

# **Eating and drinking habits of young London-based Irish men: a qualitative study**

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## **Abstract:**

This qualitative study is based on interviews with young Irish men living in London, regarding their diets and their views on healthy eating. The data were analysed using thematic analysis. Interviewees gave various reasons for adopting unhealthy eating habits, including the cost of healthy foods, their lack of time and ability to cook, and their prioritisation of drinking. Views about the status of different foods also affected their eating habits: red meat, for instance, was considered 'masculine', while lighter foods associated with healthy diets were considered 'feminine'.

**Keywords:** Irish; qualitative; eating; health; masculinities; gender

## **Introduction**

### ***Obesity and gender***

The number of men rated as obese in England was estimated to increase from around 4.3 million in 2003 to over 6.6 million by 2010. This would be more than a 50 percent rise in obesity among men as compared to an expected increase in obesity levels for women of around 20 percent, from just under 5 million in 2003 to 6 million in 2010 (Zaninotto *et al.* 2006). There are serious health risks associated with being obese such as heart disease, cancer and diabetes. One explanation for this is a response to

technological, temporal and spatial changes in social living which has seen an increase in the consumption of fast-food and convenience food, and in eating outside the home. These factors have contributed to a change in the nutritional balance of the average diet (Chou *et al.* 2004). The Foods Standards Agency found that the types and quantities of foods consumed by adults aged 19 to 64 years in Britain were failing to meet the World Health Organisation's target (Henderson *et al.* 2002). The UK Government has sought to reduce health inequalities among the population by encouraging healthier eating, and in particular the consumption of fruit and vegetables.

A study across 23 countries which examined the gender differences in healthy food choices found that young men were significantly less likely to report healthy eating practices than women. Young men reported that they ate significantly less fruit and fibre and more high fat foods than women. However, the men in this study believed eating healthily was important to some degree, but not as strongly as women. The reasons for these gender differences could not be fully explained, although it appeared that they were partly due to women's greater weight control involvement and their stronger beliefs in healthy eating (Wardle *et al.* 2004).

### ***Men's dietary practices***

Research shows that food choices are influenced by interpersonal, social, cultural, and environmental factors (e.g. Raine 2005). Men's eating habits are believed to be affected by attitudes of hegemonic masculinity from an early age (Gough 2006), which influence men's identity and behaviour (see Connell and Messerschmidt 2005). Boys have been found to be less likely to diet than girls from early adolescence, with

the gender differences in dieting further increasing as they get older (Von Soest and Wichstrøm 2009).

In Western society the male body ideal is related to muscularity and not necessarily to a reduction in weight, whilst the ideal female body is more strongly connected to slenderness (McCabe and Ricciardelli 2001). In a study with men who were trying to lose weight they reported to be doing so for health reasons, unlike the women they knew, whom they claimed were dieting for vanity reasons (De Souza and Ciclitira 2005).

Social attitudes that define masculinity in terms of power and status appear to be the very ones that undermine men's health: men need to increase their consumption of healthier foods that are viewed as 'feminine', and reduce their intake of less healthy foods positioned as 'masculine' (Courtenay 2000a). Dieting in the UK media is presented as a women's area, which may contribute to men's greater disinclination to diet or to engage in healthy eating practices (Gough 2006). However, men's views about masculinity may be showing signs of incorporating healthier attitudes about food.

### ***Media representations and gender***

There have been some shifts in how traditional masculinity and the ideal masculine body has been portrayed in the media since the early 1990s. Male models are generally white, young, muscular and slim. Muscularity/hardness and softness have been combined to portray men and masculinity as strong and powerful but also gentle and tender (Gill 2009). The footballer David Beckham, is viewed as a 'metrosexual man', having conspicuously subverted images of traditional heterosexual masculinity,

which appear to have softened and diversified the contemporary notion of masculinity (Coad 2008).

Nevertheless, it is unclear what effects these media images of different types of masculinity have had on men's health-related practices. In one study investigating men's food-related ideals and how they relate to food practices, living habits, and masculine identities, participants portrayed the stereotypical bachelor "who does not know how to cook and has a 'who cares?' attitude towards food" as representing an out-dated version of masculinity (Sellaeg and Chapman 2008, p. 120).

From a constructionist perspective, different social experiences do not cause gender differences between men, rather, men and women learn to adopt different behaviours to enact or demonstrate gender as socially and culturally prescribed. Courtenay explains, "if men want to enact the dominant ideals of manhood, they must adhere to cultural definitions of masculine beliefs and behaviours and actively reject what is feminine" (2000b, p. 11). The most dominant constructions of masculinity are unhealthy while the dominant feminine constructions are largely healthy. So the men and boys who adopt these signals of gender and manhood are rejecting the healthy or feminine modes and adopting unhealthy beliefs and behaviours.

Men construct a variety of masculinities: ethnic, gay, professional etc. The health-related beliefs and behaviours men adopt will vary depending on the type of masculinity they are constructing and their social class positioning (Courtenay 2000b).

