Health Needs and Concerns of Male Students Attending UW-Stout

by

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Abstract

Student Health Services (SHS) at UW-Stout was interested in discovering the health needs of the male students it serves. SHS planned to use this information to improve healthcare services for men. In spring 2009, four focus groups were conducted with (N=24) male, degree-seeking, non-distance education students ages 18 or older. The sample contained students from a variety of majors and a majority of the sample was Caucasian and freshmen. During the focus groups, participants discussed their health behaviors, care-seeking behaviors and physical and mental health concerns. They also discussed the services they would like to see offered through campus healthcare. A qualitative analysis revealed main themes: concerns over violence with female perpetrators, relationship stress, and common illness and family history. Implications for SHS are also presented. Recommendations include using technology to promote healthy behaviors and creating services to make men feel more comfortable seeking care at SHS.

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Table of Contents

.....Page

Abstract.....2

List of Tables.....7

List of Figures.....9

Chapter I: Introduction.....11

Statement of the Problem.....11

Purpose of the Study.....11

Limitations of the Study 11

Methodology.....12

Chapter II: Literature Review.....13

Risky Behaviors.....14

Care-Seeking Behavior.....19

Masculinity & Health.....20

Men's Health Concerns.....24

Providing Health Services to Men.....25

Summary of Men's Health Related Literature Review.....29

Student Health Services at a Midwestern University.....30

Focus Groups.....31

Motivation for Current Study.....32

Chapter III: Methodology.....34

Subjects.....34

Subject Selection/Recruitment.....34

Procedure....35

Measures....37

Qualitative Analysis....40

Limitations....41

Chapter IV: Results....42

Question One. What Do You Do When You Are Ill?....46

Question Two. How Do You Stay Healthy....51

Question Three. How Do You Learn About Health Issues....55

Question Four. What Injuries/Illnesses/Diseases Are You Worried About Getting Now – While You Are in College....58

Question Five. What Injuries/Illnesses/Diseases Are You Worried About Getting in the Future – When You Are 40 Years or Older....64

Question Six. Violence....74

Question Seven. Body Image....77

Question Eight. Reproductive Health....81

Question Nine. Mental Illness....84

Question Ten. As Men, if You Create Healthcare on Campus, What Services Would You Offer....88

Chapter V: Discussion....96

Limitations....96

Conclusions....97

Summary of Findings....107

Recommendations....107

Summary of Recommendations....111

References....113

Appendix A: Invitation E-mail.....122

Appendix B: Confirmation E-mail..... 123

Appendix C: Reminder E-mail.....124

Appendix D: Consent Form 125

Appendix E: Prize Winner E-mail 127

Appendix F: Thank You E-mail 128

List of Tables

Table 1: Participants' College Majors.....42

Table 2: Total Responses and % of Total Responses by Question.....44

Table 3: Question One "What Do You Do When You Are Ill?" Responses by Construct.....46

Table 4: 'Severity' Responses by Sub-Construct.....47

Table 5: 'Self-Care' Responses by Sub-Construct.....49

Table 6: Question Two "How Do You Stay Healthy?" Responses by Construct.....52

Table 7: Question Three "How Do You Learn About Health Issues?" Responses by Construct.....56

Table 8: Question Four "What Illnesses/Injuries/Diseases Are You Worried About Getting Now – While You Are in College?" Responses by Construct.....59

Table 9: 'Common Illness' Responses by Sub-Construct.....60

Table 10: Question Five "What Illnesses/Injuries/Disease Are You Worried About Getting in the Future – When You Are 40 Years or Older?" Responses by Construct.....65

Table 11: 'Family History' Responses by Sub-Construct.....67

Table 12: 'Chronic Illness' Responses by Sub-Construct.....69

Table 13: 'High Risk' Responses by Sub-Construct.....70

Table 14: 'Cardiovascular Problems' Responses by Sub-Construct.....72

Table 15: 'Existing Problems' Responses by Sub-Construct.....73

Table 16: Question Six "Violence" Responses by Construct.....75

Table 17: Question Seven "Body Image" Responses by Construct.....78

Table 18: 'Addressing Concerns' Responses by Sub-Construct.....80

Table 19: Question Eight "Reproductive Health" Responses by Construct.....82

Table 20: Question Nine "Mental Illness" Responses by Construct.....85

Table 21: 'Family History' Responses by Sub-Construct.....87

Table 22: Question Ten "As Men, if You Could Create Healthcare on Campus, What Services Would You Offer?" Responses by Construct.....89

Table 23: 'Convenience' Responses by Sub-Construct.....90

Table 24: 'Pamphlets' Responses by Sub-Construct.....94

List of Figures

Figure 1: Percentage of Question One "What Do You Do When You Are Ill?" Responses by Construct 47

Figure 2: Percentage of 'Severity' Responses by Sub-Construct 48

Figure 3: Percentage of 'Self-Care' Responses by Sub-Construct 50

Figure 4: Percentage of Question Two "How Do You Stay Healthy?" Responses by Construct.....53

Figure 5: Percentage of Question Three "How Do You Learn About Health Issues?" Responses by Construct.....56

Figure 6: Percentage of Question Four "What Illnesses/Injuries/Diseases Are You Worried About Getting Now – While You Are in College?" Responses by Construct.....59

Figure 7: Percentage of 'Common Illness' Responses by Sub-Construct.....61

Figure 8: Percentage of Question Five "What Illnesses/Injuries/Diseases Are You Worried About Getting in the Future – When You Are 40 Years or Older?" Responses by Construct.....66

Figure 9: Percentage of 'Family History' Responses by Sub-Construct.....67

Figure 10: Percentage of 'Chronic Illness' Responses by Sub-Construct.....69

Figure 11: Percentage of 'High Risk' Responses by Sub-Construct.....71

Figure 12: Percentage of 'Cardiovascular Problems' Responses by Sub-Construct.....72

Figure 13: Percentage of 'Existing Problems' Responses by Sub-Construct.....73

Figure 14: Percentage of Question Six "Violence" Responses by Construct.....75

Figure 15: Percentage of Question Seven "Body Image" Responses by Construct.....79

Figure 16: Percentage of 'Addressing Concerns' Responses by Sub-Construct.....80

Figure 17: Percentage of Question Eight "Reproductive Health" Responses by Construct.....82

Figure 18: Percentage of Question Nine "Mental Illness" Responses by Construct.....85

Figure 19: Percentage of 'Family History' Responses by Sub-Construct.....87

Figure 20: Percentage of Question Ten "As Men, if You Could Create Healthcare on Campus, What Services Would You Offer?" Responses by Construct.....90

Figure 21: Percentage of 'Convenience' Responses by Sub-Construct.....91

Figure 22: Percentage of 'Pamphlets' Responses by Sub-Construct.....94

Chapter I: Introduction

Statement of the Problem

Men in the United States have a lower life expectancy than women and have a higher risk of developing many diseases ("Masculinity and Men's Health", 2008). Men also exhibit many high-risk behaviors, which increase their risk of getting illnesses, diseases and injuries (Courtenay, 1998). Despite these risks, men are less likely than women to practice health-promoting behaviors and are less likely to seek care from a healthcare professional (Courtenay, 2000a). Male college students also exhibit these behaviors, putting their health at risk (Courtenay, McCreary & Merighi, 2002). To properly serve male students, college healthcare professionals need to be fully aware of college men's health needs and concerns. While research has revealed the issues that should concern college men, few studies have been done to discover the health issues about which these men are actually concerned.

Purpose of the Study

This study was done to determine which health issues concern male students at UW-Stout. Administrators at SHS requested the study in an effort to learn more about the needs of the male population that they serve. The goal of the current study was to provide SHS with information to improve the on-campus healthcare services offered to male students. SHS administrators also planned on using the information from this study to develop a survey for a larger, future study.

Limitations of the Study

A major limitation of the study was the small sample size (N = 24). Another limitation was the nonrandom selection of participants. Focus group participants self-selected and signed up to be in the study. Due to this nonrandom, self-selection, results cannot be generalized to the

entire male student population at UW-Stout. Specifically, participants were not representative of the entire male student population in race or class status. Almost all of the participants (96 %) were Caucasian and a majority (58%) were freshmen. Only one graduate student participated. Finally, each focus group session lasted only one hour, which did not provide enough time to explore comments in more depth and detail. The data analysis is also a limitation. Qualitative analysis has the potential for subjective biases due to the inductive method used.

Methodology

The following chapter discusses what is already known in the literature about men's health risks, care-seeking behaviors and health concerns. Chapter III presents the methods and procedures that were followed during this study and Chapter IV presents the results of the study. The final section discusses the study's limitations and main findings. Chapter V concludes with a series of recommendations for SHS to improve their services for male students.

Chapter II: Literature Review

In the United States, men die younger than women ("Masculinity and Men's Health", 2008), as life expectancy for males is 5 years less than it is for females. Men also have higher death rates for 12 of the 15 leading causes of death (Heron et al., 2009). Young men also die at a greater rate than young women. Among 15 to 24 year olds, males account for more than three out of every four deaths (Courtenay, 2000a).

Not surprisingly, given the above data, certain illnesses and diseases occur in higher rates in men. The prevalence of overweight and obesity is higher for men in all age groups up to age 80, and among college students, more men than women are overweight (Courtenay, 2000a; U.S. Department of Health and Human Services [DHHS], 2009). Men have higher rates of hypertension than women in every age group until approximately age 60 or 70 (Courtenay, 2000a). Men start having heart attacks and strokes in large numbers about 10 years earlier than women do ("Masculinity and Men's Health", 2008) and more men than women have been diagnosed with coronary artery disease (DHHS, 2009). More males than females get cancer and, in general, more males than females die from cancer (Nicholas, 2000). Males also account for two out of every three deaths from melanoma (Courtenay, 2000a).

Men also have a greater risk of suffering from certain injuries. They are 14 times more likely than females to die from a work-related injury (Heron et al., 2009) and are at a greater risk for being in an automobile crash (Courtenay, 2000a). They are also more likely to die from a self-inflicted injury. Each year in the United States, four times as many males as females die by committing suicide (Centers for Disease Control [CDC], 2004; "Masculinity and Men's Health", 2008).

Given all the above, the question becomes "Why do men have a shorter lifespan, greater susceptibility to various illnesses, and increased prevalence of injuries?" Partial answers to these questions are explored below.

