

Women's accounts of help-seeking in early rheumatoid arthritis from symptom onset to diagnosis

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Abstract

Background—As interest in gender and health grows, the notion that women are more likely than men to consult doctors is increasingly undermined as more complex understandings of help seeking and gender emerge. While men's reluctance to seek help is associated with practices of masculinities, there has been less consideration of women's help-seeking practices. Rheumatoid arthritis (RA) is a chronic disease that predominantly affects women and requires prompt treatment but considerable patient-based delays persist along the care pathway. This paper examines women's accounts of help seeking in early RA from symptom onset to diagnosis.

Methods—We conducted in-depth interviews with 37 women with RA <12 months in Canada. Analysis was based on a constant comparison, thematic approach informed by narrative analysis.

Results—The women's accounts featured masculine practices associated with men's help-seeking. The women presented such behaviours as relational, e.g. rooted in family socialisation and a determination to maintain roles and 'normal' life.

Discussion—Our findings raise questions about how far notions of gender operate to differentiate men and women's help seeking and may indicate more similarities than differences. Recognising this has implications for policy and practice initiatives for both men and women.

Keywords

Rheumatoid arthritis; hegemonic masculinity; relational settings; delays; women's help-seeking

Introduction

Rheumatoid arthritis (RA) is a chronic autoimmune disease. Symptoms of pain, joint swelling and fatigue are intermittent and can be severe, debilitating, unpredictable and often curb function and limit daily life.¹ To mitigate disease, effective treatment is required within 12 weeks of symptom onset.¹ Considerable delays, however, occur between symptom onset and commencement of effective treatment.¹ Delays have been divided into patient-, disease-, and physician- and system-related factors.¹ Current reports from symptom onset to treatment initiation in different countries show a delay ranging from a median of 6 to 42 months.¹ A recent study in Europe found the median delay from symptom onset to assessment by the rheumatologist was 24 weeks and highlighted the patient, physician and system contributions to delay.² In a 2013 study of a range of rheumatology centres in Belgium, only one in five early RA patients received treatment within the optimum 12-week window, and this was reported as largely patient-related delay.¹ In the UK, studies have shown that patient factors contributed most to delays, often due to a lack of awareness of RA and its presenting symptoms.^{2,3} Patient-related delay between the onset of RA symptoms and the first appointment with a healthcare professional is influenced by multiple factors such as disease severity and help-seeking behaviour of the patient.^{1,4-7} A recent study in Canada however, found family physician and referral time counted for most delay.⁸

Although the quantitative evidence has found no differences in the length of time, it takes men and women to seek help at the onset of RA,⁹⁻¹¹ the context, barriers and drivers in gaining a diagnosis may differ. For example, in several studies the physician delay was significantly longer in women than in men.^{1,10,11}

RA is three times more common in women than men, and appears to be less severe in men.¹² So, it is particularly important to examine in more depth the help-seeking practices of women in the therapeutic window (at which stage they may well not be aware that the symptoms are RA).⁹ Longstanding qualitative research provides a more in-depth understanding of men and women's consulting behaviours in early RA. Locker found that the decision to consult the GP was guided by the nature, severity and suddenness of symptoms.¹³ A few years later, Reisine (1987) found that for women (post diagnosis), the role of mothering could delay help seeking.¹⁴ Although one recent qualitative study noted that both women and men delay in consulting the GP for early symptoms,¹⁵ there is very little examination of women's help-seeking practices in early RA. There is some evidence of women's experiences of medication use^{16,17} in early RA and delayed seeking help.¹⁷ Other research explores women's experiences of being mothers with inflammatory arthritis (post diagnosis).¹⁸ More broadly, evidence shows that overall, women do have higher symptoms rates than men¹⁹ and that women consult their general practitioners (GPs) more frequently than men.²⁰

