

Men's strategies after a heart incident: A class-based masculinities approach

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A thesis submitted to the

Faculty of Graduate and Postdoctoral Studies

In partial fulfillment of the requirements for the MA degree in Human Kinetics

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Acknowledgements

I would like to express my sincere gratitude to my thesis supervisor Alex Dumas for his continuous encouragement, enthusiasm, and patience during the course of this project. The long (and productive) discussions and continuous support are what encouraged me most during this process. You have taught me so many things that will surely be useful in my professional career.

I would also like to thank my committee members, Michael Robidoux and Stephen Stuart for their continuous support, thoughtfulness, recommendations, and guidance during the process. Additionally, I would like to thank the School of Human Kinetics for providing the necessary tools required for my development of skills and knowledge required for the preparation and composition of a research document.

I would also like to acknowledge the *Conseil de recherche en sciences humaines du Canada* for their financial assistance, and the assistance of the CSSS de Gatineau during the recruitment process which made this project possible.

Lastly, I would like to thank family and friends, for the continuous support, and long, and sometimes difficult, discussions during this process. Your support has further encouraged me to persevere in moments when it was most difficult. You have always encouraged me in my academic career, and know you will continue to do so in the future.

To all, thank you.

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Abstract

Men in economically advanced societies are more at-risk of premature mortality due to heart disease than women, and this risk is inversely proportional to their socioeconomic status (SES). In Canada, many public health reports indicate that cardiovascular disease represent about one third of all causes of death and that men's mortality rates from these diseases are two times higher than women, making it the main contributor to health inequality.

Underprivileged men have been identified as being less receptive to cardiac rehabilitation guidelines, yet research promoting heart healthy behaviours has often neglected the social mechanisms that influence the lifestyle of this population. This study aims to understand the social variation in dispositions and commitments toward body care of men from two contrasting socioeconomic groups who have suffered from a cardiovascular incident requiring hospitalization. It draws primarily on Pierre Bourdieu's socio-cultural theory of practice and his concept of bodily habitus in order to understand distinctive lifestyle patterns in the context of cardiac rehabilitation.

Qualitative data was collected through 60 semi-structured interviews of an average duration of 90 minutes. Participants were Francophone men (average age of 57.3) from the Outaouais region of the Province of Québec, Canada. A thematic content analysis showed strong social variation in terms of lifestyle and identified different dispositions towards body care in the context of heart disease.

Results are organized according to three key strategies for human flourishing following a heart incident that are relevant to understand the dispositions to adopt (or not) health practices in the context of cardiac rehabilitation: (a) achieving a sense of security; (b) preserving autonomy; and (c) maintaining dignity. The comparison between socioeconomic groups highlights the incompatibilities of healthcare services and rehabilitation programs with the priorities of

underprivileged men. It also flags the potential ethical and political dimension of healthcare by examining notions of health citizenship. In conclusion, the thesis discusses the socio-political characteristics of cardiac rehabilitation programs, and the usefulness of class-based masculinities as an alternative point of view to understand health implications of lifestyles.

Chapter I – Introduction

Men's Health in Canada

Masculinity, Poverty, and Health

The 2012 Report on the state of public health in Canada emphasizes the importance of addressing sex and gender as a matter of health (CPHO, 2012). The different roles and responsibilities associated with masculinity contribute to the unique experiences of health among men. Although there are many social determinants of men's health, such as education and income, overall, men's health outcomes are worse than women. As Evans, Frank, Oliffe, and Gregory, (2010) argue 'the tendency for men to engage in high risk practice (e.g., excessive use of alcohol; high speed driving etc), avoid preventative care, delay treatment, and ignore health information and physician recommendations can be interpreted as practices of masculinity and, in turn, contribute to poor health outcomes for men' (p. 9).

Gender disparities in health exist despite Canada's universal healthcare system and social support programs. Gender differences in health outcomes have been explained by biological factors and social factors; with no single explanation for all causes of death, traditional gender roles are considered a major contributor (Dumas & Bournival, 2012). As indicated by Geenberg and Normandin (2011, p.1), 'in Canada, life expectancy at birth is 4.7 years longer for women than men'. Canadian men suffer more death than women in 14 of the 15 leading causes of death (Statistics Canada, 2009). Oliffe, et al. (2010) highlight five leading causes of death where men's death rates are significantly higher than women's: cardiovascular disease, suicide, motor vehicle accidents, infectious diseases, and liver diseases. These researchers argue the contribution of lifestyles to the contraction of these diseases and causes of death attest to the impact masculinities' has on men's health practices (Oliffe, et al., 2010).

The inclusion of socioeconomic variables within gendered analysis of health highlights the specific health disparities between underprivileged men (those who experience high unemployment, frequent use of soup kitchens, food banks, and shelters, or living in public housing, and frequently requiring government aid to secure basic needs, etc.) and other, more privileged, socioeconomic groups. Generally speaking, men characterized by high levels of social and material deprivation, experience worse health outcomes than women and men who are more privileged. For example, in Canada, a recent government report highlighted the extent of national health inequalities by reporting that life expectancy by neighbourhood income quintile shows an 8.4 year difference between men of the lowest quintile and women of the highest quintile (and an 5.4 year difference with men from the highest quintile) (Greenberg & Normandin, 2011). In order to explain these social inequalities in health, this study proposes an intersectional approach to lifestyle that examines the interaction of masculinity and social class.

Underprivileged Men and Cardiovascular Disease

Social epidemiology studies on the social gradient have restated the impact of cardiovascular disease [CVD] in health inequalities (Alter, Naylor, Austin, and Tu, 1999; Chan, Gordon, Chong, & Alter, 2008; Steptoe & Marmot, 2002; Worcester, Murphy, Mee, Roberts, & Goble, 2004). Cardiovascular disease is an important public health issue because it reflects the population's engagement with healthy lifestyles. In Quebec for instance, Pampalon, Hamel, & Gamache (2008) have shown premature death rates of men in the lowest income quintiles are 3.4 times higher from cardiovascular disease than men in the highest income quintiles. Similarly, they indicate that there is a 7.1 year life expectancy difference between men and women in the same low income quintile, resulting primarily from cardiovascular disease, the leading cause of potential life years lost (Pampalon et al., 2009). Underprivileged men in the province of Quebec

are 2.9 times more likely to die from cardiovascular disease than women of the same socioeconomic strata (Pampalon et al., 2009).

In response to these statistics, most major public health institutions have established cardiac rehabilitation programs. The Canadian Guidelines for Cardiac Rehabilitation and Cardiovascular Disease Prevention [CACRC] indicate the modest success of cardiac rehabilitation [CR] programs despite the efforts of specialists in behaviour modification (Stone, & Arthur, 2005). The changes CR programs make to lifestyles are proven to help with health outcomes, if adopted (Stone, & Arthur, 2005; Grace & Scholey, 2005; Young, 2005). Recent data have shown that CR programs can improve lifestyles of patients and lower the rate of mortality by 25%, yet, despite the potential effectiveness of programs only approximately 30% of eligible cardiac in-patients enrol (Grace et al., 2011). As argued by Grace and colleagues, sociocultural factors such as gender may not be adequately considered for their role in the compliance of cardiac rehabilitation programs and the modification of risk factors in cardiovascular health (Grace et al., 2011). Despite research on increasing the use of CR programs social structural factors are under emphasized and program use remains low.

Several studies and reports focus on increasing the use of CR programs (Cooper, Jackson, Weinman, & Horne, 2002; Grace et al., 2011; Meillier, Nielsen, Larsen, 2012; Worcester et al., 2004). These studies identify low program referral rates (only approximately 20% of eligible patients), and high dropout rates (23.6% of attendees) as two areas on which to focus (Grace et al., 2011; Worcester et al., 2004). Multiple causes for low usage, including factors that are specific to individuals, such as gender, age, smoking, activity level, and unemployment are identified. Although the reports mention the contribution of these factors they are not examined.

Study Context

This study is part of a larger study which examined the social variation of lifestyle practices of men from contrasting socioeconomic strata and who have been hospitalised following a cardiovascular incident (Dumas, 2007). Sixty participants were recruited from the urban areas of the Outaouais region of the province of Quebec. The larger study focuses on three themes: socioeconomic inequalities, social capital, and masculinities. All sixty interviews were collected between 2008 and 2009, were transcribed verbatim and integrated into the qualitative analysis software QSRNVivo.

The Outaouais region was selected following the results of the public health warnings of two research reports from the region's Direction of Public Health (Direction de la santé publique). Reports singled out the high social gradient in health and high level of cardiovascular diseases in comparison to other areas of Quebec (Regie regional de la santé et des service sociaux de L'Outaouais, [RRSSSO], 1996, Courteau & Finès, 2004). The reports expose the health paradox of the region, which is the poor health standing relative to its high income per capita. A plausible explanation would be the area's high social inequality and geographic segregation between socioeconomic groups. The inner-city poverty rates strongly contrast the surrounding communities characterised by civil servant workers (Castaldo & Fraots, 2011). This inner city core once housed the region's industrial working class, but during the 1960s a transition from working class to an underprivileged population occurred as a result of industry leaving the city. The contrasting level of social and material deprivation of this region makes it a valuable context to study social variation of lifestyle and care of the body.

Aim of the Study

The aim of this study is to understand the social variation in dispositions and commitments toward body care of men from two contrasting socioeconomic groups who have suffered from a cardiovascular incident requiring hospitalization. More research on understanding how men of different classes embody ideological characteristics of masculinity, and adopt distinctive health practices can contribute to developing specific cardiac rehabilitation programs, and adapting health policy for vulnerable populations. Furthermore, it is hoped that the results will provide a better understanding of the relation between masculinity and health.

This introduction is followed by a 1) literature review on men's health in Canada and health inequalities; 2) theoretical framework presenting Pierre Bourdieu's socio-cultural theory of practice, concept of body habitus and masculinity theory; 3) methodology; 4) a research article which incorporates the results and discussion; and 5) final conclusion.

Chapter II - Literature Review

MEN'S HEALTH, GENDER, AND LIFESTYLE

Men's Health in Canada

In Canada, males outnumber females in all leading categories of illnesses (CPHO, 2012; Evans, Frank, Oliffe, & Gregory, 2011; Oliffe et al., 2010). Men's health is particularly dire in cardiovascular disease where mortality rates, below 75 years old, among men are twice that among women (CPHO, 2012). Among men, mortality rates due to circulatory disease are 1.62 times higher than women, 188/100, 000 versus 116/100, 000 (CPHO, 2012). Similarly, for ischemic heart disease, the death rate among men is twice that of women, 110/100,000 versus 55/100,000 (CPHO, 2012). These ratios are important because circulatory diseases are the leading cause of death in Canada (representing 31% of all life years lost), and they highlight the health disparities between men and women. They are also suggestive of the need for closer attention to gendered health policies.

A gendered perspective on health care can help increase initiatives and programs that improve men's health. Despite the increasing concern over men's health in Canada, researchers identify Canada as falling behind other first world nations in several public health initiatives (CPHO, 2012; Robertson, Galdas, McCreary, Oliffe, & Tremblay, 2009). For instance, the Canadian healthcare system has no central agency for research in men's health, men's health policy, or collecting examples of best practices for men's health (CPHO, 2012; Evans et al., 2011; Robertson et al., 2009). Mainstreaming men's healthcare by developing a single point of contact in these three areas will improve delivery and participation in men's health services (Robertson et al., 2009). Differences in gendered health practices between nations may exist because masculinities are influenced by unique cultural and economic aspects of society and

therefore, modifying men's health practices requires investigation of masculine dispositions (Connell, 2005).

Lifestyles and Social Representations of Masculinity

The popular social representations of traditional masculinity emphasize aspects of masculinity that fashion body dispositions leading to unhealthy lifestyles. For example, the commodification of the male body is becoming increasingly important in the media and popular culture (Dumas & Bournival, 2012). Men, and particularly young men, respond by regulating their bodies to reflect the popular representations of masculinity; this is seen with men's ever-increasing eating disorders, emphasis on muscle size, alcohol and red meat consumption, and violence (Evans et al., 2011). Not only do current popular representations of masculinity promote unhealthy practices, but conversely, negative health implications can also result from failure to adhere to popular representation of masculinity.

Canadian culture promotes men's engagement in idealized forms of masculinity as a result of unequal power distributions in society. Few men achieve top power positions; the men who do not reach top positions feel pressure to engage in idealized masculine practices or risk being further subordinated and marginalized (Evans et al., 2011). Although men in the top positions do not always display idealized masculinity, they often promote ideological configurations of masculinity for less dominant men to comply with (Robidoux, 2012). The pressure to avoid losing status, from failure to act consistently with ideological configurations of masculinity, results in men engaging in unhealthy masculine practices (Connell, 2005). Furthermore, the loss of status alone can cause powerful social anxiety and lower a man's sense of inner worth (Charlesworth, Gilfillan, & Wilkinson, 2004). Men have to represent their masculinity through practice and different classes of men use different practices to do this.

Many sociologists refer to the concept of class-based masculinities in order to explain the different forms of masculinity based on social class (Courtenay, 2000; Pyke 1996). In a study on young, British men, Lee, Macdonald, and Wright, (2009) argue that social structures establish the context in which people interact and think towards health and the body. For example, they indicate that social class is one of the most powerful factors in shaping men's relationship to their body and their physical activity practices (Lee et al., 2009). In other words, their views of the body coincide with the socialisation occurring within social environments both on socioeconomic and gender terms.

After identifying gendered lifestyles as the prime contributors to the health differences between men and women, researchers have called for more research to offer explanations for men's unhealthy lifestyles. Dumas and Bournival (2012) offer explanations for lifestyles' use in the social representation of gender: "the lifestyles adopted by men and women contribute to a process of gender distinction, and because they are symbolically charged with gender connotations, they are made public through performances that reproduce gender differences" (p. 39). This creates pressure on men to follow masculine norms and results in the adoption of unhealthy practices. In Evan's and colleagues (2011) summaries of statistics for young men in Canada they highlight that "young men are three times more likely to die from accidental death than women; four times more likely to die from suicide; and half as likely to seek out health services" (p. 10). Several researchers argue that men who feel stigmatized from not reaching positions atop of social and masculine hierarchies respond by adopting practices that hold symbolic meaning to compensate for their lack of power and ultimately create higher risk of injury or illness (Courtney, 2000; Evan's 2011).

Risk Taking

In the following sections I will investigate men's unique consumption of alcohol and health care, and their interaction with health care providers because collectively they reveal men's orientation to risk practices. The social mechanisms that produce gendered inequalities in health are often derived from gendered socialization, where men acquire a specific relationship to the body that is less preventative, more competitive, risk oriented, and ultimately more harmful to health than that of women to their own bodies (Aiach, 2001). Men's practice of 'risk taking' is important for explaining gender differences in health. Several researchers identify men's risk taking practices in order to conform to norms of masculinity as a root cause of unhealthy lifestyle practices (Connell, 2005; Evans et al., 2011; Sabo, 2005). For example, adolescent males' increased use of anabolic steroids highlights the pressures they are subjected to in order to conform to a socially valued body form (Gill, Henwood, & McLean, 2005; Sabo, 2005). For young men the surface of the body acts as a key source of identity, and musculature represents a visible display of strength, a dominant ideal of masculinity. Users of such illicit drugs are at risk of various side effects that can include acne, atrophy of the testicles, liver disease, cardiovascular disease, depression, and increased aggression (Sabo, 2005).

The assertion of autonomy is another masculine ideal associated with risk behaviour. Men resist institutions that attempt to control the body, promoting uniformity and conformity (Gill et al., 2005). Men's over-expression of independence also reduces social capital and negatively impacts health (Dumas & Bournival, 2012). For example, in the context of illness, older men often refuse support from family members and friends (Dumas & Bournival, 2012; Klinenberg, 2001). Particular social institutions that control people's bodies and practices, such

as schools and hospitals, evoke resistance and the expression of independence from men who are compensating for their failure to achieve ideological and hegemonic masculinity.

The impact of various forms of masculinity on health practices is evident in men's use of alcohol, medical services, and their interaction with physicians. The pressure men feel to demonstrate ideological versions of masculinity is evident as men negotiate the health care system and construct their masculinity in relation to their health challenges. Men's use of alcohol in combination with other gender roles underscores how masculinity can orient men to particularly unhealthy practices.

a) Alcohol and masculinity.