Risky Behaviors

The discrepancy in death and disease rates between males and females can be partially explained by men's behavior. Courtenay (2000a) reported that men are more likely than women to engage in 30 behaviors that are associated with an increased risk of disease, injury and death. Men and boys are more likely than women and girls to participate in risky sports and recreational activities, such as skydiving, hang gliding, scuba diving and mountain climbing (Courtenay, 2000a). Men further engage in risky behaviors in the areas of driving, substance abuse, sexual activity and health (Courtenay, 1998; 2000a). Men are also more likely than women to be both perpetrators and victims of violence, with the most common type of violence in the United States involving males committing violence against other males (Brooks, 2001). College men are no different, engaging in more risky behaviors related to driving, drug use, sex, physical violence and health promotion (Courtenay, 1998).

Driving. Men are more likely than women to drive dangerously. Men take greater risks while driving by being more likely to tailgate or run red lights (Courtenay, 2000a). Despite engaging in more dangerous driving, men are less likely to wear their seatbelts (Courtenay, 1998; 2000a).

Male college students are also less likely than college women to use seatbelts (Courtenay, 1998; 2000a). College men also combine risky behaviors involving driving and substance use. In one survey of male undergraduates, 43.8% of freshmen and 51.6% of seniors admitted to drinking and driving (Heck & Pinch, 1990).

Substance use. The use of tobacco, alcohol and steroids is greater among men than women. More men than women are cigarette smokers (Courtenay, 2000a). Men are also more likely to abuse alcohol (Brooks, 2001) and both the quantity and frequency of alcohol consumption are higher among men (Courtenay, 2000a).

College men also engage in riskier substance abuse practices than college women, such as smoking cigarettes and pipes (36.8% of men versus 28.9% of women), chewing tobacco (14% of men versus 1% of women), drinking five or more alcoholic drinks a day (43.8% of men versus 27% of women) and using recreational drugs or steroids (2.6% of men versus .4% of women) (CDC, 1997; Courtenay, 2000a; Courtenay, McCreary & Merighi, 2002). College men are more likely to engage in binge drinking (50.7% of men versus 40% of women) (Wechsler, Lee, Kuo & Lee, 2000). The use of marijuana (44.6% of males versus 40.8% of females), cocaine (6.7% of males versus 6.5% of females), inhalants (11.7% of males versus 7% of females) and injection drugs (1.3% of males versus .2% of females) is also greater among college males than college females (CDC, 1997).

Sexual activity. Men engage in a number of risky sexual behaviors. They are more likely than women to be sexually active and begin sexual activity at an earlier age (Courtenay, 2000a). Men are more likely to combine sexual activity and substance use by having sex while under the influence of alcohol or other drugs (22% of men versus 13% of women) (Courtenay, 2000a).

College men are more likely than college women to be sexually active (85.2% of men versus 79.3% of women) (Campbell, Peplau & DeBro, 1992; Helweg-Larson & Collins, 1994; Reinisch, Sanders, Hill & Ziemba-Davis, 1992; Wiley, James, Furney & Jordan-Belver, 1997). Although Schwartz (1999) did not find a significant difference between male and female

students' age of first intercourse, the average age was 16.1 years for college males and 16.9 years for college females, college men are more likely to have a greater number of sexual partners (11.2 for men versus 5.6 for women) and to be non-monogamous (19% of men versus 10% of women) (Prince & Bernard, 1998; Reinisch, Sanders, Hill & Ziemba-Davis, 1992). Compared to female students, male students are also more likely to use alcohol or other drugs before having sex (16.3% of men versus 8.3% of women) (Wiley et al., 1997).

Violence is also combined with sexual activity. Brooks (2001) found that 34% of college men admitted to engaging women in unwanted sexual contact, 20% admitted to attempting unwanted intercourse and 10% admitted to completing unwanted intercourse.

Men engage in risky sexual behavior by not always taking the proper precautions to prevent disease or pregnancy. In a survey of sexually active 14 to 24 year old males, 23% reported having unprotected sex "all or most of the time" and 48% reported having unprotected sex "some of the time". In addition, 56% of these individuals reported not using a condom at their most recent sexual encounter (Raine, Marcell, Rocca & Harper, 2003). Despite engaging in these risky sexual behaviors, men are less likely to be tested for HIV (DHHS, 2009).

Like males in general, male college students also engage in unprotected sex. In one study, 55% of college men reported not using a condom during their most recent sexual encounter (Wiley et al., 1997). College men are less likely than college women to have ever used a condom during sexual intercourse (86% of men versus 94% of women) (Caron, Davis, Halteman & Stickle, 1993; Helweg-Larsen & Collins, 1994). Caron et al. (1993) also found that male students were less likely than female students to have used condoms while attending college (75.8% of men versus 83.3% of females). Male students were also less likely to have used a condom with their most recent sexual partner (48.2% of men versus 55% of women).

Further, compared to college women, college men are less likely to be tested for HIV (25% of men versus 55% of women) (Prince & Bernard, 1998).

Health promotion. Men jeopardize their health not only by engaging in risky behaviors, but also by not engaging in healthy behaviors. Specifically, compared to women, men engage in fewer health-promoting behaviors (Courtenay, 1998). They are less knowledgeable about health and are less likely to engage in a variety of preventative and self-care techniques, such as restricting activities or staying in bed for both acute and chronic conditions (Courtenay, 1998; 2000a).

Men are less likely to conduct self-examinations or to obtain preventative screenings and checkups (45% of men versus 77% of women). Men are less likely to practice self-exams for testicular cancer than women are to practice self-exams for breast cancer (Courtenay, 1998). Men are less likely to have had their cholesterol levels checked or to be regularly screened for high blood pressure (Courtenay, 2000a).

The above is also true for college men when compared to college women. Even though college men are among those at the highest risk for getting testicular cancer, three out of four do not know how to perform testicular self-examination (Courtenay, 2000a). College men are also less likely to conduct self-examinations for skin cancer (Courtenay et al., 2002). Their failure to conduct skin cancer self-exams is especially problematic since men are also less likely to protect themselves from developing skin cancer (36% of men versus 53% of women) (Koh et al., 1997). Although men are exposed to sunshine more often, women are 1.5 to 4 times more likely than men to protect themselves by using sunscreen (Courtenay, 1998; 2000a). Lastly, college males are less likely than college females to have their blood pressure checked every year (Courtenay

et al., 2002). They are also less likely than college women to have physical or dental exams every year (Courtenay et al., 2002).

Men even differ from women in the most basic behaviors of sleeping and eating. Men get significantly less sleep and eat less healthily than women do (Courtenay, 1998; 2000a). Men eat less fiber and fewer fruits and vegetables (Courtenay, 2000a). Among college students, men, compared to women, engage in a greater degree of risky diet behaviors, such as eating chips and fried foods, red meat, salt, sugar and foods that are high in fat (Courtenay, 2000a; Courtenay et al., 2002).

Men also affect their health by choosing unhealthy strategies to cope with stress. In one study, over half of the strategies male undergraduates used to cope with stress were less than desirable, meaning they appeared to focus on how to escape from feeling stress rather than how to deal with it effectively (Davies et al., 2000). Another study of male undergraduates revealed that 17% of freshmen and 35% of seniors used the less desirable coping behavior of withdrawal/isolation instead of more desirable behaviors like talking and exercise (Heck & Pinch, 1990).

Interestingly, despite all of these increased health risks, men do not seem to be aware of their vulnerability. Men perceive themselves as being less vulnerable to disease than women (Nicholas, 2000). In addition, men are less knowledgeable about health issues. Nicholas (2000) suggests that men may be unfamiliar with the signs and symptoms of cancer and with cancer screening recommendations.

College men also underestimate their vulnerability. College students, both male and female, underestimate their risk of having a heart attack. Both male and female college students are optimistically biased about their overall heart disease risk and are unaware of a number of

commonly known risk factors for heart disease (Green, Grant, Hill, Brizzolara & Belmont, 2003). Davies et al. (2000) discovered that male college students are aware of their family histories and the diseases that they may be susceptible to developing. However, these same students believe that other college men are unaware or unconcerned that their current behavior could affect their future health.

Care-Seeking Behavior

Despite their health risks, men tend to conceal their vulnerability and are reluctant to ask for help (Courtenay, 1998). Men visit healthcare providers less often than women and utilize significantly fewer health care services (Courtenay, 2000a). Men are more likely to have not visited a doctor or other health professional in the past 12 months or to have never contacted a doctor (26% of men versus 12% of women). Men are also less likely than women to have contacted a dentist or other dental health professional within the previous 6 months (39% of men versus 45% of women) (DHHS, 2009). Men use fewer outpatient mental health services, even though they are more likely to meet criteria for psychiatric diagnoses in their lifetimes. When they are speaking to a healthcare provider, men are more likely to focus on physical problems and less likely to disclose mental and emotional problems (Schofield, Connell, Walker, Wood & Butland, 2000). As a consequence of men's reluctance to seek help, males' health problems are often more serious when they do finally visit a healthcare provider (Courtenay, 2000a).

College-aged men are similar, in that they are less likely to engage in positive health care-seeking. For example, they are less likely to have a regular physician. Of individuals aged 18 to 29 years, 53% of males do not have a regular physician, compared with 33% of females (Courtenay, 2000a). Men aged 20 to 24 were also less likely than women of the same age group to have received a health or family planning service in the last year (51.9% of men versus 80.5%

of women) (CDC, 2009). Among college students, males make fewer medical visits than females and are more likely to delay seeking care for sexually transmitted infections and psychological problems such as depression (Courtenay, 1998). They are less likely to consult a physician when unfamiliar symptoms arise (Courtenay et al., 2002). Male undergraduates report a reluctance to seek help for medical or emotional problems unless they are in extreme physical or emotional pain (Davies et al., 2000).

Further exacerbating college males' health, when college men do seek care, they show a poorer degree of medical compliance. They are less likely than college women to go to all scheduled appointments, to take prescription medications as directed and to fill prescriptions immediately (Courtenay et al., 2002).

Masculinity & Health

In order to get a better understanding of men's health, research has been focused on discovering why men engage in risky behaviors. Research has revealed that risky behaviors may be the product of male socialization, masculine social norms, and adopting masculine gender roles (Courtenay, 1998; 2000b; Courtenay et al., 20002; Levant et al., 2009).

