the participants from expressing ideas regarding men that might be heard as morally deprecating. This is because there seems to be an *ideological dilemma relating to 'otherness' and 'us-ness' in the context of offering views about men's lower life-expectancy*, particularly when healthy lifestyle is under consideration. In offering their views, on the one hand, the participants should be able to objectify the group of 'men', and themselves as members of that category, and give realistic and credible explanations for the topic at hand. On the other hand, however, they should avoid moralistic viewpoints and overly strict accusations of men acting irresponsibly. Otherwise other participants of the interaction – even the interviewer – might have asked if they are themselves following all the advice of healthy lifestyles. As Bergmann (1998) observes, morally loaded vocabulary carry risks for its users since the speakers are held accountable for their morally loaded expressions.

> [I]nteractants who partake in moral discourse run the risk of becoming themselves the target of moral activities. Moral engagement is to a very high degree self-reflexive, and moralization over some issue easily leads to accusations and other forms of (counter-) moralization. This provides the background for the observation that moral activities frequently are mitigated, covered, and neutralized or are positioned within a nonserious humorous or ironic frame. (Bergmann 1998, 288.)

This dilemmatic situation was managed by four discursive practices. Firstly, men's unhealthiness and unhealthy habits were largely discussed as consequences of structural (societal and cultural) conditions. This was rhetorically most effective when linked to valuable structural conditions such as work. Secondly, the 'us-ness' regarding the category of men was negotiated in certain contexts. The most clear

group of 'us' was based on occupational group which resulted from the structural condition of the labour market being interpreted primarily in terms of manual labour. The 'us-ness' was further fostered by the collective reproduction of manual labourers' group identities. Thirdly, the gender difference in health was easier to discuss through the most obvious 'others', the women, which rendered it possible to give credible explanations for the difference without the threat of 'blaming the victim'.

Finally, the dilemma discussed above was also managed by the use of the concept of the 'Finnish man', which was frequently referred to as an explanation for men's behaviour, choices and attitudes regarding health. The 'Finnish man' links 'us' with 'them'. The 'Finnish man' is a useful concept for managing the dilemmatic situation between 'our' and 'their' unhealthy lives for it is a depersonalised concept which does not refer to any concrete person but simultaneously concerns all the participants of interaction, including the interviewer. It both sets the limits for conceptualisation of those men whose lives are under consideration, locating them in the Finnish cultural context, but simultaneously broadens discussion to equally cover all different groups of men in Finnish society instead of just those that the participants represent. What is even more important is that the 'Finnish man' links the qualities attached to the concept with cultural traditions and history, thus making male characteristics, conceptions and activities understandable. Accordingly, the behaviours or attitudes, which otherwise might be criticised or disapproved of, become non-individualised elements of Finnish culture.

The concept of 'Finnish man' exemplifies a local hegemonic view of masculinity (Connell & Messerschmidt 2005) in a sense of a dominating, taken-for-granted description of masculinity. I base this claim on two notions in the material. First, the 'Finnish man' was used in many contexts throughout the interviews without being questioned or challenged by other participants in the focus groups (e.g., 'what do you mean by the "Finnish man/men", do you mean us or some other men?'), which, in my view, attests that the contents of the concept is collectively shared by the participants. In other words, the 'Finnish man' was discussed as a taken-for-granted description of Finnish men as a national and gendered group of people. Similarly, behaviours explained by descriptions of 'Finnish man' were neither challenged nor questioned within the interviews. Secondly, the participants did not actively disentangle themselves from the attributes attached to the 'Finnish man'. Instead, in some contexts, it also called for collective espousal of certain characteristics attached to the concept. This was most apparent in the case of men's reluctance to seek help in case of health problems. In discussing the topic, the men clearly treated the concept as a description of 'us' making a distinction with other men who do not act in accordance with the

rule. The simultaneous imaginary quotations and references to well-known Finnish proverbs demonstrated the shared knowledge, and potential commitment, to ideas at the heart of the concept of the 'Finnish man'. These arguments give me a reason to conclude that the 'Finnish man' is a concept which most clearly depicts widely shared cultural assumptions related to men in Finland and thus forms a potentially available anchor-point for their collective self-identification practices.

'Taken-for-grantedness' of the 'Finnish man' likely derives from the relatively impersonal topic of discussion analysed in this chapter. The explanations for gender differences in health do not call for manifestations of the individual self, which would potentially lead to morally threatening positions, to the same extent as in other contexts where personal characteristics (opinions, conditions, activities) related to health are under consideration. A general perspective on men's health does not explicitly encourage the participants to take a stand on whether they belong to the group or not. As it may be argued that the 'Finnish man' offered a potentially available anchor-point for self-identification practices, this self-identification did not actually take place in constructions of men's health in an individual sense. Instead, the 'Finnish man' was used in collective descriptions of 'us' where possible contrary themes and moral assessments related to health-damaging behaviours (reluctance to seek help etc.) did not cause threats to individual speakers' positions. My conclusion is that this is the particular reason for why the concept of the 'Finnish man' and its use in the explanations for men's behaviours did not result in negotiations of contrary themes but kept a position of unquestioned and taken-for-granted shared reality.

Out of health-related behaviours and choices discussed within explanations for gender difference in life-expectancy, men's reluctance to seek medical help (visiting a doctor) was clearly the least negotiated issue. Instead, it was attributed to men as a vital part of men's health-related thinking. Although one of the younger participants criticised 'older men' for their reluctance to seek help for their health problems and distanced himself from this type of stand, there were no opposite accounts claiming that men really go to a doctor when they need to. This was an interesting exception in my interview material in one important respect. As we shall see in the next chapter, the participants' accounts of health behaviour and health-related choices were characterised by compliance with the 'imperative of healthiness' (Backett 1992b). Reluctance to seek help is clearly in contradiction with this general rule where the interviewees more or less explicitly sympathised and even endorsed certain ways of thinking and acting that were indisputably harmful to health. This kind of exception to the rule is interesting for getting a broader picture of men's health-related discourses. Therefore, I will get back to discussing men's reluctance to seek help in the last chapter of the study.

7 MASCULINITY, HEALTHINESS AND HEALTH-RELATED LIFESTYLE CHOICES

In discussions on health information and 'men's health', an individual and his decisions, motives and purposes were rarely considered due to the non-personal, and non-specific, broad and general nature of the topics. In order to proceed towards more concrete discussions on the health-related choices that, among others, the health information deals with, and which were often mentioned to be reasons for the gender gap in health, I now focus on men's interview talk and health-related behaviours. In the analysis of the data, I examined thoroughly those parts of the interviews where central elements of healthy lifestyle (i.e. physical exercise, healthy nutrition, reasonable alcohol drinking and refraining from smoking) were discussed. My idea was to focus on these activities for chasing up whether the 'conflict' between masculinity and healthy lifestyles could be identified in the most well known risk factors of many chronic diseases. This idea was based on both theoretical reasons as well as observations in the research material. On the one hand, physical exercise, nutrition, alcohol and smoking are those lifestyle factors that are most often investigated in association with the health of a population. Accordingly, they also constitute the 'hard core' of advice for healthy lifestyles (don't smoke, don't drink to excess, exercise regularly, adopt a low-fat diet), what Lawton (2002) calls 'current orthodoxies of preventive medicine'. On the other hand, these lifestyle choices were recurrently mentioned as bedrocks of healthy lifestyles in the interviews as well.

For analysing contrary themes and gendered meanings attached to health-related behaviours, I examined the interview talk in two respects. First, I wanted to clarify to what extent there is an agreement on healthiness or un-healthiness regarding each of these activities. In reading the interviews, I paid attention to whether possible health consequences of selected behaviours were either taken for granted resulting in a strong, shared agreement on its healthiness or un-healthiness or, instead, contested, challenged or even rejected (weak agreement). I further analysed the counterclaims and negotiations in order to identify the contrary themes requiring negotiation in interaction. The second aim of the analysis was the extent to which these activities were described in gendered terms. In this analysis, I concentrated on all such expressions that involved gender either explicitly or implicitly. The most obvious gendered distinctions were those where the participants expressed ideas of a specific activity being mostly something that 'we' or 'they' do, or what men or women are mostly interested or involved in ('definition by difference').

The list of activities included is deliberately limited and does not cover many important topics such as car-driving, sexual behaviours or occupational safety. Rather than describing the wide variety of health-related topics and behaviours in men's lives, the analysis is aimed at clarifying the role of gender in the most widely discussed elements of healthy lifestyles. It is also worth keeping in mind that conceptualising activities like drinking or eating as 'health-related behaviours' within the interview context does not, obviously, reflect the differing ways in which the same activities are given meaning in other contexts of everyday life. In approaching the participants' talk about these activities as a discussion of 'health-related behaviours', I do not intend to claim that the participants themselves would interpret the activities as 'health-related' in all possible contexts. On the contrary, these discussions should be read as highly context-bound considerations of four different activities which, in the interview setting, are called 'health behaviours'.

7.1 Physical exercise

Physical exercise and health

As demonstrated in Chapter 4, physical exercise and good physical condition appeared to be central themes in men's health talk. Throughout the material, men pointed to physical exercise as a profound means to improve health. Agreement on healthiness was, thus, very strong. Not a single participant expressed ideas about exercise being futile for improving health. It is still worth noting that there were, again, exceptions to this rule when the discussion moved from general exercise to concrete activities; both excessive training and certain types of sports and 'wrong' ways of performing physical exercise that may lead to injuries were considered to be harmful for one's health.

The interviewees generally assessed lack of physical activity and a sedentary lifestyle to be central constituents of bad health and emphasised the importance of regular physical exercise in maintaining and improving health. Whilst lack of physical exercise was seen as a negative extreme of personal inactivity, the participants also frequently pointed to excessive training which, in turn, represents another negative extreme of inordinate activity. Though emphasising the regularity of physical exercise, the participants often stated that nothing should be done in excess. Excessive training was doomed in that it may predispose people to injuries, which counteract the positive effects of physical activity to health. In addition, at a more abstract level, the idea of excessive training was considered deleterious because of its obsessive character.

In her study among British middle-class families, Kathryn Backett (1992a) found her respondents often constructed their health-related ideas in terms of balance. Disapprovals with excesses in behaviour were expressed in terms of 'everything in moderation', 'not going overboard' and a desire for 'balance' between different health-related practices. Excessive training, which participants of my study referred to, may easily be seen as a behaviour breaking the balance in lifestyle. From the point of view of balance, any excess trespasses the equilibrium between healthy and less healthy, or detrimental, behaviours. However, the balance does not only concern concrete activities but general attitudes to health as well: 'For the majority of this sample an over-concern with health could be viewed as fanatical or obsessional and thereby as, in effect, unhealthy' (Backett 1992a, 263). It may be argued that any excessive activity can be disapproved of its obsessive nature, even without explication of potential negative health effects. In the continuous search for self-control, obsessions represent uncontrolled behaviours and uncontrolled selves.

Another topic where possible counter-effects of physical exercise were discussed was in relation to certain types of sports involving heightened possibilities for injuries. An even more important theme was the 'wrong' ways of doing exercise. The participants emphasised, in much the same way as discussions on excessive training, that physical exercise should not be conducted in extreme and/or fatiguing ways that increase the chance of injuries. Although this comes close to disapproval with excesses, criticism of the 'wrong' ways of doing exercise is oriented with technical performance and knowing how to exercise in the right way. It was often pointed out that every person should 'know his limits'.

As noted above, the participants widely agreed with the positive health-effects of physical exercise and the only criticisms concerned excessive training and the 'wrong' ways of doing exercise. Although all these critical insights focused on possible injuries representing counter-effects to health, injuries were interpreted in other ways, too. In the excerpt below, the participant answers my question about how he evaluates his present health.

Excerpt 7.1.

T6: Well the way it is, is that when they say that (2) an athlete has (.) doesn't have a day's good health, except on sick leave, *if he could stay* (on sick-leave, smiling)..
IP: Yes.
T6: (bursts into laughter) There's always <u>something</u> (.) one thing and another (1) there are bangs, again I got an injection to (.) shoul- (.) I mean the elbow.
IP: ahah.
T6: That's how it <u>is</u> (.) <u>nothing else</u> but those (.) all right, no, no problems, <u>feeling good</u>, that's all there's to it.

IP: Yes.
T6: No diseases of that so *that*
IP: Hmm.
T6: What's normal is (.) it's from skiing, it's from work
IP: Aha.
T6: You never know.
IP: Aye (.) ye[s.
T6: [*Like* this here (pointing to elbow) is again something from a hobby
IP: Ah[a.
T6: [From just one time out rowing (.) this got sore
IP: Aha (.) [aye
T6: [and it didn't go away. (T6:1, born 1946.)

Although the majority of talk about injuries from sport and exercise dealt with ways to avoid injuries which, in turn, were described as indications of the 'wrong' ways of doing exercise, the participant in Excerpt 7.1 does not consider injuries from this perspective. Instead, he takes the injuries for granted as an inevitable part of physical exercise. More precisely, he considers injuries to be an unavoidable part of *an athlete's lifestyle*, which is what he indirectly identifies himself as by referring to a proverb (an athlete doesn't have a day's good health). Simultaneously, taking a subject position of an athlete absolves the speaker from potential accusations of being careless for the injuries and damage to health. From this perspective, the excerpt illustrates how an identity of an athlete is valued to an extent which exceeds the normal imperative of responsibility for health obliging 'ordinary people' to avoid negative health-effects from, among others, physical exercise and sports.

As the only exception to the rule of avoiding injuries, the previous excerpt is also interesting from the point of view of gender. Sabo (1989) has noted that sports are one of the rare areas of life in Western cultures where pain is more important than pleasure. In his view, 'the pain principle' of sports is particularly important to boys and men, since the early socialisation to sports culture frames adult men's perceptions as well.

> Boys are taught that to endure pain is courageous, to survive pain is manly. The principle that pain is 'good' and pleasure is 'bad' is crudely evident in the 'no pain, no gain' philosophy of so many coaches and athletes. … We learn to ignore personal hurts and injuries because they interfere with the 'efficiency' and 'goals' of the 'team'. (Sabo 1989, 185.)

Following Sabo's line of thinking, the previous excerpt might also be read as a construction of a masculine identity that is based on physical toughness, ability, and endurance, which are often associated with and communicated through achievements in sports (cf. Connell 1990). Somehow ironically, the injuries from sports work as

'achievements' as well, representing internalisation and compliance with a masculine way of doing exercise. However, in order to analyse constructions of masculinity in relation to physical exercise more thoroughly, and potential conflicts related to it, we need to get back to more explicitly gendered features of this talk.

Gendered forms of physical exercise

In discussions of unhealthy ways of performing sports, excessive training and 'wrong' types of sports and technical performance, the participants repeatedly noted that women generally tend to have more rational and healthy ways of doing exercise. It was concluded that women typically do not perform physical exercise to excess but, instead, do exercise in more moderate and balanced ways. Despite this general tendency, some of these accounts included ambivalent features.

Excerpt 7.2.

P4 (-77): well I at least have a bit this feeling that like (1) nowadays women go in for exercise more (3) I don't know the figures but somehow just this feeling that women go to more fitness classes and aerobics and (3) and that sort of things (.) that women actually do maybe even more exercising (3) than men which, I suppose, wasn't (1) which earlier used to be just the other way around.
IP: Aha..
P2 (-75): Maybe women, women maybe go in for sort of sensible (.) sensible exercise like (.) in a way sensible exercise, something like (3) something like (1) walk-, walking and something like that and if you think (1) they have to go out and walk when they (other women) say "how about a walk", but yourself you (a man) get this (.) bugger, running or somewhere, sort of something sensible but just like you know (laughing) (.) That women maybe can take it a bit (.) take it sort of easier and it doesn't have to be always like (.) always like, you know, all swe-, sweaty and it's like maybe (2) maybe in a way, in a way a bit like (.) maybe more suitable exercise for women. You shouldn't bust a gut if you go to do something. (FG1:17.)

Participant P2 points to women's more reasonable and moderate ways of doing physical activity and takes walking as an example of women's moderate and more rational ways of doing physical exercise. He also contrasts women's activities to those of men in noting that women's types of activities differ from men's in that they are not performed to extreme levels. On the other hand, within the accounts of women's reasonableness, there are other tones involved, too. While discussing walking, the speaker simultaneously distances himself from walking by expressing his preference to go out for a run. In addition, he also contemplates that activities involving lower efforts might be generally 'more suitable for women'.

In my interpretation, this vacillation is caused by the tensions between cultural assumptions of distinctive features of men's and women's ways of doing exercise and their assumed healthiness. These tensions lead to negotiating different sides of physical exercise in order to find an appropriate location for the speaking self. On one hand, expectations related to healthy physical activities lead to disapproval with excessive training. On the other hand, the speaker seems to be obliged to make a distinction between men and women on the suitability of different types of activities as well as ways in which these activities are performed. Arguably, this is due to potential femininity attributed to certain types of physical activity. This tension is most clearly seen in the way the participant talks about 'sensible' ways of doing exercise in two different contexts. At the beginning of the account, when discussing women's exercise, 'sensibleness' refers to an avoidance of extremes characteristic of men's exercise. When distancing from walking he, in turn, uses the word sensible to describe a meaningful and purposeful way of exercising, which contrasts with women's non-goal-oriented walking.

When physical activity was discussed in general terms, it became noticeable that the 'right', moderate way of doing physical exercise was located between the two extremes of a lack of exercise and excessive training. In the previous excerpt, where gender is explicitly involved in the discussion, the accounts move to more concrete definitions of different types of physical exercise and their suitability for men and women. As we shall see later in the chapter, there were clear distinctions between different types of exercise in their gender-appropriateness in the interview material. Simultaneously, the spectrum of exertion of activity is articulated in a more detailed way. While general considerations of physical activity operated on a relatively simple scale of *lack of exercise – moderate exercise – excessive exercise*, gendered talk about activity requires a redefinition of the category *moderate exercise*. In my interpretation, the participant's expressed preference for running refers to the effectiveness of the activity. While walking might be more reasonable when compared to excessive and extreme forms of physical exercise it represents *an activity which may be 'too moderate', i.e. ineffective*. Therefore, the category of moderate exercise is split into two differing types of doing exercise: ineffective exercise and moderate but effective exercise.

Figure 7.1. Divisions of healthy exercise in general vs. gendered accounts

The effective, 'sweaty' way of doing exercise parallels with ideals of sports where effectiveness of exercise, necessary for gaining achievements, is measured by efforts, commitment and pain ('no pain, no gain'). As these requirements for a 'sensible' way of exercise are detached from women's physical exercise in the excerpt, it may be argued that the construction of gendered divisions of exercise is based on an association between men's 'effective' exercise with 'sporty' ideals and women's 'ineffective' exercise with qualities of recreational non-target-oriented exercise. Both of them are thus 'in a way sensible' ways of doing exercise when interpreted within the context of gendered expectations related to exercise. The speaker concludes this at the end of his account when saying that the 'ineffective' exercise is 'maybe in a way, in a way a bit like (.) maybe more suitable exercise for women'. As noted several times earlier, the formulation is again cautious highlighting the participants' overall tendency to avoid strict and categorical statements about men and women.[1] Despite this, the gendered construction of suitable exercise for men expressed above operates with a binary opposition where 'masculine sporting competence is opposed to non-masculine (or feminine) inactivity or lack of skill' (De Visser & Smith 2006, 686.)

In the previous excerpt, the participants mentioned a few types of physical activity that they saw as women's preferences for physical exercise: gymnastics[2], aerobics and walking. These were the most often mentioned gendered physical activities throughout men's interviews. However, by saying that those activities are gendered, I do not point only to men's tendency to describe them as belonging to women's preferences in choosing a suitable type of physical exercise. These activities also involve deeper gender-related attributes as will be discussed in the next excerpt. It is the latter part of an interview episode from a focus group whose first part was analysed in Chapter 5 (Excerpt 5.11). The discussion started from the notion that 'women's magazines' include a lot of articles related to health and well-being and with my question of whether women, then, are more interested in health issues. As the discussion goes on, one of the participants discusses femininity in terms of 'fussing' publicly about health by pointing to aerobics as the 'wrong' type of physical exercise for men.

[1] From this perspective, it is interesting to pay attention also to the discursive structure of the account. The 'men do sporty things' argument is 'sandwiched' in-between the presentations of an alternative argument of 'avoiding extremes is sensible' which, according to Riley (2003, 103), provides rhetorical strength to the previous argument by 'acting to inoculate, or protect, the speaker from being categorized as having only one perspective, while effectively arguing for this perspective'.

[2] The original Finnish spoken-language word used in the excerpt, 'jumppa', refers to gymnastics but has broadened to cover other similar types of physical exercise such as aerobics or guided exercise conducted at work places during the breaks. It is, however, a clearly gendered word which refers to women's activities.

Excerpt 7.3.

P5 (-75): And it's maybe on th-, on the other hand there's also that it's (.) it's maybe a bit effeminate (.) to read Men's Health and (.) er gabbing on about diet and (.) the re:st of it.. (.) Of course if the other lads are of the same type, it might then be quite (.) natural but it's on (.) yes (1) yes, on average it's maybe not (.) it's maybe a bit (.) it's a bit (1) effeminate when you, you know (.) talk too much about, well (1) they (women) maybe have a bit different (.) different kind of attitude (.) er (.) [to well-bei[ng.
P2 (-78): [Well (.) [there you see it. You go on a break and say "Anybody going to aerobics tonight?", well (.) (All start laughing) No (.) No way. (.)You'll have plenty of time to yourself after that (.) so..
IP: But that was (.) what like Mika (P2) was just saying there that well (.) there's quite a bit like (.) and when we're talking here it's just for men that it's come up this exercise so that (.) that for men like this doing health (.) what (.) what we do for our health, it hangs a great deal on thi- this physical condition (.) like. So I suppose what it's down to is that talking about exercise (.) sport is OK. (1)
P2 (-78): Mmm
IP: Of course (.) aerobics might not be quite the right type of sport! (laughter)
P2 (-78): It was (.) it was a bit of an exaggeration[
IP: [Uh[uh.
P2 (-78): [but as (.) however (.) however it's *such like*..
P5 (-75): But very well this (.) really in those exercises during breaks (.) that we have, well (1) er (.) you know (.) (chuckles) well ther-, (.) there (.) almost all the women take part (.) in the break exercises but it's (1) like (2) many men leave it out altogether (.) even if they were completely like (.) free, no meetings or anything (.) they just simply don't take part, it's like too high a threshold for them to come (.) er (.) to do exercises even though it would undoubtedly do them good when they (.) sit (.) *in a room and gape at the* [*screen*
IP: [What is (.) what is then the threshold there?
P5 (-75): Don't, don't (.) I don't know what (1) what it can be there (.) maybe it's (.) maybe i-, I don't know if it's (.) do they think it's somehow effeminate, it's embarrassing to go there like (.) with the women (.) in a way (.) or to go there to perform a bit sort of (.) aerobic (chuckling) type movements. I don't know then. (FG2:16–17.)

As was concluded in Chapter 5, P2's comment about a man going on a break and asking his workmates whether someone is going to aerobics tonight embodies a highly female-attached way of physical exercise which, in turn, serves to illustrate how public 'fussing' about health – and especially expressing 'wrong' types of interest in it – is not expected of men. That the rest of the participants burst into laughter immediately after P2's comment demonstrates the shared nature of this knowledge. The conclusion that 'you'll have plenty of time to yourself after that' articulates the potential threats arising from that kind of unacceptable behaviour referring to social isolation within the male company.

From the point of view of gendered meanings attached to physical exercise, the continuation of the discussion includes interesting issues, too. When I make my rhetorical question about whether aerobics is not regarded as the right type of sport for men, the previous speaker (P2) softens his previous comment by belittling it: 'it was a bit of an exaggeration'. Accordingly, we may again conclude that making overly strict categorisations on men and women within an interview seems to be considered as somehow politically incorrect, which leads the speaker to rectify his account even without any criticism directed towards him. Another conclusion is that the tension related to political correctness primarily concerns the interviewee and the interviewer, and not the other interviewees: it is the interviewer who is mostly suspected as having possible counterarguments.

In P5's last account, men's reluctance to participate in exercise during breaks is explained by the fact that the men may find it 'effeminate' or 'embarrassing' to join the group where the majority of participants are women. Why this is so may be seen to be a result from the dually effeminate character of this type of exercise. First, as women form the majority in the concrete exercise group during the breaks, the whole activity is thus easily seen as feminine. But simultaneously, despite local and particular characteristics of a specific group, the activity also generally holds feminine characteristics related to exercise having similar features with aerobics. It is also these potentially effeminate effects of aerobics that make it possible for the speaker to claim that men are reluctant 'to go there to perform a bit sort of (.) aerobic (chuckling) type movements'. The previous excerpt is thus an illustrative example of how generally perceived gendered connotations of certain types of physical exercise are interpreted and used as arguments in local settings and particular contexts.

7.2 Nutrition and diet

In Chapter 5, which dealt with interpretations of health information in interview talk, nutrition was clearly the most frequently discussed topic when uncertainties related to health information were considered. Information on healthy diets was frequently used as an example of fluid information about health, justifying a general conclusion that health information cannot be seen as completely reliable. One potential reason for this is the broad media coverage of food and diverse risks related to nutrition that the interviewees themselves referred to. This notion does not, however, provide us with a full picture of how nutrition is discussed in the interviews. Despite the uncertainties expressed in relation to nutrition, it was also evident that the participants knew about the central advice for healthy nutrition and claimed to have followed the advice

without criticising the information in this context. In my view, this contrast between the two ways of talking about food and health derives from two distinct contexts. While the information may be criticised at a general level, talking about individual health and health-related lifestyles again brings up the normative expectations related to making healthy choices in life.

Another possible reason for frequent criticism on food information, discussed in Chapter 5, was the potential feminine meanings attached to food and diet. Throughout the interviews, nutrition was the theme which most clearly included references to women and femininity among the four health-related behaviours analysed in this chapter. Thus, it might be argued that nutrition seems to be the most gendered topic among those discussed here. 'Genderness' of nutrition was, first, seen in how cooking, as well as making choices about the food the family eats, were said to be women's responsibility. Many respondents explained that it is women who are primarily responsible for cooking and shopping for food for the family, hence their greater interest in food and nutrition (see Excerpt 6.9). As Roos, Prättälä and Koski (2001, 47) have observed, 'food itself is coded as feminine because purchasing, preparation and presentation of food is in many senses regarded as essentially women's work'. Secondly, women were frequently claimed to be more interested in food and diet, compared to men, due to the large coverage of dieting/ nutrition issues in magazines and TV-programmes principally directed at female audiences, as we saw in Chapter 5 (see also Excerpt 7.3 of this chapter). Thirdly, in relation to the latter, nutrition is claimed to be more of a 'women's issue' because of women's alleged interest in control over body-weight and keeping slim. Among gendered attributes attached to food and nutrition, this was the one that provoked the most resistance among men. This is because in cases where diet is linked with being on a diet, controlling body weight and appearance (keeping one's figure), nutrition is associated with aesthetic values that are culturally attributed to femininity and are, thus, something that men must oppose (Aoki 1996; Tiihonen 2004; De Souza & Ciclitira 2005). The latter gendered perspective was previously discussed in Chapters 5 and 6.

As several examples of the previous analyses have shown, the participants tend to estimate the healthiness of their own lifestyle differently from contexts where healthiness is discussed on a broader and more general level. Despite criticism of the fluidity of information and highly gendered attributes attached to food in non-individual contexts, the men without exception asserted their compliance with healthy eating when talking about their own diet. However, these accounts included contrary themes and were not that coherent as when talking about 'people in general'. Both dilemmatic themes of the obscurity of healthy food and its association with femininity were incorporated in talk about food and nutrition, but in a significantly

more subtle form in comparison to non-individual contexts. The negation of these contrary themes is the topic of analysis in this section.

Tension between healthy food-habits and 'gabbing about diet'

When asked directly about the healthiness of their own diet, the participants not only tended to assess their diet as healthy but also expressed arguments supporting this claim, thus highlighting the normative expectations involved. The most typical argument was to express moderation in terms of food consumption, a balanced and varied diet and keeping routine eating times. However, it was striking that the majority of descriptions of healthy food did not explicate the terms as 'varied' or 'balanced' diet. In some cases the participants named types of foods they avoided ('greasy' or 'junk' food) or, in rare cases, the food they ate (emphasising eating vegetables) as markers of their healthy diet. In these arguments, however, a notable feature was that the argumentation was more frequently based on avoided food-stuffs rather than lists of healthy ones. In some cases, the participants based their argumentation on cholesterol measurements or some other medical tests.

The normative expectations were also manifested in the ways in which *other people's* unhealthy eating habits were described. In many cases, the participants depicted other peoples' (especially work mates') eating habits in a deprecating tone, suggesting that 'many of them do not pay any attention to what they eat'. This can be read as the construction of an identity of a responsible, healthy citizen whose qualities are implicitly expressed in taking distance from those who act carelessly, the 'unhealthy others' (Crawford 1994).

Parts of the next two excerpts have previously been analysed from the perspective of how medical tests are being used in the self-evaluation of health (in Chapter 4). I return here to the same excerpts, another in its full length, from another perspective in order to illustrate 1) how healthiness of one's own diet also requires justifications due to normative expectations related to healthy lifestyles and 2) how 'moral work' involves potential conflicts and threats to identity which are, then, resolved by distinction-making with other groups of people.

Excerpt 7.4.

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IP: Yes, there was someone (.) someone said that like (…) shift-workers have
pretty much these over-weight problems (.) or that you can have them when
there's when no time (T4: hmm) to have regularly any physical exercise and,
and anyway (.) you still eat (2) eat sort of (.) possibly even around the
clock (T4: aye) when you're in the night shift and so. Well have you had
talk about this there (at workplace)?
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T4: Well (3) I wouldn't sa:y we have, there's one who's slightly ove-, overweight in our shift, but he's surely not having any physical exercise and (2) likes sweet stuff and (IP: Aye.) (2) But there's not been any that sort of chat about it that.. (IP: Aye) But yes there are plenty of them (1) in our (.) work place, who have like over-weight and so (IP: Hmm) They fetch sausage from there (chuckling) (IP: Aye.) from the store and (IP: Aha.) Some shifts have even such a habit that they (.) fetch like kilos of it, (both chuckle), sausage.
IP: Well it's surely fast (T4: aye.) when you fetch it from close range (T4: aye) (3) Aye (.) Aye and then we get onto the eating bit then you're (.) you're (.) you think you own diet is still pretty good as it is?
T4: Aye, oh yes Pajamäki (the occupation health doctor) (1) when he was looking (2) at those blo-, blood values, well, he says that (.) *that* in his opinion there's no (.) no need to make any (.) changes in the *food* and habits that *they're*..
IP: Like the cholesterol values are?
T4: That was exactly five.
IP: Aye.
T4: I've had it even lower, it's been four-six, four-seven but (.)
IP: Yes.
T4: It was exactly five and then the good cholesterol was one-nine-two that (IP: Aha.) he said it's that high it (.) now was if ADL or HDL, (IP: well) whichever it was but (.) that it was that high (.) that it's just fine and (IP: aha.) the liver values were (1) twenty-three and that's, I suppose, (3) *now is it* from zero to eighty the (.) (IP: mm) so there's still (.) so I can still afford to take a drink (laughing).
IP: (laughs) Aye.
T4: And then the (2) missus, well (.) yes, she gives me salad every day and tries to feed me it that (2) (IP: Aye.) (.) And she doesn't do any fatty food and (.)
IP: mm (1) Yes.
T4: *Like that*.. (T4:8, born 1949.)

This part of the conversation starts with a consideration of the influences of shift-work on weight control and goes on to eating habits of the participants' work mates. When describing the eating habits of some of his work mates, the participant does not include himself in the group of workers who eat sausages in the night-shift ('they fetch like kilos of it'). Nevertheless, his own role in buying and eating sausages during the night-shift stays partly open, since he does not say explicitly that he does not do it himself. For this reason, it is interesting how the discussion continues. In response to my question of how the participant himself evaluates his own diet, he does not give his own assessment but, instead, formulates his answer on the basis of conclusions of the occupational doctor and blood tests. In his argumentation, the doctor's opinion ('there's no need to make any changes in the food and habits') gives an unchallengeable justification for a claim about the healthiness of his diet.

The participant's long and detailed consideration of his blood values could be argued to be an in-advance reaction to a potential accusation, from my side, of him eating unhealthy food, too ('are you sure you haven't gone to the store yourself?'). Even

if that was not the case, it is evident that the participant is giving his best evidence to assure me that his eating habits are healthy or, at least, that they have not caused him any health problems. After detailed discussion of his blood values he further fosters the idea of his healthy diet by referring to his wife, who gives him 'salad every day' and 'doesn't do any fatty food'. This description includes, however, sudden contradictory elements. While the thread of the story is to convince the interviewer that he follows a healthy diet, he suddenly says that his wife '*tries* to feed' him salad, which seems to be in conflict with other expressions. The verb *try* might indicate that the speaker is actually reluctant to eat salad, and that it is solely his wife's intention to get him to eat healthily, which does not fit other parts of the speech.

In my interpretation, the speaker's subject position is threatened in two different ways. The first threat occurs when his work mates' eating habits are under consideration, which forces the participant to reconsider 'us-ness' of this category. As he describes some of his work-mates as having unhealthy eating habits, this predisposes the speaker to potential accusations of unhealthy eating, as a member of the group. As a reaction to this he, in the middle part of the excerpt, distances himself from the irresponsible work-mates and constructs a healthy identity. At the end of the excerpt the participant, however, faces another threat. An overly ardent attitude to a healthy diet might create an association with effeminate behaviour such as 'gabbing about diet' (see Excerpt 7.3 above) and 'fussing about health'. The distancing is made by describing cooking as women's responsibility[3] ('*she* doesn't do any fatty food'), and attributing interest in healthy diets as a subject that concerns women ('*she* tries to feed me salad'). The verb try suggests that he himself does not (fully) share these feminine values and concerns. From the point of view of gendered features of a healthy diet it can be argued that the excerpt demonstrates the border between masculine and feminine areas related to food. Considering test results and other (technically based) objective facts are appropriate means for justifying the healthiness of one's own diet, especially in a potentially conflicting situation. On the other hand, however, an active everyday concern for one's health and diet is considered to be feminine which could, therefore, lead the speaker to another dilemmatic position during the course of the interview.

As mentioned above, the feminine attributes of diet were rarely topics of conversation when food was discussed in a personal context. Rather, the participants took the subject position of a health-aware citizen and expressed disapproval of some

[3] One means for distancing himself from the feminine area can be found in the way how the participant calls his wife. The Finnish word 'emäntä', translated here as missus, means originally a farmer's wife. Use of this term augments the idea that cooking belongs to women's responsibilities by referring to traditional division of work in agrarian communities. Nowadays, the term also collocates in urban working class language.

other people's unhealthy eating habits, as was discussed in relation to the previous excerpt. The next excerpt follows the same line of reasoning.

Excerpt 7.5.

IP: By the way how (.) I forgot to ask at the time I was asking about how you yourself estimate your health, well, at the time I forgot to ask that (.) how if you compare er your health to other men of your age (.) well what do you think of your health?
K7: Well (.) I would say that it's well (1) above the average certainly that (.) even if, if you only look at the blood values so (.) that already (.) that alone *so that* (2)
IP: Aha.
K7: *and that* (.) it's *because* the exercise bit is in (.) and that you can also see in the stuff they bring to eat (.) that, well (.) at least it seems to me straight off that that (.) I can already see it in the food (.) which of us, sort of (.) which of us has a body in better co-, condition, *so*.. (entire speech with laughter.) (K7:12, born 1968.)

In this excerpt, food choices are used as an additional argumentation to the speaker's better physical condition compared to other men of his age. Although 'the stuff they bring to eat' is not specified, it is obvious that it refers to unhealthy food. In this way the other people around him (where he is arguably referring to his work mates) differ from the speaker in relation to their physical condition, which the speaker 'can already see in the food'. Food, in this instance, becomes a signifier of healthy lifestyles, a marker of those who take care of themselves or those who do not. However, it is interesting that the whole speech about food is expressed with smiles and laughter. This might be taken as an indication that the speaker wants to soften the ideas he is expressing. Criticising work mates for their unhealthy habits and positioning oneself in a better and more valued position on the basis of this is a morally fragile project, which may easily result in being heard as arrogant, contemptuous or as a health-fanatic. It is then plausible to assume that laughter creates an atmosphere where this criticism might be taken as intentional exaggeration which, in turn, frees the speaker from accusations.

Extremes of gendered food: salad and sausage

In most cases when men assessed the healthiness of their own lifestyles, femininity associated with a healthy diet was not explicitly discussed. Instead, the discussions were dominated by health-aware notions of attempts to eat healthily. Only in a few cases was the potential conflict between femininity and the masculine self of the speaker even referred to, in a more or less implicit way, as was the case in Excerpt

7.4. In discussing personal diet, there were no explicit expressions of a tension (or an ideological dilemma) between healthy nutrition and masculinity. This is an interesting finding taking into account how frequently the participants, in non-personal contexts, took food and diet as examples of feminine health issues and pointed to 'gabbing about diet' as effeminate behaviour. In my view the plausible explanation for this is that the personal context calls for health-aware and responsible responses, which limits the variation of descriptions.