Men's alcohol abuse and its impact on health have been widely discussed in masculinity studies. In particular, men's risk taking practices are seen in lopsided statistics for deaths related to alcohol use and its impact on deaths from motor vehicle accidents. Donald Sabo (2005) argued that gender differences in alcohol related fatalities are often associated to gender roles (femininity and masculinity). Garfield, Isaco, and Rogers (2008) used the United States statistic of 79 646 deaths as a direct result from alcohol use from 2001-2005, of those 57, 429 were men, to exemplify gender role contributions (Centers for Disease Control and Prevention [CDC], 2008 as cited in Garfield et al., 2008). Sabo (2005) uses the male characteristics of travelling more often after drinking, sensation seeking, and male bravado to explain the US Census Bureau statistics: 1998, age adjusted death rates from automobile accidents, 29.3-26/100 000 for men versus 9.4-10.7/100 000 for women. He further explains how motorised vehicle accidents represent 78% of fatal injuries among younger men, and alcohol abuse is often an aggravating factor in these situations.

Gender differences in alcohol consumption also have consequences on other aspects of health statistics. With regards to heavy alcohol use, in Canada 29.0% of men are considered regular heavy drinkers compared to 11.1% of women (Lukassen & Beaudet, 2005). High alcohol consumption is also apparent in Canada where death rates attributed to cirrhosis of the liver are 2.9 times higher for males (Statistics Canada, 2010). Furthermore, epidemiological studies in Canada show drinking patterns and bouts of heavy drinking among depressed men have also been tied to accidental or violent deaths and associated diseases (CPHO, 2012). Health statistics illustrate trends in men's alcohol use (abuse), and gender construction explains why men consume alcohol in risky ways.

Men's higher alcohol consumption may also be related to the role that advertizing and other media play in the construction of masculinity. Garfield et al (2008) relate the social construction of masculinity and male alcohol use thus: "alcohol consumption represents a demonstration of masculinity, enhances male camaraderie and sociality towards the opposite sex, and provides a temporary escape from emotional problems." (p. 479). Sabo's (2005) study on men's health highlights how beer commercials play on constructs of masculinity to influence male consumers connecting masculine value with alcohol consumption. His study highlights how alcohol consumption is perceived as a 'reward' within many social spheres (work, relationships, and sport). In sum, male drinking behaviour is widely embedded in the sociocultural context that associates increased drinking with greater levels of specific types of masculinities (Garfield et al., 2008; Sabo, 2005).

b) Medical consumption.

The consumption of medical services is also gendered. For instance, men less frequently use health services. In Canada only 72% of men age 12 and up reported consulting a physician in

the previous year compared to 85% of women (Statistics Canada, 2001). Men's lower usage of health services has been explained by the threat of undermining popular Western traits of masculinity (Evans et al., 2011; Garfield et al., 2008). Evans et al., (2011) argue that men's resistance to regular medical treatment and follow ups is partly due to the fear of having their masculinity threatened by being labelled as vulnerable, dependent, weak, or sick—all traits he believes are associated to social perceptions of femininity. Similarly, men's higher unwillingness to disclose feelings of vulnerability and to seek help from others reflects how men's socialization conflicts with using health care services (Evans et al., 2011; Garfield et al., 2008). For example, Garfield et al. (2008) explain that one in seven men use mental health services in their lifetime compared to one in three women because of men's unwillingness to talk about psychological distress.

Not only are ideological masculine identities associated with low use of health services, they also contribute to poor service delivery for men. In a report focusing on prescription lifestyles (lifestyle medicine), Garfield et al. (2008) describe how one in four men acknowledges waiting as long as possible before consulting a physician if they are sick, in pain, or concerned about their health. Characteristics associated to masculinity ('strong silent type', 'toughness', and 'not complaining') also contribute to men's fewer interactions with health practitioners, lower access to quality information provided by physicians, and lower likelihood of complying with medical recommendations in order to reduce risk factors associated to illness (Garfield et al., 2008; Oliffe & Thorne, 2007).

c) Doctor-patient interaction.

Doctor-patient interactions are also a concern for men's health because their quality and frequency impacts the detection and prevention of diseases. In Canada, the Chief Public Health

Officer (2012) has noted a lower frequency of consultation between men and their physicians. Similarly, Oliffe and Thorne's (2007) longitudinal study of Australian and Canadian prostate cancer patients outlines the contextual barriers that contribute to shorter consultations between men and male physicians in comparison to female physicians in primary care. These barriers include less active cooperation, fewer questioning of psychosocial issues, and less discussion of emotions (Oliffe & Thorne, 2007). This study shows that better quality of care from gender sensitive communication helps increase the efficiency of prostate cancer treatment. Conversely, it also shows that poor communication is linked to fewer and shorter medical consultations and lower standards of treatment.

For Oliffe and Thorne (2007), some traits associated to masculinity (self-sufficiency and hyper-independence) also negatively affects communication. For example, the perceived social status of the physicians, whether real or imagined, can subordinate patients resulting in communication conflicts (Oliffe & Thorne, 2007). Communication is further limited by ideological masculine identities through men's fear of being perceived as effeminate, homosexual, or weak (Evans et al., 2011). These issues in communication remain despite research showing effective communication improves patient satisfaction, treatment, and understanding of their health status (Oliffe & Thorne, 2007).

Strategies for Masculine Health

The improvement of men's health services is an effective means of preventing diseases and decreasing morbidity and mortality. In this respect, researchers identify important areas of focus as the collection of examples of good practices, creating networks for gathering research evidence, and revising policy in health promotion (Courtenay, 2000; Robertson, et al, 2009). Canada can improve men's health practices by implementing policies designed from research

specific to men's lifestyles. For example, in an Australian study on men's usage of chronic arthritis self-management programs, Gibbs (2007) found that policies must accompany men to reformulate and renegotiate their perceptions of their masculine 'self' in order to sensitize them to seek health services. Sadly, without gender specific policies to assist men, the amount of pain the men could tolerate was the main motivator in undertaking the reformation of a new identity and healthy practices (Gibbs, 2004).

Researchers identify the need for specific policies that incorporate the impact of masculinity in men's self-management of health concerns. Studies indicate that men fail to define life and health problems in medical terms and instead see such problems as threats to their masculinity or in gender terms. This results in fewer men seeking help from medical professionals (Farrimond, 2012; Klingemann, & Gomez, 2010). Researchers explain the difference in use of the health care system between men and women through the association of health problems with gender connotations as opposed to medical implications (Farrimond, 2012). Gibbs (2007) emphasizes this difference in perspective in her study on men's and women's use of health services when they face the same barriers of work commitments and a lack of time. Educating boys and men to use health care services in a non-gendered fashion could help overcome these barriers.

Policies promoting the use of gender sensitive language in health care programs require further research. For instance, Gibbs (2004) argued that contrary to prediction, health promotion of self-management programs were more likely to fail if the message could be associated to ideological configurations of masculinity. By adopting the strategies of other developed countries in male-based policies for health promotion and health care, Canadian health agencies

may begin to catch up in the areas Canada is falling behind. Changes in cardiac rehabilitations programs may indicate gender specific strategies in improving men's health.

Gender and Cardiac Rehabilitation

The Canadian Guidelines for Cardiac Rehabilitation and Cardiovascular Disease Prevention [CACRC] indicate the modest success of cardiac rehabilitation programs despite the efforts of specialists in behaviour modification (Stone, & Arthur, 2005). A 2011 report on the CACRC states in Canada that “only approximately 30% of eligible cardiac in-patients enrol in CR programs” (Grace et al., 2011, p. 1). As argued by Grace and colleagues, sociocultural factors, such as gender, may not be adequately considered for their role in compliance with cardiac rehabilitation programs and the modification of risk factors in cardiovascular health (Grace et al., 2011). The changes cardiac rehabilitation programs make to lifestyles are proven to help with health outcomes, but only if adopted (Stone, & Arthur, 2005; Grace & Scholey, 2005; Young, 2005). Stone and Arthur (2005) identify controlling risk factors through adoption of healthy lifestyle practices as a significant and highly cost effective means of reducing the likelihood of CVD. Improvements in guideline adherence and program participation in the highest risk populations will result in the economically greatest cost-effective improvement in the program (Lowensteyn, Coupal, Zowall, & Grover, 2000; Nielsen, Faergeman, Foldspang, & Larsen, 2008). Specifically, underprivileged men make up high risk populations (Anand, Razak, Davis, Jacobs, Vuksan, Teo, & Yusuf, 2006), and consideration of their gender roles may help increase usage of programs and adoption of heart healthy practices (Emslie & Hunt, 2009).

UNDERSTANDING UNDERPRIVILEGED MEN'S HEALTH

Epidemiology Trends, Health Status and Social Inequalities

The health gradient in Canada can largely be explained by income, education, employment and working conditions, and health practices. Social epidemiology has often shown a correspondence between health and the social gradient; men and women in the lowest income quintiles are unhealthier than their counterparts in the highest quintiles. The health gradient can refer to a number of health indicators such as life expectancy, potential life years lost, mortality, and chronic disease (Butler-Jones, 2008; CPHO, 2012; Oliffe et al., 2010).

The gradient within a same-sex group is much steeper for men than women in Canada. As indicated by life expectancy, the difference between men in high and low income neighbourhoods are 4.7 years and for women it is 2.3 years (Butler-Jones, 2008; Oliffe et al., 2010). Marmot and Wilkinson (2001) attribute this to the importance of relative status. They argue that position in income hierarchy relative to those surrounding a person, as well as material circumstances, are important to health. Ideological masculine norms emphasis on status may be an additional explanation to the gradient difference between men and women.

Education level is also responsible for the health gradient. Current gender trends in educational attainment indicate that the gender gap in life expectancy is likely to widen as fewer men are entering higher education (Butler-Jones, 2008; CPHO, 2012; Oliffe et al., 2010). Lower education contributes to higher unemployment and poorer working conditions. Both of these conditions significantly contribute negatively to health status due to increase stress, as a result of high work demands, low job satisfaction, increased risk of injury, and job insecurity (Marmot, 2006; Oliffe et al., 2010).

The Impact of Unemployment on Health and Well-Being

Researchers in epidemiology and sociology focus on the relationship between health and work status. The effects of unemployment on health are threefold: poverty from a lack of income, stress, and health practices (Marmot & Wilkinson 2006). Financial strain is the largest factor relating unemployment and health, but the stressful experience of losing employment, and the change in health practices that occur with unemployment are significant contributors (Marmot & Wilkinson 2006; Raphael, 2012; Stringhini, Berkman, Dugravot, Ferrie, Marmot, Kivimaki, & Singh-Manoux, 2012). Furthermore, researchers show that poverty from these continual strains affect health from the decreased control over life circumstances, and hence, a person's capacity to take action (Raphael, 2000).

Unemployment, job insecurity, and lack of social benefits all contribute to poor health. By studying various types of labour markets Marmot and Wilkinson (2006) identifies the effects of the negative impact "the Mac- jobs" has on health (p. 78). The service industry 'mac' jobs represent part-time work in insecure, and low paying food service jobs. Instability in this work area results in fewer apprenticeship positions for training skilled workers (Marmot & Wilkinson 2006). Constraints of unemployment benefit programs stress workers to balance the risks of taking lower paying, insecure jobs versus leaving benefit programs (Marmot & Wilkinson 2006). The end result is more people either working in insecure jobs or being unemployed and supported by benefit programs.

Unemployment effects health by removing life purpose and impacting health practices. The loss of work creates a stressful life event as there is an associated loss of latent benefits of work, such as routine, self-esteem, and the respect of others (Marmot & Wilkinson 2006). Stigmatization with being unemployed contributes to a loss of status, which some researchers

suggest in combination with the loss of purpose contribute to the severe health implications unemployed men experience (Dumas & Bournival, 2012; Marmot, 2004). Health practices change with the anticipation of job loss and unemployment, leisure time provides fewer physical health benefits, such as, rejuvenation, and low resources results in poor nutrition (Marmot & Wilkinson 2006).

The impact of social position on lifestyle must not be taken lightly (Lynch, Smith, Kaplan, & House, 2000). For example, smoking is highest amongst the lowest income and poorly educated families (Butler-Jones, 2008; CPHO, 2012). Mortality-related alcohol consumption is highest among men in the lowest income quintiles (Butler-Jones, 2008; CPHO, 2012; Goodman, Nishiura, Hankin, Holder, & Tilford, 1996). As well, Cerin and Leslie (2008) show how both income and education level were equally important determinants of an individual's participation in physical activity. Gender and socio-economic positioning cannot be considered alone; the way these issues are approached requires careful consideration because factors do not simply add to one another, they interact creating complex health problems.

Threats to Masculinity

Poverty and the resulting marginalization can lead to men rely on masculine norms to define their self-worth. For example, men who are culturally and economically disadvantaged experience feelings of shame and use characteristics of traditional masculinity to establish their value in society (Charlesworth et al., 2004). In this sense, masculinity is important to underprivileged men because it is a representation of their inner worth (Charlesworth et al., 2004).

According to Garfield et al, (2008):

Many of the health differences between men and women can be traced back to male socialization...men experience tremendous pressure to adopt masculine

norms throughout their lives, and research has found that violating these gender norms often has more severe consequences for men than women. (p.475).

A situation, such as help seeking and the associated connotations of vulnerability, may trigger a real threat to a marginalized man's masculinity (Farrimond, 2012). Over time, these threats may also threaten health.

The response to situations undermining masculinity can result in what Connell (2005) identifies as protest masculinity: "a collective practice... where there is a response to powerlessness, a claim to the gendered position of power, a pressured exaggeration (bashing gays, wild riding [motorcycle]) of masculine conventions" (p. 111). For Connell (2005), such protest is often triggered by a physical weakness or inferiority. It consists of an over-compensation that is manifested in aggressive pursuit of status.

The threat to status, which undermines masculinity, comes from the marginalization of underprivileged men and helps to clarify the health problems of many underprivileged men. Status' connection with violence and masculinities helps to illustrate its impact on health. Violence represents an extreme end of the masculine expression spectrum where one man shows superiority, increasing status through physical domination over another (Courtenay, 2000). The relationship between violence and masculinity is seen in the "overrepresentation of men who use violence, especially heavy violence including homicide, sexual violence, racial violence, robberies, grievous bodily harm, and drug offences" (Sabo, 2005, p. 335). Acts of violence are frequently provoked by shame and humiliation, and are more common among marginalized groups (Charlesworth et al., 2004; Sayer, 2005). Violence shows how protest masculinity can illicit the over expression of masculine characteristics, such as domination, status, and physical superiority. The social essence of masculinity requires a strong social theory in order to

understand its impact on health, as well as an approach that includes other structuring dispositions of society.

Chapter III –Habitus, Masculinities, and Intersectionality in Cardiac Rehabilitation

HABITUS

This study draws on Pierre Bourdieu's sociocultural theory of practice and the concept of habitus in order to understand the lifestyles of social groups by considering the interplay between an individual's internal structures and the larger construction of society as a whole. It will help to understand the connection between the individual and society, internal systems of choice and the external social world, position in society, and practices that shape the body. Habitus is produced by history and by structures; it is a socially acquired, embodied system of schemes of dispositions, perceptions, and evaluations that orient and give meaning to practices (Bourdieu, 1984). In other words, it helps explain what guides people's 'choices' from a sociocultural perspective rather than a rational perspective (Bourdieu, 1984).

In this respect, Bourdieu argues that the habitus reflects the 'interiorisation of exteriority and the exteriorisation of interiority' (1984). Through a process of embodiment, the social conditions of a person's environment are incorporated into a person's internal mental structures, i.e., one's schemes of perception, disposition and appreciation, and then externalised in the form of practices (Wacquant, 2011). The expression 'poverty breeds poverty' exemplifies this process. Habitus relates this process of simultaneous embodiment of external structures (social condition, class) and expression of internal structures (frame of reference, identity) (Maton, 2008). Understanding the cyclical relationship that exists between structures and practices is important in analyzing how class and masculinity contribute to health.

Through studying practices generated by one's habitus the social scientist can uncover the deeper level dispositions, appreciations, and perceptions that guide people's actions (Laberge

& Kay, 2002). Social practices refer to actions and lifestyles. Bourdieu (1984) emphasizes the focus on practices and lifestyles in analysis of social structures and the body. For the study of men's attitudes and dispositions towards body care, practices, lifestyles, and the relationship to the body are best studied by focusing on body habitus.

Body Habitus

The body is an important dimension of the habitus. In *Distinction*, Pierre Bourdieu (1984) discussed class relations towards the body by the 'body habitus'. This concept was defined as:

An incorporated principle of classification which governs all forms of incorporation, choosing and modifying everything that the body ingests and digests and assimilates, physiologically and psychologically. It follows that the body is the most indisputable materialization of class taste (...) which express[es] in countless ways a whole relation to the body, i.e., a way of treating it, caring for it, feeding it, maintaining it, which reveals the deepest dispositions of the habitus (p. 190).

