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Abstract

Defining and describing health has traditionally been the role of medical experts. Although a rich literature has recently established the importance of *lay* accounts of health, one important gap relates to gay men's accounts of health. Data from 11 focus groups involving 45 gay men were thematically analyzed to investigate gay men's views of health. Two contrasting positions on a possible relationship between sexuality and health—there is no link or there is a definite link—were identified. In addition, five key ways gay men talked about health were identified: health is the absence of disease, is functional ability, is fitness and exercise, is psychological, and is multifaceted. Although there are similarities in the ways gay and other men talk about health, important differences exist, which suggest that issues of sexuality need to be considered by health policy and service planners so that responsive health services can be provided.

Keywords

gay men's health, sexuality, masculinities, lay accounts of health, qualitative methodology, thematic analysis

Introduction

Health has traditionally been defined by biomedical experts rather than lay people. This has resulted in health being conceptualized in narrow terms, usually relating to the absence of disease and illness, and a privileging of biological factors. Psychosocial impacts on health tend to be underplayed in these traditional definitions (Antonovsky, 1996; Lee & Owens, 2002; Watson, 1998). Although a now popular biopsychosocial approach (Engel, 1977) has acknowledged the interplay between biology, psychology, and society in relation to health, it is still possible to claim, as Watson (1998, 2000) did, that there has been a failure to seriously explore men's health as a personal, cultural, and social phenomenon. In particular, *gay* men's accounts of health remain relatively unknown.

Lay perspectives on health are important to understand for many reasons. For instance, these perspectives play an important role supplementing (and sometimes challenging) expert/professional understandings, and having both is important to the development of policy and services to maximize potential health gains for individuals and communities (Smith, 2007). Lyons and Chamberlain (2006) detailed three further reasons. First, and very practically, people's views of health will influence decisions regarding seeking professional help. Second, perceptions of health relate to people's ideas about what constitutes

illness (and health) and will influence health-related behavior. Third, "people's ideas about health can tell us what this concept means for everyday life and social values, and how it may be employed in certain ways for specific ends" (Lyons & Chamberlain, 2006, p. 43). By exploring lay views, we can understand the complexities of the relationships between individuals and their (multiple) communities (Hodgetts & Chamberlain, 2000) and the ways they live, work, and play within them as real, living, embodied individuals (Smith, 2007).

Lay perspectives on health (or more often illness) have been increasingly investigated over the past few decades. Such data have been used to explore the nature of health issues (Rogers & Pilgrim, 1997), including people's understanding of the causes of illness (e.g., Blaxter, 1990; Hodgetts & Chamberlain, 2000), the construction of health knowledge in families (e.g., Backett, 1992), and explanations for disparities in health (e.g., Blaxter, 1997; Popay et al., 2003).

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Men's accounts of health (e.g., Robertson, 2006; Watson, 2000) and illness (e.g., Allison & Campbell, 2009; Cameron & Bernardes, 1998; Nielsen, Brixen, & Huniche, 2011) have been more frequently investigated over the past decade or so, and central to understanding men's health is the relationship between "masculinity/masculinities" and health policy and practice (O'Brien, Hunt, & Hart, 2005, 2009; Robertson, 2006, 2007).

In relation to gay men, Robertson's (2003b, 2006, 2007) work is an exception. However, while his study of men in the United Kingdom included 7 gay men (out of a total of 20), his analysis did not focus on sexuality or use sexuality as a key explanatory factor. What is identified in Robertson's work is that gay men viewed health through a lens of sexual health and risk, relating this particularly to HIV/AIDS.

This article is concerned with the ways gay men talk about health. The aim is that by identifying gay men's interlinking of health and sexuality (or not) and their constructions of health, the promotion of health for gay men will be better facilitated. This is important because multiple studies indicate that gay men have poorer health outcomes than heterosexual men or the male population in general in a number of areas (e.g., Drabble, Keatley, & Marcelle, 2003; Wolitski, Valdiserri, & Stall, 2008). Some of this research has reported that when compared with heterosexual men, gay men have a higher incidence of eating disorders (Russell & Keel, 2002); suicide and suicide attempts (Skegg, Nada-Raja, Dickson, Paul, & Williams, 2003); depression, panic attacks, and psychological distress (Cochran, Sullivan, & Mays, 2003); and have an elevated risk for anxiety, mood, and substance use disorders (Bostwick, Boyd, Hughes, & McCabe, 2009). Gay men, especially those attached to gay communities, are also reported to be more likely to use nonprescription drugs, including alcohol, at higher levels (Van de Ven, Rawstorne, & Treloar, 2002) and more likely to smoke tobacco than heterosexual men (Dilley, Simmons, Boysun, Pizacani, & Stark, 2010).

