

Masculinity beliefs and willingness to seek help among young men in the United Kingdom and Pakistan

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Abstract

Health-related behaviors including help-seeking are related to men's felt and perceived masculinity. This study explored whether findings from studies of links between masculinity and health-related behavior in developed "western" contexts applied in the more strongly patriarchal cultural context of Pakistan. Online questionnaires were completed by male university students aged 17-30: 307 in Pakistan and 105 in the United Kingdom. Analyses revealed that compared to British men, Pakistani respondents had less egalitarian beliefs about gender relations, gave more importance to their own masculinity, considered non-traditional behaviors to have greater negative implications for men's masculinity, and were less willing to seek help. Among Pakistani men, lower willingness to seek help for physical and mental health was predicted by having less egalitarian gender beliefs, giving greater importance to personal masculinity, and considering non-traditional behaviors to have greater negative implications for men's masculinity. Among British men, greater perceived masculinity of help seeking predicted help seeking for physical concerns, and less importance of personal masculinity predicted help seeking for mental health. The results highlight a need for sensitivity to men's gender identity concerns when providing and encouraging use of health care, and to be aware of how cultural norms shape individuals' beliefs and behavior.

Introduction

Life expectancy is shorter for men than women, and young men have a higher risk of premature death (World Health Organization [WHO], 2016). Men's shorter life expectancy is influenced by being less likely to enact healthy behaviors, undergo screening, or seek help for psychological or physical problems (Galdas, Cheater & Marshall, 2005; Hing & Albert, 2016; Seidler, Dawes, Rice, Oliffe & Dhillon, 2016; White et al., 2011; WHO, 2014a; 2014b; 2015; Yousaf, Grumfield & Hunter, 2015).

Rather than simply attributing poorer health and unhealthy behavior to biological sex, it is important to consider gender identity and gender role beliefs (Butler, 1999; Courtenay, 2000; West & Zimmerman, 1987). Connell (1995) introduced the concept of "hegemonic

masculinity” to refer to dominant definitions of “real men” and “masculine” behaviors. Hegemonic masculinity is expressed through “masculine” behaviors set up in opposition to their “feminine” or “non-masculine” alternatives. Courtenay (2000, p.1385) argued that “health-related beliefs and behaviours, like other social practices that men and women engage in, are a means for demonstrating femininities and masculinities”. Health-related hegemonically masculine behaviors include physical strength, lack of concern about physical and psychological health, and not seeking help for health issues: their opposites tend to be considered “feminine” (Addis & Mahalik, 2003; Connell, 1995; Courtenay, 2000; de Visser & McDonnell, 2013; de Visser & Smith, 2007; Mahalik, Burns & Syzdek, 2007; Mahalik, Good & Englar-Carlson, 2003; Mahalik, Lagan & Morrison, 2006; Oliffe et al., 2011; Robertson, 2006; Sloan, Gough & Conner, 2010).

Men need not engage in *all* hegemonically masculine behaviors to be considered masculine, but men who enact more of these behaviors are more likely to be considered masculine (de Visser, Smith & McDonnell, 2009; de Visser & McDonnell, 2013). Hegemonically masculine behaviors provide “masculine capital” that may allow or compensate for non-masculine behaviors (de Visser & McDonnell, 2013; Ravenhill & de Visser, 2017). The health implications of masculine capital are important: men who wish to feel and be perceived as masculine may avoid “unmasculine” or “feminine” behaviors such as self-care and seeking professional help.

Studies of masculinities and health have tended to focus on men in developed western contexts. However, because gender norms are socially constructed, hegemonically masculine behaviors and the masculine capital associated with them may vary between cultures. The only published comparative study of masculinity and health found many similarities between Kenyan and US college students (Mahalik et al., 2006). In both countries, men who more strongly endorsed traditional masculine norms were more likely to believe that it was important for men to: manage personal problems on their own; be physically strong; and not admit being unwell. They were also less likely to attend physical or mental health appointments. However, there were also important differences. In Kenya - but not the USA - stronger endorsement of traditional norms was related to a lower likelihood of monitoring signs of illness, or consulting a health professional about physical or psychological concerns. It is therefore important to explore beliefs about masculinity, and masculinity-health links in other cultures, such as those in Asia.