Sociologists have used body habitus as a tool for empirical research to study subjects in impoverished conditions and comment on greater social issues. For example, Wacquant conducted a study on the social blight and racial issues of the black ghettos in Chicago (2004). This study uses habitus' orientation of the men towards the destructive sport of boxing to uncover the social structures that generate certain values causing men to undertake damaging practices (Wacquant, 2011). Similarly, Dumas and Laberge (2005) use bodily habitus to study physical activity practices in ageing women. Their use of habitus helps to highlight how structural inequalities effect health dispositions in later life.

The Relationship to the Body

Laberge and Kay (2002) explain that in order to understand the logic of choice in one's health practices, the degree of attention and interest one has to their body, and the degree of risk they will assume, the sociologist must delve into a person's deeper dimension, the bodily

disposition. Bourdieu (1984) describes this bodily disposition as one's relation to their body, explaining how conditioning and education from one's position in the social structure generates the relationship to their body:

The social conditionings linked to a social condition tend to inscribe the relation to the social world in a lasting, generalized relation to one's own body, a way of bearing one's body, presenting it to others, moving it, making space for it, which gives the body its social physiognomy (Bourdieu, 1984, p. 474).

Bourdieu (1984) identifies two opposing types of relationships to the body (instrumental and reflexive) that are fashioned by the characteristics of living condition in the working class and professionals. The instrumental relation to the body represents a belief that is generally shared by working classes that bodies are used as a means to an end; in contrast, the reflexive relation is indicative of the more affluent classes, who conceive their bodies as an end in itself (Bourdieu, 1984).

Sociologists developed these concepts by including other angles of analysis, such as gender, age, generation, or ethnicity, which impacts the various ways culture influences lifestyles. For Bourdieu (1984), pressure to conform to social class discourses is a form of socialisation that begins at an early age and that involves a lasting relationship to the body. For example, Lee et al (2009) show how class conditions and masculinity shapes young men's relationship to their bodies and their engagement in particular type of sport and exercise. For instance, young men from private Australian schools engage in practices that affirm their masculinity through a display of economic capital and well-groomed body appearance, whereas, young men from public schooling engage in hard physical training affirming their masculinity by using their bodies in an instrumental fashion (Lee et al., 2009). Sport and physical activity participation represents a visible manifestation of such differences.

Capital

Pierre Bourdieu's notion of capital is important for identifying people's social positions, their resources, and their groups of reference. This concept refers principally to the different type of valued forms of resources. Two forms of capital are central to his approach: cultural and economic. A third form is also identified as social capital, which are the resources one can access as a result of their membership to a social group (Wacquant, 1998). Cultural capital primarily represents status and includes education, language articulation, bodily appearance, and social connections (Bourdieu, 1984; Moore, 2008). Distinctly, economic capital is largely a result of income and material possessions (Bourdieu, 1984; Moore, 2008).

These forms of capital are relatively autonomous from one another, yet they interact in their positioning of people within society. The relative positions people hold in society are useful in analysing how living conditions and power relations condition individuals to engage in certain practices (Dumas & Bournival, 2012). As such, capital is important for analyzing health because it often determines people's living conditions, their social and material conditions, and their social positions relative to others. It is the meeting of position and dispositions, mental structures and social structures, and their congruency or disjunction that generates practices.

MASCULINITIES

In addition to practices and identity that develops from class position, masculine identities continually develop in function of cultural expectations (Connell, 2005). In this way, masculinity, as a part of the social structure, orients practices and lifestyles. These are commonly referred to as gender roles, which shape men's dispositions to their bodies and health. Health researchers need to consider how these masculine dispositions, guided by position within the social hierarchy, shape practices during health activities such as cardiac rehabilitation.

Masculinities' Regulation of Practices

As part of a man's vision of the world, masculinity shapes values, tastes and preferences, and orients one's lifestyle practices. In this sense, masculinity is a structure in society that organizes lifestyles. Looking at the example of the ideological masculine characteristic of autonomy we can illustrate how this organization of lifestyle practices occurs. Establishing autonomy leads some men to act independently (Connell, 2005; Gill, et al., 2005). Men, who do not have access to social power and resources necessary for establishing autonomy in constructing their masculinity, seek other means to validate their gender (Courtenay, 2000). Continuous marginalization of underprivileged men by social institutions spawns a need for independence and control resulting in a generalised resistance to authority (Connell, 2005). Men who experience inferiority and inequality are prone to over compensate through the expression of certain specific masculine characteristics such as autonomy, and dominance.

The concept of masculine protest is important in understanding how masculinity contributes to anti-normative practices in underprivileged men. Several studies have described how underprivileged men's reaction to inequality obstructs their participation in health care programs (Courtenay, 2000; Evans et al., 2011; Oliffe & Thorne, 2007). Connell (2005) describes how those men, who feel powerless in society, have a tendency to resist institutions of power and people of authority by displaying ideological characteristics of masculinity. For instance, young poor men, who experience powerlessness during childhood, resist authority by claiming a gender position of power (Connell, 2005). As well, this is seen in the "collective practice of working class, especially ethnic minority, street gangs in the United States" (Connell, 2005, p. 111). Researchers have defined this exaggerated claim to the importance of masculinity in Western culture as 'masculine protest' (Connell, 2005).

Scholars also refer to ‘policing masculinity’ as another way masculinity regulates practices (Connell, 2005). For example, “gay bashing” shows how some groups of men that adhere to strong masculine ideals, enforce heterosexual norms and practices (Connell, 2005, p. 105). Similarly, Gill et al (2005) supports this notion, showing how men regulated their lifestyles by criticizing other men’s body appearance, such as piercing ears and wearing brand name clothing. Much of male forms of masculinity are reproduced by the social threat of having one’s masculinity undermined.

Men avoid engaging in situations and practices that threaten to undermine their gender identity. The narrow definition of ideological masculinity makes complete and constant adherence to the norms by men nearly impossible (Charlesworth et al., 2004; Pyke, 1996). In an attempt to meet masculine ideals, men carefully monitor their lifestyle practices in order to not lose status by exhibiting more feminine traits and characteristics. Such a loss of status has been linked to feelings of shame, low self-worth, low social and symbolic capital, anxiety, and social disadvantages (Charlesworth et al., 2004; Sayer, 2005).

Masculinities’ Regulation of the Body

The body is a crucial site of expression for masculinity; men use their bodies to physically display characteristics central to masculinity and promote the dominant definition of masculinity. Men’s emphasis on their bodies is partly the result of the visibility of the male body in popular culture (Dumas & Bournival, 2012; Gill et al., 2005). Men manage their bodies in ways to display class and acquire status (Connell, 2005; Gill et al., 2005). For Sabo (2005) the increase use of anabolic steroids testifies to the status men acquire from strength and muscular appearance.

Social context shapes definitions of masculinity, which in turn shape the way men regulate their bodies. Men's use of their bodies, displaying masculinities and reflecting social conditions, expresses how social class and gender effects health dispositions. Gill et al's (2005) study highlights the ways younger men model their bodily appearance in function of their societal and economic circumstances. These authors suggest that men's approach to their bodies coincided with the erosion of the work force and labour markets; men use their bodies in an instrumental fashion and as a means of displaying of physical capital (Gill, et al., 2005).

The Intersectionality of Masculinity and Social Class Inequalities in Health

The intersectional approach is appropriate for analysing dimensions of complex problems, such as gender and socio-economic inequalities in health. Although intersectionality is difficult to define and its analytical procedures are unclear, researchers strongly argued for its usefulness in the study of men's health inequalities (Annandale, 2013; Robertson, et al, 2009). For these authors, this approach is valuable for studying the inequalities within and between social groups. Intersectionality allows the analysis of the interaction of categories at the point of intersection (Annandale, 2013; McCall, 2005). In this study, the interacting categories are masculinity and class, and the point of intersection is cardiac rehabilitation. The intersection among multiple dimensions and modalities of social relations creates a unique hybrid category (Annandale, 2013; McCall, 2005). Again, in this study the unique hybrid category will be class-based masculinity in health. The hybrid category becomes the focus of the analysis, comparing the dimensions in relation to other social groups, such as underprivileged men's masculinity versus privileged men's (McCall, 2005). In this respect, the intersection of class and gender is useful in comparing lifestyle practices and dispositions between groups at different levels of socio-economic status.

Several authors have built on Bourdieu's sociocultural theory of practice to link the intersecting roles of social class and masculinity in health practices. Drawing on this approach, Lee et al (2009) highlight the interaction of masculinity with the other social categories (class, education, ethnicity, and geography) and argue that the most important factor in young men's physical activity choice is their relation to class norms (Lee, et al., 2009). Hence, masculinity has different degrees of influence in shaping practices depending on an individual's class.

To help explain anti-normative practices, scholars have called for an understanding of masculinity in the wider context of social class (Courtenay, 2000). Pyke's (1996) study on power inequalities in relationships explains that as men have more accepted forms of power (social economic status) their use of hegemonic masculinity is accepted as more justified and they express ideological masculine characteristics less. Further, as class decreases, masculine characteristics are less accepted and men express them more (Pyke, 1996).

Researchers explain this difference of men of different classes emphasizing ideological masculine characteristics as a result of underprivileged men using masculine characteristics to obtain status and negotiate social position (Charlesworth et al., 2004; Connell, 2005). In other words, men at the lower end of the social hierarchy have fewer means of experiencing power and status; therefore, they rely more heavily on the social value of masculinity. In order to be empowered, underprivileged men expand the use of masculinity into many different situations (Connell, 2005). In lower social economic status communities, over emphasis on status and pride (humiliation avoidance) has been linked to the disproportionate amount of violence of young black men (Sabo, 2005). Violence provides the opportunity to avoid humiliation through fighting and can increase status by the physical domination of others (Charlesworth et al., 2004; Sabo,

2005; Sayer, 2005). To explain different expressions of masculinity in different classes, and their related impact on health requires an intersectional analysis.

Researchers advise that studies on health should consider how the practices adopted by men are contingent on, and mediated through, unique social context and aspects of identity, such as age, socio-economic group, ethnicity, and sexuality (Robertson, et al, 2009). In this study, by not exclusively focusing on gender in the analysis allows opportunities to look at different axes of analysis, such as class, which interact to influence the gender practices that effect men's compliance to cardiac rehabilitation programs. Analyzing the intersection of some of the different social factors that contribute to men's health gives a sense of the interconnections that exist within the socioeconomic and gender hierarchy that contribute to the health inequalities seen in the Canadian populations. Body habitus as a relational concept in conjunction with the intersectional approach provide the framework to analyze the multifaceted issue of men's lifestyle management in cardiac rehabilitation.

Habitus as a Tool for Studying Cardiac Rehabilitation

Habitus can be used as a tool in order to account for the social and material circumstances involved in cardiac rehabilitation of men. Habitus helps in understanding the link between social structures and lifestyle practices that contribute to cardiovascular disease. It helps explain how social factors contribute to practices, but it does not replicate a single social structure, therefore, no one structure can be universalized perfectly (Bourdieu, 1984). This is because habitus is a result of the layering and storing of the diverse environment an individual encounters (Wacquant, 2005). Habitus can help uncover the structuring process of masculinity. By examining internal dispositions and the collective practice of men, masculinity's impact on lifestyles can be further understood. Connell (2005) supports masculinity as a collective practice stating men respond to

the circumstances of their lives collectively as much as they do individually. The analysis of health requires inclusion of the many social structures that men interact with and therefore an intersectional approach is justified (Annadale, 2013).

Chapter IV - Methods

This methods section will begin with an overview of the research project, and then explain how a masculinity approach can be included in the analysis. It concludes with laying out four key components of the project: the sample population and their characteristics; the recruitment process; the interview process and interview guide; and finally how the data was managed and analysed.

Project Overview

This study is part of a larger research project funded by the Social Sciences and Humanities Research Council of Canada, and was undertaken in urban areas of the Outaouais region of the Canadian province of Québec (Dumas, 2007). It explores three axis of analysis, i.e., social and material living conditions, social capital, and masculinities, in order to better understand the social variation of lifestyle of men suffering from cardiovascular disease.

As indicated in the theoretical framework, this specific study of masculinity draws on Pierre Bourdieu's theory of habitus. It applies the concept of class-based masculinity to better understand class, gender and the body habitus in the context of cardiovascular disease.

A critical examination of the health practices of men from different social classes requires a method capable of capturing various viewpoints within a population under study (Hesse-Biber, Leavy, & Yaiser, 2004; Lafrance, 1998; Taylor, 2001). Hence, in this study, the methods enable the researcher to capture the perspective of the underprivileged men in order to compare them with the middle classes group. More practically, understanding the different types of masculinity and their impact on lifestyles is achieved by in-depth semi-structured interviews that are firmly constructed from Pierre Bourdieu's social cultural theory.

Evolution of the Project

This project began in 2007 under the supervision of Prof. Alex Dumas. Four graduate students have completed their thesis on the data. The intersectional approach of class and gender used in this thesis is a distinctive lens to examine the data. Figure 1 shows the transition from the initial work of the overall project to the specific work during this thesis. The project was designed, participants were recruited, and interviews were performed and transcribed, prior to the start of this thesis. During this thesis, sixty interviews were read and coded for themes linked to masculinity, participant characteristics were refined, men were grouped according to their classification as “underprivileged” or “middle classes”, a theoretical framework integrating the components of socioeconomic class and masculinities theories was developed, data was analyzed using the new class-based masculinities framework, and a coherent model was created to present and discuss the results.

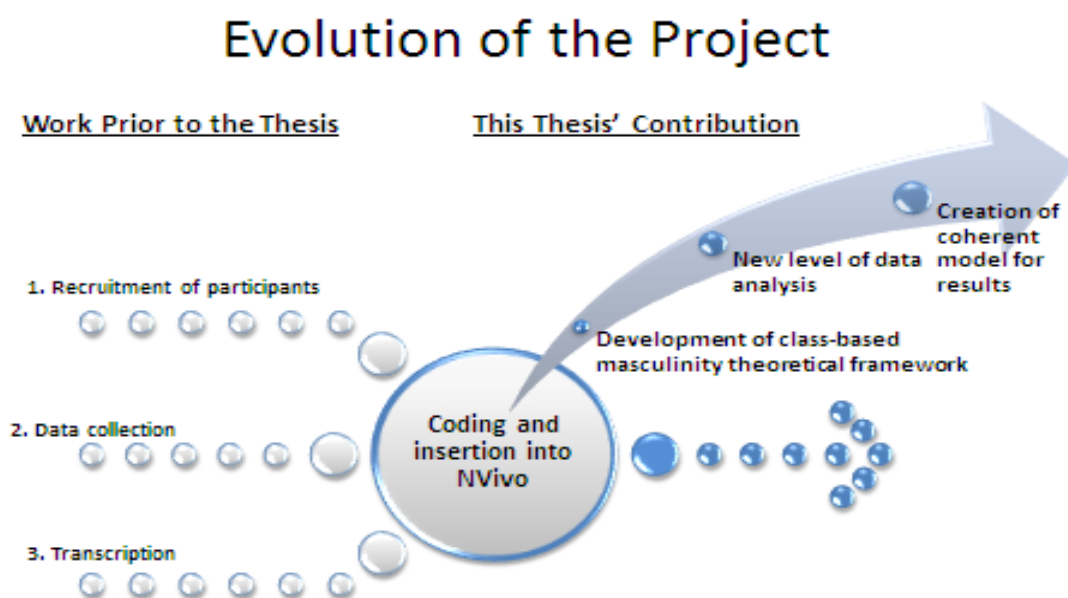


Figure 1. Differing components of the work done on the overall project versus this thesis.

Population and Sample

The research's geographic locations, shown in figure 2, were selected due to their high variance in social and health inequalities. The difference in mortality rates between socioeconomic groups is one of the highest among metropolitan areas of Quebec (Courteau, Émond, & Garvie, 2002; RHASSO 1996).