Method

Theoretical Orientation

The study is situated within the newly demarcated field of critical lesbian, gay, bisexual, transgender, and queer (LGBTQ) health psychology (Peel & Thomson, 2009) and so does not take heterosexual research as its benchmark; rather, it looks at gay men's health in its own right (Harrison & Riggs, 2006; Riggs, 2005). The research is informed by a critical realist position (Willig, 2001), which theorizes people's accounts as constructed, yet at the same time accepts them as descriptions of events and personal experiences that have some basis/meaning in

reality. This means men's talk is not treated as representing their inherent attitudes or beliefs, nor is it treated as "just talk." Instead, these data are (semi) public accounts that report, at least to some degree, men's understandings of health and their health-related experiences and understands these as shaped through (New Zealand's) socially available meanings and constructions related to masculinity, sexuality, and health.

Design

A qualitative design with focus groups and thematic analysis was used. Focus groups were selected as they provide an environment for open discussion among participants and are an excellent method for obtaining cultural discourses and shared cultural information (Colucci, 2007; Wilkinson, 1999, 2003). A semistructured guide was developed to ensure consistent topics were covered across all groups.

A total of 45 gay men were involved in 11 focus groups held in Auckland and Christchurch, New Zealand's two largest cities by population, to discuss issues related to identity, community, and health. The men were recruited through publicity in the gay press, posters at gay bars and sex-on-site venues, and various websites. Four participants who agreed to host a focus group recruited other men to take part; 17 men were recruited this way. The focus groups ranged in length from 75 to 150 minutes. All focus groups were recorded with the consent of the participants. Ethical approval for the research was granted by the University of Auckland Human Participants Ethics Committee; written informed consent was obtained from each participant.

Participants

Participants ranged in age from 24 to 64 years, with 37 years as the median. Nearly all identified as gay, others as homosexual or queer (see Table 1). The sample achieved some ethnic diversity: New Zealand European/Pākehā ($n = 29$), Māori ($n = 2$), Indian ($n = 2$), and Chinese ($n = 2$); some men did not report ethnicity. Although data were not directly collected about socioeconomic status, during the focus groups the men identified a range of educational qualifications, and most were employed in technical and professional occupations. The men lived in many parts of both cities, and in Auckland they did not just reside in those neighborhoods known to have a high concentration of gay men and colloquially known as the "gay ghetto" (Hughes & Saxton, 2006; Stevens, 2004).

Data Analysis

The data set consisted of transcripts (and audiotapes) of the focus groups. An orthographic transcription that preserves all the words spoken (Wilkinson, 2003) was provided by

Table 1. Focus Group Participants' Demographics

Location	Age ^a	Ethnicity ^b	Health Issues Reported	Identity ^{a,b}
Auckland	30, 47, 42	NZ (2), NZ/Māori	None	Gay (3)
Auckland	24, 24, 30, 32	NZ (2), Canadian, Sth African/NZ	Depression (2), asthma	Gay (4), queer, homosexual
Auckland	39, 40, 40, 40	NZ (4)	None	Gay (4)
Auckland	32, 39, 48	NZ, Celtic	None	Gay (3), queer
Auckland	24, 27, 29	NZ, American	None	Gay (3), queer
Auckland	26, 30, 35	NZ (2), Indian	Hearing, depression, mental health	Gay (2), homosexual
Auckland	39, 48, 50, 51, 55	NZ (3), British, Japanese	Sight, prostate and testes cancer	Gay (4), homosexual
Christchurch	27, 30, 33, 37, 37, 42	NZ (5), Chinese	HIV+ (2)	Gay (6), queer, homosexual
Christchurch	25, 40, 51, 57, 58	NZ (3)	None	Gay (3), queer
Christchurch	33, 34, 41, 42, 53, 64	NZ (2), NZ/Māori, Indian, Australian	Knee replacement, type II diabetes, high blood pressure	Gay (6), takatāpui, homosexual
Auckland	20s, 29, 30	Chinese, Latino, Indonesian	None	Gay (2)

Note. NZ has been used to group a number of different labels including European, Caucasian, Pākehā, New Zealander.

a. Some values missing as age, ethnicity, and identity not always provided.

b. In some instances multiple identity labels were provided.

a professional transcriber and rechecked by the first author for accuracy. NVivo software was used to manage the coding of the data set.