A small study explored men's experiences of RA²¹ and drew on the concept of hegemonic masculine practices which may act as a barrier to men asking for support in clinical settings. The 'hegemonic man' is identified as a cultural ideal of manhood with associated traits and behaviours as part of the social construction of a particular form of idealised masculinity rather than any biological determination. Men do not necessarily meet the normative

standards but masculine practices often follow the hegemonic pattern of behaviours.²² Research on men's help seeking has consistently associated men's reluctance to seek help with hegemonic masculinity associated with stoicism and rationality.²³ A Western cultural masculine ideal emphasises toughness, an ability to control emotions and a high pain threshold,²³ with illness threatening masculine identity.²⁰ Galdas and colleagues²⁴ reported that some men exhibit a high pain tolerance to avoid appearing weak or hypochondriacal, which influences their help seeking. O'Brien et al noted a widespread reluctance to seek help in the accounts of their male participants; help-seeking challenged ideals of masculinity and was associated with weakness and womanly behaviour.²⁰ Binary oppositions of gender underpin the often held assumptions that women use health services more than men.^{25,26} Women's supposed willingness to consult has been linked to traditional views of femininity supposedly making women more amenable to seeking medical help.^{24,25} The literature suggests that stereotypical or traditional gender roles influences both women and men's help-seeking behaviour.^{23,24,27} Gendered illness behaviour patterns are complex,^{28,29} however, and are not regarded as being determined by traditional notions of femininity and masculinity. Increasingly, research emphasises that men and women respond to symptoms in similar ways. For example, feminine behaviours can be exhibited by men extending beyond a binary opposition of gender.^{20,23,29,30} This research offers support for the proposition that gender is flexible and diverse, and characteristics associated with gender, though influential, are not determinants of behaviour. An emerging androgyny has been suggested whereby femininity and masculinity are recognised as practiced by both men and women.³¹ Building on this literature and research, our analysis is unique because we apply the concept of hegemonic masculinity to the help-seeking accounts of women with early RA from symptom onset to early post-diagnosis.

Methods

We recruited 37 women with a self-reported diagnosis of RA <12 months through patient organisations and local medical centres. To be eligible, participants were adults, English speaking and lived in the province of British Columbia (BC) Canada. Participants were aged between 30s and 70s, employed full or part-time, retired or on sick leave and included a range of household types: single, with spouse, with dependent or adult children. The majority lived in the lower mainland (Vancouver and surrounding areas) in communities ranging from urban to rural and remote in Northern and Eastern BC. Participants gave written consent and chose pseudonyms. The University of British Columbia's Behavioural Research Ethics Board approved the study.

Participants engaged in one in-person in-depth interview, which was audio-recorded and transcribed verbatim. Participants agreed to follow up phone calls for clarification, 19 of which took place (of approximately 20 min). This analysis does not include the follow-up phone call data. The interview guide was modelled on the pilot study guide,³² organised around three broad sections: (1) symptom onset, impact and what helped; (2) getting to the GP appointment, rheumatologist and diagnosis and (3) early post-diagnosis experiences. Findings have been reported elsewhere on medication use,¹⁷ accessing health services through research,³³ ethics in qualitative accounts of help-seeking³⁴ and occupational disruption.³⁵

Data analysis

Interviewers checked transcripts against recordings and removed identifying details. Analysis was iterative and thematic, based on constant comparisons and a narrative approach.^{36,37} Two authors read transcripts independently, annotated initial observations including relationships between and within transcripts. All authors plus a sociologist team member then read a selection of transcripts independently. Agreement was reached on broad codes after discussion and the data transferred into Nvivo-8. Coding was organised according to illness trajectory from onset to post-diagnosis, and cross-cutting sub-codes such as ‘maintaining control’ and ‘being stoic’. Deviant cases were sought and all transcripts re-read for consistency by AT and PA. AT returned to the literature on help seeking and gender^{16,20–31} and applied an interpretive gendered lens to the analytic themes already identified in the data. This gendered interpretation was then checked against a selection of transcripts by AT and discussed with the team based on the original analytic themes. Agreement was reached between authors on the gendered analysis. AT then checked the interpretation against all transcripts, applying a narrative lens, e.g. tracing the ways storied accounts unfolded as moral action, and as sites where moral selves were constructed anchored in cultural ideologies.³⁷ The themes presented in this paper were conceived as representing the participants’ accounts of their experience of early RA in the context of daily life, in a broader cultural and structural setting.

