

Canadian Men's Self-Management of Chronic Diseases: A Literature Analysis of Strategies for Dealing With Risks and Promoting Wellness

American Journal of Men's Health
2017, Vol. 11(4) 1077–1095
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sagepub.com/journalsPermissions.nav
DOI: 10.1177/1557988315577674
journals.sagepub.com/home/ajmh



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Abstract

This article reviews the qualitative research on men's self-management of mental and physical chronic diseases, with emphasis on strategies for dealing with risks and promoting wellness. Using Bardin's method of document analysis, it was focused on the findings of Canadian qualitative studies published in French or English from 2005 to 2011. Boltanski's theory on *social uses of the body* inspired the analysis. Living with a chronic disease threatens men's sense of masculinity and self-image, as well as their perceived ability to fulfill expected social roles. Social images of men's bodies influence how men express their emotions, attributes, and attitudes, or acknowledge the need for and seek social affirmation. Self-management has been documented in Canadian qualitative literature as a complex phenomenon influenced by the social environment, personal capacities, feelings, perceptions, and potentials. The extent of how all these features interact within the scope of men's mental and physical health and illness experiences was partially revealed in this study. The findings underscore the social invisibility of men's bodies, especially those of men facing social inequities. Attending to principles of social justice can ensure that future research on men's health will amplify the range of men's voices and allow them to be heard. Recommendations address also the international scientific community interested in advancing men's health research, especially in those countries that lack a national men's health policy.

Keywords

literature analysis, Canadian qualitative evidences, Francophone, Anglophone, aboriginal, and sexual minority men, scholarly and gray literature

International scholars believe men's health and wellness to be affected by various psychological, physiological, social, cultural and environmental factors, and the remedy to require implementation of targeted gender-specific actions (Wilkins & Savoye, 2009). Addressing the factors that undermine men's health is a gender equity issue (World Health Organization, 2002) that demands cultural awareness and respect for diversity in gender health policies, strategies, and plans of action.

Stereotypical attitudes toward men, invisibility of men's health, negative media representations of masculinity, and lack of specific health education about promoting men's health are the major issues (Garlick, 2003; Logan, 2005; Spitzer, 2005). More than 10 years ago, the scarcity of resources for men's health and social services

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and limited access to what was available were denounced in Canada; such health service deficits are especially concerning given our knowledge that men delay the search for medical help (Galand, 2001). Canadian data indicate that immigrant men are at increased risk for chronic diseases (Newbold, MacDonald, & Kennedy, as cited in Hyman, 2007). Since unhealthy expressions of masculinity (Mikkonen & Raphael, 2010) and the lack of recognition of men's health disparities in Canada are synergistically linked, it is important to attend to the bases for men's health risks, including the social determinants of health and gender-specific dynamics in order to promote men's health. Canadian scholars have reiterated the importance of applying a gender-specific approach that incorporates a communication style and interventions that are gender sensitive (Bilsker, Goldenberg, & Davison, 2010) to attenuate the negative impacts of the current level of attention to men's health, considering the lack of a national men's health policy (Robertson, Galdas, McCreary, Oliffe, & Tremblay, 2009). For several years, the Canadian nonofficial research agenda on men's health has been primarily informed by Health Canada's Gender-Based Analysis Policy (Health Canada, 2000). Most recently, the Canadian Institutes of Health Research–Institute of Gender and Health (n.d.) warned of the urgent need for increased attention to boys' and men's health from all perspectives.

Since social determinants of health relate to places and conditions where individuals are born, live, work, and age (World Health Organization, n.d.), it was considered the existence of multidimensional strategies for dealing with nonmedical issues as risks and burden to promote wellness as it relates to men's self-management of mental and physical chronic diseases. These multidimensional strategies include actions to change unhealthy habits, adopt a new lifestyle, use of psychological coping strategies, creative ways of dealing with physical and functional changes and impairments, as well as consciously refraining from risky behaviors. These are particularly relevant to the promotion of healthier behavior because disease self-management is a complex phenomenon that is influenced by the social environment, personal capacities, feelings, perceptions, and potentials (Aujoulat, Marcolongo, Bonadiman, & Deccache, 2008; Brooks, 2008) that are mobilized in conjunction with family, community, and health professionals (Richard & Shea, 2011).

With the intention of documenting the state of Canadian knowledge on these sorts of strategies (including the ability to perform certain tasks, develop skills and set-up adaptive mechanisms to new conditions/situations), it was explored qualitative research evidence in scholarly and gray literature that integrated or synthesized the findings of studies on Canadian men's health, with particular attention to the experiences of Anglophone,

Francophone, and Aboriginal men, and sexual minority men. This manuscript addresses this knowledge gap and proposes an integrative, analytical synthesis of the relevant research findings.

Theoretical Framework

Boltanski's (1971) theoretical ideas about the social uses of the body guided this literature analysis. He states that we have a limited understanding of bodily needs, meanings, and functions, partly due to cultural underpinnings that ignore the body. He postulates that one's use of his or her body differs depending on one's social rank (in this study, we used Boltanski's original terms "class," "upper," "lower" that would be equivalent to the modern terms, social economic status, high and low) and related priorities: for instance, those from the middle/upper class view their bodies as an object of beauty, pleasure, and wellness, for which its good condition should be maintained, while those from the lower class emphasize the development and maintenance of bodily strength, allowing them its maximal use for physical labor.

This framework posits that inherent in social status is an implied code of manners appropriate to dealing with one's body, resulting in specific trends in health behaviors. Those from the middle/upper class tend to be more attuned to their bodily needs or morbid sensations and signs, and are more likely to voice concerns regarding (and even overinterpreting) them. Individuals belonging to the lower class tend to be less sensitive to bodily sensations, possess fewer skills to interpret them, and consequently are less likely to express their feelings and needs and are more likely to neglect bodily signs and symptoms. This may explain social class differences in individuals' inclination to seek medical care and engage with health care professionals, learn the medical terminology used, recognize their bodies' signs and symptoms, and convey this information to those professionals. These differences involve important interlinked dimensions that reflect how social class influences individuals' use and care of their bodies; these differences also affect demand for medical care and define the scope of individual and collective health behaviors to manage chronic disease and related issues. These ideas inspired this study and, in particular, the development of the coding categories that further guided how it was read and retrieved the research evidence used in the analytical work.

Aim

To examine the Canadian qualitative research evidence on men's use of their bodies, targeting men's self-management strategies in dealing with mental and physical chronic diseases, especially risks and burdens, and promoting wellness.

Research Questions

Two questions led this study: (a) Which personal characteristics and social representations influence men's self-management of mental and physical chronic diseases, particularly their strategies for dealing with risks and burdens and promoting wellness? (b) How do perceptions of masculinity influence men's view of their bodies and their self-care and the self-management of chronic diseases?

Method

Boltanski's (1971) theoretical ideas framed this analysis in that was focused exclusively on the verbatim comments of men experiencing certain illnesses, revealing the language and discursive framing that men use about their body and health. Studies were retrieved in two areas: (a) men's health and illness experiences with some of the most common mental and chronic physical diseases/conditions in Canada, that is, cancer (prostate), circulatory diseases (high blood pressure), respiratory diseases (asthma), diabetes, mental health problems, substance abuse, alcohol dependence, and depression (Bilsker & White, 2011; Haydon, Roerecke, Giesbrecht, Rehm, & Kobus-Matthews, 2006, Statistics Canada, n.d.) and (b) men's self-management strategies for dealing with mental illness and chronic physical disease, that is, intentions to change or adopt new behaviors and to deal with personal risks factors such as tobacco smoking, high blood pressure, high cholesterol, overweight and obesity, unhealthy eating, physical inactivity, alcohol use, unsafe sex practice, and illicit drug use that could interfere in the wellness promotion.

