



HARINGEY MAN MOT PROJECT

A REVIEW OF THE LITERATURE: MEN'S HEALTH-SEEKING BEHAVIOUR AND USE OF THE INTERNET

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Men's Health: A Review of the literature

Men's health-seeking behaviour and use of the internet for health

INTRODUCTION

Men's health is an area of public health concern (Baker, 2002; European Commission, 2011; White, 2006;), which prior to the year 2000 has been a relatively under-researched area (White, 2001; Baker, 2002; Courtenay, 2000b; Meryn & Jadad, 2001; Gough, 2006). Over a decade ago, the British Medical Journal published a special issue on men's health which highlighted that although men were advantaged in certain areas such as being paid higher salaries than women, that this was not reflected in their health status (Meryn & Jadad, 2001). Data consistently shows disparities in the health and health outcomes of men compared to women (European Commission, 2011; Meryn & Jadad, 2001; Courtenay, 2000b). Life expectancy in males is less than that of their female counterparts, for example, in England for the period 2009-2011, life expectancy at birth by gender was 78.9 and 82.9 for males and females respectively (ONS, 2013b). This pattern is replicated in almost all countries around the world, despite the higher socio-economic position held by many men across society (Gough & Robertson, 2010).

In Europe, morbidity and mortality data show that men are over-represented in statistics on cardiovascular disease (CVD) and non-gender specific cancers. Interestingly, these health inequalities are evident between men living in different countries, as well as in male populations living within the same country (European Commission, 2011). Although male mortality and morbidity from some long-term conditions seen today are related to biology, what is apparent is that biological explanations alone cannot fully explain these statistics. A biological view overlooks the complex interplay of the wider determinants of health, which include socio-economic, cultural, psychological and behavioural factors (Courtenay, 2000b).

The health behaviours and beliefs of men have been implicated in the health differences between men and women. It is well documented that men are

reticent about accessing healthcare services (White, 2001; Banks, 2001; Gough, 2013) and are less likely to visit their general practitioner (GP) when ill (ONS, 2011; HSCIC, 2009; McCormick et al, 1995, European Commission, 2011), with the exception of in the very late years of life (HSCIC, 2009). Evidence also suggests a tendency for men to present at the later stages of illness or when disease has reached the more critical stages (European Commission, 2011). In addition, when men do seek help they are less likely than women to present with concerns regarding mental health (Corney,1990).

Besides the poor uptake of healthcare services, there is also evidence that men are more likely to engage in other health damaging behaviours, such as substance misuse, risk taking, and non-engagement with preventative care which can also be detrimental to health (Courtenay 2000b; European Commission, 2011; Galdas et al, 2004). This in turn has resulted in a heightened interest to conduct research in the area of men's health. However, what remains a poorly understood area is why men engage in health-damaging behaviours, which in the main appears to be culturally accepted and practiced as 'the norm' by many. Unfortunately, this view left unaddressed gives men the licence to disengage or maintain their disengagement (Gough, 2006). Interestingly, the European Social Survey findings reveal that traditional gender role ideals have somewhat shifted amongst the employed population. Amongst both men and women there has been a decline in viewing men as 'breadwinners' and women as 'homemakers'. A point to note is that a greater shift in attitudes was found amongst men (NatCen, 2012).

Aim

This paper reviews the literature on men's health-seeking behaviour, in addition, to the use of the internet for health. Given the scope of the review, health-seeking behaviour was limited to reviewing four key areas, namely the influence of masculinities, masculine capital, institutional social structures and communication within medical consultations.

Method

The following databases were searched in September 2013 for studies published between 2000 and 2013.

- (a) PsychINFO
- (b) MEDLINE
- (c) EMBASE
- (d) PsyArticles
- (e) CINHALL

The reference list of the review articles were hand searched in order to find other potential studies. Only studies published in English were sought. Studies selected for the review were those with a focus on gender and health-seeking behaviour and men's use of the internet for health. The main themes to emerge from the studies are discussed in this paper.