Male socialization. Courtenay (1998) concluded that male socialization may be partly to blame for men's risky behaviors. Men are socialized to be decision-makers and to avoid seeking help from others. They are also taught to emphasize rationality and to reject emotionality and the expression of feelings. From an early age, men are discouraged from seeking help by peers, parents and other adults. This socialization can influence men to conceal their vulnerability and avoid seeking care from a healthcare professional. In a study of male undergraduate students, the most frequently cited barrier to seeking health services was a need to conceal vulnerability and be independent (Davies et al., 2000). According to a theory by Courtenay (2000b), men

demonstrate their masculinity by denying weakness or vulnerability and appearing strong and robust. They also practice emotional and physical control and dismiss any need for help. Courtenay (2000b) also theorizes that men take risks and dismiss their health needs in order to legitimize themselves as the stronger sex. In contrast, females are socialized to be knowledgeable about their bodies, to recognize vulnerability to illness and to express their emotions (Sabo, 2000). Research has shown that men will avoid these practices and other health-promoting behaviors that they believe are the norm for women ("Masculinity and Men's Health", 2008).

Masculine social norms. Adopting traditional masculine norms influences men's health behaviors and care-seeking behaviors. Levant et al. (2009) examined how gender role conflict and the conformity to masculine norms are associated with risky health behaviors and negative attitudes toward seeking psychological help. Gender role conflict occurs when men experience stress from attempting to fulfill the requirements of the masculine gender role (Levant et al., 2009). Higher gender role conflict was found to be a predictor of greater health risk behaviors ($t = 3.07$; $p = .003$). Levant et al. (2009) also found conformity to masculine norms to be a predictor of negative attitudes toward seeking psychological help ($t = -3.83$; $p < .001$). Courtenay (1998) found that men who adopt traditional attitudes about manhood also have greater health risks than men who hold less traditional attitudes. Young men who hold traditional beliefs (e.g., "a guy should be sure of himself" and "not act like a girl") have more sexual partners and are more likely not to use condoms consistently. College men who adopt traditional attitudes about manhood experience higher levels of anxiety and depression. Traditional masculinity is also associated with smoking, alcohol use and drug use in young men.

Masculine norms seem to be present in the behaviors of substance use, violence and eating. Masculine camaraderie is a part of certain patterns of alcohol abuse and displays of masculine toughness are present in patterns of violence. Masculine symbolism is even present in men's diets, specifically a diet high in red meat and low in fresh vegetables (Schofield et al., 2000).

Adopting masculine norms may influence a man's risk of developing certain diseases. Nicholas (2000) suggests that adopting a masculine gender role may influence cancer screening for early detection, symptom recognition, help-seeking and psychological adaptation to cancer. Men are less knowledgeable then women about health and may be unfamiliar with specific screening recommendations and common symptoms of cancer. Men are also less likely than women to report physical symptoms and to visit a physician. Many men have been socialized to believe that reporting symptoms is a sign of weakness, so they may ignore cancer symptoms and delay seeking care. Adopting masculine norms may also lead to poorer adaptation to cancer. Men may feel that many behaviors associated with adaptation are inappropriate or unmanly, such as seeking and receiving social support, expressing emotions and asking for help (Nicholas, 2000).

Masculine norms may also influence a man's expression of disease or illness. For example, depression may be expressed differently by men and women. Adhering to the masculine gender role, men may suppress any expressions of illness or choose to express their depression through masculine outlets such as alcohol or drug abuse and aggression (Brooks, 2001).

Masculinity may also affect a man's choice to seek care for depression or other illnesses. Generally, conformity to masculine norms is associated with negative attitudes toward seeking

psychological help (Levant et al., 2009). Young men are often reluctant to use health care services because of embarrassment or associating help-seeking with inappropriate masculine behavior (Armstrong et al., 1999).

Masculine norms and college aged men. Masculinity affects the health of college men as well. Male college students are more likely than female students to hold risky health-related beliefs, such as believing that it is important for a person to be physically strong and believing that a person should always try to control emotions (Courtenay et al., 2002). Among college students, the adoption of traditional male gender role attitudes is linked with higher levels of anxiety and depression, greater cardiovascular reactions to stress and higher levels of maladaptive coping. Traditional values that men should be independent, self-reliant and strong are also associated with poor health behaviors related to substance use, safety, diet, sleep and sexual activity. College men who hold traditional beliefs are less likely than those with nontraditional beliefs to seek help from others or to use professional health services on campus (Courtenay, 2000b; Courtenay et al., 2002).

Gender role conflict. Gender role conflict occurs when men experience stress from attempting to fulfill the requirements of the masculine gender role (Levant et al., 2009). The masculine gender role requires men to be independent and strong, to deny weakness or vulnerability, to control their emotions, and to dismiss any need for help (Courtenay, 2000b). Gender role conflict has been found to have an effect on men's health and care-seeking behaviors (Levant et al., 2009). Men who experience gender role conflict exhibit greater levels of risky health behaviors (Levant et al., 2009). Greater levels of gender role conflict are also associated with a negative view of help-seeking (Blazina & Watkins, 1996; Good & Wood,

1995). Blazina and Watkins (1996) found that in college men, experiencing gender role conflict was associated with increased levels of anger and alcohol usage.

Men's Health Concerns

As indicated above, ample research on men's health has revealed multiple issues that concern men. However, few studies have been done to discover the health issues about which men are actually concerned. In the few studies done, focus groups and surveys of college students and young men have revealed concerns about alcohol and substance abuse, body image, anger management, stress, sexuality and pregnancy (Davies et al, 2000; Heck & Pinch, 1990; Raine et al, 2003).

In a set of focus groups done with male undergraduate students, the most discussed topic was alcohol and substance abuse. Many of the men thought alcohol was important in building social confidence, attracting women and coping with stress, anger and loss. Although the men were aware of the possibility of future alcohol problems, they expressed few feelings of current vulnerability (Davies et al., 2000). The second most discussed topic was concerns over body image (Davies et al, 2000). Specifically, men were concerned about their physical appearance and maintaining a desired weight. They were also concerned about the effects that physical inactivity had on their appearance.

During these focus groups, anger management was also frequently discussed. Some men felt this was the most important issue that men face. Participants spoke about men expressing anger by shouting, hitting walls and becoming involved in verbal and physical fights. They also spoke about the negative effects that men's anger may have on others, as they may experience a fearful social atmosphere or be the victims of physical harm (Davies et al., 2000).

Further health issue concerns of college males are as follows. Male college students cite school workload as the most frequent cause of stress. Nearly half (49%) of male college freshman and three-quarters (77%) of male college seniors indicate a need for additional sexuality information (Heck & Pinch, 1990). Young men may also be concerned about unwanted pregnancies. In a survey of 14 to 24 year old males, Raine et al. (2003) found that 93% of respondents disagreed with the statement "I would feel happy if I got someone pregnant right now."

As stated above, ample research on men's health has revealed multiple issues that concern men. This research has revealed men's health risks and identified the risky behaviors that men exhibit. Research on men's health has also examined men's care-seeking behaviors and the relationship between masculinity and health. Numerous studies have identified the health issues about which men should be concerned. However, only a handful of studies have sought to discover the health issues about which men are actually concerned. Sabo (2000) believes that more quantitative and qualitative research is needed to deepen the current understanding of the health needs of boys and men.

Providing Health Services to Men

Due to men's reluctance to seek health care services, health professionals should put in extra effort to get men involved in health care. Men need to be told that it is important for them to be involved. For example, Armstrong et al. (1999) believe that men will continue to be reluctant participants in reproductive healthcare until they are given clear messages that their needs are important and that they are vital in efforts to promote reproductive health in both genders.

Getting men to participate in healthcare may mean a solution to many of these problems. Many communities and college campuses have developed interventions to address men's health needs and to involve them in healthcare and discussions about health. These interventions include the creation of men's health clinics, men's growth groups and educational programs about testicular cancer and testicular self-exams. The following two subsections describe these interventions. The third subsection contains suggestions to help health professionals working with men. These suggestions are aimed at increasing men's comfort with using healthcare.

Community interventions for men. To meet the needs of men, several communities have created health clinics specifically for men. Baltimore created the Men's Health Center, a primary clinic for men (Jarrett, Bellamy & Adeyemi, 2007). Raine et al. (2003) described a reproductive health clinic that was aimed at serving male adolescents and young adults. The clinic was established within a traditional family planning clinic for young women. Clinic administrators were concerned about the effect that this might have on the female patients. A survey completed by the female patients showed that 98% were very or mostly satisfied with the care they received before male services began. After male services were implemented, 92% of the female patients were very or mostly satisfied. Just 12% of females reported being bothered by the presence of male clients at the clinic.

The Young Men's Clinic opened in New York City to specifically address the sexual and reproductive health needs of adolescent and young men (Armstrong, 2003). To make men feel more comfortable, the clinic also provides medical, social work, mental health and health education services. Men's magazines, Sports Illustrated and Men's Health, and sports and entertainment videos were provided in the waiting room (Armstrong, 2003). The Young Men's Clinic found that condom usage increased among their patients. Specifically, among males who

visited the clinic initially and for a follow-up visit in the same year, the proportion who reported condom usage at last sexual encounter increased from 32% to 47%. The proportion who reported talking with their sex partner about birth control use increased from 43% to 67% (Armstrong et al., 1999).

Campus interventions for men. College campuses are also creating health services specifically for men. San Francisco State University opened a men's health clinic to provide outpatient health services designed specifically for men (Rogers, Harb, Lappin & Colbert, 2000). Men's growth groups have also been implemented on college campuses. The groups created a supportive social structure for male college students, modeled healthy expressions of emotions and provided a safe space for men to discuss sensitive issues. During these growth group sessions, men were able to discuss a wide range of topics, including relationships, sexuality and dating experiences, dealing with depression and what it means to be a man in society. Participants reportedly bonded with each other and developed a support structure that they lacked before joining the group (Vareldzis & Andronico, 2000).

Rudolf and MacEwen Quinn (1988) implemented a nursing educational program to increase college males' knowledge of testicular cancer and knowledge and practice of testicular self-examinations. The program was successful; of the participants who had never practiced testicular self-examinations, 63.9% performed it at least once after the program.

Tips for college health professionals. College health care providers are in a position to influence young men's behavior. Providers that care for young men who are just developing health behavior patterns are able to facilitate the adoption of good health habits and attitudes (Forrest, 2001). Because college men lack routine healthcare, any contact with a healthcare provider is an important opportunity for education, assessment and intervention. Courtenay

(1998) believes that interventions should be designed to help college men change behaviors that increase their health risks. He further believes that men need to be taught the importance of receiving routine evaluations and taking personal responsibility for their health.