Results

Typically during RA onset, participants described consulting a GP when symptoms were resistant to self-management strategies such as over the counter (OTC) medications and/or were sudden and severe, unremitting, debilitating and disrupting daily life or they could not explain them and perceived that something was ‘wrong’ or ‘abnormal’ (e.g. visible swelling). Several described consulting when their initial assumptions about symptoms no longer made sense to them and were becoming functionally disruptive: I thought ... I strained something. Big deal ... it will get better in a day or two. I continued to work and I was going ... to visit my folks and I didn’t want to be hobbling along so about the third day I just went to a walk-in clinic (Marie). A predominant theme to emerge was the firm and restrained response to pain that featured in the women’s accounts, demonstrating their control, and resistance to medical appointments. Such tendencies have been linked to stoicism and stereotypical masculine help seeking behaviours.²³

‘Being stoic’ as a way of managing symptoms

The women described ongoing pain and debilitating symptoms in the context of their daily lives. They reported ‘pushing through’ and how they ‘kept going’ illustrating a need and ability to control their symptoms and their lives. They conveyed a shared common sense response to early symptoms: ‘It’s just life’. Several demonstrated self-reliance in their descriptions of negotiating pain and debility in the face of employment and family obligations. Many expressed endurance and adversity as integral to their lives, and sense of self:

It's the way I am. I like life ... I have had some tough years ... Blind father and mom with an amputated leg ... I prefer to be positive. I am not a negative person. And our family; we're mostly like that. We try to be on the upbeat about things because there are people who are so much worse off (Debbie).

Reflecting other participants, Debbie described the importance of a positive attitude to symptoms, illustrating her mental control. She emphasised her place in the family in her positive approach to life, illness and disability, making sense of her actions as 'who I am' in a relational setting, rather than drawing on a gendered identity. Debbie constructs her identity as an aspect of family socialisation encouraging an expressive acknowledgement of 'others' who are much worse off. This positioning alongside others is a way of building moral identity and revealing cultural values. Others gave similar accounts:

Anything to get your mind off your problems. ... that's my upbringing ... from my grandparents right down to my parents ... Carry on ... nothing gets accomplished if you just sit on your rear-end. You've got to get up and at them ... For instance my father ... was very much this person that he would have to pretty much be on his deathbed to keep away from work. He would go and it was his duty to get in there and work. And my mother is the same way (Jessie).

Many reported their mental resolve as a taken for granted response to symptoms (e.g. pain) emphasising family socialisation:

I just did it ... carried on the way I normally did with the Advil ... I am very realistic. My mom was very straight laced. We were never pampered. If you had a scrape in your leg you better ply it together. So I think mentally I just kind of shut it away for a while (Shari).

As further evidence of their self-reliance, the women described mobilising a range of self-management strategies in negotiating symptoms and daily life including self-medicating, pacing, re-organising schedules and adapting to symptoms.

Before seeing the GP

This stage was arduous yet became routine; for long periods of time, several did not consider a GP consultation as an option, they just carried on.

Some women explicitly noted avoiding a GP appointment. Barbara-Anne (not typical of the participants because she suspected she had RA due to family history), like many in our sample, described consciously resisting medical help. She was determined not to become a patient like her grandmother who had had RA: I didn't want to be like my Omma (grandmother). Barbara-Anne described severe episodes of pain and fatigue over a prolonged period, which she negotiated alongside her roles as a paid employee, mother and homemaker (using medication, pacing, adapting and spousal support). She relayed symptom control, in order to fulfill parenting responsibilities: I could barely walk. I would hobble along ... I was a homemaker at the time so ... I used to push myself ... when the kids were young I would stay up really late to clean the house. And even if I was tired I would say: 'No I'm going to keep doing this' (Barbara-Anne). Others expressed an ability to tolerate pain, a tendency to avoid or delay medical appointments, and positioned themselves as

different to generalised others who they conveyed as more apt to consult: I have a high pain tolerance ... I don't tend to ... go ... a lot of people would ... A doctor's appointment ... a lot of times for me is like sticking needles in my eyes. So I do tend to avoid those kinds of situations at all costs (Charlize). In these examples, the participants use rhetorical devices of positioning alongside others to construct moral identities in the context of culturally valued behaviours.