These topics were relevant to Boltanski's ideas about social differences in views and treatment of one's body in health-related contexts as expressed in men's language and discourse, health priorities, individual and collective health behaviors, as well as mastery of signs and symptoms in their health-related communication.

Literature Search Strategies

Several criteria to select studies for analysis were applied: (a) Canadian qualitative studies and community project reports; (b) conducted with outpatients, (c) published or completed or made available between 2005 and 2011, and (d) written in English or French. The criteria for exclusion of studies were (a) unclear or no identification of men's quoted statements and (b) a sample of fewer than three men per studied variable, as recommended by Pires (1997) to prevent a major methodological threat for internal comparison and analysis. The initial retrieval of published articles in English generated more than 200 publications perusing the databases: Scientific MEDLINE, CINAHL,

PsychoINFO, Sociological Abstracts (Sociofiles), Annual Reviews—Social Sciences, Psychology and Behavioral Sciences, using as keywords the target diseases and personal risk factors, and as key terms, chronic disease and self-management. In this search, self-management meant an array of tasks, use of skills, and mobilization of potentials as proposed by Schulman-Green et al. (2012). Special attention was given to those publications that clearly displayed the accounts, narratives, and verbatim comments of men who were study participants, and evidence related to the conceptual areas we intended to explore. The exclusion criteria—mainly the lack of clear identification of men's verbatim comments—drastically reduced the number of eligible articles. Since the essence of our analysis was the utilization of men's direct quotes, only publications with such quotes were kept in the final reduction.

Therefore, the prefinal *corpus* of studies for review was composed of the following: 18 French (including 3 master's theses in social work, sociology, and nutrition) and 40 English publications, plus 5 publications on sexual minority men, 6 on Aboriginal men exclusively, and 7 community-based research documents. After a thorough reading of these publications, the number of documents included in the final analysis was reduced to 7 French and 16 English publications and 3 community-based document (2 about Aboriginal health and 1 about sexual minority among Anglophone men), along with 5 sexual minority (4 with Anglophone and 1 with Francophone men) and 6 Aboriginal men articles.

The retained publications related to studies that employed various types of qualitative research designs: 9 exploratory, 7 descriptive, 4 ethnography; 4 participatory action research; 3 phenomenology, 2 grounded theory; 2 literature review; 2 life narratives, 2 discourse analysis, 1 qualitative modeling; 1 case study; 1 secondary data analysis; and 1 qualitative survey.

Analytic Approach

Jones' (2004) and Sandelowski and Barroso's (2002) suggestions for the analysis of qualitative research results were partially followed. The work method was as follows: Step 1—The principal investigator in collaboration with research assistants appraised the quality of the retrieved publications using these criteria for qualitative studies: (a) used precise concepts; (b) developed and linked concepts or ideas to each other; (c) offered new information about, insight into, or formulation of the target phenomenon; (d) the research design was relevant to studying the phenomenon in a given context; (e) the sample met the representativeness criteria; (f) the data were sufficiently rich to provide adequate description of men's strategies regarding health management; (g) reduction of the phenomenon corpus in its main characteristics

Table 1. Overview of the Analytical Work.

Analytical hypotheses	Areas of empirical evidence retrieved as direct quotes	Relevant features of Boltanski's theory	Conceptual dimensions of the analytical answers
Differences in men's personal characteristics and social representations directly relate to how they prevent and self-manage mental and physical chronic diseases, particularly their strategies for dealing with risks and burdens and promoting wellness	Style of seeking medical and social services & influence of sense of masculinity Interest in learning about one's body Ability to manage unfavorable and unpleasant situations Influence of representations of health and chronic diseases Representations of a healthy man's body and a body with chronic disease	Language about body Language about diseases Understanding of bodily needs Understanding of bodily meaning Understanding of bodily functions	Conceptual Theme 1: Men's personal characteristics and social representations: Related conceptual categories: Interest in learning about health issues Coping with feelings Attitudes and health-related decision making Awareness of dissonance and critical views Ability to make health-related decisions Personal representations and associated impacts Reactions to the burdens of health problems
How men's perception of masculinity influences their view of their bodies and self-care in the context of self-management of chronic diseases	Sense of masculinity and contemporary social discourse about their bodies General influence from culture Dealing with chronic diseases' impact on masculine identity, social roles, and life plans Coping with uncertainty and doubts Critical awareness of personal health choices Attitudes toward decision making Men's reactions to body breakdown	Understanding of bodily priorities Search for medical care/help Relationships with health professionals	Conceptual Theme 2: Influences of perceptions of masculinity Related conceptual categories: Societal influences of sense of masculinity on men's view of their bodies and self-care Criticized masculinity reshaping views of risks Burden of particular meanings of masculinity over self-care

(Mucchielli, 1996); (h) analysis of the data and clarity of data interpretation was thorough; and (i) the findings were relevant within the theoretical framework. Step 2—Bardin's (2007) method of document analysis was applied by (a) formulating analytical hypothesis and inferences, (b) identifying indicators of correspondence of meanings among texts, and (c) conducting an inductive process of aggregating ideas into sets of conceptual meanings.

Aware of the possible variations and differences in the original documents' reporting, the decision was against using any form of authors' narrative data, employing only the direct quotes (raw data) of men as reported in the publications to avoid the recombination of meanings, which could produce a major interpretative bias. The evidence retrieval was organized according to five conceptual dimensions: personal characteristics, social representations, cultural influence, perceptions of body, and strategies of self-management and their empirical features. This method was intended to provide a more structured and objective way to identify the relevant data by multiple retrievers: it was successfully used in a previous study

to conduct a similar type of literature analysis (Zanchetta, Monteiro, Gorospe, Pilon, & Peña, 2010). The data elements to be retrieved were determined by three of the coauthors who are experts in oncology nursing, and men's, immigrant and community health, along with an ad hoc consultant in the area of primary health care. This framework was equally inspired by Boltanski's ideas, mainly with regard to health behaviors and interactions with the health care system. An overview of the analytical work is displayed in Table 1.

Verification of Final Interpretation

Some researchers recommend testing the interpretive validity of qualitative analysis and results by querying different audiences about issues of culture, ideology, gender, textual language, relevance, advocacy, and standards of respectability (Creswell, 2013; Miles & Huberman, 1994). It was used the strategy of inviting male medical practitioners, mostly in primary health care settings, as natural experts to review an early draft of this manuscript.

Findings From the Literature Review

The retrieved literature was classified in two groupings of men's thoughts and behaviors regarding (a) strategies for dealing with risk for chronic conditions related to obesity, unhealthy eating, suicide, smoking, mental illness and unsafe sexual practices; and (b) strategies for dealing with burdens related to mental health issues, such as depression and posttraumatic stress disorder (PTSD), addiction and epilepsy, and those related to physical diseases/conditions, such as diabetes, cardiovascular disease, prostate cancer (PC), stroke, asthma, sleep apnea, HIV infection, and joint pain. Subgroups included in the study samples were distinguished by language, culture, age, and sexual minority to explore how different groups of men think, speak, and act regarding their own bodies. Because of inconsistently described sociodemographic information, analysis of men's discourse by social class was not possible, but specify findings were assembled by subgroups to some extent.

The results are presented by sections and subsections according to the research questions and conceptual dimensions. Although the findings were identified as applicable to specific subgroups of men, such as Francophone, Anglophone, and Aboriginal, as well as gay, bisexual, and transgender men, they were not intentionally aggregate in these subgroups findings; rather their particularities related to implemented strategies were emphasized. Thus, the analysis and reporting do not collate the findings by subgroup.