Within all this 'health-aware' talk about food and diet it was somehow confusing to me that very often healthy diet was not specified in any way, despite vague notions of 'varied' and 'balanced' diets. This was particularly notable in the lack of statements about concrete healthy food-stuffs. In accounts of unhealthy eating habits, the most often mentioned issues were 'too much fat', 'too much salt' and 'too much sugar', accompanied with references to irregular eating hours, which was expectable in the case of shift-workers. In a few cases, unhealthy nutrition was described in terms of lack of vegetables, i.e. through deficiencies in diet. Basically all the rest of the accounts operated with terms such as 'bad diet', 'unhealthy nutrition' or 'junk food'. This gave me the impressions that a 'healthy diet' is most often described in a negative manner: healthy eating involves avoiding unhealthy food.

Throughout the interviews there were, however, two exceptions in the general rule of the absence of concrete food-stuffs incorporated in men's talk about healthy/unhealthy food. Several participants took up, at some stage of the interview, two food-stuffs: salad and sausages. When I started to read those parts of the interviews in a detailed way, I shortly realised that those foodstuffs were used similarly in two different contexts. First, 'salad' was used as a signifier of healthy food while sausage was the marker of 'greasy' and unhealthy food. This distinction had, however, a clear gendered dimension as well. In talking about men's and women's diets, as well as gendered attributions of food, several participants referred to men's tendency to eat sausages and women's preference for salad. In this way 'salad' was a signifier of healthy, feminine food while sausages exemplified unhealthy, masculine food. Although some participants mentioned other foodstuffs in gendered contexts as well (e.g., full fat milk and heavily salted butter, see Excerpt 6.9), the sausage/salad distinction was the only systematically gendered division of foodstuffs frequently mentioned.

O'Doherty Jensen and Holm (1999) found in their extensive review of literature on gendered features of food that in most European countries the national survey studies have reported a similar tendency in men's and women's food choices. While the greater proportion of energy consumed by men is derived from meat, animal products and alcohol, women eat significantly more vegetable products and fruit. In Finland, according to the survey of the *Finnish National Health Institute* (Helakorpi

et al. 2003), the percentage of women and men who had eaten fresh vegetables 6–7 times during the past week were 45% and 29%, respectively. Furthermore, 27% of women reported that they had not eaten sausage dishes in the past week while 10% reported having done so 6–7 times during the past week; the respective shares among men were 13% and 19%. Thus, there seems to be a gendered distinction between men and women in the food choices of vegetables and sausages, reported in survey studies.

In addition to the concrete meanings of certain food-stuffs, it was clear that the salad/sausage distinction was a symbolic division in interviews as well. Presumably, 'sausage' was in a sense a general term to signify unhealthy food with a clear gendered division. It was also notable that 'sausage' was systematically used as an example of other men's unhealthy eating habits; the participants did not talk about their own sausage consumption. It might be argued, then, that 'sausage' was the term used to denote concrete contents of diet of *those men who were seen as having unhealthy eating habits*. Similarly, salad was often referred to mean other vegetables too, and used as an upper level general term for 'green stuffs'. Salad was also a gendered term in its frequent association with women's diets. Yet there were two differences in the use of the term 'salad' in comparison with 'sausage'. First, the men used the word 'salad' to describe the consumption of vegetables generally. Secondly, while no one used synonyms to describe sausages, salad (and vegetables generally) was also referred to as 'green stuffs', or even 'rabbit food'.

Excerpt 7.6.

IP: Now here somebody said that well (.) if them women know more about health and are more interested then it (.) then they should like transfer it more (.) to men (3) this that they know and their expertise. What do you think of that?(2)
K8: Oh yes it certainly back home there when you (women) trans-, transfer it there certainly, yes there easily comes the sharp objection that (.) go, go yourself (unclear) (IP: Yeah, yeah.) that's about information then.
IP: So do you mean exercise or what?
K8: Yes and generally, yes, exercise.
IP: Yeah, yeah.
K8: Then when they (women) put the dishes of rabbit food before you and there's many a one (1) that doesn't eat it. (…) I'm talking generally (IP: Uhuh, oh yes, yes), (1) as far what I've seen from the side.
IP: So men like don't (.) don't take much of it.
K8: No, no they don't. (K8:12–13, born 1971.)

As mentioned earlier in this chapter, the discussions on personal food choices rarely included even implicit references to the potential femininity of certain dietary habits. In non-personal contexts, in turn, the conflict was sometimes expressed in even

drastic ways. While not one of the interviewees used expressions like rabbit-food when talking about their own diet, the non-personal contexts allowed for the use of this type of term. A notable feature of this, as in the excerpt above, was that the speakers distanced themselves from having negative attitudes towards eating vegetables, while using belittling terms fluently in non-personal contexts. The interviewee expressed the idea that there are 'many' men who do not eat the rabbit food offered to them by women and justifies this claim by what he had 'seen from the side', indicating that this does not represent his own ideas. The distancing is further strengthened when I inserted an additional and generalising question ('So men like don't take much of it?'). Instead of relating his idea to consider some but not all men, the participant categorically states 'no, they don't'. Even though explicit conflicts between the feminine interest in healthy food and the masculine self did not appear *in personal contexts* when discussing food choices, *discussions of food included features of hidden dilemmatic relations between diet and masculinity*. This was evident in the differing terminology used to denote men's and women's diets.

7.3 Alcohol

Alcohol was among the most widely discussed themes in the interviews and was often spiced up with 'laddish' humour. However, when I started analysing the discussions on alcohol in the interviews, I got the impression that alcohol was somehow, simultaneously, both present in and absent from discussions. It was present in that alcohol drinking was quite often discussed, especially when compared to some other health-related issues, such as smoking. It was also present as a recurrent theme of humour, particularly in the focus groups. Nevertheless, at the same time, the majority of all discussions on alcohol were notably superficial compared to other health-related topics. When reading the transcriptions and listening to the tape-recordings, I had a feeling that many of the participants tried to avoid overly personal discussions on alcohol. A recurrent phenomenon in discussions on the health influences of alcohol was that they finished with an overall notion of the importance of 'moderation' in relation to drinking, without this rather obscure concept being defined in any explicit way (with few exceptions that I will discuss below). This resulted in a lack of more thorough considerations of alcohol and health. In addition, humour emerged as a discursive means for the participants not to get too seriously involved in discussions of alcohol.

The simultaneous presence and absence of alcohol in the interviews led me to reconsider the task I had set for the analysis. As the alcohol episodes seemed to be

partial and biased, how would it be possible to analyse the patterns of the speech that were set as objectives of the analysis, i.e. negotiations of healthiness/un-healthiness of alcohol drinking and constructions of gender in relation to alcohol?

In re-reading the interviews, I shortly noticed that the two types of materials, the personal interviews and focus groups, differed from each other in alcohol talks in two major respects. First, while alcohol drinking was quite often discussed in personal interviews, the focus group discussions included significantly fewer, and more superficial, contemplations of drinking. Secondly, while there was lots of humour involved in the alcohol talks in focus groups, the personal interviews involved other modes of speaking as well. Alcohol, and especially the participant's own alcohol drinking, was also discussed in rather serious ways, instead of humour. The noticeable differences between the two materials led me to analyse the discourses on alcohol in personal interviews and focus groups in a more detailed way. It became evident that before being able to move towards the original objectives of the analysis, the differences between the two sets of data needed to be clarified. As the personal interviews were characterised by discussions of drinking in moderation while focus groups served very little material for analysis, despite the use of humour, I decided to focus my analysis on these two topics: drinking in moderation and alcohol-related humour.

Health and alcohol in personal interviews

Alcohol was relatively frequently discussed in personal interviews as a determinant of health. Eight of 15 interviewees spontaneously mentioned the use of alcohol as one of the factors associated with health in lists of health-related factors that the interviewees prepared at the beginning of interviews. In addition, alcohol was also discussed in almost all of the rest of the personal interviews, where the discussions were initiated either by me or the participant. In the personal interviews, alcohol was discussed both in the contexts of an individual's health and men's health, in general. In the contexts where alcohol was discussed in the interviewee's personal life, the obvious first question concerned the frequency and the level of consumption that the interviewee drinks. As expected, the answers varied.

Some of the interviewees commented that they used alcohol very little (such as 'just a beer after sauna') indicating that alcohol did not have any significance in their life and did not influence their health. Particularly in these cases, as alcohol was not a major, distinctive topic of the interviews, I did not want to 'interrogate' the interviewees more about their alcohol consumption (which may, of course, be taken

as a limitation of interviews). The more interesting parts of the interviews were those where the interviewees were not sure about how to describe their alcohol consumption and started, thus, to negotiate the 'level' of their own drinking by making various comparisons. A typical point of comparison was the group of 'large-scale consumers' of alcohol, or just 'alcoholics'. References to alcoholics typically included stories about co-workers who were known to have problems with drinking and who have been directed to therapy or fired due to drinking. Many concluded that paper-mill workers are known to use alcohol more than many other professions due to shift-work, although several interviewees pointed out that the majority of alcoholics have 'dropped out' of the work force as a result of increased control at the work place. In her study on interviews with Finnish carpenters and loggers, Ritva Prättälä (1997) reported similar stories about drinkers who had lost their jobs as a result of decreased tolerance of drinking at work. Despite these changes in management, shift-workers were still described as a vulnerable group to alcohol problems because of changing working times and difficulties to get rest, accompanied with long off-duty periods. This collective 'knowledge' of the frequency of alcohol problems among the paper-mill workers rendered it possible to locate the problems in the group problem-drinkers.

References to problem-drinkers did not, however, make it simple to avoid potential accusations about one's own inordinate drinking. As noted above, non-problematic drinking was regularly defined as 'moderate drinking'. Since 'moderation' is a vague category, in the rare cases when I started to ask more concrete questions about the interviewee's drinking, the discussions resulted in negotiations of moderation. The next excerpt is from an interview, where the interviewee had spontaneously mentioned alcohol as a factor related to health. When talking about the influences of shift-work on health, he had mentioned that he often takes a couple of beers with his work-mates after a night-shift in order to get sleep in the daytime, which I was told was a problem by many of the interviewees. Nonetheless, when focusing on his alcohol consumption, I found the speaker to be reluctant to talk about it. Before the conversation in the extract, I asked the interviewee twice about his drinking habits to which he responded by talking about something else. In the excerpt I return to the list of health-related factors the participant had prepared in which he had marked alcohol with a minus indicating that it had a negative effect on his health.

Excerpt 7.7.

(Part 1.)

IP: Now how about when you put alcohol, what we were just talking about a bit (2) talking so that (1) so how does it go (1) yeah (.) you put a minus there (T3 begins to laugh) well, so[
T3: [I, thought about it for a long time myself (still laughing)
IP: Yeah, but (T3: because they..) but let's ask this way, that, that er do you (.) would you say that you (.) yourself drink too much (.) or that (.) from the point of view of your health (.) do you, in your[own opinion?
T3: [Well (5) Not as I see it, I don't (.) Somebody might see it, as I say, that I like drink often, although I don't take much. That is, of a night I'll take a couple of beers (.) or after a night shift a beer or two. (IP: Yeah) Four nightshifts (.) then I drink alcohol on four days in a row (IP: yeah, yeah) But (chuckling) I don't properly drink one day's load.
IP: Yeah, of course that's a bit different thi[ng
T3: [that is, somebody might think it's pretty (.) risky well (both laugh). So that's what I mean.

(Part 2.)

IP: Yeah, yeah, but it er.. but it didn't occur anyway to you that (.) for example, that you should cut down on drinking alcohol or something?
T3: N:o. And if that's what I thought well (.) then I'd certainly not drink (bursts into laughter) (1) that is I haven't (4) at least so far I'm not in any way addicted (IP: Mmm..) and not likely to be (3) (IP Yeah), but (.) quite many of them there do have such (1) problems (.) on shift work (2) (IP: Yeah) and even if it doesn't show on the job anymore, but *you do* hear a few of those stories from civilian life (.) (IP: aye) certainly there's all the rest (.) human relationships *and all* (IP: Yeah, right) Oh yes, (1) quite a few of us, like me, I've divorced (.) sometime ago (2) and (.) those that's divorced there's quite *a few*. (IP:Oh yes) And then when you think (.) here (1) over thirty years well (.) there's a terrible lot of lads that's committed suicides and things like that so (.) you remember (IP: workmates?) Yes you remember over the years and (IP: Ahah) quite a lot of them has been just (.) all messed up with (.) the booze. (T3:10–11, born 1949.)

The thread of the excerpt is the interviewee's attempt to define his own drinking as non-problematic, which probably arises from the way I ask the question ('would you say that you yourself drink *too much* … from the point of view of your health?'). Although drinking 'in moderation' is not explicitly mentioned, the argumentation for non-problematic drinking is based on the notion of moderation. Moderation is grounded in many different argumentative strategies that provide interesting perspectives.

In the first part of the excerpt, the participant discusses his alcohol consumption in the context of his work. As mentioned earlier, he explained drinking after a night-

shift to help him get to sleep in the day-time. At the same time, however, he insists that he drinks in moderation by noting that although he drinks often, the amounts are small. This gives him an opportunity to draw the conclusion that he actually drinks quite little because he does not 'properly drink one day's load', which implicitly gives an idea that he does not drink to get drunk. Together with the legitimate 'purpose' of drinking, i.e. to maintain work-ability by ensuring he is able to get rest, his drinking can be thought to be very reasonable, instead of problematic. This conclusion is fostered by an ironic comment that 'somebody might think it's pretty risky' which, arguably, refers to the idea that drinking too little may be considered as either harmful as such or as a sign of abnormality by other people.

After the first part, I continue the theme by asking whether the interviewee has thought about reducing his alcohol consumption. As a response, the participant baldly concludes that he has not thought about reducing his drinking because if he thought so, he would not drink ('if that's what I thought well then I'd certainly not drink'). Despite this, he goes on to formulate other reasons for not thinking he should reduce his intake of alcohol, which are based on two different issues. The first thing he discusses is dependency. By stating that he is not dependent on alcohol and does not think he will be, either ('at least so far I'm not in any way addicted and not likely to be'), he makes it evident that his drinking is under control. Another perspective is the implicit comparison between himself and those who have drinking problems. This type of indirect 'definition by difference' was a recurrent theme in men's interview talks about alcohol. Although not said explicitly, those with drinking problems define the controlled speaking self who, due to control, has actually no problems with drinking. The drinking problem is located in the wider context of (shift-) work as an environment, a condition of life, which causes many problems for all people involved. Without control, those problems defeat the person, which easily leads to drinking. Being able to resist may be interpreted as psychological and moral strength.

Another interesting theme in the excerpt, in addition to the ways in which the speaker justifies his own drinking as moderate, is how health influences are discussed. In fact, the participant does not answer my question about whether he thinks he is using too much alcohol regarding his health. The problems he mentions are more about social relations rather than health. This was a regular finding in all the interviews. Drinking was interpreted as non-problematic in terms of lack of social problems arising from any extensive and inordinate drinking, such as problems at the workplace and in the family or losing control. In just one case, the interviewee concluded that his drinking was not a problem since he did not have any health problems. Nonetheless, even in this case, the health influences concern acute

outcomes of past ways of drinking and not the future influences of current ways of drinking.

Assessments of drinking follow the same logic involved in interpretations of physical exercise in seeking moderation. In the same way as both lack of exercise and excessive training were seen, in essence, as unhealthy, absolutism was thought to be an another unhealthy extreme, as hinted in the previous excerpt. Many interviewees described absolutism as socially undesirable, as a characteristic of a person which may be taken as a sign of abnormality. In addition, in these contexts, the positive health effects of 'appropriate' use of alcohol were mentioned several times. Thus, the two extreme points of comparison, problem-drinking and absolutism form limits for acceptable, and healthy, drinking. This 'golden mean' of drinking includes, however, a large grey area in-between the extremes, an area which was not explicated in the interviews. It may be argued that statements such as 'one should drink in moderation' are examples of a rhetorical form of a common-place, which refers to shared argumentative elements of common-sense 'whose truth or desirability is taken for granted' (Billig 1996, 240, about the concept also 220–232). As a common-place, drinking in moderation is an accepted and valued norm for drinking, even though the exact meaning of the concept is lost.

Absolutism was frequently used as an extreme opposite to problem-drinking but, like problem-drinking, it was also viewed as negative for one's health. This was interestingly discussed in an interview where the interviewee told me that he has not had a drink for over five years.

Excerpt 7.8.

T1: I haven't (.) boozed, been on the booze for five years (IP: Ahah) (1) either, that (2) I haven't had a drink (2) and I'm not allowed to have one until next year when I'm fifty, then I'll (.) then I'll allow myself after that.
IP: Ahah, you allow yourself (T1: I allow myself) not the wife giving permission (laughing).
T1: Not the wife giving permission but well (.) the wife used to go on about it earlier (.) the way I drank when I had a longer time off I used to drink (.) so that for once it felt like a long time off (IP: Uhuh). And then the next night if you fancy a cup in front of the telly then *you'd pretty soon hear it* "you were drinking last night", and some funny looks, and when on top of that the wife's (.) a public health nurse by profession well (IP: Ahah) so, well (laughing). That way of course (.) the surveillance works.. (laughing) (T1:9, born 1955.)

Five and a half years ago, the interviewee had filled in a questionnaire about his alcohol consumption at the occupational health unit of the mill and marked that his family members had reacted to his drinking. To his surprise, the occupational

nurse had told him that his scores were very high and recommended he should stop drinking or at least to reduce it significantly. The interviewee had decided to 'close the bottle completely' and not to drink at all 'for a while'. After some time he had had a conversation with work-mates at the mill about a forthcoming seminar, which was assumed to end with drinking (based on previous experiences from these seminars).

Excerpt 7.9.

T1: ..on the night shift I stopped there by the finishing cutter for a chinwag with the lads, there was just one of them lads from Mänttä, well (.) then I says, that I won't take anything there (at the seminar), seeing as how I'm in dry dock right now (1) and erm the rest of them starts in a na-, nasty way asking like "well how long are you going to be like that" (in a nasty tone) and (.) that just hit a nerve and I says that "bloody hell" that "now when we're on talking about it well (.) until the nineteenth of November two thousand and five! (1) (IP laughs) That's when I'll be fifty, if I'm spared"[4]. (1) Well (.) there's an old saying that "a spoken word is like a stone you've thrown and can't take it back" (IP: Uhuh). (2) And so (1) that's what happened that (1) here I am and (1) it's gone all right and the workmates have mostly only been concerned that (IP laughs) (1) "are you still on the wagon, do you not (.) take a drop", "for God's sake man get yourself away to the doctor, (IP laughs) there must be something wrong" (IP, laughing: that sounds pretty) (T1 laughs) well, well (IP: Uhuh) (2) But really well (.) that's the story, when many a one asks " what sort of a bet have you made and how much" (IP: Uhuh) well I (said) "it's not (a matter of) a bet", but I, that (.) as I've always said myself, that when I say something it holds, and that's that. (T1:10–11, born 1955.)

In the interviewee's account, the decision to stop drinking is described as the result of his work-mates teasing him about how long he will lay off drinking. The work-mates' lines highlight both the normativity of drinking and the socially shared abnormality of abstinence. While drinking in events like a seminar organised by the employer may be a common topic of conversation within the group of employees, non-drinking is an issue which turns the discussion into the individual and makes him accountable for his behaviour. Although the decision is described as a more or less spontaneous and slightly angry response, the rest of the speech in the excerpt does not give the impression that the speaker would consider this type of teasing irrelevant, derogatory or hostile. Contrary to this, the depictions about his work-mates' reactions to his absolutism are told as funny stories, which result in both participants' (me and the interviewee) laughing. Therefore, it is worth asking, why the depictions are interpreted as humorous? How the humorous depictions in the latter part differ from that work-mates' comment, which made the speaker angry ('that just hit a nerve'), and led him to promise to abstain from drinking for several years?

[4] Date of birth has been changed for maintaining the anonymity of the participant.

The interviewee's account of his drinking may be read as a narrative where the production of a positive identity is at the centre of the story. Interpreted this way, his work-mates' comments on how long he can be without alcohol can be seen as a publicly expressed doubt of, first, whether his intension not to drink can be taken as a serious attempt and, second, whether he thinks he will be able to keep his promise. This, at least potential, accusation leads him to intensify his decision to stay without alcohol and make a pointed, even extreme promise not to drink for several years. The interviewee points to the potential accusation of not being able to keep the promise by concluding at the end the excerpt that 'when I say something, well that's how it is'. From this perspective, it is interesting what happens in the middle of the excerpt where the tone is quite different from a serious tone at the beginning and end of the excerpt. After telling the story about the conversation with work-mates about his decision to stop drinking, the participant summarises the consequences of his abstinence from alcohol:

> It's gone all right and the workmates have mostly only been concerned that (IP laughs) (1) "are you still on the wagon, do you not (.) take a drop", "for God's sake man get yourself away to the doctor (IP laughs) there must be something wrong".

In this conclusion regarding the consequences of abstinence, it is interesting how the account in still centred on the reactions of work-mates, which highlights *the social importance of drinking or abstaining from drinking*. By referring to the (possibly illusory) lines of work-mates he describes the tensions actualised due to abstinence. The work-mates' comments continue the same themes generally characteristic of alcohol-related talk in interviews, acceptability of moderate drinking and abnormality of absolutism. While 'taking a drop' every now and then would locate the person within the limits of normal, despite the vagueness of the term, not taking even a drop puts him outside the boundaries of normal behaviour. As an ironic conclusion, there is some abnormality in the person, who is considered to be in need of a doctor's investigation due to evidence that 'there must be something wrong' with him.

Due to 'abnormality', it is striking how the references to work-mates' responses are described in a humorous way where the speaker, in fact, is the one who is laughed at but who takes the role of being ridiculed for granted. In my interpretation, the humour in the middle part of the excerpt serves to stabilise the threatened identity of the speaker. While abstinence from drinking may be a potential marker of (social) deviance, the right way of responding to potential accusations restores the speaker's position in the group. By expressing humorous doubts about his own relative abnormality the participant portrays social and cultural competence regarding alcohol-related

discourse. Laughing about the same things as those who drink allows him to belong to the group and prevents ideas of him being *truly* deviant. Sharing the assumption that absolutism is deviant, abnormal and a state close to illness in humour represents that the participant does not conflict with collective norms concerning drinking despite his personal decision to abstain from alcohol. It simultaneously also convicts other people that the speaker does not hold such viewpoints that might be critical towards other people's drinking habits. The excerpt thus interestingly illustrates how competence of discourse may be equally or even more important than observable activities in maintaining social order in male groups.

The excerpts analysed in this section also illustrate another key feature of alcohol-related talk. While there were few examples of explicitly gendered accounts of alcohol, there was a tendency to discuss drinking in male contexts, i.e. with workmates, friends or alone. The women were mostly absent as participants from contexts of drinking. In exceptional cases when the women were mentioned to have a role in drinking, they were by and large positioned as controllers of drinking (cf. Virtanen 1982, 34–44), as we saw in Excerpt 7.8. Women's drinking was mentioned only a couple of times in the interviews. It may thus be concluded that drinking was most often described as a male activity, i.e. as something men do in male company.

Humour in alcohol talk

While reading the focus group transcripts, I paid attention to three major issues in alcohol talks. First, the vast majority of all episodes where alcohol was mentioned resulted in laughter. Secondly, in some of these cases, where alcohol was mentioned and resulted in laughter, alcohol or drinking was not the actual topic of the episode. Instead, in some contexts, alcohol was 'planted' in the discussion, where the original theme was something else. Thirdly, there were only a few episodes where health influences of alcohol drinking were discussed. In those episodes, a recurrent theme was that people should drink in moderation and avoid binge drinking without, however, explicating what moderation meant in this context.

In a closer reading of humour related to alcohol, I often noticed that the perceived humour was not actively intentional from the side of the speaker as if he was telling a joke. Instead, in several contexts a mere mention of alcohol made the other participants chuckle. For instance, in one of the focus groups where I had started the discussion by asking the participants to list issues that threaten Finnish men's health, one of the participants mentioned alcohol. This was immediately followed by other participants' spontaneously chuckling, which the speaker himself, then, took

part in. There was no explanation given as to why the participants found the subject to be so funny. The only way I was able to interpret the laughter was to see it as a collective response to bringing the 'forbidden fruit' of alcohol into discussions on men's health. The collective response of laughter seems to strengthen the fellowship of the participants by articulating 'what we all know, although we might not want to say it aloud'. The recurrent chuckles over alcohol, together with a notion that no other theme was discussed in humorous ways to the same extent, give reason to conclude that ideas about alcohol as a 'forbidden fruit' were greatly shared by the participants. As was noticed in the previous section, one of the key themes of alcohol-concerning humour was the vague concept of moderation in drinking and absolutism as an opposite to 'proper' drinking. The next excerpt is from an early part of a focus group discussion where we list things that threaten men's health.

Excerpt 7.10.

P2 (-70): Well boozing of course (.)
IP: Aha.
P2 (-70): (is) a risk (2) or if you take too little (3) you can't get relaxed[(laughter)
P1 (-61): [just right, just right then (smiling) (FG4:3.)

In the excerpt 'boozing' is contrasted with 'taking too little'. Moderation in drinking is thus constructed on the basis of the extremes. The humour is, again, rather obscure but seemingly relates to the idea that to 'get relaxed' requires an unspecified amount of alcohol, which may occasionally exceed the limits of 'moderation'. It might also be read as a reference to *people* who drink too little and cannot, therefore, get relaxed. This kind of attitude and person might represent a fanatic, possibly religious-based, abstinence from alcohol and other joys of life, which seems to be a recurrent theme of jokes about absolutism. In the interviews in general, absolutism, rather than binge drinking, was more often taken up as a point of comparison to moderate drinking. Furthermore, when absolutism was mentioned, it was always defined as a 'problem', accompanied with laughter while another extreme, alcoholism, was never a matter of laughter. The next excerpt is an interesting case of subtle meaning-making related to moderation.

Excerpt 7.11.

IP: Mmm.. Well let's say if you had to put a plus or minus on your own living habits which would it b[e?
K8: [It would be a plus.
IP: Yeah (2) how would you (.) justify that?

K8: (sighs) well as I see it (.) I try to eat (.) fairly healthily and I take exercise (.) (IP: yeah) and alcohol (.) isn't a problem (laughing). (K8:10–11, born 1971.)

At the end of the excerpt, the interviewee takes up his drinking habits as one indicator of the healthiness of his own lifestyle. It is interesting, however, how talk about alcohol differs from other issues mentioned. While trying to eat healthily and doing exercise are more or less defined as healthy activities, noting that alcohol 'isn't a problem' is a significantly more abstract expression. With this expression the speaker does not deny that he uses alcohol and leaves the amount of drinking unspecified. The laughter following this notion may be interpreted in two ways. On the one hand, it may be taken as a softening laughter related to discussing the delicate issue of one's own drinking. On the other hand, it could be interpreted as an emphasis of one's masculine position where it is even necessary to note that the speaker does not refuse a drink (this perspective will be further considered in the next chapter).

As was mentioned above, the majority of humour used in the context of alcohol was equivocal chuckling where the actual topic of laughter was not explicated. Taken that alcohol was mostly discussed in 'male' contexts, it is plausible to interpret humour as a 'bonding ploy' (Schwalbe & Wolkomir 2001; 2002) where laughter is a marker of 'what we mutually know' and which, thus, creates feelings of trust and fellowship. From this perspective, the next excerpt, which is one of the rare examples where women's drinking was mentioned in the interviews, gives an additional view to the bonding function of alcohol talk. Before the excerpt we discuss gender difference in life-expectancy and men's stress as a probable reason for it.

Excerpt 7.12.

P2 (-57): They don't get stressed so much, the women (…)
P4 (-64): That's because when they blow their tops they put it onto us!
(General laughter)
P3 (-72): They delegate the stress!
P4 (-64): Yeah, they delegate, yeah it's absolutely true!
P2 (-57): Yeah, it's like. I don't know what it's like[
P4 (-64): [bla[me men always, well
P2 (-57): [why is it that,
that, but some such (.) yes they always can take us men, always know how to (.) to do such that (.) if you take just a little bit of something (.) worries and (2) there's something like, well they (.) they know how to blame it on somebody else, there can of course be things like that, but in my opinion they just don't, they don't, they somehow cannot, a Finnish (.) bloke in my opinion is one that (.) well he gets sort of (.) stressed a bit for nothing like and, and (.) dwells on things.[
P4 (-64): [Even on things where you can't, where you can't make any difference at all.

P2 (-57): Yeah, well and pointless things (1) and it might be that they don't, *the women like (.) they don't think so much and they* (.) and they more like let things go a day at a time and (.) somehow the way, the way of thinking, would it be for mental welfare like, there, that they only have (1). In my opinion they have more like (3) the way they think it's (3) somehow like more free and carefree. (Somebody chuckles.) I don't know if it, if into that seven years if such (.) an idea puts a few mo-, more years in (1) it might be. (…)
P2 (-57): You're stuck there (1) (talks to P4 who has been talking about the redecorating going on at home) build this and that, nail down the skirting boards and cursing and blinding, get all stressed with them 'cos they're a bit off the straight and they don't fit and (.) then comes the wife in the door and (.) "see to our Kalle and Kaisa (meaning children in general) and that while you're at it, I'm off for me keep-fit class (several participants chuckle) and then we'll be having a couple of (.) beers like". (P4: well..) You'll have, well if it's (.) if it's like this with every fifth gang so (1) here you have some (.) well (.) it's a bit more carefree like, you know (1). They (the women) don't get stressed with skirting boards there (laughing) they're off to the keep-fit! (General laughter) That on top of everything else, they get a bit more exercise that way, so.. (raises hand indicating drinking movement)
P4 (-64): Yes they get us all worked up with them skirting boards (P2: Yeah! Exactly!) they don't stress themselves. (FG3:13–14.)

As the topic of the discussion is gender difference in life-expectancy, the excerpt is full of rather pointed distinctions between men and women, 'us' and 'them', as was noted in Chapter 6. Among them, P2 points to women's ways of thinking as 'more free and carefree' in contrast to the 'Finnish bloke's' disposition to get stressed 'a bit for nothing'. As the discussion continues, P2 gets back to men's responsible mentality and takes P4's redecoration work as an example of how men get stressed about their many responsibilities. He takes women as the counterpoint to this by referring to women's carefree attitude. From the point of view of alcohol, it is interesting how drinking is 'planted' in the discussion where the original topic was about something else. Going to keep-fit class and having 'a couple of beers' after that are signifiers of women's more 'carefree' attitude and that they do not get stressed to the same extent as men. What makes P2's latter account humorous is its carnivalistic nature. In the story, the man is a henpecked husband who redecorates the home, takes care of the children and gets stressed while the wife goes out for fitness and beer. Simultaneously, the humour of the story points to some of the salient meanings of alcohol in the Finnish culture: drinking is associated with independence and autonomy, and the bar may be called 'the realm of male freedom' (Alasuutari & Siltari 1983). The carnivalism turns the gendered composition upside down which the participants found absurd and thus humorous.

As demonstrated above, health impacts and gendered attributes of alcohol were somehow both present and absent in men's interviews, especially in focus groups. The primary means for discussing both themes was humour. The potential health effects were routed through humorous considerations of the dangers related to abstinence from drinking in focus groups and there were only a few examples of more serious contemplations of the negative effects in personal interviews. Even in these cases, the effects of 'problem' drinking were largely considered in terms of social rather than health consequences. Gendered characteristics of drinking were similarly discussed through humour in obscure and implicit ways.

In my interpretation, evasion of discussions on the health effects of alcohol relates to two different things in the two sets of data. In personal interviews, drinking is a delicate topic since it easily leads to a threatened position where a person's drinking habits may become a subject of tight scrutiny. Taken that there was only one participant who explicitly told me that he does not drink at all (see Excerpts 7.8 and 7.9), for the rest of the participants 'moderation' in drinking was an easy way to conceptualise reasonable drinking, yet it was also a dangerous category due to its vagueness. 'A couple of beers sometimes' sounds like a reasonable and rhetorically effective way of defining one's drinking habits. Further 'interrogation' might, however, end in questions about what one means by 'a couple' or 'sometimes', which might challenge the prior reasonableness. As many participants referred to past events in the paper mills where people were fired for their drinking, participants may have been unsure as to the confidentiality of the interviews. Therefore, the superficial 'drinking-in-moderation' is the best statement to stay on the safe side. In this respect, my interviews seem to share similar features with how drinking is discussed in doctors' and patients' interaction in general practice (see Lindfors & Raevaara 2005; Peräkylä & Sorjonen 1997; Raevaara 2003). Studies of doctor – patient communication in general practice have revealed that drinking is mostly discussed in evasive ways, where doctors tend to avoid making direct questions and patients are reluctant to give direct answers. Maybe my own reluctance to 'interrogate' interviewees about their drinking was a similar attempt to avoid discussing delicate matters that may have been considered too personal?

In the focus groups, there was an additional reason for not discussing drinking in too much detail. While each participant may have been unwilling to talk about his own drinking habits due to the possibility of being 'interrogated' or compared with other's, another reason for evasion of detailed descriptions is arguably the solidarity between the participants. Discussing drinking habits in detail might lead somebody

from the group into an awkward position if his personal habits were scrutinised. This was, of course, also a more general phenomenon in the focus groups where participants avoided topics of conversations that might have concerned very private issues. Regarding alcohol, humour is the superior means for discussing shared and collective topics while keeping the conversation strictly on a non-private level. Humour and laughter are effective resources for managing delicate and moral issues of health in face-to-face interaction (Haakana 2001; Bergmann 1998, 288).

Alcohol drinking has long had a male label. In his analysis, Virtanen (1982) noted that the history of Finnish drunkenness is strongly equivalent to the history of male drunkenness. Before the 1970s women's drinking was rare and strongly deprecated. Due to industrialisation and urbanisation in the 1950s, however, alcohol had gradually become a part of everyday life in towns where pubs and restaurants formed a new public space for amusement and communication. Urbanisation resulted in sociological studies on suburbs and the pub-cultures in them in the 1980s (Kortteinen 1982; Alasuutari & Siltari 1983; Sulkunen et al. 1985; Ahola 1989). The studies, interestingly, show how the pubs lowered the threshold for women's drinking which started to become more common and simultaneously reshaped the gender order of drinking.

The general trend regarding the gendered appropriateness of alcohol drinking is that men and women have become more equal in their relation to alcohol both in terms of the amounts consumed and public acceptability of drinking. Regardless of the acceptability of women drinking nowadays, women's drinking is still more controlled than men's. As Paakkanen (1992) points out, despite the increase in women's use of alcohol, drinking is still primarily considered to be masculine behaviour, especially when it comes to drunkenness. A drunken woman opposes the conventional image of women and femininity.

The gendered features in men's interview talk on drinking echo old traditions of drinking – and especially drunkenness – being primarily male behaviour. A most interesting finding relating to this is, however, the furtive manner in which masculinity and drinking are expressed. My claim that drinking is implicitly constructed as a male and masculine behaviour is rooted on three arguments. First, drinking was mostly discussed in male contexts, such as in male company, or drinking alone. Women were not mentioned in these contexts, with the rare exception presented in Excerpt 7.12. What is notable, however, that in this interview episode the topic of discussion is not men's drinking, or even drinking at all, but alcohol brought in to illustrate other themes of conversation. Secondly, the humour clearly acted as a means for male bonding in the interviews. It created an atmosphere of mutual trust and a feeling of shared knowledge of 'what we mutually know', as well as creating a space between 'us'

and the interviewer. A recurrent theme of humour was the abstinence of drinking instead of drinking too much which, in my interpretation, fosters the idea of drinking being a culturally shared male practice. Finally, the exceptional case of a participant who had stopped drinking interestingly revealed some norms related to drinking as a male practice. The detailed way in which abstinence from drinking had been discussed in the participants' social circles gives reason to believe that non-drinking is some sort of transgression of men's social order. While drinking may not always be a private issue, abstinence from it is never a private issue. Non-drinking seems to make a man more accountable for his decision compared to a man who drinks.

That the gendered features of drinking were not discussed explicitly in the interviews may relate to three different things. It may be due to generally superficial and obscure ways in which drinking was described. It may also reflect the participants overall cautiousness when speaking about gender, particularly when talking about health issues in individual contexts. The third possible explanation is that gendered attributes of drinking may be socially shared to the extent that their explicit discussion was not necessary, or might even be a transgression of mutually shared gendered knowledge. The brotherhood must not divulge all its secrets.

7.4 Smoking

The non-negotiable un-healthiness of smoking

Out of four health behaviours studied in this chapter, smoking was clearly the behaviour with the least contrary themes related to discussions of its possible health influences. It was widely agreed by the participants that smoking is unhealthy. In the rare instances where the harmful effects of smoking were debated, the counterarguments could not be based on the health impacts of smoking itself but, instead, were related to smoking in a wider context that included all factors that influence health.

Excerpt 7.13.