Reluctance to re-consult the GP

For some, the pathway to diagnosis after seeing the GP was straightforward. Some GPs recognised symptoms as warranting further exploration, arranged blood tests and a rheumatologist referral. Several of the women did not secure a referral and continued to manage ongoing and worsening symptoms alongside daily life. Danielle, a mother of a young child, described how she was misdiagnosed and continued to take OTC medications, until she was taking them like smarties¹⁷ displaying her self-determination to carry on.¹⁷ Danielle described how she self-medicated and put the blinders on in order to continue her studies, and kept 'pushing, pushing, pushing' to the end of her course. Danielle's words illustrate her single-mindedness in maintaining control of daily life and an anticipated future. Her determination to keep going swamped her better judgement and encouraged risky health behaviour in order to get through life.

Some women described a reluctance to re-consult their GP based on previous consultations, when they had reportedly been told their symptoms were a sign of just getting older, something you just have to live with, or just aches and pains or otherwise felt their symptoms had been dismissed as trivial. Some participants anticipated negative labelling in subsequent consultations and wanted to avoid being seen as 'complainers', 'neurotic' or 'hypochondriacs' and drew on negative female stereotypes to explain how they felt they were perceived in the consulting room when, for example, they had symptoms but no visible signs of disease. Resisting this label, several expressed recognising when a GP visit was required and not consulting for trivial symptoms; rather medical help was only warranted for serious symptoms. Consulting one's GP was presented as moral and judicious behaviour, and a rational and responsible illness action:

I'm not one to go to the doctors ... I don't like hypochondriacs. I don't want to be one. So you say: "OK, so that's just an ache. Just get over it. It will go away." But when you know I guess you just know ... I pay attention and I try not to dwell on things that aren't serious but ... I know when it's an issue and that's when I will go and see the doctor (Jane 2).

Typically, the women positioned themselves as different to others who they suggested would visit GPs, such as older people, or 'types' inclined to consult. In this way they continued to build their moral identity according to culturally valued behaviours, e.g sound use of medical resources. Their reasons included not wanting to bother the GP, an overburdened health care system, and anticipating that the GP would be of no help. They continued to self-manage which included a reliance on OTC medications,¹⁷ support from family members and for some, flexible employment conditions.

Family ‘push’ to consult the GP

Several women discussed family members persuading them to consult the GP. Spouses, mothers, daughters, sisters, aunts, fathers and work colleagues were reportedly instrumental in participant decisions to consult (but not uncles, brothers and sons). Barbara-Anne described consulting the GP after years of independently negotiating RA symptoms and daily life and resisting family members’ advice. When symptoms disrupted daily life and hampered her role as mother and worker, she consulted her GP. The combination of her desire to maintain control of her life and family ‘push’ prompted her consultation:

My parents, my dad ... kind of knew but he knew not to talk to me about it because I would get very standoffish and say: ‘You can’t tell me what to do’. But my sister ... she was the one ... She really, really pushed me ... I told her my symptoms ... She’s like: ‘Barbara-Anne you know, you’ve got to go’. ‘Yeah OK’. I ‘m not one to run to the doctor very often. It takes me a lot to phone. So it’s like: ‘OK I’ll phone’ (Barbara-Anne).

Jane described how her daughter persuaded her to revisit the GP, in the context of ongoing and deteriorating symptoms and a search for a diagnosis:

I think it was the lump and ... my daughter bugging me saying: ‘There’s something wrong with your hand. Why don’t you do something about it?’ ... me feeling, well I have to tell her that I did something about it. Because I told her ‘Well it’s not gout’ so then she said, ‘So what is it then?’ And I said ‘Well the doctor doesn’t know’ so she said ‘Well why don’t you go back to your doctor?’ So then I think there was a bit of a push there and ... I thought ... my foot still hurts ... the pain was getting worse. (Jane-2).

