

Factors affecting men's help-seeking in the early detection of prostate cancer: implications for health promotion

Keywords

Prostate
Health promotion
Neoplasms

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Abstract

Background: This paper reports the findings of a phenomenological study to understand and interpret the experience of a group of men before, during and after their attendance at a charity-based service for the early detection of prostate cancer.

Methods: A comprehensive review of the literature on men's help-seeking behaviour regarding their health was undertaken. Semi-structured interviews were then conducted with a purposive sample of 12 men who had attended the service in the previous 3 months.

Results: Resultant data showed that men experience social, psychological and structural barriers to help-seeking including a threat to masculinity, embarrassment, fear and guilt at using an under-resourced health service. Participants attended the service due to a variety of motivating factors which are often complex and interrelated. However, fear of cancer, the value of early detection, the media and encouragement by women were key cues to action. Participants felt reassured and empowered by the process, largely due to the interpersonal and communication skills of health professionals working within the early detection service.

Conclusions: The findings highlight the need for health policy makers and health promoters to understand men's help-seeking behaviour, provide them with information in a relevant and meaningful way and provide services for the early detection of prostate cancer which should be of high quality and person-centred. © 2004 WPMH GmbH. Published by Elsevier Ireland Ltd.

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Introduction

This study arose as a result of the lead researcher's work with a major charity in Northern Ireland which has provided a men's health programme since 1997 where the key aim is to raise awareness amongst men and their partners as to the value of the early detection of prostate cancer. This is achieved by working with men and women in a variety of settings, providing health promotion workshops, an information help-line, health education litera-

ture and a clinic staffed by experienced urologists where men can attend for clinical assessment. Through this work the researchers became increasingly aware of the differences between men and women in how they consider and act on their health beliefs. This anecdotal evidence provided the impetus for this study which aimed to identify, understand and interpret the lived experience of men who have attended a prostate early detection service and elicit the factors that influenced their help-seeking behaviour.

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Men have a 1 in 6 chance of dying from cancer before the age of 75 whereas women have a 1 in 9 chance. Prostate cancer is the second most common cause of death amongst men in Northern Ireland. On average, there are 492 registered cases of prostate cancer in Northern Ireland and 209 deaths each year [1].

There is a feeling among men that health-related behaviour is foreign to their culture and that they are not permitted to be as expressive in their illness behaviour [2]. If health promotion strategies targeted specifically at men are to be effective, understanding the context and meaning of their help-seeking behaviour is crucial [3].

In Western society men are more likely to be viewed positively if they possess traits such as being strong, controlled, silent and logical compared with women who will be more valued if they display gentleness, warmth and tact [4,5].

Men seem to consider themselves to be particularly invulnerable in terms of their health behaviour [6]. Their health choices are concomitant with their perceived sense of role, place within society, self-esteem and in particular masculinity, making it difficult for men to seek help regarding their health, preferring instead to continue with a facade regardless of the consequences [7].

Men delay seeking help when they are ill [8] and under-use primary health care services [9]. Although they are aware of risks associated with their behaviour, they tend to avoid addressing these [10]. Even though urinary symptoms interfered with their activities of daily living this was still not seen as a sufficient reason to consult a doctor [11].

Subjects and methods

Qualitative research is particularly suited to developing concepts in the natural, rather than the experimental, environment [12]. This may be more suitable when discussing potentially embarrassing areas of inquiry in this study. Phenomenology, which explores the experiences of everyday life [13], was chosen because it enabled insight to be gained into participants' meaning and experience of accessing the early detection service. The approach is feasible and suitable when the research question concerns the meaning of a phenomenon [14]. According to Bergum it is '... a *human* experience that strives to "interpret and understand" (as is

the aim of this study) rather than to "observe and explain", which is an approach normally found in a *natural science*' ([15], p56).