To assist health professionals working with men, Courtenay (2004) developed a health practice guideline. He suggests that health professionals make men feel more comfortable by humanizing or normalizing their concerns. Professionals can lessen men's embarrassment or shame by telling them that asking for help or acknowledging pain are normal experiences and are not unmanly. The guideline also cautions health professionals not to be fooled by men's displays of invulnerability. Men's physical and mental conditions are often serious when they finally do visit a healthcare provider. Finally, providers should devise a health maintenance plan for college men, which could include periodic physicals, screenings, self-examinations and self-care techniques.

Men that participated in a focus group conducted at an Oregon university provided suggestions for how college campuses could improve their services for men (Davies et al., 2000). They suggested that health centers offer free services, offer health classes and programs, provide incentives to men for participating in interventions and establish a men's center and library. These men also expressed an interest in developing a telephone service in which men could call and speak with a health professional to find out if their symptoms warrant a visit to the health or counseling center (Davies et al., 2000). Courtenay (1998; 2004) has also suggested college campuses use an anonymous telephone line.

Campus health centers can take advantage of technology by using telephone lines, the Internet, or E-mail and electronic chat lines to reach male students who may be reluctant to visit the clinic. It has been suggested that these methods could be used to assess a student's need for

treatment and to reassure him that he is not seeking help unnecessarily or prematurely (Davies et al., 2000).

Summary of Men's Health Related Literature Review

Research has shown that compared to women, men die younger and suffer from obesity, hypertension, coronary heart disease and cancer at higher rates (Courtenay, 2000a; DHHS, 2009; "Masculinity and Men's Health", 2008; Nicholas, 2000). Men are also more likely than women to be in an automobile crash and to die from a work-related injury or a self-inflicted injury (CDC, 2004; Courtenay, 2000a; Heron et al., 2009).

Research also shows that men in general and male college students are more likely than their female counterparts to engage in risky behaviors related to driving, drug use, sex, physical violence and health that are associated with an increased risk of disease, injury and death (Courtenay, 1998; 2000a). Compared to women, men also engage in fewer health-promoting behaviors (Courtenay, 1998). Men, including college men, are less knowledgeable about health are less likely to practice self-exams or to obtain preventative screenings and checkups (Courtenay, 1998; 2000a; Courtenay et al., 2002).

Despite their health risks, men conceal their vulnerability and are reluctant to ask for help (Courtenay, 1998). Men in general, as well as college men, visit healthcare providers less often than their female counterparts (Courtenay, 2000a). Among college students, men are less likely to consult a physician when unfamiliar symptoms arise and are reluctant to seek help for medical or emotional problems unless they are in extreme pain (Courtenay et al., 2002; Davies et al., 2000).

Research has revealed that risky behaviors may be the product of male socialization, masculine social norms and adopting masculine gender roles (Courtenay, 1998; 2000b;

Courtenay et al., 2002; Levant et al., 2009). Men are socialized to be strong, independent and rational. They are taught to control their emotions and are discouraged from admitting weakness or seeking help from others (Courtenay, 1998). Men demonstrate their masculinity by taking risks and dismissing any need for help (Courtenay, 2000b).

To address men's health needs, communities and college campuses have created men's health clinics, growth groups and educational programs. To make men feel more comfortable seeking help, clinics offer a range of services – medical, social work, mental health and health education. Men's magazines and sports and entertainment videos are also available in the waiting room (Armstrong, 2003). Men's growth groups have created a supportive social structure for male college students, modeled healthy expressions of emotions and provided a safe space for men to discuss sensitive issues (Vareldzis & Andronico, 2000). An educational program aimed at increasing college males' knowledge of testicular cancer and self-exams successfully increased practice of testicular self-examinations (Rudolf & MacEwen Quinn, 1988).

Student Health Services at a Midwestern University

Healthcare at a Midwestern University is provided through an on-campus clinic. The clinic is located in a free-standing building on the north end of the campus. The clinic is open weekday mornings and afternoons and is closed during the summer. Student fees provide funding for on-campus healthcare, so most office visits and lab work are done at no cost. Additional fees are charged for some procedures and medications.

Staff includes a physician, nurse practitioners, nurse clinicians, a medical terminologist and office staff. Services include: diagnosis and treatment of illnesses and injuries, diagnosis and treatment of common mental health concerns, physicals, preventive health screenings,

immunizations and vaccines, diagnosis and treatment of STDs, minor surgical procedures and laboratory testing. The clinic also provides contraceptives for men and women and has a limited supply of common prescription medications and orthopedic supplies. The clinic's mission is to promote and maintain a healthy campus community. Along with the University Counseling Center, the clinic is the main provider of health care on campus for male and female students.

Focus Groups

Focus groups have been used to gather information on a variety of health-related topics and "... have become a regularly used research method within the health arena." (Mansell, Bennett, Northway, Mead & Moseley, 2004, p. 79) Robertson (1998) used focus groups to study the mental health needs of gay men and to explore their experiences and views of health and health care. Robertson (2006) has also held focus groups with men and health professionals to discuss masculinity and its effect on preventive health. Other researchers have used this method to explore the health beliefs of diabetic men (Hjelm, Bard, Nyberg & Apelqvist, 2005) and men's sexual health concerns (Khan et al., 2008). Robinson (1999) reports that focus groups have been used to gather data on several health-related topics, including examining attitudes on illness and health behaviors, studying peoples' experiences with diseases and health services and investigating health behaviors and health knowledge in youth.

There are many advantages to using focus groups in a qualitative study of men's health. Focus groups are a highly efficient technique for qualitative data collection. The amount and range of data is increased by collecting information from several people at the same time (Robinson, 1999). Focus groups provide an opportunity to explore participants' thoughts and feelings in more depth than is often feasible with a survey or interview (Mansell et al., 2004). This method is valuable when conducting a formative evaluation. Focus groups facilitate the

expression of criticism and the exploration of various solutions, which are valuable when the goal is to improve services. Focus groups are also recommended as a method for studying sensitive topics. The method is particularly suited to the study of attitudes and experiences and other participants can provide support by sharing their experiences (Robinson, 1999).

Focus groups were chosen as the method for the present study because of the sensitive nature of the topic. The researcher believed that the participants would feel more comfortable and be more willing to discuss their personal experiences if they had the support of other college men and were able to hear other people's stories. Focus groups were also chosen because of their efficiency. The researcher believed that it would be too time-consuming to collect data using personal interviews. Finally, focus groups were able to provide a wider range of information, experiences and attitudes than would have been possible with a survey.

Motivation for Current Study

The current study was done so the researcher and Student Health Services (SHS) at the University of Wisconsin Stout could learn more about the health needs and concerns of male students. The administrators at SHS expressed concern over male students' underutilization of campus health services. Over the past three years, 2006 to 2009, male students have accounted for just 21% to 25% of total visits made to SHS (J. Lawrence-Ramaeker, personal communication, October 19, 2009). A survey administered in 2006 provided some information on UW Stout students' health needs and care-seeking behaviors. This study found that significantly more males than females were unaware of SHS. The survey also revealed that males report having fewer health needs and see themselves as being in good health. Males are also less likely to seek care for health needs, partly because they believe they are able to take care of themselves (Greene, 2007). After receiving these results, SHS was interested in finding

out what specific health concerns male students had. The current study was done to give SHS more information about male students' current and future health concerns and care-seeking behaviors. The current study also asked men to discuss the services that they would like to see offered for men's healthcare on campus. The goal of the current study was to provide SHS with information so they could improve the on-campus healthcare services offered to male students. SHS also planned on using the information from this study to construct a survey for a larger, future study. Detailed information on the current study is provided in the following chapter.

Chapter III: Methodology

This study was conducted to discover the health issues that concern male students at UW-Stout. The administrators at Student Health Services (SHS) were prepared to use this information to improve the on-campus healthcare services that they offer to male students. SHS also planned to use this information to construct a survey that would be implemented in a larger, future study. The research method and procedures implemented in this study are discussed below. The study was fully approved by the IRB prior to the beginning of data collection.

Subjects

Focus groups were comprised of male students attending the University of Wisconsin Stout. To be eligible for participation in the focus groups, subjects needed to meet the following criteria: must be male, at least 18 years of age and degree-seeking and cannot be distance education students.

Subject Selection/Recruitment

The Office of Budget, Planning and Analysis (BPA) randomly selected a sample of students that fit the selection criteria. For each selected individual, the BPA provided the investigators with first and last name and UW Stout E-mail address. An E-mail was sent to each individual, describing the purpose of the focus groups and inviting the student to participate (Appendix A). Interested individuals were instructed to contact the investigator to sign up for a focus group session. A total of 1,039 invitation E-mails were sent to the randomly selected individuals. Investigators received seven responses, for a response rate of less than 1%. Due to the low response rate, the study was also advertised using SONA systems. SONA is an online tool used by UW-Stout's psychology department as a participant pool. Investigators post descriptions of their studies on SONA and students sign up to participate in a study to fulfill a

General Psychology course requirement. Twenty-two participants signed up for the study on SONA, resulting in a total of 29 participants signed up for the study.

All participants were sent a confirmation E-mail indicating the date, time and location of their particular focus group session (Appendix B). Participants were also sent reminder E-mails on the day before and the morning of their focus group session (Appendix C).

Procedure

Four focus groups were conducted with the 24 participants. All of the groups were held in meeting rooms in the Memorial Student Center. For each session, the room was set up in conference style with one table in the center of the room and participants seated around the table. Sessions lasted one hour, with one session held over the lunch hour and the remaining three sessions held in the late afternoon. Two trained male graduate students were present during the discussions, with one student serving as facilitator and the other serving as a note taker. Sessions were also recorded using a digital voice recorder, which was placed in the center of the table. To increase participation, a complimentary lunch and beverage were provided. Participants were also entered into a drawing to win one of two $50 Wal-Mart gift cards.

When participants arrived at their focus group session, they were greeted by the facilitator, who marked off their name on an attendance sheet. Each participant was given a table tent that displayed their first name and two copies of the consent form (Appendix D). Participants were instructed to read the consent form, sign one copy and return it to an envelope on the table, and keep the remaining copy for themselves. Participants were also informed that lunch was ready and instructed to select a lunch and a seat at the table.

At the designated start time, the facilitator closed the door and welcomed the participants to the session and thanked them for attending. The facilitator mentioned the recording

equipment and note-taking and turned on the recorder. Participants were assured that their names would not be used in any reports created from the focus groups. The facilitator then introduced himself and the note-taker and explained the purpose of the study. Rules for the session were introduced, such as participants were welcome to speak at any time, participation was voluntary and participants were free to leave at any time, participants were not required to comment on any topic that they did not feel comfortable discussing and that comments needed to remain confidential. The facilitator answered questions and then the participants introduced themselves by stating their first name, year in school and major.

