Why Don't Men Seek Help? Family Physicians' Perspectives on Help-Seeking Behavior in Men

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BACKGROUND. Men tend to underuse primary care health services despite their susceptibility to particular types of illness. The purpose of this study was to report the family physician's perspective on why men do not access the health care system for medical problems.

METHODS. We used focus group interviews to identify major themes. The participants were family physicians in active practice randomly selected from a list of 500 full- and part-time teachers. Four focus groups were formed from 18 participants (12 men, 6 women), in practice an average of 17 years. Eleven of the physicians were in community practice.

RESULTS. Three key themes were identified: (1) Support: Men appear to get most of their support for health concerns from their female partners, little from their male friends. Their pattern of seeking support tends to be indirect rather than straightforward. (2) Help Seeking: Perceived vulnerability, fear, and denial are important influences on whether men seek help. They look for help for specific problems rather than for more general health concerns. (3) Barriers: Personal barriers involved factors related to a man's traditional social role characteristics: a sense of immunity and immortality; difficulty relinquishing control; a belief that seeking help is unacceptable; and believing men are not interested in prevention. Systematic barriers had to do with time and access; having to state the reason for a visit; and the lack of a male care provider.

CONCLUSIONS. Many of these findings are supported by psychological theories. Future research should apply these theories in more transferable populations and settings. However, an in-depth understanding of the patterns of men's use of primary care services is needed before we can determine if a regular source of primary care would have a positive impact on their health.

KEY WORDS. Men; health behavior; health services accessibility; family practice. *(J Fam Pract 1999; 48:47-52)*

The literature describes a relative underuse of health care services by men despite the fact that men are susceptible to particular types of illness and disease. Men are less likely than women to actively seek medical care when they are ill, choosing instead to "tough it out."[1-5] In comparison with women, men appear to be more susceptible to dependence on alcohol and other drugs, violent death as a result of accidents or suicide, work-related incidents, and premature death due to serious illness.[6-11] Nevertheless, men consult family physicians for health-related problems less frequently than do women,[12,13] possibly decreasing their chance for early detection, treatment, and even prevention of disease.

Guspers et al[9] conducted a study to examine the morbidity of men and women according to episodes of illness in general family practice offices in the Netherlands. They found the largest difference in the prevention and diagnostics category. These investigators counted episodes of illness instead of visits to the physician and found that rates of visits for women were 5 times higher than for men in all age groups. In addition, men had 1 1/2 times as many trauma diagnoses as did women, and because men live approximately 8 fewer years than women they use fewer services.[14] There are a few additional studies on male use of health care services, and several others on components of men's health status[15-17] and the relevance of social economic status.[5] However, little is known about the perceived and real barriers that prevent men from accessing the health care system.[18] There needs to be more on this topic — in particular, a description of the barriers to seeking help and how men use primary care as their key contact source for medical care.

There are various psychological theories that try to explain help-seeking behavior. The Health Belief Model

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has been applied to many studies of health behavior.[19] It proposes that the likelihood of someone undertaking a health behavior is a function of the perceived susceptibility to and severity of the disease and the perception of the effectiveness of the behavior in dealing with the health threat. The Theory of Reasoned Action[20] proposes that intentions to change health behaviors are a function of perceived norms about that act. The more someone evaluates an act as positive and believes that others favor it, the greater the chance that he or she will perform it. Further research is needed to apply the theories to men's help-seeking behavior.

The purpose of this study was to report the physicians' perspective on why men do not make visits to family doctors for help, and to gain insight into men's patterns of seeking health care. In particular, we wanted to explore the role of social factors, health beliefs, perceived barriers, and work as possible determinants of men's health and their help-seeking behavior. These factors were identified as themes in an earlier unpublished pilot study on this topic. In that pilot, we conducted a series of meetings of a group of male family physicians and social workers over several months. These meetings were conducted as open discussions of the topics of providing care to men and of the experience of being male patients. We decided to conduct studies of both physicians and of men in general for the pilot study; this paper describes the first study that interviewed only physicians. Family physicians provide almost all of the primary adult care in Canada, and information from our pilot study suggested that physicians may be part of the reason men do not consult.

METHODS

This research is based on data that was collected using focus groups. Four focus groups were conducted by the 2 investigators and run as described by Krueger[21] and Morgan.[22] Only 4 focus groups were run as the investigators reached saturation for new themes. There were 4 to 6 participants in each focus group. A total of 18 family physicians participated.