P3 (-76): I (…) smoke myself, and every time there it says that "Smoking kills" or something of the sort. (2) So that (1) even if (.) that's what it says, that smoking kills, so OK, (1) there's plenty of other things to kill you so I don't (1) like (.) take it that way (.) kind of but.. (FG1:6.)

In the excerpt, warnings on a cigarette box ('Smoking kills' etc.) represent information about the harmful effects of smoking. The participant does not disagree with the information but defines the dangers of smoking as belonging to wider realities of life.

The reasoning that there are 'plenty of other things to kill you' in addition to smoking is a type of rhetorical strategy which DeSantis (2003) calls a 'life-is-dangerous argument'. Rhetorical credibility of the 'life-is-dangerous argument' is founded on the indisputable mortality of life: 'life is hard and then you die'. The inner logic of the argument comes close to the idea, represented previously in Excerpt 5.9, by another participant of a focus group: 'the only sure thing, that everybody's going to die of something! So it only depends on you, that you take the risk that you die of one thing or another.' According to this argumentation, risks involved in smoking exist and cannot be denied. Nevertheless, neither can anybody disclaim the fact that every person will, after all, die for some reason. This inference is concluded with a notion of choice between the causes of death which positions smoking in a complex series of choices that people are inevitably forced to make in their lives. Due to the mortality of life, separate choices, such as smoking, lose their meaning. Another variation of this argumentation is to explicitly compare the harmful effects of smoking with other threats to health, as in the next excerpt.

Excerpt 7.14.

P3 (-75): On the other hand (.) the way it is that smoking is dangerous, but the car exhaust fumes (.) are still just as bad (.) *anyway*. (1) If you're around the cen- (.) in the centre of town around four o'clock, well (.) hr. (1) (IP:hmm) it would be better to breathe through a filter than (1) straight in. (FG2:5.)

This argumentation shares the same logic with the 'life-is-dangerous argument' but differs from it in its explicit point of comparison. Car exhaust fumes offer a rhetorically convincing point of comparison for two reasons. First, exhaust gas is something people breathe the same way as tobacco smoke which strengthens the relevance of the example. Secondly, exhaust gas is an example, which everybody knows, independent of whether a person smokes or not. It, thus, creates an idea that 'we are all in the same boat'. Even if a person her/himself does not smoke, s/he is not safe, anyway.

The 'Life-is-dangerous argument' is one of five central arguments that DeSantis (2003) found cigar-smokers use when challenging or rejecting information about the potential health effects of cigar-smoking. In his ethnographic study, DeSantis observed processes of 'group rationalisation' for smoking in regular clients' conversations in a small cigar-shop for three years. According to DeSantis (2003, 446–447), the primary function of pro-smoking arguments was to 'inoculate regulars [regular clients] from the potential dissonance-causing and anxiety-creating effects of antismoking messages'. In addition to the previously presented 'life-is-dangerous argument' the

four others were 1) the all-things-in-moderation argument, 2) the health benefits argument, 3) the cigars-are-not-cigarettes argument and 4) the flawed research argument.

Comparing DeSantis' results with my research material, there are certain similarities between the two studies, but remarkable differences as well. The life-is-dangerous argument is one of DeSantis' five types of arguments, which is the most congruent with my material as described above. The 'flawed research argument', instead, was not directly used by participants of my study. As stated at the beginning of this section, the information about the dangers of smoking was not explicitly rejected as such. Instead, counterarguments against antismoking campaigns pointed to other threats to health that exist around us and thus set smoking within a wider framework. In the same way, no explicit references to the beneficial outcomes of smoking were made in the interviews ('health benefits argument'). In DeSantis' study, health benefit arguments mostly concerned perceived stress-reducing effects of cigar-smoking, especially within the company of other regular clients. In my interviews, the stress-reduction argument was expressed only implicitly. An example of this will be presented at the beginning of the next chapter (Excerpt 8.2), where a participant considered that 'it's so stressing this present life to the extent that smoking and alcohol from time to time are part of a normal day'. Even though smoking and alcohol consumption are implicitly justified by the stressfulness of life, it can hardly be claimed to represent an active form of the 'health benefit argument' for smoking and drinking.

The fact that the harmful effects of smoking were not denied directly in any of the interviews, fosters the idea that there is a strong agreement, among the participants, of the un-healthiness of smoking. This agreement is the strongest and most widely shared of all health-related behavioural factors discussed in this chapter. What is also striking with smoking, in comparison with other behaviours, is that there are no 'all-things-in-moderation arguments' expressed in relation to tobacco. While drinking, certain foods and diets and most physical exercise may be seen as appropriate if taken 'in moderation', smoking does not fall under this rubric. Smoking is thus a strictly bipolar behaviour: either a person smokes or does not smoke. In accounts of smoking, there did not appear to be such relativisation of its health effects which were typical in accounts of other health-related behaviours, pointing to the frequency and intensity of behaviour under consideration.

The widely shared agreement on the un-healthiness of smoking has important consequences for normative and moral aspects involved in men's health talk. As has been noticed in the previous chapters, public consideration of one's own lifestyle, in terms of its healthiness, is an issue which involves moral judgements. Shared

knowledge of the dangers of smoking easily leads to the conclusion that smoking is irrational behaviour. Accordingly, for a smoker, there are no uncertainties related to the negative health impacts of smoking that could, in turn, offer a legitimate and convincing way to respond to potential accusations for a person's irrational and irresponsible behaviour. The next extract represents considerations of the moral perspectives of smoking.

Excerpt 7.15.

(Part 1.)

P1 (-56): It's a hellish bad job getting rid of it (smoking)! *I've tried (.) bloody hell it's difficult*. (1)
P3 (-50): I think that it's (.) for many it's su*ch* a question of habit, [like smoki[ng.
P1 (-56): [it's [it's a habit and like. If sometimes I go to town well (.) I leave my cigarettes at home. (.) Four or five hours go by and I don't even think of the whole damned cigarettes. When I go back home, (2) shoes off, (.) onto the balcony and have a drag. (general laughter)

(Part 2.)

P2 (-48): It's (.) it's one such (1) factor. Well, I have to (.) say that I do smoke too so that it's not (.) as if (.) but maybe it's only (.) an ingrained habit. (.) But (.)(IP: Hmm) it is certainly that breaking away from it (.) well it's not that (.) it's not that black-[and-white.
P3 (-50): [so you don't see that as a bad thing or what?
P2 (-48): we[ll I wouldn't say that it's like that
P3 (-48): [You don't feel [that it's a dan[ger (.) that it endangers your health [or?
P2 (-48): [aha [aha [I haven't thought of it that way (.) in my mi*nd* (2)
P3 (-50): Or[do you mean that it's better to have tarred lung[s?
P2 (-48): [This is, here there's many [many other things too you can resort to (.) well take one sort of (1) a less (.) lesser evil then (1)
P3 (-50): But is it (.)[is it lesser? [
P2 (-48): [If you sta- [if you start comparing to if I would buy well (1) half a bottle of Koskenkorva spirits every day. (1)
P3 (-50): [And is that what you're comparing smoking to[?
P2 (-49): [(laughs) [Ay:e! (laughing)
(FG6:11–12.)

The preceding excerpt is an interesting exception in my interview material in two aspects. First, it includes the most extreme case of understatement of the harmful effects of smoking although the participant (P2), even in this 'extreme' case, does not actually deny the negative health impacts. Secondly, the excerpt is the only case of strong disagreement between participants in the interviews which resulted in a

heated discussion. The dispute between two of the three participants of the focus group reveals, interestingly, some morally-loaded features of talk about smoking.

The excerpt starts with a participant's (P1) bleak, even anguished, description of his attempts to stop smoking. When P1 seems to have difficulties in continuing his story about the difficulty of quitting smoking (pauses in talk and spoken quietly in low tones), another participant (P3) accompanies P1 by stating that in his view 'for many' smoking is 'such a question of habit'. His comment encourages P1 to go on. The key word in P3's comment is *habit*, which P1 catches and uses in his story about how he can manage without cigarettes for hours if not at home where he is used to smoking. In his account, home is a place where smoking is so strongly habitual that he cannot resist it. His story convinces other participants and no-one expresses criticism.

From the point of view of criticism, the latter part of the extract is interesting in how another account of smoking is not accepted the same way as in P1's case. When P2 starts to discuss his own smoking habits, P3 suddenly starts to 'interrogate' him about his conceptions of the dangers of smoking ('so you don't see that as a bad thing or what?'). The difference with the first part of the discussion is striking particularly in the way in which P3 participates in the conversation. While accepting P1's views about smoking and even accompanying and supporting his views, P3's stand to P2's account is totally different. The most liable reason for P3's abrupt reaction, in my view, is P2's admission that 'maybe it's only an ingrained habit'. Saying that smoking is *only* an ingrained habit may sound as if he is indicating that smoking is a habit among others and does not, thus, require any special consideration.

The use of the word 'habit', in the context of smoking, has been a subject of debate in smoking research. Perkins' (1999) commentary article is categorically titled '*Tobacco smoking is a "dependence", not a "habit"*'. According to Perkins, researchers should avoid using the word habit (or habitual) in relation to smoking because, as he concludes, the word habit, commonly used by the lay public, differs from the research definition of 'dependence' in tending to refer to 'behaviours that occur with regularity but are not particularly intractable or dangerous to public health' (ibid., 127). In the same way, P3 may also interpret P2's expression 'maybe it's only an ingrained habit' as an underestimation of the harmful effects of smoking. This interpretation may not be sufficient since P3 himself also uses the word habit when commenting on P1's first sentences.

Irrespective of which of P2's expressions are the ones that make P3 start his further criticism, the rest of the discussion contains P3's provocative questions and P2's responses to them. In my view, the two most important things in the dialogue are, first, the direct, interrogative and even aggressive manner in which P3 asks his questions

and, secondly, the equivocal responses P2 gives to them (e.g., 'I haven't thought of it that way in my mind'). My interpretation about these features of dialogue is that, as distinct from other health-related behaviours, the agreement of the un-healthiness of smoking is strong to the extent that it gives P3 a legitimate reason to interfere in P2's personal affairs. The extract discussed here was the only case in my material (in focus groups) where a participant directly criticised another participant's lifestyle choices. The participants' dialogue, therefore, gives reason to conclude that smoking differs culturally from other health-related behaviours in terms of where the borders of privacy are set. While it might be inappropriate to criticise another person's diet or lack of physical exercise, smoking is a legitimate subject for such interference. It may thus be concluded that moral judgments related to healthiness of lifestyles are most strong in the case of smoking due to wide agreement on its harmful effects.

P2's equivocal responses further foster this interpretation. As noted above, the harmful effects of smoking cannot be directly denied, which results in relativisation, or, in an extreme case, trivialisation of the health-effects of smoking, which are rhetorical strategies that can both be seen in P2's responses. His last counterargument, where he contrasts smoking with the imaginary excessive use of spirits, comes close to DeSantis' (2003) 'cigars-are-not-cigarettes' argument[5]. In the same way as cigar-smokers discursively shield themselves from the health-threats of cigar-smoking by referring to the unquestionable dangers of cigarette-smoking (which was compared to the alleged lesser health-effects of cigar-smoking), P2 takes excessive drinking as an example of behaviour, which is clearly more harmful for health than smoking. An extreme point of comparison provides him with a rhetorical tool for claiming that smoking is not, after all, the worst thing a man can do to his health. Simultaneously, he can also cut the sharpness of the criticism directed towards his irresponsible behaviour with the imaginary example. The fact that he does not drink half a bottle of *Koskenkorva* spirits every day suggests that he is a responsible person. If he drank excessively, then the criticism towards him would be justifiable.

Another way to consider P3's criticism towards P2 is to compare P2's account of smoking with that of P1. P1's description of his smoking includes a highly negative attitude towards smoking, which is clear in expressions like 'it's a *hellish bad job* getting rid of it, *bloody hell it's difficult*' and 'I don't even think of the whole *damned cigarettes*'. By expressing these negative views about smoking, and stating that he has tried to give up, he constructs himself as a victim of 'damned cigarettes'. In his story about attempts to quit smoking, it is of less importance whether the continuation of

[5] Cigar-smoking was not separately discussed in my interviews. All accounts of smoking referred to 'cigarettes' or 'smoking', in general. Therefore, it is obvious that the 'cigars-are-not-cigarettes argument' was not represented in a literal sense in my material.

smoking is attributed to 'habit' or 'dependence': the point is that he admits that he is hooked and cannot control his addiction. P2, in turn, does not express any direct critical views towards his smoking. What is maybe even more important is that he does not follow P1's lead in articulating his willingness to stop smoking. Therefore, P2's talk about smoking may easily be heard as careless, especially if compared to P1's account, which may lead P3 to react in a different way as in P1's case.

P3's differing reaction to the two accounts of smoking sheds light on the moral expectations involved in talk about one's own smoking. The un-healthiness of smoking is a widely shared fact and does not involve such uncertainties as in the cases of other health-related behaviours. P1's open confession about being addicted to tobacco solves the moral dilemma related to 'getting rid of' a harmful behaviour: in case he has tried to quit it, but failed due to addiction, the victim cannot be blamed. P2, in turn, does not act in accordance with this moral manuscript, and faces, thus, disapproval from P3.

Smoking and concealing gender

Smoking was the most 'unproblematic' of the behaviours analysed in this chapter in terms of its gendered characteristics. Smoking was discussed in gender-neutral ways and did not, thus, involve contrary themes related to its gendered appropriateness. The only cases where smoking and gender were discussed were the accounts where the participants put forward women's increasing smoking rates as an issue potentially diminishing the gender gap in health. In a few cases, girls' smoking was referred to in a disapproving tone, which might be taken as an indication that boys' smoking is still somehow more acceptable than girls', probably due to the conventional image of women as health-aware and responsible (cf. Pietilä & Rytkönen 2006, 24–25). Despite rare exceptions, the general conclusion drawn from the interviews was that men smoke more than women, although smoking itself was not discussed in gendered terms. In other words, the accounts pointed to the gendered distribution of smoking but did not, however, address it as a gendered behaviour as such.

Smoking has historically had a masculine label. The reasons for this are found in the distribution of smoking[6] as well as in tobacco advertising. Until the 1960s, smoking was very rare among women in Finland, while more than half of men

[6] In Finland, the share of smoking women increased during the 1960s, was relatively stable for around 15 years when it again grew in the late 1980s. After that there have not been significant changes in women's smoking: for the past 20 years the share of smokers among women has been around 20%. (Vartiainen 2005.) Men's smoking has decreased since the 1960s from the rate of 50–60% (Rimpelä 1972, 113–116) to 26% in 2003 (Helakorpi et al. 2003).

were smokers (Rimpelä 1972, 116; Rimpelä 1978). Therefore, smoking has long been associated as a man's habit and been attributed with masculine characteristics. Accordingly, men were the primary target group of tobacco advertising which was clearly seen in ultra-masculine characters such as the *Marlboro Man* and *Camel* adventurer. Due to the gendered changes in smoking and advertising, smoking seems to have lost some of its earlier masculine qualities. Hunt, Hannah and West (2004), found in their study, based on a survey measuring associations between smoking and gender role orientation, that neither the masculinity nor the femininity score (measured using Bem Sex Role Inventory, BSRI, for defining respondents' gender role orientation) had any significant association with smoking amongst men in any of the three generations studied. The authors take this as an indication that smoking has remained a less gendered phenomenon for men compared to women.

It may also be claimed that 'non-genderedness' of smoking could be attributed to changes in public perceptions of smoking in recent decades. During the past 20 years or so, public opinion has become increasingly negative towards smoking. Along with this, the legislation regulating smoking has tightened (see Hakkarainen 2000). Together with dominating views of smoking being an addictive habit, it may be concluded that smoking is characterised by public disapproval (with association to sin), legislative regulations (with association to crime) and bio-medical problem (with association to disease) instead of pleasure. If one is to compare smoking with other unhealthy habits, such as drinking or unhealthy food, smoking offers little space for representing pleasurable effects related to it. Drunkenness as well as salty and fatty food may be presented and interpreted as temporary (masculine) transgressions, especially within certain social contexts (such as sauna-evenings, hockey-matches etc), associated with male traditions. While in some contexts there may be possibilities to consider smoking as a masculine transgression as well (such as smoking breaks at a construction site or in other physical work), this is not likely to occur in an interview with a health researcher. In this context, it seems, smoking cannot be characterised by any positive features, not even as a gendered, masculine transgression.

Conclusions

The analyses of this chapter lead to two important conclusions. First, there are certain consistent differences in how health-related activities are discussed in personal and non-personal contexts. When talking about their own life and health-related behaviours, the men tended to comply with advice related to healthy lifestyles with rare references to gendered characteristics of health-related habits. Instead, when

talking about the same activities from a general, non-personal perspective, the accounts involve more gendered features and, in some cases, ideas of ardent interest in health issues being in conflict with appropriate traditional male conduct. Secondly, despite the general tendency to discuss healthiness and gendered characteristics of health-related behaviours differently in personal and non-personal contexts, there are important variations *between the behaviours* in this regard: the four health-related activities carry different attributes in terms of their healthiness and genderedness.

Smoking was clearly the most unproblematic and, consequently, least discussed behaviour as all of the participants agreed that it was unhealthy. Discussions of alcohol, in turn, were characterised by the indirectness and subtlety of the given views, both in terms of the health effects and gendered attributes of drinking. While the 'appropriate', healthy level of drinking was discussed in abstract terms (such as moderate vs. excessive drinking), the gendered features of drinking were also discussed in equally blurred ways. Drinking was in most cases attached to male companionships in terms of drinking-occasions, such as sauna-evenings organised by the company. Humour acted as a recurrent tool for avoiding overly concrete discussions of alcohol-drinking. Smoking and alcohol thus offered little variation in discussions of healthiness/ unhealthiness and gendered characteristics of the behaviours, however, for different reasons: while smoking was infrequently discussed due to its obviously unchallengeable negative health effects, drinking seemed to represent a collectively shared 'forbidden fruit' related to male companionship and male culture.

Jeff Hearn (1998) has considered men's ways of theorising men in social theory and concluded that men, as a category, have largely been taken for granted, implicit and untheorised. One of the dominant discursive practices in men's theorising of men has been *absence, fixed presence and avoidance*, in which men and indeed the gendered naming of their practices, which might include such practices as men's sexualities, violence or drinking, are either absent, avoided or present yet non-problematic: 'Men are implicitly talked of, yet rarely talked of explicitly. They are shown but not said, visible but not questioned' (Hearn 1998, 786). According to Hearn, not explicitly talking about men and their practices is a 'structured way of not beginning to talk of and question men's power in relation to women, children, young people, and indeed other men' (ibid). Applying these ideas to men's interview talk, it might be claimed that the 'fixed presence' of alcohol in men's talk, where drinking is often a topic of humour but rarely discussed in explicitly gendered ways, indicates a hegemonic, taken-for-granted position of drinking as a fundamentally male practice. Perhaps thus the most gendered practice is the one which is least explicitly discussed?

According to a recent survey, Finns have widely adopted key messages of health promotion (e.g., Aarva & Pasanen 2005). Regular physical exercise and healthy nutrition, in particular, have attracted people's interest in recent years. In respondents' ratings of factors with significant influence on health, both physical exercise and nutrition have increased substantially in comparison to smoking and alcohol. One possible reason for this is that the harmful effects of smoking and alcohol consumption may have become somewhat an 'old hat' for people due to numerous anti-smoking and anti-alcohol campaigns among the Finns over the past few decades (Aarva et al. 2005). People may in a sense be 'too well' aware of their harmful effects when asked by a researcher. Physical exercise and nutrition are, then, more interesting topics provoking active consideration and discussion. In my interview material, physical exercise and dietary habits similarly offered more variation compared to smoking and drinking both in terms of healthiness and gendered features involved in them. In men's interview talk, physical exercise was, to a large extent, discussed as a health-promoting activity, while nutrition and diet were themes with the most examples of conflicting views.

Physical exercise seems to have a central position in men's health-related thinking, which is frequently expressed in the interviews. In my interpretation, there are three major reasons for this. First, physical ability is a traditional male quality associated with physical strength and endurance. In an age where the need for physical strength at work and in domestic life is less pronounced, the role of physical exercise increases as an arena where physical ability is demonstrated. As Whitson observes:

> Sport has become, it is fair to suggest, one of the central sites in the social production of masculinity in societies characterized by longer schooling and by a decline in the social currency attached to other ways of demonstrating physical prowess (e.g., physical labour or combat) (Whitson 1990, 19).

Berrett (1997) similarly notes that while during the eighteenth and nineteenth centuries production formed the 'backbone of male identity', either directly or indirectly via licences for voting and breadwinning, the rise of middle-class jobs, that did not require physical prowess, changed the opportunities for traditional self-identification. Organised athletics became concomitant of a modern society, which 'compensated for the deprivation of productive satisfaction by resuscitating more primitive sources of manhood, such as bloodshed and violent cameradie, and restraining them within a format of ritualized physical competition' (Berrett 1997, 811).

Secondly, physical exercise obviously fits well with health promotion ideologies as well as the overall fitness boom in Western societies (Glassner 1989). In comparison to other health-related behaviours addressed in this chapter, physical exercise differs, however, from the others in one important respect: while dietary advice, moderation in drinking, and smoking, in particular, revolve around *abstaining from certain activities or substances* potentially harmful to one's health, physical exercise comprises a form of *active doing for health*. This may be particularly important when considering manual workers' preferences. As Karisto et al. (1993, 190) note, part of a masculine working class habitus is to appreciate concrete good things in life. As health itself, and several of the abstinences related to maintaining it, are rather abstract issues without immediate, visible outcomes, physical exercise offers a concrete form of doing instead of abstaining. It might also be argued that passive restraining from activities has traditionally been more greatly associated with femininity, compared with the masculine ideals of freedom, activeness and purposeful action.

Thirdly, the measurability and calculability involved in physical exercise enables concretising the results and making healthy activity visible. Simultaneously, it also allows competition in comparing the results with other men or with one's own earlier achievements. Along with this, calculability of exercise parallels with the masculine conception of the body as a machine whose functions can be measured, improved by certain practices and fixed in case of malfunctions. In physical exercise the body acts as a tool whose superiority is assessed by the performance.

Nutrition and diet differ significantly from these qualities of physical exercise. As was found in analyses on men's interpretations of health information, food and diet were the most often mentioned topics in examples of inconsistent and even contradictory information about health, which does not make it possible to follow coherent 'rules' for a healthy life. That is probably due to the fact that leading a 'healthy diet' is a far more complicated set of choices than one-dimensional choices of whether to smoke or not to smoke, to drink another beer or not and so forth. The analysis of men's interpretations of healthy food showed that healthy food is more often conceptualised around choices of food to be avoided than an active consumption of health-enhancing food-stuffs. In this way the food choices in men's interview talk seemed to be based more on abstinence from certain foods rather than active 'healthy' choices, which distinguishes these choices from the active 'doing' of exercise. In addition, food, diet and dieting, in particular, are loaded with feminine meanings in terms of purchasing and preparation as well as assessing the healthiness of food.

The analyses also demonstrated how moderation and balance tend to act as key concepts in assessing the healthiness of all other behaviours, except smoking.

There are several plausible reasons for why balance and moderation fit so well when conceptualising rather abstract concepts such as the healthiness of behaviours. First, as Gough and Conner (2006, 390) point out regarding men's food-related argumentation, 'warranting one's eating habits on the grounds of balance and moderation is rhetorically effective as it connotes reasonableness and rationality'. Another perspective on the same issue suggests that the popularity of 'moderation' and 'balance' arises from the complexity of issues under consideration: in case the limits of healthy and un-healthy in the continuums of behaviours are difficult to discern, moderation and balance correspond to the same abstractness while offering a rhetorically convincing principle for healthy choices. This may be particularly applicable regarding behaviours with strong moral expectations, such as drinking.

Concepts of moderation and balance act on the basis of divisions of extremes. These extremes are comprised of verbalisations at the utmost ends of the terms 'healthy' and 'unhealthy'.

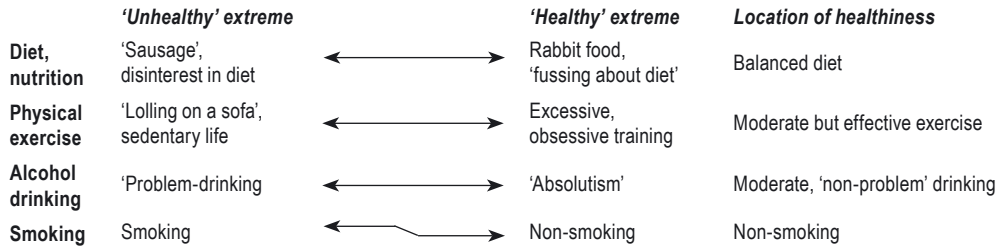

Figure 7.2. 'Unhealthy' and 'healthy' extremes and the location of healthiness in health behaviours.

The unhealthy extremes are relatively unproblematic in representing central messages of health education. The only slight anomaly in conceptualisations of unhealthy behaviours in men's interview talk was identified in discussions of alcohol where the 'unhealthy' extreme was mainly constructed on the basis of the social consequences of binge drinking (at work and home) rather than on its actual health effects. The 'healthy' extremes, in turn, involve more inconsistencies, which results in variations in formulating balance and moderation. That is because the 'healthy' extreme is not, in fact, constructed merely on the basis of potential health effects of given behaviour. The 'healthy' extreme of food and diet does not represent a fully positive image of health-improving diet; instead, it connotes the gendered over-interest in food associated with feminine characteristics. Excessive training was seen as an unhealthy activity due to exposure to injuries, despite the generally health-promoting effects of regular physical exercise. The obsessive features related to excessive training

also embodied uncontrolled behaviour associated with an unhealthy way of life. Absolute abstinence from alcohol was similarly seen as somehow obsessive deviance with unhealthy connotations even though the concrete health effects of absolutism were not discussed. It may thus be concluded that the 'healthy' extremes of these behaviours are not grounded only on an assessment of their potential health effects, but on their social meanings as well.

As an exception to the general rule, smoking differs from others in one respect: while certain diet, alcohol or physical exercise may include parts that are either positive or negative for one's health, smoking is not considered to involve any positive effects for a person's physical health. Moderation and balance are, therefore, not utilised in conceptualising smoking. Smoking is, instead, understood as a bipolar activity of two conditions; either one smokes (the unhealthy condition) or not (the healthy condition).

8 ASSERTING HEALTHINESS OF LIFESTYLE – AND GUARDING THE MASCULINE SELF

In the previous chapter, I analysed participants' accounts of health-related behaviours focusing on four of the most well-known behavioural risk factors of chronic disease. In the analysis, it become apparent that there are clear differences between the participants' accounts of their own behaviours and accounts of health related behaviours on a more general level, particularly concerning other people. While on a general level health influences of certain behaviours might be questioned or criticised, accounts of one's own lifestyle were characterised by a tendency to express compliance with general advice of healthy lifestyles. It has also been concluded in the previous chapter that potential conflicts regarding 'gender-appropriate' behaviour are typically discussed and negotiated in a non-individualised context. When the gendered features of lifestyle choices were discussed in the context of the participant's own life, potential conflicts were negotiated mostly in implicit and subtle ways.

While the previous chapter addressed four selected health-related behaviours separately, this chapter approaches the health-related behaviours from a wider perspective. The interest in the analyses of this chapter was originally in how the participants of interviews construct 'healthiness' of their lifestyle as a whole and how they negotiate gender in relation to these constructions. However, from the very beginning of the analysis it become apparent that the participants tended to estimate their lifestyles as generally healthy – irrespective of their actual health-related behaviours. The considerations of one's own lifestyle were largely aimed at presenting one's lifestyle in a positive, healthy way. Therefore, I focused the analysis on the argumentation used in constructing individual 'healthy' lifestyles.

Gender was rarely involved in these considerations, at least in an explicit form. Despite this, I found some exceptional interview episodes where gender was discussed in relation to healthy lifestyles and noted that the infrequency of gendered accounts of individual lifestyles was, as such, a finding worth consideration. Furthermore, topics related to an individual speakers' own health tended to mobilise non-gendered ways of speaking, a phenomenon that I will discuss in depth in this chapter.

Asserting healthiness of personal lifestyle: justifying one's own unhealthy habits

I started all focus group discussions by asking the participants to mention, each by turns, things that threatened Finnish men's health. I wrote down the factors mentioned onto a clip chart and we started to discuss the list[1]. In most cases the conversation started by considering health-related issues in general and then moved on to consider the effects of particular factors. Before the next excerpt we had completed making the list and I asked the participants to express their first spontaneous impressions about the list: how is it possible to stay healthy when there are so many things threatening our health?

Excerpt 8.1.

P3 (-63): *aye* well, you just have to try to, like they say moderately (.) them if you can keep it (.) moderate (3) well. Not to do or do (1) some, like achieve (.) a compromise you can achieve, but it's then (.) easier *said than* (inaudible) *done*.
P1 (-61): Moderation in all things. (6) (others agree) You certainly can't like completely like (.) when you think about things like well (1) the number of things so that (1) there's no way you can like, an opti-, optimal state, you can't (.) *like* o-, one person like (.) keep them things under control (.) (FG4:4.)

The excerpt illustrates well the general progression of conversation at the initial stage of interviews. As the participants found it quite difficult to start discussing the topic with many uncertainties, they would resolve this problematic situation by refering to 'moderation in all things'. Generally speaking, the more abstract the health-related issue(s) under consideration was, the easier it was for the participants to refer to moderation as a guiding rule of life. Another issue of major interest at the beginnings of interviews was the regularity of how the participants proceeded in the discussion after the initial confusion about control of the number of health-threatening factors. Invariably, the next step was to go on to consider behavioural factors of health, bypassing, simultaneously, those factors not relating to individual choices. Taking into account that many participants mentioned factors related to their daily environment that posed concrete and acute dangers (such as chemicals and accidents at work), it is striking that the discussions almost entirely covered topics regarding lifestyle choices and factors presumably leading to chronic diseases.

The following excerpt also represents the beginning of a discussion that started right after the list of health threats was completed. It highlights the participants' general

[1] The complete lists of health-threatening factors from each focus group are provided in Annex 1.

orientation to discuss behavioural things instead of environmental, socioeconomic or other external factors. The factors mentioned which threaten men's health included ageing, diet, physical exercise, smoking, alcohol, industrial chemicals, stress, (problems in) human relations, injuries from physical exercise, traffic, air pollution, war and terrorist attacks. At the end, I deliberately added inheritance.

Excerpt 8.2.

(Part 1.)

IP: Well (1) now we can add to that then if there (.) in this discussion if anything else comes to mind. That's how you come to think of more when you talk about things for a while, add to them as we think of them. So (1) let's take a look at that list, it's quite long and contains a lot of different things and I'd just like to ask how you think it looks? How then (.) a person can manage to stay healthy if there are that (.) many and different kinds of issues? (3)
P1 (-49): Well there's nobody ever got out (.) got out of this a-, alive but (.) yes there are indeed some such (.) eating (.) habits yes certainly (.) more attention is paid to them (.) now than when I was younger (slowly) *that* (2) In some way I suppose you start to appreciate your health (.) state (.) state of health more when you're getting older. (1) And it's the same with many other things here (.) like (.) exercise (.) it's as if (.) at some point in your life it gets less attention and then at some other point (.) it starts to increase. When you're younger there's certainly a lot of it and then (.) there comes a regressive phase and then at some point it dawns on you that you should do something 'cos otherwise you don't (1) the outcome will not *be good*. (2) *But* the smoking and drinking are likely the same way (.) the same thing that (1) somewhere around twenty to thirty you don't so much size up i-, the consequences, at the time it doesn't feel but then when you're old*er you start* to think a bit more seriously. (The whole speech is spoken quietly, slowly and 'meditatively'.) (4)

(Part 2.)

IP: Now when that came up, when you said that at this age (.) er (.) you start to think so have you, Jouko (P3), and you Martti (P2) for your own part felt that for you, that you have (.) started to think more about health? (2)
P2 (-49): Ye:s quite a bit I've thought and (1) myself I've tried to exercise and (1) eat healthy stuff and (2) yes, it surely comes to my mind. (2)
P3 (-54): Yes you (.) do start to pay quite a bit of attention to this (.) to eating habits and (1) to living habits in general and (2) it's so stressing this present life to the extent that (.) smoking and alcohol from time to time are part of (1) a normal day and exercise a bit less when there doesn't seem to be time for it and (.) through that the need for rest (.) is even more noticeable so that.. (2)
P2 (-49): *Aye* (.) what's good for me is that I don't smoke (.) even if (.) I enjoy a drink (laughs). I go out with the dog every day and do an hour's walk so (1) in that sense *but* (.) tobacco is bad. (FG5:4–5.)

In my view, there are three very important general issues in the excerpt. First, it is notable that even with a long and heterogenic list of different threats to health, the participants merely discuss the behavioural factors in addition to ageing which, being the first factor mentioned, started to lead the discussion. In fact, the thread running through the whole excerpt is consideration of the different viewpoints related to physical exercise, diet, smoking and alcohol at different stages of life and especially how these views may change when they get older. This reflects what Riska (2000) has called 'life-stylism', where people increasingly interpret health and illness as being caused by individual lifestyle choices as Blaxter (1997) has shown in her study. A possible explanation for this is the participants' presuppositions regarding the interview situation. As I had introduced myself to the interviewees as a university researcher of the School of Public Health, it seems plausible to assume that many of them associated my position with health education. This, in turn, may have resulted in the participants' tendency to discuss issues that they thought the interviewer was 'looking for', i.e. issues related to health behaviour. As Blaxter (1990, 153) has pointed out, people have absorbed the central ideas and vocabulary of health education campaigns resulting in their tendency to consider lifestyle choices as the 'correct' or 'expected' answers in interviews. In addition, in an interview situation, it may be easier for participants to discuss concrete life choices instead of more abstract risks related to their environment that would possibly require knowledge of chemistry and other natural sciences. It might also be claimed that although talking about lifestyle poses a dangerous question about individual responsibility for health, it simultaneously emphasises the individual power of control over health.

The second notable issue here is how easily the participants associate 'thinking about health' with 'doing for health', and attach personal moral obligations to live in healthy ways to a more general discussion on the importance of health at different stages of life. This moral work is emphasised throughout the excerpt but is especially prevalent in the second part of it. In response to my question, 'how can a person manage to stay healthy if there are that many and different kinds of issues' threatening health?, the first participant ironically comments, 'well, there's nobody ever got out got out of this alive', which refers to the inescapable death of every human being ('life-is-dangerous argument', DeSantis 2003). The irony used here can be read to claim that 'it is unhelpful to consider various threats to health because we are all going to die, anyway'. After this ironic starting comment he goes on to consider how the importance of health and involvement in health-threatening or health-improving activities change over time. His conclusion is that when a man gets older he starts to appreciate health more than when he was younger and, consequently, starts to 'think a bit more seriously' about it.

To continue the discussion about ageing and health, I asked the other participants (P2 and P3) about their thoughts on their own lives: have they 'started to think more about health?' Both participants basically start their answers the same way, saying that they have, indeed, started to think more about it over time. It is notable that expressing this idea does not seem to be enough since both participants continue their accounts by concretising their answers with reference to activities they claim to have been involved in (exercise, eating healthy food, living habits in general). One way of reading the responses is to approach them as if they were ready-made counterarguments for possible criticism: 'well if you say you have thought more about health, so what have you actually done for it?' It seems that *thinking* about health is not enough without a concrete reference to *doing* something about it.

The third important issue in the excerpt, relating to the previous notion of emphasising 'doing' for health, is how the speakers endeavour representing healthiness of their own lifestyle. This is not, of course, an unforeseen finding as such, as the previous chapters have shown the participants tend to emphasise health and healthiness in all their talk about their own lives. This, however, poses an additional matter of interest in the argumentation they use when asserting healthiness of their own personal life. How is personal healthiness constructed in the interview? What are the elements of health and healthiness in these constructions?

In the analysis of research material, I identified five different rhetorical strategies for asserting healthiness of personal lifestyles[2]. The first strategy is based on *questioning and relativisation of health-related information*, a topic that has been previously discussed in Chapter 5. The information dealing with a large number of people may not predict individual cases of health and illness, a fact that the participants often referred to. Although heavy drinking and smoking are indisputably harmful at the population level, there are 'plenty of cases' where the health outcomes of individual people are not in line with general statistics. These exceptions to the general rules are often taken as examples of the incompleteness of knowledge about health. As was noted in Chapters 5 and 7, nutrition was the most often discussed topic when questioning health information.

Another strategy which is closely linked with the previous one is *locating the health-related habits and behaviours in a larger context*. Here, the separate health-related actions, choices, habits and circumstances, as well as their health outcomes, are assessed in relation to other behaviours and choices within the framework of the variety of health-related factors.

[2] An early version of this analysis was presented in Pietilä 2006b.

Excerpt 8.3.

P3 (-76): I (…) smoke myself, and every time there it says that "Smoking kills" or something of the sort. (2) So that (1) even if (.) that's what it says, that smoking kills, so OK, (1) there's plenty of other things to kill you so I don't (1) like (.) take it that way (.) kind of but.. (FG1:6.)