The facilitator went through the list of 10 questions, including follow-up questions and prompts as needed. Following the discussion, participants were thanked for their involvement and reminded of the purpose and significance of the study. Due to the sensitive and personal nature of the topics under discussion, pamphlets for the University Counseling Center and Student Health Services were distributed. Participants were asked to record their demographic information (age, ethnicity, year in school and major) on index cards. Participants also provided their e-mail addresses on the index cards – the addresses were used to enter the participants into the random drawing for the $50 Wal-Mart gift cards. Two additional pieces of paper were handed out to each participant. One of the papers was a comment card, where participants could write any additional comments on the discussion. The other paper was used for participants to record their name and E-mail address if they were interested in receiving a copy of the written report that would be generated from their responses. The facilitator again thanked everyone for their participation and dismissed the participants.

After all of the focus group sessions were completed, the participants' E-mail addresses were entered into a spreadsheet in SPSS 16.0 and a random number generated chose the two

winners for the $50 Wal-Mart gift cards. One week after the focus groups, the winners were sent an E-mail thanking them for their participation in the study and notifying them that they could pick up their prize at Student Health Services (Appendix E). The remaining participants were sent an E-mail thanking them for their participation and informing them that their names were not chosen in the gift card drawing (Appendix F).

Measures

The investigators created 10 questions for the facilitator to ask during the four focus groups. The questions were ordered so that the discussions would begin with general, broad questions and lead into more focused, personal questions as the participants became more comfortable with the process and each other. The questions were asked in the same order during all four sessions. The investigators also created separate rewordings for some of the questions. The facilitator was able to use these reworded questions in the event that participants did not understand the main questions. The investigators also created prompts for some of the questions to illicit further response. Due to the sensitive and personal nature of the topic of the discussion, the investigators prefaced some of the questions with facts and statistics. This information was designed to normalize responses and make the participants feel more comfortable responding to the questions. The prefacing information, main questions, reworded questions and prompts are as follows:

Question 1: What do you do when you are ill?

Rewording: What do you do when you are sick/injured?

Prompt: Do you seek care or do you take care of yourself?

Prompt: Where do you seek care?

Prompt: What makes you decide to go to the doctor vs. take care of yourself?

Question 2: How do you stay healthy?

Rewording: What do you do to protect your health and prevent illness?

Prompt: What are your experiences with exercise? Dieting/nutrition? Taking vitamins/supplements? Going to the doctor for screenings?

Question 3: How do you learn about health issues?

Rewording: How do you obtain information about health issues?

Prompt: Do you read information someone or do you talk to someone?

Prompt: Where do you read information?

Prompt: Who do you talk to?

Question 4: What injuries/illnesses/diseases are you worried about getting now – while you are in college?

Question 5: What injuries/illnesses/diseases are you worried about getting in the future – when you are 40 years or older?

Question 6 Prefacing Information: One issue that is often associated with men is violence. Men are more likely than women to be the perpetrators of violence and, in some types of violence, they are also more likely to be victims. Men can also be victims of domestic violence. We do not hear as much about men being victims because they are less likely to report abuse, but research suggests that 10-20% of males will be sexually assaulted at some point in their lifetimes.

Question 6: Are you concerned about violence (for example – fist fights, sexual violence or domestic abuse)? Are you concerned about the health impacts of witnessing or experiencing violence?

Question 7 Prefacing Information: Just as we are less likely to talk about men being the victims of violence, we are less likely to talk about men having concerns about body image. Body image is often thought of as a women's issue. However, men also experience eating disorders and dissatisfaction with their bodies. Just as is the case with being a victim of violence, men are less likely to report their concerns with body image. Men may be less likely to report having negative attitude toward their bodies, but do report a strong motivation to improve the appearance of their bodies.

Question 7: Do you or other college men you know ever have concerns about body image? What do you do to address concerns with body image?

Question 8 Prefacing Information: One aspect of college men's health that is focused on by healthcare providers is reproductive health. Many students think about this area in terms of STIs or condoms, and ignore other aspects of men's reproductive health.

Question 8: Are there other reproductive health issues that you are concerned about – for example, testicular self-exams, erectile dysfunction, infertility, dealing with the emotional aspects of relationships?

Question 9 Prefacing Information: We know that there is a genetic basis to mental illness and that it can run in families. We also know that stress can influence mental illness.

Question 9: Do these facts make you concerned about mental illness? What do you do to address these concerns? Where would you seek help for these concerns?

Question 10: As men, if you could create healthcare on campus, what services would you offer?

Rewording: What health services would you like to see offered on campus?

Prompt: What services would you like to see that address current health concerns – injuries/illnesses/diseases that men are experiencing while attending college?

Prompt: What services would you want that address future health problems – services that could help college men prevent future injuries/illnesses/diseases?

Prompt: Would you want to receive any health education materials – online, posters, pamphlets, presentations, one-on-one consultations?

Prompt: Would it be helpful or useful to receive information about illnesses/diseases that can occur later in life?

Qualitative Analysis

As previously stated, each focus group was recorded using a digital voice recorder. Following each focus group session, the facilitator, note taker and primary investigator met to check that the digital voice recorder had worked properly. These three individuals also engaged in a debriefing session following each focus group to allow the facilitator and note taker to provide the investigator with any additional information about the discussion. The note taker E-mailed the typed notes from the session to the investigator and clarified any questions the investigator had regarding these notes. The digital voice recordings were transcribed by a graduate student at the Applied Research Center. The note taker's typed information was added to each appropriate transcription.

The primary investigator and another graduate student read all the transcripts and note taker's information. Each of the four transcripts was printed on a different color paper to assist with coding. The investigator and graduate student read through each of the transcripts multiple times. The first reading was done to become familiar with the content and to identify possible themes. All subsequent readings were done to solidify themes and code specific comments. The graduate student contributed to the data analysis by identifying themes, but did not participate any further in the analysis.

The primary investigator continued the analysis by organizing the themes. For each of the 10 questions asked during the focus groups, the investigator identified the themes that arose from the participants' responses. The investigator then identified the specific responses that fit into each theme by cutting up the transcripts by comment and taping each individual comment onto sheets of paper, with a separate sheet used for each theme.

Limitations

A major limitation of the study is the small sample size (N = 24). Another limitation is the nonrandom selection of participants. Focus group participants self-selected and signed up to be in the study. Due to this nonrandom, self-selection, results cannot be generalized to the entire male student population at UW-Stout. Finally, each focus group session lasted only one hour, which did not provide enough time to explore comments in more depth and detail.

Chapter IV: Results

A total of four focus groups were conducted using male undergraduate and graduate students enrolled at UW-Stout. All participants were at least 18 years of age and were degree-seeking and non-distance education students. Two trained male graduate students served as focus group facilitators. Five individuals who signed up for the study failed to attend the focus groups, resulting in a total of 24 participants. The first two focus groups consisted of six participants each. Five individuals participated in the third focus group and seven individuals attended the final group.

Demographic information collected on the participants included age, ethnicity, year in school and college major. Participants' ages ranged from 18 to 36 years, with a mean of 20.3 years. Twenty-three participants (96%) indicated their ethnicity was Caucasian. One participant identified himself as Japanese. Fourteen participants (58%) identified themselves as freshmen, five (21%) as sophomores, two (8%) as juniors, two (8%) as seniors and one (4%) as a graduate student. Table 1 lists the 14 college majors that were indicated and how many participants indicated each major. One participant indicated that he had more than one major and two participants indicated that they were currently undecided.

Table 1

Participants' College Majors

Major	Number of participants
Applied Mathematics and Computer Science	1
Applied Psychology	1
Applied Science	1

Major	Number of participants
Business Administration	2
Construction	2
Career, Technical Education and Training	1
Engineering Technology	3
Golf Enterprise Management	1
Graphic Communications Management	1
Hotel, Restaurant and Tourism Management	2
Information Technology Management	2
Packaging	2
Psychology	3
Technology Education	1
Undecided	2

As stated in Chapter III, themes or constructs were identified for each of the 10 discussion questions. A total of 552 responses were made during the focus groups. Table 2 indicates the number of responses that were given for each discussion question, along with each question's percentage of the total responses made during the focus groups.

Table 2

Number of Responses and % of Total Responses by Question

Question #	Question	# of responses	% of all responses
1	What do you do when you are ill?	85	1
2	How do you stay healthy?	64	12
3	How do you learn about health issues?	48	9
4	What injuries/illnesses/diseases are you worried about getting now – while you are in college?	33	6
5	What injuries/illnesses/diseases are you worried about getting in the future - when you are 40 years or older?	40	7
6	Violence [a]	109	20
7	Body image [b]	46	8
8	Reproductive health [c]	29	5
9	Mental illness [d]	39	7
10	As men, if you could create healthcare on campus, what services would you offer?	59	11
Totals		552	100

Note.

[a] The entire question is as follows. One issue that is often associated with men is violence. Men are more likely than women to be the perpetrators of violence and, in some types of violence, they are also more likely to be victims. Men can also be victims of domestic violence. We do not hear as much about men being victims because they are less likely to report abuse, but research suggests that 10-20% of males will be sexually assaulted at some point in their lifetimes. Are you concerned about violence (for example – fist fights, sexual violence or

domestic abuse)? Are you concerned about the health impacts of witnessing or experiencing violence?

[b] The entire question is as follows. Just as we are less likely to talk about men being the victims of violence, we are less likely to talk about men having concerns about body image. Body image is often thought of as a women's issue. However, men also experience eating disorders and dissatisfaction with their bodies. Just as is the case with being a victim of violence, men are less likely to report their concerns with body image. Men may be less likely to report having negative attitude toward their bodies, but do report a strong motivation to improve the appearance of their bodies. Do you or other college men you know ever have concerns about body image? What do you do to address concerns with body image?

[c] The entire question is as follows. One aspect of college men's health that is focused on by healthcare providers is reproductive health. Many students think about this area in terms of STIs or condoms, and ignore other aspects of men's reproductive health. Are there other reproductive health issues that you are concerned about – for example, testicular self-exams, erectile dysfunction, infertility, dealing with the emotional aspects of relationships?

[d] The entire question is as follows. We know that there is a genetic basis to mental illness and that it can run in families. We also know that stress can influence mental illness. Do these facts make you concerned about mental illness? What do you do to address these concerns? Where would you seek help for these concerns?