### ***Healthy eating and socioeconomic status***

Research indicates a clear relationship between socioeconomic status and obesity. Socioeconomic status is linked with cultural norms and expectations, behavioural risk factors, environmental influences, and ethnicity (Ball and Crawford 2005). In the UK, there is a higher incidence of obesity among people with low levels of education and wealth (Wardle *et al.* 2002). People from higher socioeconomic backgrounds are more likely to monitor their weight, diet to lose weight, and engage in regular physical activity (Wardle and Griffith 2001).

### ***Minority ethnic groups and eating***

A study of ethnicity and health in the USA found that out of six areas studied, diet was the only area, which showed a consistent pattern for men and women, irrespective of their ethnic background. There were consistent gender differences, with men holding riskier beliefs and engaging in riskier behaviours than women. Effects for ethnicity were also observed, with a gender/ethnicity interaction found only in the diet domain (Courtenay *et al.* 2002). The relative isolation of people belonging to a minority ethnic group can contribute to poor health practices (Kulmatycki and Lazowski 2005). A UK House of Parliament report on ethnicity and health concluded that ethnic health inequalities result from many interlinking factors, of which the relative poverty of British minority ethnic groups was the most significant (Postnote 2007).

### ***Irish migrants: mental and physical health***

It was not until 1999 that the Health Survey for England included Irish people as an ethnic group distinguishable from other 'whites'. Until then, the Irish had remained

largely invisible to policy makers (Leavey *et al.* 1997). As a result the significantly impaired physical and mental health in this group passed relatively unnoticed (Foster 2003). In the 2001 census, approximately 691,000 people in England identified themselves within the 'White Irish' category (about 1% of the total population). Living standards are a major problem for the Irish community in Britain. Statistics show that from the use of central heating (a helpful indicator of living standards) the Irish are ranked as having the lowest living standards along with Pakistanis and Bangladeshis (Office for National Statistics Office 2001a). For Irish men aged 45 to 64 years living in London, homelessness is a particularly problem (Randall and Brown 2005). The 'White Irish' category also has the largest percentage of all non-native groups in residential care (Office for National Statistics Office 2001b).

Epidemiological research has consistently revealed poorer health among Irish immigrants at every social level, compared with the population of England and Wales as a whole. Furthermore, these differences have been found to persist in the second generation of Irish immigrants, and the stressors associated with migration seem to increase health risk behaviours such as smoking and excessive alcohol consumption (see Walsh and McGrath 2000). Malone and Dooley's (2006) study looked at second-generation Irish immigrants living in London and found that although second generation Irish participants were of about the relevant health messages relating to fat intake, they struggled, and often completely failed to follow those recommendations.

Along with poor physical health problems, the Irish community have a higher incidence of mental health problems than any other group apart from African-Caribbeans (Leavey *et al.* 1997, Bracken *et al.* 1998). The incidence of anxiety, depression, and phobia, is significantly more common among Irish men than other non-native groups (Sproston and Nazroo 2002).

Alcohol use amongst the Irish both in Ireland and the UK has been widely documented (e.g. Tilki 2006, Leavey *et al.* 1997, Foster 2003). Alcohol misuse is a delicate issue where Irish people are concerned, because the Irish are often stereotyped as drunks. When health professionals encounter an Irish patient, alcohol use may become the focus rather than any underlying social or psychological problems (Tilki *et al.* 2008). What emerges clearly from the existing research is that the issue of maintaining a healthy lifestyle through healthy eating for Irish men has not been adequately addressed by researchers or policy makers, and needs to be further explored.

As rates of obesity continue to grow in the UK, the question of healthy eating is of increasing importance. Psychological research has attempted to address men's eating habits, but there is still little research on the diets of men from minority ethnic groups. This study aimed to explore issues regarding the eating habits of young Irish men living in the UK.

## **Methodology**

Qualitative methods were employed to gain a broader understanding of participants' views about their eating habits. This research was informed by feminist methodology (e.g. Henwood *et al.* 1998, Wilkinson and Kitzinger 1996). What participants say can only be viewed as partial accounts given in the particular context of a research interview; their accounts are not taken as 'truths', but are representations that can be elucidated through the critical analysis of lay narratives (Robertson 2007). They may be taken as illustrative of the range of discourses circulating in a particular place, time and culture (Braun *et al.* 2003).

The researchers acknowledge that by adopting an interpretative constructionist perspective they actively constructed the interview data together with participants (Henwood and Pidgeon 1994). The first-named author who carried out the interviews is a 24-year-old, white Irish male psychology assistant, with an interest in men's attitudes towards healthy eating and the wellbeing of Irish men living in Britain.