The analyzed evidence from the studies revealed three types of methodological weakness that limit the results: (a) unclear identification of men's verbatim accounts; (b) no information on social and economic factors associated with self-care and self-management, and (c) limited attention to subgroup differences by marital status, religion, immigration cohort, gender orientation, or cultural affiliation.

Description of the Findings to Answer the Analytical Questions

Inspired by certain features of Boltanski's (1971) theory, raw quotes were used to capture the essence of men's language about their body, illness, meaning of bodily reactions to diseases, and some indication of their level of health literacy in terms of their understanding of bodily functions, origins of diseases, treatment aims, medication effects, health priorities, as well as their overall contact with services and professionals. The integration of the retrieved evidence is intended to portray what is known about men's self-management strategies regarding chronic disease and promotion of personal wellness with attention to their implied or explicit awareness and sense

of masculinity. This section presents the conceptual themes: Men's personal characteristics and social representations; Influences of perceptions of masculinity describing their conceptual features.

Men's Personal Characteristics

Results characterized men in terms of their interest in learning about health issues; coping with feelings; attitudes toward health-related decision making; awareness of dissonance; and ability to make health-related decisions.

Interest in Learning About Health Issues. Receiving a medical diagnosis of a disease increases men's interest in learning about their body. When a health care professional encouraged them to seek health information, Anglophone men were motivated to learn and become active partners in cancer screening and follow-up (Davison, Oliffe, Pickles, & Mroz, 2009), PC treatment (Hagen, Grant-Kalischuk, & Sanders, 2007; Milne, Spiers, & Moore, 2008), asthma and hypertension management (Bajcar, 2006). Learning about their bodies and its mechanisms during depression onset put Francophone men in a constant state of alert regarding physical and mental signs but left them unsure of their ability to decode those signs (Roy, 2008). When experiencing suicidal thoughts, they had problems understanding their illness. The lack of "concrete" cues and physical manifestations led them to claim that depression was an invisible dysfunction of the brain inside a good, functional body (Roy, 2008).

Older Anglophone men experiencing multiple comorbidities and using several medications expressed a desire to learn about medication effects. Their lack of knowledge sometimes led to risky behavior. For instance, men who were simply prescribed antiepileptic medication without further instruction experimented with reducing the intake of medication (Bajcar, 2006). With little or no understanding of epilepsy and medication effects, specifically inadequate levels of medication, these men put their life at risk from an unmanageable epilepsy crisis. Interest in learning was also reported by Francophone men with depression who took courses on the disclosure of emotions (Roy, 2008), and Aboriginal men who learned to adopt strategies for diabetes management through self-discipline (Iwasaki, Bartlett, & O'Neil, 2005).

Other types of interest in learning about health and the body were documented, for instance, gay Francophone men viewed online pornography as a source of information about sexual practices and their effects on physical and emotional health (Corneau & Rail, 2010). Another study reported that obese (heterosexual) Francophone men wanted to learn how to decode food label nutritional

information once they became aware of false advertising claims and controversies regarding good food (Van der Mast, 2010).

Coping With Feelings. Learning about health does not necessarily translate into wellness. Health knowledge is not the only factor that can enhance and sustain feelings of safety, competence, and confidence in the self-management of disease. A health literate individual can benefit from cumulative experience, social learning, autonomy, and social interactions (Zanchetta, Monteiro, Kaszap, Gorospe, & Pilon, 2011). For example, despite being instructed on how to prevent PC-related complications, the effects of medication and self-assessment of their clinical conditions and medication taking, Anglophone men reported no significant increase in their self-confidence to do so (Milne et al., 2008). In another study, military Francophone men coping with PTSD felt more hopeful on receiving peer support, but maintained an unhelpful stoic stance about enduring pain and "hanging tough" under the influence of military training that stressed the development of skills and the courage to face adversity as an emotionally "strong" team member (Roberge, 2007).

Mental health issues are particularly fraught with stress and stigma. Feelings of loneliness and the strain of waiting to receive medical help exacerbated the fears of Francophone men who were trying to get a diagnosis of depression confirmed; they especially worried about being labelled mentally ill in their work environment (Roy, 2008). They reported feelings of shame and astonishment related to having to ask for help and wait for a medical confirmation of their need for mental health services (Roy, 2008). A single father living in shelter for homeless people -with his son- during a depressive episode disclosed how such an environment compromised his feelings of safety (Roy, Charland, & Tremblay, 2009).

Bisexual Anglophone men's perception of society's intolerant attitudes about bisexuality diminished their motivation to seek resources for mental health (Ross, Dobinson, & Eady, 2010). Another study revealed that Anglophone men in rehabilitation for addiction experienced a range of disturbing feelings: powerlessness, frustration, and anger over their condition, as well as mistrust of other individuals, which undermined their intentions to seek health information and their confidence in self-care (Palmer & Daniluk, 2007). Van der Mast (2010) reported that some Francophone men learned about obesity-related risks from their fathers and recalled painful memories of having an obese father who was a victim of bullying. These men's weight loss was motivated by negative feelings (e.g., malaise, guilt, and self-deception) as well as healthy expectations (e.g., to increase physical mobility and improve pain management and self-esteem). Green

and King (2009) reported that Anglophone men who were recovering from a minor stroke and whose physical impairment diminished their ability to remain the breadwinner and family protector spoke of perceived threats to their physical and emotional integrity and their new feelings of weakness and vulnerability. In a study of Anglophone men dealing with multiple chronic diseases, the men admitted being dissatisfied with their body image because of loss of strength, physical abilities, and autonomy (Clarke, Griffin, & The PACC Research Team, 2008).

Feelings of social exclusion were reported by Aboriginal men who felt devalued by the mainstream society that ignores their fate and health care professionals who undermine their intention to seek health information (Mussell, 2005). In another study, Anglophone gay men reported feelings of exclusion from gay culture because they had a chronic disease (Jowett & Peel, 2009).

Attitudes and Health-Related Decision Making. Data from two studies confirmed that some men tend to suppress their feelings about health-related fears and concerns, affecting their reactions and behaviors, including risk taking. For instance, Anglophone gay and bisexual men said they relied on mutual trust and their intuitive sense of relative safety with casual sexual partners to justify their decision not to practice safe sex (Gastaldo, Holmes, Lombardo, & O'Byrne, 2009). In another study, Anglophone men newly diagnosed with PC appeared indifferent and were not interested in seeking health information and postponed making decisions about treatment, perhaps to avoid the related suffering and physical dysfunction (Davison et al., 2009).

Other studies indicated that men react differently to cancer diagnoses and treatment, with a willingness to gather and master PC-related information to help them resume a healthy lifestyle and make safe, informed decisions (Olliffe & Thorne, 2007). For instance, in one study, Anglophone men used humor to manage embarrassing situations related to physical dysfunctions that arose after PC treatment. Their humorous comments helped them deal with several types of concerns: (a) acknowledging the possibility of leaking urine when going out in public and using pads, (b) fears of being rejected by a woman because of their erectile dysfunction, (c) awareness of disappointing their wives because of their sexual dysfunction, and (d) negative impacts on their global quality of life, self-confidence, and self-esteem (Hagen et al., 2007; Katz, 2005).

I lost all my body hair, except on my head, which I was losing anyway [laughs]. My breast increased in size, which is very embarrassing at times, especially when I go swimming in a pool. I guess I should get a training bra! (Hagen et al., 2007, p. 212)

Emotional self-awareness was revealed in a study of Anglophone men undergoing rehabilitation for addiction; the men realized the benefits of becoming more open-minded, overtly sharing their emotions, and circumventing self-pity by cultivating and encouraging a spiritual attitude. They described this as an “awakening” and justified their autonomous attitude by living apart from their relatives and former social environments as a strategy to avoid relapse, reflecting a greater degree of self-care (Palmer & Daniluk, 2007, p. 207).