Thematic analysis was used to identify repeated patterns of meaning across groups. The specific approach to analysis was an inductive and data-driven one, focusing initially not only on the semantic content but also the latent constructs informing, and articulated through, participants' talk (Braun & Clarke, 2006). The process of analysis involved the first author repeatedly reading the transcripts and coding the entire data set, which resulted in a demarcation of common themes. Provisional themes were reviewed and discussed by all authors, and further refinement of the coding and analysis was undertaken until the salient patterns repeated across and within transcripts were identified and agreed on (Braun & Clarke, 2006). All names used in quoted material are pseudonyms to maintain confidentiality, and other minor details have been changed if potentially identifying. The quotes presented have been edited slightly with some punctuation added to facilitate reading.

A number of measures were taken to ensure research quality, in addition to the noted strategies of using a standardized moderator's guide and agreement among authors. The principles advanced by Yardley (2000) to guide the quality of a qualitative study were taken into account. In particular, fit between theory and method, awareness of the literature and previous empirical work, and methodological competence and skill in the research team were high. A clear documentation of the research and analytic processes was maintained. Finally, the researchers were

reflexive on how their assumptions and views may have affected the research and regularly discussed these (Adams, 2010).

Results

This article focuses on patterns across gay men's talk about two main dimensions: (a) the ways the men connected (their) sexuality to health and (b) the ways the men constructed health.

Sexuality and Health

When directly asked about a connection between sexuality and health, a sizeable portion of men challenged the idea that sexuality might be related to health.

Interviewer: I wonder if being gay do you think that affects your health at all?

Doug: Not as much as being a man affects my health, I think it's a secondary influence if it is an influence

George: I think I think for me it actually makes my health status better because I'm much more relaxed about seeking medical assistance whatever the issue might be whereas my perception is that a lot of my straight friends battle on and they don't want to be seen to be weak so they won't go to the doctor whereas I've I have no worry about appearing weak at all I just don't care so I think that is a benefit

for me for the mindset that I've puts me in that position

Scott: I think for me especially after I came out I did some risky things, not so much sexually although I was being reasonably explorative I suppose, but I did things like I would stay out all night, you know like walk home at dawn you know and then be knackered the following day and then I'd get up, for three years I had this constant cold because I was just never getting enough sleep, I was getting a lot of exercise but I think and I've seen a lot of guys who get into that rut

In this extract, Doug provides a "gender"-based analysis of his health, which undermines the notion of the influence of sexuality on his health. Scott and George, in contrast, articulate clear behavioral links between being gay and health and so prioritize sexuality as an explanatory variable. While Scott reports the link between being gay and health as mainly negative, relating to the "lifestyle" he "adopted" after he came out, George reports a positive effect of being gay—his sexuality enabled a (masculine) identity where medical help-seeking was not associated with vulnerability or weakness, and so avoided. Instead of individualizing this to personality, he provides an analysis where sexuality is the crucial ingredient. The expression of such differing views within groups was common:

Interviewer: Do you think that being gay has any relevance or impact on your health status, how healthy you are

Graham: I think I am more likely to live longer because I am gay

Aaron: Why's that

Graham: I think if I was straight I would be I wouldn't be doing half the things I am doing now and be a lot less fitness things lot more into just fitting the straight sort of role model thing and likely to have a heart attack a lot earlier than I will do, so for me it's like healthier being gay, I think I am a healthier gay man than I would be as a straight man

Charles: Assuming that you were married and had kids and grandchildren and that you followed that pathway

Graham: Yeah I'm sure I'd be boring

Arjun: I don't know from my experience I lived a straight life I was married and now I am gay, I felt that there was no difference in my health status back then or my health status now, nothing has changed for me, not even the slightest tiny tiny weeny bit

Graham claims a positive association between health and being gay, drawing primarily on a construction of health

as fitness, but also on a wider notion of social engagement. In constructing heterosexuality as limited (and "boring") in what it can offer men, homosexuality is situated as the more desirable (and health-invoking) option. In contrast, Arjun challenges any association with sexuality and health, a position that is bolstered by his experiential authority (Kitzinger, 1994) of having "lived" straight and being gay. The implicit model of health informing his talk is individualized: context becomes far less relevant in determining "health status"—something that can easily be measured. Like Arjun, a minority of participants dispute *any* link between being gay and health.