Although the UK and Pakistan are both patriarchal societies in which wealth, privilege and

power are concentrated in the hands of men, UK society is less gender stratified, and it has a longer history of movement toward gender equality. This is reflected in indicators such as secondary school enrolment (UNICEF, 2016), and women's representation in parliament (World Bank, 2017). Weaker gender stratification may be reflected in more egalitarian gender beliefs, which are not compatible with rigid patriarchy. Because Pakistan and the UK differ in their degree of gender segregation, a comparison of masculinity-health links in these two countries allows insights into culture-independent and culture-specific influences of gendered beliefs.

One could expect that in less gender-egalitarian societies, sharper distinctions would be made between "masculine" and "feminine" behaviors, and that there would be more pressure to conform to rigid gender norms. Furthermore, the more "collectivist" Pakistani culture may have stronger expectations of conformity to social norms than the more "individualistic" UK culture (Markus & Kitayama, 1991; Asghar, Torrens, Iftikhar, Welsh & Harland, 2020; Shah & Amjad, 2011). UK research has found that people with less egalitarian gender beliefs perceive larger differences between masculine and feminine behaviors, ascribe more masculine capital to hegemonically masculine behavior, and believe that feminine behaviors have a larger negative impact on men's masculinity (de Visser & McDonnell, 2013). However, there is a lack of research using the same measures in different countries.

This study was designed to explore cross-cultural similarities and differences in: beliefs about masculinity; beliefs about gender and health-related behaviors; beliefs about the masculine capital associated with different behaviors; and links between intended health behavior and beliefs about gender and among young men in Pakistan and the UK. Extant literature allowed formulation of five hypotheses:

- 1) Pakistani men would have less egalitarian beliefs about gender relations than UK men.
- 2) Pakistani men would give greater importance to their own masculinity than UK men.
- 3) Compared to UK men, Pakistani men would perceive a bigger difference in the masculinity of men who engage in hegemonically masculine behaviors and men who do not.
- 4) Pakistani men would be less willing than UK men to seek help for health concerns.
- 5) In both countries, men would be less willing to seek help if they: had less egalitarian gender beliefs; gave greater importance to their own masculinity; perceived a bigger difference in the masculinity of men who do and do not engage in hegemonically masculine behaviors; and perceived help-seeking as less masculine.

METHODS

Participants

University students were recruited in early 2017 in Pakistan (307 men) and the UK (105 men). Respondents' ages ranged from 17 to 30 years (mean = 21.5). Some questionnaires were discarded because respondents did not live in the UK or Pakistan ($n = 3$), or did not identify as male or female ($n = 2$). The only eligibility criteria were that participants were university students aged 18-30 years. Pakistani men were older than their UK counterparts (PK mean = 22.1; UK mean = 20.5, $F_{(1, 410)} = 27.14$, $p < .01$), and gave greater ratings of the importance of their religion beliefs (PK mean = 8.76; UK mean = 2.64, $F_{(1, 410)} = 436.28$, $p < .01$), but there were no significant differences in the proportions in paid employment (PK = 17%; UK mean = 14%, $\chi^2_{(1)} = 0.40$, $p = .40$).

Procedure

Ethical approval was granted by the first author's institution. Numerous university departments in the UK and Pakistan were asked to forward information about the study to their students. It was not possible to calculate a response rate as it is not known how many departments distributed the message, nor how many eligible students received it. To enter the questionnaire, students had to follow the link in the recruitment email, and indicate that they had read and understood the participant information page, and consented to the confidential processing of their data. After completing the questionnaire, participants could opt into a raffle for £100 of shopping vouchers.

Materials

Gender Egalitarianism was assessed using the Sex-Role Egalitarianism Scale (SRES: Beere et al., 1984; Cronbach α in this sample = .87; UK sub-sample $\alpha = .73$; Pk sub-sample $\alpha = .85$). Respondents used 7-point Likert scales ("strongly disagree" to "strongly agree") to respond to 10 statements such as "The husband should be the head of the family". Higher mean scores on the scale indicated less egalitarian beliefs about gender relations.

Importance of masculinity was measured by an item taken from previous UK research: "How important to you is it to be [masculine / feminine]" using a 0-10 scale ("not at all" to "extremely"; de Visser & McDonnell, 2013).

Perceived masculinity of health-related behaviors was assessed by two questions taken from previous UK research (de Visser & McDonnell, 2013). Participants used a Likert scale

(“0 = not at all”; “10 = extremely”) to rate the masculinity of consulting health professionals for minor physical health concerns and consulting psychiatrists/psychologists for emotional/psychological problems.