The excerpt above has been previously discussed in Chapter 7 (Excerpt 7.13) as an example of the *life-is-dangerous* argument (DeSantis 2003) and the idea that 'risk is part your life' (Lupton & Tulloch 2002b). It is notable that, in my interview material, the idea of positioning health behaviours into wider context, and representing them thus as relative to many other things in life, was most visible in the accounts about smoking. This may be due to the widely agreed un-healthiness of smoking as I suggested in Chapter 7. The uncontested harmfulness of smoking offers few opportunities for questioning the consequences of smoking as such which, in turn, results in setting the points of comparisons outside of it.

Despite rather abstract notions of the existence of 'plenty of other things to kill you', health-related behaviours were also positioned in a larger context by referring to an individual's limited possibilities to lead a healthy life. As Backett (1992a) noted in her ethnographic study, the interviewees tended to legitimise their health-related behaviours 'in terms of their appropriate social contexts' and referred to various constraints involved in their particular stages of life (i.e. the need to care for children, domestic work, work pressures, pregnancy and so on) for contextualising their health-related choices. The participants of my study similarly pointed to a lack of money and time as reasons for not being actively engaged in health-promoting activities, as well as to work pressures and problems in relationships as reasons for their unhealthy behaviours (e.g., Excerpt 8.2).

The third rhetorical strategy used for representing healthiness of lifestyles, as a whole, is *seeking balance between healthy and unhealthy behaviours*. In the next excerpt from a focus group, a participant considers how taking care of health changes with age.

Excerpt 8.4.

P4 (-64): Greasy food and that, well, it's not, it's not so like somehow (.) uppermost in your mind I would say when you're under (.) thirty still. So that at least I haven't thought, but I've always taken a lot of exercise that it hasn't (.) I've never bothered to, and still don't really watch *what I'm putting in my mouth, so..* (FG3:5.)

Seeking a balance has often been reported as a feature of lay people's constructions of health-related lifestyle choices (Mullen 1992; Backett et al. 1994; Backett & Davison

1995). It is important to note, however, that 'balancing' is not actually one single strategy but consists of several different ways of representing equilibrium between health-protecting and harmful aspects of life. The excerpt above represents a strategy of *compensating unhealthy behaviours with healthy ones*. In the excerpt, compensating 'greasy food' with exercise may relate to weight-control and not to other health-outcomes of an unhealthy diet (such as cardiovascular diseases). Despite this, the excerpt illustrates a way to assess healthiness of lifestyles by referring to a mutual balance between the different behaviours, where the health-enhancing factors compensate for the potential harmful consequences of the unhealthy ones. Henwood et al. (2002, 185) similarly observed on the basis of men's interviews that some of the interviewees viewed engaging in fitness and exercise regimens as 'a means of self-protection from habits and lifestyles that were otherwise self-destructive (alcohol and drug abuse)'. Reading the excerpt from the perspective of gender suggests again that physical exercise seems to be a rhetorically strong argument for men in assessing healthiness of life.

Despite constructing the balance between different health-related behaviours, the balance may also be sought between general compliance with and exceptional transgressions of a healthy way of life which leads to *compensating transgressions with representations of general compliance with advice of healthy lifestyles*. Interestingly, sporadic transgressions discussed in the interviews typically concerned occasions of 'non-moderate', heavy drinking of alcohol. In these cases, compensation may be conducted in two different ways. First, the transgressions may be compensated for by other healthy activities following the transgression. After a sauna-evening with lots of drinking, the hangover may be wiped out by having a good 10 kilometre run. Secondly, occasional heavy drinking may also be compensated for by a notion of generally moderate consumption of alcohol. Several participants admitted to having had occasions of heavy drinking, but described this as not having any significant impact on their health as overall they considered themselves to be light to moderate drinkers. According to this logic, the low combined alcohol consumption outweighs occasional heavy drinking and thus represents generally moderate use of alcohol which, in turn, represents control, responsibility and health-awareness of the speaker.

After analysing the various 'balancing' strategies, the most interesting finding is that the compensations do not always concern a person's own unhealthy habits, as in the next excerpt (previously discussed in Excerpt 8.1 of this chapter).

Excerpt 8.5.

P2 (-49): *Aye* (.) what's good for me is that I don't smoke (.) even if (.) I enjoy a drink (laughs). I go out with the dog every day and do an hour's walk so (1) in that sense *but* (.) tobacco is bad. (FG5: 5.)

In the excerpt, the logic of balancing involves the speaker's health-related activities and those unhealthy behaviours that he does not lead. In other words, the speaker compensates for his own (possibly) insufficient efforts to promote his health by referring to a substantially harmful behaviour (smoking) that he has avoided. *Compensating unhealthy (or insufficiently health-promoting) behaviours by avoiding more unhealthy behaviours* is based on the notion of the 'unhealthy others' (Crawford 1994) that are referred to as opposites to the healthy self. As suggested in Chapter 7, the harmful effects of smoking are agreed to the extent that it renders it possible to make an easy comparison with generally unhealthy smokers. That the speaker does not smoke, and does not thus engage in the extreme of unhealthy behaviours, makes his lifestyle generally healthy. Another example of compensating unhealthy habits by the avoidance of more unhealthy ones was previously discussed in Chapter 7 in the context of smoking. The next excerpt is the latter part of Excerpt 7.15, where the participants had a heated discussion about one interviewee's smoking.

Excerpt 8.6.

P2 (-48): This is, here there's many (…) many other things too you can resort to (.) well take one sort of (1) a less (.) lesser evil then (1)
P3 (-50): But is it (smoking) (.)[is it lesser? [
P2 (-48): [If you sta- [if you start comparing to if I would buy well (1) half a bottle of Koskenkorva spirits every day.(1)
P3 (-50): [And is that you're comparing smoking to[?
P2 (-49): [(laughs) [Ay:e! (laughing) (FG6:11–12.)

As concluded in Chapter 7, the harmful effects of smoking are so widely agreed that compensating it needs to be grounded in the rather extreme example of drinking half a bottle of spirits every day. Although participant P3 seems unconvinced about the adequacy of this argument, the conversation illustrates the balancing strategy where the unhealthy habits are compensated by the more unhealthy behaviours that the speaker is not involved in.

Both examples of balancing (compensating unhealthy habits with either healthy habits or avoiding more unhealthy ones) are expressed in relation to a certain, specified unhealthy behaviour, instead of considerating healthy lifestyles more holistically. This is, according Backett (1992a), a distinctive feature of lay understandings of the healthiness of one's own lifestyle.

> In lay systems of constructing health a common pattern seemed to be that respondents traded-off a 'good' behaviour for a 'bad' behaviour to balance out their overall health rather than being moderate or conformist over a wide range of behaviours. (Backett 1992a, 272.)

The fourth strategy for asserting healthiness of lifestyle is *representing numeric information about one's own health status, physical condition and health-promoting activities* (previously discussed in Chapter 4). When speaking about their health, the participants often put forward numbers of kilometers skiing, cycling or swimming that they had completed during the past season, and referred to tests of physical condition to assert that their good condition was objectively verified by independent and neutral observers. The various medical tests (especially blood tests) were, in turn, referred to as indicators of good 'internal' health, which would otherwise be difficult to attest. The same way as in the tests of physical exercise, the cogency of medical tests is partly grounded on the role of an outside specialist, a doctor, in conducting them. The general conclusion of the analysis was that numeric information represents factual and objectified indicators of health and activities related to them (physical exercise, in particular), which absolves the speaker from potential counterarguments regarding subjective, and thus potentially biased, assessments of the healthiness of their lifestyle.

In addition to the previously introduced strategies for asserting the healthiness of one's own lifestyle, there emerges a fifth form of argumentation which is not directly used to represent healthiness of lifestyles but, instead, to prevent possible accusations of irresponsible, unhealthy behaviours. Even if one's behaviours and habits were not fully healthy, *expressing one's intension to change unhealthy habits* includes a message that, despite his actual behaviour, the speaker acknowledges the importance of healthy ways of life and intends to act according to this in future. A similar finding was made by Kathryn Backett (1990) who found that while her interviewees expressed health-awareness, their behavioural practices did not follow the expressed ideas of the importance of health.

> Regularly when respondents considered if they had changed anything regarding their health, many of them explained that, whilst there had been little change in their actual behaviours, what <u>had</u> changed was their awareness or consciousness of health and healthy practices. Thus what was important was to demonstrate that one knew what one <u>should</u> be doing for health and be able to put forward other, perhaps even more socially responsible, reasons to explain why so little of the knowledge was put into effect. (Backett 1990, 12, emphases original.)

In my material, this idea was presented in its clearest form in the beginning of Excerpt 7.15, where the participants discussed one interviewee's (P1) smoking. In the excerpt, P1 told the other participants about his attempts to quit smoking and described what a 'hellish bad job' it is to get rid of 'damned cigarettes'. Other participants' responded emphatically to this story and did not criticise the speaker for his smoking, which became interesting when another participant was strongly criticised for smoking just a few moments later. As I suggested within this analysis, the differing attitudes towards the two smokers arguably arose from their different ways to judge their own smoking: while the first speaker condemned smoking and expressed a willingness to quit and had attempted to quit it, another participant did not take a sufficiently moral stand against smoking. In addition, addiction, which was the reason given by the first speaker for his failure to stop smoking, might be regarded as a convincing reason for 'why so little of the knowledge was put into effect' (Backett 1990, 12).

> In a culture where rationality and self-control are supremely valued, a person who affirms that he cannot control himself loses face and is ridiculed. However, a person who intends to exert control, but cannot despite his best 'will power', is admired and excused for his failing. One is only condemned if one does not try. (Stein 1985, 210–211.)

The need to express intention to change unhealthy habits puts forward the moral dimensions of healthiness of lifestyles. In case a person has not been able to live in accordance with the norm of healthiness, the least he can do is to condemn the unhealthy activities and express an aim to change his life. As Blaxter (1997, 756) observes, 'if one cannot deny the reality of one's own disease, one can at least respond "healthily" to it'. Similarly, if one cannot deny the reality of one's own unhealthy behaviours, one should at least respond 'healthily' to it. Repenting the sins in public opens an opportunity for atonement.

As noted several times earlier, the harmful effects of smoking are widely agreed and it is not possible to negate the detrimental effects of smoking. This, in turn, leads to cut-off thinking regarding smoking; a person either has this harmful habit or does not. Smoking is largely attributed to nicotine dependence, which distinguishes smoking from other health-related behaviours discussed in this study. While lack of exercise and an unhealthy diet, for instance, may be attributed to a person's lack of willpower and other things describing personal choices, smoking is caused (maintained) by a chemical agent. As I have earlier argued (Pietilä 1997, see also Aarva et al. 2005), addictiveness and 'being hooked' have become the key attributes attached to smoking which, simultaneously, act as a more or less legitimate reason

for not being able to stop it. Nicotine is an outside force that a person may not be able to resist. This also results in the 'victims' of the chemical agent being absolved from blame, at least if they express their willingness to try and quit.

While the previous excerpt about smoking was somehow an extreme example of how a publicly expressed intension to change an unhealthy habit absolves a speaker from moral judgements, there are plenty of examples of subtler references to the same issue in the material. Whilst stopping smoking is a concrete favourable aim, other health-related behaviours do not involve as clear aims which people should aspire to. Therefore, especially in discussing diet and physical exercise, the expressed intensions to lead a healthy life are often expressed in more vague forms. One example of this is the latter part of Excerpt 8.2 of this chapter.

Excerpt 8.7.

IP: Now when that came up, when you said that at this age (.) er (.) you start to think so have you, Jouko (P3), and you Martti (P2) for your own part felt that for you, that you have (.) started to think more about health? (2)
P2 (-49): Ye:s quite a bit I've thought and (1) myself I've tried to exercise and (1) eat healthy stuff and (2) yes, it surely comes to my mind. (2)
P3 (54): Yes you (.) do start to pay quite a bit of attention to this (.) to eating habits and (1) to living habits in general and (2) it's so stressing this present life to the extent that (.) smoking and alcohol from time to time are part of (1) a normal day and exercise a bit less when there doesn't seem to be time for it and (.) through that the need for rest (.) is even more noticeable so that.. (FG5:4.)

As my question to the participants is based on the expression 'have you started to think more about health', it is understandable that both participants respond to it by referring to their ideas about the importance of healthy ways of life. What is interesting, however, is that while concretising their accounts by references to 'doing' they use formulations that both articulate intentions to have healthy habits but remain, simultaneously, relatively obscure. Saying that '*I've tried* to exercise and eat healthy stuff' and that a person starts to '*pay quite a bit of attention* … to eating habits and to living habits in general' reflect a crucial element of how intentions to lead a healthy life are formulated: although both of the expressions leave aside what the speakers have actually done for their health, this does not vitiate the statements. This is because statements like these are not primarily made for reporting true activities. In my view, the primary aim, instead, is to *express compliance with advice of healthy lifestyles*. This becomes particularly clear in the last account of the excerpt where the speaker admits that 'smoking and alcohol from time to time are part of (his) normal day' due to his stressful life at present. Disclosing these types of unhealthy habits

does not pose a moral threat to the speaker due to an expressed agreement with the importance of healthy lifestyles.

Excerpt 8.8.

IP: Yes, well (.) let's go a bit to those (2) maybe living habits more, that (.) well I'll just like to ask one more thing about, what do, how do you (.) think (.) describe your own living habits from the health perspective (.) as a whole, you know, so do you think that your living habits are healthy?(3)
K8: (sighs) *Well*, reasonably, just that the cigarettes I should (2) leave *out*
IP: Mmm.. Well let's say if you had to put a plus or minus on your own living habits which would it b[e?
K8: [It would be a plus
IP: Yeah (2) how would you (.) justify that?
K8: (sighs) well as I see it (.) I try to eat (.) fairly healthily and I take exercise (.) (IP: yeah) and alcohol (.) isn't a problem (laughing).
(K8:10–11, born 1971.)

There is an interesting difference in how the interviewee responds to the two different questions. When I ask the first question about the interviewee's lifestyle, 'do you think that your living habits are healthy', the interviewee answers, after a meditative pause, in a relative way pointing out that he 'just' should leave out the cigarettes. When I, in turn, ask a more clearly defined and bipolar question of whether he would mark his living habits with plus or minus, the interviewee does not hesitate a second before answering that 'it would be a plus'. After that he, again, finds it more complex to give an unequivocal justification for his choice pointing out that he *tries* to eat 'fairly healthily', does exercise and that alcohol is not a problem for him, utilising the same rhetorical strategies for representing healthy lifestyles as discussed above. Thus despite the uncertainties and complexities related to an assessment of the healthiness of lifestyles, the interviewee seems very eager to make a categorical statement that his lifestyle is, indeed, healthy.

Cracks in 'health awareness discourse': guarding the masculine self

The first part of this chapter has focused on the assessment of the healthiness of one's own lifestyle. As it turned out, the 'moral imperative of healthiness' (Backett 1992a) seems to set strong expectations for how one's own lifestyle is discussed in an interview context. This results in a general tendency to consider a person's own lifestyle as healthy, despite possible 'rough edges' around it, such as smoking. Another theme I analysed in reading the 'lifestyle talk' was how the interviewees represented their masculinity when speaking about their own health-related choices and habits.

This was an important part of reading the interviews since the starting point of the whole study was the claim, made in several earlier studies, about masculinity being in conflict with healthy lifestyles. One would assume, then, that this conflict could be traced in men's interview talk about their own health, and especially relating to the healthiness of lifestyles, in either explicit or implicit form. On the basis of my analysis of the interviews, it became apparent that, regarding one's own lifestyle, the potential conflict was never expressed in any explicit way. The accounts were dominated by a discourse of health-aware responsible citizens.

Despite this general tendency, in some parts of the interviews, there were tones that give reason to approach them as potential discursive practices of guarding the masculine self when speaking about health. One of these rare examples is at the end of the excerpt already discussed twice in this chapter (Excerpts 8.2 and 8.5). As concluded earlier in the chapter, the thread of the excerpt is the way in which the participants seem to face a moral expectation to represent the healthiness of their lifestyle and a willingness to lead a healthy lifestyle when answering my question of whether they have started to think more about health as they get older. Within all argumentation addressed to convince the interviewer (and possibly other participants as well) of the good intentions of the speaker, there is one exceptional expression amongst the accounts. In participant P2's last account, after referring to his non-smoking as a good thing for his health, he suddenly notes 'even if I enjoy a drink', which somehow does not fit the account, and even contradicts the rest of it.

Excerpt 8.9.

IP: Now when that came up, when you said at this age (.) er (.) you start to think. Have you, Jouko (P3), and you Martti (P2) for your own part felt that for you, that you have (.) started to think more about health? (2)
P2 (-49): Ye:s quite a bit I've thought and (1) myself I've tried to exercise and (1) eat healthy stuff and (2) yes, it surely comes to my mind. (2)
P3 (-54): Yes you (.) do start to pay quite a bit of attention to this (.) to eating habits and (1) to living habits in general and (2) it's so stressing this present life to the extent that (.) smoking and alcohol from time to time are part of (1) a normal day and exercise a bit less when there doesn't seem to be time for it and (.) through that the need for rest (.) is even more noticeable so that.. (2)
P2 (-49): *Aye* (.) it's good for me that I don't smoke (.) even if (.) I enjoy a drink (laughs). I go out with the dog every day and do an hour's walk so (1) in that sense *but* (.) tobacco is bad! (FG5:4–5.)

The discursive structure of P2's last account represents what Riley (2003) has called 'sandwiching' pointing to how an alternative argument is located in-between the central argument. This allows the speaker to avoid being heard as having only one perspective on the issue under consideration. In this example, 'even if I enjoy a drink',

accompanied with softening laughter, may thus be interpreted as an alternative argument to the central argument of the speaker's healthy lifestyle. Interpreted this way, it shows to the other participants that while the speaker represents general compliance with healthy lifestyles and control over his life, he simultaneously allows himself transgressions within it. This account provides a good example of *control and release* of healthy lifestyle habits (Crawford 1984). Even more importantly, it demonstrates how health-awareness discourse, which dominates talk about one's own lifestyle, is on some occasions challenged. In my view, the challenge in the previous excerpt arises, at least partly, from a need to protect the masculine self of the speaker.

From a general perspective, the sentence challenges one to consider why an alternative argument for a person's healthy lifestyle is expressed. A liable interpretation is that it is addressed to the other participants as a counter-argument that the speaker does not, after all, lead a completely healthy lifestyle in all respects. In order to track the reason for this, we need to pay attention to the interaction in the excerpt. Before P2's last comment, participant P3 has said that, by ageing, 'you' start to pay 'quite a bit' of attention to eating habits and to 'living habits in general'. However, after this he admits that, due to a stressful life, 'smoking and alcohol from time to time are part of a normal day' thus acknowledging that his 'living habits' are not completely healthy. P2 starts his account as a continuation of what P3 has previously said by commenting that 'it's good for me that I don't smoke'. This comment has two potential consequences. Evidently, it tells the other participants that P2 has, in this respect, healthier living habits than P3 has. However, when saying this, he simultaneously puts himself in danger of being criticised for the comment. This is because his comment highlights smoking as an unhealthy habit and undermines P3's account of his attempts to live a healthy life, and thus locates P3 in a threatened position. P2's comment might thus be heard as an over-representation of his own healthy lifestyle, which is annoyingly based on a comparison with P3. To put it briefly, P2 is in danger of being heard as a black-and-white critic of those whose living habits are not completely healthy.

As a result P2 jockeys for his position by admitting that he (too) 'enjoys a drink', releasing P3 from the awkward situation of being a sinner due to his smoking and alcohol drinking. Use of alcohol, as an example of a not-completely-healthy-lifestyle, brings up an interpretation of defending the masculine position. It refers to an activity that is a socially shared and accepted form of masculine behaviour, even if it conflicts with healthiness, as was discussed in Chapter 7. Pointing to drinking thus acts as a signifier of being a companion of the shared male culture, of being one us, 'lads', and not one of those 'nags' who judge other people's habits. Alcohol thus acts as a discursive 'bonding ploy' within male company.

The same type of reference to alcohol emerged in another excerpt which has also been discussed earlier (Excerpts 7.11 and 8.8). When considering his lifestyle as a whole, the speaker refers to his eating habits and exercising and notes that 'alcohol isn't a problem' for him. That he starts to laugh when saying this has been discussed in Chapter 7 in relation to humour concerning alcohol. Reading the excerpt again from the perspective of gender suggests that the reference to alcohol acts, similarly as in Excerpt 8.9, as an affirmation that the speaker is not a 'fanatic' about health issues.

Excerpt 8.10.

IP: Mmm.. Well let's say if you had to put a plus or minus on your own living habits which would it b[e?
K8: [It would be a plus
IP: Yeah (2) how would you (.) justify that?
K8: (sighs) well as I see it (.) I try to eat (.) fairly healthily and I take exercise (.) (IP: yeah) and alcohol (.) isn't a problem (laughing).
(K8:10–11, born 1971.)

Saying that 'alcohol isn't a problem', accompanied with laughter, is a rather different expression from another conceivable formulation of 'I don't drink much', especially if said gravely. Laughter and reference to extreme drinking hint to the listener that the speaker drinks, sometimes even excessively, but in a controlled way.

The two previous key expressions ('even if I enjoy a drink' and 'alcohol isn't a problem') are good examples of implicit and subtle ways of 'doing gender' in the interview context. The genderedness of these accounts may easily be questioned due to their vague formulations. In my view, the evidence for the genderedness of the accounts is found in-between the lines of talk. In reading the accounts, I tried to imagine a woman saying the same phrases. That I could not imagine a woman saying either of these sentences *in this context*, was the final reason for interpreting them as gendered talk and representations of masculinity.

The third example of guarding the masculine self within an interview about the healthiness of one's own lifestyle does not incorporate similar problems regarding the reading of gender in it. The next excerpt has previously been analysed in Chapter 7 (Excerpt 7.4) and an earlier part of the excerpt was used in Chapter 4 (Excerpt 4.6). As noted in Chapter 7, the speaker uses several indicators from medical check-ups (cholesterol levels etc.) to demonstrate his healthy eating habits. However, it was also noted that there is a strikingly contradictory perspective to the topic at the end of the excerpt attached below.

Excerpt 8.11.

T4: And then the (2) missus, well (.) yes, she gives me salad every day and tries to feed me it that (2) (IP: Aye.) (.) And she doesn't do any fatty food and (.)
IP: mm (1) Yes.
T4: *Like that*.. (T4:8, born 1949.)

After trying to convince the listener of his healthy eating habits, supported by test results, the interviewee suddenly refers to his wife in a way that conflicts with the previous perspective. The key sentence of the excerpt, 'the wife tries to feed me (salad)', alienates the speaker from the femininity of 'salad'. In this way the sentence may be read as an assertion of the speaker's masculine stand on the issue under discussion.

All three examples of guarding the masculine self arise, in fact, from a similar interactive context, and may be interpreted as the same type of responses to specific requirements involved in interaction. What is common in every one of them is that in all three parts of the interviews the speaker's masculine position is in some way threatened. In all of these contexts, the speaker has been dangerously close to being heard as having too passionate or even fanatic a stand on healthiness. If we subscribe to the idea that 'fussing about health' is the feminine extreme of health-awareness in men's thinking about gendered aspects of health, then the three examples of this section can be interpreted as counter-claims for potential accusations of being 'fussy' about health. A 'softer' interpretation is to see the expressions as representations of competence in different vocabularies (or 'scripts', Sobal 2005) related to health. This perspective suggests that offering 'masculine' interpretative versions is not directly about diminishing the potential threat of femininity incorporated in representing the health-aware self, but relates to convincing other participants of the speaker's knowledge and cultural competence in differing vocabularies related to health. However, what is common to both views is that these examples show that the men are aware of these different gendered discourses when talking about their own health-related lifestyles.

In the previous chapters it became clear that traditional ideas about manhood as oppositional to health-awareness and care of the self were most easily expressed in non-personal contexts, while talking about individual health and personal lifestyle choices were by and large dominated by the health-awareness discourse. As concluded in this section, involvement of traditionally masculine interpretations of one's own health-related lifestyle mostly takes place in contexts where the speaker's masculine position is jeopardised. However, in the material, there were a few examples of cases that represented situations somehow in-between the personal and non-personal contexts. Interestingly, the discursive practises utilised in these contexts are in

a sense rooted in the configuration of health-aware and (traditionally) masculine standpoints.

The next excerpt is from an interview episode where we discussed how the significance of health may change when men get older and how this sometimes results in increased efforts to improve health and physical condition. Several participants mentioned examples of their own fathers or older acquaintances who changed their lifestyle habits, typically after the emergence of chronic diseases or even sudden deaths within their close social circles. The topic of the conversation thus differs from others analysed in the chapter in that it does not directly concern the speakers themselves but their parents, relatives or acquaintances. Within this discussion participant P4 gives his own example of his father's newly emerged health-awareness.

Excerpt 8.12.

P4 (-76): Me father's anyway one of those (.) that now he's started (.) well (.) maybe in our family it's like this that (.) the more me mother knew the more me father suffered (chuckles) so well (.) now me mother's such a one that she gets behind him and says "and now off you go!" (fast) (1) that (.) out for a run every day and (1) like (.) in certain things it's starting to go a bit too far that they have su*ch* bloody (.) vitamins (.) additives (.) in packets there that (1) it's like a load of athletes.. (FG1:9.)

The apparent subtext of the excerpt is that his mother actively urges his father to involve himself in health-promoting activities such as regular physical exercise and a healthy diet. It is, however, interesting how the initiative of a healthy lifestyle is not attributed to the mother from the very beginning. In starting the story, P4 says that his *father* has started (to engage in health-promoting activities) but changes the course of the story, after a short break, and continues it by telling about his mother's efforts to get his father active. The account ends with the conclusion that these efforts have resulted in somehow extreme forms of health ('it's starting to go a bit too far'), which is emphasised with a rhetorical distinction between ordinary people and athletes. The account is grounded in relatively traditional discursive scripts where it is a woman (mother) who takes care of her own and the man's health in a passionate and extreme, even aggressive way. Purchased nutrients form an important element in the story: the 'bloody vitamins' and 'additives', generally associated with women's health, foster the idea that *both the initiative and the means for health-promoting activities come from the mother's side*. Even though the father is not described as resisting this, he is the one who 'suffers' from the health-awareness activities of the mother.

After the excerpt, the discussion continues with one participant's (P2) account of his father's changing attitude to working hard which the participant interprets as a sign of his father's changing thoughts about health. After this I turned to participant

P4 and asked him to tell me more about the changes in his father's lifestyle. This time, P4 tells the group that his father has dropped weight 'a lot' and started to do exercise remarkably more than earlier. In this context, the reason for a change in lifestyle is solely attributed to the father's own initiative and will. In addition, P4 notes that his father has decreased extensive working in his own private firm and plans to retire prematurely and sell the firm. This gets me back to his mother's role in the father's lifestyle changes.

Excerpt 8.13.

IP: Well (.) you said that you (.) mother has been involved in
it quite a [bit
P4 (-76): [Aha[:h!
IP: [in[this
P4 (-76): [Ay[e:! (laughs)
IP: [*business*..
P4 (-76): Yes she's one of those (.)[
P2 (-75): [coaches[(laughs)
P4 (-76): [oh yes (.) she's the last word as a tough trainer that (1) dad comes home from work well (.) she gives him (.) salad *and* (.) a bit of chicken then says "and when you've eaten we'll go out for your exercise" and (.) then there's no questions asked that..
IP: Well, what about when this or (.) do you remember any time when this like would have started or, or has it just like always been (.) your mother (.) did that, but that at some point [that your father just started accepting it?[
P4 (-76): [It started [a couple of, couple of years back so that, our well (.) in the family (.) the husband in this family we knew, he must be surely (2) five, six years younger than my father (1), well he had (1) in a year he had three bad infarcts and (1) that's when we in our family (1) started to look a bit what we were doing and..
IP: Uh huh (2) then your father has like, like (.) in a way (.) even if your mother has been there (.) been like working on it (laughing) and moving it along, still in a way it has been absolutely[absolutely on his own initiative[?
P4 (-76): [Yes [yes.
(FG1:10–11.)

Theoretically, the most interesting issue in the excerpt is the fluctuating way in which P4 locates the initiative for his father's attempts to change his lifestyle in a healthier direction. At the beginning of the excerpt he, as a response to my question of his mother's role in the father's change in lifestyle, describes his mother as a 'tough', demanding and even authoritarian trainer of his father. After his first account I ask about when his father's lifestyle change began and ask him to specify his mother's role in it. He replies to my question by telling me a story about the sudden heart attacks of a family acquaintance, which was the time when 'we in our family started to look a bit what we were doing'. At this stage of the excerpt he describes changing lifestyle habits as being a collective decision of the family. At the end of the excerpt he, again

as a response to my specifying question, claims that despite his mother's central role in promoting a healthy lifestyle for his father, it was his father's own initiative to start to live in a healthier way. Reading the excerpt from the point of view of agency thus interestingly shows how descriptions of the initiative for a healthy way of life fluctuate from the mother to the whole family and further to the father.

In my interpretation this oscillation in accounts of agency derives from an exceptional context where general and particular events and public and private spheres of life co-exist and are taken into account in speech. These different elements within the context beget *a tension between traditional, general interpretations regarding health* (women take care of health which is not one of men's interests) *and health awareness discourse regarding personal health* (an individual should bear the responsibility for his/her own health). While the beginning of the excerpt, and the discussion preceding it, deal with relatively general themes, the heart problems of a family acquaintance and its effects on the family bring a remarkably more personal load to the discussion. This is based on the fact that the health problems are both personalised and specified. Therefore, it is no longer about abstract health problems that abstract people (or men) suffer from but, instead, it is about real people with real diseases. This particularisation of health and illness simultaneously leads to individualisation and personalisation of agency related to health. Specification of a threat to health calls for a rational actor to make active decisions for the sake of his own health.

Conclusions

In the chapter I have analysed the ways in which men construct the healthiness of their own lifestyles in an interview context and the discursive practices and strategies they utilise when doing so. The key finding of these analyses is that assessing one's own lifestyle is, to a large extent, framed by the 'health-awareness discourse' and, consequently, constructions of one's own lifestyle are characterised by attempts to convince other participants of the healthiness of this lifestyle.

This is not a surprising result since several previous studies have also pointed to the 'moral imperative of healthiness' (Crawford 1984; Backett 1992a; Lupton 1995) which has significant effects on how people attach moral expectations to talking about their health-related lifestyles (e.g., Conrad 1994; Sachs 1996). As Lupton (1993) has concluded, acting against advice on healthy lifestyles may be taken to reflect an individual's lack of willpower, moral weakness and laziness. For this reason, in an interview context, people are expected to consider moral meanings attached to their

lifestyle and respond to these expectations accordingly. Talking about health is not only to talk about health in general but to talk about one's own health in particular and especially about the person, oneself, in this context. This leads to an attempt to represent one's own lifestyle in a positive, healthy light accompanied with minimising effects of the 'rough edges' of unhealthy habits by justifying and (de-)contextualising them.

Within the analyses of this chapter, there emerged a few cases that may be read as efforts of 'guarding the masculine self'. What was common to all these cases was that in the contexts they occurred the speaker's masculine position was in some way threatened. In all of these contexts, the speaker may be seen as being close to having too passionate or even fanatic a stand on healthiness. Accordingly, the cases of 'guarding the masculine self' may be interpreted as counter-claims for potential accusations of being 'fussy' about health. These examples also show that the men are aware of these different gendered discourses when talking about their own health-related lifestyles.

From a methodological point of view, it is worth noting that data from personal interviews and focus groups did not notably differ from each other in this respect. 'Excuses' for unhealthy habits and other forms of representing healthy lives occurred similarly in both types of research material. It might have been expected beforehand that interaction within a male focus group makes it easier to represent more 'masculine' interpretations on health compared to interviews where social pressures are presumably weaker. The notion that the two sets of data did not have differences in expectations to represent a self with healthy lifestyles negates the assumption that male group pressures would emphasise masculine interpretations over health-awareness.

9 LOCATIONS AND MANAGEMENT OF 'CONFLICTS' BETWEEN HEALTHINESS AND MASCULINITY

The starting point of this study focused on the claim that (hegemonic or traditional) masculinity conflicts with healthy lifestyles and taking care of one's own health (e.g., Harrison 1978; Harrison et al. 1989; Kimmel 1995; Courtenay 2000a; 2000b; Nicholas 2000; Möller-Leimkühler 2002; White 2002; Möller-Leimkühler 2003). In research on men's health, this claim has been used as an explanation for men's unhealthier habits and, consequently, for their lower life-expectancy. In this vein, 'masculinity' has been conceptualised as a system of norms leading men to risk-taking activities and trivialising information on healthy living habits. A closer look at the claim reveals that it includes several problematic presuppositions, particularly regarding the conceptualisation of masculinity as a consistent model throughout time and place. Taking one model of masculinity, whether it be 'hegemonic' or not, as culturally and temporally static and as an unvarying norm that all men follow is a deterministic and essentialist explanation. It tends to consider different roles, ways of thinking and acting as men's innate characteristics and easily leads to mere reproduction of traditional models of masculinity instead of their critical exploration.

In recent years, discursively oriented studies on men and masculinities have challenged this view by approaching masculinities as cultural and discursive positions that are flexibly utilised and negotiated to construct differing ideals of masculinity for purposes of situational identity work (e.g. Cameron 1997; Edley & Wetherell 1997; Willott & Griffin 1997; Gough & Edwards 1998; Edley & Wetherell 1999; Wetherell & Edley 1999; Willott & Griffin 1999; Edley & Wetherell 2001; Gough 2001). An essential component of these negotiations is the ideological nature involved in differing positions. Even if not talking about 'hegemonic masculinity' in the singular, it is evident that some models or positions of masculinity are more acceptable, more valued and more eligible compared to others. This ideological feature produces tensions in the negotiations of masculinities.

Another problematic presupposition in the previous thinking of masculinity and health is that 'healthiness' and 'healthy lifestyle' are somehow assumed to have similar, pervasive meanings for everyone regardless of age, socioeconomic status and so forth. A large body of literature on 'lay' beliefs and constructions of health has shown how the concept of health, health-related behaviours, other determinants of health and different causalities of health and illness are interpreted and negotiated in a variety

of, and sometimes contradictory, ways in relation to requirements of everyday life and daily practices (e.g., Calnan & Williams 1991; Davison et al. 1991; Backett 1992a; 1992b; Davison et al. 1992; Mullen 1992; Saltonstall 1993; Backett et al. 1994; Backett & Davison 1995; Lawton 2002; 2003; Hughner & Kleine 2004). Simultaneously, it has also been demonstrated that 'risk-taking' is a more complex category of activities and motivations amongst the lay public compared to mainstream health promotion literature where the 'risk-behaviours' and their potential consequences are typically considered detached from their everyday contexts (see Lupton & Tulloch 2002a; 2002b). The studies on lay views of health have also demonstrated how healthiness is a highly moral and ideological issue (cf. Lupton 1993; Conrad 1994; Bunton & Burrows 1995; Lupton 1995). Accordingly, talking about health in an interview context simultaneously involves talking about the self: 'accounts of health and illness are accounts of social identity' (Blaxter 1997, 747, cf. Radley & Billig 1996).

This study has analysed men's interview talk about gender and health for exploring the potential dilemmas relating to contrary themes involved in discourses of healthiness and masculinity as well as their interrelations in displaying a healthy masculine self in interaction. In the previous chapters, I have analysed men's ways of assessing individual health, talk about the role of health information, constructions of 'men's health' as a gendered social phenomenon, perceived healthiness and gendered aspects of four key health-related behaviours as well as negotiations of the healthiness of personal lifestyles. The analyses have shown that interview talk involves ideological and contradictory themes related both to the healthiness of lifestyles as a 'moral virtue' (Conrad 1994) and constructions of the masculine identity of the speaking self. Before getting back to discuss the research questions of this study and offer explanations for variations in men's talk about health, masculinity and their interrelations, I briefly summarise the key findings of the previous chapters.