Sampling was purposive (theoretical) in character, participants being selected according to the needs of the study, providing cases rich in information for in-depth study [16]. All of the participants had thus attended the service, within the previous 3 months, because they had concerns about their prostate health. This was considered to be a reasonable period of time for the participants to reflect accurately and meaningfully on their experiences, thus reducing recall bias [17].

The sample of 12 men was deliberately constituted from men predominantly in the age range 50–59, the age group where early intervention is more likely to lead to a cure. It is unusual for men to seek help until they are older and the service rarely sees men below the age of 50 years. Older men's experiences were, however, also considered vital. Consequently the sample included men in their 60s. The ultimate size of the sample was determined by the principle of saturation [18] where interviews are carried out until the researcher determined that there is little new to be learnt from subsequent interviews.

Semi-structured interviews, with a core 'areas of enquiry' guide, were used to collect data as they have a loose initial structure, using open-ended questions, which permits the interviewer to respond to emerging areas of interest [19]. The guide, which was administered by an experienced interviewer, was designed to permit probing, clarification, and reflection. The areas of enquiry for interviews are shown below:

Semi-structured Interview – Areas of Enquiry

- Motivation and reasons for attending, time-scales involved and preconceptions about the service
- Prior attitudes regarding healthcare services and help-seeking
- Prior knowledge around prostate cancer and the benefits of early detection
- Personal experience of the visit including examination, investigations, provision of information and staff attitudes
- Anxiety/health gain following the visit and the overall benefit of the service
- Views on future health promotion strategies for working with men in terms of this service and in general terms

Observational notes, which were considered integral and indispensable elements of the data, were made on participants after each interview. Verbatim transcriptions were made of the tape-recorded interviews and checked for accuracy. Security of the tapes and master transcripts was assured.

Data analysis was undertaken where all of the participants' descriptions were read to "... acquire a feeling for them, a making sense out of them ..." ([20], p59). Significant statements, pertaining to the phenomena under investigation, were extracted and their meaning spelt out—known as formulating meanings. These formulated meanings were then organised into clusters of themes which were integrated into an exhaustive description of the phenomena. As far as possible, attempts were made to preserve the richness of the data because what is sought in phenomenology is 'a first-person description that stays in the first person' ([21], p19).

Credibility was assured through consistency in data collection and meticulous data analysis. Participants were asked to confirm the accuracy of the data and its analysis in capturing their 'stories'. Data saturation was achieved whereby the last two interviews did not reveal anything significantly different from that which had already been gleaned.

Ethical issues, to ensure the welfare of the respondents [22], were central to the planning and implementation of this study. Permission, including 'areas of enquiry', was obtained from the Research Ethics Committee. Even though participation was voluntary and reporting completely anonymous, referral protocols were put in place in the event of subjects needing further assistance as a result of issues raised by their participation in the study.

Results

This study sought to understand the factors which influence the process by which men, both symptomatic and asymptomatic, make their decision to seek help in relation to perceived concerns around cancer and cancer symptoms from a cancer early detection service. An overview of the results suggested an explanatory framework which charts the paths which men might expect to follow in their quest for help (Figure 1).

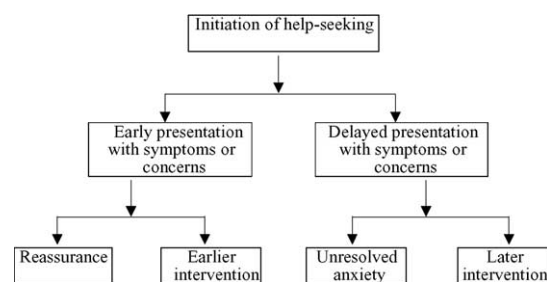


Figure 1 Explanatory framework of men's help-seeking.

It is apparent that an early decision to seek help in relation to perceived cancer symptoms would enhance the possibility of a positive outcome. Analysis of the data yielded a number of emergent themes which enhance our understanding of the dynamic of help-seeking depicted in Figure 1.