### ***Recruitment, participants and ethical approval***

Two participants were acquaintances of the first author, and a snowball sampling technique was used to recruit further participants (Heckathorn 2002). It is unclear how the interviewer's prior knowledge of two of the participants will have affected the course of the interviews, and whether or not recruiting participants through word-of-mouth allowed participants to discuss the issues more openly. It has been posited that researchers and participants engage in the process of data production to co-create knowledge about men's health and illness (Manderson *et al.* 2006). This sampling technique was used, as young Irish professional males are a difficult to reach group. It can be difficult to recruit men for interview-based research of any kind, and particularly for health-based research. Various factors can influence participant disclosures, such as the physical location in which the interview takes place (see Oliffe 2009). The challenges of recruiting men for interview-based research are well-known and have been linked to dominant ideals of masculinity (Brown 2001), long work hours and limited flexibility, signifying independence, rationality and control in saying no (Butera 2006). The researcher's identity as a young Irish man inevitably influenced the involvement of potential participants and determined the feasibility of collecting the data (Adler and Adler 2001). The fact that the interviewer was also of similar age and socioeconomic status to the interviewees, and that they took place in



either the researcher's or the participant's home, is likely to have encouraged participants to take part in this study and to feel more comfortable about being interviewed.

The ten young Irish men were 23 or 24 years old, and five were postgraduate students and four were professionals. Nine participants were heterosexual, one homosexual; none were married, and one was living with a girlfriend. None of the participants lived with their family, and they were all responsible for buying and preparing their own food. One reported being of mixed heritage (Egyptian-Irish), one described himself as Anglo-Irish, and the other eight described themselves as White-Irish. All of them had been living in London from between six months and four years. Ethical approval was given for this study by Middlesex University. All participants gave signed consent to participate in this research.

### ***Interviews***

The authors carried out a review of the literature on eating, health and masculinity, in order to formulate broad interview questions. Questions addressed the issue of choice with regard to food, typical foods consumed, body shape, 'masculinity' of food choice, health worries, dietary health implications, and whether participants enjoyed preparing and eating food. The interviews lasted between thirty and fifty minutes, were audio-recorded and transcribed verbatim. All identifying features have been changed.

### ***Thematic analysis***

When the interviews were completed, the transcripts were analysed using thematic analysis as outlined by Braun and Clarke (2006). Thematic analysis was used to

identify, analyse and report patterns within the data. Rather than describing and organizing the data in great detail, the two researchers interpreted various aspects of the topic (Boyatzis 1998). A theme was represented by a patterned response within the data of something important in relation to the research question. The researchers decided which themes were to be selected, and this analysis helped form the basic approach to the research question. A rich thematic description of the entire data set was carried out in order to give a sense of the predominant themes. Themes were considered in relation to the promotion of men's health.

Twenty main themes were identified and the four themes that were further analysed are discussed below. The aim of the study was to gain some insight into the views young Irish immigrant men have about their eating habits. Although the findings from such a small qualitative study cannot be generalised to all young Irish men in the UK, the themes which emerged from the data may give some indication as to how cultural imperatives are maintained or become exacerbated upon emigration.

## **Analysis**

### ***1. Lifestyle choices: lack of time or unwillingness to cook***

All the participants reported seldom having time to cook healthy food, and that they often ate unhealthily when they were either busy at work or socialising. They reported frequently choosing take-aways or processed food because those foods were quick and easy. People who live on their own often report the lack of time as a reason not to cook their own meals (Sellaeg and Chapman 2008). Although some participants aspired to a healthy diet, they did not live up to these ideals. Participants gave various reasons for not eating healthily:

Roger: I'd definitely like to have a proper meal every night, but maybe because of what I do and stuff like that I'd be a bit busy...I am 23, is going to be an age when your food is not regular your meals are not regular, you're out a good bit.

Ronan: There would be days when I might have toast for the whole day. That generally comes when I work hard.

All participants reported being aware that fast-food, processed food, and take-aways were unhealthy, which suggested that advice and information about dietary health have been understood, but that it has not changed their eating behaviour. They gave various reasons as to why they persist with these eating practises. Dermot explained:

I find they [food choices] are mostly constricted by ravenous hunger. And when I get really hungry I don't eat healthily. Because I order pizzas and eat fast food then, because I need to eat instantaneously.

All participants had spent a number of years living outside of the family home, and have had opportunities to develop culinary skills. However, they all regularly ate in restaurants or cafeterias, or ordered take-away meals. Ability to cook directly affected their food choices, as Kevin explained:

I have a lot of choice but it's really up to my ability in cooking, I'm a bit hit and miss. I experiment and about 66 percent of the time it's a bit of a disaster.

Two participants explicitly talked about how their diet could be healthier if they had a girlfriend, echoing research, which has shown how men in the West continue to expect women to take responsibility for providing them with healthy meals (e.g. Roos *et al.* 2001). Excuses were linked to being single, i.e. too busy, too lazy, or prioritising alcohol consumption over healthy eating. Roger said that his diet would improve if he lived with a girlfriend:

It could be a bit of toast, a couple of biscuits. Or it could be an Indian, Chinese, noodles, Thai, pizza... if you're living with your girlfriend or something like that maybe in a few years or whatever your meals are going to become more regular, and you're going to have a standard normal meal like meat, vegetables, spuds etc. I'd like that but at the moment it's just not, I can't do that myself.