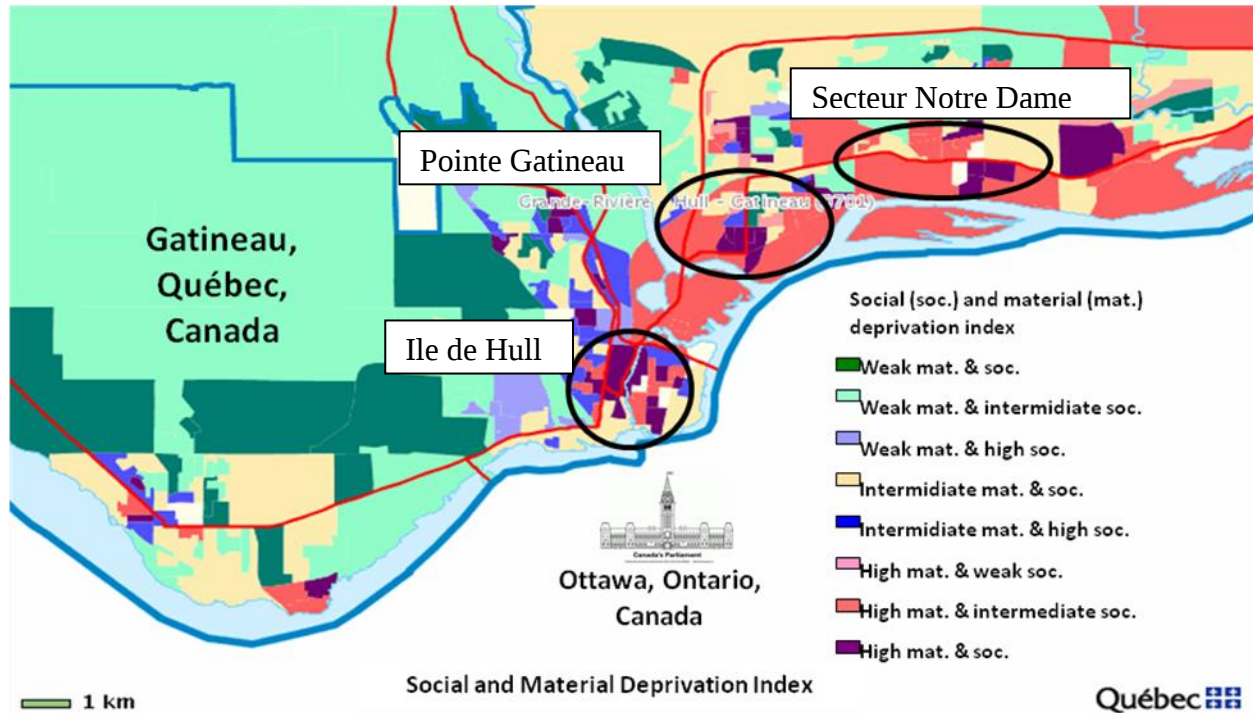


Figure 2. Three sites of data collections correspond to large contrasting social and material deprivation.

The study consisted of sixty in-depth, semi-structured interviews with men classified based on the Quebec index of material and social deprivation. The index uses indicators including education, employment, income, marital status (widowed, separated, or divorced), living alone, single parent family, etc, to measure levels of socioeconomic status. The sample was purposively selected in order to capture detailed information about the influence of masculinity in the greater context of class on men's lifestyle choices following cardiac surgery. All sixty men spoke French

as a first language and resided in neighbourhoods that ranged from high to low social and material deprivation (areas where the median annual income of neighbourhood residents ranged from above \$55,000 to below \$20,000), aged 25–84 years, and had experienced a cardiovascular incident requiring medical intervention and hospitalisation. To help limit other influencing conditions on lifestyle, only physically independent men, as defined by the Québec Ministry of Health and Social Services, were selected.

The initial sample was divided into four classes based on their level of social and material deprivation: high social and material deprivation, low social and material deprivation, lower-middle class, and upper-middle class. However, for the purpose of this study the participants were divided into two comparative groups by merging the two first and two last groups into “underprivileged” and “middle classes”. Table 1 identifies detailed characteristics of the participants.

Table 1.

Comparison of characteristics of participants from contrasting socioeconomic groups

Participant characteristics	Underprivileged (n=31)	Middle classes (n=29)
Completes public rehabilitation program	5	27
Follows a medical regimen	20	26
Attends regular medical follow-up exams	17	26
Smoker	24	12
Sedentary	18	17
Single	16	2
No regular contact with family	17	1
No children	8	1
History of drug addiction	15	0
History of imprisonment	13	1
History of child abuse	11	2

Thirty one men were categorized as underprivileged. The underprivileged group is based on definitions on a series of classical characteristics associated with social and material deprivation (high unemployment, frequent use of soup kitchens, food banks, and shelters, or living in public housing and frequently requiring government aid to secure basic needs). All the men in this class had experienced unstable employment with either long-term periods, or numerous short-term bouts, of unemployment and had worked in precarious conditions (part time work, low income security, low social benefits, or work undeclared). Most of the men were not professionally trained and worked in occupations such as construction, manufacturing, transportation (tow truck, removals, food delivery, trucker, and bus driver), charity, cleaning, or low-level administration. These men share the characteristics of low education as well as living in underprivileged areas. The difficult self-reported life experiences such as experiencing childhood abuse, legal incarceration, infrequent contact with family members, and living in isolation for a significant proportion of their lives were characteristic of this group, with the majority of men sharing these experiences. Most did not engage in regular cardiovascular exercise; many did not adopt healthy eating habits; and a large portion of the group did not take any prescription or non-prescription medication for their cardiac disease. The majority of the men's lifestyle practices were incompatible with cardiovascular health, despite their awareness of health experts' recommendations. Particularly with regard to recreational drug and/or alcohol abuse, and/or tobacco consumption, low attendance to medical follow-up consultations, and low participation in free information seminars on heart health.

The remaining twenty-nine men make up the middle classes. The middle classes were based off of characteristics of the middle to upper-middle classes (low social and material deprivation), such as blue or white collar workers, medium to high levels of education, living in

privileged areas, and low or no financial worries. Eighteen of the men are from the lower middle class and eleven are from the upper middle class. Very few, if any, of these men had characteristics similar to those in the underprivileged group. Discernable differences were in socio-demographic data (e.g., stability of work, education, neighbourhood conditions, etc.), which were primarily used as dividing between the middle classes and underprivileged group, and in life circumstances (e.g., divorce, childhood abuse, widowed, etc.).

Recruitment Process

Participant recruitment involved two distinct strategies to obtain a sample of contrasting socioeconomic status men. The first strategy used posters and oral presentations of the research in the field at local soup kitchens, homeless shelters, food banks, and businesses (eg., pubs, restaurants, corner stores), as well as the publishing of a short explanatory article in a local newspaper. Thirty-six out of sixty men were recruited as a result of the first strategy. The remaining twenty-four men were recruited by a second strategy, which involved contacting individuals who subscribed to a registry held by a cardiac rehabilitation clinic situated in a local public health centre. In a combined effort between the coordinator of the research project and with the help of nurses at the clinic, explanatory recruitment letters were sent out to men whose postal address located them in neighbourhoods associated with a particular socioeconomic status. It is important to note the men were paid (\$30) for their participation in the study. This is important for two reasons: one, men were asked why they did the study, which further characterised the need for money or material deprivation. Two, in a small way, the study directly benefited the men involved. The benefit aligns the project with the principles of the Tri-Council ethical standards for creating social infrastructures that supports research participants (Brown, 2005).

Interview Process and Questions

Semi structured interviews were conducted in locations chosen by individual participants. The interviews lasted between 60-90 minutes. The participants determined the location of the interviews. All interviews were transcribed verbatim and fictitious names were chosen by the participants in order to preserve their anonymity.

An interview guide (Appendix 6) was used to gather rich and in-depth information on four areas of Pierre Bourdieu's socio-cultural theory. As well, masculine specific questioning was included throughout the interview guide. The men's perceived value of illness prevention, sense of control over their future health, and perception of cardiac rehabilitation were also elicited.

The first series of questions addressed the participants' socioeconomic life circumstances and characteristics, the quality of their social environment, and the history of their cardiovascular disease. The topic of occupation was discussed at length as it, potentially, related to many of the themes involving masculinity and socioeconomic status. The second series of questions were directed at lifestyles and perceptions and appreciations of their health and health practices. Specifically, inquiries were made about the relationship with their doctor, their handling of health problems, and the change in their practices from before to after their heart disease. The third series of questions addressed the availability of resources which may have disposed participants to particular lifestyles. These questions were intended to uncover various barriers and constraints in physical activity and caring for their health. The final series of questions explored the personal trajectory of perceptions, attitudes and appreciation in regards to the recommended lifestyle by health professionals throughout the heart intervention process (diet, physical activity, medication compliance, medical follow-ups, etc.).

Analysis of Data

For the overall project, all the recorded data was imported into the data management software QSR NVivo 8 for analysis. Each transcript was read in its entirety to identify important themes in the individual interviews. Excerpts were coded, classifying portions of the interviews as themes, by two independent coders. The themes were divided according to classification between masculinity, socioeconomic status, and social capital. Themes that fit in more than one category were included in each. Analyses were compared to ensure consensus and consistency between the coders.

For this thesis, the health beliefs and experiences of illness of men were investigated using a constructivist perspective to develop themes that answer questions about social structures (Aguinaldo, 2012; Braun & Clarke, 2006). Masculinity represents the influences of gender on social practices and body care (Verdonk, Seesing, & de Rijk, 2010). Thematic analysis allowed the researcher to make meaning from the data that was useful in theorizing about the sociocultural contexts and structural conditions (Braun & Clarke, 2006).

The thematic analysis required discussion and consideration of epistemological perspectives, theory used to inform the research, the methodology that guided the analysis, and the specific aspects of deductive or inductive analysis, by the supervisor and researcher prior to undertaking the analysis. The thematic analysis' aim was to identify themes as a description of the data; therefore, the researcher first decided what counts as a theme (Braun & Clarke, 2006; Joffe & Yardley, 2003).

Thematic analysis is flexible in its approach; this analysis was a thematic analysis that includes two steps, an initial vertical analysis of each interview and a subsequent comparative horizontal analysis. To a large extent the focus was to perform a thorough vertical analysis,

reading through interviews and previously coded excerpts, taking notes, creating additional themes, and meeting with members of the original research team to discuss impressions and ideas.

Braun and Clarke's (2006) general structures to the process of analysis offered six phases of the process of noticing patterns of meaning in thematic analysis. The first five phases directed the vertical analysis. The first two phases were the process of familiarization with the data and the construction a list of potential codes from the data (Braun & Clarke, 2006). The third phase occurred after the researcher coded the data in their entirety; when he re-focused at the broader level of themes in order to relate potential themes and sub-themes in a structural hierarchy. The fourth phase was a refinement of the themes, removing themes that the data did not support. The refinement of themes was done in two levels: the first level involves the review of the coded data extracts to confirm a coherent pattern, and the second level confirmed coherence in relation to the entire data set (Braun & Clarke, 2006). The fifth phase was a process of clarification through establishing definitions and names for the themes (Braun & Clarke, 2006). The themes were based out of theory; therefore, the definitions were guided by these theories. Identifying what was interesting about each theme and the story each theme told in relation to the research question helped to solidify each theme independently and in relation to one another (Braun & Clarke, 2006). The sixth phase was the final analysis and write-up in the production of the report (Braun & Clarke, 2006).

The second step was a subsequent horizontal analysis that grouped themes, and made comparisons to highlight relevant differences and similarities between participants. The themes that emerged from each interview were compared and contrasted in order to determine the main themes and subthemes. Here themes that were similar were combined and themes with multiple

meanings were separated. Particular attention was paid to higher order themes that emerged from the entire data, which described how masculinity's interaction with body habitus in turn guided health practices during cardiac rehabilitation. A coherent model to present the results was created, this allowed for a new level of analysis by showing the relationships between themes and health practices.

Chapter V- Research article

Men's strategies after a heart incident: A class-based masculinities approach

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Abstract

Men in economically advanced societies are more at-risk of premature mortality due to heart disease than women, and this risk is inversely proportional to their SES. Underprivileged men have been identified as being less receptive to cardiac rehabilitation guidelines, yet research promoting heart healthy behaviours has often neglected the influence of social mechanisms on lifestyles. This study aims to understand the social variation in dispositions and commitments toward body care of men from two contrasting socioeconomic groups who have suffered from a cardiovascular incident requiring hospitalization. It draws chiefly on Pierre Bourdieu's socio-cultural theory of practice and concept of bodily habitus. Qualitative data was collected through 60 semi-structured interviews of an average duration of 90 minutes. Participants were Francophone men (average age 57.3). Results are organized according to three key strategies for human flourishing following a heart incident that are relevant to understand the dispositions to adopt (or not) health practices in the context of cardiac rehabilitation: (a) achieving a sense of security, (b) preserving autonomy, and (c) maintaining dignity. The paper discusses the socio-political characteristics of cardiac rehabilitation programs and the usefulness of class-based masculinities to understand health implications of lifestyles.

Key words: Men, health, Bourdieu, class-based masculinity, flourishing, cardiac rehabilitation, heart disease, security, autonomy, dignity, health lifestyles, underprivileged men

Health Inequalities, Men and Cardiovascular Diseases

Men in economically advanced societies are more at-risk of premature mortality due to heart disease than women, and this risk is inversely proportional to their SES (Chan, Gordon, Chong, & Alter, 2008; Steptoe & Marmot, 2002; Worcester, Murphy, Mee, Roberts, & Goble, 2004). In Canada, the Chief Public Health Officer's (2012) report indicates that cardiovascular disease (CVD) represents 29% of all causes of death and that men's mortality rates from these diseases are two times higher than women, making it the main contributor to health inequality. Pampalon et al (2009) have provided a detailed picture of these trends by drawing on the social and material deprivation index in the province of Québec. Premature death rates (between the ages of 34 and 75) from cardiovascular disease (CVD) of men in the lowest income quintile are 3.4 times higher than men and 10.4 times higher than women of the highest income quintile (and 2.9 times higher than women of the equivalent income stratum) (Pampalon et al., 2009). In this respect, gender and socioeconomic status (SES) can be conceived as two valid axes of social stratification in the study of men's cardiovascular health.

Although most major public health institutions have developed cardiac rehabilitation programs in order to improve secondary prevention, the Canadian Guidelines for Cardiac Rehabilitation and Cardiovascular Disease Prevention indicate their modest success in terms of participation rates (Stone, & Arthur, 2005). Researchers identify two key points for improvement: the low enrolment (approximately 30%) of eligible patients (Grace et al 2011) and high dropout rates (51% within the first 100 days) (Martin et al., 2012).

In response to low enrolment and attendance rates, studies have detailed typical profiles of patients that influence participation. Characteristics of non-participants include sedentary lifestyles (Lane, Carroll, Ring, Beevers, & Lip, 2001), disabling co-morbidities (Suaya, et al.,

2007), social isolation, difficulties accessing transportation (Schulz, & McBurney, 2000), scheduling conflicts, lack of time, apprehension about program format, and lack of motivation (Evenson, Johnson, & Aytur, 2006; Farley, Wade, & Birchmore, 2003). The lack of knowledge of risk factors for CVD, and on the benefits, and content of cardiac rehabilitation programs also contribute to non-attendance (Tod, Lacey, & McNeill, 2002). Furthermore, Grace and colleagues (2011) argue sociocultural factors, such as gender and employment status, may not be adequately considered for their role in the compliance of cardiac rehabilitation programs and the modification of risk factors in cardiovascular health. Despite research on increasing the use of cardiac rehabilitation programs, sociocultural factors appear to be underemphasized.

Although health promotion and cardiac rehabilitation have been put forward as solutions to reduce the incidence of CVD, few studies have provided a detailed analysis of class-based lifestyles and cardiac rehabilitation of men. By drawing on sociocultural and gender approaches to social inequality, this study aims to compare and contrast the dispositions and commitments towards caring for the body of two contrasting socioeconomic groups of men who have suffered a cardiovascular incident requiring hospitalization.

Masculinity, Health and Anti-normative Lifestyles

Gender differences in health have been explained by biological and social factors, and with no single explanation for all causes of death, gender norms are considered a major contributing factor (Dumas & Bournival, 2012). Many of the health differences between men and women can be traced back to gender socialization (Garfield, Isacco, & Roger, 2008). As described by Evans, Frank, Oliffe & Gregory (2010), ‘the tendency for men to engage in high risk practice (e.g., excessive use of alcohol; high speed driving etc), avoid preventative care, delay treatment, and ignore health information and physician recommendations can be

interpreted as practices of masculinity and, in turn, contribute to poor health outcomes for men' (p. 9). Risk-oriented lifestyles described by several researchers are seen in underprivileged men's attitudes towards health and health care (consumption of unhealthy diets, tobacco use, alcohol abuse, high tolerance to pain, inappropriate use of medication) (Charlesworth et al., 2004; Courtenay, 2000; Dumas & Bournival 2012).

In a study on social policy, programs, and promotion of men's health in Canada, Robertson et al. (2009) advise that studies on health should consider how practices adopted by men are contingent on, and mediated by, the unique social context and aspects of identity (age, socio-economic group, ethnicity, and sexuality). Two areas of enquiry are often proposed for improving delivery of men's healthcare. First, scholars call for a better explanation of the role played by men's anti-normative health practices and their reactions to socioeconomic inequality (Courtenay, 2000; Dumas, Savage, & Stuart, 2013). Second, there is a continuing interest on the influence of traditional masculine characteristics, such as dominance, self-reliance, and stoicism, in low adherence to normative health lifestyles (Courtenay, 2000; Evans et al., 2011; Oliffe & Thorne, 2007; Savage, Dumas, & Stuart, 2013).