Cancer, threat, vulnerability and early detection

Essentially, men in the sample were concerned by cancer. The mention of the word itself seemed to evoke a negative reaction. One man summed this up: *'the word cancer, when I hear it mentioned, I do squirm with it'*. They described prostate cancer as a *'taboo'* subject. They felt that they, and other men, might be perceived in a negative way if they talked about their health to others or sought help about their health. There was anxiety about being seen as *'paranoid'* or *'a hypochondriac'*. Some thought that they might be seen as *'weak'*, or *'not as strong'*. Men felt it almost inappropriate and not masculine to be open about health: *'I think it is almost one of those taboo subjects that men don't talk about ... They don't want to hear you going on about your problems'*.

The strategy of humour was used to dilute their embarrassment or divert attention away from sensitive issues. This was encapsulated by one man: *'... men are maybe trying to cover up by trying to make a joke of it, you know what I mean, make fun of it in some way'*.

Participants embraced the concept of the early detection of prostate cancer, believing that it is *'... one that's curable'*. However, they recognised that men found it difficult to seek help and recognised very clearly that they felt fear when thinking about cancer: *'they're scared in case they find something'*. Some, however, were less understanding of other men: *"If you were*

aware of it and you didn't address it then 'don't cry for me Argentina!'"

Parallels were drawn with established cancer detection services for women, with respondents wanting greater surveillance for the early signs of cancer in themselves: 'I would actually like to go and get a check up every year or something like that - like an MOT on the car or whatever'.

Participants recognised the value of early detection for both themselves and other men and saw information as an intrinsic part of feeling empowered. This applied to them before, during and after their consultation. They felt reassured by 'knowing what to expect'.

External motivators to seek help

Participants differentiated themselves from women in terms of how they thought and talked about health. They felt that women knew their bodies better than men; 'any women that I know, know their bodies intimately - Men don't take that same interest in their bodies that women do'. The main reason attributed for this increased somatic awareness amongst women was the emphasis placed on breast cancer which was considered 'the big issue'. Media coverage of breast cancer was described as 'propaganda' which 'has gone through the roof'.

Men identified that women go to the doctor more often than themselves: 'I think it's a macho thing for men that they won't go to a doctor'. The perceived threat of the condition, moderated by the man himself, would determine if they sought help. It would generally have to be 'something serious' and a participant thought that '... they will go for sprains or breaks or things that are physically broken or whatever but these other things they tend to hold back'.

Women were seen as the arbiters of the family's health, one participant describing his wife as 'the guardian of the family'. They were perceived as ensuring that health matters were discussed and acted on. One participant stated: 'I knew, to be quite honest, when I mentioned it to her that she would be on the phone the next morning [laughs]'. Women were also considered to be more open than men about health matters: 'it's not the sort of thing that guys would go into the pub and talk about, whereas the women always get into wee groups in the pub or wherever and they talk about breast cancer and whether they've had a smear test etc'.

There was a consensus amongst participants that media coverage of prostate cancer had increased in the recent past. Men admitted knowing little about prostate cancer apart from the fact that it was the 'biggest killer' and that it generally 'affected men in their fifties and upwards'. Age was a factor for most of the participants: 'just a realisation that I was in the age bracket, I was likely to be vulnerable shall we say ...'

One participant had pain in his 'groin area' which he associated with the prostate. Five participants had lower urinary tract symptoms which were usually described as 'water works problems'. One man had 'severe' urinary symptoms for 10 years. Others described waiting for 3 to 6 months and 2 years before seeking help about their symptoms.

Three men had attended health promotion workshops, provided by the lead researcher, around the early detection of testicular and prostate cancer. One had made an appointment for the early detection service the next day and the other two delayed for 2 and 3 months. Two men were prompted to attend by male friends. One participant didn't want to go to his own general practitioner because the rest of his family attended the same doctor. Two thirds of participants were pleased that they were going to see an 'expert' or 'specialist' doctor and some expressed concerns at their general practitioner being able to assess them properly.

Men, power and control and perceptions of statutory health services

The men in this study expressed in very clear terms that they wanted power and control to rest with them when accessing services. The individual should be the arbiter of whether or not they feel empowered.