Interviewer: Do you think this idea we talked about with gay community or gay culture do you think there is anything inherent in that that wants people to be healthy or

Morris: No I think that I think that health and gay are unrelated concepts, health can either be good health or bad health, gay is in the spectrum of sexual orientations and the only way you can put them together is in terms of what do you do sexually and you can end up with bad health whatever your orientation so I don't really see the two are necessarily related

Morris invokes an individualized idea of health that distinguishes it from sexuality. In talk like this, the idea of sexuality is a narrow one: rather than being part of a culture in which men are embedded, sexuality is framed as just one facet of identity (Keogh, Dodds, & Henderson, 2004). However, the most common view expressed was that sexuality *does* affect health. In contrast to the views expressed by George and Graham, this impact was mainly seen as negative, with being gay likely to result in poorer health outcomes:

Evan: I worry about gay men's health ah a lot and I think it's for example in the field I work in alcohol and drug, gay men are overrepresented in the statistics of negative impact by misuse of alcohol and other drugs but underrepresented in their connecting with services to help them. HIV rates in this country are rising dramatically you know I think we have a Kleenex attitude towards health we pick it up use it throw it away, I don't think we have don't think that my experience of gay men is that we don't have we are not enmeshed in a health culture you know

Interviewer: How does that compare with men as a culture do you think it's different or the same

Evan: No I think it's part of our culture is about you know identity recognition you know that we should be, not should be, we have the ability to

be healthy men, healthy minds, healthy bodies and I think some of us gay men struggle with that and I think a lot of that's because of issues like internalized homophobia, the running away stuff you know

Different models of health underpin Evan's account of a negative link between gayness and health, with tensions between the individual and societal. Initially, health is discussed in relation to disease, with alcohol, drug use, and HIV identified as domains in which gay men fare badly. Subsequently, health is framed in terms of culture and society, with gay *culture* to blame for gay men's poorer health (gay culture did not "embrace health"). However, the heteronormativity of wider society, which clearly negatively affects gay men's health (Ministerial Advisory Committee on Gay and Lesbian Health, 2003), is not raised by Evan as a problem; instead, it is individual *men's* responses to this context that are framed as problematic, through his identification of "internalized homophobia." This concept refers "to the negative and distressing thoughts and feelings expressed by lesbians and gay men about their sexuality, and which are attributed to experiences of cultural heterosexism and victimization" (Williamson, 2000, p. 105). Internalized homophobia, at least partly, conceptually, places the "blame" for poorer health with gay men themselves and has been widely used as an explanation for (gay) health disparities and as the basis for health interventions (Williamson, 2000). Others have critiqued its usefulness and appropriateness as internalized homophobia can be used uncritically and "without due concern for its sociopolitical consequences (i.e., to repathologize the "sick" lesbian or gay individual and focus attention away from the more salient issues of cultural and institutionalized heterosexism)" (Williamson, 2000, p. 97, see also Aguinaldo, 2008; Kitzinger, 1996, 1997).

Describing and Defining Health

In an attempt to elicit discussion in areas of health that the participants considered important, the questions posed about health were usually very open-ended. Yet, in most groups, the men initially appeared to find it difficult to describe and define health:

Interviewer: As I say the topic is about health so maybe just if we start if we kind of start off talking about what does health mean to you

Nick: That's really broad

As this extract illustrates, hesitancy, uncertainty, or a questioning often started men's discussion around health. However, after initial doubts, the men talked extensively about health. In their talk, health was conceptualized in a

number of recognizably different ways, which is consistent with previous research investigating lay accounts of health (e.g., Blaxter, 1990; Hewlett, 2005; Hughner & Kleine, 2004; Manderbacka, 1998; O'Connor, 2002).

Health is the absence of disease. The most common construction across the accounts was a medicalized one, where health was framed in terms of disease and illness.

Rahul: I would say that health is more like the absence of a clinically diagnosed disease whereas well-being is more towards your esteem and the way you sort of integrate into the community.

Nick: Health is a clinical.