The anti-normative lifestyles of men who feel powerless due to their position in the social hierarchy can be the expression of 'protest masculinity' (Connell, 2005). Such men have a tendency to resist institutions of power and people of authority by displaying ideological characteristics of masculinity. Responses to situations that undermine masculinity can result in what Connell (2005) identifies as 'a collective practice... where there is a response to powerlessness, a claim to the gendered position of power and a pressured exaggeration of masculine conventions' (p. 111). The recourse to masculinity in compensating for feelings of inferiority contributes to explain the health and lifestyles of low income men (Charlesworth,

2004). The concept of ‘hypermasculinity’ has also been drawn upon to express the health risks linked to the overemphasized forms of masculinity in low-income men (Dumas & Bournival, 2012).

Pierre Bourdieu and Class-based Masculinity

The body is a crucial site of expression for various forms of class-based masculinities, as well as a representation of one’s lifestyles (Lee Macdonald, & Wright, 2009; Pyke 1996). In *Distinctions* (1984) Bourdieu exposes the intersection of socioeconomic class and masculinity by presenting his notions of instrumental and reflexive relationships to the body. The first referring to working classes and how they perceive their body as a means to an end, whereas the second type refers to dominant classes who perceive the body as an end in itself. Boltanski (1971) used this concept more explicitly to explain the social variations of attitudes and practices towards health. While recognising the strong influence of socioeconomic factors on one’s care of the body, the impact of masculinity is increasingly being documented. Gill, Henwood, and McLean’s (2005) study highlights the ways men model their bodily appearance in relation to different socio-economic and ethnic backgrounds, sexual orientations, and different regional locations. For these researchers a striking homogeneity is shared in discourses towards the body resulting from masculinity. Lee et al., (2009) argue that men engage in practices that fashion a masculine body type and draw on their body as a means of displaying physical capital.

As an integral part of Pierre Bourdieu’s conceptual apparatus, the notion of body habitus has been widely used to understand the variation of lifestyles of social groups in a given society. In the field of public health, it enables researchers to assess the barriers and socialization processes occurring within a given socioeconomic strata, and to grasp class/gendered patterns of care of the body and management of chronic diseases (e.g., Cockerham, 2013; Dumas et al.,

2013; Poland et al, 2006; Savage et al., 2013; Williams, 1995). Its usefulness to study lifestyle inequality lies in its capacity to understand how living conditions associated to a social position fashion distinctive perceptions, preferences, tastes, and attitudes towards the body, which in turn orient the adoption of discrete sets of practices. Although there have been a substantial number of frameworks to study health behaviours, the contribution of Bourdieu's sociocultural theory lies in its focus on social structure, social reproduction, power relations, and social significations of practices (Cockerham, 2013).

There are two components in this approach that are relevant for the study of anti-normative behaviour in the context of men's health. The first is more phenomenological. By drawing on people's lived experiences, it conceives practices as the result of embodied practical knowledge. In this sense, lifestyles are understood as the outcome of socially acquired sets of priorities and tastes fashioned by living conditions (e.g., material, familial, and social characteristics), rather than the product of rational calculation or personal attributes (Bourdieu & Wacquant, 1992). The second component refers to the sociology of affect (Bourdieu, 2000), and identifies various sources that increase human flourishing, i.e., dignity, autonomy, absence of pain, etc (Sayer, 2005). Why do people feel compelled to pursue unhealthy behaviour when they wholeheartedly know they should not? This suggestion is at the heart of Bourdieu's social critique of judgment and taste. Human beings are emotionally connected to the world, and capable of, and susceptible to, suffer and flourish, which shapes their dispositions and practices. Andrew Sayer's two volumes, 'The moral significance' (2005) of class and 'Why do things matter' (2011) extend Bourdieu's socio-cultural theory by focusing on the role played by class-related emotions on concerns for flourishing (that may run against normative standards) (Sayer,

2011). In this sense, social variation of health lifestyles can be traced to the different means people use in the process of moving towards human flourishing.

This qualitative study focuses on key strategies towards human flourishing, in order to identify dispositions and commitments towards body care. While specific conditions of flourishing have been discussed for their bearing on various components of lifestyles, they have yet to be used in an empirical study examining health lifestyles and cardiac rehabilitation. It is argued that the strategies used by men to achieve a sense of security, preserve their autonomy, and maintain their dignity after a heart incident are the outcomes of socioeconomic inequalities and have a strong influence on the degree of investment in cardiac rehabilitation.

Methods and Context

This study is part of a larger study funded by Social Science and Humanities Research Council of Canada. It examined the social variation of lifestyle and cardiac rehabilitation practices of men from contrasting socioeconomic strata by focusing on three themes: socioeconomic inequalities, social capital, and masculinities. The Outaouais region in the province of Québec (Canada) was selected following public health warnings of two research reports of the region's Direction of Public Health. The reports expose the health paradox of the region: poor health standing relative to high income per capita. It singled out the high social gradient in health, and high level of cardiovascular diseases in comparison to other areas of Québec (RRSSSO, 1996; Courteau & Finès, 2004).

This specific study consists of sixty in-depth, semi-structured interviews with two socioeconomic groups of men. All men were French-speaking, lived in neighbourhoods that ranged from high to low social and material deprivation (areas where the median annual income of neighbourhood residents ranged from above \$55,000 to below \$20,000 CAN), were aged

between 25–84 years, (average age 57.3), and had experienced a cardiovascular incident requiring medical intervention and hospitalisation. See Table 1 for participant characteristics. The underprivileged group (n=31) was associated to high social and material deprivation (high unemployment, frequent use of soup kitchens, food banks, and shelters, or living in public housing and frequently requiring government aid to secure basic needs). The middle classes (n=29) were defined by low social and material deprivation (blue or white collar workers, medium to higher levels of education, living in privileged areas, low or no financial worries).

As presented in Table 1, both groups differed in terms of socio-demographic data and lifestyle. Key differences between the underprivileged versus the middle classes are in lifestyles and health practices seen in their adherence to: public cardiac rehabilitation programs (31% vs 90%), following a medical regimen (69% vs 87%), attending regular medical follow up exams (59% vs 87%) and smoking (83% vs 40%). As well, key differences are seen in their life circumstances: history of drug and alcohol addiction (52% vs 0%), estranged from their families (55% vs 3%), single (48% vs 7%), no children (26% vs 3%), history of imprisonment (45% vs 3%), and history of childhood abuse (38% vs 7%). The groups' levels of sedentariness were similar (58% vs 59%) as a result of physical laborious work versus engagement with cardiovascular exercise.

Participants were recruited from the urban areas of the Outaouais region of the province of Québec between 2008 and 2009 and interviews were transcribed verbatim in French. Recruitment used two distinct strategies. The first strategy involved the publishing of a short explanatory article in a local newspaper, and used posters and oral presentations featuring the research at local soup kitchens, homeless shelters, food banks, and various businesses. The second strategy involved contacting individuals who subscribed to a registry held by a cardiac

rehabilitation clinic in a local public health centre. With the help of nurses at the clinic, the coordinator of the research team sent explanatory recruitment letters to men whose postal addresses featured neighbourhoods associated with a particular socioeconomic status.

Interviews were conducted in locations chosen by individual participants, lasted between 60-90 minutes, and were recorded along with interviewer notes on impressions gleaned during and after the interview. Pseudonyms were chosen by the participants to protect their anonymity. The interview guide used was consistent with Pierre Bourdieu's socio-cultural theory. Four themes were discussed: (a) socioeconomic life circumstances, (b) lifestyles, perceptions, and appreciations of health and health practices, (c) resources available, including barriers and constraints, and (d) trajectories of perceptions, attitudes, and appreciations towards health professionals and recommended practices during the heart intervention process. The interview transcripts were imported into the data management software QSR NVivo 8 for analysis. Each transcript was read in its entirety to identify important themes in the individual interviews. Excerpts were coded, classifying portions of the interviews as themes, by two independent coders. The thematic analysis included a vertical analysis of each interview and a comparative analysis. Each interview was read, auto-coded and coded, and then compared in order to highlight differences and similarities between participants. Particular attention was paid to higher order themes, which showed the relation between masculinity and lifestyle.

Results

Our results are organized according to three key strategies for human flourishing following a heart incident that are relevant to understand the dispositions to adopt (or not) health practices in the context of cardiac rehabilitation: (a) achieving a sense of security, (b) preserving autonomy, and (c) maintaining dignity. Table 2 presents the ways each socio-economic group of

participants pursues these strategies to distinctive ends. Although strategies are presented separately for analytical and presentation purposes, it should be noted that they are interconnected.

Achieving a Sense of Security

Achieving a sense of security after a heart incident was present in all interviews and was sought by minimizing threats to social and physical vulnerabilities. The underprivileged participants managed their social and physical vulnerabilities through continuity of their identities (gender and class) and lifestyles, whereas the middle classes group strove to manage their vulnerabilities by making recommended changes in their health practices in order to help alleviate threats to their security.

Minimizing Threats to Social Vulnerabilities

The continuity of identity and the maintenance of personal values, commitments, and attachments were important distinctions between groups. The level of commitment to gender roles in response to CVD varied between groups. Many underprivileged men adopted ‘hyper-commitments’ to traditional forms of masculinity despite the health risks they involved. This finding is consistent with Courtenay’s (2000) inference that men who are denied access to positions of power can develop a form of masculinity characterized by risk-oriented lifestyles. In this respect, many framed risk-taking in terms of traditional masculinity and as a means to differentiate from femininity: *“Men are more stubborn then women. We don’t want to see it, we don’t want to see what’s wrong. We’d rather just have things pass than complain... I know my heart is tired, it’s certain. But I’m very pig headed, my father never went to the hospital either, it’s in the family”* (Eddy, 47, unemployed). Rhetoric of masculinity and toughness were often presented as being incompatible with secondary prevention: *“There are people who can take the*

pain [of CVD] because they have a good attitude. It's your attitude that makes you live. It's nothing else" (Joseph, 79, formerly in the army, seasonal unemployed). Acting stoically when facing physical limitations at work, despite the discomfort of the symptoms, was also frequently mentioned: *"there was [a co-worker] who came to take me. He was supposed to take me to the hospital... I said "no, no, it's going to pass. I feel better already"* (Jean, 35, cook). They engage in physically strenuous labour and tolerate high levels of pain despite the known risks to their health: *"I didn't even want to go to the hospital. I told myself: 'ignore it'."* (Lionel, 55, community support); *"I have [angina] pain but it never stops me"* (Francois, 58, delivery driver). Drawing on Sayer (2011), the underprivileged participants attempt to preserve the things that matter to them, the characteristics of their identity, values, and attachments-all of which make up their self-worth. They resist the idea of physical weakness and are more inclined to pursue contraindicated activities (e.g., intense physical exertion after surgical interventions to their heart).

Conditions of material deprivation, the management of economic insecurities and threats to socioeconomic status, also strongly contributed to deprioritized commitments towards improving cardiovascular health and towards adhering to health guidelines. *"I am what you could call a workaholic.... I need to work. I won prizes as the most productive mover.... I had to quit lifting loads.... But it didn't take long before I went back moving furniture again.... then I had my fourth heart attack"* (Paul, 44, former mover). Similarly, Joseph (79, seasonally employed and unemployed) explains that for financial reasons he will work as long as he is physically able to, although he has been advised against it: *"If I am capable to lift my butt then I will work. But I'm not supposed to"*. Pierre-Luc, a 57 year old truck driver, was asked what the hardest part of going through the heart attacks and operations: *"The loss of money... the security*

of a salary, the guarantee of a decent life”. For the underprivileged men, the importance of paid work, expressed in terms of economic viability and employee reliability, conflicts with post-operative recovery. Max explains how after he was hospitalized for complications with his heart he immediately returned to work. *“Oh no! I didn’t take any time off. I went back on my tow truck, 2 or 3 hours after getting out the hospital”* (Max – 44 year old, tow-truck operator).

Analysis of middle class respondents’ interviews shows that threats to identity and to personal values were much less present. Their commitments to masculinity were expressed in terms of preserving long term socioeconomic status, and less in terms of characteristics of traditional masculinity and gender roles. As argued by Robidoux (2012), ideological traditional masculinity may not be representative of those at the top of social hierarchy. Preserving their masculinity had much less bearing on their adherence to normative health guidelines. They felt threatened by exposing their vulnerabilities and accepting help from family, friends, and co-workers: *‘My wife knows everything about my physical state. She knows that I have certain physical restrictions. She tells me: “be careful.” I have no objection to that. I have a disease of the heart. I’m conscious of that. And for me it’s not, it’s not humiliating’* (Marc, 58, accounting director).

CVD acted more as a biographical rupture in their lives, where values and attitudes shifted and new behaviours were adopted in order to improve their health. Furthermore, their life circumstances (work, financial, social, and family environments) offered more support in adopting lifestyle changes. For instance, unhealthy practices adopted at work, within families, and during social activities were identified as areas of adjustment under the guidance of cardiovascular health guidelines: *‘My dad had to do hard physical work, so he was always hungry. He needed to eat! But me, who learned to eat like him, I sit on my butt for 8 hours a day,*

in an office, pushing a pen. It can't be good. It takes time to break old habits. That's life!' (Jean-Paul, 73, banker). Stable employment and work benefits (paid sick leave) secured their socioeconomic position, contributing to their greater willingness to make the most of their convalescence.

The middle classes group were more inclined to adapt their lifestyles by reducing risk-oriented practices (alcohol consumption, aggressive sport participation, and physical exertion), selecting new practices (improving diet and physical fitness), and by mobilizing their social networks (family members and friends) in order to compensate for their health condition in ways that allowed them to maintain their identity. The "security of change" summarizes many of their justifications to improve their health and extend their quality of life.

Minimizing Threats to Physical Vulnerabilities

Managing threats to physical vulnerabilities was a second strategy for achieving a sense of security. Whereas the middle classes group attempted to prioritise health enhancement by multiple means, underprivileged conditions tended to downplay the consequences of symptoms, severity of the disease, impact of risk factors, and risk of disease progression. In this respect, as pointed out in Courtenay's (2000) seminal article on health and well-being, lower status men's attention to their physical well-being undermines and threatens their power and authority. Participants in this group resisted the idea of physical weakness in order to continue with their daily activities: *'Personally, I'm more of a person who thinks [my health] is better than it really is. I am traveling around and I am in bad health, but it's only when the problems of the heart gets to 80% bad then it is serious. Me, I am only 50%'* (Eddy, 47, unemployed). In another example, Albert, a 73 year old retired welder, explains how he downplayed the symptoms of a myocardial infarct by never going to the hospital: *'I never went to the hospital. Had I gone they would have*

caught my stroke.... I'm hard on my body you know.... It was an infarct. I don't want to go to the hospital for nothing, I feel no need'. They also minimized the seriousness of the disease through weak emotional investment towards their diagnosis and prognosis: 'It doesn't even tempt me to know what was happening. I didn't even ask my doctor' (Lionel, 55, community worker). In Charelsworth et al's. (2004) study on men's experiences of living inferiority, familiarity of surroundings was reported as important aspects of their sense of security. Similarly, the results of this study show an increased need for security resulting from the instability provoked by their disease. Retaining previous lifestyles provided security and comfort by maintaining familiar physical environments. In this sense, sudden lifestyle changes recommended by health guidelines created further instability, were perceived as impractical, and offer no concrete guarantee in the men's quality of life.

In a divergent socioeconomic setting, the middle classes group attempt to minimize the threats to their physical vulnerabilities by increasing their investments in health practices. The participants were more likely to be active and attentive to addressing their health needs: *'I now listen to my body. I use to have a habit of doing unhealthy things. I now analyze my condition. I keep a closer eye on my body'* (Jackie, 61, civil servant). More specifically, they expressed more willingness to introduce a physical activity regimen (participating in local exercise classes, walking, skiing, cycling) and diet plans (in accordance with national health guidelines) in their daily lives. They are also more receptive to health professionals, to attending cardiac rehabilitation programs, and to recommendations made during cardiac rehabilitation (e.g., health monitoring, emergency consultation and assessment, medication compliance, etc.): *'At every cardiac rehabilitation session they [health care professionals] give you information, and chat with all the guys there. You find out what you were doing wrong and what you can do to fix it. I*

have put it into practice. I follow it to the letter' (Julian, 65, retired accountant). This group also showed more diligence in conducting personal research and seeking out specialized health care services to mitigate unwanted side effects of CVD: *'I consulted a sexologist. I wanted to know. If I have a serious problem, I want to know what is going to happen'* (Richard, 62, laboratory technician).