The sample comprised metropolitan Toronto community- and academic-based family physicians in full-time practice. They were recruited from the master list of 500 full- and part-time teachers in the Department of Family and Community Medicine at the University of Toronto in April and May of 1996. Fifty names were randomly selected from the original list of 500 physicians. We used a random sampling, because we believed any family physician could inform us on the matter. Physicians were called by one of the investigators (F.T.) and invited to participate in a lunch-hour focus group for a discussion on why men do not go to family doctors. The 50 selected physicians were called, but only 37 would talk to the investigators. Of the 37 that were contacted, 4 lived outside the area, 2 were retired, 2 were not in family practice, and 1 was on a long-term leave. These 9 were excluded, because we wanted to interview only physicians in active practice who could attend a local meeting. Eighteen of the remaining 28 physicians agreed to participate and attend the focus group, giving an overall response rate of 64.3%.

Of the 18 focus group physician participants, 12 were men and 6 were women. They ranged in age from 39 to 64 years, with a mean age of 45.3 years. Length of practice ranged from 9 to 33 years, with an average of 17 years in practice. Eleven of the physicians were in community practice and were either part-time teachers or were not teaching at the time. The other 7 were either full-time academic faculty or part-time teachers.

The interviews covered the various factors that have been identified as possible determinants of men's recognition of their health care needs, as well as their use of the primary health care system. They included questions on social factors, health beliefs, barriers to seeking care, and the role of work. The questions were developed on the basis of current literature on the components of men's health and help-seeking behavior. These elements included availability and quality of social support (eg, peer, opposite sex, and partner support)[23-28]; the Health Belief Model[19]; barriers to heath care use, including recognition of needs; socioeconomic status (health status, individual need, systemic barriers, work status)[1,2,4,9]; and work (men's identification with work, role strain).[29]

TABLE 1

Questions Posed to Our 4 Focus Groups of Physicians

Social

Do you think your male patients ever discuss their health concerns with others?

What do you think is the relative importance of your male patients' peers and partners in relationship to their health care needs?

How do you think your male patients usually decide to consult you?

Health Beliefs

What importance do you think perceived vulnerability to illness plays in your male patients' health beliefs?

How much do you think your male patients believe that changes in their behavior or lifestyle will be effective in improving their health?

Do you think they believe preventive health maneuvers and health promotion efforts are effective?

Barriers to Seeking Care

Do you think your male patients do a good job attending to their own health care needs?

What do you think are the most common barriers that make it difficult for them to attend to their health care needs?

Work

What are the unique elements of men's work that you think may affect their health?

A question guide was developed from the literature (Table 1). The focus group sessions were audiotaped and transcribed verbatim. Sessions lasted from 60 to 80 minutes.

The text analysis strategy used 2 methods: (1) immersion, a process that gets researchers intensively involved with the data so that they become sensitized to the content, range, and various subtleties within it; and (2) crystallization, a process that reflects the gradual formation and emergence of themes offered by participants.[30,31]

The 2 investigators read the transcripts independently and examined them for key words and emerging themes using the two-step approach adapted from Crabtree and Miller,[30] Miles and Huberman,[32] and Willms et al.[33] First, each investigator read the transcript several times. Then they each chose segments of text from the transcript that they viewed as a response to the open-ended questions asked in the focus group. The investigators met to discuss their chosen text segments. Once consensus was reached, they worked independently on the second step that involved developing a set of thematic categories that included specific themes. They did this by sorting and resorting the agreed on text segments. They met again to discuss and refine them, and to come up with a consensus on the final categories and themes and their accompanying text.

RESULTS

Three major themes emerged out of the data analysis (Table 2): (1) support: how men get support for their health concerns; (2) help seeking: help-seeking behavior patterns; and (3) barriers: real and perceived barriers that prevent men from going to doctors.

SUPPORT

Support from Partners and Peers

Two themes emerged involving support from partners and peers. Most of the physicians agreed that men do not seek much support for their health concerns. However, when they do seek support, it is usually from a female partner. These women are the ones who listen to their health concerns and urge them to seek medical help.

"I can't recall ever being told by a patient that they have talked to a friend who said 'Go to the doctor for that,' as opposed to hundreds of men who have talked to their wife or female friend who said 'Go to the doctor for that.' "

Men do not seek support from their male peers, except in cases where they view the health problem as "safe," such as a sports-related injury.

"[They discuss health care concerns] with other men as long as it is a sports-related injury. If it is a sports-related injury they will discuss it with their golfing partner, their squash partner or their running partner."