FINDINGS

MEN'S HEALTH SEEKING BEHAVIOUR

The Influence of masculinities

'Man' as a risk factor

Courtenay (2000a) proposed being male and the practice of masculinity as possible risk factors for poor health. Connell (1995) introduced the concept of hegemonic masculinity in 1995, which refers to dominant ideals about what it means to be a 'real' man, which include stoicism, appearing strong and brave and risk taking (Banks, 2001). However, these deep-rooted culturally held social norms are said to influence men's behaviour, such as men avoiding accessing healthcare as a demonstration of masculinity. As looking after ones health has been socially constructed as a feminine endeavour (Courtenay, 2000a), a man who challenges these norms runs the risk of being branded 'deviant' (Dolan, 2010). Courtenay (2000a) argues that men who dismiss the need for help within the health sphere are constructing male norms of masculinity, and so 'when a man brags, "I haven't been to the doctor in years", he is simultaneously describing a health practice and situating himself in a

masculine arena', (pg. 1389). That said, a singular definition of gender and masculinity is unhelpful, as many men will enact a combination of both healthy and unhealthy behaviours within a masculine framework (O'Brien et al, 2005; De Visser & McDonell, 2013, Robertson, 2003). For example, health-related masculinity can be expressed through participating in sport and physical activity, thus not all masculine behaviours are damaging.

In accepting the typical model of masculinity, which assumes men have no interest in their health, men are subjected to being stereotyped as belonging to a homogenous group who behave in the same way and in all contexts, which is not the case (Galdas et al, 2004; Banks, 2001). Gough (2006) goes further to suggest that even using the term 'men's health' lends alludes to the view that all men are the same. This has led to the concept of hegemonic masculinity being heavily criticised by many researchers (Connell & Messerschmidt, 2005; Wetherell & Edley, 1999). Rather than looking for variables other than gender to explain the presence of hegemonic masculinity there are concerns that researchers may merely look for its existence within the data they collect. A further concern is that all enactments of masculinity are viewed as damaging to health, a view that has been contested by some (eg. O'Brien et al, 2005).

Masculinities and the medical encounter

Although women are perceived as over-utilising services healthcare and for presenting with non-serious health problems, it appears that men are disadvantaged when they attend for medical consultations. Courtenay (2000b) conducted a review of the adult population in the US to explore gender differences in behaviours that have an influence on health and life expectancy. The findings revealed that the duration of women's medical consultations lasted significantly longer than men's, and that men were given less and briefer medical explanations. In addition, men were found to receive less preventative health advice compared to their female counterparts, for example, on how to conduct self-examinations at rates of 29% for men and 86% for women for testicular and breast self-examinations respectively. These

practices suggest that sexism may be present within medical consultations (Roter & Hall, 1997, cited in Courtenay, 2000a).

Although inconclusive, some health communication studies have provided evidence that female practitioners are preferred due to the style of communication they use. This has been described as being more patient-centred, egalitarian, and showing interest in the psychosocial aspects of health (Roter and Hall, 1998). However, it should be highlighted that to make comparisons based simply on gender alone are incomplete. In addition, the attitudes of healthcare professionals have been found to impact on men's use of healthcare services (Robertson & Williamson, 2005). For example, a qualitative UK study of ten male GPs aged 35-53 years was conducted to gain insight into their experience regarding the health-seeking behaviours of their male patients (Hale et al, 2010). The study specifically examined male GPs perceptions of their patients health needs and their views on how and why they arrive at a decision to seek help. It also explored GPs own beliefs about health and health behaviours to see whether they influenced their consultations with their male patients.

The findings suggest that the GPs attitudes towards working men who had little contact with healthcare services were positive. Respondents ascribed this behaviour as their patients demonstrating hegemonic masculinity through non-attendance, with one GP stating '...the working guys come in with stuff that stops them from working' (Hale et al, 2010, pg. 706). However, non-working men who consulted with their GP more frequently were criticised, alluding to the fact that they presented with health problems that were not 'real'. This view is evident within an account from a GP who likened non-working men to women and trivialised their attendance. Women were perceived to over-utilise healthcare services and of having 'too much time' on their hands, evident in GPs account, '...the non-working men who've got the attendance profile that you associate with non-working women' (Hale et al, 2010, pg. 706). However, attendance was legitimised by GPs if men presented within a masculine framework, one of maintaining a stoic identity,

being coerced to attend by a spouse, or in communicating that the visit was delayed until the problem became 'real'. These examples illustrate how gender stereotypes can make their way into medical consultations. The authors suggest that the GPs negative attitude towards the non-working patients might be non-verbally communicated, a finding supported by Hale et al (2007) which indicates that some males felt male GPs held negative attitudes related to their use of healthcare services.