Rahul: Yes absence of a clinical disease if if

Nick: So so if you had a clinical disease you would be unhealthy

Rahul: I think in a strictly

Nick: Medical sense

Rahul: Medical sense yeah

Such a framing of health around illness and disease is very commonplace (Blaxter, 1990; Radley, 1994), and in this way, gay men did not differ substantially from other men and women in their talk. Rahul and Nick's defining of health as "absence of clinical disease" draws heavily on *traditional* biomedical and scientific discourses of health, where "a traditional axiom of medicine [is] that health is the absence of disease" (Boorse, 1977, p. 542). Within the absence-of-disease paradigm, if physical symptoms of illness are not evident, then an individual is/can be considered healthy (Breslow, 1972; Lawton, 2003).

In defining health "strictly" in terms of biomedical illness, they also offer this as almost the fundamental (i.e., real or pure) definition of what health is. The effect of this framing is that social aspects of health are downplayed, or become positioned as of secondary importance to the physical body, where health ultimately resides. Another effect is that health itself is constructed in the *negative*, with an illness rather than a wellness orientation (Antonovsky, 1996).

However, the men's accounts were rarely straightforward or unitary when talking about health. For example, in this extract, Rahul precedes his definition by demarcating two relevant domains for thinking about "health"—health, as defined medically, and "well-being," which encapsulates emotional/mental and even social elements. This broader construction of "well-being" allows for two things: a narrow focus on health, but the simultaneous inclusion of the other elements of a biopsychosocial approach, even if they are constructed as not what health is about fundamentally.

Health is functional ability. A second common construction of health related it to the ability to function well in daily life.

Shane: It's about function as well, so not just how [the body] looks, but is it functional and that's mental and physical health because there are so many gits that you meet out there, they may have a great body but they are just, you talk to them and no one is home

Interviewer: Hmmm

Shane: So that would be nice to have a nice well rounded well mannered gay man who looks OK

In contrast to the negative focus in the previous definition of health, Shane's account is all about potential and ability, with the way a body functions as central. However, rather than *just* focusing on physical aspects and the ability to carry out physical daily function, a definition reported in other studies (Hughner & Kleine, 2004; Manderbacka, 1998), Shane explicitly includes mental aspects of functioning as well. The incorporation of physical and mental domains is consistent with recent research into straight New Zealand men's accounts of health, where health is reported to involve both a sound mind and an able body (Hewlett, 2005; O'Connor, 2002). However, Shane's account implicitly requires not just lack of factors that affect mental well-being but also requires some level of intelligent engagement—someone has to be “home.”

Health is fitness and exercise. Related to the construction of health around functional ability, participants also articulated a link between health and fitness.

Graham: I like to keep fit, I am not apologizing for it but I suppose I do that because my father had a heart attack in his 50s so I thought right I am going to look after my body I probably over exercise but I like doing it so, but I do I suppose up here there's something about staying attractive to men, I suppose it's a, I would say you're more likely to keep fit if you're single and whether you're straight or gay than if you're in a partnership, I see a lot of people let themselves go when they have finally found a partner or married, I am talking about straight or gay I guess, so I am not apologizing if I don't go to the gym but I swim a lot, cycle a lot tennis bike so no apologies, I just feel fitter and healthier and it allows me to live a better life by being fit

In Graham's account, his father's heart attack (implicitly constructed as unhealthy due to lack of exercise) is offered as the rationale for his own focus on “keeping fit,” with exercise reported as a means to attain health (“it allows me to live a better life”). Being healthy is implicitly broadly construed in quality of life terms (“staying attractive to men”) rather than just physical functional ability or “fitness.” Graham's account makes sense within a strong promotion by Sport and Recreation New Zealand (a government agency

responsible for increasing participation in physical recreation) of the benefits of exercise for health and well-being. However, he also orients to the notion that his exercise could be framed as *excessive*, and thus considered *not* healthy or even harmful (Mond, Hay, Rodgers, & Owen, 2006; Sudi et al., 2004), but his twice-articulated refusal to “apologize” seems to preempt the possibility of harm through exercise, or that his approach to exercise is (mentally) pathological. Exercise, regardless of how much he does, is framed *as* healthy through his broad quality of life conception of health rather than one limited to the physical body/effects (where “excessive” exercise could be seen as putting severe strain on body systems).