Perceived masculinity of men was assessed using items adapted from UK research (de Visser & McDonnell, 2013; Ravenhill & de Visser, 2017). Respondents used Likert scales (“0 = not at all masculine”; “10 = extremely masculine”) to rate the masculinity of men with or without three masculine characteristics: physical strength, heterosexuality, and a high-earning job. The eight men in this 2x2x2 design were described as: “A man who is [physically strong / weak], [heterosexual / homosexual] and [high-earning / unemployed]”. These behaviors were chosen because they were more applicable to the Pakistan than those specified in de Visser & McDonnell’s (2013) study of British men. The *Masculine Capital Score* was computed as the difference between masculinity ratings of the man with all three hegemonically masculine characteristics (i.e., physically strong, heterosexual, high earning) and the man with none of these (i.e., physically weak, homosexual, unemployed). Ratings of the eight men were also used to create measures of the perceived *masculine capital* associated with the three characteristics (de Visser & McDonnell, 2013; Ravenhill & de Visser, 2017). The mean rating of the four weak men was subtracted from the mean rating of the four strong men to give a measure of the masculine capital associated with physical strength. Similar procedures were used to measure the masculine capital associated with heterosexuality and high-earning.

Willingness to discuss physical health concerns was assessed as the mean of responses to four novel items (Cronbach α in this sample = .67; UK sub-sample α = .67; Pk sub-sample α = .68). Respondents used Likert scales (“0 = I would never do this”; “10 = I would definitely do this”) to respond to the question “If you were worried about your physical health, how likely is it that you would talk to ...?” with four stems: “parent/carer”; “brother/ sister/other family”; “friend”; “doctor or other health professional”. After modifying the root to “If you were worried about your emotions or psychological well-being, how likely is it that you would talk to ...?”, the same items assessed *Willingness to discuss mental health concerns* (Cronbach α in this sample = .71; UK sub-sample α = .66; Pk sub-sample α = .74).

Analysis

MANCOVA was conducted to test the first four hypotheses: the required sample size to detect small-moderate differences ($d = 0.35$: Cohen, 1988) with 80% power and $\alpha = .05$ was 102+ per group. Age was entered as a covariate because Pakistani men were older than UK

men. To test the fifth hypothesis, correlates of willingness to discuss health concerns were explored: the required sample size to detect small-moderate differences ($r = .20$: Cohen, 1988) with 80% power and $\alpha = .05$ was 64+ per group. This was followed by linear regression to determine which bivariate correlates had significant independent multivariate associations with willingness to seek help.

RESULTS

Hypotheses 1-4: Between-country differences in beliefs about gender

Table 1 displays tests of hypotheses one to four. In support of hypotheses one and two, Pakistani men had significantly less egalitarian gender beliefs, and gave significantly greater importance to their own masculinity than did British men. In partial support of hypothesis three, Pakistani men had significantly larger Masculine Capital Scores, and perceived a significantly greater difference between the masculinity of heterosexual men and homosexual men, but there were no differences in the perceived masculinity of physical strength or help-seeking. In partial support of hypothesis four, Pakistani men were significantly less willing to seek psychological help, but no less willing to seek help for physical concerns.

Table 1

Hypothesis 5: Correlates of willingness to seek help

There was partial support for hypothesis five (Table 2). Among Pakistani men, greater willingness to seek help for physical health or mental health was significantly related to having more egalitarian gender beliefs; giving less importance to their own masculinity; and having smaller Masculine Capital Scores. It was not related to the perceived masculinity of help-seeking for physical or mental health. Among British men, greater willingness to seek help for physical health was related to greater perceived masculinity of help-seeking for physical health, but not egalitarian beliefs, importance of own masculinity, Masculine Capital Scores or perceived masculinity of help-seeking for mental health. Among British men, greater willingness to seek help for mental health was related to less importance of own masculinity, and smaller Masculine Capital Scores, but not egalitarian beliefs, or perceived masculinity of help-seeking for physical or mental health.

Table 2

To further test hypothesis five, multivariate regression analyses were conducted (Table 3). Among Pakistani men, there were two significant multivariate correlates of greater willingness to discuss physical health: less importance given to own masculinity, and smaller

Masculine Capital Scores. Three variables were significant multivariate correlates of Pakistani men's greater willingness to discuss mental health: more egalitarian gender beliefs, less importance given to own masculinity, and smaller Masculine Capital Scores.

Among UK men, only greater perceived masculinity of discussing physical health was a multivariate correlate of greater willingness to discuss physical health. Less importance given to own masculinity was the only significant multivariate correlate of willingness to discuss emotional health.