The findings also revealed that the GPs own health-seeking behaviours were dissimilar to that of their male patients in that they adhered to stoicism, a characteristic they viewed positively within their working male patients. Albeit a small study, the findings should be carefully considered, as if male patients feel that they are viewed negatively by their male GP for their help seeking practices, this may have an adverse effect on both the consultation and the frequency of visits by male patients

Institutional Social Structures

The Workplace

More men than women are employed within roles that involve exposure to danger, for example, the construction field, a male dominated arena. Within the workplace across Europe, men account for 95% of fatal accidents and 76% of non-fatal accidents (European Commission, 2011). This setting provides an opportunity for men to demonstrate masculinity (Courtenay, 2000a). Dolan (2010) conducted a small study in the UK using qualitative methodology to explore how working class men understand and experience masculinity and its perceived impact on men's health practices and health-seeking behaviours. The eleven participants lived in the West in two different socio-economic areas, one deprived and one less deprived. All participants described themselves as white and heterosexual. Their accounts showed representations of working class masculinity and how these can sometimes influence health behaviour. Examples were used from within their working environment, as a main arena in which masculinity was constructed and maintained. Men spoke of the dangers of the workplace, with many

mentioning strength and risk taking; 'I did a lot of demolition work....It's sort of a macho thing...I enjoyed that kind of shit-hole environment....That was part of the attraction to it, the danger' (pg. 592).

Men would sometimes add to the danger within workplace by seeing who could conduct tasks the quickest by way of a competition. One participant shared an example of when he worked for a wholesale butchers recounting, 'How fast can you get through this?....It's not very often we'd cut ourselves. But when we did we went out in style [laughs]' (pg. 592). Other participants gave examples of when health and safety regulations were ignored and occasions when they were expected to work with dangerous substances without adequate protection. There were also accounts given of when social pressure led some to conform and maintain certain unhealthy working practices to avoid being labelled a 'sissy' or 'wimp. 'Fuckin' wimp. You don't need a fucking harness..... I'm shit scared but I have to...You're seen as a trouble maker if you don't do it....You can lose your job' (Pg. 592-593). Social norm theory proposes that unhealthy and healthy behaviour is fostered by perceptions of how one's peers behave. Peer influence has been found to have a profound impact on behaviour (Berkowitz, 2004).

The Media

The media has been implicated in reproducing and reinforcing male stereotypes and often construct men as all being the same. Gough (2006) conducted a study to explore the representation of men within a UK national newspaper, namely The Observer, in November 2005, using qualitative methodology. Men were presented as a homogenous group who were disinterested, passive and naive recipients of health and a group requiring help, whilst women on the other hand were depicted as strong and proactive.

Although hegemonic masculinities are ever present within men's health literature and often presented as the most important aspect of men's identity, the need to challenge it has been articulated by researchers (eg. Jefferies and Grogan, 2012; Courtenay, 2004), including Gough (2006), who specifically

called for the need for the adoption of a psychosocial approach, which acknowledges the importance of the social context. The argument that leaving 'unhealthy' masculinities unchallenged gives men the licence to free themselves from engaging in health-enhancing behaviours has also been expressed by Gough (2006).

Health promotion initiatives have been designed underpinned by hegemonic masculinity ideals with limited success (Robertson & Williamson, 2005). However, whilst it is acknowledged that it has a role to play, other factors impact on health-seeking behaviour, such as ethnicity and socio-economic status (Galdas et al, 2004; Coles et al, 2010) and sexuality (Robertson and Williamson, 2005). The findings of a study carried out by Cole et al (2010) of eighty-two men aged forty years and over in two deprived boroughs in North West England partially support the idea that men should be targeted using an understanding of hegemonic masculinity but that they should also challenge notions that men should be targeted exclusively in this manner. The qualitative study aimed to explore men's understandings of their health within a social context. Many participants did not welcome being stereotyped by advertising and rated existing health promotion material poorly. They disliked stereotypical portrayals of the masculine body as young and athletic, as they did images depicting men as beer drinkers and made suggestions for the future advertising of health promotion interventions. The point was made that it is not necessarily the norm for men to frequent what are considered to be typical male spaces, 'A lot of men don't go to pubs, a lot of men don't go to clubs, a lot of men don't go to sports fixtures and stuff like that. More men go around supermarkets' (Coles et al, pg. 933). The authors concluded that a range of health promotion strategies should be used and in diverse locations.