## ***2. Being an Irish man, consuming alcohol, and the cost of a healthy diet***

The consumption of alcohol as a priority over a healthy diet was a prominent theme. Men in the UK are more likely than women to drink above recommended amounts, to binge drink, and to take illicit drugs (Office for National Statistics 2006). Men are more likely than women to increase their alcohol consumption in response to stress (Courtenay 2003). Research shows that alcohol use by first and second-generation Irish men living in the UK is often higher than English men as well as other migrant groups (Foster 2003). One of the key factors for young Irish men in the UK drinking unhealthy amounts seems to be migration (Tilki 2006). Participants in this study gave various reasons for drinking more alcohol and eating less healthily in the UK. Neil explained how he had increased his alcohol consumption since living in London:

I've a gastro issue and I've been on antibiotics for the last two months and she (doctor) said it's basically down to my diet. It's a culmination of binge drinking which in Irish terms is anything more than seven units, realistically here, everyone drinks more than seven units. Some people will drink fourteen or twenty-one units in a night out and I wouldn't be immune to that either.

Convenience and the need to satisfy hunger quickly when socialising and drinking often resulted in participants consuming fast food and take-aways. Eoin reported:

I replace food with drink. I take a liquid diet, from Friday to Sunday. Yeah no I drink heavily, my diet would be very bad and I would eat only once a day, and I eat whatever I can get. Most of the time I'd eat out and it's probably take-away food... The only limit would be money, so eh, I probably buy cheaper food, which I don't know, might not be as healthy.

Ryan explained that alcohol was a priority expenditure and healthy food was too expensive in London:

Since I have moved to London things have changed, because obviously there wouldn't be as much food in the house...At home I couldn't get past 11 am without eating properly...in London...I'd go right through until five or six in the evening and then I'd realise...I'd spend more on drink than I would on food. If I had a fiver or tenner left, unless I was really hungry, I'd probably spend it on a pint first.

The issue of identifying with being an Irish man and what that entails appeared to have various consequences on how the participants viewed themselves and how they reported this as affecting their eating practices. Dermot commented:

Traditionally being white Irish I've always eaten *potatoes* as a vegetable...I've never really eaten any fruit or vegetables, whatsoever, which is from when I was a kid...Men in Ireland like meat, veg and potato you know solid dependable food. For men it probably tends to be less adventurous.

Interestingly, the link between being Irish and masculinity appeared to be softened for Dermot following his migration from Ireland to London, which had resulted in him having a more varied diet:

Dermot: I definitely wouldn't have, as an Irish man, had sushi or anything like that before, but as of now living in London, I'm more open to various food types and I actually love sushi and eat it a lot.

### *3. Masculine versus feminine food*

All participants expressed the view that certain foods could be described as having traditional masculine characteristics. As in other studies, all participants reported that meats, particularly red meats, had strong masculine connotations (Roos *et al.* 2001, Gough and Conner 2006). Dermot commented:

Stereotypically there would be laddish foods like kebabs and burgers and things like that... solid dependable foods.

Ronan considered 'macho' foods as unhealthy yet not for girls:

There are definitely foods that are macho, that girls can't handle. Steak has to be up there. That is bigger than your face; I definitely think that is a manly food... Anything that's big meaty and unhealthy.

Constructions of masculinity include the promotion of risky behaviours and acting in a fearless fashion (Courtenay 2000b). Participants demonstrated their conformity to 'hegemonic masculinity' in rejecting what they considered to be healthy feminine food. When asked about unmanly foods, seven participants referred to the activity of dieting as well as the physical size of the food. The feminine foods described were all typical of those eaten when on a diet, i.e. salads and vegetables:

Eoin: There might be the image that things like salads, green salads and that kind of thing are unmanly. But that's probably just because they don't have meat in them.

Many men have a 'drive for muscularity' wherein they wish to be bulkier and more muscular than they currently are (McCreary and Sasse 2000). For nine of the participants, feminine food was viewed as insufficient because it was 'lighter', as Roger put it:

I suppose girls would like lighter fish and all that kind of stuff...Maybe they would have that preconceived idea to eat more healthily than guys would.

#### *4. Dieting as a female activity*

The aversion to dieting for many men seems to be linked to them viewing it as a 'feminine' pre-occupation. In line with previous studies (e.g. De Souza and Ciclitira 2005), eight of the ten participants expressed a traditional view that dieting is something women do, mainly because society puts pressure on women to have a slim figure. Men's behaviours are not just about behaving like a typical man, but *not* behaving like a woman (see Seymour-Smith *et al.* 2002). Eight participants suggested that men do not concern themselves with dieting because it is a female concern.

Dermot described how women eat less and that this is somehow negative:

Men don't worry as much about their weight so they wouldn't be thinking about what they're eating all the time. For instance, if you go to a restaurant a man wouldn't be worrying about ordering a thing on the menu that's least likely to make him gain weight... Women eat less because they think they are massaging their mental health but it actually has more destructive consequences.