The following sections present results from each of the 10 questions. For each question, main constructs and sub-constructs identified from the responses are described.

Question One. What Do You Do When You Are Ill?

Three main constructs were identified from a total of 85 responses to the first discussion question. These constructs were 'Severity', 'Self-Care' and 'Tough It Out'. 'Severity' consisted of comments that indicated treatment of an illness or injury depended on the severity of that illness or injury. Participants made a total of 39 comments that fit into this construct. 'Self-Care' consisted of comments related to treating an illness or injury without seeking help from a medical professional. Thirty-five comments were identified as belonging to the 'Self-Care' construct. The final construct for the first question, 'Tough It Out', consisted of comments that indicated participants did not take action to treat an illness or injury. 'Tough It Out' contained 11 comments. Table 3 indicates the frequency of responses by construct and the percentage of the question's total responses that belong to each construct. Figure 1 represents the percentage of total responses for the question by each of the three constructs. The following sections further define and discuss each of the three main constructs and present sub-constructs identified for each.

Table 3

Question One "What Do You Do When You Are Ill?" Responses by Construct

Construct	# of responses	% of all question one responses
Severity	39	46
Self-Care	35	41
Tough It Out	11	13
Totals	85	100

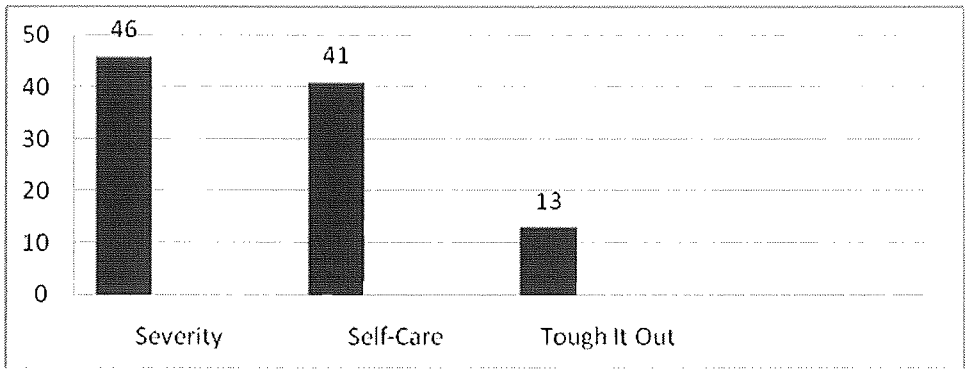

Figure 1. Percentage of question one "what do you do when you are ill?" responses by construct.

Construct #1. 'severity'. 'Severity' consisted of responses indicating that participants' decisions on how to treat an illness or injury depended upon the severity of the illness/injury. Participants indicated that depending on their severity, they would either choose self-care or seek assistance from a medical professional. Two sub-constructs, 'Symptom Severity' and 'Persistence', were identified. Table 4 indicates the frequency of responses by sub-construct and the percentage of the construct's responses that belong to each sub-construct. A discussion of each sub-construct follows.

Table 4

'Severity' Reponses by Sub-Construct

Sub-Construct	# of responses	% of all construct responses
Symptom Severity	26	67
Persistence	13	33
Totals	39	100

Figure 2 represents the percentage of total responses for the 'Severity' construct by each sub-construct.

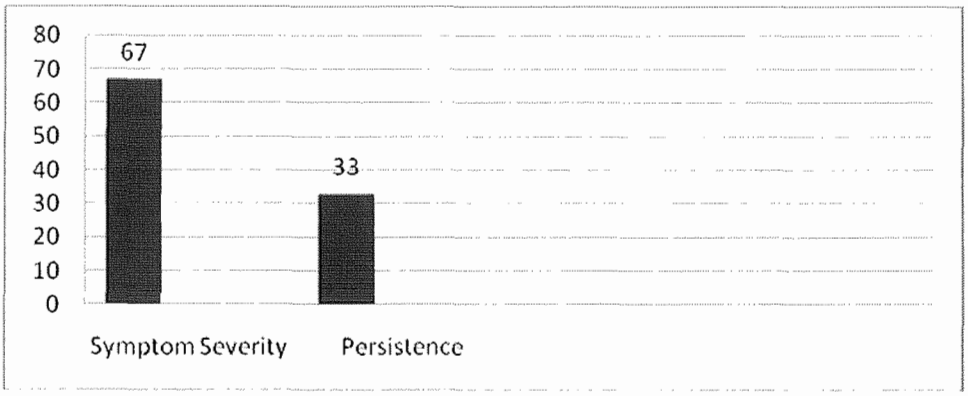

Figure 2. Percentage of 'Severity' responses by sub-construct.

'Symptom severity'. Participants indicated that their decision on how to treat an illness or injury depended in part on the severity of their symptoms. If the symptoms were serious, such as severe bleeding or vomiting, participants indicated that they would seek medical attention by calling or visiting their home physician, Student Health Services or the hospital. Examples of responses in this sub-construct included:

> "If you got a symptom like throwing up or uncontrollable shivers or like intense pain in places."
>
> "I guess it kind of depends. Like if I'm throwing up constantly and my blood is coming out I'm probably going to go to a doctor."
>
> "Depends on how bad the injury is I guess. I don't know. If it's just a cut or something like that, like you need stitches, usually I don't go in."

'Persistence'. Persistence of symptoms also contributed to the decision of whether or not to seek medical attention for an illness or injury. Participants were more likely to seek medical attention if symptoms continued for a longer duration. The required time period varied depending on the severity of symptoms, with participants indicating that they would seek help

after one day of extreme pain compared to waiting several weeks for a cold or a sore throat. Responses in this construct included:

> "If it goes on for like more than two weeks and you're like consistently getting worse then I'm probably going to go to a doctor or something."
>
> "If it's like extreme pain, you'll deal with it for maybe a day. And if it doesn't go away then you'll go and get it looked at."

Construct #2. 'self-care'. The construct 'Self-Care' was defined as treating an illness or injury without seeking help from a medical professional. 'Self-Care' included responses of treatments involving taking over-the-counter medications, increasing fluids, resting, self-diagnosing the problem and taking vitamins. Each of these treatments was identified as a sub-construct. Table 5 indicates the frequency of responses by sub-construct and the percentage of the 'Self-Care' construct's responses that belong to each sub-construct.

Table 5

'Self-Care' Responses by Sub-Construct

Sub-Construct	# of responses	% of all construct responses
Medications	11	31
Fluids	10	29
Rest	7	20
Self-Diagnosis	4	11
Vitamins	3	9
Totals	35	100

Figure 3 represents the percentage of total responses for the 'Self-Care' construct by each sub-construct. A discussion of each sub-construct follows.

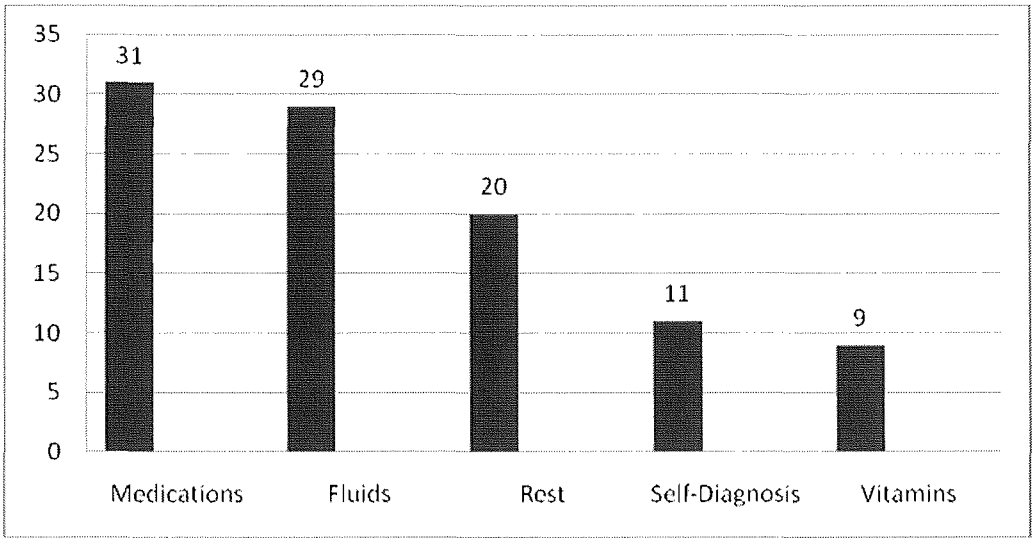

Figure 3. Percentage of 'Self-Care' responses by sub-construct.

'***Medications'.*** Responses indicated that participants used over-the-counter medications to treat their illnesses. These medications included pain medications like Ibuprofen and cold medications like Nyquil and Dayquil.

'***Fluids'.*** An increase of fluids was used to treat common illnesses like a cold or the flu. Participants mentioned that when they were sick, they would drink a lot of water or orange juice.

'***Rest'.*** Rest was also provided as a way to treat illnesses and injuries. Rest was used to treat a cold, the flu or a sore throat. Rest was also used to treat injuries, such as staying off of a sprained ankle. A typical response included:

"That and just lying low. Getting a lot of sleep."

'***Self-diagnosis'.*** Responses also revealed that participants would sometimes self-diagnose instead of talking to a medical professional. Several participants chose to look up their symptoms using WebMD and one participant indicated that he would receive a diagnosis by calling his mother. A sample response from this sub-construct was:

"I'll normally rough it out pretty far then if it's something really bad check WebMD."

'Vitamins'. Vitamins were also used to help treat an illness such as a cold or the flu. Responses also indicated that individuals would take vitamins when they began to feel sick or when other people near them became sick in an effort to prevent a cold or the flu from developing. Responses included:

"I normally just take a bunch of Centrum if I start feeling sick."

"My friends give me Vitamin C packets that you can just put in water and I take like two or three of those in a day when I'm sick."

Construct #3. 'tough it out'. 'Tough It Out' consisted of comments indicating that participants did not take action to treat an illness or injury. Responses revealed that when individuals became ill or injured, they would not change their behavior and would not seek medical care and would choose to wait until their health improved. Sample responses from this construct included:

"Tough it out. I'm sick right now and I'm going to classes."

"So, I don't know if I'm sick I stick it out."

"I press on. People tell you to relax and rest, but I just can't ever afford it."

Question Two. How Do You Stay Healthy?