In Graham's account, as in Shane's prior extract, sexuality and health appear as intermeshed concepts in men's talk. Although fitness defines *health* and well-being, fitness is also articulated as about the production of a desirable male body, through which to obtain a sexual (or relationship) partner (Robinson, 2008). In contrast to Shane's account, the body surface (rather than interior) is the desirable commodity, which offers another “logic” for his investment in it.

In contrast to positive accounts around exercise, discussion about (team) sport was very limited and mostly negative.

Shane: If I had been straight I probably would have played rugby [. . .] because I am gay I haven't committed to team sports that I actually quite like because of that whole acceptance thing and now it is too late even if I was to join some sort of gay team sport because I have got these I suppose my own insecurities which has perhaps developed into body consciousness and self-consciousness and stuff I don't know but I just couldn't now, too late but that is fine, just play badminton and squash that is okay, but that is something that I always thought of is that yeah I never played team sport because of that.

When sport was mentioned, it typically related to “minor” or individual sports, which are preferred by some gay men (Plummer, 2006; Wellard, 2003), or “alternative” sport venues/contexts, such as the *Gay Games*. Shane's poignant reporting of nonparticipation highlights the intersections of masculinity, sexuality, and sport within culture and is an example of the negative view many gay men have of team sports (Robertson, 2003a). In contrast to our participants, who did not construct sport as a domain of health, sport *is* frequently mentioned in discussions around (straight) men's and boys' lives, especially in relationship to masculinity, health, and well-being (e.g., Messner, 2005).

Health is psychological. Although the physical was frequently invoked in talk about health, nonphysical

dimensions also often appeared in the way men talked. In many focus groups, health was framed in psychological terms.

Martin: I know for myself the probably the most unhealthy aspect of before I came out and that I had to struggle with and every now again I still struggle with it but not very often now

Shane: Gin

[laughter]

Martin: It was just self-hate you know, I would get to points where I absolutely self and I mean luckily I was aware enough to know that that was something you could deal with and it was part of accepting yourself and all that kind of stuff but I am sure it affects a lot of people still

Interviewer: So it is definitely I am getting the idea that it is definitely wider than the physical it is that kind of

Shane: Hell yeah

In a clear example of a private "biography" of health issues being made in a public setting (Blaxter, 1997), Martin frames the psychological as fundamental to (lack of) health; in contrast to a construction of "health is absence of disease," here mental well-being is constructed as the fundamental element for health. However, in locating mental well-being as fundamental, this is not an asexual account of health. Societal heteronormativity (Kitzinger, 2005) implicitly underpins his account; his story embodies the (negative) effect this can have on individual men's mental health (Mao et al., 2009), illustrated by evidence that gay men are an "at-risk" population for mental health problems (Sandfort, de Graaf, & Bijl, 2003).

Health is multifaceted. Focusing on these different constructions of health erases the fact that within most groups, health was talked about as complex and varied, with many facets, and meant different things to different people.

Interviewer: I wonder if you could start talking about what the idea of health means to you

Cole: Exercise or lack of [laughter] that is about it

Interviewer: Was there any other aspects of health apart from exercise do you think

Jack: Looking after yourself

Marshall: Diet

Greg: And rest, heaps of rest

Wayne: Your whole lifestyle

Ricky: Sorry

Wayne: Your whole lifestyle, try and eat well, get plenty of rest, enjoy life

Interviewer: So is it just about physical health or is there other dimensions do you think

Greg: Sexual health

Ricky: Mental health

This multidimensional framing of health is consistent with other research (Aday, 1994; Senior & Viveash, 1998) and fits the World Health Organization's definition that "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (World Health Organization, 2006). In this group, although different *elements* of health are identified, they seem to cohere into a somewhat unified concept of "health." One participant invoked the idea of a symbiotic relationship to suggest different domains cannot be separated:

Nick: I was thinking more along the lines of [. . .] it is healthy environments and healthy environments with a healthy person inside so it is kind of symbiotic relationship

In other groups, men discussed more explicitly tensions between various components of health, which may not be integrated to produce an overall healthy person.

Alistair: It's hard to perceive healthiness

Sean: Well that's right yeah

Alistair: You can perceive fitness

Sean: But it's also hard to for me it's hard to perceive fitness in a sense because

Alistair: But if you separate them out and I don't know medically if that's the right thing to do if you can separate out and okay be fit but you can have disease, that will impact on your fitness presumably in some cases more than other but you can be fit and not necessarily healthy it seems to me I may be talking through a hole in my hat here but that's [laughter]

Murray: Fitness and healthiness are different things

Alistair: Yes, yes that would be my perception

Murray: They overlap vaguely but they're distinct

David: Yeah very distinct

The focus group discussion later returned to the issue of this overlap.