Table 3

DISCUSSION

There were many similarities between male university students in the UK and Pakistan, but also some important differences. There was support for the first two hypotheses and partial support for the third and fourth. Pakistani respondents had less egalitarian gender beliefs than their UK peers, and gave more importance to their own masculinity. This reflects the observation that although wealth, privilege and power are concentrated in the hands of men in both countries, Pakistan is more gender stratified (World Bank, 2017; UNICEF, 2016). Pakistani men also perceived a bigger difference in the masculinity of men who engage in hegemonically masculine behaviors and men who do not, and they were less willing to seek help for mental health concerns. Help-seeking was not perceived to be a source of masculine capital and may have detracted from men's perceived and felt masculinity (Addis & Mahalik, 2003; Galdas et al., 2005; Hing & Albert, 2016; Oliffe et al., 2011; Mahalik et al., 2003; Yousaf et al., 2015)

Supporting the fifth hypothesis partially, men with less egalitarian gender beliefs, and men who placed greater importance on their own masculinity were less willing to seek help: this was more obvious among Pakistani men. This reflects Mahalik et al.'s (2006) cross-cultural study of college students: Kenyan men's conformity to masculine norms predicted intended use of healthcare services, whereas this was not the case for men in the USA. However, it should also be noted that the relative lack of significant effects among the UK men may be due to the smaller sample size. These findings and those of past studies highlight a need to consider between- and within-culture variation in the links between masculinity beliefs and health behavior (de Visser & McDonnell, 2013; de Visser & Ravenhill, 2017; Mahalik et al., 2006). Strategies used in "western" countries to promote men's engagement with health care services - e.g., embedding health promotion within "masculine" domains such as football

clubs (e.g., Hunt et al., 2018) - may be effective in other contexts. However, there may be a need to adapt them to match culture-specific gender norms: they should make purposeful and targeted use of specific techniques - including normalising help-seeking - and should tailor language and terminology to make it clear, convincing, and culturally appropriate (Seidler, Rice, Ogrodniczuk, Oliffe, & Dhillon, 2018). There may also be a need for health professionals to address their own gendered assumptions (Seidler et al., 2018).

The results suggest that in less gender-egalitarian cultures one would find that more masculine capital would be ascribed to hegemonically masculine behavior. However, further quantitative and/or qualitative research could explore the extent to which living in a more individualistic culture (UK) or a more collectivist culture (Pakistan) affects the links between gender beliefs and health-related behaviors (Hofmann et al., 2010; Markus & Kitayama, 1991). Although “non-masculine” behaviour is often considered “feminine” (Connell, 1995; Courtenay, 2000), we were unsure whether this would apply in two different cultures. We therefore focused only on perceptions of masculinity and how they affected willingness to seek help. Future research could explore the influence of oppositional gender constructions.

One limitation of this study was the use of self-reports of willingness to discuss concerns rather than actual behavior. However, measurement of behavior requires demanding longitudinal designs, and intentions are an acceptable proxy for behavior (Sheeran et al., 2016). Furthermore, the results of this study of students may not be generalizable to other young adults or to older adults (de Visser et al., 2005). Research with larger and more representative samples is needed, because concerns about identity and gender-appropriate behavior are heightened during emerging adulthood (Arnett, 2000), and university students may have different gender beliefs than older, less educated, or less socially privileged people (Lynott & McCandless, 2000; Vespa, 2009). Future research could also compare a broader range of countries with different levels of gender egalitarianism (European Institute for Gender Equality, 2017), and examine additional components of hegemonic masculinity.

Future research could validate some of the measures used here: the measures of beliefs about gendered behavior have been used successfully in the past (de Visser & McDonnell, 2013; Ravenhill & de Visser, 2017), but not the measures of intended health behavior, and nor had the measures been used in Pakistan. Furthermore, the psychometric validity of some constructs operationalised through a small number of items is unknown. Future research could compare them to translated and culturally-validated measures such as the Conformity to Masculine Norms Inventory (Mahalik et al., 2003).

In conclusion, there is a need to consider men's gender identity concerns when providing, and encouraging engagement with, health care (Addis & Mahalik, 2003; Mahalik et al., 2006; Seidler et al., 2018). This may be particularly pertinent in cultures characterized by stricter gender roles. More broadly, there is a need to challenge restrictive gender beliefs that may dissuade men from using health services (Leaper & Friedman, 2007; Mahalik et al., 2006; Mahalik & Morrison, 2006).