Seven participants reported that they believed that men are encouraged or pressurised to eat large quantities of food and not to diet. Ronan explained:

Psychologically I think I should be eating more. Probably because I'm a man and I wouldn't put myself under the same pressures as a girl would put themselves under.

Two participants reported that they try not to put on weight, noting that their appearance was important to them and they both exercised regularly. Both acknowledged that this went against what is perceived as stereotypically 'manly' behaviour, and referred to a 'metrosexual' culture. Neil explained:

There has been this move towards this more kind of 'metrosexual' kind of, you know like, men looking after themselves, men who dare to care, this whole culture.

Ryan commented that it had become 'cool' to diet in recent years, but spoke negatively about this:

In recent years healthy eating has been publicised and is kind of the 'in thing' at the moment...It's kind of cool to be drinking your health shakes and stuff like that...I think that vegans and people who eat kind of like soya based products just for the fun of it.

## **Discussion**

This study aimed to explore young Irish men's views about healthy eating and their eating habits while living in the UK. All of the participants reported that eating a well balanced diet was important for their health and yet they reported various reasons why they did not achieve this, such as not being willing to cook, being hungry, lack of time, not having a female partner, spending their money on alcohol, and not liking 'feminine', i.e. healthy foods.

Men have higher rates of risky behaviours and lower rates of healthy practices than women. These behavioural differences make a contribution to gender differences in morbidity and mortality. One factor which seems to contribute to the gender difference in eating habits is women's worries about weight, which is linked to differences in food choices and dieting (Wardle *et al.* 2005).

All the participants reported some desire to eat healthily suggesting that they are aware of the relevant health messages, but only two of the ten participants stated that they did so. Eight out of ten of the participants viewed dieting as a female preoccupation, describing this activity in various negative ways. This accords with the way (heterosexual) men seem more willing to respond to health promotion which encourages them to lose weight for 'health' reasons rather than for image concerns (Ziguras 1998, De Souza and Ciclitira 2005).

The reasons for men not eating more healthily are clearly complex. An analysis of British men's attitudes to food and health found that there is cynicism



about Government health messages, and that healthy food is rejected on the grounds of its 'poor taste', and not feeling satiated by healthy food. When the issue of satiety was further investigated, it was found that this was affected by whether a person ate alone, in company, at work, or at leisure (Gough and Conner 2006).

One reason for not eating healthily given by two participants was that they did not live with a female partner. This was in line with studies which have indicated that heterosexual men view female partners as their main source of encouragement to be healthier (Seymour-Smith *et al.* 2002, De Souza and Ciclitira 2005). Health related behaviours, not just healthy eating, are often regarded as a feminized concern (Robertson and Williams 2009), and contribute to the social structuring of gender and power (Courtenay 2000a). Research has suggested that the media promotes men's health as being women's responsibility (Lyons and Willott 1999). Young men are positioned as 'risk taking superheroes' unwilling to take responsibility for their own health, thereby reinforcing unequal social relations and women's nurturing role. Although this superficially positions women in control of men's health, women remain relegated to the domestic sphere, 'shopping and cooking for their man' whom they need to use manipulation to influence (Courtenay 2000a).

Participants in this study described red meat as a particularly manly food, and thought 'masculine food' should be large in size or quantity. Unmanly or feminine foods included salad and 'lighter meals', typical of diets, which did not contain meat but only vegetables or salad. Healthy foods continue to carry negative connotations for men who position masculine characteristics in terms of physical strength and bulk, independence, and risk taking (Connell 1995). This study suggests that some men's views about food have not changed significantly from a decade ago when research found that men, unlike women, valued red meat and other foods associated with

masculine traits such as size and strength (O'Doherty Jensen and Holm 1999, Roos *et al.* 2001).

As in other recent studies, hegemonic masculinity was both valorised and criticised by male participants (e.g. Seymour-Smith *et al.* 2002), with participants reporting that they eschew 'feminine' foods such as salad, while simultaneously stating that they would prefer to eat more healthily. Masculinity continues to be valued more highly than femininity (e.g. Phoenix and Frosh 2001). While men need to be encouraged to take responsibility for their own health (e.g. De Souza and Ciclitira 2005), the desire to be masculine appears to cause problems.

In this study, as in others (e.g. Seymour-Smith *et al.* 2002), the participants constructed themselves as hapless about their diets. Men's behaviours are often not just about behaving like a typical man but about *not* behaving like a woman (see Seymour-Smith *et al.* 2002). If men think that it is better to risk the health dangers of being a 'real man' than being a feminised male, and thus protect their view of hegemonic masculinity, health practitioners may be better advised to find a way to persuade men to perform masculinity differently for the sake of their health.