Another participant described how colleagues encouraged her to consult as they noticed her worsening symptoms resistant to her creative self-management strategies:

... [ice-packs] became a more common sight then I was getting people saying ... ‘What is wrong with you and what are you doing about it?’ ... This doesn’t look normal ...’ Finally a couple of coworkers who are friends ... became quite concerned and said: ‘This isn’t getting better, it’s not going away. Your treatment ... fine if it’s helping you get through the day but I think you need to get this checked.’ So I guess that probably was what helped me (Charlize).

Spousal support was indicated across the age-range. Participants described both practical and emotional support in daily life as well as advice about treatment options.

After the GP: pushing for the specialist referral

Several women proactively sought information and speedier referrals as opposed to passively waiting for the referral. They described how they navigated the health care system and negotiated meetings with health professionals. Some developed an increasingly assertive approach as a result of their experience (reported unmet needs in the healthcare system): There is a perception that the healthcare system is going to take care of you. I think it’s all what you put into ... your own care in that you have to be persistent ... if something doesn’t

sound right you should really pursue it. Diagnosis is not an exact science. They're speculating to a certain degree (Bianca). Some participants, rather than being deferential, actively negotiated a rheumatologist referral with their GPs who were reluctant to pursue a rheumatologist consult. These participants tended to have prior knowledge of the health care system, through a friend, colleague or a member of their social network. Maple's onset was sudden, severe and debilitating and her symptoms were resistant to self-management strategies. In this context, her spouse supported her in seeking a rheumatologist's assessment, but her GP was reluctant to refer: So I kept pushing her. I said: 'Can you refer me to ... a rheumatologist? This has been going on for five weeks now.' And she was: 'I don't know we should do more testing' (Maple). Several finally made the decision to seek help from their GP, but with no positive outcome (no effective/prescribed treatment, referral, or definite diagnosis) and so continued to self-manage. Some sought advice from trusted others (e.g. a work colleague or physiotherapist) or proactively located new GPs: I went to my family doctor ... she really didn't do anything ... it happened again ... several times ... and I was talking to the physiotherapist (at work) he ... said ... 'You should go get checked for rheumatoid arthritis ... it's not normal for your hands to swell like that' ... I had gone back to my doctor a few times and that's when I changed doctors (Sarah). The women sought information in order to know the cause of their symptoms and to take action. For several, this newfound knowledge induced anxiety, but was a prompt for them to push for a specialist referral. They used the information they gained on the Internet to validate their requests to their GP:

... the wrist pain it returned in spades. I got on the Internet ... concluded very quickly that this is rheumatoid arthritis. I went back to my GP and I said 'I think I've got RA'. And she said: 'Well what would make you think that? You're walking in here telling me what your diagnosis is' ... I told her: 'I've got these symptoms. They match the diagnostic criteria.' And I want the RA factor test. ... And so she said: 'Well if you insist' (Teresa).

In this way, the women displayed attitudes and characteristics often portrayed as typically masculine – self-determination and taking control^{21,23,24} as they sought a diagnosis.

Post referral

The participants' accounts of post referral experiences varied. For some, the wait, as one participant noted, was 'easy' (short, effective prescribed medication, controlled symptoms) but for others it was not. One participant described this stage as 'brutal' (long, ineffective medications, escalating symptoms). For most, it was problematic. Reported wait times ranged from one day to one year (see Table 1) with most reportedly waiting between 6 weeks and 6 months between referral and rheumatologist appointment. For some, this period was characteristic of the trek along the care pathway from symptom onset: it involved mobilising a raft of self-management strategies prior to and post the initial GP visit for symptoms which were eventually diagnosed as RA. Commonly, participants expressed uncertainty and anxiety about their condition and the possibility of an RA diagnosis. Increasingly prominent in the period between gaining a referral and a rheumatologist meeting was information seeking, which often increased anxiety and prompted a push for an earlier rheumatologist meeting. During this period, the women described continuing to self-

manage (e.g. self-medicating, pacing and in some cases visiting alternative therapists) with limited or no formal support (beyond prescription analgesics and anti-inflammatories). A major strategy was to search for information on the Internet. For some, this meant returning to the GP and negotiating an earlier rheumatologist appointment. For several, the Internet was a key strategy, and illustrated an emerging e-patient.³⁸ At the referral stage, the majority suspected they had RA and were keen to access information about the condition, treatments and the implications it had for their daily lives and future. Most knew little about RA and described how, during this period of uncertainty, they (or family members) searched the Internet and elsewhere for information. Some described how an Internet search prompted them to gain a speedier referral “Get me in with anybody” (Nicolette). The Internet was used by several in an attempt to gain control of an uncertain situation, left unresolved by a GP appointment.