TABLE 2

Themes and Sub-themes that Emerged from Focus Groups of Physicians

Support: how men get support for their health concerns
- Partners
- Peers
- Patterns of sharing (eg, indirect)

Help seeking: men's help-seeking behavior patterns
- Importance of perceived vulnerability, fear, and denial
  - Triggers and high thresholds (eg, after an illness)
  - Influence of partner
  - Influence of others
- Influence of external factors (eg, illness of other men)
- Specific versus general pattern

Barriers: the barriers that prevent men from going to doctors
- Personal barriers
  - Male gender-specific and social roles; eg, immunity/immortality, giving up control, not accepted behavior, prevention not important
- Systemic barriers
  - Waiting time
  - Hours
  - Disclosing reason for visit
  - Lack of male family physicians
  - Location
  - Work (linked with time)

Patterns of Sharing

Physicians also described their perceptions of patterns of sharing health care concerns. Most participants felt that men were more likely to share their concerns in an indirect rather than a direct or straightforward manner. For example, the physicians described how their male patients would often come for a visit with no complaints or just general complaints about their health; however, these men hoped that the physician would ask pointed questions to find out why they were really there. The exception to this was when a man had a specific problem that was not complicated, like a sports-related injury.

"I would say they come for the general specific problem hoping that I would ask the right question."

HELP SEEKING

Perceived Vulnerability, Fear, and Denial, and the Influence of Partners and Others

Participants perceived their male patients as having a high threshold of tolerance before seeing the doctor. These men needed to feel very vulnerable before they sought help. Men would often need to be persuaded to see a doctor by their partners. However, all of the physicians noted that there was a recent trend among young men who were coming in on their own, with their partners close behind them. Almost all of the physicians viewed the influence of partners as critical to these men's decisions to seek help.

Older men (older than 55 years) with a history of serious illness or numerous risk factors sought medical help on their own regardless of whether they had partner encouragement.

"There is a group of people we consider very much health concerned and who are taking more interest in their health, especially people under 50, 55. The other group I would say talks a lot about health . . . those having undergone major physical illness. They spent a lot of time talking to each other about their [recovery]. A lot of my patients, I think, get *talked to* by their wives, not *talk with* their wives. The wife says, 'You know, you aren't doing enough exercise, Joe, and you are smoking and drinking too much, and you better go and see the doctor.' The next thing is, 'I made you an appointment to see the doctor.' "

Influence of External Factors

External factors were perceived to be important in influencing men to seek help. For example, men were more likely to seek help when they had a close friend who recently became ill, particularly if the friend had a diagnosis of prostate disease. They were motivated to seek help by their fear of acquiring a serious health problem and initiated contact with a physician on their own.

"You see them come in: 'I have just had 2 friends who have prostate cancer, and I need a rectal.' . . . very typical. That's a big thing now, prostate cancer."

Specific Versus General Patterns

The physicians believed that although their male patients arrived at their offices with general complaints about their health, they were usually there for a specific problem. Participants felt that female patients were far more likely to consult for general items, such as complete check-ups and preventive medicine. Meanwhile, men would have to have a tangible problem before they sought help (eg, getting a physical for a special driver's license or a focused musculoskeletal problem).

"They come because they have an acute something, twisted ankle, sore throat: 'I want you to fix it today, because I have to go back to work.' Sometimes they are very open: 'I've been sick for 3 days. I don't like being sick; make me well.' "

BARRIERS

We asked physicians why they thought their male patients did not attend to their health care needs. Physicians identified 2 types of barriers: personal and systemic.

Personal Barriers

Personal barriers had to do with traditional social roles. This included feeling a sense of immunity and immortality; difficulty relinquishing control; a belief that seeking help was not acceptable behavior for men; and believing that men are not interested in prevention.

"The vulnerability issue."
"Giving up control."
"Talking about confidential, private, and psychological issues."

Systemic Barriers

Physicians identified systemic barriers in the delivery of primary care services that they believed their male patients perceived as deterrents to getting proper medical help. These included long waiting periods before the patient gets to see the doctor; limited hours of operation; and having to disclose the reason for the visit to an assistant or receptionist. However, several doctors noted that they did not believe that these barriers were specific only to men (although they had been gender-specific in the past).

"There are a few men who certainly call . . . and say they absolutely hate sitting in the waiting room. I think if they can be brought right into the room . . . I don't know if it is actually people seeing them, or whether it drives their anxiety to a greater height by having to sit there."

"I wonder if one of the barriers also is that when you do make an appointment people might ask what it is for. It may be something they may not want to say over the phone to a receptionist. That was an issue in my office and we stopped doing that."