I can't go back and see them until I'm more solid . . . I know if I went back into that I'm inviting trouble for myself. I'll start using drugs again.

In another study, self-reliance was exhibited by Aboriginal men with diabetes who appreciated laughing as a healing practice learned from their ancestors and community; they also learned how to use physical exercise to control stress related to their diabetes (Iwasaki, Mackay, Mactavish, Ristock, & Bartlett, 2006):

Relationships. It's not always perfect; there's always an issue to deal with. If its bills, if its children, we need support, trying to find proper support systems in the home-something that [happens] if you have the right ingredients within the house. Well then, you're able to fall back on that support that you need, then life would get a little bit more manageable. (Iwasaki et al., 2005; p. 981)

In a study of military Francophone men with PTSD, adopting a courageous attitude helped them to disclose their condition to others, engage in psychotherapy, consult a resource person, become introspective, and resume work. Once they underwent psychotherapy where they learned how to avoid aggravation of their PTSD and deal with the negative influence of unsupportive peers, they were willing to help others facing the same condition, without adopting the “role of a rescuer” or being condescending (Roberge, 2007).

In another example of beneficial health behavior, Van der Mast (2010) reported that overweight Francophone men adopted new, positive attitudes to overcome habits of overeating as a strategy to deal with loneliness and monotony and that allowed them to better endure bullying in social situations. Interestingly, some men believed that being overweight was socially acceptable (and considered normal) for a mature man and that having a voluminous belly was simply an undesirable part of a healthy man's body. Opposing views were held by other men who had learned about the protective factors related to a healthy diet. They tended to seriously observe calorie counting in their diet and read product labels to carefully consider nutritional value when purchasing food.

Awareness of Dissonance and Critical Views. Several studies indicated that men were aware of dissonance between their needs and available health services or dominant cultural norms or social expectations. For example, in Roy's (2008) study of Francophone men dealing with depression, the men waiting for diagnoses confirmation were aware of the limitations of a congested health care system. The long wait for an evaluation by a family doctor as prerequisite for access to psychological services discouraged their pursuit of assistance. A similar reaction was reported in Van der Mast (2010) when Francophone men dealing with obesity were frustrated by unhelpful responses instead of immediate support and action. It was also an issue for Francophone men with PC who wanted urgent medical treatment, feeling they had no time to seek a second opinion or alternative response (Zanchetta, Cognet, Xenocostas, Aoki, & Talbot, 2007; Zanchetta, Perreault, Kaszap, & Viens, 2007).

For similar reasons, Aboriginal men eschewed using health clinics for health information or preventative care and did not consult health care professionals because of their discomfort over long wait times, communication/language problems, cultural differences, presence of a female health care professional, privacy concerns, unfamiliarity with the counselor or the counseling method, as well as a lack of trust. Instead, they acquired health information from friends and family members (Inuit Tuttarvingat, 2008; Mill, Lambert, Larkin, Ward, & Harrowing, 2008), those they trusted.

When military Francophone men spoke of their awareness of wearing a social “mask” to hide any hesitation about fulfilling their duties, even in moments of emotional crisis due to PTSD, they knew they were acting according to social expectations but did not question the appropriateness or risks of their decisions (Roberge, 2007). Another study reported that acquiring knowledge about secondary smoking risks for their children's health did not lead young and middle-aged Anglophone men to cease smoking, but they did begin to physically separate themselves from their children when they smoked (Olliffe, Bottorff, Johnson, Kelly, & LeBeau, 2010).

Critical awareness of the risks of certain personal health choices affected men's health information seeking, self-care, but did not necessarily deter risk-taking behavior. For instance, gay and bisexual Francophone men used pornographic material to explore their sexuality in fictitious, safe situations, and to simultaneously satisfy their sexual curiosity and fantasies and protect themselves from the risks of unsafe sex. They resisted the prescriptive discourse about condom use, as well as the condemnation of their sexual choices (Corneau & Rail, 2010). Other men discussed the subcultural acceptance of “bareback sex” (i.e., sexual penetration without the use of

a condom) and swallowing and taking of fluid with sperm to satisfy sexual fantasies, aware of the risk for sexually transmitted diseases. Engaging in known risky behavior was also an attitude documented in a sample of Anglophone men who had unprotected sex with men and exposed themselves to HIV risk (Gastaldo et al., 2009).

Eating was another focus of dissonant behavior. For instance, the assimilation of Western eating and activity habits and gender norms prompted some Anglophone men of South Asian descent to learn about and adopt protective behaviors and healthier choices in their daily life to better control their diabetes and related restrictions (OliFFE, Bottorff, et al., 2010). Their intention and attempts to incorporate more physical exercise and a healthier diet in their daily routine were undermined by the conveniences of life in Canada (e.g., easy access to dairy products, alcohol, and processed foods, and driving rather than walking). In another study, Sellaeg and Chapman (2008) reported that single, professional Anglophone men who had a regular weekly dinner with friends, struggled to adhere to a healthy diet. Aboriginal men with cardiac disease commented on the incorporation of a great deal of processed foods in the Western diet that they had adopted, partly due to the historic devaluation of their traditional Aboriginal diet (Angus et al., 2007, p. 1098):

We never had that stuff [processed foods] in our diet before. We ate a lot of venison, beaver, we had bears we ate . . . but we lost all that when the Europeans came and said, "You can't do that any longer."

Ability to Make Health-Related Decisions. Men's ability to deal with their illness and cope with disease-led changes was reported to be easy when they could accept lifestyle changes. But sometimes men are unable to adopt beneficial changes and react negatively to their illness or resist taking preventative action. Having knowledge about the body and medical conditions seemed to positively influence men's ability to manage unfavorable and unpleasant situations. For instance, when Francophone obese men with sleep apnoea used a breathing assistive device, they acknowledged how much use of the device had improved their physical condition and social life. They also decided to prevent further health complications by improving their diet (Van der Mast, 2010). When living with untreated or newly diagnosed PTSD, military Francophone men were aware of their inability to deal with family and peers due to feelings of intolerance, loss of self-confidence, and revolt (Roberge, 2007).

Body and lifestyle changes, such as long-term limitations caused by disease can jeopardize men's ability to maintain intimate and sexual relationships. For instance, gay, bisexual, and transgender men of African descent,

and Anglophone men with HIV, expressed disappointment over their affective, emotional, social, and sexual life because of relationships ending and difficulties in dating and establishing new relationships or finding sexual partners (Jowett & Peel, 2009). Anglophone men with PC revealed how the disease diminished their satisfaction with intimate relationships and social functioning (Hagen et al., 2007; Katz, 2005), as illustrated in this excerpt:

I had to stop thinking about this clinically and accept the idea that I was heading into the theatre of the absurd, and I was to play the part of the lesbian! [Use of] the dildo gives me the sexual capacity to serve my partner more reliably than I might have been able to achieve as a potent male (with or without Viagra). (Warkentin, Gray, & Wasserug, 2006, pp. 391-392)

Men's ability to assess and apply health information to make decisions to manage their health issues, and their subsequent sense of safety, depended on their understanding of *wait and see*. Despite having received medical information about depression, young adult Anglophone men who were waiting for a medical confirmation felt unable to deal with their fears of stigmatization and potential loss of job and intimate relationships (OliFFE & Phillips, 2008).

Dealing effectively with health information does require specific abilities of men as informed, skilled consumers. First is the ability to critically assess health information. A positive example of this was exhibited by obese Francophone men who accepted their female partners' challenges to select and buy healthier foods, learn to read food labels, and control their consumption of food high in fat and salt (Van der Mast, 2010). On the other hand, in Sellaeg and Chapman's study (2008), Anglophone men with PC demonstrated a poor ability to understand medical test numbers, disease incidence and statistical probability, and thereby critically assess the available health information.