Seeing the rheumatologist

The Internet prepared some for the rheumatologist diagnosis (Sally). One participant pushed for further testing to confirm a diagnosis after “digging” on the Internet for information; Sarah asked her rheumatologist about the [Anti-CCP] test: and he said ... it’s not covered ... I did a bit of research on my own and discovered yes it is covered you just have to go through the medical Labs ... I went back to my GP and got a requisition from her, had the test done, and that came back high (Sarah).

The women also conveyed the importance of feeling in control post-diagnosis, and on prescribed medication regimens. Several searched for further information on the Internet after they had seen the rheumatologist. This indicated a disinclination to defer to the specialist’s knowledge alone. They searched the Internet, discerned reliable and valid information, and assessed its credibility:

I search ... The Mayo Clinic and it is world-renowned ... So the information, one would assume, would be something reliable ... The ones that are written by physicians at a specific hospital or a specific university that you can trace and track. Those I put more validity into ... You have to use your common sense you can’t believe everything you hear. And two doctors will say different things ... Medicine is a practice. They’re practicing always (Jean).

Discussion

Summary of main findings

The women gave accounts that featured illness and help-seeking behaviours associated in the literature as masculine practices demonstrating the similarities between men and women’s accounts of help-seeking. They pushed through pain as they delayed an initial GP consultation; they actively mobilised resources and sought to control symptoms as illness progressed and they pushed for a diagnosis in their attempts to maintain daily life, and to fulfill roles and responsibilities. Several women revealed how they pressed their GP for a specialist referral rather than defer to medical authority. The women’s self-sufficiency and delayed help seeking was anchored in the practical circumstances of daily life and relationships with family and others. Their accounts featured relational and expressive

practices, traditionally aligned with femininity, alongside what has been identified in the literature and public discourse^{20,23,25} as traditionally idealised masculine traits and behaviours. Our analysis builds on previous work and shows the limitations of organising men and women's behaviours around binary oppositions of gender.^{20,23,25}

Limitations and strengths of the study

Accounts may be best understood as representations of moral selves and practices and constructions where *'agency is negotiated, identities are constructed, and social action mediated'*.³⁶ However, following Somers, individuals are guided to act by their structural and cultural contexts, *and* by the stories through which they construct their identities'.³⁶ In this way, the accounts can be seen both to illustrate cultural values and reflect action. The women constructed positive identities drawing on culturally valued illness behaviours of being self-reliant and self-directed, and 'being stoic' in the context of relational settings. Our analysis shows that 'masculine practices' featured in the accounts of the women participants. This study is of limited scope as it focuses on experiences of early RA; both men and women's responses to other conditions may vary. However, RA has been the focus of study in sociological research in part because it is characterised by symptoms similar to other chronic conditions. Patients self-reported their help-seeking from symptom onset to early post-diagnosis, so for example the table is based on memory. Although this is not a limitation in terms of an analysis of how the participants gave accounts of their illness actions, it is a limitation of the 'factual' quality of the table. We did not explicitly compare geographical areas. This analysis does not include men in the sample. Although this was attempted we were only successful in interviewing one man. For phase 2 of this study, more men were recruited and analysis is forthcoming.