Summary of key findings of analyses

In *Chapter 4*, which focused on men's assessments of personal health, it was found that dilemmatic features of the topic related primarily to the abstractness of health. In the initial stage of analysis it was found that, first, all but one of the participants of the personal interviews assessed their health to be at least relatively good and, secondly, that an assessment of personal health seemed to necessitate argumentation for the claim made of one's own state of health. This represents the normative character of good health, on the one hand, and its abstractness, on the other. Typical arguments for asserting good health were lack of diseases and ailments, functional

capacity (achievements in physical exercise and sports and an ability to work, in particular), and results from different medical tests (especially, consideration of 'blood values'). The potentially contradictory elements, which led the participants to consider different aspects of their health related most often to temporal dimensions of health. Assessments of their current state of health incorporated considerations of past health (ailments, diagnoses, medical tests and measurements) as well as future health. In this respect, there were two important issues, which illustrate how temporal dimensions of health are intertwined in assessments of current health: assessments of health-related behaviours and results from medical tests. Consideration of one's own health-related behaviours moves the assessment of health to concern future health instead of current health which, in my view, highlights the 'binding force' of healthiness: the essential part of 'good' health is to act for it. Medical tests, in turn, act in both directions of past and future health as they are used both as objective indicators of past health and predictors of future health. Regarding future health, the tests, however, simultaneously involve contradictory and dilemmatic elements. Heightened cholesterol levels or blood pressure moves the individual into a 'grey area' of health where (s)he is 'healthy yet ill' (Adelswärd & Sachs 1996; Sachs 1995). It may thus be argued that an *ideologically-driven dilemma in assessments of health stems from normative expectations to represent a healthy self in an interview, on the one hand, and difficulties to conceptualise abstract health on the basis of its obscure indicators, on the other.*

Chapter 5 was devoted to men's interpretations of health-related information. Health education and other health information delivery were generally considered important. However, when health information was discussed more thoroughly and in a more concrete manner, the information delivery was criticised for its inability to give clear and unequivocal instructions for healthy lifestyles, and advice for leading a healthy life was considered to be confusing as it changes continually and includes contradictory elements, particularly in relation to nutrition and diet. When information was depicted in highly normative terms, as 'rules' that the individual should live by, the previous contrary themes lead to *an ideological dilemma: an individual ought to act in accordance with given instructions and rules even though they may include contradictory elements which actually renders it impossible to follow them literally in daily life.*

In discussions on health information, newspapers and magazines were frequently used as examples of sources of information. In talks about magazines, there emerged a clear gendered division between men's and women's magazines. Women were thought to receive more information about health due to the fact that magazines targeting women write more about health than those targeting men. The most gendered

conflicts emerged in contexts concerning the reading of these magazines. In extreme cases, reading women's magazines (or other health magazines such as *Men's Health*) in public settings, such as at the work place, was associated with effeminate behaviour such as 'fussing' about health. This was one of the contexts that may be interpreted as an indication of a conflict between health awareness and (traditional) images of masculinity. It was notable, however, that the 'extreme' interpretations representing a conflict between masculinity and 'fussing' about health typically emerged in the focus groups, where talk was about men and health information 'in general'. When talking about their own personal lives, the men emphasised the importance of getting information about health.

Chapter 6 approached 'men's health' as a social phenomenon on the basis of the participants' explanations for why men die younger than women. In the initial analysis of the material there turned out to be five themes of explanation that the participants recurrently used in explanations for the gender gap in life-expectancy. The first concerned gender differences in the labour market and work where men's physically harder, more dangerous and more stressful work was thought to cause a deterioration in their health which, in turn, was considered to result in men's higher mortality. Secondly, psychosocial factors were discussed as reasons for gender differences in health. Women's greater social contacts and openness to talk about health and other problems were concluded to improve women's health. On the other hand, the 'gloominess' of Finnish men was used to explain men's depression and lack of social contacts which was thus assumed to have an impact on men's health. Thirdly, gender differences in health were accounted for by men's and women's different attitudes towards bodily signs and help-seeking. It was concluded that women take care of their health more intensively and keep track of their bodily signs better than men. In the most concrete form this was articulated in men's and women's differing dispositions to seek help for bodily ailments. Fourthly, the participants referred to women's biological advantages. It was concluded that because women 'preserve life', it is their biology which makes women less vulnerable to illness. However, it become clear that biology was a rather vague category for explaining the differences and was thus often combined with notions of boys' and girls' differing socialisation and tended to focus on motherhood as both a physiological and social phenomenon. Fifthly, differences in health-related lifestyles were often referred to as a cause for women's higher life-expectancy. Women's lifestyle choices were described as being healthier than men's, which was concluded to be one of the reasons why women live longer than men. A notable characteristic of men's explanations was that they operated, to large a extent, on bi-polar gendered divisions, where perceived qualities of both genders were contrasted with each other. These qualities were seldomly challenged or

questioned and thus acted as taken-for-granted generalisations of men and women, masculinity and femininity. Descriptions of men's and women's qualities, attitudes, behaviours etc. were often rather pointed, even essentialist, and were often rooted on relatively traditional views of gender and the gender order.

It was also interesting that when giving explanations for gender difference in life-expectancy, the participants tended to attribute the difference to women's healthier lifestyles and not to men's unhealthy lifestyles. The men talked very little about men's health-related choices, particularly about the *reasons for their unhealthy choices*. Instead, they discussed women's greater health awareness and healthier habits resulting in considerations of motherhood and concerns with appearance as reasons for women's healthier ways of life. In my interpretation, the bias results from an *ideological or moral dilemma relating to 'otherness' and 'us-ness' in the context of offering views about men's lower life-expectancy*. The group of 'men', whose shorter life was the theme of discussion, is interestingly a category including 'them' and 'us', other people and 'me'. In my interpretation, this prevented the participants from expressing ideas regarding men that might be heard as morally deprecating, and resulted in avoidance of moralistic viewpoints and overly strict accusations of men acting irresponsibly.

In *Chapter 7* I analysed the four most widely discussed and known health-related behaviours (physical exercise, diet, alcohol and smoking) from two perspectives. First, I was interested in the extent to which there was a consensus among the participants regarding the 'healthiness' (or un-healthiness) of these behaviours and analysed the different kinds of uncertainties or contradictory elements that were attached to these behaviours in the interviews. Secondly, I analysed the behaviours from the perspective of the gendered attributes attached to them; i.e. to what degree these behaviours were seen as more typical, appropriate or acceptable for men or women. My idea in doing so was to unpack two issues. First, I wanted to demonstrate how healthiness or un-healthiness of different 'health-related behaviours' are not necessarily agreed upon to the same extent and do not thus form equally healthy or unhealthy sets of activities. Secondly, I was curious to explore how the level of genderedness varied between the behaviours.

Smoking differed clearly from other behaviours in both respects. The harmful effects of smoking were very strongly agreed upon among the participants, and virtually no-one challenged this viewpoint. Smoking was also not negotiated much in terms of its gendered characteristics since basically no gendered attributes attached to smoking emerged. The health-promoting effects of physical exercise were largely agreed upon by the participants with the exception of 'excessive' or 'obsessive' training. The gendered aspects of physical exercise related to certain types of exercise or sports

that were seen as either more 'suitable' for men or women. The most conflicting gendered ideas were expressed in contexts where men's participation in 'female' types of exercise was discussed. These discussions involved drastically masculine ideas of such behaviour being non-masculine with references to social exclusion as a result of participating publicly in 'effeminate' forms of physical exercise.

Alcohol and diet were more complicated topics both in terms of their healthiness/un-healthiness and gendered attributes. Discussions of alcohol-drinking included very few explicit considerations of its health-effects. Even in cases of 'problem-drinking', the harmful effects discussed were mostly of a social nature. The same implicitness characterised gendered talk about alcohol. There were a lot of humorous descriptions about alcohol and some of them could be interpreted as 'laddish' joking of shared knowledge of male behaviour and the 'forbidden fruit' of drinking. The inconsistent and obscure information of the health effects of diet was, in turn, a very often and very explicitly discussed topic throughout the interviews. Simultaneously, it was clearly the 'most gendered' behaviour among the four. Although the men expressed ideas of a healthy diet being important for an individual's health, this confronted both the perceived obscurity of a healthy diet and the clearly feminine attributes attached to diet and healthy food, which were expressed most clearly by belittling generalised expressions such as 'salad', 'green stuff' and 'rabbit food'. It may thus be concluded that out of these four behaviours, *nutrition and diet are the topics that come closest to an ideological dilemma between masculinity and healthy ways of life*. Conflicts involved in discussions of health-related behaviours were most often managed by the notion of 'everything-in-moderation', particularly regarding physical exercise, alcohol-drinking and healthy diet.

Chapter 8 broadened the discussion of some of the themes outlined in Chapter 7 covering healthy lifestyles as a whole and the separate activities therein. The interviewees generally tended to regard their lifestyles as healthy, independent of their various unhealthy habits. Central discursive practices related to asserting the healthiness of personal lifestyles was to compensate for unhealthy habits with healthy ones and a relativisation of their health effects, as well as considering unhealthy habits as occasional transgressions and thus as sporadic exceptions from their generally healthy ways of life. One more interesting discursive practice representing healthiness was to emphasise attempts or plans to change lifestyles in a healthier direction, a strategy which parallels with a way to assess personal health on the basis of health behaviours. Focus on future health and healthy choices acts as a declaration of moral commitment to active 'doing' for one's own health, which highlights the ideological and normative expectations for the healthiness of personal lifestyles.

The basic dilemma arose from a difficulty to meet the expectation to represent an 'absolutely' healthy lifestyle and construct it from habits whose actual healthiness varied. Within the analyses, there emerged a few cases that may be read as efforts of 'guarding the masculine self' and thus representations of conflict between the masculine self and healthy lifestyles. Common to these cases was the fact that in the contexts in which they occurred, the speaker was in close to being heard as having too passionate or even fanatic a stand on healthiness and, hence, the speaker's masculine position was in some way threatened. Accordingly, cases of 'guarding the masculine self' may be interpreted as counter-claims for potential accusations of being 'fussy' about health. These examples showed the men being aware of traditionally gendered discourses when talking about their own health-related lifestyles.

Conflicting themes, dilemmas and their (discursive) management

As a general finding of the study, the previous analyses are consistent in that men's interview talk is, to a large extent, characterised with explicitly expressed compliance with and commitment to healthiness of lifestyles. Regarding possible conflicts between masculinity and health-awareness, discourse of healthiness appeared to be a stronger norm or 'logic' that the participants applied in interpreting the topics of the interviews, compared to 'traditional' discourses of masculinity. In other words, the participants more eagerly expressed views that demonstrated their 'health awareness', knowledge of different 'health risks' and emphasised their moral obligation to take care of their individual health compared to traditional assumptions of health and healthiness being something that men have to resist (Courtenay 2000a, 2000b). The potential conflicts and dilemmas between constructions of masculinity and healthiness emerged most often in implicit expressions, between the lines of accounts.

Interview talk is, of course, full of inconsistencies and contradictory elements. The general finding of men's tendency to base their identity work in an interview on constructions of a 'healthy responsible citizen' rather than on traditionally masculine images thus requires consideration of contextual variations in talk. Therefore, I summarise these variations in relation to the specified questions of this study introduced at the beginning of Chapter 3 relating to the variety of conflicts or dilemmas, their discursive management, the variation of gendered attributes attached to health and healthiness as well as the contextuality of these variations in interview talk.

Regarding *conflicts and dilemmas*, the analyses of this study have demonstrated that men's interview talk involves a variety of different types of contrary themes and dilemmatic topics. The dilemmas do not, however, relate only to the relationship between constructions of masculinity and health, as a plethora of previous studies on men's health would assume. Instead, both constructions of ideals of masculinity and healthiness incorporated contrary themes and ideological features separately from each other. In fact, healthiness seems to include the most contrary themes which result in a consideration of its meanings and even dilemmatic situations when talking about health.

'Internal' conflicts and dilemmas of healthiness were largely based on an abstractness of health. As noted several times in the previous chapters, our thinking of health is so heavily bound to its counterpoint, illness, that for healthy people without long-standing diseases, ailments or functional limitations health is often a non-issue and a rather amorphous concept, the meanings of which are difficult to piece together. In my interpretation, the very abstractness of health, when accompanied with normative expectations to assert healthiness of the self, caused dilemmatic situations and positions for the participants in expressing their *assessments of their own state of health, interpreting health information and considering the healthiness of their own personal lifestyles* (Chapters 4, 5 and 8). All these topics necessitated contemplating complex interactions and causalities related to health.

There also emerged internal conflicts between different constructions and ideals of masculinity in men's interview talk, although this was not a tension that frequently occurred within the research material. In some contexts, men considered the differences between various groups of men in terms of occupation, education or of other qualities which differentiated 'others' from 'us'. These distinctions also involved normative features in valuing some forms and qualities of masculinity, proper 'male' behaviours and ways of thinking, to be more greatly appreciated compared to others. It was also noted in Chapter 6 that 'otherness' and 'us-ness' created problems in men's constructions of men's health. However, rather than concerning conflicts between different forms of masculinities, the tension arose from difficulties in defining conformities within various groups of men. An 'auxiliary' concept taken up in these discussions, a 'Finnish man', acted as a generalised identity, which united 'us' and 'them'. As the men tended, in many contexts, to talk about 'them' when discussing negative features of men and masculinities, 'men's health' as a topic of discussion inhibited projecting negative things onto 'them' but simultaneously demanded an objectification of 'us' as well. In my interpretation, *men's reluctance to discuss reasons for men's unhealthier habits was caused by awareness that explanations concerning 'them' were becoming potential accusations addressing 'us'*. It could therefore be

claimed that this is another kind of dilemma compared to those discussed above: while in assessments of personal health status, healthiness of lifestyles and adoption of health information the abstract object causing problems in interpretations was 'health', here the abstract concept is 'men'.

The analyses on men's talk revealed that in many contexts men were careful when making generalising claims about gender. They often softened their conclusions regarding gendered aspects of health awareness as well as 'men' and 'women' as generalised objects (although some very pointed gendered views were also expressed, particularly in focus groups). This was probably caused by an awareness that expressing such views could be perceived as narrow-minded, old-fashioned and sexist. This is understandable in a society such as Finland, where egalitarian values and equality between men and women are highly regarded compared with many other societies (Segal 1993, 632–633; Connell 1995, 204–205). Expressing sexist ideas about women, alternative masculinities and gender relations may be generally considered inappropriate behaviour in a culture where egalitarian values are respected and widely discussed in public. In a particular context of interaction, such as an interview, this results in softened expressions regarding gender presumably due to presence of an 'outsider', i.e. the interviewer, whose opinions are not known and difficult to predict. This can also be interpreted as an ideologically-driven issue, if not a dilemma, where traditional and modern ideals relating to the gender order produce tensions in talk. Therefore, the participants approach these topics cautiously.

Finally, conflicts between masculinity and healthiness were reflected in the research material although, as mentioned earlier, frequently in implicit ways and typically in non-personal contexts. When talking about their own lives and lifestyles, the participants did not express ideas of masculinity being in conflict with healthy ways of life. On the contrary, their accounts were characterised by explicitly expressed compliance with and commitment to healthiness. The conflicts between masculinity and healthiness emerged in non-personal contexts where 'other' men, and their behaviours, were discussed. The concrete topics where the possible ideological dilemma between masculinity and health was discussed related mainly to real or imaginary situations where a man engages in certain activities considered feminine. Reading health magazines, potentially regarded as feminine, in a public setting such as at work or taking part in 'women's type' of exercise such as aerobics were the contexts where the conflict was most notable. Another theme in conflict with masculinity, which occurred in several contexts, was 'fussing' about health. All these contexts concerned 'proper' masculine behaviour where the effects of potentially 'effeminate' activities were considered as not being in line with expectations for male behaviour. Dooming 'fussing' about health might also be comparable with notions of avoiding

any form of 'obsessive' and/or 'excessive' attitudes to health, thus representing a certain type of extremism which conflicts with the principle of 'everything-in-moderation' characteristic to men's conceptions of health. This became apparent in men's assessments of the healthiness of their own lifestyles, discussed in Chapter 8. The rare examples of 'guarding the masculine self', where healthiness was to some extent downplayed for, arguably, presentation of the masculine self, emerged in contexts where considerations of one's own lifestyle were close to being considered as 'fussing' about health.

The ideological dilemmas emerged and negotiated in men's interviews varied not only in terms of themes and contexts but also in their internal logic. In its 'clearest' form an ideological dilemma is interpreted as a conflict between two ideologies or two ideologically-driven topics, such as those relating to the relationship between 'masculinity' and 'healthiness'. In some cases, such as those stemming from the abstractness of healthiness, the dilemma is not, however, 'duplex' in the sense of two competing ideological ways of thinking. Rather, the dilemma is, regarding its ideological aspects, a dilemma of 'one-way ideology' where a normative, and thus ideological, expectation to assert healthiness of the self clashes with difficulties in giving concrete meaning to healthiness and relating choices within individual's everyday life. In these cases, there exists no 'counter-ideology' causing the conflict (to assert healthiness vs. not to assert healthiness or to assert illness), which distinguishes these cases from 'duplex' ideological dilemmas. The reason why I, nevertheless, call them ideological dilemmas is that despite the absence of 'counter-ideology', the dilemma is rooted in ideological and normative expectations regulating the consideration of the subject: assuming healthiness was not normative, resulting in no obligation to assert healthiness of the self, then no dilemma within the considered topics would emerge either.

Discursive and rhetorical management of dilemmas obviously varied a lot depending on the topic under consideration. The discursive practices that the participants adopted in discussing potentially dilemmatic themes for resolving contrary and conflicting issues were largely oriented to rationalising abstract and contradictory topics. Taking a rational stand on normative issues, and thus representing a rational self, might be seen as a means for representing a masculine self (cf. Hearn 1998, 788). As Connell (1995, 164) points out 'a familiar theme in patriarchal ideology is that men are rational while women are emotional', an idea which has been found to be dominant across populations and cultures (Williams & Best 1990, for a critical perspective on this dualism see Petersen 1998, 72–95). Search for and use of rational positions to contrary themes of healthiness highlights the 'internal' dilemmas related to health and healthy lifestyles: in many cases 'unhealthy' responses may be

seen as rational, especially when it comes to knowledge about risks. As Lupton and Tulloch (2002a) have demonstrated, engagement in risky behaviours may also be a conscious and rational choice. However, 'fully' rational positions are often difficult to reach which is the plausible reason for the participants' tendency to emphasise a 'golden mean' in their conceptions of health. Warranting healthiness of personal lifestyles on the grounds of balance and moderation is 'rhetorically effective as it connotes reasonableness and rationality' (Gough & Conner 2006, 390). In an age of self-control, obsessions represent uncontrolled behaviours and uncontrolled selves; therefore, excessive behaviours are doomed.

From the point of view of situational identity work in the interview context, variations of discursive practices may be read as portrayals of verbal competence of differential discourses relating to health and masculinity (cf. Robertson 2003b), a phenomenon which could also be called 'trading of competence' (DeVisser & Smith 2006). Although some descriptions may be more eligible and appropriate, having thus normative power, it is of high importance to be able to manage different vocabularies, discourses and interpretative repertoires. Participation in an interview with a health researcher necessitates, first of all, competence in public health discourse whereas some other contexts of interaction require the use of other discursive resources and cultural stocks of knowledge. The necessity to master different vocabularies stems from situational identity work where competence is displayed for other participants of interaction. However, independent of the immediate requirements involved in interaction, competence of public health discourse may be seen as a more fundamental necessity for a modern man. Jesse Berrett (1997) interestingly discusses this in his analysis of diet and masculinity in post-war America, characterised by seeking economic success, professional capability and high status.

> Diet … helped to reconcile traditional masculine individualism with the restrained corporate world. Providing a putatively healthful means of regimentation that ensured a middle-class man's economic success, it connoted adulthood, expertise, possession of the store of knowledge by which such men have commonly reckoned their authority. But diet also mandated the imposition of discipline, submission to experts, and rigid self-control. Workplace lore would be supplanted by the science of nutritional values and exercise; having mastered this language, the male dieter had achieved mastery of himself … (Berrett 1997, 816.)

The last lines of quotations from Berrett refer to a crucial point regarding modern citizenship: to feel like a secure, controlled and moral person, we need mastery of public health language as part of our self-concept. To be a 'fit participant' in social

life (Radley & Billig 1996) demands knowledge of health and competence to use health discourses.

While discursive practices used for managing contrary aspects of healthiness were largely based on pursuing rational positions, using politically correct language in discussions of gender was mainly mediated by avoidance of overly strict statements. In stating ideas that might be heard as sexist, the participants used several softening discursive strategies, such as relativisations, disclaimers ('I personally do not think that way but..', see Hewitt & Stokes 1975) and non-agentic formulations which all distance the speaker from expressed ideas that may engender criticism or counter-arguments.

Gendered aspects of healthiness also varied a lot, both in terms of the topic under consideration and the context in which the ideas were expressed. As noted above, diet was the 'most gendered' among the four behaviours analysed in Chapter 7 while there were basically no gender-related attributes attached to smoking. However, the primary conclusion made on the basis of analyses, relating to the overall topic of this study, is that health-related behaviours cannot, by any means, be considered as having equally feminine meanings and thus an 'effeminate influence that the men (therefore) must oppose' (Courtenay 2000a). It was also found that the attributes attached to behaviours varied substantially depending on the context in which the concrete activities took place. While good sweaty running may be regarded as very masculine, going to aerobics may, in turn, be considered behaviour of 'wimps' and 'poofs'.

It is self-evident that all of the findings of the previous analyses of empirical data have to be interpreted within the context in which the data were produced, i.e. as contextual and situational knowledge created collaboratively by both the interviewer and interviewees in interaction. The moral imperative of health and healthiness (Backett 1992a; Lupton 1995) surely result in the participants' tendency to express 'pro-healthy' ideas that they expect the interviewer to be looking for. From this perspective, there was one interesting exception. While the participants tended to express both doubts about health effects of different behaviours and their gendered features generally in implicit and/ or softened ways, men's reluctance to seek medical help (going to a doctor) differed from other activities in both respects. In analyses in Chapter 6 it was striking how congruently the participants described not going to a doctor to be typical for Finnish men, without basically any criticism addressed to this potentially health-damaging practice. It was also very strictly considered to be male behaviour, distinct from women's tendency to care for their health, keep track of their bodily signs and seek help in time. What could explain this?

In my interpretation, coherence of descriptions of Finnish men's reluctance to seek help in time fundamentally relates to how the topic was brought into the discussion. Reluctance to seek help was, importantly, not a topic of discussions initialised by the interviewer but, instead, a theme that the interviewees themselves started to talk about as a concrete example of 'Finnish men's' unhealthy habits and attitudes. It may therefore be suggested that the topic did not involve normative expectations to give 'right answers' since the questions were not addressed by the interviewer. Another key issue is that discussions of men's reluctance to seek help were regularly associated with considerations of the concept of a 'Finnish man' which, as I have discussed above, acted as an 'auxiliary' concept in conceptualising and articulating conformities within heterogeneous groups of men, which is ideologically a slippery topic. In my view, the idea of men's reluctance to seek help functioned as a 'ventilator' through which pressures of the imperative of healthiness were balanced. 'Not going to a doctor' was mainly discussed on a general level and not in the participants' own personal lives. If the interviewees were asked about their own contacts with health care professionals, it may be assumed that their responses would have, again, followed the imperative of healthiness. If it happened, the strict gendered attributes of 'not-going-to-a-doctor' would presumably also be tempered.

Another phenomenon holding similar features to those discussed above was men's eagerness to refer to 'women's vanity' as a constituent of their healthier lifestyles. This interpretation was also offered by the participants, particularly in the focus groups, and not the interviewer. Similarly as the reluctance to seek help, 'women's vanity' acted as a generalised gendered quality. Women's claimed interest in maintaining their looks, particularly through dieting and physical exercise helped to conceptualise gender differences and gave a 'natural' explanation for their healthy lifestyles. Being conceptualised as a strictly feminine characteristic, interest in looks did not carry normative power over men's own behaviours. As a stereotypical notion, stating that women are vain did not make the speakers feel that they had to justify their highly gendered generalisation, which is an interesting exception within the general rule of avoiding strict categorisations.

The role of motivation in appearance has been a topic in some studies on men and masculinities. As Sarah Grogan and Helen Richards (2002) noted, on the basis of focus groups of 8–25 year old boys and men, muscularity is one of the central features representing good physical condition, fitness and an active way of life for men. When participants' accounts of the degree of idealised muscularity were analysed in detail, the discourses turned out to be more complex. The appropriate level of muscularity was considered to be an eligible thing and was clearly contrasted with fatness representing a lack of willpower. Interestingly, however, the study participants

expressed negative views towards bodybuilders. Body-building was thought to be too narcissistic and obsessive in relation to one's body and appearance which, in turn, was associated with femininity. On the other hand, 'getting fat' contradicted the masculine aim of control over the body. Accordingly, as the authors note (ibid., 230), 'exercising to improve body image was considered feminine-appropriate behavior unless they [boys and men] were exercising to avoid getting fat'. Constructing ideals of the male body on the basis of two extremes had a vital function in the reproduction of idealised masculinity.

Both men's reluctance to go to a doctor and women's vanity as a driving force of their interest in health issues may be read as discursive practices maintaining certain gendered limits between men and women regarding the subject of health where the traditional roles, preferences and normative expectations are changing. In other words, they may serve as discursive havens of the traditional gender order in a world where traditional images of men and women do not offer a stable basis for self-identification (cf. Pietilä & Rytkönen 2006, 25), as some kind of masculine totems in a world with fractured gendered ideals.

In this study, *contextual variations in accounts of masculinity and healthiness* have been described throughout the analyses since one of the constitutive assumptions of the study has been the idea that men's accounts of healthiness and masculinity are situational constructions, produced interactively by participants, rather than reflections of static and fixed 'attitudes' or 'beliefs' (cf. Radley & Billig 1996). Therefore, summarising these variations is obviously a rather difficult task. Nonetheless, I will briefly return to one thread running through all of the analyses.

Throughout the analyses, it became apparent that there were clear differences between accounts of participants' own ideas, behaviours, practices and motivations and general accounts when they were discussed in relation to other people or generalised social phenomena. While on a general level health influences of certain behaviours were in some cases questioned and even criticised, accounts of one's own lifestyle were characterised by a tendency to express compliance with advice of healthy lifestyles. It was also concluded that contrary themes and potential dilemmas involved in the perceived reliability of health information were discussed and negotiated in a non-individualised context. When lifestyle choices were discussed in the context of the participant's own life, scepticism and criticism were mostly expressed in implicit and subtle ways, if expressed at all. Similarly, masculinity, femininity and differences between men and women were articulated in more explicit ways in non-personal accounts.

This consistent mode in contextual variation leads to two conclusions. First, assessing one's own lifestyle was, to a large extent, framed by the 'health-awareness

discourse' and normative expectations representing a healthy self and 'pro-healthy' thinking. Secondly, the expectation of political correctness regarding gendered views was stronger in individual contexts compared to non-personal topics and groups situations. Accordingly, in this study, it seems that the less personal the topic of discussion was the more possible and acceptable it was to transgress and challenge both healthiness and gender-related political correctness.

In relation to both healthiness and gender, sceptical views on health and traditional images of gender emerged more frequently in focus group discussions than personal interviews. An exception to this was observed in topics relating to the participants' own lifestyles, where no substantial differences between two sets of data were found, as noted in the end of Chapter 8. This interestingly demonstrates how focus groups and personal interviews yield different types of data. Interpretations and discursive practices in group discussions differed in many respects from those in individual interviews, which have been discussed in many parts of this study. This gives reason to conclude, as has been noted by several authors (e.g., Alasuutari 1995; Wilkinson 1998) that focus groups are more focused on articulating shared, collective knowledge compared to personal interviews where an individual speaker's own ideas, feelings and conceptions are under consideration. In addition, the study has highlighted that the moral, normative expectations on individual speakers are not that strong in the focus group discussions, probably due to the interviewer's smaller role. Personal interviews, in turn, emphasise the interviewer's role as an outside controller of the views expressed and a person who may – more or less legitimately – judge them.

Modern vs. traditional discourses of masculinity and health

A rather obvious result from the analyses of this study is that a simplified notion of masculinity being in conflict with health-awareness and healthy lifestyles cannot be sustained. This is not a remarkable finding as such since several authors (Watson 2000; Robertson 2003a; 2003b; De Souza & Ciclitira 2005; De Visser & Smith 2006; Robertson 2006) have earlier pointed out that modern men are increasingly interested in health issues and express 'pro-healthy' ideas in interviews. A rather more interesting outcome of this study is the notion of the multiple ways in which men negotiate and reconstruct gender and health in interviews, taking note of 'old' and 'new' ideals and contrary themes related to masculinity and health. It is therefore worth considering the relationship between traditional and modern discourses of masculinity and health, and the ways in which they are involved in men's interview talk.

Robertson (2006) has explored men's interpretations of responsibility for health in relation to current dominating ideas of masculinity in the UK. In his analysis, Robertson considers traditional and modern discourses of men's attitude to health, 'don't care' and 'should care', and combines these ideas with Crawford's (1984) notions of control and release. On the basis of these concepts he has formulated a model of the relationship between health and current hegemonic masculinity, presented below in Figure 9.1. The core idea of the model is that modern hegemonic masculinity takes note of both traditional and modern discourses of health, and discusses responsibility both in terms of individual control and temporary transgressions of it, i.e. release.

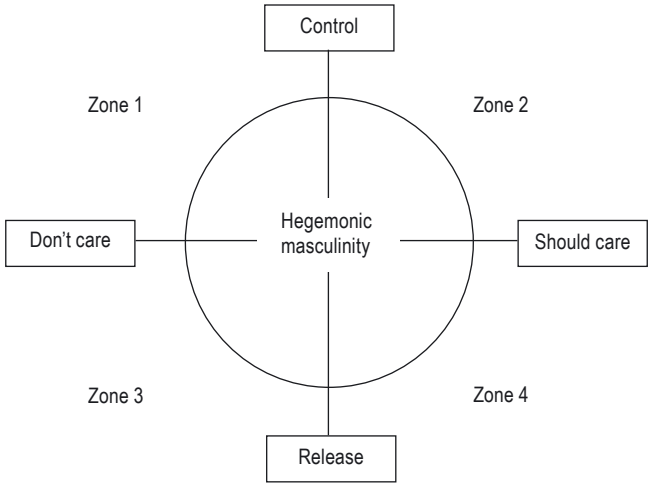

Figure 9.1. Model of the relationship between health and hegemonic masculinity (Robertson 2006)

In the current hegemonic discourses of masculinity and health, extremes related to individual responsibility and gendered meanings of health are avoided by seeking balance. Traditional 'don't care' discourse is doomed for its 'irresponsible' stand on health, while extensive 'should care' thinking is also rejected for its obsessive nature and its potential effeminate influences. For the same reasons, while temporary releases are accepted in lives of generally controlled selves, overly ardent control represents obsession and fanaticism that do not fit the ideals of a modern man. According to Robertson, modern hegemonic masculinity is largely constructed on the basis of avoidance of excesses and on the search for a rational balance between the extremes.

The findings of my study are in line with Robertson's ideas of hegemonic discourses of the healthy male citizen who avoids excesses while confronting temporary transgressions in a generally controlled way of life. My analyses on men's interview

talk have highlighted the normativity of the healthiness of lifestyles and individual responsibility as the guiding principle representing the responsible and rational self. This highlights the highly individualised and morally loaded manner in which health issues are discussed in the interview context, and that 'current orthodoxies' of health promotion (Lawton 2002) are a central part of everyday discourse on health. This may be accounted for by extensive health promotion campaigns amongst the lay public as well as overall 'healthicisation' (Conrad 1994) of everyday life. A modern man has thus adopted an idea that he 'should care' for his health and that he is supposed to express this view when interviewed. In this context, it is other men or men as a general, wide category of people who 'don't care' for health. Despite this, it is necessary to note that the increasing valuation of health is not the only thing which blocks out the traditional views of health conceptualising health-awareness as 'effeminate influences that the men must oppose' (Courtenay 2000a). My analyses have also shown that men simultaneously avoid categorisations of gender that are too strict and utilise similar balance-seeking in constructions of gender, as with health. The modern, rational and controlled self eschews extremes in talking about gender as well, which may be taken to reflect the significant role of egalitarianism in modern hegemonic discourses of gender.

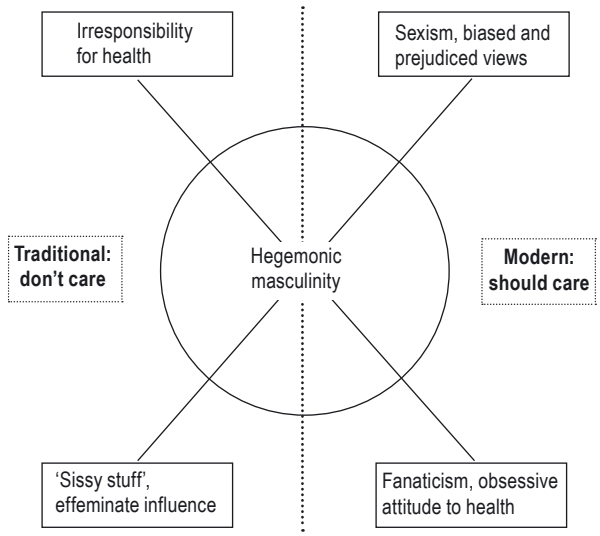

Figure 9.2. Model of the interplay between traditional and modern discourses of health and gender.

Figure 9.2 represents the interplay of traditional and modern discourses of health and gender, and is a modified version of Robertson's (2006) model on the relationship

between health and hegemonic masculinity, presented in Figure 9.1. It illustrates one of the key general findings from the analyses of this study. When speaking about health and gender, the men take note of both traditional and modern discourses around health and gender but notably tend to avoid extremes related to the subjects. Regarding health, the extreme of traditional 'don't care' discourse is eschewed as it represents irresponsibility for health and clashes with modern ideas of the responsible healthy citizen. On the other hand, the men also take into account another extreme, a fanatic attitude to health, as an issue associated with obsession and thus an uncontrolled, imbalanced self, which also conflicts with the idea of control and rationality. Talk about gender is similarly characterised by seeking balance between two extreme discourses. While the men's talk include traditional tones of rejecting 'sissy stuff', they are simultaneously cautious for not expressing male-chauvinist and sexist views and hence being heard as having prejudiced and biased thoughts about women, femininity and gender relations.

Although some interviewees conveyed rather pointed ideas about women's ways of thinking and effeminate influences of certain behaviours, these expressions were consistently softened, most often by humour. Taking this into account it is interesting that there are, however, certain specific topics where the expectation of political correctness related to gendered accounts is not strictly followed. Claims of women's 'vanity' and men's reluctance to seek help, as well as interpreting certain types of sports to be effeminate (particularly aerobics), were treated as collectively shared 'facts' that were laughed at notably without hesitation. It seems to me that these types of issues are raised in interaction to keep the balance between modern and traditional discourses: with these exceptionally traditional ideas, the interviewees maintain the mutual confidence of disentangling 'sissy stuff', while displaying generally modern values where strict gendered categorisations do not belong.

By referring to 'hegemonic masculinity' in the interplay of modern and traditional discourses, I am obviously not suggesting that the results of this study generally represent Finnish men's ways of thinking across socioeconomic, geographical or age groups. Instead, I suggest that the recurrent use of specific discursive practices in managing the balance between the modern and traditional discourses stems from locally hegemonic (Connell & Messerschmidt 2005) ideas among the working class men I interviewed. In this study, social class has not been a constitutive concept structuring the questions set for analyses nor has the aim been to create class-based theory on men's conceptions of health. The group of working-class men was identified as informants in order to guarantee a relative homogeneity of the material and to provide an analysis of constructions of healthiness and masculinities in a localised

setting. Despite this, it is necessary to consider the results in relation to the social class of the research participants.

Previous research has shown that people in higher socioeconomic classes are more receptive to health messages and lead healthier lifestyles than working class people (e.g. Calnan & Williams 1991; Karisto et al. 1993). Working class men's unhealthier living habits, and even exaggerated masculinity practised through risk-taking and other 'compensatory' behaviours (Harrison 1978), have been suggested to be caused by their subordinated status in the labour-market and other social hierarchies. Karen Pyke (1996) analysed how interpersonal power is interdependent with broader structures of gender and class inequalities on the basis of remarried individuals' interviews about marriage. She found that shop-floor men compensate for their subordinated status by engaging in ultra-masculine pursuits such as drinking, using drugs and sexual carousing, which were used to display their 'independence from the control of their wives and the "establishment" (i.e. higher-status men)' and defying existing power structures (Pyke 1996, 538). In addition, as Karisto (1991) has pointed out, the traditional style of working class men rebels against everything considered mild and diluted and prefers everything that is strong, powerful, heavy, big and full-flavoured regarding, among others, food, coffee, alcohol and tobacco. Therefore, the 'real men code' easily regards healthy lifestyles as 'soft, light and somewhat feminine, "sissy" – something opposing the masculine myth' (ibid., 32).

Some parts of the interviewees' discursive practices, analysed in the previous chapters, may be taken to reflect similar class-based discourses that act to compensate for their lower status and powerlessness, as discussed by Pyke (1996). Most notably this emerged within discussions of health information (Chapter 5) where information delivery was, to a large extent, constructed as hierarchical 'orders' and 'rules' from an anonymous health authority, which controls and restricts people's lives. Health information was described as a normative relationship between those who command and those who have no choice but obey, even in cases where they do not fully understand or agree with the injunctions. Accordingly, the criticism towards health information delivery may be interpreted as a class-based revolt against ruling power, as 'grumbling at health-managers'. This may also be one reason why 'fussing' about health was doomed: those who do so become in some sense representatives of 'them', the 'establishment' (Pyke 1996), those who 'try to rule us'.