Second is the ability to manage disease-related symptoms. Knowledge or misinformation about the side effects of prescribed medication or alternative treatments can affect men's actions positively or negatively. For instance, having unpleasant symptoms from taking medication for antihypertension provoked fears, worries, and doubts about the medication, and mistrust in the prescribed regimen among adult and elderly Francophone men (Proulx, Leduc, Vandelac, Grégoire, & Collin, 2007). While men with knowledge about alternative methods for treating or managing their asthma successfully used a combination of allopathic and alternative methods to prevent events that could trigger an attack, and to better control and tolerate symptoms (Loignon, Bedos, Sevigny, & Leduc, 2009).

Third is the ability to recognize helpful health interventions. Knowledge of helpful lifestyle changes can motivate men to improve their habits. For instance, Anglophone men at risk of cancer learned to cook as a way to avoid eating unhealthy food, even for older men with several comorbidities (Davison et al., 2009). Moreover, taking yoga classes helped men with coronary heart disease develop ways to develop and maintain a sense of control (Angus et al., 2007).

The appropriate use of health information was also related to being able to introduce changes in one's daily life. This was demonstrated in a study of bisexual Anglophone men who commented favorably on the importance of exercise, spiritual involvement, healthy support networks, and arts activities. These factors were considered important for providing a source of pride and self-esteem as well as a focus apart from the challenges and struggles related to men's bisexual identities (Ross et al., 2010).

Personal Representations and Associated Impacts. Men's representations of body, health, and chronic diseases seemed to be intertwined with their thoughts on self-control, self-determination, and self-expression, even within a macro-perspective. For instance, Aboriginal men with a cardiac condition perceived chronic disease as a consequence of a systemic deprivation of goods, healthy food, and access to health educative and preventative services, expressed in terms of receiving inadequate education, employment, and leisure opportunities (Inuit Tutturvingat, 2008). Awareness of such deprivation is related to the social invisibility of Aboriginal peoples, and their consumption of unhealthy foods and hazardous goods. Marginalized Aboriginal individuals develop a sense of social injustice and disempowerment as the root cause of disabling outcomes, including chronic diseases (e.g., blindness, amputations, drug addiction, depression, suicide), witnessed by generations of Aboriginal families.

Representations of idealized bodies were part of men's discourse. Gay Francophone men viewed the ideal/healthy body much as reflected in pornographic images—muscled, agile, slim, perfect, and tanned. Viewing pornography stars' beautiful bodies lead them to question their own body image; they acknowledged that such images could negatively influence their self-esteem and promote dissatisfaction with their bodies (Corneau, & Rail, 2010).

Dissatisfaction with one's body and its social identity may affect men's mental health. As transgender individuals experience dissatisfaction with their body prior to gender self-identification and gender reassignment treatment, transgender Anglophone men dealing with issues of gender transition-related care expressed negative views of mental illness; their compromised self-agency

and self-image negatively affected their emotional state (Bauer et al., 2009). The lack of an affirming social identity similarly affected bisexual Anglophone men with mental health issues who were unhappy over having to repeatedly disclose their minority sexual identity to health professionals in initial and follow-up interviews (Ross et al., 2010).

Men's representations of the obese body were severely critical. The language they used was replete with negative words, such as ugly, lazy, neglectful, morbid, disgusting, showing an absence of self-respect and self-care for one's body and health, lack of discipline, overconsumption. They also recognized the use of food as a source of emotional comfort, and emphasized that prevention of obesity by developing good nutritional habits was never an appealing message for men. This made it difficult to deal with the association between overeating and emotions since they believed that "when a man is looking for help and solutions, he does not want to speak about a problem and its related emotions." They also expressed symbolic connections among men, food, and embedded masculinity: men are meat lovers and eat spicy, virile food; they love a greasy diet of ribs, bacon, and triple hamburgers (Van der Mast, 2010).

Bodily changes that affected sexuality were frequently distressing to men. For instance, Anglophone men experiencing the side effects of PC treatment, such as hot flushes (after hormone therapy), perceived their bodies as similar as a woman's or feminized (Hagen et al., 2007). Bowel dysfunction provoked thoughts about an impaired sexual body (Katz, 2005), while erectile dysfunction confirmed a body's incapacity to provide sexual satisfaction (Evans et al., 2005; Warkentin et al., 2006).

Reactions to the Burdens of Health Problems. Men's initial reactions to bodily change and impairment due to health problems tended to be negative. For instance, Aboriginal men resisted accepting responsibility for self-care and engaged in reckless behavior; some rejected any change in lifestyle despite having a cardiac condition (Inuit Tutturvingat, 2008), while other Aboriginal men living with diabetes dealt with issues of cultural identity, and disabilities reporting high levels of stress due to physical pain, discomfort, and perceived inability (Iwasaki et al., 2006).

In cases of depression relapse related to job loss, homelessness, divorce, feelings of failure as a father and breadwinner, work overload, and suicidal ideation, Francophone men resorted to using cocaine and alcohol and engaged in gambling (Roy, 2008; Roy et al., 2009). Young adult Anglophone men ignored the health information they were offered while waiting for medical confirmation of depression; they reacted by drinking alcohol and abusing drugs as coping mechanisms, instead of

seeking help (OliFFE & Phillips, 2008). This sort of reaction was also reported in another study with Aboriginal men (Mussell, 2005).

On receiving a diagnosis of PC, Anglophone men experienced an emotional roller coaster; they described their initial reactions as surprise, chaos, helplessness, hopelessness, anxiety, traumatic shock, panic, and disbelief, and struggled with insomnia (Hagen et al., 2007). Other men who were experiencing side effects from PC treatment spoke of how their mental health worsened in response to body breakdown (Warkentin et al., 2006). Those dealing with urinary incontinence expressed deep embarrassment over having to relearn "potty training" (Hagen et al., 2007).

A few studies revealed men's more positive reactions. Francophone men considered their endurance in the face of uncertainty and doubts as part of the duties of men as fathers, professionals, and sexual partners. For example, one single father dealt with his depression by focusing on fathering his young son (Roy, 2008). To relieve their PTSD-related emotional distress, military Francophone men engaged in individual activities such as watching videos and exercising vigorously (daily) and focusing on contact with nature (e.g., birds, wind, clouds). They hid their condition from family, friends, peers, and even their military superiors to avoid discussions, but this changed once they found a community organization that offered supportive services for veterans (Roberge, 2007).

In a study of Anglophone men facing a second diagnosis of PC, the men reported a sense of awakening and transformation—by facing something to fight against, to be fixed or beaten, and actively seeking health information, hoping to be able to participate in their medical treatment and self-management with greater knowledge:

I saw it [prostate cancer] as another thing I got to beat, and I love winning! And I feel confident that I can beat this thing. And if there were other things that have to be beaten, and if I could be part of it, I want to be part of it. (Hagen et al., 2007, p. 217)

Other positive reactions were reported by Anglophone men who experienced sexual dysfunction from post-PC treatment and struggled to find a successful strategy to deal with their sexual restrictions. In adopting a "more pragmatic view" of their dysfunction, they considered it less painful to forego sex than use unsatisfactory alternative methods to achieve sexual performance (Hagen et al., 2007). Men in their late 50s were able to discuss using a dildo with their female partners as part of their erotic life (Warkentin et al., 2006). For gay, bisexual, and transgender Anglophone men and those of African descent with HIV, a "gay bar" was considered a safe place for positive social interactions and provided a sense of

belonging and authentic support (Husbands et al., n.d.). Participation in group therapy helped Anglophone men connect with other men and discuss their emotions, a particularly important source of support to those facing discrimination (e.g., racial, sexual orientation) or social exclusion (e.g., over psychiatric disorders; Ogrodniczuk & OliFFE, 2009). Furthermore, older Anglophone men who were returning to community life after psychiatric hospitalization were pleased with the support they received,

I never dreamed or knew that people would support you. You know what I mean? Because it's the first time . . . I'm so surprised. (Hebblethwaite & Pedlar, 2005, p. 272)

OliFFE et al. (2009) reported that Anglophone men with mobility limitations resulting from knee pain adopted alternative measures to keep active by walking instead of doing vigorous exercises.