Relating the findings to existing literature

Our findings reinforce existing evidence about help-seeking in chronic illness that both men and women delay seeking help in early RA^{1-11,13,15} and avoid medical consults for long-standing multimorbidities including RA.³⁹ Reflecting what we found, the importance of control has been evident in accounts of men's help-seeking in particular conditions and associated with hegemonic masculinity.^{20,23,24} In line with accounts of men^{20,23} and accounts of both men and women,³⁹ controlling illness was seen as key in order to maintain everyday lives,³⁹ roles and responsibilities.^{20,23} For example, the women conveyed the need to fulfill 'the work ethic' and to perform domestic tasks as 'a mother', despite risking pain and further damage. As is commonly associated with men's help-seeking, the women described being persuaded to consult their GP by family members.²⁰ Unlike men's accounts in the literature, whereby over-coming symptoms is expressed as 'manliness'^{23,40} women conceived such behaviours to be relational in nature, e.g. socialised in the family. This relationality has been associated with femininity and women's help-seeking.²³ As O'Brien and colleagues²⁰ noted, the men in their focus groups presented their masculinities by drawing on hegemonic gender and notions of acceptable practice for men. The women in our study presented positive identities by drawing on cultural norms of moral identity, help-seeking and self-managing rather than on idealised versions of femininity⁴¹⁻⁴³ (or masculinity). This may have been because the women were not explicitly asked about

femininity/gender. It could also have been because there are more penalties for not displaying masculinities than for not displaying femininities.⁴⁴ Women do not have available to them the same normatively valued forms of symbolic representation as men, thus they draw on cultural idealised behaviours rather than femininity.³⁶ Several women displayed a reluctance to visit their GP, anticipating negative labeling and what they perceived to be stereotypical notions of women consulting for trivial symptoms.²⁵ Displaying self-sufficiency, after meeting with their GP, several actively undertook Internet searches, and pro-actively sought early referrals to the rheumatologist. The accounts illustrated little evidence of hegemonic (or emphasised) femininity, constructed in opposition to masculinity,⁴⁵ as passivity and dependence and associated with a willingness to defer to authority and a readiness to consult health professionals.^{20,23} It may be more helpful to examine the similarities in men's and women's help-seeking and interpret accounts as ways of expressing moral action in the context of a set of fundamental principles and values.^{36,46} In this context, *gender* intersects within a spectrum of social and cultural practices that constitute our social world. This directs us to investigate greater contingencies of agency,^{36,46} reflect on how far key practices of femininity and masculinity influence behaviour and look beyond the binary oppositions of gender as others have identified.^{20,22,23,25,28,30}

Presentations of 'stoic'⁴⁷ behaviours and avoiding medical help in both men and women can reflect not only cultural values but mask the context in which help-seeking takes place. For example, in avoiding medical help, one may be demonstrating a moral responsibility to self-manage and avoid using scarce resources. In this context of judicious use and responsibility, there may be a fear of stigma for both men and women who do not respond to illness in culturally approved ways.⁴⁷ It has been claimed that men are more likely than women to convey a reluctance to seek help, which is seen as problematic for men's health. However, the perception that women are relatively willing to consult health services can pose problems for how their help-seeking is interpreted and understood.²⁵ The more recent literature emphasises how not all men and women conform to traditional behaviours and that masculinities and femininities are both diverse and flexible.^{20,23–25,28,30} Our analysis helps break stereotypical views of women's help-seeking and the binary oppositions of masculinity and femininity. As has been identified in a recent review,⁷ more research is needed which compares men and women's accounts of help-seeking.

Conclusion

Our findings have implications for health care interventions. Regarding RA, the predominant approach currently is to increase RA awareness in the public. While this may address the knowledge gap for recognising RA symptoms, it does not fully address the process leading up to seeking help and subsequent care pathway. Addressing the stigma around seeing GPs for musculoskeletal symptoms, which may be prevalent in both men and women, is one solution. These findings, if found to be more widespread, could inform interventions to promote help-seeking among women for similar conditions. They may also provide a better understanding of how and why women seek help and how for example cultural and relational aspects may influence help-seeking. Further consideration of how issues of moral identity work to encourage particular behaviours and how these are associated with consulting may help tailor health messages and interventions for both men and women.