Participants felt that other men should have the right to choose to have a 'check-up' and emphasised the value of early detection and prevention: 'If somebody is healthy and they go and have a check-up ... they don't know they are healthy until somebody actually tells them ... somebody physically says "there is nothing wrong with you, you are clear" ... how are they going to know (there may be a problem), until it ... might be too late?'

General practitioners were perceived as 'reactive' rather than 'proactive', being more concerned with balancing budgets and controlling expenditure on medication. Lack of

time to provide a good quality service was also identified: *'he just doesn't have the time for you'; '... the GP in normal surgery hours has 40–60 people sitting there and it is a case of get in, what is your problem? Have a look and kick you out again ... They are so busy you almost feel as if you shouldn't be there'*. One man stated that his doctor would want to see someone with *'real illnesses'* and not somebody who *'has to go to the loo in the middle of the night'*.

Methods in promoting men's health

Participants were asked for their ideas and thoughts on promoting the early detection of prostate cancer amongst other men. It was considered important for promotion to begin with younger men. It was thought that if men attended for an early detection check and were reassured then they might re-attend. This would then establish the habit of attendance, perhaps on an annual basis.

One participant felt that the value of the programme should be directed at *'more macho aspects of society ... rugby clubs, the football clubs, to the military ...'*. Most men saw the difficulties in trying to encourage men's awareness of, and early attendance at, a detection service. An *'open house'* approach might be better where *'people could wander in and lift literature on it and wander around again freely and if they wanted to speak to people again freely'*. However he was pessimistic about the potential for success: *'I can never see that happening really ... I can't see people en masse. It's going to be a struggle to get people through the door all the time really I think'*. The work place setting was, however, identified as an area where a high proportion of men could be targeted.

Most participants recognised the role that the media might play in raising awareness. However, they were very aware that the level of coverage was very low compared with the coverage of cancers that affect women. It was felt that men wouldn't have the same interest in health matters anyway and would be unlikely to read health-specific material.

Discussion

Underlying the interpretation of all of the themes were several theoretical considerations, namely the nature of masculinity and

its effect on men's behaviour, the role of fear in adopting health behaviours and the concept of health empowerment.

Masculinity is essentially a contested concept with explanations given within the positivist/biological paradigm at variance with social constructionist and post-modern accounts [5]. It is a state of being rather than a single variable [23]. It was clear from observing and conversing with the men in the sample that they attribute their maleness to a combination of biological and social factors which is unique to their own personal context – an essentially social constructionist view [24]. Several tensions emerge. First, there is the interfacing of socially constructed gender characteristics such as inexpressivity, independence, dominance and invulnerability with the perceived breakdown of a primarily gender-determining characteristic, the prostate.

Secondly, there is the tension between these characteristics of masculinity and the fear continuum, which may go from mild anxiety to a state of debilitating terror. As a sense of threat is recognised as a motivating factor in social cognition theories of health behaviour [25,26], its effects must be taken into account in the help-seeking process. This sense of threat may also be conceptualized as a *'cue to action'* ([27], p21) and can often result from media intervention and coverage.

Empowerment is a key principle of health promotion [28–30], which is a subjective phenomenon, dependent upon issues such as self-esteem and self-efficacy and is allied to the individual's perceptions of how he relates to society. It is closely linked to a sense of mastery, locus of control and power [31]. The autonomous nature of the relationship between the participants and professionals greatly aided this process. Professionals strove to facilitate a strong sense of control [32]. This is believed to be strongly linked with the low levels of anxiety experienced by participants. Professionals at the early detection service always explain to men the rationale behind processes and investigations.

Societal expectations (social norms [33]) can lead men to behave and communicate in certain ways which they think are expected of them [4,34]. The male-female distinction in terms of behaviours and communication traits exists in all cultures [35]. Because being concerned about health, or *'being healthy'* is per-

ceived as a feminine trait by men, it may leave some men feeling vulnerable and threatened when thinking and talking about health.