Influences of Perceptions of Masculinities

The results revealed major sources of influence deriving from dominant societal views of men's bodies, behavior and self-care; men's critical views of masculinities and risk; and the perceived burden of particular meanings of masculinities over self-care.

Societal Influences of Sense of Masculinity Over Men's View of Their Bodies and Self-Care. The role of masculinity-bound culture and its influences over self-management was clearly identifiable from men's health-related discourse about expected behaviors. Evidence from several studies revealed that men's words and terms included references to physical strength, autonomy, sexual potency, invulnerability, perfection, ability, and flexibility.

Criticized Masculinity Reshaping Views of Risks. Van der Mast's study (2010) about male obesity and overweight is rich with representations of contemporary masculinity from Francophone men's perspective within the social context of the Canadian province of Quebec. Their beliefs about masculinity included the following: (a) a virile man is one who displays a calm strength and stability and transmits confidence in his ability to take care of himself; (b) a man, "with a capital M," is smart, a family protector, courageous in facing difficulties, and responsible for transmitting good values; (c) a man is represented by his own words; someone who is strong, with a well-built body, good character, and aware of his own choices; (d) a man remains cool-headed and has a successful family and professional life; and (e) a man is a source of strength and solidarity, evoking notions of action, aggressiveness, ambition, and protection: a kind of family hero.

These men argued that some social environments undermine their sense of agency and sense of autonomy for self-caring. They expressed some embarrassment in acknowledging their weight concerns, related to beliefs that concerns about weight are typically a woman's issue. Some men felt that their peers consider weight concerns as a "sissy, gay thing." They believed that society expects men to be less sensitive to their own health issues and needs than women, although they may hold themselves responsible for their children's health. For instance, weight-management programs most often target women; while men are "programmed" to adopt risk-taking behaviors and neglect thoughts about their own future well-being.

One man claimed that weight-management programs were a marketing plot to "reformat the male paradigm," while others noted that in the gym clubs the contemporary image of an ideal man refers to one who is slender and flexible. Men denounced the cult of beauty for men as expressed in soap operas and posters in clubs, images that stress slimness and complained that the image of a successful, slim man is associated with an advantage in job interviews and hiring. They noted that having prominent muscles is no longer considered a masculine asset since the media now emphasize women's appreciation of men who cook and take care of their bodies. They criticized the current body-focused discourse, stating that positive self-awareness rather than body image allows men to feel good, play sports, and improve their health and well-being. They also stated that obese men should be reminded about their inner "warrior" nature (Van der Mast, 2010). Similar accounts about body and masculinity were shared by gay Francophone men who stated that strength, muscle building, and self-centeredness were important assets for achieving an ideal masculine physical appearance. They claimed that the objectification of men inherent in this sort of body cult has recently become a matter of social pressure for heterosexual men too (Corneau & Rail, 2010).

Burden of Particular Meanings of Masculinity Over Self-Care. In Roberge's (2007) study, Francophone men experiencing PTSD disclosed that in Canadian military culture, masculinity connotes professional success and heterosexuality; and a man is expected to be competitive, invulnerable, determined, brave, a "go-ahead" type. They discussed stereotypes about a soldier's role within military culture: he is expected not to cry, not be hurt or reveal it, not be listed as sick (i.e., seek treatment), and not ask for leave to travel home. The expression of most emotions was barely accepted due to the collective representation of traditional masculinity, and disclosure of emotions only occurred between close military peers. Their accounts of illness experiences seemed imprinted by the effects of an unfriendly work environment. For

instance, a man complained about unfair treatment as a kind of punishment for being sick, denouncing that more time was dedicated to fighting "the system" than treating him. Another man questioned what he had actually accomplished in terms of helping others while in the army, especially at the cost of his extreme emotional fatigue and the ferocious nightmares related to his recent past. Other military men had an opposite reaction and volunteered in self-help groups for veterans as a form of payback for help received.

A particular influence of the cultural perception of masculinity and men's health was documented on men's health information-seeking behavior. Anglophone men revealed that the search of health information, especially about sexual matters, was influenced by ethnocultural norms. For instance, among Anglophone men of African descent with PC, discussion of sexual issues as consequences of medical treatment was less frequent (Evans et al., 2005). Punjabi Sikh men who were dealing with diabetes and issues of lack of exercise and poor diet revealed that their former traditional roles as farmers and breadwinners were associated with their present commitment to maintain their autonomy about self-care (Olliffe, Grewal, et al., 2010). A conflict between traditional male skills and modern ways of life was disclosed by Aboriginal men who were dealing with mental health issues and feelings of powerlessness; they experienced this dissociation as loss of their place in the family and community and resulting insecurity (Inuit Tuttarvingat, 2008). These men felt that their undermined gender roles interfered with their successful adoption of healthy behaviors and did not know how to acquire the skills to remedy this.

Summary of Analyzed Evidence

The following paragraphs describe some intellectual struggles to review raw data generated from studies designed from different conceptual, theoretical, and methodological perspectives. In this literature analysis, Boltanski's theory was used to interpret men's statements as embodied performances of masculinity: "This is how I am 'doing' with my body, from my location within Canadian society." Consequently, it was not possible to probe or translate the fine details of men's intricate responses and actions to prevent and manage chronic diseases. Using Boltanski's assumptions about language, the analyzed evidence indicated some trends: men have difficulty speaking about health concerns; having common health issues supports the creation of a social bond and safe space for dialogue; social vulnerabilities/health inequities impose barriers to intentions to self-manage; men express concerns that resources are not tailored to their needs/preferences; and no men referred to available information on how to adapt to having a chronic disease.

The evidence illustrates the scope of men's inclination to seek medical care and interact with health care professionals, demand medical care, adopt new individual and collective health behaviors, as well as change how they view their bodies when they have a health problem. When seeking medical care, men were discouraged by barriers to receiving immediate solutions, and this seemed to be associated with feelings of fear, powerlessness, and loneliness. However, being rushed into making decisions, poor communication, and a lack of support from some health professionals was a frequent challenge. Men's interactions with health professionals, and difficulties in finding accurate health information and accessing services combined with their urgent need to solve problems quickly, were common, intertwined themes. In their demand for medical care to manage mental and physical chronic diseases, men's strategies are influenced by a lack of systemic infrastructure in men's health care delivery.

Feelings of solidarity and support among men with similar diagnoses are key findings, accounting for the most cited collective health behaviors. Some men were more active in self-monitoring and self-controlling their behavior and lifestyle toward a path to healthier living and wellness promotion. Knowledge about and availability of alternative health management strategies in combination with following physician's recommendations accounted for successful experiences when dealing with chronic conditions. Some men, however, took up reckless coping strategies, and negative treatment side effects triggered greater fear.

Finally, men's views and use of their bodies were influenced by their idea of living with a chronic disease, which tends to threaten their sense of masculinity and their self-image in terms of their perceived ability to fulfill their expected social roles. Overall, the findings on men's use of their bodies were greatly influenced by social images of the male body as a tool for expressing (or repressing) emotions, attributes, and attitudes, or reminding men about their need for social affirmation.