Despite this, arguably one of the most important findings of this study is the notion that 'local hegemonic masculinity', and local hegemonic discourses, of working class men seem not to be grounded in 'anti-health ideology' (Karisto et al. 1993). The findings of this study support the idea that health awareness has gradually become one of the central elements of the dominant ideal of masculinity. If working

class men were to consider health in a way similar to the social elite, it is plausible to assume that the idea of healthiness will permeate through the majority of the Finnish male population, at least when it comes to competence in public health discourses and discursive representation of a good citizen in an interview context. One potential reason for this is that Finland is claimed to be a very homogeneous culture (Mäkelä 1985) where 'we are all more or less influenced by the same cultural climate' (Karisto et al. 1993, 187). The class-based differences in orientations and preferences in lifestyle choices may thus be smaller in Finland compared to some other countries and cultures. Despite this, as Karisto et al. (1993) point out, some groups of the Finnish population may have very different preferences and ways of interpreting various issues in life compared to the generally homogenous and consistent cultural climate dominated by middle-class orientations. For instance, long-term unemployed, poor, chronically ill or other marginalised groups may interpret health-related issues very differently in comparison with those having a position in the labour market.

Implications for the promotion of men's health

The analyses of this study give reason to offer some ideas that may be used when delivering information about health and illness to men in media and personal communications, such as primary health care. Although I hope that this study generally gives several other ideas for those working in the fields of health promotion and media, I introduce four particular ideas that I myself regard as the most justified on the basis of this study.

Health information should acknowledge a multiplicity of factors affecting health and the relative character of statistical information. The analyses of men's interpretations of health information (Chapter 5) demonstrated certain scepticism involved in their ideas about information delivery. It became clear that a central object of criticism towards health information was the perceived fluidity and inexactness of information, particularly regarding advice for healthy lifestyles. The interviews echoed an idea that the men wanted information about health to be precise, consistent and sometimes even unrealistically 'water-tight' but, simultaneously, they criticised the information delivery for being based on assumptions as if statistical associations were applicable in all individual cases. As basically all the participants had their own examples of cases where the statistics-based 'absolute' rules had not worked, particularly relating to heavy smoking and drinking, the exceptions were taken as vitiating rather than proving the rules. It also became apparent that the 'official' health promotion campaigns were to some extent confused with information coming

from advertisements and other sources with commercial interests, which presumably undermined the perceived reliability of the information. The men also interpreted information in highly normative terms, as something they were commanded to do, which aroused opposition.

Nowadays, people are confronted with information about health every day. Risk-estimates related to many daily practices, food and other mundane issues easily create anxieties among people, especially due to the large extent of information, which covers basically all aspects of life. Therefore, when discussing threats and the possible effects of unhealthy practices, the information should be realistic and contextualised, rendering it possible to estimate the likelihood of potential outcomes in an individual's life. Stewart et al. (2004) suggest that when presenting health risks, it is necessary to provide the absolute risk (or benefit), and not just the relative risk. For instance, while reporting that a certain medication lowers the risk of stroke by 40% sounds very effective, the readers should also be told that in absolute terms it reduces the risk from 5 per 1000 people to 3 per 1000 people which, in turn, may not be regarded as that big an innovation. In addition, Stewart et al. (2004) point out that the risks should be put in context, especially when the risk is small. As people generally tend to underestimate common risks and overestimate uncommon events and threats, it is important to present the information in a way which locates the issues under consideration in the context of other health-related factors, practices and events. As discussed in Chapter 5, presenting too strict causalities between behaviours and their health-effects easily provokes competing opinions. Although there are strong statistical associations between certain behaviours and diseases, these associations do not result in causal effects in the case of an individual. Neglecting this decreases the perceived trustworthiness of the information because it makes people feel that they are treated as simple-minded and because it undermines the perceived objectivity of advice. Formulating messages in a way which acknowledges that epidemiological knowledge is above all about likelihoods and not strictly definitive arguably increases people's confidence in information.

Benefits of healthy habits should be concretised. Deborah Lupton (1993) has observed that risk-estimates typically focus on the likelihoods of the *occurrence* of negative health outcomes, even if the probability is very small, instead of the likelihoods of *avoiding* those negative outcomes. In Chapter 5, several of the men's accounts reflected the idea that when receiving a 'full blast' of information about various risks, people find it impossible to try to avoid a number of risks involved in everyday life. This gives reason to suggest that the messages delivered to people should be formulated in more positive ways: the information should be focused on how to improve health and feel better, instead of focusing on threats. The information should emphasise the *benefits*

from healthy practices and encourage people to get involved in health-promoting practices. This inevitably requires that the benefits are presented in concrete forms. As noted in the previous analyses, the men I interviewed tended to prefer things that are calculable and measurable. Presenting the positive effects of healthy practices and habits would thus benefit from being formulated in such a way that the effects can be followed and assessed, preferably in some numerical form. Taken that many men are interested in sports and other forms of competition, numeric information relating to healthy practices encourages seeking new achievements.

Despite this, it is important to keep in mind that competitiveness and numeric information may simultaneously be a two-edged issue in promoting men's healthy lifestyles. As Swedish studies (Sachs 1995; Adelswärd & Sachs 1996) have demonstrated on the basis of how cholesterol values are discussed in patients' and nurses' communication, people are not always capable of understanding the differences in numeric representations of their test results and, even more importantly, neither are the nurses always able to explain these issues to their patients. As these studies have shown, numeric information requires a lot of knowledge and without this knowledge for interpreting the test results people may feel guilty or even develop a fear of death. This is, of course, totally counter-effective for health promotion activities. In my view, information delivery about health should generally avoid messages that demoralise people. Moralistic terms and expressions easily provoke opposition since they create a feeling that institutions govern individual's lives and choices, which fits poorly with Western individualism and ideas of free choice.

Physical exercise fits the masculine ideals as a means to promote individual health. In my interviews, physical exercise and sports were clearly the most often mentioned methods to improve and maintain personal health. This is probably because physical exercise is associated with traditional masculine values such as strength, endurance and skill. Physical activity is also calculable and measurable which renders it possible to see the results and achievements in a more concrete form. Exercise is also about being active instead of about abstaining from certain substances or behaviours, which men easily interpret as feminine. In addition to many other positive effects of regular physical exercise, this may be particularly important concerning the reduction of weight. On the basis of their interview study among middle-aged British men on men's dieting and attempts to reduce weight, De Souza and Ciclitira (2004) concluded that men's tendency to avoid issues labelled as feminine has its implications for health promotion. They suggest that health promotion may be more successful among men if the 'pressure to appear appropriately masculine' is taken into account in health promotion campaigns.

> As dieting is not acceptable (heterosexual) male behaviour, it may be that it is not generally discussed among men; or if it is, men may not be as supportive as women. Men may be happier to talk about 'getting fit' or even 'losing weight' than to admit they are 'dieting'. (De Souza & Ciclitira 2004, 801.)

In their report, De Souza and Ciclitira also pointed out that, in relation to weight control and weight reduction, men prefer exercise instead of dieting due to differing gendered attributes attached to the activities (cf. Gough & Conner 2006). The findings of this study are in line with the previous studies in that physical exercise is regarded as more appropriate male behaviour compared to 'dieting'. This suggests that advice on how to improve personal health might benefit from conceptual modifications acknowledging the gendered meanings associated with the terminology in use.

Mobilising positive qualities of traditional masculinity to enhance men's health. The findings of this study foster the previous notions that men's health promotion would benefit from being gender sensitive. This means that gendered attributes of certain behaviours should be taken into account when communicating health issues with men. This should not, however, be taken merely as a restriction of how to discuss things with men, as in the case of dieting. A gender sensitive approach also suggests that some traditionally masculine characteristics may be mobilised for strengthening efforts to improve men's health. Emphasising rationality, courage, autonomy, strength and self-control, when adequately attached to health-related aims and changing unhealthy habits, may provide men with culturally alluring motivation and 'scripts' (Sobal 2005) for interpreting these goals in a way that corresponds to their masculine characteristics. An interesting example of this is provided by Kilmartin (2005) in her study on depression among men. She suggests that health professionals should try to help the men suffering from depression by resisting 'the cultural pressure to be masculine when it conflicts with life goals' (ibid, p. 97). This may be done by emphasising positive masculine qualities such as *courage* in expressing feelings, which challenges dominant images of masculinity, or *leadership* in showing other men how to deal with emotions.

Implications for future research on men's health

Several studies have pointed to a lack of differential analyses within varying groups of men and suggested that studies on men's lives and health should be more tightly linked to their social circumstances (e.g., Watson 2000; Henwood et al. 2002; White 2002). As Gough and Conner (2006, 388) state, future research should gain more understanding of '*how* ideals of masculinity are enacted by *individual* men situated

within *particular* social and health contexts' (emphases original) and local settings (Connell & Messerschmidt 2005). This study has attempted to follow this idea by focusing on one particular group of men. However, it is obvious that there may be substantial variations in health-related ideas and discourses between different groups of men by, for instance, age, occupation, or socioeconomic status to mention a few. Fagerli and Wandel (1999) found in their large surveys on opinions on food and health that women's responses were less related to their socioeconomic backgrounds compared to men and that gender differences were more pronounced between than within socioeconomic groups. This indicates that socioeconomic differences may be particularly important among men. Several qualitative studies have also reported occupational differences in ideas related to food and other health-related practices (e.g., Prättälä 1997; Roos et al. 2001; Roos & Wandel 2005; Wandel & Roos 2005). Despite widely endorsed discourses of healthiness, various socioeconomic groups may adopt significantly different 'lay epidemiologies', or ways to interpret and conceptualise health and illness and their origins. In my view, the most important challenge for future studies on men's health is to explore 'lay epidemiologies' in different groups of men, particularly in disadvantaged and marginalised groups, where unhealthy behaviours cluster.

Ageing has rarely been an issue in studies on men and masculinities, nor is older men's health adequately considered (as exceptions of this, see Thompson 1994; Hänninen 2006). This may be considered a deficiency due to the increase of older men in society caused by growing life-expectancy. Ageing of the population inevitably changes the gender roles related to caring, for instance, resulting in men caring for their demented wives (see Kirsi et al. 2000; 2004). Generally, different age groups of men may have significantly differing views of gendered characteristics of various practices; for example, as Tiihonen (2004) has suggested, whereas previous generations of men considered vanity to be a feminine trait, younger men today are often just as concerned about their appearance as women are, thus blurring the boundaries between masculinity and femininity.

This study has been based on interviews with men. It means that analyses of men's talk cover their 'public' accounts but not 'private' accounts (Cornwell 1984) taking place elsewhere in men's personal lives. As talk and descriptions are to a significant extent context-bound and these different contexts presumably produce differential knowledge, future research would certainly benefit from mixing data from different contexts, such as using participatory methods in different institutional sites. This would also help to deepen our understanding of gendered attributes attached to different health-related behaviours.

In the course of this study it became apparent that men's accounts of health-related behaviours may differ a lot from their actual daily practices. Though comparisons between talk and action have not been relevant within this study, there are good reasons to suggest that approaches combining an 'interaction' perspective with 'factist' perspectives (Alasuutari 1995) might help to develop theory about contradictions in men's health-related talk and thinking. One potential topic for this type of research might be men's reluctance to seek help. A range of studies exist reporting men's infrequent use of medical services as well asothers that have explored men's ideas relating to the topic from a cultural point of view. However, I think that future research would profit from integrating both perspectives.

The final words: do we need to 'change' masculinity to improve men's health?

This study has explored the ideological and dilemmatic aspects of healthiness and masculinity, contextual negotiations of contrary themes and their discursive management within interaction. It revealed that healthiness is the primary logic according to which several issues of life are interpreted when discussed with a health researcher. In the middle of conflicting ideas and dilemmas relating to health and gender, men are caught between several 'rocks' and 'hard places' in attempting to puzzle-over and construct a healthy masculine identity.

Different concepts of masculinities have been important in men's studies because, as Clatterbaugh (1998, 25) notes, 'it is hoped that by understanding what creates and maintains a masculinity, new and healthier ways of being masculine can be found'. Accordingly, studies that have been based on an assumption of the 'lethal character of traditional masculinity' (Riska 2000, 1672) have often involved considerations of attempts to 'reconstruct' and give 'new meaning' to masculinity (White 2002, cf. Harrison 1978). Whether men and masculinities have changed or are in the middle of change has been a topic in several studies (e.g. Brittan 1989; Messner 1993; Segal 1993). This study takes part in these discussions by demonstrating how the 'canon of pathological masculinity' with its traditional images of men ignoring health issues categorically cannot be sustained when the men themselves are given the floor to speak about health. The findings, however, give reason to believe that this is not so much because of changes in masculinities but in the pervasive manner in which discourses of healthiness dominate social life in post-modern societies. This idea highlights, again, problems involved in over-simplified explanations for the relationship between 'masculinity' and men's actions that tend to treat them as two sides of the same coin. That men's ideas about health, or at least that their way of talking about health might

have changed, does not as such give any reason to believe that 'masculinities' – as cultural ideals of manhood – have encountered profound changes.

This idea might be illustrated by considering Pollock's (1988) notions regarding the 'type A' male personality and associations of this psychological category with larger societal processes.

> The 'type A' man is aggressive, hostile, manifests an exaggerated sense of time urgency, and most distinctively, is driven by extreme competitiveness. Significantly, these attributes are roughly the same as those ideally required of the ambitious aspirant within a competitive, capitalist industrial system. (Pollock 1988, 389.)

Adapting Pollock's ideas, it could be argued that 'men's new health awareness' may not be taken to reflect changes in the 'hard core' of traditional ideals of masculinity but, instead, represents new ways to enact it. It is possible that healthiness offers a new arena for men's competitiveness, in terms of achievements in sports or lowering cholesterol levels, for instance. Taken that very many traditional values of masculinity are endorsed in the labour market and many other fields of social life, it is possible that men's increased health awareness is not linked with valuing the qualities of the 'New man' (Rutherford 1988) as representing new, alternative forms of masculinity. Instead, emphasising personal achievements in the field of health may even act as representations of a 'Retributive man' (ibid) as an adaptation of healthiness and modern requirements for the 'hegemonic', successful masculine self. From this perspective, changes in masculinities may well be more visible in other aspects of life, such as caring for children and the aged, rather than in health-related activities that might be valued without actually challenging many of the traditional masculine ideals. Hence, regarding 'reconstructions' of masculinity, a bigger and more significant future challenge might be to urge men to take care of the well-being and health of people close to them, their children, spouses, parents, relatives and friends, in addition to their personal health.

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Annex 1.

FACTORS THAT THREATEN MEN'S HEALTH – LISTED IN FOCUS GROUPS

Focus group 1. (FG-1)
Participants: 4 men aged 26–28 years, 2 workers and 2 official

Factors:

1. Diet
2. Life stage, life situation
3. Life conditions (e.g. housing conditions)
4. Physical exercise
5. Smoking
6. Alcohol
7. Drugs
8. Daily routine
9. Traffic (IP added)
10. Pollution
11. Tolerance of stress
12. Family
13. Age (IP added)
14. Attitude to own lifestyle
15. Inheritance (IP added)
16. Medication
17. Work (including work conditions)

Focus group 2. (FG-2)
Participants: 6 men aged 24–28 years, 4 workers and 2 officials

Factors:

1. War
2. Wrong eating habits
3. Other wrong living habits, e.g., smoking and alcohol consumption
4. Stress
5. Lack of sleep
6. Accidents
7. Living environment, people next to you
8. Diseases (chronic diseases added later on)
9. Lack of exercise
10. Wrong way of doing exercise leading to injuries
11. Genes
12. Environmental pollution and catastrophes
13. Indifference to health

Focus group 3. (FG-3)
Participants: 4 men aged 31–46 years, 2 workers and 2 officials

Factors:

1. Over-weight
2. Cigarettes
3. Pollution
4. Fatty Food
5. Immobility (lack of exercise)
6. Stress
7. Alcohol
8. Traffic
9. Shift work
10. Accidents
11. Slippery road conditions
12. War
13. Lack of mental well-being
14. Injuries from sports
15. Bad work conditions
16. Wrong eating habits
17. Bad construction (of buildings)
18. Terrorism
19. Unqualified doctors
20. Indifferent parents
21. Society
22. Inheritance (IP added)

Focus group 4. (FG-4)
Participants: 3 men aged 33–42 years, 2 workers and 1 official

Factors:

1. Smoking
2. Stress
3. Lack of daily routine
4. Over-weight
5. Unhealthy diet
6. Sexually transmitted diseases
7. Lack of exercise
8. Chemicals at work
9. Work accidents
10. Traffic
11. Boozing
12. Loneliness
13. Problems in relationships
14. Inheritance (IP added)

Focus group 5. (FG-5)
Participants: 3 men aged 49–54 years, 2 workers and 1 official

Factors:

1. Age (ageing)
2. Lifestyle (Eating habits, lack of exercise, smoking, alcohol)
3. Chemicals at work
4. Asbestos
5. Lack of variety in work
6. Stress
7. Balance and feeling of continuance in life
8. Loneliness
9. Problems in relationships
10. Injuries from physical exercise
11. Air pollution
12. War
13. Terrorism
14. Inheritance (IP added)

Focus group 6. (FG-6)
Participants: 3 men aged 47–55 years, all workers

Factors:

1. Lifestyle (boozing, smoking)
2. Nutrition
3. Physical exercise
4. Injuries from physical exercise
5. Shift work
6. Lack of rest
7. Environmental pollution and chemicals
8. Traffic
9. Chemicals at work (and asbestos)
10. Ageing (IP added)
11. Medication
12. Drugs
13. Increase of allergies
14. Human relations
15. Stress
16. Inheritance (IP added)
17. Over-emphasised hygiene

Annex 2.

FACTORS ASSOCIATED WITH HEALTH – LISTED IN INDIVIDUAL INTERVIEWS

Interviewee K1:
Work
Physical exercise
Living habits
Attitudes
Family
Work mates
Management (at work)
Environment
Inheritance
Leisure time

Interviewee K2:
Physical exercise
Living habits
Over-weight
Work conditions
Pollution
Industrial chemicals

Interviewee K3:
Food
Substance abuse
Physical exercise
Human relations
Work
Attitudes

Starting from Interviewee K4, in advance listed factors were:
Work
Smoking
Genes
Traffic
Human relations

Additional to above mentioned factors:

Interviewee K4:
Alcohol
Physical exercise
Nutrition

Interviewee K5:
Healthy lifestyle
Alcohol
Physical exercise

Interviewee K6:
Physical exercise
Alcohol
Nutrition

Interviewee K7:
Diet
Eating habits
Physical exercise
Stress
Environmental factors

Interviewee K8:
Eating habits
Alcohol
Physical exercise

Interviewee T1:

Attitude towards life
Hobbies
Alcohol

Interviewee T2:
Rest
Physical exercise
Eating habits

Interviewee T3:
Shift work
Alcohol
Physical exercise
Control of life

Interviewee T4:
Nutrition
Physical exercise
Leisure time
Hobbies

Interviewee T5:
Hobbies
Living conditions
Age
Attitudes
Wealth

Interviewee T6:
Physical exercise
Eating habits
Leisure time
Sleeping
Alcohol

Annex 3.

ORIGINAL INTERVIEW EXCERPTS IN FINNISH

CHAPTER 4.

Excerpt 4.1 (page 94)

(OSA 1.)

T1: No (.) mää pidän oikeestaan sen (terveyttä) (.) kohtuullisen hyvänä (1) siis näin että (.) viime (3) viime, tota noin nin, keväänä (.) jollen mä nyt väärin muista (erityisen hitaasti), mää toi Leena (työterveyshoitaja) sen nyt tietäs paremmin tietenki (1) niin (.) terveystarkastuksessa toi veren- (.) verenpaine (.) alapaine oli koholla. Ja sitä seurattiin sitten (.) toki (1) kevään mittaan ja sitten kun mää viime kesänä tuurasin (1) tuurasin tässä päivähommassa kans seittemän viikkoo tota meitin pääluottoo niin (.) tota (.) sitä seurattiin niinku päivätyön vaikutuksia (.) kun mää tein jatkuvaa kolmee vuoroo (.)
IP: joo
T1: kuitenkin (.) Niin tota se tasaantu! (…)

(OSA 2.)

T1: Mä oon tossa viimestelyssä ollu töissä nyt (1) tää on viidettä vuotta (.) *varmaa sitte* (.) mä olin aikasemmin kuljetuksessa firman kuljetuksessa mutta kun se loppu ni (.) mää siirryin viimestelyyn ja (.) Siinä vaiheessa sillon (.) niit oli ollu useempana vuonna rytmihäiriöitä tuolla pumpussa.
IP: Ahaa.
T1: Niin niitä tutkittiin sitten keväällä sillon (3) viis vuotta takaperin ja (.) ja kun Hatanpäältä (terveyskeskus Tampereella) sitten oli seu- seurantalaitteet mihinkään rasitustesteihin mä en joutunu että (.) ihan vaan se seurantalaite oli ja kaikkia kokeita tietysti otettiin verikokeita (puhuu nopeasti) ja näin poispäin niin (.) niin tota. Sitten kun lääkäri totes mulle (.) että mulla on normaalia pienempi taipumus rytmihäiriöihin (IP: joo) n:e loppu! Semmosia jotakin semmosia tuntemuksia (puhuu nopeasti) (.) myöhemmin on ollu mitä (.) vähä joka ainoolla (.) että (.) pumppu tekee niin kun kuperkeikan siellä (IP: nii:) muljauksia (.) niin niitähän ny jo- (.) kun tuolla on puhunu (.) niin yhdellä sun toisella että (.) Mutta pääsääntösesti muuten en mää niinku (.) koen (.) oman (.) terveyden tilan (.) nn..(.) *voisko* sanoo ihan kohtalaisen hyvänä..

(OSA 3.)

IP: Joo, joo
T1: hyvänä että tuolla (1) avantosaunallakaan niin ei (.) ei mitään semmosia tuntemuksia oo ollu että (.) (IP: joo) *että olis* (.) heikkoo tehny tai mitään muutakaan että (.) Joskus toki semmosta niin kun (2) kun äkkiä nousee pystyyn nii:n ja (.) ja sitten joskus kotona saunoessa niin (.) niin tota on tullu sitten semmonen tunne että on niinku *että* nyt on parempi ku istuu paikallaan. Sekin mä oon ajatellu vaa että joskushan toi ihmisen verenkierto tekee niitä (.) temppujaan (IP: nii:) ja ku se ei oo mitään semmosta toistuvaa (.) että ylihuomenna taas ja (.) vaan että se on joskus (IP: mmm)

se sattuu harvon ni mä oon pitäny sen (.) että (.) että niitähän tulee ihmisille (.) kaiken näkösiä ja (.) (IP: nii) vaikka niitä tutkitaanki niin mitään selvää ei saa, että mistä se johtuu.
IP: Nii, nii jus[tiin.
T1: [Mä oon pistäny sen semmosen piikkiin nää..
IP: Joo.
T1: Mutta tosiaan niin ku pääsääntösesti niin mä pidän kohtalaisen hyvänä. (T1:1, s. 1955.)

Excerpt 4.2 (page 99)

K4: No se (terveys) on tällä hetkellä (.) omasta mielestäni ihan hyvä *ettei* siinä mitään *että* (1) Kuitenki harrastaa liikuntaa (.) kohtuudella ja (IP: mmm) (.) sillain että (2) ei ny (.) mitään (.) mitään ihmeellistä ainakaa oo tällä hetkellä.
IP: Joo.
K4: (.) Mielestäni oon käy- (.) minäki oon käyny kaiken maailman kuntoremonttikursseja ja muita käyty täältä (IP: mmm) oon useemman kerran ollu niin että (.) tiedän et on semmonen (.) että sil- siäki on, näytti että on (.) kunto on (.) kohtuu hyvä *että*. (K4:1, s. 1956.)

Excerpt 4.3 (page 100)

IP: Minkälaisena sä koet oman terveystes tällä hetkellä?
K2: No (1) mä koen kyllä, että mä olen (.) melkeen paremmassa kunnossa, ku (.) muutamia vuosia sitten, että noin (1) Enemmän tullu tuota kuntoilua harrastettua nyt tässä (.) sanotaan semmonen (3) mitähän siitä olis (1) ainakin lähemmäs kymmenen vuotta on.. (.) Mä kävin, semmosen (.) tän kuntolomaviikon tuolla Peurungas. (1) Se oli joskus yheksänkuusko se ois ollu se ensimmäinen. (1) Siitä se sitten alko, ku huomas että (naurahtaa) (1) ei ollu ihan niin hyvässä kunnossa, ku itte oletti olevansa (.) kunnossa, että noin (IP: mm) (2) Sit on menty noita Pirkan- (.) kierrosta ny sillain osittain, että tänä vuonna mä hiihdinki sitten jo sen, että noin (1) oon soutanu ja pyöräilly, että.. (2) Ja pyöräilen noita, työmatkaa, mulla on tossa kesäsin (1) 15 kilometriä edes takasin toi (1) (IP: aha) työmatka niin.. (.) Siitä tulee semmosta kivaa päivittäistä. (naurahtaa) Ja kyllähän tää (.) työkin on semmosta, ku mä (.) oon (.) tuolla telehommissa, ni (.) joutuu kiertelee tuol tehtaalla portaita aika paljon päivän mittaan että (1) (IP: niin). Kyllä semmosta (.) hyötyliikuntaa ja sitten on tietysti kotona (.) mä (.) mulla on tommonen (2) puun (.) keräys ku lämmittelen sillain keskuslämmityskattilaa puilla niin mä (2) siinä tulee sitä sitten (.) halon hakkuusta lähtien (naurahtaa) (IP: nii) kaikenlaista erilaista liikuntaa. (K2:1, s. 1956.)

Excerpt 4.4 (page 101)

IP: No onkos teille tota lääkäri nyt antanut kovin paljon tämmösiä muita elämänohjeita että miten (.) miten pitäis sitä terveyttä ylläpitä[ä?
PI-2: [Joo:!
Ky:llä (erityisen voimakkaalla äänellä) ja (.) ja kävin mä tuolla (1) tuolla oli tän Hengitysliiton (1) sellanen sellanen (1) niinku koulutusiltapäivä (IP: mmm) tuolla Laaksossa (.) ni olin mä sielläkin ja siähän nyt oli tällasia niin ku jumppaohjeita ja (IP: joo) muita tälläsiä siinä (1) siinä neuvottiin et siellä oli sit niin ku lääkäri ja (1) ja kuntohoitaja ja, ja..
IP: No tuleekos niitä tehtyä?

PI-2: No: joskus aika vähäsen (voimakkaalla äänellä) tota noin että (IP: joo) että mutta (1) mut sanotaan että mää oon i:käni ollu kova liikkumaan mutta (1) nyt tahtoo olla se että ku (1) ei oikeen niinku (1) kykene niinku talviaikaan mut sanotaan niin ku kesällä ni (.) pyörällä menee aika (.) aika (.) aika mukavasti (IP: Joo) että (.) että pääsee. Mutta kävely (.) kävely on nyt oli varsinkin ettei tahtonut huoneen toisest päähän toiseen päähän päästä mutta (.) mutta tota noin (1) pyörällä on (.) niin ku nytte (2) Mulla kolme vuotta (.) just kolme vuotta sitten ni (2) todettiin sellanen niin ku (1) joku kasvain täällä (.) keuhkossa ja (.) se leikattiin mut se oli (.) jotain entisiä (2) keuhkokuumeen arpia
IP: a:[haa vain niin[
PI-2: [että ne [ne oli (.) ne oli hyvänlaatusia. (IP: joo) Ettei siinä ollu mitää (.) mitään ja (1) ja kyä mää oikeen hyv-, se leikkaus meni o: ikein hyvin ja samaten se paraneminen siitä ja (.) sit mä aloin ajaa fillarilla sillo (2) toukokuun puolenvälin jälkeen se oli sitte ja (1) ja sit menin lopputarkastuk-, lääkäri oli vähän vihainen et ei ois saanu fillarilla ajaa (nopeammin)
IP: ah[a
PI-2: [ajoin mä (.) yli 2000 kilsaa sinä kesä[nä
IP: [O:ho[(naurua)
PI-2: [fillarilla että ettei se (.) että aika hyvin meni (.) mutta sanotaan viime kesänä ei menny ku tuhannen kilome[triä
IP: [a:ija[a
PI-2: [et[tä se oli
IP: [joo (.) ei sekään ihan mikään vaatimato[n määrä kyllä oo
PI-2: [Juu että se oli ja (.) juu ja toissa kesänä meni ky- kyllä toista (.) toista tuhatta.
IP: jo[o
PI-2: [Että tota noin että (.) että no nyt mä oon ajanu (.) nyt ei oo paljon tullu ku (.) se oli justiin et tää (astma) on ollut nyt *semmone* niin ku aktiivisessa vaiheessa ni (.)
IP: Ni[in
PI-2: [Ni tota ei oo (1) oikein viittinyt repäistä nytte että.. (PI2:2–3, s. 1934.)

Excerpt 4.5 (page 103)

IP: Jos alotetaan (.) ihan, ihan siitä, että (.) että minkälaiseks sä koet oman terveytes tällä hetkellä?
T4: Hyväks. Mä olin viiskytviis vuotis tarkastuksessa ja, nyt hiljattain, ja mä oon (.) ainakin noi veri-, veriarvot on ihan normaalit.
IP: Joo. Oliks se (terveystarkastus) täällä työpaikalla vai?
T4: Joo tääl oli työpaikalla. Ei mulla niin ku omasta mielestäni mitään terveysongelmaa tällä hetkellä. (T4:1, s. 1949.)

Excerpt 4.6 (page 104)

IP: Joo (.) Joo no siitähän päästäänkin ny heti tohon ravintoon sitten että tota (.) sä oot (.) pidät omaa ruokavalioos kuitenkin ihan (.) ihan semmosena hyvänä?
T4: Joo kyllä tää Pajamäki (työterveyslääkäri) (1) kun noita (2) niitä ver- veriarvoja katteli ni sano *että* (.) että hänen mielestään ei (.) ei tarvi mitään (.) muutoksia tehdä ravint*oon* ja tottumuksissa että *ne on*..
IP: Niin ku kolesteroliarvot on..?

T4: Se oli tasan viis.
IP: Joo.
T4: On mulla alempikin ollu, neljäkuus neljäseittemän on ollu mutta (.)
IP: Nii
T4: Se oli tasan viis ja sitten se hyvä kolesteroli oli yksyheksänkaks että (IP: joo) sano että se on kuitenkin niin korkeella se (.) oliks se ny ADL vai HDL, (IP: nii) kumpi se nyt sitten on mutta (.) että se oli sen verran korkeella (.) että se on ihan hyvä ja (IP: joo) maksa-arvot oli (1) kakskytäkolme ja sehän on kai (3) *onkos se nyt* nollasta kaheksaankymmeneen se (IP: ymm) (.) että on siinä viä (.) varaa vähän viinaaki ottaa (nauraen)
IP: (nauraa) joo. (T4:8, s. 1949.)

Excerpt 4.7 (page 105)

IP: Miten muuten tosta kun (.) unohdin kysyä siinä vaiheessa kun kysyin että miten sä itse arvioit omaa terveyttäs niin niin, unohdin siinä vaiheessa kysyä, että (.) miten jos öö vertaat omaa terveyttäs saman ikäsiin muihin miehiin (.) niin minkälaisena pidät terveyttäs?
K7: No (.) kyllä mä sanosin, että se on niin ku (1) keskiarvoo parempi varmasti että (.) ihan vv- vaikkei muuta kattosi ku veriarvoja niin (.) se jo heti (.) pelkästään *että* (2)
IP: Jaa.
K7: *ja sillai* (.) sitte *just* että toi liikuntapuoli on ja (.) se että kyllä noista eväistäkin sen näkee (.) että tota (.) mä ainakin koen sen jo heti (.) että mä näen sen jo meidän eväistä, että (.) että kummalla ne, meillä niin ku (.) että, kummalla meillä toi kroppa paremmassa kunnossa o-on *että* (koko puheenvuoro naurahdellen). (K7:12, s. 1968.)

Excerpt 4.8 (page 108)

P2 (-49): *Mun* isäni nii (.) ny oli vähän yli seittemänkymmenen nii (.) kuoli ni (.) ni sehän sai aivo- (.) verenvuodon (.) meillä on suvussa semmosta (2) vikaa että (1) aika usea on saanu (.) aivoverenvuodon. (.) Ni kyllä se pikkasen niinku pisti *miettii* (1). Meinaa isähän halvaan- (.) puhekyky meni ja liikuntakyky (1) toinen käsi ei pelannu ollenkaa (.) *että kyllä* se pikkasen miettiin pis*tää*. Se eli siinä varmaa useemman vuoden ja.. (4)
P3 (-54): No mulla se on niin tuoreesta muis-, tuoreessa muistissa se (.) isän poislähtö ni (.) *se on* täs ollu viime kuukausina hyvinkin esillä (.) äitin kautta (1) että (.) ku se jaksais vaan uskoo että se elämä jatkuu *niin* (3) Sitä on (.) kans varmaan toi perimä (.) yks syyllinen siihen että (1) niitä sydänvaivoja sitten rupee olee (.) meidän suvussa yhdellä jos toisella että.. (2) Se oli kans, kerkis jonkun matkaa yli seittemänkymmenen toi isäukko että.. (3)
P2 (-49): Kyllä (.) kyllä noi aika pitkäikäsiä on (.) sukua on mutta ne on just ne aivoverenvuodot sitten vanhemmille kun tulee (.) että.. (.) (IP: mm, joo) Se on joku heikkous tuolla (1) tuolla päässä jossain verisuonissa, siä on kai joku semmonen, kehu velipoika ku oli tutkittavana nii (.) siä on joku semmonen haara mikä repee tota niin (.) mutta se on kai pienellä korjattavissa jos semmonen on (2) ja käski munkin mennä tota noin niin (.) niihin magneettikuviin ja (.) Että jos on semmonen perinnöllinen vika (.) niin voidaan (.) se on pieni juttu kai korjata (.) vahvistaa sitä suonen sitä haarakohtaa että (.)
IP: Nii.
P2 (-49): (.) se on mikä ratkee siinä. (FG5:6.)

Excerpt 4.9 (page 110)

P6 (-75): Mä luulen et siin on justiin se mitä Mika (P2) sano (.) et siin on takaraivossa se että (2) että (.) miehillä on se että ne näkee ittensä että ne on kunnossa ”en mää tarvii noita” (.) ennemmin mää otan sen Tekniikan maailman taikka jonkun (.) vastaavan lehden sieltä että no ”mää oon ihan hyvässä kunnossa” elikkä (.) se tää (.) miehen täytyy saada se semmonen radikaalimpi herätys siihen että nyt täytyy tosiaan tehdä jotain. (.)
P2 (-78): Monella (.) sanotaan et (.) monella miehellä on kuitenkin ollu (1) pojasta asti semmonen (1) urheilu- (.) urheilutausta siellä ja (.) on tehny ja pelannut kaikkee (1) ja (.) on semmonen kuva ittestään että (.) on niinku vielä pystyy (.) pystyy semmosia, tiettyyn suoritukseen siellä urheilupuolella niin (.) Se, se saattaa pysyä aika pitkään (.) ennenkö sen sitten huomaa ettei se (.) mikä se todellisuus todella on. (FG2:16.)

Excerpt 4.10 (page 111)

P6 (-75): Mut *siin* (.) siinä on tietyllä tavalla sekin pelko että sitte siinä vaiheessa huomaaki (.) ku sinne menee (.) että (1) ensinnäkin voi huomata itte kautta muut huomaa, että kuinka huonossa kunnossa ettei venykään näin ja näin että (1) kaikki muut pääsee ja (.) itte rupee puuskuttaan jo puolessa välissä että (.) ei jaksa. (FG2:17.)

Excerpt 4.11 (page 111)

IP: Jos nyt lähetään tässä liikkeelle ihan siitä, että, että kysysin, että minkälaisena sä (.) pidät nyt tällä hetkellä omaa terveyttäs?
T2: Ihan terveyttä terveytenä, ettei puhuta (.) sanotaan niinku sairauksia taikka mitään tämmöstä (.) yle:iskuntoilua taikka (IP: mmm.. ei) sellasta, että pystyykö harrastaan jotain.
IP: Ei vaan ihan, että sanoisit sä olevasi terve?
T2: En.
IP: Et?
T2: En.
IP: Joo. (4) No minkälaista (.) voi-, voinko kysyä, että minkälaista vaivaa tai..?
T2 : No tota (2) semmosta, että (1) vatsa ei pelaa niin kun normaali ihmisellä sen kuuluu pelata (1) ja tota (1) sitten mulla on omat epäilyni (1) sen suhteen mitä on tullu (.) kehoon kahdenkymmenenseittemän vuoden tupakoinnista ja..
IP: Aha.
T2: Mutta tota (.) mä oon mielummin epätietosena siitä, että mitä mulla on, ku se että mä menen lääkärin kans juttelee.
IP: Joo, joo.
T2: Neljä ja puoli vuotta odottanu, mutta en oo vielä saanu mentyä.
IP: Niin, niin. Joo(.) j[oo.
T2: [Oireet on kaikki ihan (1) viittaa (.) määrättyihin asioihin. (1) (IP: mhmm) Saa nähdä koska saa sitten ittestään tarpeeks irti. (T2:1, s. 1958.)