Preserving Autonomy

Autonomy and control were major themes in the interviews. Strategies to preserve autonomy are expressed in relation to illness and healthcare (health services, medical bureaucracy, and relationships with health care providers). They were broken down into two interrelated components: maintaining self-command and exercising agency. Generally speaking, adhering to health guidelines was perceived as a threat to autonomy within the underprivileged groups, and conversely, as an enhancer of autonomy for the middle classes of men.

Maintaining Self-command

As a component of autonomy, self-command is defined as the “steady equanimity which enables a man... to exert his reasoning faculty with coolness, and to do what existing circumstances require” (Ham, as cited in Ogilvie 1883, p. 26). More precisely for this study, it refers to a peaceful state of mind and a sense of self-control over one’s lifestyles regardless of whether it differs with normative health prescriptions. The consequences of maintaining self-command differed greatly between both socioeconomic positions. The underprivileged group tended to react in highly defensive ways towards restrictive health and medical regimens, perceiving them as threats to their autonomy and personal commitments. In almost every interview strong opinions were expressed regarding the need to retain self-control:

They tell me to watch my cholesterol; they tell me to watch my sugar, and all the things like that. Yes, they say I have to change my habits. That makes me laugh.

There is no cutting salt for me... I like lots of salt. My wife, she says, 'watch what you are going to eat there'... She always is putting her nose into my affairs. She tries to control me.... Shit! You want me to eat like a bird?! Look at my size; I'm not going to eat like a bird. (Claude, 56, bus driver)

Threats to self-command were also expressed by calling into question the feasibility and effectiveness of health regimens and questioning the authority of the medical system: *'If you don't take them [prescribed medications], you'll die. The doctor said "you won't last long." ... I had said to myself: "they are dumb"'* (Danny, 37, unemployed). They were aware of barriers to adopt recommended lifestyles. The barriers and lack of opportunities for adopting health guidelines showed incompatibilities with the health-oriented approach promoted by health institutions:

I said to myself, look, I am tired of fighting against life. Life is not that great.... It wouldn't be the same if I had a big house, and a big bank account, a limo, big car, truck and all. Maybe then. Life would be nice, but when you fall on social aid, pfff, you don't have a life anymore my friend. (Max, 44, tow truck operator)

Amongst the most noticeable examples of these defensive responses were their commitments to paid work and resistance to prescribed work restrictions (e.g., lifting restrictions, rest period, etc.). Hence, many expressed the idea that their sense of self-control was being infringed upon because of incompatibility between personal, work, and institutional schedules:

It's the wait. The wait for the doctors.... They send you to go and sit for 4 hours before your turn arrives. Because they will not wait, "hurry for your appointment. No it's urgent". They want to see you immediately, but for you to see your specialist, a cardiologist, he will not rush. You have to wait your turn. You have to wait for your appointment. You don't have a choice. (Pierre-Luc, 57, trucker)

The middle classes group felt capable of maintaining their self-command despite various implications and commitments associated to health regimens. Middle class circumstances provide a highly different meaning to health guidelines; they were used to enhance autonomy. Interviews in this setting clearly reflect a higher receptiveness to relinquishing control to health

institutions. Healthcare and support networks are perceived much more as a means to enhance autonomy and maintain self-command.

Exercising Agency

The second component of autonomy is exercising agency. Cockerham (2005) defines agency as a process where individuals critically evaluate and choose their course of action by considering their past habits, the present, and the future. In our study, underprivileged participants exercised their agency in responding to interactions with health professionals and the hospital setting (clinics, offices, labs, and group rehabilitation). Again, increasing agency had distinct bearings on conformity to health guidelines for each group. Many underprivileged men exerted their independence via managing emergencies and their CVD symptoms by their own means and beliefs (e.g., self-medication, self-treating). Their desire to assert their autonomy was often expressed as resistance to healthcare systems, resistance to social support, weak investments in interactions with healthcare professionals, limited interactions with counselling or support groups, and rejection of prescribed treatment regimens and work limitations. For example: *‘There is a coffee meeting for [cardiac rehabilitation]. You can do activities and all sorts of things. It’s not my taste. I don’t have time for that. It does not tempt me’* (Danny, 37, unemployed); *‘My wife brought the ambulance. They came and checked me out; I didn’t want to go to the hospital. I said “no, no, it will pass there...”’* (Fernand, 63, former labourer); *‘The ambulance came three times. Apart from that [seeing the paramedics] I never saw the doctor. Hospitals make me sick. I’m allergic to doctors’* (Lionel, 55, soup kitchen clerk).

In a quite different setting, participants from the middle classes exercised their agency with a distinctly different approach. They maintained physical autonomy by implementing health recommendations into their lives. They invested more efforts in reducing disease progression and

co-morbidities: *‘No one had told me “if you drink lots of beer it will do this. If you smoke lots it will do that. If you do this, if you eat the way you want it will do that.”.... Once they told me that I stopped everything’* (Jean-Marie, 77, shipping and delivery clerk). The interviews clearly show that they perceive fewer threats to their autonomy. They made stronger efforts to readjust their lifestyles, personal relationships, and social environments in order to better their chances to maintain their cardiac rehabilitation requirements:

My wife read [the documents of the CRP].... She must be sensitive to my needs.... I've always told my wife: “If you make meals that are high in fat.. you do not really love me. Well anyway, you don't me love very much.... Do you want to increase my health problems? If I constantly eat fat, if I constantly eat fatty meats, if I constantly eat desserts that are fattening, well then you do not love me!”.... It's like giving sugar to a diabetic; well you don't really love that person, do you? This aspect is clearly important in our relationship! (Jean-Marc, 57, senior manager)

The middle classes group's active involvement in their health caused them to seek additional support and use specialized health care services. They were prompt to request help in moments of unstable symptoms, made frequent requests for health related information, and had increased interaction with health care professionals in the hopes of reducing their symptoms.

Maintaining Dignity

Although dignity can be defined as a sentiment intrinsic to all humans, its specific features are closely related to social position because they depend on social interaction and power relations (Sayer, 2005). See content in Table 2. Maintaining dignity was achieved by the participants through gaining pride and avoiding shame, and was viewed as a distinctive strategy to flourish, shaping their concern for care of their body and normative lifestyles. The analysis shows that the underprivileged participants strove to maintain a baseline level of dignity, which often did not involve strong investments in health, whereas the middles classes continued their pursuit of a dignified life by attempting to extend their health.

Gaining Pride

As described by Connell (2005), the adherence to traditional forms of masculinity was identified as a source of pride for many underprivileged men. Pride in gender status has led to conceiving unhealthy lifestyles of underprivileged men as ‘hyper-masculine responses to class inequalities’ (Dumas and Bournival, 2012, p. 43). In this respect, many actions of the underprivileged group were adopted despite the health risks and physical discomforts they imposed. Male bravado was expressed in the avoidance of healthcare services, postponing physician appointments, and attitudes of fighting the disease were often cited as sources of pride: *‘call the ambulance only when I crash to the ground. Then you send me to the hospital!’* (Eddy 47, unemployed). Resisting CVD induced pain and help seeking also reaffirmed masculinity:

Shit, did my chest hurt, I had trouble breathing, walking, I was soaked [by sweat], and I was coughing like crazy.... I had headaches, sweating all the time. I was like this for two months.... Two months my man! I'm a one tough man! (Boxer, 46, unemployed).

Working class masculine identities were associated with being independent, uncompromising, stringent, industrious, and strong, having a high pain tolerance and a high commitment to paid work. Work as a source of pride also came into contradiction with their cardiac rehabilitation:

They used to call me Paul-the-Machine. I have always taken my body to its limit.... After my second heart attack, the doctors gave me strict instructions that I couldn't lift more than 15 kilos... that I needed to get a lot of rest, that I had to change my eating habits, stop smoking and to completely change my lifestyle.... But I am a mover, so, I went back to moving furniture... I know it is stubbornness, I know it is pride. I can't accept the fact that my body can't follow through with the work anymore.... In the end you're constantly going back to the hospital.... I don't think I am an overly proud person, but I have pride when it comes to my values as a man. I am a man, and a man is made to work, we're made to be strong... but I know it is stubbornness... My boss told me: “listen, you're going to have to be careful”. I said: “I am not going back into the office” So I stayed on the truck up until I had my 4th and 5th heart attacks. That was my last job. (Paul, 50, unemployed mover).

The relationship between dignity and health lifestyles was conceived differently by middle classes participants; they were much less inclined to compromise their health in order to secure their pride. If maintaining pride was an issue, their health itself was conceived as an enabling factor, rather than a barrier. For instance, engaging in activities with family, participating in leisure activities, or maintaining performance and work were sources of pride that could not be achieved in a state of ill-health. Hence, pride was gained by managing their CVD.

Avoiding shame.

Shame is a social emotion and a powerful indicator of social inequality because it is the result of social judgement (Sayer, 2005). Bourdieu (2000) describes shame as a form of bodily emotion that results from an inscription of a relation of domination into the body. Several researchers have explained the influence of shame on lifestyles (Charlesworth et al., 2004; Scheff, 1990; Yagasaki, 2013) and the influence of shame on men's health practices (Dumas & Bournival, 2012; Sabo, 2005). The avoidance of shame had a powerful influence on the health practices of men in the underprivileged group. Two main strategies for avoiding shame impacted cardiac rehabilitation practices the most: resisting the need for care and concealing body impairments. These strategies decreased communication and interaction with healthcare professionals and were starkly contrasted by the middle classes group. First, many underprivileged participants expressed their embarrassment in seeking help. One describes how he did not want anyone to know he was experiencing weakness, dizziness, and feeling faint:

I stood, I walked quietly. I felt like I was going to fall. I walked quietly, like I was a little old man. But I stood straight. I made it like nothing happened. Because there was people around and I didn't want to be ashamed. So I walked just more slowly, nice and slow. (Jay, 34, unemployed)

Second, the underprivileged group of men also spoke heavily of the emotional difficulties from a loss of physical strength: *'It does bother me; I did lose it [my strength]. I used to bench press 225 pounds, now I can do nothing but the bar. I'm miserable'* (Pierre-Luc, 57, trucker). Sayer (2011) outlines how shame from physical impairment severely impacts patients' level of dignity. This led to avoidance strategies to reduce exposure of their physical vulnerability (physical weakness, sexual dysfunction, or pain) by concealing their symptoms about their health with their health care providers, family, and friends: *'I never speak of this [his stress that causes symptoms] with anyone. I don't talk about it with people'* (Eddy, 47, unemployed). Erectile dysfunctions evoked strong emotional responses and were often concealed: *'It's the hardest thing after your heart attack. Don't even ask me if it's harder after the operation because I never try anymore'* (Francois, 58 limo driver, casino host). The social environments of their working class create greater fear of judgement and lead to risk practices. One participant explains that he feels like he has to prove himself to his friends, despite the risk of overstraining his heart: *'I give a good helping hand, I have to try even harder with my buddies, when they are around, I work to show that I still have strength'* (Albert, 73, retired welder).

In contrast, middle class participants were more concerned with avoiding health complications (loss of physical and mental independence) and adjusting their unhealthy lifestyles to ensure a quality of life for their remaining years. These participants avoided taking 'unnecessary risks': *'No, I don't take risks. I don't take risks anymore because I don't have the energy. For swimming, to push there, I wouldn't, I wouldn't'* (Michel, 72, retired printing press operator). Similarly, in these situations, they are less preoccupied with social judgement in discussing sensitive issues with health care providers, spouses, and in cardiac rehabilitation groups: *'We talk about that [erectile dysfunction] a lot. All the guys together, it takes up a lot of*

the talk [in cardiac rehabilitation].... Before my heart attack I was pretty sexually active. Today, well, if it happens, it happens. End of story. It's not a bigger deal than that' (Frankie, 48, translator).

Conclusion

The Chief Public Health Officer's (2012) report on the state of public health in Canada emphasizes the importance of addressing social determinants of health in order to improve global health and reduce health disparities. A statistical report identifying the extent of national health inequalities reported a gender gap in life expectancy of 4.7 years (women outliving men), and showing a 8.4 year difference between men of the lowest quintile and women of the highest quintile (and a 5.4 year difference with men from the highest quintile) (Greenberg & Normandin, 2011). Although masculinity and socioeconomic status have been identified as two significant determinants of health, their interaction in cardiovascular health and cardiac rehabilitation were previously understudied. Drawing chiefly on Bourdieu's sociocultural theory of practice, our study used a class-based masculinities approach in order to explain the social variation in lifestyles of two contrasting socioeconomic groups of men after suffering from a cardiovascular incident requiring hospitalization. Results show strong social variation in terms of lifestyle and identify different dispositions towards the body care in the context of heart disease.

In 'The killing fields of inequality', Göran Therborn (2014) identifies a conceptual model composed of three types of inequalities relevant for the analysis of lifestyle equalities: vital, existential, and those pertaining to resources. By focusing on inequalities per se, his approach provides a more structured reading of the overbearing and interrelated variables that constitute most social determinants of health models. Similarly, the results of this study are broken down into three means (achieving security, preserving autonomy, and maintaining dignity) for human

flourishing by exposing experiences of masculinity while recognizing the unequal access to resources in different socioeconomic classes.

This approach to inequality highlights the striking correspondence between social position, gender, lifestyle and concern for cardiovascular health. In this sense, the different orientations towards ‘human flourishing’ observed in each of the socioeconomic groups were the outcome of absolute and relative dimensions of social position (e.g., absolute and relative poverty). Participants from the underprivileged group fulfilled their need for security by maintaining their lifestyle, resisting the control of health guidelines, and preserving their dignity as a minimum standard for quality of life. Participants from the middle classes appear to achieve a sense of security by adopting changes to improve their health and by investing in health as a means to continue a dignified life. These contrasting strategies towards flourishing reflect the class-based identities of the participants.

An important limit of behavioural psychology and moral philosophy has been their focus on individual behaviour in abstraction from social structure (Sayer, 2011). Contrary to these individual-centered approaches, in this study, lifestyle is conceived primarily as the outcome of social structure (gender and class), which fashions dispositions towards cardiovascular health. This predicates the use of an intersectional approach for analysing the multiple social dimensions of health that converge in cardiac rehabilitation. The intersection of gender and class helps to understand the mismatch observed between cardiac rehabilitation guidelines and their underprivileged patients’ daily experiences of life.

Although cardiac rehabilitation programs are effective in reducing mortality they risk having their potential benefits negated if they omit adapting their policies to sociocultural issues. As our results emphasize, healthcare should consider delivering programs designed in function

of underprivileged men who are hypersensitive to threats to their autonomy and sense of control. Data shows that this is particularly true during emergency consultation, follow up assessments, and conveying the importance of early recognition and treatment of disease progression. Men's tendencies to conceal symptoms and their difficulties to mobilize quality social network should be further considered. Some authors also argue for a more professional-humanist philosophy in order to reduce barriers in the patient-health professional interaction (Therborn, 2014). If healthcare providers are more knowledgeable of the impact of sociocultural barriers, it is likely that they will be better equipped to assist patients' adherence to health guidelines. These suggestions are in line with healthcare services current push towards patient centered care and offer an opportunity to place the patient at the center of the treatment plan (Epstein, Fiscella, Lesser, & Stange, 2010).

Social policy's role in alleviating some of the most detrimental effects of poverty should also be attended to. A recent report in public health shows the rise in socioeconomic inequalities witnessed during the last two decades is participating in an increase in health inequalities (Courteau, Marleau, & Garvie, 2014). In this light, the aforementioned mismatch between health services and social circumstances of patients is also likely to be maintained if no significant changes are implemented. Lack of security and instability in the lives of vulnerable men must be addressed by health services with the collaboration of other social services that shares responsibility for safeguarding basic quality of life issues.

From a research perspective, studies need to find novel means to recruit men from the lowest socioeconomic classes. Why would they participate in health research when they are burdened by other priorities? Collecting data from within these populations require building partnerships with local social and health services. Although CVD are common conditions, once

patients leave the hospital setting, targeted recruitment for underprivileged groups is difficult. In this study, recruitment of underprivileged participants was pursued for over a period of one year and was facilitated by the support of many local organizations. This may explain the underrepresentation in research of underprivileged and underserved men.

How many societal resources are to be allocated for reducing health inequalities? To what degree are social policy and healthcare services responsible for cardiac rehabilitation practices of adult men once they have left the hospital? Future research should focus on such political and ethical questions by highlighting the relations between socioeconomic variables and bodily dispositions, and their impact on practice.