Masculine Capital

'Man points'

The extent to which a male demonstrates dominant masculine ideals will influence the degree to which he will be perceived as masculine (de Visser et al, 2009). Masculinity has been identified as a contributing factor associated

with men's ill-health. Despite this, there is some evidence that aspects of masculinity can be health-enhancing (Gough 2013; de Visser et al, 2013). Displays of masculinity are said to result in the earning of 'masculine capital', defined as a form of 'credit' that counterbalances the display of non-masculine behaviour. However, the credit 'value' assigned to a behaviour is dependant upon whether it is rated as masculine or non-masculine, which will be influenced by the social context in which the behaviour is enacted (de Visser & McDonnell, 2013). Additionally, it is proposed that men who deviate from masculine social norms are able to accrue masculine capital by alternative means. For example, if a man losses 'man points' through the engagement in non-masculine behaviours such as abstaining from alcohol, this can be counteracted by engaging in an alternative masculine behaviour such as sport. This concept is captured in an account from a female participant in a study UK study of 731 predominantly white male and female university students aged 18-25 years using mixed methodology. The study examined how masculine capital is gained through masculine behaviour and how it is used to sanction non-masculine behaviour. The findings supported the notion of masculine capital, 'You might get somebody who is quite camp and they might also be sort of you know a star rugby player, you know what I mean? So it kind of depends really on them as a whole' (de Visser & McDonnell, pg. 9).

A further study endorsed a hegemonic view of masculinity but also found evidence of where men departed from a 'hegemonic' stance in providing some other reasoning for doing so (O'Brien et al, 2005). For example, fire fighters whose role gave them access to a strong masculine identify voiced that consulting for even trivial problems or for preventative care was important as it enabled them to maintain their health and in doing so keep their job. These studies provide some evidence of how masculine capital can be used to construct and maintain masculinity but also challenge feminine behaviours, which are seen to pose a threat to masculine identity. Similar to other researchers, de Visser & McDonnell (2013) call for gendered stereotyping to be challenged.

Metrosexual Masculinity

The term 'metrosexual' masculinity has been proposed as a form of masculine capital. Visser and McDonnell (2013) coined the term to describe a 'complex sophisticated style combining orthodox masculine characteristics of heterosexuality and financial power with a traditionally "feminine" concern about appearance' (pg. 6). Both James Bond and David Beckham were identified as examples of metrosexual archetypes within this study. Bond was defined as masculine due to his toughness and sexual prowess. However, respondents alluded to the fact that he lost 'man points' due to having a feminine streak and for his choice of drink, namely cocktails, considered a women's drink.

THE USE OF THE INTERNET FOR HEALTH

UK internet use

The internet has expanded rapidly since it was first developed in the late 1960's and is today a medium for the global transmission of information (Leiner, 2012). Based on the findings from the Opinions and Lifestyle Survey), in 2013 73% of the adult population in Britain accessed the internet on a daily basis, representing an increase of 35% from 2006 (ONS, 2013a). For everyday activities, adults aged 25-34 years used the internet more than other age groups. A significant growth in household internet connectivity has occurred, with 83% of households having an internet connection, which compared to 80% in 2012 and 57% in 2006 (ONS, 2013a).

Approximately 14% of adults had never used the internet in 2013 (ONS, 2013b). Having no interest in the internet is the main reason given for not accessing the internet (Oxford Internet Survey OxIS, 2013). However, it should be noted that reasons are multiple and vary across individuals and within social contexts. Not requiring the internet was the main reason given by households with no household internet access (59%), whilst 20% stated lack of computer skills, 13% high equipment costs and 12% high access costs as further reasons.

Modes to accessing the internet

The ways in which people access the internet is changing, with access via mobile phones having doubled over the three-year period of 2010-2013, from 24% to 53%. Wireless internet access is increasing rapidly in line with the number of wifi hotspots being provided. In 2013, 61% of adults accessed the internet when on the move, with higher levels seen amongst 16-24 year olds (94%), compared to 17% in those aged 65 and over. The mobile phone is a very popular form of accessing the internet in younger age groups (16-24) at the rate of 89%, with 51% of 45-54 year olds accessing the internet using this device. Tablet and laptop devices are gaining popularity with 32% of adults using them. The 25-34 age group report the highest rates of accessing the internet in this way, at the rate of 43%.

Social Networking

Social networking has increased rapidly, although recent figures suggest that this growth has reached a plateau in the last two years (OxIS, 2013). In 2013, it was estimated that 53% (ref) to 61% of adults participated in social networking, of which the highest participation rates were seen in 16-24 year olds at 93% (ONS, 2013a). Interestingly, a major growth has been observed in use amongst 45-54 years olds, with 51% participating in 2013, representing a 41% increase from 2007. In addition, an 8% increase has been noted in the 65 and over age group and just under a 15% increase in use between 2011 and 2013 amongst the 55-64 age group, representing the largest increase in use across age groups in this period (OxIS, 2013).