Several participants stated that they thought the lack of a male physician was a barrier for some of their male patients, especially those in the younger age bracket.

"My assistant is a woman, and I think that is sometimes a bit of a hindrance, especially talking about personal issues with trying to get an appointment for such and such a thing. . . . I think men feel much more sensitive, especially male teenagers . . . very secretive about anything having to do with their genital organs."

In addition, the location of clinics and absence of physicians in the workplace were identified as barriers.

"If you are . . . working . . . and can't get time off from your factory job to go to a doctor — it is a big deal to get time off — it is a lot harder."

DISCUSSION

The purpose of this study was to explore with family physicians their perceptions about why men do not go to physicians for help. The analysis resulted in 3 major themes: (1) Support: Men appear to get most of their support for health concerns from their female partners (if they have one), little from male friends except in certain circumstances, such as in the case of a sports-related injury. The pattern of support tends to be indirect rather than straightforward. (2) Help Seeking: Perceived vulnerability and fear

appear to be important motivators for seeking help, and denial often prevents men from thinking they need help. Their help-seeking patterns tend to be specific rather than general. (3) Barriers: The personal barriers involved traditional social roles. Men experienced a sense of immunity and immortality; had difficulty giving up control; believed that seeking help was not acceptable behavior for men; and believed that men are not interested in prevention. The systemic barriers were related to time and access, having to state the reason for visit, and lack of a male care provider.

There is little information in the literature about how men obtain support for their health concerns, but the finding that men get most of their support from female partners is consistent with the results of other studies.[34,35] For example, in their family medicine–based survey Norcross and colleagues[34] found a strong positive influence of female partners on the help-seeking behavior of men. Men were almost 3 times more likely than women to be influenced to seek health care by a member of the opposite sex. There are few studies to help explain why men do not turn to male peers for support. Shumaker and Hill[36] examined the association of social support and men's health in their review of the literature. They concluded that although social support is positively associated with better health for both sexes, the relationship is less clear for men. The reason was that the social support received is different for men: men's social networks are more extensive but less intensive; their peer group significantly decreases in size as they grow older; they are less likely to have confidants; and they receive less emotional and health-related support from children and friends.[36]

The patterns of men seeking help described by the physician participants in this study conform to some well-known theories of health behavior, including the Health Belief Model[19] and the Theory of Reasoned Action.[20] Another explanation for the help-seeking patterns described by the participants in our study comes from the psychological literature on male social roles. In a study of college students, Good and coworkers[37] found that the characteristics of the traditional male social role (power, competition, restrictive emotionality); worries about expressing affection to other men; and concerns about expressing emotions were all negatively associated with past or future psychological help-seeking behaviors. Furthermore, they found that the less traditional the man's social role, the more likely he was to seek help.

Other studies in the psychological literature may also help to partially explain our findings about the personal barriers to seeking help. Levant[38] identified 4 internal barriers that acted as deterrents to men seeking help from family physicians. These were difficulty in admitting the existence of a problem, difficulty in seeking help, difficulty in identifying and processing emotional status, and fear of intimacy. These 4 obstacles are consistent with our findings. Since both our study and the one by Levant[38] are based on descriptive research, these findings need to be rigorously tested.

There is little research on external barriers to health-related behaviors; we believe that many are common to both sexes. It may be important to use quantitative methods in future research to test our 3 new findings (having to state the reason for visit, the lack of a male care provider, and location of clinic) as they may be significant issues for family medicine. Future research could compare patient satisfaction and use of family practice with or without the following features: asking the reason for the visit, having male providers available, and having a convenient location with extended hours. Most important, however, is that future research needs to examine attitudes directly from the male patients and not their physicians.

LIMITATIONS

Our sample size was small, and the participants consisted of urban physicians, most of whom had been involved with teaching. This would limit the transferability of our findings to family physicians in other settings. However, we believe we obtained a good sampling of the target population's opinion, because we attained saturation after 4 focus groups. A further limitation is that all of the findings are based on the family physician's perspective. Future research should investigate nonteaching family physicians in community practice, as well as men with and without regular sources of primary care.

CONCLUSIONS

Three key themes were identified by our study: (1) support: men appear to get most of their support for health concerns from their female partners, little from their male friends; (2) help seeking: perceived vulnerability, fear, and denial are important influences on whether men seek help; and (3) barriers: personal and systematic barriers (perceived and real) that prevent men from seeking care. An in-depth understanding of the patterns of men's use of primary care services is needed before we can determine if a regular source of primary care would have a positive impact on health.[39]

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