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Table 1.

Comparison of characteristics of participants from contrasting socioeconomic groups

Participant characteristics	Underprivileged classes (n=31)	Middle classes (n=29)
Completes public rehabilitation program	5	27
Follows a medical regimen	20	26
Attends regular medical follow-up exams	17	26
Smoker	24	12
Sedentary	18	17
Single	16	2
Regular contact with family	17	1
No children	8	1
History of drug and alcohol addiction	15	0
History of imprisonment	13	1
History of child abuse	11	2

Table 2.

Social variation of lifestyle in the context of heart disease. Key strategies following a heart incident as reported by two socioeconomic groups of men.

Underprivileged Men		Middles Classes of Men	
A. Achieving a Sense of Security			
The security of continuity		The security of change	
Minimizing threats to social vulnerabilities	➤ Continuity of identity: maintain personal characteristics, commitments, values, lifestyle, and work ethic. ➤ Commitment to traditional forms of masculine identity despite known risks and outcomes of CVD. ➤ Pursuing contraindicated activities (continued engagement with physically strenuous labour). ➤ Weaker priority given to health status in comparison to economic viability and sustainability (abstention from periods of convalesce, excessive labouring).	➤ Gender identity is not seriously threatened despite consequences of CVD. Commitment to a form of masculinity that is expressed in terms of SES. ➤ Confidence that their self-value will be maintained by their social support systems and employee benefits. ➤ Do not feel threatened by receiving care, being supervised, monitored and reinforced by health professionals and social environment (spouse, sisters, mothers, co-workers). ➤ Adjusting previous values in terms of health. ➤ Selecting new practices and adapting to new lifestyle in order to follow cardiovascular health guidelines (participation in non-aggressive sport, reduction of tobacco, alcohol, salt and high caloric food).	
Minimizing threats to physical vulnerabilities	➤ Maintaining self-worth and value by resisting the idea of physical weakness. ➤ Minimizing the seriousness of CVD by downplaying their severity, symptoms, risks factors, likelihood of progression and prognosis to continue daily activities. ➤ Maintaining familiarity (lifestyles) and physical environments to reduce instability provoking by CVD and cardiac rehabilitation guidelines.	➤ High degree of investment in health enhancement. ➤ Actively attentive to normative cardiac rehabilitation: close attention on initial risks of over exertion, possibility of disease progression, lifestyle change (active lifestyle, supervised exercising, prescribed diet plan, etc.) and health care recommendations (cardiac rehabilitation programs, health monitoring, emergency consultation and assessment, medication compliance, appointment attendance). ➤ Active involvement in obtaining additional information on cardiovascular health.	
B. Preserving Autonomy			
Health guidelines as a threat to autonomy		Health guidelines as enhancing autonomy	
Maintaining	➤ Highly defensive to threats to autonomy and	➤ Responsive to relinquishing control of their body to	

self-command	personal commitments: strong opinion on retaining self-control over their body and lifestyles. ➤ Calling into question the feasibility of health enhancement, lifestyle changes and program adherence. ➤ Dismissive of work restrictions (lifting restrictions).	health institutions and professionals. ➤ Feel capable of maintaining self-command despite health prescriptions. ➤ Regain a sense of control by adhering to recommended health regimens and feel empowered by the prospect of improving health by modifying lifestyle.
Exercising agency	➤ Clear disposition to gain independence from the hospital setting and medical bureaucracy (schedules, waiting times, spatial confinement, hospital policy) ➤ Managing emergent health conditions linked to CVD by own means and beliefs (self-medicating, self-treating). ➤ Limit interactions with health care institutions and support: limiting communication of health status, medical procedures, treatments, side effects, and symptoms; limited interaction with counselling and support groups; rejection of prescribed regimens.	➤ Ensuring physical potential by embracing health recommendations that are likely to reduce disease progression and co-morbidities. ➤ Do not express being threatened by lifestyle change. Readjusting environments (personal relationship, home, work) to better suit cardiac rehabilitation. ➤ Request additional support or specialized health services. Prompt to seek help from health professional (i.e., uncertainty of symptom management or unstable symptoms). Less resistant to share information with health professionals.

C. Maintaining Dignity

<i>Dignity as the baseline for quality of life</i>		<i>Continuation of a dignified life</i>
Gaining pride	➤ Pride taken from gender status and defining masculinity in avoidance healthcare (postponing appointments and assessments, attitude of fighting the disease, maintaining high pain thresholds). ➤ Work as sources of pride and working class masculine characteristics contradicted cardiac rehabilitation practices (independent, uncompromising, stringent, industriousness, strong, high commitment to paid work).	➤ Health is a means to gain pride in other life domains. ➤ Pride is gained by the ability to successfully manage disease by overcoming personal, social and organisational obstacles.
Avoiding Shame	➤ Avoiding the need for care (communicating needs and seeking help). ➤ Concealing losses of abilities (exposing physical weakness, symptoms of illness, insecurities, and emotions) and social environments. ➤ Avoiding situations that evoke a fear of judgement.	➤ Avoiding further health complications and loss of physical and mental independence due to unhealthy lifestyles or ‘unnecessary’ risk taking. ➤ Comfortable with addressing sensitive issues (erectile dysfunction, loss of libido).

Chapter VI Conclusion

Several public health reports have identified the problem of health inequalities present in the urban areas of the Outaouais region of the province of Québec, Canada. Disparities in mortality rates between socioeconomic groups are among the highest in metropolitan areas of Québec (Courteau, Émond, & Garvie, 2002; RHASSO, 1996). For the health authorities, this region is characterized by a paradox: its high average socioeconomic status (average incomes per capita of \$69, 226, low unemployment rates of 5.7%) in comparison to its large health inequalities (Courteau, Émond, & Garvie, 2002). A plausible explanation for this situation would be the areas' high social inequality and geographic segregation between socioeconomic groups. The inner-city poverty rates strongly contrast with the surrounding communities, characterised by civil servants. The inner city once housed the region's industrial working class, but with industry leaving the city during the 1960s, a transition from working class to an underprivileged population occurred. The contrasting level of social and material deprivation of this region makes it a valuable context in which to explore the concept of social variation of lifestyle and care of the body.

In response to this problem, this study aims to understand the dispositions and commitments towards body care of sixty men from contrasting socioeconomic circumstances suffering from heart disease. It draws on sociocultural theory that conceives lifestyles as the outcome of social structure (gender and class) rather than the sole product of rational choice (Wacquant, 2004). The comparative component of the analysis identifies different dispositions towards the body that engendered sharp differences in lifestyles observed between socioeconomic groups. Whether participants adhered, or not, to normative health guidelines was largely the outcome of different orientations towards 'human flourishing' (achieving security,

preserving autonomy, and maintaining dignity). The level of concern for health within the hierarchy of priorities was fundamental in explaining the lifestyle differences.

Pierre Bourdieu's sociocultural theory of practice, particularly his notion of body habitus, was the main concept used to understand key differences between groups. Andrew Sayer's (2011) extension of the concept of habitus was also applied in order to better explain commitments and strategies for flourishing that may or may not lead to normative health lifestyles. Sayer's basic question 'Why things matter to people?' leads to a more humanist approach to anti-normative behaviour in the contexts of health and healthcare, and a deeper understanding of the social construction of people's ethical dispositions towards their lives. Furthermore, this sociocultural theory lends well to the use of gender and masculinity theory. Also, Reawyn Connell's approach was used to explain the influence of gender in one's relation to the body. For instance, Connell's (2005) concept of protest masculinity helped to frame the anti-normative practices of underprivileged men. Their 'hyper-masculine responses the class inequalities' show the need to include both masculinity and social position in an analysis of health and lifestyle. In this respect, the results of this study support the need for intersectional approaches that are inclusive of social class and gender.

As many studies have suggested, the results support wider social policy that may reduce the burden of the effects poverty has on healthcare. The mismatch observed between cardiac rehabilitation programs and social circumstances of patients is likely to remain if no significant changes to social policy and organisation of health care are implemented. In order to create an environment that optimizes personal investments in health, healthcare services should target specific partnerships with existing social programs that support vulnerable populations. Hence,

cardiac rehabilitation programs and healthcare services could benefit from addressing three key areas impacting men during their cardiovascular recovery:

First, programs should diversify their services with respect to various groups of men who may face more structural obstacles or may be less ‘culturally’ inclined to actively participate in a health regimen. As argued by Farrimond (2011), marginalized men face greater challenges in reshaping their identity for health improvement after an illness. Many underprivileged participants described the incompatibility of adhering to health guidelines in relation to their work (the requirement to physically work and the meaning work held in their lives). Their attachment to masculine norms orients them to maintain high-risk practices in the context of cardiac rehabilitation (excessive labouring and physical exertion, consumption of unhealthy diets, tobacco use, alcohol use (abuse), weak convalescing time, inappropriate use of medication, managing unstable symptoms by their own means). Rehabilitation programs need to assist participants to negotiate the changes brought by a cardiovascular incident.

Second, results of this study show the challenges of reaching out and providing illness prevention services for vulnerable men who have experienced social inferiority and powerlessness for the most parts of their lives. Health professionals should be attentive to such groups who have been largely unresponsive to health programs and who may be hypersensitive to threats to their autonomy and sense of control. Data of the study shows that low responsiveness to heart healthy guidelines is particularly true for emergency consultations, follow up assessments, and in the early detection and treatment of disease. The structure and delivery of the healthcare system is subject to resistance from men because of strong gender socialization (Evans et al., 2011; Garfield et al., 2008).

Third, men's tendencies to conceal symptoms, and their difficulties to mobilize relevant human health resources and social network should be further considered in cardiac rehabilitation programs. The emotions experienced resulting from decreased physical capacities and sexual performance should not be underemphasized, especially for men with a long history of low self-worth. Some authors emphasize a professional-humanist philosophy in order to reduce barriers in the patient-health professional interaction (e.g., Therborn, 2014). If healthcare providers are more knowledgeable of the impact of sociocultural barriers, it is likely that they will be better equipped to assist patients' adherence to health guidelines. These suggestions are in line with healthcare services' current push towards patient centered care and offer an opportunity to place the patient in the center of the treatment plan (Epstein, Fiscella, Lesser, & Stange, 2010).

These avenues for improving cardiac rehabilitation face major challenges that may go beyond masculinity and socioeconomic status. The biographic trajectories of underprivileged participants also contain significant and traumatic life events (childhood physical and sexual abuse, incarceration, drug addictions) that have shaped their identities, attitudes and lifestyles. Although undesirable circumstances also characterize the middles classes, no comparison could be made in terms of the frequency and severity of such experiences between both groups. The vertical analysis of each interview strongly suggests a need for mental health services in conjunction with any institutional program promoting cardiovascular health.

This study helps focus the complex problem of men's cardiovascular health through the intersection of gender and socioeconomic class. A comparison between socioeconomic groups highlights the incompatibilities of healthcare services and rehabilitation programs with the priorities of underprivileged men. It also flags the potential ethical and political dimension of healthcare by examining notion of health citizenship. To what extent are social policies and

healthcare services accountable for the cardiovascular health and rehabilitation of adult men once they have left a hospital? This study offers a starting point to improve the delivery of healthcare services to vulnerable groups of men in a context of social inequality.

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Appendix 1: Letter of recruitment

Étude sur les hommes ayant subi un incident cardiaque

Bonjour Monsieur,

Je suis professeur à l'Université d'Ottawa et je mène présentement une étude sur la santé des hommes de l'Outaouais.

Votre nom a été sélectionné à partir d'une liste de personnes ayant suivi le Programme de réadaptation cardiaque du Centre de santé et des services sociaux de Gatineau (CSSSG).

Comme vous le savez peut-être, l'Outaouais détient un des taux de maladies cardiovasculaires les plus élevés au Québec. Nous croyons que vous pouvez nous aider à comprendre pourquoi la santé des hommes est moins bonne qu'ailleurs.

Je suis à la recherche d'individus voulant se prêter à une entrevue de 90 minutes pour discuter de leur santé et de leur qualité de vie après avoir subi un incident cardiaque.

Chaque participant recevra \$30 pour sa compensation.

Soyez assuré qu'advenant votre refus de participer à l'étude, aucun suivi quel que ce soit ne sera entrepris après la réception de cette lettre.

Pour plus d'information, veuillez me contacter au XXX-XXXX poste XXXX ou m'écrire par courriel au: XXXXXX

Dans l'espoir de vous rencontrer pour une entrevue, je vous prie d'agréer l'expression de mes salutations distinguées.

Alexandre Dumas, Ph.D.

Appendix 2: Letter of anonymity and confidentiality

Monsieur,

Cette étude universitaire a été subventionnée par le Conseil de recherche en sciences humaines du Canada. Les résultats seront analysés et publiés dans des revues scientifiques et contribueront à avancer les connaissances dans le domaine de la santé cardiaque.

Nous devons réaliser plusieurs entrevues pour répondre aux objectifs de la recherche. Notez que chaque entrevue sera dirigée et analysée par un chercheur/étudiant dans le domaine de la santé publique, et se fera avec une seule personne à la fois dans un endroit déterminé par l'interviewé.

Celui-ci a l'assurance que son anonymat sera protégé et que sa conversation demeurera confidentielle.

Votre nom a été sélectionné à partir d'une liste de personnes ayant suivi le Programme de réadaptation cardiaque du Centre de santé et des services sociaux de Gatineau (CSSSG). Cette liste a été produite selon les règles du Comité d'éthique à la recherche du CSSSG et aura été consultée uniquement par le service de réadaptation cardiaque du CSSSG.

Soyez assuré que le personnel du CSSSG n'aura aucune information sur votre acceptation ou refus de participer à l'étude et qu'aucun suivi quel que ce soit ne sera entrepris après la réception de cette lettre.

S'ils le désirent, les interviewés recevront les résultats finaux de l'étude qui englobent l'ensemble des entrevues.

Merci,

Alexandre Dumas, Ph.D.

Appendix 3 – Letter of information

Objet : Lettre d'information sur une étude sociologique en promotion de la santé en contexte de réadaptation cardiaque.

Madame, Monsieur,

Je suis Professeur à la Faculté des sciences de la santé de l'Université d'Ottawa et j'aimerais vous signaler le commencement d'une étude subventionnée par le Conseil de Recherche en Sciences Humaines du Canada. L'étude traitera des pratiques de santé des hommes en contexte de réadaptation cardiaque en Outaouais. Pour bien mener à terme cette étude, nous avons besoin de votre coopération pendant notre période de recrutement de participants de recherche.

Nous recherchons donc votre collaboration afin de nous offrir le droit d'exposer nos affiches de recrutement (voir document annexé) dans votre établissement. Pour ce faire, j'aimerais bien vous rencontrer pour vous présenter les détails de l'étude.

L'étude requiert aux participants de recherche de se présenter à une entrevue de 90 minutes traitant de leurs pratiques de santé en contexte de la réadaptation cardiaque. Notre stratégie de recrutement consiste à 1) afficher nos annonces dans certains centres de santé et plus particulièrement des centres de réadaptation cardiaque et 2) d'obtenir la collaboration d'organismes en réadaptation cardiaque pour nous suggérer des noms de participants (préalablement consultés) qui pourraient être intéressés à participer à une entrevue.

Cette enquête de type sociologique vise principalement à mieux cerner les normes et valeurs d'hommes de quartiers moins bien nantis en ce qui a trait à la façon de traiter et d'entretenir leur corps après la manifestation d'un trouble cardiaque. Elle vise également à mieux saisir les facteurs socioculturels qui peuvent inciter ces hommes à poursuivre ou non un programme de réadaptation cardiaque comme stratégies de maintien et d'amélioration de leur qualité de vie. Les résultats contribueront au développement de programmes et de politiques sociales plus efficaces en matière de promotion de la santé.

À noter que le projet sera assujetti aux règles du comité de déontologie en recherche de l'Université d'Ottawa et du Comité d'éthique en recherche du centre de santé et de services sociaux de Gatineau. Dans l'espoir de vous rencontrer, je vous prie d'agréer l'expression de mes salutations distinguées.

Alexandre Dumas, Ph.D.
Professeur
(XXX) XXX-XXXX poste XXXX

Appendix 4: Consent Form

L'activité physique chez les hommes en contexte
de réadaptation cardiaque

Nom du chercheur principal: Alexandre Dumas, Ph.D.

Nom des assistants de recherche : Mathieu Savage, Cindy Bergeron.

École des sciences de l'activité physique,

Faculté de sciences de la santé, Université d'Ottawa

Numéro de téléphone: (613) 562-5800 poste 2453

Courrier électronique: adumas@uottawa.ca

Note: Les recherches avec des sujets humains requièrent le consentement écrit des sujets de recherche. Cette exigence ne signifie pas que le projet dont il est question comporte nécessairement un risque. En raison du respect auquel ont droit les personnes qui participent à la recherche, l'Université d'Ottawa et les organismes de subvention de la recherche ont rendu obligatoire ce type d'accord.

