A Study of Information-seeking Behaviors and Processes of New Zealand Men During Periods of Life-stress

Peta Wellstead
Adjunct Faculty, Open Polytechnic of New Zealand, Email: peta@freelanceinformationservices.com

New Zealand men have poor health outcomes in a range of domains compared to women. They also report barriers (both personal and structural) in their information-seeking behaviors and processes to improve health and wellbeing. This paper reports a research project in progress that is investigating the information-seeking behaviors and processes of New Zealand men during episodes of life-stress that may place them at risk. The project is investigating the ways that information can be provided to encourage men to engage in information-seeking in a more timely way to improve their health and wellbeing. Results from a pilot study for the current project conducted in 2013 (n = 307) suggest that New Zealand men face considerable barriers accessing information and support, and the pathways to care are often unclear or absent. The findings from the current nationwide study will present opportunities for service providers to be better informed about ways to engage men with information and support in ways that appeal to them. Greater appeal and applicability of information may result in more timely uptake by men experiencing life-stress and result in improved health outcomes. The information-seeking behaviors and processes of men and women across the lifespan needs to be acknowledged more readily by LIS practitioners and supported by appropriate curriculum innovations.

Context

New Zealand is a country of almost 4.5 million people. New Zealand is a bicultural country; 67.6 percent of the people have European heritage, 14.6 percent belong to the Māori ethnic group. New Zealand is also a country of migrants; 22.9 percent of people in New Zealand were born overseas. For people born overseas who live in New Zealand, the most common birthplace is England (Statistics New Zealand, 2013). The laws, customs and social norms of New Zealand society as a whole are strongly based within English traditions and history, although re-engagement with Maori traditions and culture has been as an aspect of New Zealand civic life over the last 30 years or so.

The Health of New Zealand Adults 2011/12 survey (New Zealand Ministry of Health, 2012a) confirmed ongoing differences between men and women in health status, health behaviors and health service use. The survey reports that while men have poorer health than women in many areas they are less likely than women to have visited a doctor, practice nurse or dental health care worker in the past year.

Of particular concern for the health and wellbeing of the New Zealand community is that, while New Zealand women haver higher rates of diagnosed mental health conditions and reported psychological distress, New Zealand men commit suicide at very much higher rates. There were 380 male suicide deaths (17.0 deaths per 100,000 male population, age-standardised) in 2010. In the corresponding period there were 142 female suicide deaths (6.4 deaths per 100,000 female population, age-standardised). The ratio of

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male to female suicide death rate was 2.7:1 in 2010. In the age range 15–24 years, the elevated rate of male suicide is even more obvious with 23.8 deaths per 100,000 population (New Zealand Ministry of Health, 2012b).

Another feature of NZ society is the rate of road trauma and its impact on community wellbeing. Despite substantial progress over the last 30 years, New Zealand still lags behind many other countries in road safety, and road trauma deaths are high. Over 250 deaths occur on NZ roads each year. Road crash death is highest in 14–44 year-olds and a significant proportion of these deaths occur in men. Alarmingly, in 2011, 12, 574 New Zealanders were killed or injured in road accidents, two thirds of these were men, and many women killed or injured were in motor vehicles driven by men (New Zealand Ministry of Transport, 2012).

Research in Progress

As a precursor to the current research a pilot study was conducted in 2013 by the Mental Health Foundation of New Zealand to test the survey and to gather a range of data to find out more about the exposure that such research can generate, gaps within networks that can reach possible participants, value of an online survey for this cohort of participants and the robustness of the research design. Three hundred and seven men (307) took the survey and these data were used to redesign the survey and to seek funding from Movember to undertake the nationwide study.

Movember is an international association that is highlighting the health needs of men through advertising, political lobbying, fund raising, and grants to projects that are investigating the health needs of men. Its major awareness raising initiative is a project to encourage men to grow a moustache during November—hence Movember.

The current research is being conducted using an online survey (as was the pilot study) during April and May 2014. Further data will be collected using focus groups. The project has been promoted throughout New Zealand through community and government networks, the media, and stakeholder groups. A Reference Group of eight members from a range of agencies who offer support to men has been formed and this group is providing guidance and support to the project.

The project has major three goals:

1. It is investigating the information-seeking behaviors and processes of New Zealand men as it relates to health and wellbeing;
2. It is soliciting the views of participants about ways that the health and wellbeing of New Zealand men can be supported by effective information delivery;
3. It is soliciting the views of participants about ways NZ men might be encouraged to seek information and support more readily during periods during periods when their wellbeing might be compromised.