The 'Digital Divide'

The Oxford Internet Study (2013) finding estimate that there has been a 5% decline in non-use of the internet during the past 2 years, which in 2013 was 18%. This decline goes some way to reducing disparities in internet use. However, it is important to highlight that the digital divide persists with regards to age, socio-economic status, disability, region and even at the level of access. For example, one in five adults are without access (OXIS, 2013) and

more specifically, only 40% of households with adults aged 65 years and over had internet access compared to 74% of households in the 16-64 age range.

Income is a further factor affecting internet use. Of those in the high earning bracket (over £500 per week), internet use is almost at 100% coverage. In comparison, 6% of low earners (less than £200 per week) had never used the internet, representing a 3% increase from 2011 (ONS, 2013b). The Oxford Internet Survey (2013) findings reveal that there has been a major increase in internet use amongst the lowest income groups by approximately 15%-23%, with much of the increase occurring during the period 2011-2013. A large increase in internet use has been observed amongst those with the lowest educational attainment (no qualifications), where 40% now use the internet, representing an increase of 9% from 2011. Despite these increases, this group continue to experience disparities in internet access (OxIS, 2013).

Although men are more likely than women to use the internet, at rates of 88% and 84% for men and women respectively, there is evidence that the gender gap has decreased over the years to render such differences insignificant (ONS, 2013b). However, differences are observed when comparing non-users by age group and gender. For example, there is an 8% difference in non-use amongst adults aged 65-74, at levels of 28% and 36% for males and females respectively. This difference increases to 14% for males and females aged 75 years and over (ONS, 2013b). Despite there being evidence that the 'digital divide' is narrowing, such as the rise in internet access by those in low income groups, people without qualifications, retired people and individuals with disabilities, disparities still persist.

The use of the internet for health

The internet can be used as a means to both acquire and share health information (Hardy, 1999), with the advantage of the user being able to maintain anonymity (Kirschning & von Kardorff, 2008; Pollard, 2007). It may also contribute towards addressing health inequalities by providing access to health information to groups of population who are marginalised (Ellis-

Danquah, 2004). However, as aforementioned, it is important to highlight that marginalised groups are often less likely to have access to the internet (OxIS, 2013; Murray et al, 2003a).

The use of the internet for health has attracted much attention. However, despite the potential benefits of internet use in this area, several concerns have been raised by researchers. These include fears that it may encourage social isolation (eg. Doring, 1999 cited in Kirshning & von Kardorff, 2008), concerns regarding website credibility, as it is an unregulated medium (Larner, 2006; Rains & Karmikel, 2009) and that it may provide a pathway to non-conventional healthcare (Hardy, 1999), or may result in users finding misleading health information, or arriving at an incorrect self-diagnosis (Larner, 2006).

Furthermore, concerns have been raised regarding the internet posing a threat in challenging the medical profession (Nwosu and Cox, 2000). Hardy (1999) refers to this as 'deprofessionalisation', which refers to a shift in control from the health professional as a gatekeeper of health information towards giving access to the lay person. However, this move may not be viewed positively by all. Health seeking via the internet has led to reports of users feeling autonomous and empowered, for example, to manage their long-term condition (Seckin, 2010; Millard & Fintak, 2002). It is also reported that the internet can help users to prepare for medical consultations and in making decisions regarding treatment options (Seckin, 2010). Internet users gather health information for various purposes, including for the preparation, or following a medical consultation, to gain information regarding medication prescribed and for self-diagnosis purposes, or for help with managing a long-term condition (Rains, 2008).

Health information for use within health encounters

The gathering of health information by patients for use within health consultations has been implicated in affecting doctor-patient communication (Stevenson et al, 2007; Nwosu and Cox 2000; Murray et al, 2003a; Murray et

al, 2003b). The findings of a UK study of 300 obstetricians and gynaecologists consultants and trainees revealed inconclusive results. Although it was generally felt that the internet was of benefit to patients, 40% of participants believed that the internet may have a negative impact on the doctor-patient relationship whilst 30% felt it might improve the relationship (Nwosu and Cox 2000). A US telephone survey (Murray et al, 2003a), which included people in poor health, asked questions concerning their expectations regarding taking health information to a health consultation that had been acquired from the internet health and its effect on the doctor-patient relationship. The study findings revealed that respondents believed the doctor-patient relationship would worsen only if they perceived the doctor to have poor communication skills, or if the doctor felt that their position was being challenged.