Alistair: By health do we mean fitness or do we mean

Interviewer: How would you define health

David: Well-being right across the board

Alistair: Cause I mean we have been talking about disease basically as opposed to fitness and [unclear] you can be fit and diseased cancer is an example

David: Well-being

As well as health and fitness, the concept of well-being was raised. The group negotiated an understanding that being healthy and fit healthy were different. Health was discussed as being broad and associated with being well and free from disease (well-being), whereas fitness related more to a physical ability to do something.

Discussion

The different concepts of health evident in gay men's talk bear relationships to other research on lay accounts of health. For instance, the accounts of health as the absence of disease, health as functional ability, and health as multifaceted are all common in men's accounts of health. In contrast, were the gay men's accounts of health as fitness and exercise (lack of participation in sport) and health as psychological (negative effects of heteronormativity), which are in contrast to research on heterosexual men's accounts of health.

These accounts illustrate two competing tensions in the ways health and sexuality were discussed. First, narrow accounts of health (e.g., absence of disease) and of sexuality (e.g., as something akin to sexual preference) were invoked when gay men talked about health in ways that suggested no link between sexuality and health. Implicitly individualized, each man becomes the locus of his health status, and to some extent to blame if health turns bad. Structural, systemic, or societal factors are minimized. Second, broader accounts of health (e.g., as multifaceted) and of sexuality (e.g., as a culture and a marginalized one) were invoked when gay men claimed a link between health and sexuality. However, while some invoked a positive association through a "healthy lifestyle," the majority either situated the effect as negative, either through perceived negative aspects of "gay culture" (Braun, Terry, Gavey, & Fenaughty, 2009) or the heteronormativity of mainstream society.

Sexuality intersected men's accounts both explicitly and implicitly, through reference to desirable bodies, bodily and sexual practices, and social contexts rendering gay men vulnerable. The ways gay men conceptualize health and sexuality and the relationship between the two have implications for gay men's health. The concepts and domains of health, as evident in gay men's talk, were neither simple nor static, as others have indicated (Blaxter, 1997; Manderbacka, 1998; Nettleton, 2006), and reflected the wide variation in how people think about health (Hughner & Kleine, 2008). The men's discussion drew on their personal experiences and circumstances that incorporated issues of sexuality (or being gay). Although on the surface these gay men talked about health in ostensibly very similar ways to straight men, some key differences were identified, which suggest that a gendered lens, devoid of a focus on sexuality, may not be enough for promotion of health and well-being for gay men.

One of these relates to the construct of health as produced through physical activity—a key (masculine) personal health promoting activity (Sloan, Gough, & Conner, 2009). In these men's accounts, physical activity was usually an individually orientated activity (compared with a team activity), and the purpose of the activity was not

fitness/health per se, but so they "looked good." The focus on looks, and the undertaking of exercise for appearance's sake, rather than fitness, are traditionally feminized attributes (Grogan & Richards, 2002), which are simultaneously trivialized for that very reason. Men's accounts speak to stereotyped notions of gay men as very concerned with appearance, a domain beyond the *traditional* masculine (which in the New Zealand context has been very sport-focused; King, 2004). However, if a beneficial outcome (increased fitness) occurs regardless of intent in engaging in physical activity, should this matter? There are two ways in which it might be important. First, it might delimit the *sorts* of activities engaged in, and these may be *less* health promoting than others. Second, if gay men are to be targeted in health promotion campaigns, they need to "speak to," and be relevant for, the constructs gay men themselves use and the activities, practice, and indeed identities they are likely to invest in (recognizing, of course, that there is enormous diversity across the "gay community," e.g., Clarke, Ellis, Peel, & Riggs, 2010).