Two participants (one of whom was homosexual) reported actively exercising and dieting in order to maintain a certain body appearance. They both reported that there was an increased social acceptance of the 'metrosexual' culture described by one of the participants as "men who dare to care". A recent study has claimed that the media may have superficially constructed the metrosexual concept in an attempt to make men more open to the advances of consumer advertising (Gough 2007). However, it may be a useful tool for health promoters to use in challenging and exposing the unhelpful discourses and practices of traditional masculinity.

The participants were not asked directly how their Irish background might have affected their food choices. However, the fact that the participants were all Irish appeared to play a role in their views and experiences. Factors such as ethnicity, economic status, and sexual orientation are intimately related to the social structuring of gender and power (Courtenay 2000b). Participants' comments suggest that identifying with being Irish can reinforce certain negative aspects of masculinity. As with other studies with Irish immigrant participants (e.g. Tilki 2006), participants appeared not to take very seriously the level of importance dietary choices had on their lifestyle and general health. Poor eating habits and an excess of alcohol are not just a problem for Irish immigrants, although such health-harming behaviours have been found to be more prevalent for the Irish community. All the participants in this study prioritised drinking over eating. While they accepted that a healthy diet had valid and legitimate benefits, they mostly did not follow this through. Research has suggested that the ability to drink heavily for Irish men is closely related to perceptions of masculinity (e.g. Tilki 2006).

Alcohol-related mortality in England and Wales is higher among Irish-born people than in the general population or other minority ethnic groups (Harrison *et al.* 1997). Furthermore, alcohol consumption among Irish immigrants is significantly higher in London than in Dublin (McCambridge *et al.* 2004). Despite evidence of increased mortality as well as mental and physical morbidity from alcohol-related disorders among Irish people in Britain, there has been limited attention to the social and cultural aspects of these problems. Young Irish men living in the UK are likely to be vulnerable to the development of later health-related alcohol problems, and targeted and evaluated interventions need to be developed (Foster 2003). Researchers such as Tilki (2006) suggest that alcohol can be used by Irish migrants to cope with

psychological pain and social alienation. Tilki advises that health promotion at an individual or community level must be underpinned by an understanding of the social context of unhealthy patterns of behaviour. She also advises that further research is needed to create change.

As suggested by other studies (e.g. Courtenay *et al.* 2002) gender-specific, culturally appropriate health promotion and disease prevention interventions are needed, and further educational interventions appear particularly warranted for men. However, this would have to consider the fact that men who enact gender as socially prescribed are unlikely to place a lot of value on their health or health education (Courtenay 2000b).

In conclusion, although the sample was small and the findings cannot be generalised, this study supports previous studies on the disproportionate numbers of Irish immigrants suffering poor health (e.g. Ahmad 1996, Tilki 2006). It suggests few signs of improvement in young men's eating habits and alcohol consumption, as in other studies (e.g. Sellaeg and Chapman 2008). Health campaigns should be targeted at the Irish community in the UK to help combat unhealthy life styles and promote regular exercise and healthy eating. The risks to young Irish men's health may be exacerbated because of the stresses of living a long way from home as an ethnic minority in England.

The drive to improve men's health may be thwarted by an allegiance to hegemonic constructions of masculinity (Gough 2009). Instead of reconstructing the discourse on healthy eating and exercise as acceptable masculine practices, it may be more beneficial to expose masculine discourse and practice for their negative impact on men's health. Health promotion interventions for 'obese' men, such as the HGV Man manual, which uses a car metaphor for men's bodies (Banks 2005), can locate

men's responsibility for changing their behaviour in an overly rational way. The structure of gender relations is not fixed. There are possibilities for positive change if health workers can think imaginatively about prevention in terms of culture and gender relations.

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### **References**

- Adler, P.A. and Adler, P., 2001. The reluctant respondent. *In: J.F. Gubrium and J.A. Holstein, eds. Handbook of interview research: context and method.* Thousand Oaks, CA: Sage, 515-516.
- Ahmad, W.I.U., 1996. *'Race' and health in contemporary Britain.* Buckingham: Open University Press.
- Ball, K. and Crawford, D., 2005. The role of socio-cultural factors in the obesity epidemic. *In: D. Crawford, and R.W. Jeffery, eds. Obesity prevention and public health.* Oxford: Oxford University Press.
- Banks, I., 2005. *The Haynes HGV man manual: the practical guide to healthy living and weight loss.* Yeovil: JH Haynes.
- Bracken, *et al.*, 1998. Mental health and ethnicity: the Irish dimension. *British Journal of Psychiatry*, 172, 103-105.
- Braun, V. and Clarke, V., 2006. Using thematic analysis in psychology. *Qualitative research in Psychology*, 3(2), 77-101.
- Braun, V., Gavey, N., and McPhillips, K. 2003. The "fair deal"? Unpacking accounts of reciprocity in heterosexual. *Sexualities*, 6(2), 237-261.