Stevenson et al (2007) conducted a qualitative UK study to explore the views of patients on the effect of the internet on their relationship with doctors. Thirty-four ethnically diverse patients from various socio-economic groups took part in the study of which 65% of participants were male. No support for patients wanting to challenge their doctor was found within the patient accounts. Moreover, the internet was viewed by patients as a supplementary health resource (Stevenson et al, 2007). A further US study of 1,050 doctors revealed that 85% had experienced a patient bring health information acquired from the internet into a health consultation. The main predictor of the perception that the doctor-patient relationship would deteriorate as a result of this act was the doctor feeling their authority was being challenged by the patient (Murray et al, 2003b).

The health professionals in Nwosu and Cox's study (2000) accepted that the internet might enable patients to become more informed than themselves. Seventy percent felt that a more-informed patient did not pose a threat to their authority. Of particular interest was that 50% did not feel they had the skills to conduct internet searches, and of these, 89% wanted to be trained, with few (14%) having access to internet training. Fewer than 50% reported that they would recommend a website to their patients, the main reason being that they

did not have enough knowledge of the internet to do so. Other reasons included concerns regarding the reliability and quality of information contained within websites and that information may confuse patients, lead to unrealistic expectations and give rise to litigation claims.

The internet and men's health-seeking behaviour

The internet has been proposed as an effective medium to disseminate health information to address men's health issues due to its unique features (White, 2001; Pollard, 2007; Mo et al, 2009). It is often the first place that men will visit to seek out health information (Pollard, 2007). A range of channels can be used, for example, email, chat rooms, online support groups, websites and instant messaging. Several benefits of using the internet for health have been identified, some of which may be attractive to some men as they would appear to fit within traditional male behavioural norms, that men are strong, resilient and self-reliant and stoic (Pollard, 2007). However, as men are not a homogenous group the effectiveness of this approach for all men cannot be assumed. Benefits of using the internet to influence the health seeking behaviour of men include the fact that it provides access to a plethora of information which has the ability to be updated readily, access is fast, the cost is low, confidentiality and anonymity can be maintained by and it enables men to maintain a sense of autonomy (Pollard, 2007). Despite the potential benefits of using the internet for health, several concerns have been identified including quality of the information, out of date information, internet 'addiction', disparities in internet access, user health literacy requirements and searching skills (Pollard, 2007).

Problem Pages

There has been a growth over the past six years in the number of adults seeking health information online. In 2013, 43% of adults had used the internet to find health-related information via websites such as NHS Direct, compared to approximately 18% in 2007 (ONS, 2013a). There is some evidence that individuals with a pre-existing long-term condition are more likely to use the internet for health (Bundorf et al, 2006). To-date little is known

about the online health-seeking behaviours of men. However, some studies are emerging in this area. One such qualitative study conducted in Ireland explored the use of online male problem pages, traditionally viewed as a feminine pastime, as a means for men to acquire informal advice whilst maintaining anonymity (Neville, 2012). Letters posted to an 'agony uncle' online were analysed using a content analysis approach. In recent years problem pages are beginning to feature in men's magazines and cover a range of topics, which suggests that men require help.

Neville (2012) suggests that men tend to prefer informal support and lay advice on matters of a personal nature and so might turn to an 'agony uncle' for assistance, thus challenging stereotypes of typical male behaviour, namely that men are non-expressive. During a one-week period a total of 817 letters were written, 25.5 % by men. Less than 2% were on the topic of health and medicine. Multiple masculinities were presented which at times challenged traditional masculine norms in that many letters were emotionally charged, for example, related to 'relationship commitment and infidelity'. The author suggests that the internet may serve to allow men to express their emotions as they maintain anonymity and therefore are not a risk of 'losing face' by asking for help. However, that said, in general the 'agony uncle' served to restore traditional masculine norms in his advice given to men. Future research should explore other online approaches which may provide opportunities for men to express themselves freely.

Health-seeking and mental health

Hausner et al (2007) examined gender differences in the help-seeking behaviour of individuals with self-reported depression on two internet forums, one derived from the UK (www.defeatdepression.org) and the other from Germany (www.verrueckt.de). The two sites differed mainly in their presentation style, considered an important factor when assessing credibility, in that the more professional the site appears the more credible the information it contains is perceived to be (Sillence et al, 2004; Eysenbach et al, 2002, cited in Toms et al, 2007). The UK forum, sponsored by a mental

health charity, was presented professionally using a scientific approach with a sole focus on mental health. In contrast, the German forum had a less formal approach, placing emphasis on self-help. The site provided references, but only 70% of the links related to mental health and no access to specialist articles or up-to-date research were made available through the site. During the 5-month study period the UK and German forums received 89 (48% from men) and 97 (31% from men) queries respectively. The authors suggest that a websites presentation, professional appearance and scientific basis may positively impact on its use. In the current study the findings suggest that the UK website attracted more active users and that the presentation and content of the website may have contributed towards attracting more depressed visitors.