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Table 1

Participant characteristics (self-reported at the time of initial interview).^a

	Age range	Recruited via	Symptom onset to seeing Rx	Seeking medical help for symptoms leading to a diagnosis/RA test	Referral wait time to see a rheumatologist	Diagnosis
Alicia	60s	Unknown	1 year	3 months	6–8 weeks	Uncertain but treated for RA
Barbara Anne	40s	Family doctor's office	10 years	1 year	6 months	Diagnosed
Bianca	30s	Rheumatologist office	2 years 3 months	7 months	2 months	Diagnosed
Bonnie	60s	Arthritis Newsletter	40 years	20 years	No referral	Not diagnosed
Charlize	50s	Arthritis Newsletter	4 months	Less than 1 week	3 months	Diagnosed
Cynthia	60s (estimated)	Arthritis Newsletter	1 year	5 months	2 months	Diagnosed
Danielle	40s (estimated)	Rheumatologist office	8 years	3 years	2–3 months	Uncertain but treated for RA
Debbie	50s	Rheumatologist office	2 years 4 months	2 years 4 months	3 months	Diagnosed
Dodi	50s (estimated)	Rheumatologist office	5–6 months	2–3 weeks	5 months	Diagnosed
Dorothy	30s	Rheumatologist office	1 year 10 months	2 months	2 months	Diagnosed
Flossie	50s	Arthritis Newsletter	24 years	10 years	6 weeks	Diagnosed
Jackie	40s	Arthritis Newsletter	2–3 months	2 months	2–3 weeks	Uncertain but treated for RA
Jane	60s	Arthritis Newsletter	8–9 months	5 months	1 month	Diagnosed
Jane 2	50s	Arthritis Newsletter	4 months	1 month	6–8 weeks	Diagnosed
Jean	50s	Arthritis Newsletter	19 years	8 years	2 months	Diagnosed
Jessie	50s	Rheumatologist office	3–4 months	3–4 weeks	6 weeks	Diagnosed
Julie	50s	Physiotherapist office	3 months	3–4 weeks	1 month	Diagnosed
June	50s	Arthritis Newsletter	3 months	unknown	6 weeks	Diagnosed
Kerry	30s	Arthritis Newsletter	3 months	No delay	10 days	Diagnosed
Lee	40s	Family doctor office	14 years	Unknown	Unknown	No diagnosis (has complex multi-morbidities tests ongoing)
Laurie	60s	Arthritis Newsletter	1–2 years	1–2 years	At regular rheumatologist regular appointment	Diagnosed
Maple	40s	Arthritis Newsletter	2 months	6–7 weeks	1 day	Diagnosed
Marie	60s	Rheumatologist office	3 weeks	2 weeks	1 week	Diagnosed
Marlain	50s	Rheumatologist office	4–5 years	2–3 years	<6 months	Diagnosed
Martha	70s	Unknown	9 years	6–8 years	1 year	Diagnosed
Nicole	30s	Arthritis Newsletter	1 month	2 weeks	2 weeks	Diagnosed

	Age range	Recruited via	Symptom onset to seeing Rx	Seeking medical help for symptoms leading to a diagnosis/KA test	Referral wait time to see a rheumatologist	Diagnosis
Nicolette	50s	Rheumatologist office	12 months	11 months	1 month	Diagnosed
Nora	50s	Rheumatologist office	11 months	1 month	3 months	Diagnosed
Rosie	60s	Arthritis Newsletter	26 years	26 years	1 month	Diagnosed
Sally	50s	Arthritis Newsletter	1 year	2 months	1 month	Diagnosed
Sarah	50s	Arthritis Newsletter	3 years	16 months	1 month	Diagnosed
Shari	60s	Unknown	6 months	Unknown	No referral family doctor diagnosis	Diagnosed
Sharon	60s	Family doctor office	7 years	2 years	2 months	Diagnosed
Sherry	40s	Rheumatologist office	9–10 years	5 years	6 months	Diagnosed
Smokie Jean	60s	Rheumatologist	40 years	4 years	3 weeks	Diagnosed
Teresa	50s	Unknown	11 months	9 months	5 months	Diagnosed
Yoda	50s	Rheumatologist office	3 years 6 months	1–2 weeks	6 months	Diagnosed

^a Age estimated by interviewer when not given by participant.

Note: Table amended from original in reference 17.