Six constructs were identified from the 64 responses to this question: 'Nutrition', 'Screenings', 'Exercise', 'Vitamins', 'Sleep' and 'Hygiene'.

'Nutrition' included responses of healthy eating and including certain nutrients in the diet. This construct contained 16 responses. 'Screenings' also contained 16 responses.

'Screenings' referred to comments about obtaining preventive screenings, physicals or checkups. 'Exercise', which contained 15 responses, was defined as staying healthy by being physically active. The construct of 'Vitamins' included comments indicating that participants used vitamins and supplements to remain healthy. Eleven responses were included in this construct. 'Sleep' referred to comments that were made about the importance of getting a sufficient amount of sleep each night. Four comments were made about 'Sleep'. The final construct, 'Hygiene', contained two responses and was defined as using simple hygiene measures such as hand-washing and hand sanitizer. Table 6 indicates the frequency of responses by construct and the percentage of the question's total responses that belong to each construct. Figure 4 represents the percentage of total responses for the question by each of the six constructs. The following sections further define and discuss each of the six main constructs.

Table 6

Question Two "How Do You Stay Healthy?" Responses by Construct

Construct	# of responses	% of all question two responses
Nutrition	16	25
Screenings	16	25
Exercise	15	23
Vitamins	11	17
Sleep	4	6
Hygiene	2	3
Totals	64	99 [a]

Note. [a] Percentages for the constructs are rounded to the nearest whole number, which may result in a total percentage unequal to 100.

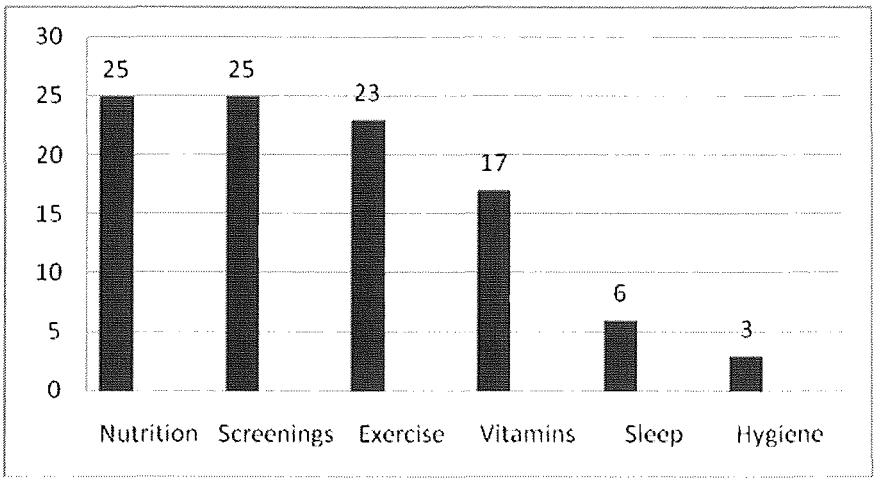

Figure 4. Percentage of question two "how do you stay healthy?" responses by construct.

Construct #1. 'nutrition'. 'Nutrition' included responses of healthy eating and including certain nutrients in the diet. Participants mentioned that they tried to stay healthy by limiting their intake of alcohol and soda and drinking plenty of water, milk or juice instead. Participants practiced healthy eating by choosing fruits and vegetables every day. They also tried to eat colorful foods, which are a good source of vitamins and minerals. One participant also ate tomatoes to include Lycopene in his diet. Sample responses included:

> "At the Commons I get salad every time I go there."
>
> "Try to limit myself from soda as well. When I'm in the Commons, I go for the milk."
>
> "I guess I've heard Lycopene, which is in tomatoes, helps with your prostate health....so I try to eat a lot of tomatoes."

Construct #2. 'screenings'. Participants were specifically asked if they obtained preventive screenings, physicals or checkups. This construct reveals the responses to this particular question. Responses indicated that individuals did not obtain regular screenings,

physicals or checkups and instead obtained them only when they were required for participation in athletics or employment. Typical responses included:

"I don't go in for an annual checkup or anything. I just go when I need to."

"Work related is the only reason I got a physical."

"When they're required. Like for a job."

Construct #3. 'exercise'. 'Exercise' was defined as staying healthy by being physically active. Participants stayed physically active by working out with weight lifting and cardio at the gym, playing sports and running. Comments about exercise included:

"Before winter, me and a couple buddies would go run like the 5K route around."

"Work out, get into sports. Like volleyball and I longboard."

Construct #4. 'vitamins'. 'Vitamins' included comments indicating that participants used vitamins and supplements to remain healthy. Responses revealed that individuals stayed healthy by taking Vitamin C, multivitamins such as One A Day and Centrum and supplements of Omega 3 fatty acid.

Construct #5. 'sleep'. 'Sleep' referred to comments that were made about the importance of getting a sufficient amount of sleep each night. One response indicated that the individual tried to sleep at least eight hours a night. Other participants spoke about getting a good amount of sleep, but did not list a specific number of hours.

Construct #6. 'hygiene'. 'Hygiene' was defined as using simple hygiene measures such as hand-washing and hand sanitizer to stay healthy.

Question Three. How Do You Learn About Health Issues?

Forty-eight responses made up five constructs that were identified from the discussion question. The five constructs were 'Internet', 'Friends/Family', 'Reading', 'Academics' and 'Experts'.

The construct of 'Internet' was defined as using information from online websites to learn about health issues. This construct contained 24 responses. 'Friends/Family' was defined as learning about health issues by talking to friends and family members. Eleven responses were made in this construct. 'Reading' indicated that participants preferred to read information to learn about health issues. This construct contained seven responses. The construct of 'Academics' consisted of three responses and included references to a "Cookies and Condoms" presentation and two school courses as sources of health information. The final construct, 'Experts', consisted of three responses that indicated individuals preferred to speak to medical experts to learn more about health issues. Table 7 indicates the frequency of responses by construct and the percentage of the question's total responses that belong to each construct. Figure 5 represents the percentage of total responses for the question by each of the five constructs. The following sections further define and discuss each of the five main constructs.

Table 7

Question Three "How Do You Learn About Health Issues?" Responses by Construct

Construct	# of responses	% of all question three responses
Internet	24	50
Friends/Family	11	23
Reading	7	15
Academics	3	6
Experts	3	6
Totals	48	100

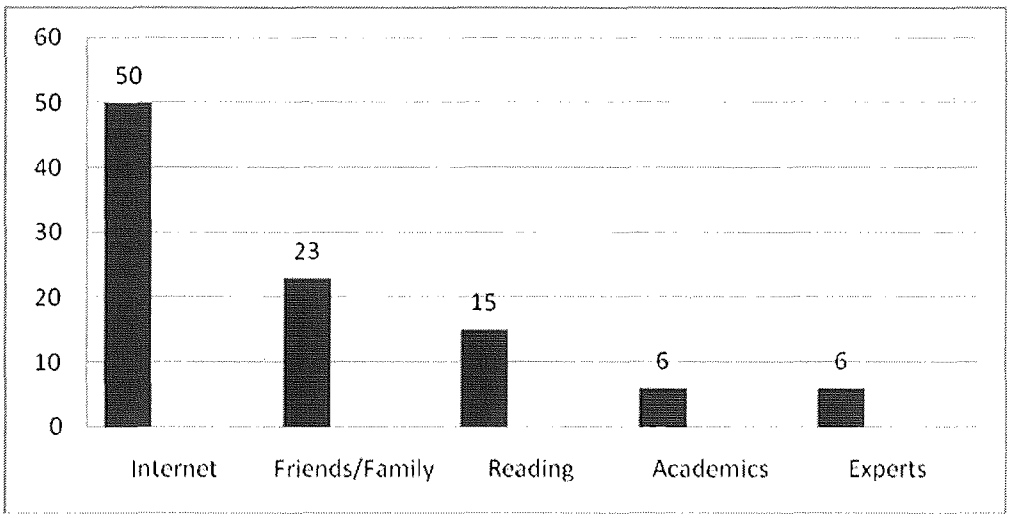

Figure 5. Percentage of question three "how do you learn about health issues?" responses by construct.

Construct #1. 'internet'. The construct of 'Internet' was defined as using information from online websites to learn about health issues. Participants indicated that the specific websites they used to access health information were WebMD, Google and the Mayo Medical Clinic Website. Sample responses from this construct included:

"Usually you can Google something and you'll get various articles and websites that will list symptoms and possible side effects of stuff."

"The internet is loaded with all sorts of information."

"WebMD is pretty good."

Construct #2. 'friends/family'. 'Friends/Family' was defined as learning about health issues by talking to friends and family members. Sources of information included roommates and friends and family members such as parents and aunts. Responses to this construct included:

"My aunt's a nurse so I guess the step before the doctor is to call my aunt up."

"I'd probably talk to friends and then if they don't know anything about it, ask my parents."

"Parents yeah. Not going to lie, I call them up and say this is going on. What's wrong with me?"

Construct #3. 'reading'. Responses to 'Reading' indicated that participants preferred to read information to learn about health issues. Participants were asked if they preferred to read information or speak to someone to gain information. The responses in this construct represent the responses that indicated a preference to read information. A sample response was:

"Read information first. It's just the manly way to be independent and try to figure it out."

Construct #4. 'academics'. The construct of 'Academics' was defined as using academic courses and programs to gain information about health issues. Participants specifically mentioned that they learned about health issues through a "Cookies and Condoms" presentation, a human biology course at UW-Stout and a health course in high school.

Construct #5. 'experts'. 'Experts' consisted of responses that indicated individuals preferred to speak to medical experts to learn more about health issues. Participants indicated that they preferred to speak to their family doctor, a general practitioner or a specialist.

Question Four. What Injuries/Illnesses/Diseases Are You Worried About Getting Now – While You Are in College?

Six constructs containing a total of 33 responses were identified for this discussion question. The constructs were 'Common Illness', 'Sexually Transmitted Diseases (STDs)', 'Injuries', 'Existing Conditions', 'Lyme Disease' and 'Food-Related Illness'.

The construct of 'Common Illness' contained responses indicating that participants were concerned about common illnesses such as a cold, the flu, mono, pink eye and meningitis. This construct contained 15 responses. The construct of 'STDs' was defined as a concern about contracting a sexually transmitted disease. Seven responses were identified from this construct. 'Injuries' contained four responses and indicated that participants were concerned about becoming injured from participation in athletics and high-risk activities. 'Existing Conditions' contained three responses and was defined as concern about aggravating previous injuries or experiencing issues with existing medical conditions. The construct of 'Lyme Disease' included two responses that indicated participants were concerned about contracting Lyme disease. The final construct, 'Food-Related Illness', also contained two responses. This construct included concerns involving campus food such as food poisoning and heartburn. Table 8 indicates the frequency of responses by construct and the percentage of the question's total responses that belong to each construct. Figure 6 represents the percentage of total responses for the question by each of the six constructs. The following sections further define and discuss each of the six main constructs and presents sub-constructs identified for each.