- Boyatzis, R.E., 1998. *Transforming qualitative information: thematic analysis and code development*. London: Sage.
- Brown, S., 2001. What makes men talk about health? *Journal of Gender Studies*, 10(2), 187-195.
- Butera, K.J., 2006. Manhunt: the challenge of enticing men to participate in a study on friendship. *Qualitative Inquiry*, 12(6), 1262-1282.
- Chou, S., Grossman, M., and Saffer, H. 2004. An economic analysis of adult obesity: results from the Behavioral Risk Factor Surveillance System. *Journal of Health Economics*, 23(3), 565-587.
- Coad, D., 2008. *The metrosexual: gender, sexuality, and sport*. Albany: Suny Press.
- Connell, R., 1995. *Masculinities*. Cambridge: Polity Press.
- Connell, R. and Messerschmidt, J., 2005. Hegemonic masculinity: rethinking the concept. *Gender and Society*, 19(6), 829-859.
- Courtenay, W., 2000a. Constructions of masculinity and their influence on men's well-being: A theory of gender and health. *Social Science & Medicine*, 50(10), 1385-1401.
- Courtenay, W., 2000b. Gender and ethnic difference in health beliefs and behaviours. *Journal of Health Psychology*, 7(3), 219-231.
- Courtenay, W., 2003. Key determinants of the health and well-being of men and boys. *International Journal of Men's Health*, 2(1), 1-30.
- Courtenay, W., McCreary, R. and Merighi, J. 2002. Gender and ethnic differences in health beliefs and behaviours. *Journal of Health Psychology*, 7(3), 219-229.
- De Souza, P. and Ciclitira, K., 2005. Men and dieting: a qualitative analysis. *Journal of Health Psychology*, 10(6), 793-804.

- Foster, J.H., 2003. The Irish alcohol misuse in England: ill served by research and policy? Some suggestions for future research opportunities. *Drugs: education, prevention and policy*, 10(1), 57-63.
- Gill, R., 2009. Beyond the 'sexualization of culture' thesis: an intersectional analysis of 'sixpacks' 'midriffs' and 'hot lesbians in advertising. *Sexualities*, 12(2), 137-160.
- Gough, B., 2006. Try to be healthy, but don't forgo your masculinity: deconstructing men's health discourse in the media. *Social Science & Medicine*, 63(9), 2476-2488.
- Gough, B., 2007. 'Real men don't diet': An analysis of contemporary newspaper representations of men, food and health. *Social Science and Medicine*, 64(2), 326-337.
- Gough, B., 2009. Promoting 'masculinity' over health: A critical analysis of men's health promotion with particular reference to an obesity reduction 'Manual'. *In: B. Gough and S. Robertson, Men, masculinities and health*. Basingstoke: Palgrave Macmillan, 125-142.
- Gough, B. and Conner, M., 2006. Barriers to healthy eating amongst men: a qualitative analysis. *Social Science and Medicine*, 62(2), 387-395.
- Harrison, L., Sutton, M., and Gardiner, E. 1997. Ethnic differences in substance use and alcohol use related mortality in first generation migrants to England and Wales. *Journal of Substance Use and Misuse*, 32(7 & 8), 849-876.
- Heckathorn, D.D., 2002. Respondent-driven sampling II: deriving valid estimates from chain-referral samples of hidden populations. *Social Problems*, 49, 11-34.

- Henderson, L., Gregory, J., and Swan, G. 2002. *The national diet and nutrition survey: adults aged 19 to 64 Years*. Vol. 1: *Types and quantities of foods consumed*. London: The Stationery Office.
- Henwood, K.L., Griffin, C., and Phoenix, A., 1998. *Standpoints and differences: essays in the practice of feminist psychology*. London: Sage.
- Henwood, K.L. and Pidgeon, N., 1994. Beyond the qualitative paradigm: a framework for introducing diversity within qualitative psychology. *Journal of Community and Applied Social Psychology*, 4, 225–238.
- Kulmatycki, L. and Lazowski, J., 2005. Program for promoting social attachment among Poles in Australia in relation to their mental status. *Psychiatria Polska*, 39(5), 997-1010.
- Leavey, G., *et al.*, 1997. Health research on the Irish in Britain: invisible and excluded. *Psychiatric Bulletin*, 21, 739–740.
- Lyons, A.C. and Willott, S., 1999. From suet pudding to superhero: representations of men's health for women. *Health*, 3(3), 283-302.
- Malone, E.M. and Dooley, J.P., 2006. Dwelling in displacement: meanings of 'community' and sense of community for two generations of Irish people living in North-West London. *Community, Work and Family*, 9(1), 11-28.
- Manderson, L., Bennet, E., and Andajani-Sutjahjo, S. 2006. The social dynamics of the interview: age, class, and gender. *Qualitative Health Research*, 16(10), 1317-1334.
- McCabe, M.P. and Ricciardelli, L.A., 2001. Parent, peer, and media influences on body image and strategies to both increase and decrease body size among adolescent boys and girls. *Adolescence*, 36, 225-240.