Remaining Gaps in Evidence

The search for articles related to Aboriginal men and their belief regarding their health, body, or illness process/understanding proved to be most difficult. They were more prone to show up in studies of intimate partner or domestic violence than on illness. Studies tend to look at Aboriginal men's health as deficit oriented, focusing on problems, failures, and negative comparisons rather than trying to understand their thoughts, experiences, and views. The retrieved evidence did not adequately address the theoretical issue of differences by social class regarding health priorities, as well as the recognition of medical

signs and symptoms and language to convey them to health care professionals (Boltanski, 1971). Therefore, this analysis remains inconclusive regarding what strategies men find helpful to deal with barriers to self-management they face in their daily lives and socioeconomic context.

Considering the subgroup distinctions, men's collective experiences and conditions for chronic disease self-management seem to be poorly researched. Diversity within the male population in Canada requires us to explore preventative strategies and conditions within the perspective of multiple social determinants of health, including age, ethnicity, culture, social support, geographic location, education, health literacy, genetic makeup, income, living and working conditions, as well as access to health services. Analysis that takes into account social determinants would provide a better portrait of available facilitators and barriers to the implementation of successful self-management strategies, as well as expand our understanding of the social aspects of men's experiences of illness. Since health information is usually transmitted informally, its content is open to misunderstanding between well-educated and less-educated individuals. Mastering both the lay and medical discourses concerned with body-related issues leads to an approximation of a formal source of health information, as well as its appropriation (Boltanski, 1971).

Analysis

It was attempted to understand how the role of disclosed masculinities shaped the way men prevented and managed chronic diseases, beyond the usual frame of risk taking, hegemonic masculinity, and with attention to the lens of social groups, by ethnicity, sexuality, social class, and affiliation. The diversity of trends in men's studies in Canada is promising and will inevitably be influenced by ethnocultural differences, increasing advocacy for men's health and social services, and consolidating health promotion approaches.

The data are presented in a hybrid social context of multiculturalism and interculturalism in which self-perception of "being a man" was shaped by a social, cultural, political, and historical life trajectory, such that diverse masculinities may be transcendent or tangential to multiple cultures and their expected roles. Canadian scholars see masculinities as being plural, relational, and situational (Deslauriers, Tremblay, Genest-Dufault, Desgagniers, & Blanchette, 2010). Masculinities are believed to be subjectively experienced, lived, and influenced by social differences embedded in race, class, and sexual orientation issues (Moffatt, 2012; Pon, 2000a, 2000b, 2004). Masculinity is a fluid and unstable identity, as well as different visions of what a man ought to be (Butler, 1999; Gamson, 2000).

Ideas of masculinity (whether traditional or contemporary) influence men's motivation to learn about health and adopt preventative behaviors (Courtenay, 2011; Robertson, 2007). Depending on the health behavior being examined, masculinity can act as a protective buffer or as a risk factor in men (Levant & Wimer, 2014). How social representations affect men's health behaviors and imprint on boys' and men's minds has been well-documented, for example, in terms of media representations that associate masculinity with risk-taking behaviors (Robinson & Robertson, 2010; Long, 2005) and with intransigence and noncompliance in following medical advice, which undermines men's sense of autonomy (Gough, 2006) and sometimes distorts the significance of health issues (e.g., depression) as a matter of masculine endurance (Clarke, 2009).

Media representations of an ideal man's body have increased in frequency (Ricciardelli, Clow, & White, 2010), stimulating men's desire to replicate these body types (Brennan, Crath, Hart, Gadalla, & Gillis, 2011; Pompper, Soto, & Piel, 2007). Corroborating Van der Mast's (2010) results, images of slender, muscular male bodies generate increased men's body dissatisfaction (Galioto & Crowther 2013).

Perceptions of men's bodies and masculinities are being reframed. As a result, men's concerns about their health, body image, and wellness are redefined toward actions and functions in daily life, fitness, existential security, and wellbeing in terms of body and mind, in balance with a masculine identity in one's multiple social roles (Robertson, 2007). As demonstrated by comments of men in different life conditions, a narrow representation of masculinity, constrained by the old stereotypes of weakness, disempowerment, and compromised masculine identity (Crawshaw, 2007; Robertson, 2010) that caused internal strife and emotional conflicts (Connell & Messerschmidt, 2005, Hearn et al., 2012), does not reflect the myriad of masculinities that exist.

Several studies have documented new understandings of masculinity and self-care (Hearn et al., 2012; Oliffe, Bottorff, et al., 2010; Roberge, 2007; Ross et al., 2010; Sellaeg & Chapman, 2008). As identified by Vassilev et al. (2011), men's discourse about self-management was influenced by contacts with their social network, which influenced constructions of the meaning of chronic diseases and accumulated health knowledge. Self-management may involve intentions to restore normalcy in the face of a sense of deviance and ideas of inferiority. Changes in daily life to practice self-management are also related to intentions to achieve happiness, wellness, and a sense of normalcy (Vassilev et al., 2011). In certain cases, men faced disease-related stigma (e.g., PTSD, PC) and their implied attributions of personal responsibility for self-care and seeking help, and for lack of control or

poor management. Clearly, self-management is influenced by ideologies of self, community experiences, and endorsement by health professionals. Men's accounts provided a very superficial picture of health professionals' educational influences on health promotion through risk monitoring and self-management.

How men talk about their bodies may point to how they use their bodies and self-manage chronic disease. A gender-shaped language about men's bodies and diseases influenced their style of health information-seeking and integration. This style was imprinted by ideas of traditional masculinity where feelings, concerns, and fears were hardly accepted or expressed. One's sense of masculinity and contemporary social discourse about male bodies seemed to have a synergetic influence on men. When Francophone men spoke about dealing with issues of being overweight (Van der Mast, 2010), and other gay Francophone men spoke of viewing pornography (Corneau & Rail, 2010), both groups used a rich language to reveal their views about a man's body that were closely congruent with Boltanski's (1971) theory on social uses of the body.

The evidence on men's strategies to monitor risks and managedisease-relatedconditions corroboratedSchulman-Green et al.'s (2012) proposed categories for the process of self-management of chronic diseases, including related tasks and skills. It was identified a trend among men to perform the following: change behaviors to minimize disease impact, sustain spiritual self, adjust to "new" self, modify lifestyle to adapt to disease, and strive for personal satisfaction. As documented by Clarke and Bennett (2013), because of men's view of body functionality, men react with exasperation over reduced quality of life and develop a self-view of being ineffectual when facing physical limitations, such as pain, fatigue, sexual dysfunction, reduced mobility, and loss of memory. The findings confirmed the explanation advanced by Perry, Ruggiano, Shtompel, and Hassevoort (2015) of imprints of masculine ideals of control, self-reliance, as well as emotional and physical toughness on self-management actions. Some older men revealed their awareness of aging and the natural deterioration of physical conditions, leading to resignation and reliance, while South Asian immigrant men recalled a sense of autonomy in their past life as rural workers and adopted walking as an effective way to exercise. Such specific aspects of masculinity were interpreted by Perry et al. (2015) as a transference of older men's confidence, autonomy, sense of industriousness and management, decision making and communication skills, consolidated from their work life into health self-management demands (e.g., reminder system to take medication).

Self-management has been documented in Canadian qualitative literature as a complex phenomenon evoking

influences of the social environment, personal capacities, feelings, perceptions, and potentials. The extent of how all these features interact within the scope of men's mental and physical health and illness experiences was partially revealed in this study.