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Table 1: Between-country differences in key variables among men in Pakistan and the UK (mean (sd))

Variables	PK men (n = 307)	UK men (105)	Difference	Effect size
Sex Role Egalitarianism Scale	4.49 (1.00)	2.39 (1.01)	$F_{(1, 409)} = 338.01, p < .001$	partial $\eta^2 = 0.45$
Importance of masculinity	8.30 (2.38)	5.30 (2.59)	$F_{(1, 409)} = 109.12, p < .001$	partial $\eta^2 = 0.21$
Masculine Capital score	4.77 (4.69)	3.50 (3.08)	$F_{(1, 409)} = 7.04, p = .008$	partial $\eta^2 = 0.02$
Strong - weak	0.97 (1.73)	1.28 (1.61)	$F_{(1, 409)} = 0.65, p = .420$	partial $\eta^2 = 0.01$
Heterosexual - homosexual	2.00 (2.91)	0.91 (1.70)	$F_{(1, 409)} = 9.35, p = .002$	partial $\eta^2 = 0.02$
High earning - unemployed	1.64 (2.09)	1.29 (1.41)	$F_{(1, 409)} = 3.02, p = .083$	partial $\eta^2 = 0.01$
Masculinity of seeking help - physical	3.50 (3.05)	3.88 (2.36)	$F_{(1, 409)} = 1.53, p = .217$	partial $\eta^2 < 0.01$
Masculinity of seeking help - psychological	3.10 (3.21)	3.43 (2.38)	$F_{(1, 409)} = 0.89, p = .347$	partial $\eta^2 < 0.01$
Willingness to discuss physical health	3.45 (2.16)	3.23 (1.97)	$F_{(1, 409)} = 0.69, p = .408$	partial $\eta^2 < 0.01$
Willingness to discuss mental health	3.81 (2.27)	4.43 (2.36)	$F_{(1, 409)} = 4.22, p = .041$	partial $\eta^2 = 0.01$

overall
MANCOVA:

$F_{(10, 400)} = 41.65, p < .001; \text{partial } \eta^2 = 0.51$
age includes as a covariate

Table 2: Correlations between willingness to discuss health concerns and key variables among men in Pakistan and the UK

Variables	Pakistani men (n = 307)		UK men (n = 105)	
	Willingness to discuss ...		Willingness to discuss ...	
	physical health	mental health	physical health	mental health
Sex Role Egalitarianism Scale	r = -.17 p = .002	r = -.21 p < .001	r = -.02 p = .984	r = -.07 p = .465
Importance of masculinity	r = -.18 p = .002	r = -.19 p = .001	r = -.16 p = .108	r = -.31 p = .001
Masculine Capital score	r = -.20 p < .001	r = -.22 p < .001	r = -.00 p = .984	r = -.27 p = .001
Masculinity of seeking help - physical	r = .04 p = .495	r = .01 p < .885	r = .19 p = .050	r = .16 p = .097
Masculinity of seeking help - psychological	r = .02 p = .688	r = -.02 p < .688	r = .13 p = .185	r = .18 p = .072

Table 3: Multivariate analysis of willingness to discuss health concerns among men in Pakistan and the UK

	B (s.e.)	B	t	significance
Pakistani men (n = 307)				
Willingness to discuss physical health $F_{(3,303)} = 7.16, p < .001, R^2 = .07$				
Sex Role Egalitarianism Scale	-0.204 (0.130)	-0.095	-1.567	p = .118
Importance of masculinity	-0.118 (0.052)	-0.130	-2.269	p = .024
Masculine Capital score	-0.062 (0.028)	-0.134	-2.209	p = .028
Willingness to discuss mental health $F_{(3,303)} = 9.38, p < .001, R^2 = .09$				
Sex Role Egalitarianism Scale	-0.287 (0.136)	-0.127	-2.113	p = .035
Importance of masculinity	-0.127 (0.054)	-0.133	-2.339	p = .020
Masculine Capital score	-0.071 (0.029)	-0.147	-2.454	p = .015
UK men (n = 105)				
Willing to discuss physical health $F_{(1,103)} = 3.95, p = .050, R^2 = .03$				
Masculinity of seeking help - physical	0.160 (0.081)	-0.192	-1.987	p = .050
Willing to discuss mental health $F_{(4,100)} = 4.48, p = .002, R^2 = .15$				
Importance of masculinity	-0.241 (0.089)	-0.264	2.696	p = .008
Masculine Capital score	-0.100 (0.067)	-0.149	1.490	p = .139
Masculinity of seeking help - physical	0.084 (0.119)	0.084	-0.708	p = .481
Masculinity of seeking help - psychological	0.089 (0.118)	0.090	-0.761	p = .449