Patterns of communication

Although some studies report gendered patterns of communication online, others have found similarities between men and women (Klemm et al, 2003; Salem et al, 1997, as cited in Mo et al, 2009). A systematic review was conducted to explore gender differences in communication patterns within online health-related support groups (Mo et al, 2009). Twelve studies were included in the review. Six studies compared the messages posted to male and female cancer support groups, five studies compared messages posted by males and females in mixed gender support groups and one study compared those posted by men in a female-dominated support group and women in a male-dominated support group. Firm conclusions cannot be made as there was evidence of gendered communication styles when comparisons were made between messages posted to single sex online support groups; there was a tendency for men to focus on practical tasks and information related communication whilst women focused on emotional issues. It is important to note that in some cases men did not always conform to gendered styles of communicating, for example, in one study, men in a breast cancer support group posted messages with an emotional focus, suggesting a challenge to traditional hegemonic norms. However, there was less evidence

of gendered communication styles in messages posted to mixed sex gender support groups. The authors highlight the fact that a range of contextual and situational factors, such as how the gender make-up of users influence how men and women use online health support groups.

Use of educational health videos

A US study was conducted using health education videos lasting 90-seconds, with links providing more information on the topic, as a vehicle for health education in men (Campbell, 2012). The videos were underpinned by evidence and were named 'Men's Health PITCHes', an acronym for Presentation of Interesting, Timely, Consumer-based Health Information. The videos contained baseball graphics and sounds to encourage viewing. The six preventative health topics focused on conditions and factors that impact on premature death in men, such as waist circumference, sleep deprivation, colon cancer and erectile dysfunction and its link with cardiovascular disease. The topics Vitamin D deficiency and the dietary prevention of prostate cancer were also included, as they had received media attention. Nine hundred and forty men and women, 75% and 25% respectively, who were taking part in a preventative programme were sent the videos at two-month intervals via a personalised email to coincide with the major league baseball season. The PITCHes were also accessible via Facebook, Twitter and the hospital website. Video viewers could forward the PITCHes to others via a link and were given the option to receive further videos or to unsubscribe. A further 1,802 individuals were sent the PITCHes after the initial four PITCHes were sent to the original cohort. An email 'open rate' of 30.74% was achieved. Total viewing time of the six PITCHes combined was in excess of 85 hours and the number of viewing sessions was 2,951. The preventing cancer video clip had the longest total viewing time (33 hours, 18 minutes), whilst the shortest was Erectile Dysfunction: learn the warning signs (3 hours, 38 minutes). However, it ranked third for average viewing time (1 minute, 6 seconds). The author suggests that the sensitive nature of the topic may have influenced viewing rates. A limitation of this study is that it did not examine the effectiveness of this approach in changing health-related behaviour or in improving

knowledge. However, the author is conducting further research to examine the effects of the intervention, in addition to its long-term impact.

Young men, mental health and the health-seeking

Technology plays an important part in people's lives, particularly in those of the young (ONS, 2013a, Ellis, et al, 2013). There is an increasing interest in the use of the internet as a tool for the delivery of health services and for promoting health in young men (Robinson and Robinson, 2010; Ellis et al, 2013). Its use in relation to mental health in men has received some attention in recent times. An Australian study of young men aged 16-24 using mixed methodology (online survey and focus groups) was conducted to explore men's attitudes and behaviour with regards to mental health and technology to inform the design of an online mental health service for young men (Ellis et al, 2013). Seventeen focus groups were conducting with a total of 118 men and in addition, 486 men took part in a national online survey, the majority being from higher socioeconomic backgrounds. The findings revealed that young men used the internet for entertainment purposes and to connect with others. Participants were more likely to seek help for a mental health problem through informal sources, such as friends, rather than seek help from a professional. However, peer support may have a great influence on the likelihood of young men accessing professional mental health services, as participants stated that they would be more likely to seek help from a professional if encouraged to do so by a friend. Although the general view of such services was negative and the participants stated that seeking professional help was a threat to masculinity, for example, '.....[seeking help] just doesn't fit the male stereotype' (pg. 6). There was a preference for self-help and action-orientated strategies, although participants did not want mental health programs to be labelled as such.