Discussion

The multidimensional nature of self-management leads Furler, Harris, and Rogers (2011) to claim that self-management is a new responsibility in terms of health policy development whose implementation has become a new task of health care services to tackle health inequities. These authors argue that the lack of necessary resources to implement self-management tasks and the appropriate health literacy to understand and use health information safely reflects the chaotic side of living with chronic illness. Such chaotic situations should motivate health professionals to work toward clients' full engagement in self-management and in health care processes rather than excluding them. The epidemiological relevance of the health inequities that could undermine clients' self-efficacy, control, social support, risk perception, outcome expectancies, planning skills, and behavioral intentions were acknowledged by Schwarzer, Lippke, and Luszczynska's (2011) study with individuals who have multiple chronic diseases and disabilities and whose multiple behavior risk factors and risk for premature death have been documented by several authors.

To improve men's effective self-monitoring of risks and self-management of disease-related conditions, it should be considered a set of intervening factors related to health care availability, and influences on self-views. Men's motivation to use health services for self-management was identified in a study with older Australian men (Jowsey, Pearce-Brown, Douglas, & Yen, 2014). These men revealed that their motivation to follow a medication management plan was triggered by fear of complications; worsening of medical conditions due to inappropriate behavior with medications; willingness to be a role model for family members; valuing health information provided by health care professionals and willingness to adhere to their instructions; and their awareness of being a financial burden on the health care system. Therefore, self-management programs for chronic diseases should explore motivation and barriers to self-management and value men's experiential knowledge by retraining these older men in skills of management, communication, and decision making (Perry et al., 2015). Innovation in self-management programs would invite clients to share their experiences of self-management; consider cultural norms and traditions related to self-management; and engage patients to accomplish their functional goals (Grady & Gough, 2014). This study's results indicate how men's

subcultures as defined by spoken language, ethnoaffiliation, food culture, notions of masculine social roles, and sexual orientation can determine social norms and traditions to support men's self-care and self-management of diseases.

Despite a lack of deep, qualitative data, the consequences of less engagement for self-management, including adoption of lifestyle changes to manage high blood pressure, was documented in a national survey of Canadians with hypertension. Respondents reported little intention to cease consuming salt, drinking alcohol, smoking cigarettes, and eating unhealthy food (Gee et al., 2012). Of note, low socioeconomic status men aged 22 to 44 years were even less likely to adhere to medical recommendations for effective self-management of hypertension (Gee et al., 2012). A prevalent masculine culture of invulnerability, toughness, autonomy, resignation, and stoicism (Clarke & Bennett, 2013) among Canadian men corroborates that one of the key promotional and marketing challenges for men's health policy in the future will be to reverse the paradigm that help seeking is synonymous with weakness in men, and rather to portray good health maintenance and prompt help seeking as being part and parcel of being a man—achieving optimum vitality, vigor, and productivity, and enabling men not just to be productive in their work, but productive also in the many other roles that they play (Richardson & Carroll, 2009).

An important gap in the analyzed evidence concerns how perceived masculinities affects men's interaction with health and social services. In a large, recent study conducted in Montreal, Quebec, Lajeunesse et al. (2013) explored how men's socialization incorporated assumptions of stoicism, autonomy, success, and aggressiveness (Harris, 1995; Jansz, 2000; Pleck, 1981). To counteract the tendency for this to undermine men's use of services, Lajeunesse et al. (2013) recommended that service providers (a) proactively offer services to men; (b) reduce waiting time; (c) attenuate men's aggressive behaviors and explore underlying causes; (d) offer concrete results during the first encounter; and (e) offer help based on concrete actions to solve men's problems and difficulties rather than deal with emotions.

Finally, despite the efforts to analyze and understand evidence about Aboriginal men, readers should be particularly cautious when interpreting findings about Aboriginal's social use of their bodies. When M. Stevenson, the Aboriginal coauthor, read Boltanski's (1971) theory, she determined that it

may not fully apply to Aboriginal men because their bodies are socially invisible due to their frequent use of alcohol and illicit drugs, and imprisonment, which make them *socially absent*. Moreover, the idea of an individual body contradicts

our concept of collectiveness. We exist as a part of a collective where our individual body does not account for social visibility.

Limitations

This analysis is limited in several respects: (a) strict adherence to the theoretical framework translated into selecting only men's verbatim comments as evidence of their recognition, awareness, and interpretation of bodily experiences. This application may overdetermine the nature of the lay discourse about the histories of diseases, signals, nomenclature, and assessment, according to Boltanski (1971); and the focus on the oral expression of illness-related experiences may have led to overlooking other relevant information; (b) the analysis relies on the scope of studies reviewed, which included only a small number with Francophone men or projects implemented in community settings; (c) the fact that it could not include all the verbatim data in this article, which would better illustrate the findings; and (d) the multiplicity of medical conditions explored may have undermined the our ability to analyze differences in the social use of bodies when dealing with conditions that are more socially evident versus privately experienced.

Recommendations

Canadian statistics about the worsening status of men's health impels researchers to produce timely and socially relevant evidence to support policy and decision makers in their actions. Canadian health and social services providers should collaborate with researchers on innovations related to the social determinants of men's health. Studies should explore the promotion of wellness and the barriers, facilitators, and challenges in dealing with health risks, prevention, and self-management of chronic diseases. Such actions could increase the visibility of men's health issues and be a precursor to the creation of men's health policy and changes in professional practice. Increased participation of men from cultural and linguistic minority groups in knowledge production about "men's language about their body" would contribute to a health promotion discourse that would resonate with those hard-to-reach subgroups. A better understanding of the diversity of men's health issues should inform the development of a national research strategy, and ideally, the creation of a Canadian Men's Health Institute, in partnership with social leaders among various communities of men to address the social inequities that hinder men's health and wellness.

For the international scientific community interested in advancing men's health research, especially in those

countries that lack a national men's health policy, it is recommended that (a) future studies should be conducted in a way to support the development of healthy policies, targeting changes in the epidemiologic portrait of men's health by working with men from the study's conception through its conduct, and considering men's diversity in terms of social and culture profiles; (b) qualitative meta-analysis studies should include unpublished graduate theses and dissertations for the richness and quantity of their quoted data; and (c) researchers and educators should focus on promoting men's issues to guide policy development on men's health promotion.

Conclusion

The lack of specificity in the Canadian men's health research agenda leaves knowledge gaps that should be addressed by the use of a theoretical framework to categorize qualitative data in a meaningful way. As a result, the findings underscore the social invisibility of men's bodies, especially those of men facing social inequities. Philosophical principles of social justice can ensure that future research on men's health will amplify the range of men's voices and allow them to be heard. If past oppression still imprints men's sense of self-determination, their ability to choose what is best for them is restrained; this consequently, limits their quality of life.

Acknowledgments

The authors acknowledge Dr. Larry Goldenberg and Dr. John Oliffe for their support in the fieldwork with community organizations in Vancouver, British Columbia. We also acknowledge the invaluable contribution of Ryerson University Faculty of Community Services with conference support grants for students awarded to M. Mohamed, T. Sizto, C. SanJose, and O. Kolisnyk that allowed them to present the preliminary results of this analysis at the Future Perspectives on Intervention, Policy and Research on Men and Masculinities Conference (Quebec, 2011), and the 5th National Community Health Nurses Conference (Halifax, 2011), as well as, Ryerson University and Centennial College with a student and faculty conference grant awarded to O. Kolisnyk to present at the Nordic conference on Masculinities in Motion: Men and (E)Quality of Life (Norway, 2012) and at the Gender and Health through Life Conference (Copenhagen, 2012) where the authors were able to "member check" the findings with the international and multidisciplinary scientific community. We thank Dr. LaRon Nelson, Prof. Roger Pilon, and Prof. Franklin Gorospe for reviewing an early draft of the article, as well as Dr. Sylvia Novac for editing it.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This publication was supported by York University Junior Faculty Research Grant, Research Group METISS Seed Grant and Ryerson University, Faculty of Community Services, Publication Grant and Writing Week Initiative.

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