CHAPTER 5.

Excerpt 5.1 (page 119)

P2 (-75): Mää luulen et se on enemmän korvien välistä kiinni. (.) Kyllä (.) nykypäivänä (.) varmaan (.) ihminen tietää mikä sille on hyväks ja mikä sille ei oo hyväks. (FG2:4.)

Excerpt 5.2 (page 120)

P3 (-72): Muttei tosta (2) jos nyt vielä puhutaan tosta (1) tiedon saannin merkityksestä, niin siittä (.) ei missään nimessä oo mitään haittaa. Ja mää uskon, tai ainakin haluaisin uskoa, että (.) joltain osin siitä on hyötyä. (FG3:6.)

Excerpt 5.3 (page 121)

P3 (-50): Mua kiinnostaa kauheesti tämmönen (1) oon seurannu pitkään näitä kaiken (.) maailman (1) kirjotuksia ja tut- (.) tutkimuksia mitä (2) mitä tuolla lääketeollisuudessa plus sitten (.) kaikki nää muut jotka tekee jatkuvasti ööö muun muassa (.) ruu-ruuista, mitä pitäs syödä. (1) Ne on tänä päivänä tätä ja huomenna taas jotain muuta (.) ja sit palataan takasi. (.) Voi oli pannassa vuosikausia (.) suola oli pannassa. (.) Mun on käsketty syödä, lääkäri, suolaa kun mulla laski verenpaine liian alas (2) mää opettelin kakskytäviis vuotta syömään suolattomia ruokia, opin täysin suolattomuuteen (1) ei muuta kun uudelleen alat suolan käytön. (.) Siihen oppi kyllä yllättävän äkkiä! (2) Siis (1) siis tää justiin, että kun (.) on (.) olemassa tota informaatioo (1) nin (.) sitähän tulee joka paikasta tuutin täydeltä (.) jos vaan haluaa seurata (.) (IP: nii) ja (.) ja meillä (.) vaimoni kans seurataan erittäin tarkasti kyllä kaikkia tänä päivänä tapahtuvaa (.) esimerkiks justiin tän ravintotekijöissä olevia muutoksia (.) tai tulevia muutoksia ja (.) ja.. (1) Todettu vaan se että (1) mennään takasin sinne vanhaan tai (2) tai johonki sinne puolivälille (1) siis (.) tänä päivänä se (1) ruoka (.) kaavio mikä oli koulussa, näille (.) peruskoulussa, kun me oltiin kansakoulussa ni (.) se on aivan toisen näkönen. (.) Ja se oli sillon ainoo oikee tapa. (1) Nyt on taas ainoo oikee tapa on joku muu (1) siis (.) ei (.) sei (.) ne ei pidä paikkaansa! (IP: mmm) Siis (.) se on hirveen vaikee jos haluaa noudattaa jotakin (.) mää (.) että nyt mä teen (.) oon – (.) elän todella terveellisesti (.) (IP: mmm) niin yhtäkkiä sää huomaat että sää et oo eläny ollenkaan terveellisesti. (IP: nii-joo) Kevytlevitteitä ei saa enää käyttää ollenkaan (.) pitää käyttää voita (1) (IP: mmm) koska kevytlevitteissä on kaikennäkösiä muita aineita. (.) Siis ei tää (.) tää on ihan siis (.) tää on ihan (2) Siis ois-ois kauheen kiva jos vois jotakin noudattaa jok-, että siis olis niinku hyötyä. (1) Mutta (.) jos sä sitä noudatat niin seuraavana päivänä sulle sanotaan että sä oot koko ajan tehny väärin. (2) (IP: mmm, niijoo et se on mmm) Että elä tossa ny sitten niinkun (1) appiukko sano aina, että ”elä tässä ny sitten jumalisesti!” kun (2) (yleistä naurua). Musta se on hyvin sanottu ett[ä
P2 (-48): [Että tulee kahdenlaista tietoo [tuutin täydeltä koko [ajan
P3 (-50): [Niin! (.) siis niin! (.) [ja se muuttuu koko ajan! (.)
P2 (-48): Niin, että ei (.) ei niinkun semmosta todellista pohjaa ei niinkun anneta (P3-50: *joo*) että [sitä muutellaan ja

P3 (-50): [Jokainen tutkija keksii (.) taikka löytää uudet tavat ja (.) ja kehuu että tää on nyt just (paukauttaa nyrkillä pöytää) ja se ja se ainoo tapa ja.. (FG6: 9.)

Excerpt 5.4 (page 123)

P1 (-49): Ja toisaalta, että (.) kuka nyt sitten sanoo, että mitkä on niitä oikeita (.) oikeen terveellisiä elämäntapoja. Että onko ne (1) mitä ny kovasti niinkun tuodaan (.) julki ni (.) onko ne todella sitä? Ei ne ny välttämättä, kyllähän ne (.) siellä (.) siellähän niitä muotiasioita on (.) siellä on (1) suolat ja sokerit ne on välillä myrkkyä (.) välillä niitä taas (1) pitäs (.) käyttää ja (.) tämmösiä (1) mitkä (1) niinku vie vähän uskottavuuttakin siltä, että (.) että (.) yhtenä vuonna joku on (.) asia on niinku (1) hyvinkin terveellistä, toisena vuonna se (.) voi olla pannassa ja (3) Ettei ne (1) emmä tiä onko sitä [
P2 (-54): [Ni[i
P1 (-49): [kuka sen viisauden nyt sitten sanoo, mikä on nyt nii[n oikeen terveel[listä?
P2 (-54): [Tuo- (1) [tuorein esimerkki on tästä tämä (.) ranskanperunoitten akryylikramiliaari, mikä hän oli, ni (.)
IP: Akryyliamid[i
P2 (-54): [nii!
P3 (-49): Joo, tä- tää on hyvä tää ku (.) puhuttiin siitä luukadosta (.) just oli lehdessä (1) luukadosta. (1) Että laihat (.) sairastaa semmosta, mutta taas lihavuus suojaa siltä, että (.) vähä ristiriitasia asioita..
P1 (-49): Joo. (FG5:9.)

Excerpt 5.5 (page 124)

P5 (-75): Mut sit toisaalta tulee (.) tulee myös se mieleen, että kyllähän näitä niinku paljon on (1) kerrotaan tutkimuksista jossa nyt no: esimerkiks tää (huokaa syvään) mikäs tää on tää ranskanperunoissa ja muissa esiintyvä tämä-tämä (1) (IP: Akryyliamidi.) akryyliamidi joka niin kun on (1) öö saattaa niinku vaarantaa terveyttä ja (2) (…) Ehkä se ihmisillä yleensäkin on se, että jos (.) tiedetään että joku (.) jollakin on taipumus aiheuttaa jotakin niin (.) se ei oo kuitenkaan niin selvä puhutaan jostain niinkun (.) mahdollisesti pienestä todennäköisyydestä isolla joukolla ihmisiä se lisää todennäköisyyttä näin ja näin paljon ni (.) ei se oo niin selvä niinku yhteys, että (.) ihmiset (.) välttämättä (.) niinkun kokonaan (.) kieltäytys jostakin tai (.) muuten. Ei välttämättä edes vähennäkään niin kun tai muuta käyttäytymistään. Et ajattelee, ettei se nyt (.) oo kuitenkaan niinku niin (.) selvää, eikä se mun kohdalle tuu, eikä muuta, että se vaikuttas (1) välttämättä. (.)
P1 (-79): Ja nykyisin, ku tutkitaan kaikkee niin paljon, niin kaikest tuntuu löytyvän sitten jotain niinkö (.) justiinsa noista ranskalaisista ja noista nii (1) jotai et et ne on terveydelle vaarallista, niin ni ei niitä niin tosissaan [enää tuu otettua.
P2 (-78): [Toinen tutkimus on taas vastaan, että ei ne ei ookkaan niin vaarallisia[, että
P1 (-79): [Nii (FG2:5.)

Excerpt 5.6 (page 125)

P3 (-75): Se tieto on liian epämäärästä. (.)
[Jotain siis suhdelukuja, että tuhannesta ihmisestä joku
P6 (-75): [Ja..

P3 (-75): määrä kuolee tähän ja tähän[
P6 (-75): [Ja luultavasti siin o[n
P3 (-75): [Ei se itteään
koske millään tavalla se (.) silleen suoraan.
P6 (-75): Luultavasti siinä on myös se pointti justiin että (1) jos haluais elää terveellisesti, ni ei sais tehdä mitään, (.) koska kaikista on tullut jotain, (.) että tää ja tää on myrkyllistä, (.) sä et syö nyt tätä etkä tätä, etkä saa tehdä näin. (1) Ja sitten sun pitäs vaan (.) olla, joka myöskin on sitten taas terveydelle vaarallista, että täytys sun tehdäkin jotain. (FG2:6.)

Excerpt 5.7 (page 127)

P4 (-64): Edellisessä elämässä olin tuolla (1) telakalla (1) tehtiin noita alumiinitankkereita ja (1) ja tota noin ni siellä yks (1) Huber-testingin kaveri sano mulle, että (1) älä viitti kävellä sinne kun ss- tossa kuvataan, näytti tällai ylöspäin, ja siel oli isotooppikuvaukset siä vähän matkan päässä menossa. Ja se sano vaan, että (.) se on kuin lottoomista, että sitä joko saa tai ei saa (.) ku se oli ikänsä ollu niissä säteilylähteitten kans tekemisissä, ja että (.) Monilla on sentyyppinenkin asenne, että juuri kun (1) puhutaan, että ympäristö (.) saastuttaa ja kaikki muut saastuttaa ja tulee (.) on otsonikatoo ja tulee raadonia ja kaikkee muuta, että mitäs se ny yks tupakka siinä (.) enää tunnu missään! (1) Että (.) että tota noin ni, se on (.) niinku se onkin hyvin pitkälle (.) se on niinku henkilöstä kiinni, että (1) tuleeko joku (1) tupakkaperänen sairaus (1) esimerkiks (.) taikka (.) taikka joku muu (1) vastaava, että (.) että tota (2) Oon nähnyt molempia (.) tapauksia, että oon nähny (.) alkoholista semmosen, että kakskytkaheksan -vuotias kaveri ei voinut enää juoda pullollistakaan, kun (.) oli haima niin huonossa kunnossa. (.) Sitten taas näkee tossa (.) semmosia jokka (1) istuskelee tossa baarissa (1) viistoista vuotta putki, eikä tunnu missään ja (.) ja tota (1) Omat isovanhemmat (1) taikka (.) iso- (.) isä varsinkin nii (.) poltti yheksänkytkaheksan-vuotiaaks asti (1) ja tällasta, että se on niin (.) niin tota (2) henkilökohtaisia asioita (.) tämmösiä perimä- (.) juttuja, että (.) Moni ei miellä niitä niinku sillä lailla, että se on vaan yks (.) yks pahe muitten joukossa. (FG3:11–12.)

Excerpt 5.8 (page 128)

P2 (-78): Niin ja välillä tuntuu, että on (.) vaikka kuinka (.) nukkus ja söis hyvin, niin silti on (.) on niitä sairauksia, että ei se.. (.) Siin on kuitenkin aina sit se semmonen pieni (2) pieni alue, mihkä ei pysty vaikuttaa. (FG2:4.)

Excerpt 5.9 (page 130)

P3 (-75): *Taikka siis johtopäätös on se*, että kaikki (.) ainoa (.) varma asia on, että kaikki kuolee johonkin! Se on sitten vaan (.) ittestä kiinni, että ottaako sen riskin, että kuolee johonkin yhteen asiaan vai toiseen asiaan, *että*.. (FG2:7.)

Excerpt 5.10 (page 131)

IP: *Joo:o*. No (.) voiko sitten sillä tavalla sanoo (.) että onko (.) onko naiset jotenkin niin ku kiinnostuneempia terveydestä (.) noin (.) esimerkiks luk- öö tutustumaan tietoon ja muuta (1) verrattuna miehiin?
T6: (1) *Ei mulla oo oikeen mutta jos* (.) nais- (.) naiset lukee enempi lehtiä nii luultavasti ne saa enempi tietoo (.) tuskin miehet lukee paljon

mut (.) no (.) se mä oon aatellu vaan että se on (.) paremminkin vaan iltapäivälehtiä
IP: mmm
T6: tuskin ne kerkee paljo (.) lukee (.) näitä muita lehtiä että.. (T6:11, s. 1946.)

Excerpt 5.11 (page 132)

IP: Niin (1) Joo mut tosiaan (.) se on sillain (.) aa (.) tavallaan jos ajattelee niitten tuottajien (.) kustantajien kannalta niin niin naiset ilmeisestikin (Valot sammuvat hetkeksi huoneesta) siis on on (.) ilmeisesti parempia kuluttajia tässä mielessä eli (.) eli eihän (.) eihän niitä terveysjuttuja myytäis lehdissä ellei niille olis (1) asiakkaita (.) siis (.) kuluttajia (.) ostajia. Et tota et (1) et voiks sen jollakin tavalla sanoo (.) niin että (.) jossakin mielessä terveys on niin kun semmonen naisten juttu (.) että naiset on jollakin tavalla (.) kiinnostuneempia tai vastaanottavaisempia näille (.) terveysasioille tai ainakin sille terveystiedolle? (.) Onko se näin? (.)
P6 (-75): Mä luulen et siin on justiin se mitä Mika (P2) sano (.) et siin on takaraivossa se että (2) että (.) miehillä on se että ne näkee ittensä että ne on kunnossa ”en mää tarvii noita” (.) ennemmin mää otan sen Tekniikan maailman taikka jonkun (.) vastaavan lehden sieltä että no ”mää oon ihan hyvässä kunnossa” elikkä (.) se tää (.) miehen täytyy saada se semmonen radikaalimpi herätys siihen että nyt täytyy tosiaan tehdä jotain. (.)
P2 (-78): Monella (.) sanotaan et (.) monella miehellä on kuitenkin ollu (1) pojasta asti semmonen (1) urheilu- (.) urheilutausta siellä ja (.) on tehny ja pelannut kaikkee (1) ja (.) on semmonen kuva ittestään että (.) on niinku vielä pystyy (.) pystyy semmosia, tiettyyn suoritukseen siellä urheilupuolella niin (.) Se, se saattaa pysyä aika pitkään (.) ennenkö sen sitten huomaa ettei se (.) mikä se todellisuus todella on.
IP: Joo
P5 (-75): Ja on se ehkä toi-toisaalta on siinä sitäkin että on (.) ehkä vähän naismaista (.) lukea Men’s healthiä ja (.) öö höpötellä ruokavalioista ja (.) m:uista (.) tietysti jos on samanhenkinen kaveriporukka niin sehän saattaa olla ihan (.) luonnollista mutta noin niinku (.) kyllä (1) kyllä noin niinku keskimäärin se ei oo ehkä (.) on se ehkä vähän (.) siinä on vähän semmosta (1) naismaisia piirteitä niin kun (.) puhua liikaa niin kun (1) niil on ehkä vähän eri (.) erilainen suhtautumine (.) öö (.)
[hyvinvoin[tiin.
P2 (-78): [Niin no(.)[siähän sen näkee. Meet tonne taukokoppiin ja sanot että tota ni “lähteekö moni aerobikkiin illalla” ni (.) (kaikki purskahtavat nauruun) ei (.) ei varmaan (.) Voit olla aika rauhassa sen jälkeen (.) että tota.. (FG2:15–16.)

Excerpt 5.12 (page 134)

IP: Joo. No mil- (.) miltä susta niin ku (.) tai (.) miltä susta tuntuu ajatus että Tekniikan Maailmassa (.) tota tulis tämmönen terveys osio jossa ois sit tota viikon jumppaohjeet ja ja (.) tota (.) viikon niin
[kun tämmönen öö.. ruokalista[(.) miten niin kun syödä terveellisesti?
K7: [(naurua) [Joo ei se (.) ei se oikeen (.) ei se oikeen istu (.) istu kyllä sen lehden (.) lehden imagoon, että (.) kyllä se niin ku enemmänki (1) tulee noi (.) semmoset että s- en nyt tiä sitte että millä siihen sais (nopeasti) (.) millä sais semmosen (1) lehden taikka julkasun, jossa ois niin ku kaikkee eli olis ihan uusi (.) uus lehti julkasu, kyllähän on olemassa miehille (.) tietysti näitä kuntolehtiä just niitä ku jotain

Bodaus ja tämmösiä (nopeasti), niissähän on niinku ravinnosta kaikennäköstä (.) tutkimuksia kaikista (.) kaikista asioista (.) ”greippi laihduttaa”, ”amerikkalainen uus tutkimus” sun muuta kaikkee (.) että (IP: mmm) tota (.) mut se ei saa olla pelkästään semmonen lehti (.) kerta (.) se e:i sitte taas (1) palvele muuta ku semmosta tiettyä kapeeta (.) kapeeta joukkoo (.) ja sitte taas että (.) siinä tarttis olla niinku vähän kaikkee että (.) se että millä rakentaa semmonen joka on niin ku kaikille (.) että se niin kun (.) kiinnostas kaikkia (.) siinä olis kalastusta, metsästystä, autoja (.) tekniikkaa kaikkee (.) että mikä on s- (.) *sitte* se pakettien suhde että (.) että millon siin on niinku riittävästi kaikille (.) kaikille sitä omaa juttua ja sitten saatasiin siihen jotain että (1) (huokaus) vaikee on sanoo (naurahtaa).
IP: No näitähän on yritetty (.) siis maailmalla (.) ihan (.) ihan siis kaupallisia (.) julkasuja on siis tää (.) Suomessakin [ilmestyvä
K7: [Men’s hea[lth
IP: [Men’s hea[lth
K7: [joo
IP: mm tota (.) tietynlainen niin ku konsepti tähän (.) että yritetään saada (.) yhdistettyä näitä asioita.
K7: *Joo* (.) Mä (.) sanosin että (.) että tommoset lehdet varmaa (.) toi- toimii (.) sanotaan että se menee ehkä (nopeasti) enemmän sille (1) akateemiselle ja sille puolelle v-varmaan ei (2) työmies ei kehtaa sitä lukee *kyllä* tossa (nauraa) työpaikall*ansa* (.) että (IP: joo) että musta tuntuu ainaki että se on semmonen asenne-juttu että jos sitä kattoo ni (.) (nauraen) kyllä sitte ollaan että (IP: Joo) [*se on*
IP: [Mikä siinä sitten on (.) (K7: se) mikä siinä kehtaamisessa (.) mitä se edustaa niin kun se lehti?
K7: No kyllä se e:dustaa sitä kato sitä just sitä samaa (.) sitä esteettisyys *näkö*kohtaa (.) eli sitä niinku pidetään et (.) se on niin kun naisten juttu että (.)
IP: Jaa jaa (K7:17, s. 1968.)

Excerpt 5.13 (page 137)

IP: Joo, se on niinku tosta (.) puhuttiin siitä tiedosta ja (1) sit niinku näistä miehistä ja naisista ni (.) niin niin (.) oon kuullu väitettävän, että (1) että monet miehet, ainakin keski-ikäiset miehet pitää jotenkin tämmöstä (.) öö (.) terveystietoo jotenkin akkamaisena, tai (.) tai (.) tai sellaisena niinkun (1) öö (.) naisten juttuna (.) jotenkin naisten hömpötyksenä (.) mitä mieltä te ootte tämmösestä? (4)
P2 (-75): No (1) no tota (1) kyllä siinä varmaan (2) kyllä siinä varmaan vähän (.) vähän sitäkin (1) sitäkin on (.) ja varmaan vanhemmilla ihmisillä viä enemmän (2) viä enemmän ja: (.) vähä (1) vähän semmonen nolo (.) nolo esimerkki sillain (.) kun meillä oli (1) olis pitäny (.) junioria lähtee neuvolaan viemään ja (2) yks kaveri tuli sitten meillä poikkeen ja emännällä oli menoo (1) Ja tota (1) emäntä lähti sitte menolle ja sanoin, että kyllä mää meen käymään sen kanssa ja sitten tää kaveri tuli mun mukaan (.) se oli (.) saman ikänen (.) saman ikänen mies mitä minä oon (.) vuoden (.) no (.) vuoden nuorempi vai mitä se on ni (1) me oltiin siinä neuvolassa ja siin oli (.) juniori meillä sitten mukana. Ja (.) sitten tää kaveri otti (.) ensimmäisen lehden mikä se sai ja se oli joku (1) se oli joku ”Terveys ja kauneus” taikka (.) ”Voi hyvin” taikka joku tällanen vastaava lehti (.) ja se luki tällain sitä siinä ja (.) mä olin siinä vieressä ja meillä oli siinä poika siinä, ni kyllä siä (.) vanhemmat ihmiset katto, että (.) mikä helvetin pariskunta tää nyt on (kaikki purskahtavat nauramaan) (.) Niinku että kai sitä niinku (.) (edelleen itsekin nauraen), emmää tiä (.) johtuko

se (.) johtuko se siitä terveys-lehdestä vai mistä se oli (.) mutta (.) kyllä siä niinku vähä (.) no (.) joo (.) vanhemmat ihmiset katteli vähä (.) sillai (.) (FG1:10.)

CHAPTER 6.

Excerpt 6.1 (page 146)

IP: Joo, se onkin (.) itse asiassa mulla oli toi seuraavana semmosena teemana tässä, tässä just noi miehet ja naiset koska.. (1) öö, (2) En tiedä tiedättekö mutta Suomessa naiset elää keskimäärin noin seittemän vuotta pidempään kuin miehet eli tällä hetkellä (.) miesten tämmönen niin sanottu keskimääräinen eliniän odote on, on siis miehillä on sei-.. vajaa 75 vuotta ja naisilla melkein 82. Mm, tuleeko teillä asioita mieleen mistä tää vois johtua? Miks naiset elää niin paljon pidempään ku miehet?
P4 (-77): Oiskohan se siinä että ku.. miehet täyttää kuuskymppiä ni (.) ne rupee makaileen sohvalla ja (.) se on sellaista velttoilua. Ja noi.. (1) naiset enemmänkin, on koko aika liikkeessä. (3) Touhuaa kaikenlaista. Voisko se olla yks semmone -?
IP: Mitäs muut?
P1 (-76): Kai noi työtkin voi jonkin verran siihen vaikuttaa että..(.) minkälaisessa työssä on ollu että.. (1) josson niinku.. (2) mies tavallaan ollu raskaammissa hommissa (.) ihan pienestä killistä lähtien. Ja (.) nainen on ollu, enemmän opiskellu ja (.) sit tavallaan viettäny sitä perhe-elämää ja sitte työelämää ja tommosta ni.. (2) oisko se (epäselvää) yhteisvaikutus siellä se, että (.) mies elää vaan töissä (.) pelkästään.
IP: Mm-m.
P3 (-76): Ni ja onhan toi niinku päihteiden, niinku tupakka, alkoholi, ni onhan se (2) paljon niinku (.) ku aattelee, miehiä. Kyllähä miehet sitte kuitenki aik- (.) paljon enemmän käyttää, kun vertaat naisiin (5). Kai seki jotai tekee.
P2 (-75): kai seki (.) kai seki sitte se ettei o pelkästään se (2) ei välttämättä se (.) taikka siis ilman muuta se työn fyysinenki raskaus, mutta sitten se semmoset haitta-, haittatekijät mikkä tulee jossain jossain, töissä sitte niinku vääjäämättä.. vääjäämättä että miehet tekee semmosta semmosta työtä että missä ehkä (.) ehkä se (.) kroppa alkaa huomaamatta saamaan (.) saamaan kaikennäkö-näköstä myrkkyä siinä että se alkaa näkyy sitte vanhemmalla iällä.
IP: tarkotat niinku raskaampaa työtä vai, vai myöskin.. (P2 -75: tai..).. tämmösiä saasteita tai (P2 -75: No, saast.. vaikka..) tämmösiä muita..(?)
P2 (-75): Tai.. no vaikka tommosta mitä mää ny sanosin, sanosin nyt esimerkiksi että joutuu tommosien kaikkien (.) ei nyt, nyt mä en tarkottanu pelkästään tätä raskautta vaan niinku tommosten liuottimien kanssa pelaileen (.) ja kaikkee tommosta (.) tommosta (.) jotai putkihitsaajia ja kaikenmaailman asbestissa tua pyärii ja just kaikkee tällästä, tällästä, että.. että kroppa on niinku ihan paskana jo siinä vaiheessa ku eläkkeelle menee. Siis lähinnä just niinku kaikkien, kaikkien epä-, epäpuhtauksien takia ja tollai. (FG1:11–12.)

Excerpt 6.2 (page 148)

P4 (-64): Naisten ammatit on eri lu-, luontosia niinku näissäkin, näissä (.) yksityisyrittäjillä, niin, niin (.) kyllähän se nyt on (.) melko selvä, et jos sää oot kampaajana tossa, niin jos sulla siellä on joku tietty porukka, niin tukkaa leikataan seuraavassa kuussa taas samanlailla, että

sulla on joku tietty kävijäkunta. Sit jos sää oot joku kaivinkoneurakoitsija tai rakennusurakoitsija, mitä yleensä taas on mi-, vähemmän naisia kuin miehiä, ni (.) niin tota noin ni, jonain vuonna rakennetaan enemmän ja sitten kun tulee lama ni ei rakenneta mitään. Ja näin ni, mutta tukat leikataan joka kuukausi! Ja siis, naisten ammatit on perinteisesti sellasia, niinku erilaisia, ei ne oo niin stressi- (.) alttiita ammatteja. Joku kahvilanpitäjä tai muu vastaava. (FG3:18.)

Excerpt 6.3 (page 150)

P3 (-50): Kyllä mää luulen että toiki kans yks (erityisen nopeasti) (.) tekijä siihen että niitten niinku toi (.) elämänkatsomus on aivan tois- (.) toisenlainen ku miehillä. (.) (Mies) Syyllistää itteensä aika helposti että (1). kun taas naiset hakee vähän niinku valosampiakin puolia (.) asioista (1) öö (.) onko se nyt ton (nopeasti) ressaantumisen tai jonk*u* mihkä*hän* sitä ny sitte vois luokitella...*en tiiä*.
IP: Olitsä Esko (P1) sanomassa tästä jotain kun alotit että murehtiiko..?
P1 (-56): murehtiiko suomalainen mies ittensä hautaan (.)
IP: Niin.
P1 (-56): Se rupee (.) mähkiin kaiken maailman (1) asioita päässään ja..
(FG6:11.)

Excerpt 6.4 (page 151)

IP: Joo (1) tota jotkut on täs sanonukki, että (.) että (1) sillain näistä vanhemmista (.) tyypeistä (vanhemmista haastateltavista), että se (.) et on huomannu sen, että vaikka monella alkaa ollakin sitten siinä joskus viidenkympin paikkeilla vähän semmosta (.) vaivaa mitä ei aikasemmin oo ollu (.) (K6: mmm) niin silti (.) öö (.) miehet ei kauheen paljon puhu [
K6: [eei (.) se on joo
IP: näistä asioista keskenään.
K6 (-76): Varsinkin suomalainen mies niin sehän on niin juro, ettei se mitään saa (.) kuitenkin tollai niin ku (.) kauheesti tommosista ruuista ja tommosista ni keskustella muutenkaan. (IP: nii) Se o vähän vaikeeta varmaan monellekin toi (.) puhuminen ittestään ja jostain vaivoistaan suomalaisilla miehillä ni (1) se on vähän semmosta (3) kituutetaan loppuun asti ja sitten ku ei enää pysty ni sitten jotain (.) miettii jotain että mitähän tarvis tehdä.
IP: Joo. Mut osaaksä yhtään sanoo, et mikä siinä on, että miks niistä vaivoista puhuminen on jotenkin niin semmosta (1) ei tunnu luontevalta?
K6 (-76): En mä osaa sitä sanoo (3) et mikä sen sitten loppujen lopuksi (.) tekee. Tiedän monta tapausta, että on niinku kitkutellu niin kauan, ettei suunnilleen päässy sängystä ylhäälle ja sitten mennään vasta lääkäriinki niinku (.) En tiä mikä siinä sitten niin vaikeeta on. Pelätäänkö, että on jotain pahempaa ja (.) en tiedä. (K6:7, s. 1976.)

Excerpt 6.5 (page 153)

IP: Mitäs toi (.) tota tos Martti (P2) ensimmäisenä viittas siihen näihin naisten ja miesten elämäntapoihin, no (.) en tiedä että kun täs sitten puhuttiin liikunnasta mutta että (.) että onko teidän mielestänne naisilla niinku muuten jotenkin terveellisemmät elämäntavat (.) kuin miehillä? (.)
P2 (-49): Kyllä mun mielestä ne miettii enemmän sitä ja (.) elää (.) terveellisemmin kun miehet (1) Syö terveellisemmin ja siten ne huolehtii ittestään paljon enemmän ja (.) jos tulee jotain menee lääkäriin mutta

miehet ei välttämättä mee heti ja (1) panttaa ja panttaa että kyllä tässä ny viä (.) ”kattellaan” (.) ne (naiset) on herkempiä hoitaan itteensä.
P1 (-49): Siin on (.) siinä on varmaan kyllä ihan suuri (.) suurikin ero että naiset hakeutuu niinkun (1) helpommin (2) tutkimuksiin ja ne tuntee jotenki (.) miehet ei kyllä mee. (1)
P2 (-49): Miehet menee sitten ku on tota ni (.) pää kolmantena jalkana sitten et ku jotain vialla
P1 (-49): *Niin* tai sitte vie[dään (nauraen)
P2 (-49): [taikka viärään! (.) Viärähän niin että (nauraen)
P3 (-54): Tää asia on aikalailla kyllä totta että (1) miähet ei sinne ihan (.) kaikista vaivoista pääsääntösesti mene. On tietenkin niitäkin jokka hyppää siä koko ajan mutta (2) iso osa meistä ei mene sinne ennenkun on ihan pakko.
IP: no mistäs tommonen ny mahtaa johtua (.) mistä (.) mikä se miehelle on että on (.) ei tuu lähdettyä sinne, sinne hoitoon tai tarkis-, tarkistuttamaan omaa tilaansa? (1)
P2 (-49): *Sitä* vähättelee sitä omaa vaivaansa ja pantataan (epäselvää) (.) vähän kolottaa niin *aattelee että* ”mitä tosta ny suotta” (1)
P3 (-54): Oisko se vähä semmone (.) vähän semmonen perinne ja (.) vähän semmonen kunniakysymyskin että ”pirujako mää siälä teen” (1) meininki että (1)
P1 (-49): O:n se varmaan vähän (.) perittyä se (1) jostakin (1) *tullu sor-* (2) *se on* vähän semmonen kunnia-asia että ”kyllä sitä ny (1) ilman lääkäriäkin tulee toimeen”. (2)
P2 (-49): Kai sitä aatellaan että ”jossei viina terva ja sauna auta ni se on kuolemaks” (naurahtaa ja muut alkavat myös nauraa) (FG5:8–9.)

Excerpt 6.6 (page 158)

K4: Mä luulen, että ku naiset on yleensä äitejä niil on enemmän ehkä vastuuta tota (1) näitten lastensa elämästä mikä on sitäkin kautta tota (3) elävät terveellisemmin ja haluavat olla esimerkkinä näille (2) perillisilleen, tai mitä nyt lapsilleen. (4) Että äiti on aina äiti kuitenkin että (.) isät on vähän enemmän (.) öö (1) ei kaikki mutta yleensä is-isällä-isillä pak-, pakkaa yleensä niinku enemmän repsahtaan *että se on niin*. Niin tota (.) (isät ovat vähemmän) sitoutunu siihen lapsen (.) lastensa kasvattamiseen, ku naiset niin (2) vois olla (1) yhtäkkiä ajateltuna tämmönenki siinä joku että. (6) Ja onhan se tietysti, että en-ennen oli vielä ööö (.) äidit oli aina kotona niin oli tietysti enemmän (.) niitten lasten kanssa. Sitäkin kautta se (3) vastuu ja muu että.. (K4:5–6, s. 1956.)

Excerpt 6.7 (page 161)

P3 (-72): Ne naiset ainakin niin kun ulospäin haluaa näyttää sitten (1) hyvältä ja kauniilta ja hyvinvoivalta (.) että (.) tosiaan pidetään nyt jonkin (1) pidetään nyt ne kilot kurissa ja halutaan näyttää meikkaamalla ja pukeutumisella siltä, että (.) ollaan, ollaan hyvässä kunnossa, kun mies taas sitten (.) no, lyödään haalarit päälle ja tukka sekasin, tehdään töitä! (FG3:15.)

Excerpt 6.8 (page 162)

IP: Mm, no mites elääkö-elääkö naiset sitten jotenkin esimerkiks terveellisemmin kun miehet? Voi-voiko se olla

selity[ksenä (naisten korkeammalle eliniän odotteelle)?
P3 (-50): [Kyllä ne ainakin hoitaa terveyttänsä[enemmän kun miehet.
P1 (-56): [varmasti, varmasti elää (terveellisemmin).
P2 (-48): Joo ja (1) kyllä siinä varmaan tiettyjä tämmösiä tekijöitä on jok-jokka (.) että niinku se asenne (1) omaan elämiseen niin se on aivan erilainen kun (1) miehillä. Onhan tietenkin poikkeuksia miehissäkin että niillä on hirveen hyvä (1) asenne ja tommonen mutta (2) se että jos (.) vertaa justiin sitä että kuinka paljon niinkun (1) naiset kesku-, keskustelee keskenään (2) kun vertaa sitä että kun miehet keskustelee keskenään (P1: onks siinä jotain eroo vai?). Ai-, aivan erilainen(.) käytäntö (P3 naurahtaa taustalla)
IP: Joo, no (.) mikäs nyt siis (1) jos nyt oletetaan että naiset sillä tavalla (.) pitää paremmin (.) enemmän huolta terveydestään niin (.) osaatteko sanoa mitään syitä että mikä (.) mistähän semmonen mahtaa johtua? (3)
P1 (-56): Naisten turhamaisuudesta. (P2 nauraa makeasti)
IP: Missä mielessä?
P1 (-56): Niitten on pakko olla aina niin hyvännäkösiä. (muut nauravat)
IP: Ahaa, eli siis ul-ulkonäkö on tää.. (muut nauravat edelleen). (2)
P3 (-50): En tiä, toihan on tommonen (1) joku (.) joku osteoporoosikin on tunnettu jo iän kaiken ja (.) se on yks mitä (.) mitä (1) äiti opettaa jo tyttärelleen ensimmäisenä että (.) pitää pitää ittensä kunnossa että liikkua että ei pääse luukato yllättämään (1) ja sitä kautta (.) se on jo niitä ensimmäisiä asioita. Ja sitten toi itsensä hoi-, huolehtiminen, hoitaminen ulkonäöllisesti (.) se on ollu varmasti se positiivinen asia (.) vaikka sen voi kääntää miehet aina negatiiviseksi. (1) Mutta se on se, se huolehtiminen (.) se on kokonaishuolehtimista. (1) Niinkun sitten huolehtiminen perheestä (P1: ky:llä, ittestään paremmin huolta) se tuntee, niin (IP: niin joo) (1) se on se kokonaisvaltasuus siinä naisella että (.) mitä miehellä ei oo (IP: joo) (P2: jos aatellaan että..) Miehet antaa kaljamahan kasvaa, naiset ei anna sitten taas. (FG6:17–18.)

Excerpt 6.9 (page 163)

IP: Tota siis, sano-.(.) sanotaan, et mä kysyn niin päin, että, että mi- (.) kun sanoit, että ehkä niin kun naiset pitää paremmin huolta terveydestään, niin miten ne pitää paremmin huolta terveydestään, mitä se (.) käytännössä tarkoittaa? Mitä naiset tekee toisella tavalla?
P2 (-78): Ainakin se lähtee siitä, että ne tunnustaa tosiaan ittelleen, että ne on huonossa kunnossa. Että se ei, varmaan miehillä on, että ”en mä nyt niin huonossa kunnossa vielä oo, että” (2) Jos vähän rupee painoo tuleen, että ”ei se nyt vielä mitään merkkaa”, mutta.. (2) Se huomataan vasta sitten siinä, kun (.) rupee oleen paikat leikkauskunnossa ja (1) täytyy tehdä niinku tosi radikaaleja muutoksia (.) siinä vaiheessa niinku, miehillä, huomataan se vasta. (2) Että e-, ei niinku (2) tiedo-, tai tiedostetaan, mutta ei niin kun tunnusteta ittelle, että ollaan huonossa kunnossa.
P4 (75): Naistenlehdet on täynnä kaikennäkösiä vinkkejä, että kuinka teet olosi ihanammaks (.) ja (.) niin poispäin ja (1) kyl se sieltä ruokakaupan (.) mysli- ja lesehyllystä lähtee se niinku se (.) hyvän olon hakeminen, se niinku sen ruokavalion kautta ja sillai ja (.) kaiken maailman (1) uutuudet mitkä vaan tulee, mitä mainostetaan, että on vähemmän rasvaa ja muuta, niin kyl se on se (2) naispuolinen henkilö, joka ne varmasti siihen perheeseen suurimmassa (.) osassa suomalaisista talouksista niin kun tuo ja yrittää saada sen äijänkin sitten niin kun (.) luopuun punasesta maidosta ja (.) ja (.) tosta suolasesta voista ja niin päin pois, että (2) Ja ehkä se (.)

juontaa myöskin juur-, en tiä onko silläkään vaikutusta, että (1) että naisia on i(.) niin kun huomattavasti paljon (.) suhteessa miähiä enemmän (.) niin kun suuntautunut tämmötteeseen (1) mmm (.) ammattiin, jossa (1) ollaan terveyden kanssa (.) tekemisissä. Sairaanhoitajat, terveydenhoitajat (.) ne on kaikki näitä (2) ter-, terveellisten elämäntapojen puolesta puhujia, niin (.) niin tota (1) sitä kautta se sieltä (2) niin kun varmastikin on. (FG2:14–15.)