Je, Monsieur _____, suis intéressé à collaborer volontairement et librement à cette recherche menée par Alexandre Dumas de l'Université d'Ottawa. L'objectif de cette recherche est d'améliorer la compréhension du rôle de l'activité physique dans la promotion de la santé chez des hommes de milieux moins bien nantis ayant subi un trouble cardiaque. Il s'agit aussi de comprendre ce qui incite ces hommes, lorsqu'ils font face à des événements ou des éléments stressants, à choisir une stratégie de promotion de la santé (par exemple, la pratique de l'activité physique) ou autre stratégie pour améliorer leur santé.

Ma participation consistera essentiellement à prendre part à une entrevue individuelle d'une durée approximative d'une heure et demie, dans un lieu de mon choix et à une heure et une date que j'aurai choisie moi-même. Pendant l'entrevue, je serai invité à répondre à des questions ouvertes à propos de : (a) mon milieu socio-économique et mon environnement social; (b) les ressources matérielles et humaines qui me sont disponibles en matière de loisirs; (c) mon histoire personnelle en matière de pratique d'activités physiques; (d) mes perceptions face à l'activité physique, la prévention en matière de santé, la santé et le vieillissement; et (e) mon expérience de la maladie cardiaque.

J'accepte que mon entrevue soit enregistrée sur bande magnétique (une cassette). Mon entrevue sera retranscrite et après, je recevrai la transcription de mon entrevue. Cette transcription me sera lue ou encore, je pourrai la lire moi-même si je le désire. À ce moment, j'aurai 2 semaines pour changer ou enlever des passages de l'entrevue et corriger les erreurs de transcription s'il y a lieu.

Je m'attends à ce que la transcription corrigée de mon entrevue ne soit utilisée que pour des fins de recherche et qu'elles seront conservées pendant une période de 10 ans par Monsieur Alexandre Dumas et selon le respect de la confidentialité. Ainsi, la cassette de mon entrevue et la transcription mon entrevue sera conservée dans un classeur barré à clé dans le bureau de

recherche de Monsieur Dumas. La cassette de mon entrevue sera détruite à la fin du travail de recherche.

J'ai l'assurance des personnes effectuant la recherche que l'information que je partagerai avec eux restera strictement confidentielle. L'anonymat sera aussi garanti. On me demandera donc de me choisir un pseudonyme (faux nom) et c'est ce dernier qui sera utilisé pour la transcription de mon entrevue. Si on cite des parties de mon entrevue dans la recherche, ce même faux nom sera utilisé et toute information pouvant mener à mon identification sera enlevée.

Je comprends que, étant donné que ma participation à cette recherche implique que je donne certains renseignements personnels, il est possible qu'elle crée un léger inconfort émotionnel à certains moments. J'ai reçu l'assurance des personnes effectuant la recherche que tout sera fait en vue de minimiser ce risque d'inconfort. Entre autres, je ne serai pas tenue de répondre à une ou à des questions qui m'apporteront un certain inconfort. Je peux à tout moment décider de ne pas répondre aux questions qui me sont posées, voire me retirer de l'étude. L'entrevue sera faite de façon décontractée et informelle. La personne effectuant l'entrevue utilisera un langage simple et les questions seront reformulées autrement si je ne les comprends pas bien. Il est bien clair que je suis libre de me retirer de la recherche en tout temps, avant ou pendant l'entrevue, sans encourir de préjudice sous aucune forme.

Si j'accepte de participer à la recherche, l'entrevue sera une occasion de partager mes expériences en matière de pratiques de santé et d'activités physiques en contexte de réadaptation cardiaque. À la fin de la recherche, je recevrai une copie du résumé des résultats de l'étude, résumé qui me sera lu si je le désire. Ma participation à cette recherche aidera à identifier des stratégies de promotion de la pratique de l'activité physique, stratégies dont je pourrai éventuellement bénéficier.

Il y a deux copies du formulaire de consentement, dont une que je peux garder. La personne effectuant l'entrevue m'a demandé si j'avais des questions concernant le formulaire de consentement ou la recherche et a accepté de répondre à toutes mes questions.

Pour tout renseignement additionnel, j'ai été informé du fait que je pouvais communiquer avec Monsieur Dumas à l'Université d'Ottawa au numéro de téléphone indiqué au début du formulaire. Pour toute plainte ou question concernant la conduite éthique du projet de recherche, j'ai été informé que je pouvais m'adresser au Secrétariat du comité d'éthique de la recherche au 819-561-8144 poste 250 ou encore par la poste au 500, boul. de l'hôpital, bureau 202, Gatineau, Québec, J8V 2P5.

Chercheur(e):

Signature

Date

Sujet de recherche:

Signature

Date

Appendix 5 – Receipt

Hommes, pauvreté et activités physiques en contexte de réadaptation cardiaque

Reçu

Reçu de participation à une étude dirigée par Alexandre Dumas, professeur en science de l'activité physique de l'Université d'Ottawa.

La somme de trente dollars (30 \$)

Signature : _____ Date : _____

Appendix 6 – Interview Guide

INTRODUCTION

Est-ce que vous pouvez me parler d'où vous venez ? Votre milieu ? Votre emploi ? (Interviewé (INT) : Explorer les conditions d'existence et les trajectoires sociales)

LA MALADIE EN TANT RUPTURE BIOGRAPHIQUE

- Pouvez-vous me décrire le contexte dans lequel vous vous trouviez lorsque vous avez eu votre crise cardiaque (CC)
(INT : Décrire la maladie (type et intensité) et le contexte – âge, contexte familial, lieu de résidence, intensité et convalescence)
- 2. Après une CC, certaines personnes vivent des **transformations dans** leur corps (visibles et invisibles). Avez-vous ressenti des changements comme ceux-là ? Lesquels ? Comment vivez-vous ça ?
- Est-ce que vous ressentez encore des signaux qui vous disent que vous avez eu une CC ?
- 3. Est-ce qu'il y a un moment donné où vous vous êtes senti que vous n'étiez «plus comme avant» ?
- Pouvez-vous me raconter dans quel contexte c'est arrivé, ce que vous avez **ressenti**, fait, etc.
- Est-ce que le monde autour de vous vous ont déjà fait sentir ça ?
- 4. Cette expérience vous a-t-elle transformée ? Comment ? (Vision du monde ; pratiques de santé ; émotions)
(INT : Explorer le contexte spécifique lorsqu'on tient compte de l'âge auquel l'infarctus s'est manifesté).
- 5. Est-ce que vous pensez que les hommes vivent la CC différemment des femmes ?
(INT : Explorer les effets secondaires ; sentiment de vulnérabilité, peur, dépendance)
- 6. Qu'est-ce que vous trouvez le plus **difficile** à vivre dans ce contexte ?
- 7. Est-ce que vous vous êtes donné des **objectifs**, des choses à faire, à essayer, à expérimenter pour les années qui viennent ?
(INT : Approfondir)

LA SANTÉ

- Est-ce que vous surveillez votre santé de près ? Ça l'a changé après la CC ?

2. Est-ce que vous écoutez votre corps pour savoir s'il y a quelque chose qui ne va pas ? Attendez-vous que votre corps vous donne des 'gros' signaux avant d'aller chez le médecin ?
3. Supposons qu'il vous arrive un petit problème de santé lié à votre condition, quels moyens allez-vous utiliser pour être mieux, pour pouvoir faire face à ce que vous vivez ?
(INT : Identifier les moyens/stratégies (TRUCS) et **les faire prioriser**).
4. Allez-vous souvent voir le médecin ? AVANT, est-ce que c'était pareil ? Ça vous dérange ?
5. Qu'est-ce qui a été la ou les causes de votre CC selon vous ? Développer (alimentation, sur poids, abus quelconque, stress, frustration, etc.).
6. Croyez-vous qu'on peu prévenir facilement les CC ? (explorer le de contrôle/fatalisme)
7. Qu'est-ce qui peut être fait, d'après-vous, pour **améliorer votre santé** maintenant ?
(INT : faire identifier les éléments et les faire **prioriser**). Est-ce que vous le faites ?)

PRATIQUES D'ACTIVITÉS PHYSIQUES

- Qu'est-ce que vous faites comme activités physiques actuellement ?
2. Vous considériez-vous comme une personne physiquement active ; (exercice, sport, etc.) ? Prenez souvent l'auto ? Marchez-vous beaucoup ?
 3. Est-ce que vous avez toujours eu les mêmes habitudes de vie (INT : Décomposer en tranches d'âge, par ex. enfance, adolescence, jeune adulte, avant mariage et après, le cas échéant, avant et après enfants, le cas échéant),
 4. Précisions sur les A.P. pratiquées (en tenant compte des **saisons** :
 - avec qui, groupe ou individuel ; fréquence, + ou – régulier
 - à l'intérieur d'un prog. De réadaptation ; lieu ; \$
 - la(les)quelles **préférez-vous** ?
 (INT : APPROFONDIR : les **profits** escomptés ? **Internes** ou **externes** au corps ?)
 6. APPROFONDIR la question au max, notamment pour voir dans quelle mesure l'activité physique rejoint des stratégies de réadaptation cardiaque
 - **sélection** : cherche à faire converger ses capacités et ses intérêts
 - **compensation** : trouve des moyens pour compenser pour ses incapacités et faire ce qu'elle veut ou aime
 - **optimisation** : met à profit ses ressources internes et externes comme moyen d'actualisation de son potentiel.
 7. Qu'est-ce qui fait que c'est facile/difficile pour vous de faire de l'activité physique ?

- Si quelqu'un organisait un club d'entraînement ici, est-ce que ça vous tenterait «d'embarquer» (explorer l'intérêt pour les clubs de marche) ?
- Est-ce qu'il y a des choses qui vous empêchent de faire certaines activités physiques/**d'en faire plus souvent** ? (Dans le contexte de la réadaptation cardiaque)

8. Pensez-vous qu'il y a des risques associés à faire de l'activité physique après une maladie cardiaque.

Perception des ressources matérielles et humaines en matière d'A.P.

- Savez-vous s'il y a des endroits où vous pouvez faire de l'activité physique près d'ici ? Vérifier le **degré d'intérêt** et la **facilité d'accès** (distance, prix, partenaires, horaire particulier, jour ou soir) ;
 - Est-ce qu'il y a des activités que vous aimeriez faire et qui ne sont pas offertes près d'ici ?
 - Est-ce que ça vous fait peur d'en faire là bas ? Vérifier sa perception des compétences en matière de supervision pour populations cardiaques des activités offertes.
2. Avez-vous déjà participé à des cours de réadaptation cardiaque ?
 - êtes-vous satisfaite de ce programme (Explorer l'environnement des programmes)
 - environnement
 - information distribuée
 - intervenants ; le cas échéant. Par ex. Aimez-vous la présence d'un instructeur ou une instructrice ? Comment aimez-vous qu'il/elle soit ?
 - modalités (format, intensité, etc.)
 - installations (e.g. piscines, vestiaires, douches fermées ou non)
 3. Qu'est-ce que vous conseilleriez à des responsables de programmes de réadaptation cardiaque pour inciter les hommes à prendre mieux soins de leur santé (AP et alimentation) ?

PRATIQUES D'ACTIVITÉS PHYSIQUES/ALIMENTAIRES/SOINS DE SANTÉ

Perception des ressources matérielles et humaines en matière d'alimentation

- Où sont les endroits où vous pouvez faire votre épicerie près d'ici ? Vérifier le **degré d'appréciation** et la **facilité d'accès** (distance, prix, qualité).
2. Est-ce que votre alimentation a changé au fil des années ? Et après l'infarctus ?
 3. Est-ce que vous évitez des aliments que vous aviez consommés dans le passé. Pourquoi ? Comment les percevez-vous maintenant (gras trans, gras, alcool, cigarette)
 4. Dans quelle mesure les pratiques alimentaires s'inscrivent dans une stratégie pour améliorer leur santé
 - **sélection** : cherche à faire converger ses capacités et ses intérêts

- **compensation** : trouve des moyens pour les aliments prohibés pour les cardiaques
- **optimisation** : met à profit ses ressources internes et externes comme moyen d'actualisation de son potentiel.

5. Où prenez-vous vos informations sur l'alimentation (livre, médias, médecins, professionnels de santé, etc.)
6. Quelle importance prennent les médicaments dans votre vie depuis la CC ?
7. Est-ce que ça vous dérange d'en consommer ? Pourquoi ?

CONCLUSION

Si vous aviez des **conseils** à donner à des jeunes pour « bien vivre en santé » qu'est-ce que vous leur conseilleriez

Appendix 7: Ethics approval

Université
d'Ottawa

File Number: H02-14-18

Date (mm/dd/yyyy): 02/20/2014



Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

Ethics Approval Notice

Health Sciences and Science REB

Principal Investigator / Supervisor / Co-investigator(s) / Student(s)

<u>First Name</u>	<u>Last Name</u>	<u>Affiliation</u>	<u>Role</u>
Alexandre	Dumas	Health Sciences / Human Kinetics	Supervisor
Adam	Smith	Health Sciences / Human Kinetics	Student Researcher

File Number: H02-14-18

Type of Project: Master's Thesis – Secondary Use of Data

Title: Cardiac Rehabilitation and Class-based Masculinity

Approval Date (mm/dd/yyyy)	Expiry Date (mm/dd/yyyy)	Approval Type
02/20/2014	02/19/2015	Ia
(Ia: Approval, Ib: Approval for initial stage only)		

Special Conditions / Comments:
N/A



Université d'Ottawa

Bureau d'éthique et d'intégrité de la recherche

University of Ottawa

Office of Research Ethics and Integrity

This is to confirm that the University of Ottawa Research Ethics Board identified above, which operates in accordance with the Tri-Council Policy Statement and other applicable laws and regulations in Ontario, has examined and approved the application for ethical approval for the above named research project as of the Ethics Approval Date indicated for the period above and subject to the conditions listed the section above entitled "Special Conditions / Comments".

During the course of the study the protocol may not be modified without prior written approval from the REB except when necessary to remove participants from immediate endangerment or when the modification(s) pertain to only administrative or logistical components of the study (e.g. change of telephone number). Investigators must also promptly alert the REB of any changes which increase the risk to participant(s), any changes which considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project and safety of the participant(s). Modifications to the project, information/consent documentation, and/or recruitment documentation, should be submitted to this office for approval using the "Modification to research project" form available at:

<http://www.research.uottawa.ca/ethics/forms.html>.

Please submit an annual status report to the Protocol Officer four weeks before the above-referenced expiry date to either close the file or request a renewal of ethics approval. This document can be found at:

<http://www.research.uottawa.ca/ethics/forms.html>.

If you have any questions, please do not hesitate to contact the Ethics Office at extension 5387 or by e-mail at: ethics@uOttawa.ca.

Signature:

Riana Marcotte

Protocol Officer for Ethics in Research

For Daniel Lagarec, Chair of the Sciences and Health Sciences REB

Appendix 8: Participant Identification Sheet

PROJET HOMMES, PAUVRETÉ ET ACTIVITÉS PHYSIQUES EN CONTEXTE DE RÉADAPTATION CARDIQUE

FICHE D'IDENTIFICATION

No d'identification :
 Région :
 Pseudonyme :
 Nom véritable :
 Quartier :
 Date de l'entrevue :
 Lieu de l'entrevue :
 Durée de l'entrevue :
 Intervieweur :

Caractéristiques démographiques

Âge :
 Lieu de résidence :
 Lieu de naissance :
 Scolarité :
 Statut civil (a été marié ou non) :
 Si marié, occupation du conjoint :
 Occupation antérieure:
 Proximité et présence de la famille :

Code

A: Physiquement actif
 I : Physiquement inactive
 01 à 10 : numéro chronologique de réalisation de l'entrevue selon la catégorie.

Appendix 9: Notes and impressions post-interview**PROJET HOMMES, PAUVRETÉ ET ACTIVITÉS PHYSIQUES
EN CONTEXTE DE RÉADAPTATION CARDIQUE**

Notes et impressions post-entrevues (à remplir par l'intervieweur)

Le logement

Type et nb de pièces :

Décorations et style dominant :

Valeur (riche, moyen, pauvre, très pauvre):

Environnement extérieur :

Autres :

Habillement

Tenue lors de l'entrevue :

Chaussure :

Autres :

Coiffure

Longueur/teinture :

Style :

Autres :

Langage

Qualité de la langue :

Accent :

Autres :

Impressions générales post-entrevue