Of the 307 men who entered the pilot survey; 282 completed it (a completion rate of 91.1%). The majority of participants had Anglo Saxon heritage (78.4%) and were between the ages of 45–64 (55%). Most of the participants (84.1%) were wage and salary earners. Half of the participants (50.9%) had university qualifications, either at graduate and postgraduate level. The majority of participants (71%) had an income above $50,000 per annum. Overwhelmingly the men in this study were married (61.8%) or had a partner with whom they live (17.1%). Of the men with children 36.1% were the parent of adult over 25. A further 30.4% have young adult children aged between 18–25. More than a quarter (26.4%) are the parent of 6–12 year olds. Of the men with children 50.6% recorded that their children lived with them.

It was clear from the results of the pilot

study that reaching men of diverse ethnic and social backgrounds was a challenge and had not been successful. In consultation with the Reference Group, industry partners and stakeholders, the research instrument was refined to reflect more closely the lives of a broader cohort of New Zealand men. Strategies were adopted to engage with hard to reach groups. Focus groups were included in the new research design as a way to engage with some of these hard to reach groups that may not have been willing (or able) to take an online survey. Stakeholder groups will support recruitment of the focus groups in an endeavour to get a wider cross-section of participants than in the pilot study.

Discussion

What was apparent from the pilot study is that when the New Zealand men were experiencing a major stressful life event many of them were unfamiliar with likely sources of information and help. The men were also unclear about appropriate pathways they could use in order to gain assistance. The pathways were either blurred or in many cases concealed by their own lack of knowledge of resources or help that might be available. They were also reluctant to seek out what they knew to be available due to their perceptions of what was normal behavior for men. These notions of "normal" created considerable gender role strain (Pleck, 1995) for them and created additional stress.

While many men expressed concern that they could not find the information and support they needed, others used a variety of strategies at different times to obtain the help they needed. These results are consistent with other studies (e.g. A. R. Berger & Janoff-Bulman, 2006; M. Berger, Wagner, & Baker, 2005; Finn & Bishop, 2006; Gottlieb, 1981; Stokes & Wilson, 1984) which show that help is mobilised in a variety of ways depending on the contextual circumstances of the help which is required. Not all available help is mobilised in the same way, or indeed, mobilised at all.

The pilot study identified some signficant issues that will be explored in more detail in the national study.

These include:

- the role of men's social networks in providing information and brokering support in New Zealand, and the type of information and support imbedded within these networks;
- the fact that many of the men perceive themselves to be socially isolated, either some or all of the time, nothwithstanding that most of the participants had a partner, employment and social status;
- the concept of information poverty within a group with seemingly good access to community resources due to their status, and
- the impact of changing gender roles within society as a contributor to men's health and wellbeing.

The last of these may contribute to anxiety among some sectors in the community. But given the poor health of NZ men, and continuing high rates of suicide, road trauma, alcohol abuse and perceptions of social isolation this is a community conversation that is imperative in order to design health policy initiatives that best meet men's need. Public health policy, and fiscal investment to provide it, is designed to empower action leading to improved health outcomes. If these improved health outcomes are not forthcoming, and clearly with regard to the statistics relating to men's poor health and wellbeing in New Zealand they are not, then a serious analysis of gaps and inequities needs to occur.

Agencies and professionals offering information and help may also wish to consider in more detail the notion of "optimum matching" in the information-seeking experience, and how services can take account of this concept more readily when attempting to support men.

More data is also required about the type of information and support that best meets men's needs when they are experiencing life-stress in order that they have clear pathways to care when they need it. There is also considerable scope to examine in more detail the notion of social network strength and provision of information and support. This research has as it major goal the development of greater understanding of men's information-seeking behavior, and ways the community agencies can develop information products and congruent services that men will find appealing and useful to improve their wellbeing.

Implications

Movember and the Mental Health Foundation will use data from the project to support other community agencies in their quest to provide more appropriate information to men so that they may more readily seek help during periods of life-stress. There has been considerable media interest in the project and data will also be provided to media outlets for dissemination in order to encourage a community wide "conversation" about the particular needs of men during periods of life stress and how information can be delivered to meet their needs.

Data from the study has the potential to provide information professionals with greater understanding of the different information seeking behaviors and processes of men and women across the lifespan. Men in most Western countries demonstrate poorer health outcomes than women and their information seeking in the health arena is often poor. Acknowledgement of these differences in information seeking behavior and processes needs to be supported by appropriate curriculum innovations. This research has the potential to support this goal both in New Zealand and elsewhere.

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