- McCambridge, J., *et al.*, 2004. Patterns of alcohol consumption and problems among the Irish in London: a preliminary comparison of pub drinkers in London and Dublin. *Addiction Research and Theory*, 12, 373- 384.
- McCreary, D.R. and Sasse, D.K., 2000. An exploration of the drive for muscularity in adolescent boys and girls. *Journal of American College Health*, 48(6), 297-304.
- O'Doherty Jensen, K. and Holm, L., 1999. Preferences, quantities and concerns: socio-cultural perspectives on the gendered consumption of foods. *European Journal of Clinical Nutrition*, 53, 351-359.
- Office for National Statistics, 2001a. *Census 2001: results and information*. [online] (Published April 2001). Available from: <http://www.statistics.gov.uk/census2001/census2001.asp> [Accessed 15 March 2009].
- Office for National Statistics, 2001b. '*Population in hospitals and other care establishments: by ethnic group*'. [online] (Published April 2001). Available from: <http://www.statistics.gov.uk/cgi/nugget.asp?id=465> [Accessed 15 March 2009].
- Office for National Statistics (2006). *Social Trends*, 36. Basingstoke: Palgrave Macmillan.
- Oliffe, J.L., 2009. Bugging the cone of silence with men's health interviews. In: B. Gough and S. Robertson (2009), *Men, masculinities and health*. Basingstoke: Palgrave Macmillan, 67-89.
- Postnote, 2007. *Ethnicity and Health*. Parliamentary Office of Science and Technology. 276. [online] (Published January 2007). Available from:

<http://www.parliament.uk/documents/upload/postpn276.pdf> [Accessed 20 July 2009].

Phoenix, A. and Frosh, S., 2001. Positioned by 'hegemonic' masculinities: a study of London boys' narratives of identity. *Australian Psychologist*, 36(1), 27-35.

Raine, K., 2005. Determinants of healthy eating in Canada: an overview and synthesis. *Canadian Journal of Public Health*, 96(3), S8- S14.

Randall, G. and Brown, S., 2005. *Future directions: A review of Irish housing needs in Irish Housing Association's key areas of operation*. London: Innisfree Housing Association.

Robertson, S., 2007. *Understanding men and health. Masculinities, identity and well-being*. Maidenhead: McGraw-Hill Education.

Robertson, S. and Williams, R., 2009. Men, public health and health promotion: towards a critically structural and embodied understanding. *In: B. Gough and S. Robertson, Men, masculinities and health*. Basingstoke: Palgrave Macmillan, 48-66.

Roos, G., Prattala, R., and Koski, K., 2001. Men, masculinity and food: interviews with Finnish carpenters and engineers. *Appetite*, 37(1), 47-56.

Sellaeg, K. and Chapman, G., 2008. Masculinity and food ideals of men who live alone. *Appetite*, 51(1), 120-128.

Seymour-Smith, S., Wetherell, M., and Phoenix, A. 2002. "My wife ordered me to come!" discursive analysis of doctors' and nurses' accounts of men's use of general practitioners. *Journal of Health Psychology*, 7(3), 253-267.

Sproston, K. and Nazroo, J., 2002. *Ethnic minority psychiatric illness in the community (EMPIRIC) - quantitative report*. London: The Stationery Office.

- Tilki, M., 2006. The social contexts of drinking among Irish men in London. *Drugs: education, prevention and policy*, 13(3), 247-261.
- Tilki, M., *et al.*, 2008. *The forgotten Irish*. London: Ireland Fund of Great Britain
- Von Soest, T. and Wichstrøm, L., 2009. Gender differences in the development of dieting from adolescence to early adulthood: a longitudinal study. *Journal of Research on Adolescence*, 19(3), 509-529.
- Walsh, J.J. and McGrath, F.P., 2000. Identity, coping style, and health behaviour among first generation Irish immigrants in England. *Psychology and Health*, 15, 467-482.
- Wardle, J. and Griffith, J., 2001. Socioeconomic status and weight control practices in British adults. *Journal of Epidemiology and Community Health*, 55(3), 185–190.
- Wardle, J., Haase, A.M., and Steptoe, A. 2004. Gender differences in food choice: the contribution of health beliefs and dieting. *Annals of Behavioural Medicine*, 27(2), 107-116.
- Wardle, J., Miles, A., and Atkin, W. 2005. Gender differences in utilization of colorectal cancer screening. *Journal of Medical Screening*, 12, 20-27.
- Wardle, J., Waller, J., and Jarvis, M. 2002. Sex differences in the association of socioeconomic status with obesity. *Journal of American Journal of Public Health*, 92(8), 1299–1304.
- Wilkinson, S. and Kitzinger, C., 1996. *Representing the other: a 'Feminism & Psychology' reader*. London: Sage.
- Zaninotto, P., *et al.*, 2006. *Forecasting obesity to 2010*. London: National Centre for Social Research/Department of Health.

Ziguras, C., 1998. Masculinity and self-care. *In*: T. Laws, ed. *Promoting men's health: an essential book for nurses*. Melbourne: Ausmed, 45-61.