Ellis et al (2013) conclude that internet features to consider when designing mental health interventions for young men include ensuring anonymity, the use of self-help strategies and action-based strategies, for example, gaming ('gamification') to improve engagement and user experience, with the

emphasis on engagement with the treatment. Other features include the offer of tailored interventions, an interactive experience, access to members of the community who have current or past experiences of mental health problems, such as via chat rooms. Robinson and Robertson (2010) raise an important issue regarding trust among users of male websites who wish to talk freely about health issues and the risk of them being 'silenced' or damaged through interacting with other users who hold traditional views of masculinity, for example, via 'male hegemonic bullying' (pg. 367). Suggestions for addressing such issues include websites having some degree of regulation or moderation.

DISCUSSION

The aim of this review was two-fold, firstly to review the literature on men's health-seeking behaviour, for which there was a specific focus on how masculinities affect the medical encounter, in addition to how masculine capital, traditional masculine norms and institutional social structures influence health-seeking behaviour. The second aim was to review how men use the internet for health. What is clear is that traditional male gender stereotypes are prevalent and are deeply embedded within society and culture. These stereotypes do men a dis-serve by making the assumption that all men are uninterested in their health, despite the obvious fact that men are a heterogeneous group. Consistent with other review findings (eg. Galdas et al, 2004), traditional masculine norms were found to influence health seeking-behaviour negatively. However, it is important to highlight that some men deviate from these norms and seek help, particularly if it is to maintain or restore a masculine identity, for example, by seeking help for a sexual health condition in order to be able to have sex, or to enable them to keep their job. (O'Brien et al, 2005).

There is evidence that institutional social structures such as workplaces (Dolan, 2010, Courtenay, 2000a), media messages (Gough, 2006) and healthcare systems (Courtenay, 2000b; Hale et al, 2010; Hale et al, 2007) influence men's health by acting as a barrier to engagement in health-

enhancing behaviours. For example, the media has a social responsibility and the impact of irresponsible reporting can have a significant on its audience. That said, the media is well placed to challenge and deconstruct traditional masculine norms. In addition, the literature suggests that sexism emerges within medical practice (Courtenay, 2006; Hale et al, 2007; Hale et al, 2010). Healthcare professionals should be mindful of the fact that a 'sexist mindset' may have a negative impact on men's experience of medical encounters and future use of healthcare services.

The literature consistently demonstrates that masculinities influence men's health seeking behaviour, although many studies use homogenous samples of white, heterosexual men from higher socioeconomic groups. Although some researchers are attempting to redress the balance (eg. O'Brien et al, 2005; Coles et al, 2010; Dolan, 2011), more investigations need to be conducted to explore differences and similarities between groups of men and within individual men. Future studies need to examine a range of influencing factors such as ethnicity, sexuality, socioeconomic status and age. There is particular need for more research exploring ethnicity and sexuality, as literature in these areas is sparse.

Adults in the UK are well connected to the internet, although inequalities regarding internet access and use exist. More adults are seeking health information online (ONS, 2013a), and for men the internet is often the first place they will look for help (Pollard, 2007). To-date few studies have specifically examined men's use of the internet for health, although there is growing interest in this area. Given that the characteristics of the internet seem to 'fit' with many of the traditional masculinity norms held by men (Pollard, 2007), intuitively the use of this medium for men's health seems plausible. The internet enables men to maintain anonymity, promote independence and offers fast access to volumes of health information.

Although the literature is limited, there is some evidence indicating men's preferences when seeking help online, which in young men includes self-help

and action-orientated approaches and contact with communities similar to themselves through channels such as chat rooms. Several aspects have been identified which may be of important when using the internet for men's health, such as maintaining anonymity and the importance of peers in health decision-making processes. In addition, other features considered to be of importance include the need for websites to be regulated or monitored to avoid those who wish to 'speak out' being rendered into silence by those holding dominant masculine norms. Other features that may be of importance include the presentation and content of the website, as a professional looking site may be perceived as more credible.

CONCLUSION

The present review has identified that health-seeking behaviour is a complex and dynamic phenomenon. It has highlighted some of the barriers and enablers of men's engagement with health services and health practices.

The internet has assisted in transforming the way we acquire health information, support and advice. However, simply making the internet available does not guarantee uptake by men. For men to change, a change in social norms is required. In sum, not all men are the same, neither are all men disinterested in their health. To reinforce dominant masculine ideals runs the risk of assuming all men are homogenous, which to use the words of Jefferies & Grogan (2012) 'provides a straight jacket for men' (pg. 912).

Research in this area is in its infancy and there is a clear need for further studies to examine the influence of masculinities on how men behave, taking into consideration variables other than gender in order to gain a more complete picture. Varied methodologies should be utilised and research should be conducted in a range of contexts and situations with heterogeneous samples.

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