A second notable feature of the men's accounts was the inclusion of psychological/mental and emotional domains of "what counts" as health. These aspects are often not included in lay accounts, which tend to focus more on physical domains (Hughner & Kleine, 2004). This resonates with other New Zealand research on straight men's accounts of health (e.g., Hewlett, 2005), which also included mental/emotional elements, and thus suggests New Zealanders perhaps have access to more holistic models/understandings than in other Western countries. If this is the case, it may reflect the particular (bi)cultural context of New Zealand, where Māori constructions of health, which are broad, and relational/contextual, and typically incorporate four domains (spiritual, mental, physical, social/extended family; Durie, M. 1998), coexist with, and thus offer a challenge to, Western, individualistic, models. However, it also appears to speak of something of the experience of gay men and suggests the difficulties inherent in simply being gay and being "healthy" (in a complete, mental/physical/emotional way), in a society where heteronormativity prevails (Brickell, 2000), despite lessened overt homophobia, and increased moves toward legal and sociopolitical equality between heterosexual and gay men.

In New Zealand, measures to address inequality have included "homosexuality" being decriminalized in 1986, human rights legislation prohibiting discrimination on the basis of sexuality from 1994, and from 2005 has allowed same-sex civil unions (but not marriages) and granted *all* de facto couples the same property rights/responsibilities. Despite such advances, it is still not, necessarily, *easy* to be gay (Flowers, 2009), and it is certainly not normative to the extent that it *never* requires explanation, and is not an identity and sexuality that can be taken for granted, and not

thought about. These men's accounts highlight the intersection of emotional/psychological and physical domains of health and raise a challenge for health promotion to take on board (Ministerial Advisory Committee on Gay and Lesbian Health, 2003).

Despite this sociopolitical backdrop that can be seen to inform men's talk, a striking feature of the accounts was that they were largely individualistic and constructed health as something men themselves can (and should) control. This is not unexpected, as it draws on the dominant discourse of individualism which pervades most aspects of life in "Western" society (Lyons & Chamberlain, 2006) and which is a feature of many governments' approaches to health care (Nettleton, 2006), including in New Zealand (Blaiklock, 2010). Although individual health actions are undoubtedly important for health, attention also needs to be paid to wider factors in health promotion work, with a focus on how they can be reduced or eliminated, and their effects ameliorated. The data reported suggest that gay men's health is harmed by effects due to societal heterosexism (as well as negative effects emanating from the gay community), resulting in some areas of health (drug and alcohol use, for example) where gay men reported poorer outcomes when compared with heterosexual men.

Limitations and Future Research

As with all research, there are limitations to this study. As is often the case with qualitative research, participant involvement required men to initiate contact with the research team, producing a self-selected sample. Although the study was advertised widely to recruit diverse participants, many potential participants will not have seen the advertising and promotional material, especially those men who do not access gay community media, and many more will have either chosen or been unable to take part, for instance, men who felt uncomfortable taking part in a group discussion. Although the research reflects the view of those men who took part, we make no claim that it captured all their views; it only captured those that were offered by them. Nonetheless, the research reported here offers a rich, in-depth, and complex account of a sample of gay men's views about the linkages of health with sexuality and their constructions of health.

As this project focused on gay men who had a degree of community involvement, future research could usefully involve gay men not attached to the gay community. The research could also be extended to provide an increased participation of gay men from minority ethnic groups and men with disabilities as well as men who have sex with men but do not identify as gay. To enhance the participation of such men, alternative data collection methods, such as online real-time (synchronous) interviews (or focus

groups), which have been successfully used in research with hard to reach groups of men who have sex with men (Adams & Neville, 2009, 2011), may be useful.

Conclusion

The aim of this research was to provide an account of how gay men (in New Zealand) talk about health. The identification of gay men's lay accounts of health has provided an opportunity to insert experiential information from gay men into debates about health, from which it has been hitherto largely missing (Adams, Braun, & McCreanor, 2010). Although the sample was small, the links and continuances with research about lay accounts from other countries, as already noted, suggests the results may be relevant outside of the New Zealand situation as well as applying to the wider community of gay men in New Zealand. The general caveat that health is a phenomenon that is locally produced and managed (Sneijder & Te Molder, 2004), and that conceptualizations of health (potentially) vary depending on "social, geographical and cultural contexts not least because within these varying circumstances repertoires of language, values, beliefs and theories are differentially available" (Nettleton, 2006, p. 40), must, of course, remain. But taking these into account, the perspectives outlined here supplement expert/professional understandings of gay men's health (Adams, Braun, & McCreanor, 2007) and have the potential to ensure a more responsive and nuanced health policy and service provision for the health and wellness needs of gay men.

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