Men use overt and very subtle ways of protecting their integrity when threatened. The findings in this study show how wide-ranging these are. Channelling and shaping threat and vulnerability can be avenues to enhance positive health choices. However, health promoters need to consider introducing threat in a measured, tailored and calculated way. They also need to be skilled in responding appropriately when threat and vulnerability become barriers [5].

The findings showed that men respond very differently to their own life experiences of cancer. Determinants of health are diverse and multi-factorial. Consequently, health promotion strategies must take into account a range of variables including men's gender characteristics. 'Health communication programmes that use multiple channels to deliver messages are more effective than those that rely on a single modality' ([36], p410).

The length of time that people waited with symptoms was alarming, reflecting other studies [37]. Acceptance of symptoms, despite the anxiety this caused, is a contradiction that many men live with [11]. Encouragingly, men in this study recognised age as the biggest risk factor for prostate cancer. However, in common with other men, they knew little else about it [38].

Once again the role of the media would appear to be significant as a cue to action and was often linked with other factors which participants had been thinking about, often for some time. It confirms that health promotion requires multi-disciplinary, collaborative strategies [39]. Further, there is a need for the medical profession to work with men to look at effective strategies to enhance reciprocal confidence and respect [40].

The findings in this study, which show a generally poor view of health services and the relationship with the doctor, have important implications for the early detection of prostate cancer. Men may not seek help if they feel they are a burden on resources and that they are not playing a role in decisions about their treatment and care. 'In current healthcare systems, both time and funding constraints can act as disincentives for doctors to explore and respond to patients' preferences regarding

the type of partnership they would prefer in the process of making decisions about treatment' ([41], p782).

Men need to feel enabled as a result of their consultation with the doctor. This means that adequate time needs to be allocated and that both parties need to know how best to capitalise on the experience. Historically, most clinical decision-making has been based on paternalism [42]. This, with a feeling of being rushed or even unwelcome, does not bode well for men attending in the first place or being able to discuss the complexities of the early detection of prostate cancer. Medical professional organisations have insisted that a counselling model is the most appropriate and empowering one when working with men concerned about prostate cancer, or with those who are exhibiting symptoms [43].

Participants had a variety of ideas and opinions on promoting other men's health on issues around prostate cancer. These findings support the notion that health promotion must extend through all levels of society through a range of strategies and settings [28,29]. Those working within the field of promoting men's health need to be adaptive, innovative, imaginative and indeed intuitive. To propose the use of intuition may seem contentious in the current drive for evidence-based practice, but the authors contend that it is an essential asset when working *with* people as opposed to delivering health promotion to people. This would seem to be particularly relevant when working with men regarding their attitudes and beliefs around health.

In conclusion, men attended a service for the early detection of prostate cancer due to a variety of motivating factors which are often complex and interrelated. They were concerned by cancer, yet recognised the benefits and principles behind the early detection of the disease; they knew, however, relatively little about it. They delayed seeking help due to a perceived masculine role which leads them to consider help-seeking and discussing health matters as difficult, sometimes foreign and unmanly. They are aware of this having a negative effect on health chances and recognise it clearly in other men. Men felt that there is more emphasis put on women's health and that by using primary health services they are a burden on already limited resources.

Women and the media can play a significant role in making men aware of issues around the early detection of the disease and encouraging them to seek help. When they do so it is crucial that the relationship that they engage in with health professionals is based on autonomy and mutual respect. They need to have confidence in the skill of professionals to meet their needs, not only in terms of clinical practice and expertise, but also in their ability to communicate in a manner that facilitates empowerment amongst men.

The men who attended the early detection service in this study felt empowered by the process of doing so. They felt strongly that the fact that they had attended increased their sense of control and that the choice to attend should remain with them. The increased emphasis on user involvement, shared decision making and community development approaches means that health promoters, regardless of any reluctance, should embrace the concept of empowerment and consider the benefits that this may bring.

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