CHAPTER 7.

Excerpt 7.1 (page 171)

T6: No se on semmonen ku sanotaan että (2) urheilijalla on (.) ei tervettä päivää nää muuta kun sairaslomalla *ku sais olla* (sairauslomalla, hymyillen)
IP: Nii
T6: (naurahtaa) Aina on jotai (.) millon mistäkin (1) on kolhuja nytkin on piikki (.) olka- (.) taikka kyynärpäässä.
IP: Ahaa
T6: (.) Tämmöstä se on (.) ei mitään muuta oo (.) normaalia, ei-ei mitää, ihan hyvä olo on, ei siinä mitään.
IP: Joo.
T6: Ei mitään tauteja eikä *semmosia että*..
IP: Mmm
T6: (.) Normaalia on (.) millon tulee hiihdosta millon tulee vaikka töissä (.)
IP: Nii
T6: koskaan ei tiedä
IP: Joo (.) jo[o.
T6: [*Niin kun* tääkin (näyttää kyynärpäätä) oli taas harrastusvika
IP: Aha[a
T6: [soudusta tuli heti kerrasta (.) tää kipeeks
IP: Joo (.) [joo
T6: [että se ei lähteny. (T6:1, s. 1946.)

Excerpt 7.2 (page 173)

P4 (-77): Kyllä mulla ainakin on vähän semmonen tunne että tota (1), nykypäivänä naiset harrastaa liikuntaa enemmän (3) en tiä lukuja mutta jotenkin vähän semmonen tunne, että naiset käy enemmän jumpissa ja aerobiceissä ja (3) ja tommosissa (.) että naiset harrastaa ehkä jopa enemmän liikuntaakin (3) kun miehet, mikä varmaan ei (1) aikasemmin on varmaan ollu just toisin päin.
IP: Joo..
P2 (-75): Ehkä naiset, naiset ehkä harrastaa tommosta järkevää (.) järkevää liikuntaa sillai niinku (.) tavallaan järkevää liikuntaa jotain tommosta (3) tommosta (1) käve-, kävelyä ja tollasta jos aattelee (1), et tottahan ne joutuu lähtee kävelee kun sanotaan (toiset naiset sanovat) et ”eiköhän mennä käveleen”, mutta se on kyllä ittelle tulee sellane (.) perkele juokseen tai johonkin niinku jotain järkevää mutta siis sillai just niinku (naurahtaen) (.) et että naiset ehkä osaa vähän (.) ottaa sillai rauhallisemmin ja ei sen tarvi olla aina niinku (.) aina sillai niinku se hiki-, hikipäässä vetämistä et se on semmosta ehkä (2) ehkä tavallaan, tavallaan vähän semmosta (.) ehkä sopivampaakin liikuntaa naisille. Ei pitäis repiä jos jotain menee tekeen. (FG1:17.)

Excerpt 7.3 (page 176)

P5 (-75): Ja on se ehkä toi-toisaalta on siinä sitäkin että on (.) ehkä vähän naismaista (.) lukea Men's healthiä ja (.) öö höpötellä ruokavalioista ja (.) m:uista (.) tietysti jos on samanhenkinen kaveriporukka niin sehän saattaa olla ihan (.) luonnollista mutta noin niinku (.) kyllä (1) kyllä noin niinku keskimäärin se ei oo ehkä (.) on se ehkä vähän (.) siinä on vähän semmosta (1) naismaisia piirteitä niin kun (.) puhua liikaa niin kun (1) niil on ehkä vähän eri (.) erilainen suhtautumine (.) öö (.)
[hyvinvoin[tiin.
P2 (-78): [Niin no (.)[siähän sen näkee. Meet tonne taukokoppiin ja sanot että tota ni "lähteekö moni aerobikkiin illalla" ni (.) (kaikki purskahtavat nauruun) ei (.) ei varmaan (.) Voit olla aika rauhassa sen jälkeen (.) että tota..
IP: Mut toi oli siis (.) mitä niinku Mika (P2) tossa äsken sanoi että siis (.) aika paljonhan tässä niin kun (.) tai tässäkin keskustelussa on just miesten kohdalla tullu tää liikunta esiin et (1) et miesten niin kun siis tää terveystekeminen (.) mitä (.) mitä me tehdään terveytemme eteen niin se paljon pyörii niinku just sem- semmosen fyysisen kunnon (.) ympärillä. Et varmaan on niin että liikunnasta puhuminen (.) urheilusta puhuminen on ihan OK. (1)
P2 (-78): ymm
IP: Tietysti (.) aerobikki ei oo ehkä niin oikee urheilulaji! (naurua)
P2 (-78): Se oli (.) se oli ehkä pikkasen kärjistetty[
IP: [Jo[o.
P2 (-78): [mutta niin kun (.) kuitenkin (.) kuitenkin tämmönen *niinku*..
P5 (-75): Mutta hyvin täs (.) itse asias tulee näis taukojumpis (.) mitä meillä on niin tota (1) öö (.) tota niin (.) (naurahtelua) kyllä siel- (.) kyllä siellä (.) lähestulkoon kaikki naiset osallistuu (.) taukojumppiin mutta on (1) niin kun (2) monet miehet jättäytyy ihan pois (.) vaikka ne olis täysin niin kun (.) vapaita ei mitään kokouksia ei mitään (.) niin he ei vaan yksinkertaisesti osallistu, se on niinku liian suuri kynnys heille tulla niinkun (.) ää (.) jumppaamaan, vaikka se kieltämättä varmast tekis hyvää
kun (.) istuu (.) *huonees ja tuijottaa* [*ruutua*
IP: [Mikä se (.) mikä se kynnys siinä sitten on?
P5 (-75): En en (.) en tiedä mikä (1) mikä siinä voi (.) ehkä sen on (.) ehkä s- en tiä onko se (.) kokeekohan sen he jotenkin naismaiseks, se on noloa mennä siihen niinku (.) naisten joukkoon (.) tavallaan (.) tai siihen jumppaamaan vähän tämmösiä (.) aerobik- (naurahtaen) maisia liikkeitä. En tiedä sitte. (FG2:16–17.)

Excerpt 7.4 (page 179)

IP: Joo ku tässä joku (.) joku sano, että tota, (…) vuorotyöläisillä on aika paljon näitä ylipaino-ongelmia (.) tai niitä saattaa tulla kun ei oo oikeen aikaa (T4: mm) sillain säännöllisesti harrastaa mitään liikuntaa ja, ja kuitenkin (.) tulee syötyä (2) syötyä noin (.) mahdollisesti melkeen vuorokauden ympäri, (T4: nii), jos on yövuorossa ja näin. Et onko teillä tämmöstä ollu siellä (työpaikalla) puhetta? (3)
T4: No (3) e:i meillä oikeen, yks on vähän yli- ylipainonen kyllä meidän vuorossa (.) mut ei se kyllä sitä liikuntaa harrastakaan ja (2) makee maistuu ja.. (IP: nii) (2) Mutta ei siitä sen kummempaa puhetta oo kyllä ollu, että.. (IP: joo) Mutta kyllä niitä paljon on (1) meidänkin (.)

työmaalla ni on niitä ylipainosia sillee että.. (IP: mmm) Makkaraa haetaan tosta (naurahtaen) (IP: nii, nii) tosta torilta ja (IP: joo) Jollakin vuorolla on ihan semmonen tapa, että ne (.) hakee kilokaupalla siitä (molemmat naurahtavat), makkaraa.
IP: No nopeetahan se tietysti on (T4: nii) kun tosta hakee vierestä (T4: nii). (3) Joo (.) Joo no siitähän päästäänkin ny heti tohon ravintoon sitten että tota (.) sä oot (.) pidät omaa ruokavalioos kuitenkin ihan (.) ihan semmosena hyvänä?
T4: Joo kyllä tää Pajamäki (työterveyslääkäri) (1) kun noita (2) niitä ver- veriarvoja katteli ni sano että (.) *että* hänen mielestään ei (.) ei tarvi mitään (.) muutoksia tehdä ravint*oon* ja tottumuksissa että *ne on*..
IP: Niin ku kolesteroliarvot on..?
T4: Se oli tasan viis.
IP: Joo.
T4: On mulla alempikin ollu, neljäkuus neljäseittemän on ollu mutta.. (.)
IP: nii
T4: Se oli tasan viis ja sitten se hyvä kolesteroli oli yksyheksänkaks että (IP: joo) sano että se on kuitenkin niin korkeella se (.) oliks se ny ADL vai HDL, (IP: nii) kumpi se nyt sitten on mutta (.) että se oli sen verran korkeella (.) että se on ihan hyvä ja (IP: joo) maksa-arvot oli (1) kakskytäkolme ja sehän on kai (3) *onkos se nyt* nollasta kaheksaankymmeneen se (IP: ymm) (.) että on siinä viä (.) varaa vähän viinaaki ottaa (nauraen)
IP: (nauraa) Joo.
T4: Ja kyllä toi (2) emäntä kyllä tota (.) kyllä se aina salaattia joka päivä koittaa syöttää että (2) (IP: joo) (.) eikä tee mitään rasvasia ruokia ja (.)
IP: ymm (1) joo
T4: *semmosta*.. (T4:8, s. 1949.)

Excerpt 7.5 (page 182)

See excerpt 4.7.

Excerpt 7.6 (page 184)

IP: No joku tässä heitti, että no (.) jos noi ny naiset tietää terveydestä enemmän ja on kiinnostuneempia niin se (.) niitten pitäis sit niin kun enemmän (.) miehille (3) siirtää tätä tietoa ja osaamistaan. Mitä mieltä sä oot siitä? (2)
K8: Kyllä se varmasti tuolla kotona kun meet siirt-, siirtään varmasti, niin kyllä siä tulee äkkiä haiseva vastalause, että (.) mee, mee itte (epäselvää) (IP: joo, joo) se on tiedotus siinä.
IP: Jaa siis tarkotatko liikuntaa vai?
K8: Niin ja yleensä niin, liikuntaa niin.
IP: Joo, joo.
K8: Sitten ku ne (naiset) lyö rehukipot eteen ni kyllä se monella (1) syömättä jää. (…) Siis yleensä (.) puhun niinku yleensä (IP: niin, niin, joo, joo), (1) mitä ny oon seurannu sivustakin.
IP: Eli miehet ei niinku (.) kauheesti ota vastaan sitä.
K8: Ei, ei ne ota. (K8:12–13, s. 1971.)

Excerpt 7.7 (page 188)

OSA 1.

IP: No mitäs tota kun sä laitoit tohon alkoholiin, siitä nyt tossa vähän puhuttiinki (2) puhuttiinki jo niin tota (1) ei ku miten se menee (1) juu (.) laitoit sä sille kohtaa miinuksen tossa (T3 alkaa nauramaan) niin, niin tota[..
T3: [Mäkin mietin sitä muuten pitkään (edelleen nauraen)
IP: Joo, mutta (T3: koska noi..) mutta kysytään niin kun niin päin, että, että mm käytätkö sä sillain (.) mielestäs (.) niin ku itte liikaa alkoholia (.) tai että niin kun (.) niin, käytätkö sä niin ku terveyden kannalta (.) liikaa omasta[mielestäs?
T3: [No.. (5) Siis en omasta mielestäni en käytä (.) Joku ehkä vois nähdä sen, kuitenkin niin ku mä sanon, että mä otan niin ku usein, vaikka mä otan vähän. Elikkä mä otan ne pari olutta iltasella (.) tai iltavuoron jälkeen oluen kaks (IP: joo) Neljä iltavuoroo (.) sillonhan mä juon alkoholia neljänä päivänä peräkkäin (IP: nii, nii) Mutta (naurahtaen) en ota kunnolla yhdenkään päivän annosta.
IP: Nii, no se on tietysti vähän eri a[sia.
T3: [Elikkä joku vois nähdä sen jo aika (.) vaarallisena, nii (molemmat nauraa). Elikkä tätä mää tarkotan.

OSA 2.

IP: Joo, joo, mutta se öö.. siis et oo ajatellu kuitenkaan niin, että (.) esimerkiks, että sun pitäs vähentää sitä alkoholin käyttöö tai näin?
T3: E:n. Ja kyllä jos mä sillain ajattelen nin (.) en mä ota sitä sitten (naurahtaa) (1) elikkä ei mulla (4) ainakaan viel oo mitään riippuvuussuhteita sen kummemmin (IP: mmm) tuskin tuleekaan (3) (IP: joo), mutta (.) aika monella siel on kyllä semmosia (1) ongelmia (.) vuorotöissä (2) (IP: joo) Ja vaikkei se enää niin ku tuo työmaalla näy, *mutta kyllä tossa* kuulee vähän niitä siviili juttuja (.) (IP: joo) tietenki siin on kaikki muutki (.) ihmissuhteet *sitten ja* (IP: nii (.) joo) Kyllähän (1) meistä aika moni, niin ku minäkin, mä oon eronnu (.) joskus aikanaan (2) ja (.) kyl tuol niitä eronneita on aika *paljon* (IP: nii joo) Ja sitten ku ajattelee (.) tässä (1) kolmenkymmenen vuoden aikana ni (.) on kauheen monta työkaveria, jotka on tehny itsareita ja tämmösiä, että (.) muistaa (IP: työkavereita?) nii, muistaa tästä vuosien mittaan ja (IP: aijaa) aika monet niist on ollu just (.) alkoholinkäytön kanssa (.) sotkussa. (T3:10–11; s. 1949.)

Excerpt 7.8 (page 190)

T1: Mä en oo (.) viinaa, viinan kans ollu tekemisissä viiteen vuoteen (IP: ahaa) (1) myöskään, että (2) ja sitä ei oo tullu maistettua (2) ja lupa on vasta ens vuonna ku mä täytän viiskymmentä niin sitten mä (.) mulla on niin kun oma lupa siihen sitten sen jälkeen.
IP: Ahaa, se on oma lupa (T1: se on oma lupa) ettei esimerkiks vaimon lupa (nauraen).
T1: Ei vaimon lupa vaan tota (.) noin vaimo tuppas rutisees aikasemmin siitä (.) mun viinan otosta siis sillain kun mä olin pitkällä vapaalla niin mä tuppasin ottaa sitten (.) sillain että tuntu kerran pitkällä vapaalla (IP: joo). Ja jos vahingossa seuraavana iltana sitten teki kupin siinä telkkaria katsoessa niin *siitä kyllä äkkiä* ”sä otit eilen illalla”, katsottiin vähän vinoon, ja ku vaimo on vielä (.) terveydenhoitaja ammatiltaan niin (IP:

ahaa), niin tota (nauraen). Tätäkin kautta tietysti (.) valvonta pelaa sillä tavalla.. (nauraen) (T1:9, s. 1955.)

Excerpt 7.9 (page 191)

T1: ..yövuorossa poikkesin tonne viimestelyleikkurille sitten poikien kans tarinoimaan, siinä oli yks just näitä Mänttäläisiä ni (.) mä sitte puhuin, etten mä siellä (seminaarissa) otakkaan mitään, että ku on tämmönen nenänvalkaisukausi menossa (1) ja krhm seura alkoi il-, ilkeellä tavalla kysyä jotenkin että ”no mihinkä saakka sä nyt ollenkaan meinaat olla” (ilkeällä sävyllä) ja (.) osu mua kiukkuhermoon ja mä sanoin, että ”ja perkele”, että ”kun tuli kerran puheeks ni (.) marraskuun yhdeksänteentoista päivään vuonna kakstuhattaviis! (1) (IP nauraa) Mä täytän sillon viiskymmentä, jos elää saan”. (1) No (.) vanha sanonta sanoo, että ”sanottua sanaa ja heitettyä kivee ei takasin saa” (IP: nii). (2) Ja tota (1) näihän siinä kävi, että (.) tässä ollaan ja (1) hyvin on menny ja työkaverit sitä etupäässä on huolestuneita ollu vaan, että (IP nauraa) (1) ”eks sää vieläkään ota, eks sää (.) yhtään”, ”mene hyvä mies käymään lääkärin puheilla” (IP nauraa) ”kyllä jotain vikaa täytyy olla!” (IP nauraen: kuulostaa aika) (T1 nauraa) niin, niin (IP: joo) (2) Mutta tosiaan ni (.) se on tämmönen historia siinä, kun moni kysy, että ”minkälainen veto teillä on ja kuinka iso” (IP: joo) ni mä (sanoin), ”ettei mistään vedosta (ole kysymys)” mutta mä, että (.) kun mä oon aina itte sanonu, että ku minä sanon jotain, niin se myös pitää ja piste. (T1:10–11, s. 1955.)

Excerpt 7.10 (page 194)

P2 (-70): No ryyppääminen tietysti. (.)
IP: Joo-o.
P2 (-70): Riski (2) tai sit jos ottaa liian vähän (3) ni ei osaa rentoutua [(naurua)
P1 (-61): [sopivasti, sopivasti sitte (hymyillen) (FG4:3.)

Excerpt 7.11 (page 194)

IP: Mmm.. No sanotaan, että jos sun pitäis niistä omista elämän-tavoistas pistää joko plussa tai miinus niin kumpi se oli[s?
K8: [Plussa se olis.
IP: Joo (2) miten sä sitä (.) perustelisit?
K8: (huokaisee) No mielestäni (.) koitan syödä (.) suht terveellisesti ja liikuntaa harrastan (.) (IP: joo) ja alkoholikaan (.) ei oo ongelma (naurahtaen). (K8:10–11, s. 1971.)

Excerpt 7.12 (page 195)

P2 (-57): Ne ei ressaa niin paljoo (.) naiset. (…)
P4 (-64): Niin kun ne purkaa sen ressin siihen, että ne aiheuttaa sen meille. (yleistä naurua)
P3 (-72): Ne delegoi sen stressin!
P4 (-64): Joo, ne delegoi, joo se on ihan totta!
P2 (-57): Niin, nii se on joku semmonen.. En tiedä mikä[
P4 (-64): [syyllis-
[tää miehet aina, nii
P2 (-57): [mistä johtuu, johtuu, mutta joku semmonen (.) kyä ne meittiä miehiä pysty-, kuljettaakin osaa aina (.) semmoseen, että (.) jos sitä vähä jotain (.) huolta ja (2) jotakin on, on tämmöstä, ni ne (.) osaa sen heittää toisen niskaan, voi siä olla tämmösiä tietenkin jotain, mutta mun mielestä

ne ei, ne ei, ne ei niinku jotenkin vaan, suomalainen (.) äijä on mun mielestä semmonen, että se (.) vähä turhaan niinku ottaa (1) paineita ja, ja.. ja vuntsii
asioita. [
P4 (-64): [Sellasiakin mitä ei, mihin ei pysty vaikuttaan yhtään mitään
P2 (-57): Nii ja, nii, turhaa semmosia (1) et siinä voi olla tämmöstä, ettei ne, *ne muijat nyt niin sillai niinku (.) vunteeraa ja ne* (.). vähä enempi päästelee menemään ja päivän kerrallaan ja (.) jotenkin se ajatus-.. maailma, oisko se ton henkisen hyvinvoinnin puolella, sitten tuolla, et niil on vaan (1) Mää oon vähän sitä mieltä, et niil on enempi semmonen se (3) ajatusmaailma jotenkin (3) jotenkin semmonen vapaampi ja huolettomampi. (Joku hymähtää) En tiä, jos se, jos se sinne seittemään vuoteen sitten tämmönen (.) ajatus tuo muutaman vuoden li-, lisää, ni (1) vois olla.
(…)
P2 (-57): Sääkin jäät sinne (1) (puhuu P4:lle, joka on kertonut kotonaan tekeillä olevasta remontista) rakentaan ja listoja naputteleen ja kiroon ja pärrään, ressaan niitten kans, kun ne on vähän kieroja eikä ne sovi ja (.) muija heippaa ovelta, että (.) ”kato tota Kallee ja Kaisaa ny siinä samalla sen aikaa, mää lähden, lähren jumppa-ryhmään (yleistä naureskelua) ja me käydään sen jälkeen pari olutta (.) juomas”. (P4: No..) Teillä menee, niin no jos se (.) menee vaikka joka viidennessä porukassa tällai, ni (1) siinä sitä on vähän (.) heti (.) vähä hulvattomampaa, katos (1). Ei ne (naiset) siä ressaa niitten listojen (naurahtaen) kaa, ne lähtee jumpalle! (Yleistä naureskelua.) Sekin siinä viä, niillä tulee silläkin vähä enempi liikuntaa, että.. (kohottaa kättään kuvaten juomisliikettä)
P4 (-64): Niin ne ressaa meitä niitten listojen kanssa (P2: Niin! Nii-i!), ne ei ressaa itteensä. (FG3:13–14.)

Exceprt 7.13 (page 199)

P3 (-76): Mä (…) itte poltan ja joka kerta siinä lukee, että ”tupakka tappaa” taikka jotain muuta tämmöstä. (2) Ettei se, (1) vaikka (.) siinä ny lukee, että tupakka tappaa, ni okei (1) tappaahan moni muukin, etten mä ny sillä sitä (1) niinku (.) kato (.) mutta tota (..) (FG1:6.)

Excerpt 7.14 (page 200)

P3 (-75): Toisaalta niinki (.) niinkin päin on, että tupakka on vaarallista, mutta noi autojen pakokaasut (.) on yhtä vaarallisia (.) *kuitenkin*. (1) (IP: nii) Liikut tuolla kesku- (.) keskikaupungilla neljän aikaan päivällä, ni (.) khrm (1) (IP: ymm) kyllä mieluummin filtterin läpi imee ilmaa (1) ku ihan suoraan. (FG2:5.)

Excerpt 7.15 (page 202)

OSA 1.

P1 (-56): (Tupakoinnista on) helvetin paha päästä eroon! *Oon koittanu* (.) *jumalauta se on hankalaa*. (1)
P3 (-50): mää luulen että se on (.) monella niinku sem*monen*
tapa[kysymys niinku siis se tupak[ki.
P1 (-56): [se on [se on tapa ja niinku. Joskus lähden kaupungille niin (.) jätän tupakit kotio (1) Neljä viis tuntia menee etten mä ees ajattele koko helvetin tupakkia. Ku mä meen kotio (2) kengät pois jalasta (.) partsalle vetäseen savut. (yleistä naurua)

OSA 2.

P2 (-48): se on (.) se on yks semmonen (1) tekijä. Kyllä munkin täytyy (.) sanoo että kyllä määkin poltan tupakkia ettei se (.) sinänsä oo että (3) mutta ehkä se on vaan (.) semmonen totunnainen tapa. (.) Mutta (.) (IP: ymm) se on tosiaan että siittä irrottautuminen niin (.) se ei oo ihan (.) ihan yks [oikonen..
P3 (-50): [niin sä et koe sitä pahaks vai?
P2 (-48): Ni[in en mää sitä niinku sillai (1)
P3 (-50): [sää et koe [että se on vaa[ran- (.) vaarantaa sun terveyttäs [vai?
P2 (-48): [niin (.) [niin. [En mä sitä sillai oo ajatellu (.) mielessä. (2)
P3 (-50): va[i meinaakko että on parempi kun on tervatut keuhk[ot.
P2 (-48): [tää o-, tääl on niinkun monta [monta muutakin asiaa mihkä voi sitten sortua nii (.) otetaan yks tommonen (1) vähä (.) miedompi paha sitte. (1)
P3 (-50): mut onks se (.)[onks se miedompi?[
P2 (-48): [Jos läh- (.) [lähtisin ny tällee vertaan sitä siihen että mää ostasin niinkun (1) puolipulloo Koskenkorvaa joka päivä. (1)
P3 (-50): [ja siihenkö sää vertaat tupakin polttoo[?
P2 (-48): [(nauraa) [nii:iin (nauraen)! (FG6:11–12.)

CHAPTER 8.

Excerpt 8.1 (page 213)

P3 (-63): *Joo* nii se on kai sitten yritettävä vaan niin sanotusti kohtuudella (.) näitä jos näit pystyy pitään (.) kohtuudella (3) tota. Olla tekemättä tai tehdä (1) niin jonkun moiseen (.) kompromissiin voi päästä, mut se se on sitten (.) helposti *sanottu ku* (epäselvää) *tehty*.
P1 (-61): Kohtuus kaikessa (6) (muut myötäilevät). Eihän sitä varmasti niinku täydellisesti pysty niinku tota (.) kun ajattelee tällästakin ni (1) asiamäärä jo niinku et (1) et semmosta optimi-optimi tilannetta ei mitenkään pysty (.) *niinku* y-yks ihminen niinku (1) hallitteen tämmöses (.) (FG4:4.)

Excerpt 8.2 (page 214)

OSA 1.

IP: niin (1) no joo mehän voidaan lisätä tonne sitten jos tässä (.) keskustelussa tulee lisää mieleen. Sillai niitä useimmiten tulee sitten enemmän mieleen, kun vähän aikaa asioista jutellaan, lisätään sen mukaan. Tota (1) katotaan ihan tota listaa se on aika pitkä ja tommonen monipuolinen lista, ihan haluisin kysyä että miltä se ny teistä näyttää? Että miten sitä (.) ihminen pystyy terveenä pysymään jos niitä on noin (.) monia ja monenlaisia asioita? (3)
P1 (-49): Eihän täältä kukaa oo elävänä (.) e- elävänä selvinnykkää mutta (.) kyllähän tossa nyt on tietysti tommosia joku (.) ruokailu- (.) tottumukset niin kyllä siihen tietysti (.) ehkä enemmän tulee kiinnitettyä huomioo (.) nyt kun joskus nuorempana (hitaasti) *että* (2). Jollakin lailla sitä vissiin alkaa arvostaa enemmän sitä terveys- (.) tilaa (.) tilannetta, kun vanhentuu. (1) Samaten noi monet muut asiat tossa niin (.) on (.) liikuntaki (.) on semmonen että (1) jossain elämän vaiheessa se jää vähemmälle jossain sitten taas se (.) rupee lisääntyyn. Nuorempana on varmaan sitä paljon ja sitten (.) tulee semmonen taantumavaihe ja sitte

taas jossakin vaiheessa havahtuu, että jotakin pitäis tehdä tai muuten ei (1) hyvä seuraa *siitä*. (2) *Mutta* taitaa olla tupakoinnit ja alkoholit vähän sama (.) sama juttu, että (1) jossain siellä kaks-kolmekymppisenä ei niitä niinku kovin paljo mieti si- seuraamuksia ne ei vielä sillon tunnu mut sitte vanhem*miten rupee* miettiin vähän syvällisemminki. (Koko puheenvuoro hiljaa, hitaasti ja ”mietiskellen”) (4)

OSA 2.

IP: No, täs ku tuli toi, sanoit että niinku tässä iässä (.) öö (.) rupee miettimään niin oottekste muut, muut Jouko (P3) ja Martti (P2) niin samalla tavalla kokenu niinku omalla kohdallanne että olisitte (1) jotenkin alkanu enemmän terveyttä miettiä? (2)
P2 (-49): Ky:llä aika paljon sitä on tullu mietittyä ja (1) itekin oon yrittäny liikkua ja (1) syödä terveellisesti ja (2) kyllä se mielessä käy. (2)
P3 (-54): Kyllähän sitä (.) aika paljo on kiinnittäny huomioo tähän (.) niin ruokailutottumuksiin ku (1) muutenkin näihin elämäntapoihin ja (2) on sen verran ressaavaa tämä nykyelämä, että toi (.) tupakointi ja alkoho:likin kuuluu aina välillä siihen (1) normaalipäivään ja liikunta vähä vähemmän kun siihen ei tuppaa oleen aikaa ja (.) sitä kautta se levon tarve (.) entisestään korostuu, että (2)
P2 (-49): *Joo* (.) mulla se on hyvä se ku mä en tupakoi (.) mitä ny (.) kohtuullisesti viinaa käytän (nauraa). Koirani kans käyn lenkillä joka päivä tunnin lenkin teen että (1) siinä mielessä *mutta* (.) tupakki on paha. (FG5:4–5.)

Excerpt 8.3 (page 217)

See excerpt 7.13.

Excerpt 8.4 (page 217)

P4 (-64): Rasvasiin ruokiin ja tällasiin nin ei se, ei se oo niin sillain jotenkin (.) päällimmäisenä mielessä veikkaisin tossa alle (.) kolmekymppisenä vielä. Että en mää ainakaan oo miettinyt, mutta mää on kyllä liikkunutkin aina niin paljon ettei (.) ikinä tullu, oikeestaan vieläkään katottua et *mitä suuhunsa laittaa, että*.. (FG3:5.)

Excerpt 8.5 (page 219)

P2 (-49): *Joo* (.) mulla se on hyvä se ku mä en tupakoi (.) mitä ny (.) kohtuullisesti viinaa käytän (nauraa). Koirani kans käyn lenkillä, joka päivä tunnin lenkin teen että (1) siinä mielessä *mutta* (.) tupakki on paha. (FG5:5.)

Excerpt 8.6 (page 219)

P2 (-48): Tää o-, tääl on niinkun monta (…) monta muutakin asiaa mihkä voi sitten sortua nii (.) otetaan yks tommonen (1) vähä (.) miedompi paha sitte. (1)
P3 (-50): mut onks se (.)[onks se miedompi?[
P2 (-48): [Jos läh- (.) [lähtisin ny tällee vertaan sitä siihen että mää ostasin niinkun (1) puolipulloo Koskenkorvaa joka päivä. (1)
P3 (-50): [ja siihenkö sää vertaat tupakin polttoo[?
P2 (-48): [(nauraa) [nii:iin (nauraen)! (FG6:11–12.)

Excerpt 8.7 (page 222)

IP: No, täs ku tuli toi, sanoit että niinku tässä iässä (.) öö (.) rupee miettimään niin oottekste muut, muut Jouko (P3) ja Martti (P2) niin samalla tavalla kokenu niinku omalla kohdallanne että olisitte (1) jotenkin alkanu enemmän terveyttä miettiä? (2)
P2 (-49): Ky:llä aika paljon sitä on tullu mietittyä ja (1) itekin oon yrittäny liikkua ja (1) syödä terveellisesti ja (2) kyllä se mielessä käy. (2)
P3 (-54): Kyllähän sitä (.) aika paljo on kiinnittäny huomioo tähän (.) niin ruokailutottumuksiin ku (1) muutenkin näihin elämäntapoihin ja (2) on sen verran ressaavaa tämä nykyelämä, että toi (.) tupakointi ja alkoho:likin kuuluu aina välillä siihen (1) normaalipäivään ja liikunta vähä vähemmän kun siihen ei tuppaa oleen aikaa ja (.) sitä kautta se levon tarve (.) entisestään korostuu, että.. (FG5:4.)

Excerpt 8.8 (page 223)

IP: Joo, no tota (.) mennään sillain vähän noihin (2) ehkä elämäntapoihin enemmän, että (.) no joo mä nyt sen vielä kysysin tosta, että mitä, miten sä niinku (.) aattelet (.) kuvaat noita omia elämäntapojas niin kun terveyden kannalta (.) sillai kokonaisuutena, että pidät sä omia elämäntapojas terveellisinä? (3)
K8: (huokaisee) *No* suhteellisen, että tarttis nää tupakat (2) pois *jättää*.
IP: Mmm.. No sanotaan, että jos sun pitäis niistä omista elämäntavoistas pistää joko plussa tai miinus niin kumpi se o[lis?
K8: [Plussa se olis.
IP: Joo (2) miten sä sitä (.) perustelisit?
K8: (huokaisee) No mielestäni (.) koitan syödä (.) suht terveellisesti ja liikuntaa harrastan (.) (IP: joo) ja alkoholikaan (.) ei oo ongelma (naurahtaen). (K8:10–11, s. 1971.)

Excerpt 8.9 (page 224)

IP: No, täs ku tuli toi, sanoit että niinku tässä iässä (.) öö (.) rupee miettimään niin oottekste muut, muut Jouko (P3) ja Martti (P2) niin samalla tavalla kokenu niinku omalla kohdallanne että olisitte (1) jotenkin alkanu enemmän terveyttä miettiä? (2)
P2 (-49): Ky:llä aika paljon sitä on tullu mietittyä ja (1) itekin oon yrittäny liikkua ja (1) syödä terveellisesti ja (2) kyllä se mielessä käy. (2)
P3 (-54): Kyllähän sitä (.) aika paljo on kiinnittäny huomioo tähän (.) niin ruokailutottumuksiin ku (1) muutenkin näihin elämäntapoihin ja (2) on sen verran ressaavaa tämä nykyelämä, että toi (.) tupakointi ja alkoho:likin kuuluu aina välillä siihen (1) normaalipäivään ja liikunta vähä vähemmän kun siihen ei tuppaa oleen aikaa ja (.) sitä kautta se levon tarve (.) entisestään korostuu, että.. (2)
P2 (-49): *Joo* (.) mulla se on hyvä se ku mä en tupakoi (.) mitä ny (.) kohtuullisesti viinaa käytän (nauraa). Koirani kans käyn lenkillä joka päivä tunnin lenkin teen että (1) siinä mielessä *mutta* (.) tupakki on paha. (FG5:4–5.)

Excerpt 8.10 (page 226)

IP: Mmm.. No sanotaan, että jos sun pitäis niistä omista elämäntavoistas pistää joko plussa tai miinus niin kumpi se o[lis?
K8: [Plussa se olis.
IP: Joo (2) miten sä sitä (.) perustelisit?
K8: (huokaisee) No mielestäni (.) koitan syödä (.) suht terveellisesti ja liikuntaa harrastan (.) (IP: joo) ja alkoholikaan (.) ei oo ongelma (naurahtaen). (K8:10–11, s. 1971.)

Excerpt 8.11 (page 227)

T4: Ja kyllä toi (2) emäntä kyllä tota (.) kyllä se aina salaattia joka päivä koittaa syöttää että (2) (IP: joo) (.) eikä tee mitään rasvasia ruokia ja (.)
IP: ymm (1) joo
T4: *semmosta*.. (T4:8, s. 1949.)

Excerpt 8.12 (page 228)

P4 (-76): (..) meijän isä on ainakin semmone (.) et on alkanu ny (.) no (.) ehkä meijän perheessä se on sillai että (.) äidin tieto lisää isän tuskaa (naurahtaa) että tota (.) siällä tota toi meijän äiti on semmone et se pistää sitte että tota että ”ei ku nyt!” (nopeasti) (1) tota (.) joka päivä lenkille ja (1) tota niinku (.) määrätyissä asioissa taas alkaa sitten ampuun ylitte että niil on sem*moset* saamarin (.) vitamiini- (.) ravintolisä- (.) paketit siellä että (1) siä jää urheilijatki kohta toiseks.. (FG1:9.)

Excerpt 8.13 (page 229)

IP: Tota (.) kerroit että sun (.) äiti
on ollu siinä ilmeisesti aikapalj[on
P4 (-76): [Jo[o:!
IP: [mukana [tässä
P4 (-76): [Jo[o:! (nauraa)
IP: [*pyörityksessä*
P4 (-76): joo se on semmone (.)[
P2 (-75): [koutshi [(nauraa)
P4 (-76): [kyllä joo (.) se on viimesen päälle rankka valmentaja että siinä (1) isä tulee töistä kotio ni (.) annetaan (.) salaatti *ja* (.) kanapalanen eteen ja sanotaan että ”sit kun oot syöny niin lähdetään lenkille” ja (.) ei siinä sitten paljoo kysellä että..
IP: Noo, mites sillon kun tää tai (.) muistat sä niin kun jonkun semmosen ajankohdan millon tää olis niinku alkanu vai, vai onks se vaan ollu niinku aina (.) äitis (.) tavallaan tehny näin, mutta että
jossain vaiheessa [vaan isäs rupes ottaan sitä vastaan?[
P4 (-76): [Se alkoi [pari v-, pari vuotta sitte sillain, meijän tota (.) semmonen tuttava- (.) tuttavaperheen mies, se on meidän isää vielä (2) varmaan viis, kuus vuotta nuorempi (1) niin sai (1) vuoden aikana kolme pahaa infarktia ja (1) sitten niin kun alettiin meidänkin perheessä (1) kattoon vähä mitä tehtiin ja..
IP: Joo-joo (2) Sit sun isäs on ihan, ihan (.) tavallaan (.) vaikka äitis on ollu siinä (.) noin niinku preppaamassa (naurahtaen) ja viemässä eteenpäin, niin se on kuitenkin ollut
tavallaan ihan[ihan oma-alotteista[?
P4 (-76): [On [on (FG1:10–11.)