Table 8

Question Four "What Injuries/Illnesses/Diseases Are You Worried About Getting Now – While You Are in College?" Responses by Construct

Construct	# of responses	% of all question four responses
Common Illness	15	45
STDs	7	21
Injuries	4	12
Existing Conditions	3	9
Lyme Disease	2	6
Food-Related Illness	2	6
Totals	33	99 [a]

Note. [a] Percentages for each construct are rounded to the nearest whole number, which may result in a total percentage that is unequal to 100.

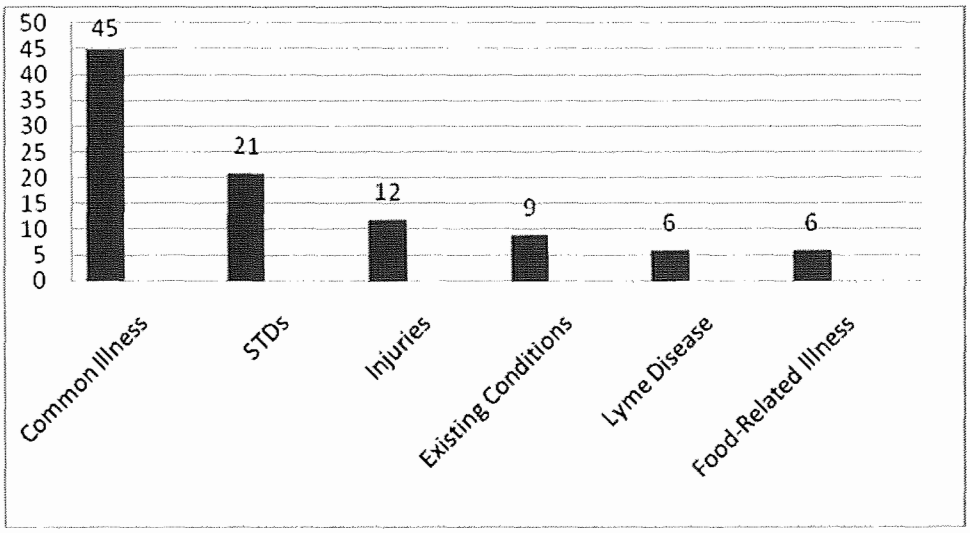

Figure 6. Percentage of question four "what injuries/illnesses/diseases are you worried about getting now – while you are in college?" responses by construct.

Construct #1. 'common illness'. The construct of 'Common Illness' contained responses indicating that participants were concerned about common illnesses. Participants

indicated that this was a concern due to the rapid spread of illnesses through dormitories and the academic consequences of becoming ill. Five specific illnesses were listed by participants and were identified as sub-constructs: 'Cold', 'Mono', 'Flu', 'Pink Eye' and 'Meningitis'. Table 9 indicates the frequency of responses by sub-construct and the percentage of the 'Common Illness' construct's responses that belong to each sub-construct.

Table 9

'Common Illness' Responses by Sub-Construct

Sub-Construct	# of responses	% of all construct responses
Cold	7	47
Mono	4	27
Flu	2	13
Pink Eye	1	7
Meningitis	1	7
Totals	15	101 [a]

Note.

[a] Percentages for the sub-constructs are rounded to the nearest whole number, which may result in a total percentage that is unequal to 100.

Figure 7 represents the percentage of total responses for the 'Common Illness' construct by each sub-construct. A discussion of each sub-construct follows.

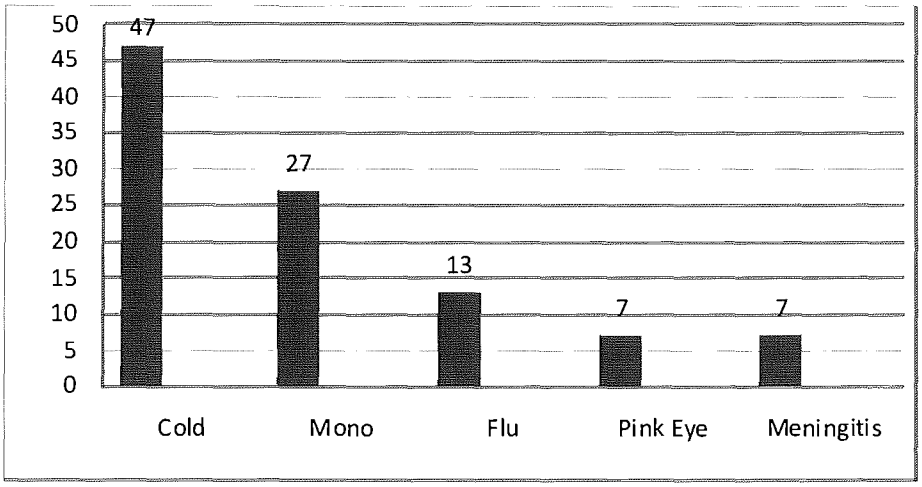

Figure 7. Percentage of 'Common Illness' responses by sub-construct.

'Cold'. Participants indicated that they were concerned about catching the common cold. Participants mentioned that they were concerned about getting ill from fellow students in classes or dormitories. Participants were also concerned about the academic consequences of getting sick, such as missing class. Sample responses in this sub-construct included:

> "Once someone gets a cold, seems like everyone gets the cold in their whole entire floor."
>
> "Just trying to stay away from the common cold. Just keeping yourself healthy and making sure that when crunch time comes you're not sick."

'Mono'. Responses revealed mononucleosis, or mono, was a concern for participants. Mono was a concern for participants who had experienced it in the past who did not want to experience it again. Others were concerned about the prevalence of mono at UW-Stout, indicating that they knew a lot of other students who had caught the illness. The following were responses from this sub-construct:

> "I got mono and that was hell."

"That's been passed through this college a lot. I've known a lot of people that have had mono."

'Flu'. There were also concerns about getting sick with the flu. Participants spoke about seeing students missing from classes during the winter and were concerned about the spread of the flu through classrooms and dormitories. One response from this sub-construct was:

"The dead of winter you start seeing the class sizes drop off. It seems like the flu always hits."

'Pink eye'. One participant indicated that he was concerned about getting conjunctivitis or pink eye.

'Meningitis'. One participant also indicated that he was concerned about getting meningitis. This participant indicated that he was concerned that meningitis was common on college campuses easily spread between people in close proximity.

Construct #2. 'STDs'. The construct of 'STDs' was defined as a concern about contracting a sexually transmitted disease. Participants did not mention specific STDs. One response from this construct was:

"I would say that I'm kind of concerned with like STDs type stuff because they say like 1 in 3 people at Stout have one."

Construct #3. 'injuries'. 'Injuries' contained responses that indicated participants were concerned about becoming injured from participation in athletics and high-risk activities. Participants were concerned about becoming injured during volleyball and other intramural sports or while doing stunts on a motorcycle or snowboard. One response also indicated concern about slipping on ice during the winter. The following were some responses from the construct:

"I don't think it's really contracting something, it's like getting an injury because I'm active."

"I find that every time I play a sport I end up getting a little ding or sprain or something."

"An injury would make it more difficult to make it to class and stuff like that on time."

Construct #4. 'existing conditions'. 'Existing Conditions' was defined as concern about aggravating previous injuries or experiencing issues with existing medical conditions. Specific concerns were about aggravating a quadriceps injury and an ankle injury. A participant was also concerned about a back injury from a car accident. Sample responses included:

"I had ankle surgery before I came to college. So I've always been concerned that something could happen."

"I ripped my quad in high school and I want to try out for track. I don't want to have to deal with that."

Construct #5. 'Lyme disease'. The construct of 'Lyme Disease' included two responses that indicated participants were concerned about contracting Lyme disease. The following responses belonged to this construct:

"I got Lyme disease last year. That sucked."

"I guess something that I'm concerned about right now is Lyme disease. I pulled a deer tick off myself last week."

Construct #6. 'food-related illness'. The final construct, 'Food-Related Illness', included concerns involving campus food such as food poisoning and heartburn. One response from this construct was:

"Heartburn. Just because of the food that we eat here. I get that a lot."

Question 5. What Injuries/Illnesses/Diseases Are You Worried About Getting in the Future – When You Are 40 Years or Older?

Participants gave a total of 40 responses to this discussion question. Eight constructs were identified from these responses: 'Family History', 'Chronic Illness', 'High Risk', 'Cardiovascular Problems', 'Existing Problems', 'Back Injuries', 'Kidney Stones' and 'Arthritis'.

'Family History' was defined as participants' concerns about health problems that run in their families. A total of 15 responses were made in this construct. 'Chronic Illness' was defined as concerns about chronic illnesses. There were seven responses in this construct. The construct of 'High Risk' included responses that indicated participants were worried about having an increased risk for certain health problems due to their personal activities or habits. 'High Risk' contained seven responses. 'Cardiovascular Problems' consisted of concerns about health problems involving the cardiovascular system. This construct contained four responses. 'Existing Problems' was defined as concerns about health problems that participants had experienced in the past. This construct also contained four responses. 'Back Injuries' contained one response and was defined as a concern about a future back injury. 'Kidney Stones' also contained one response indicating a concern about kidney stones. The final construct, 'Arthritis', included one response of a concern about having arthritis in the future. Table 10 indicates the frequency of responses by construct and the percentage of the question's total responses that

belong to each construct. Figure 8 represents the percentage of total responses for the question by each of the eight constructs. The following sections further define and discuss each of the eight main constructs and presents sub-constructs identified for each.

Table 10

Question Five "What Illnesses/Injuries/Diseases Are You Worried About Getting in the Future – When You Are 40 Years or Older?" Responses by Construct

Construct	# of responses	% of all question five responses
Family History	15	38
Chronic Illness	7	18
High Risk	7	18
Cardiovascular Problems	4	10
Existing Problems	4	10
Back Injuries	1	3
Kidney Stones	1	3
Arthritis	1	3
Totals	40	103 [a]

Note.

[a] Percentages for constructs are rounded to the nearest whole number, which may result in a total percentage that is unequal to 100.

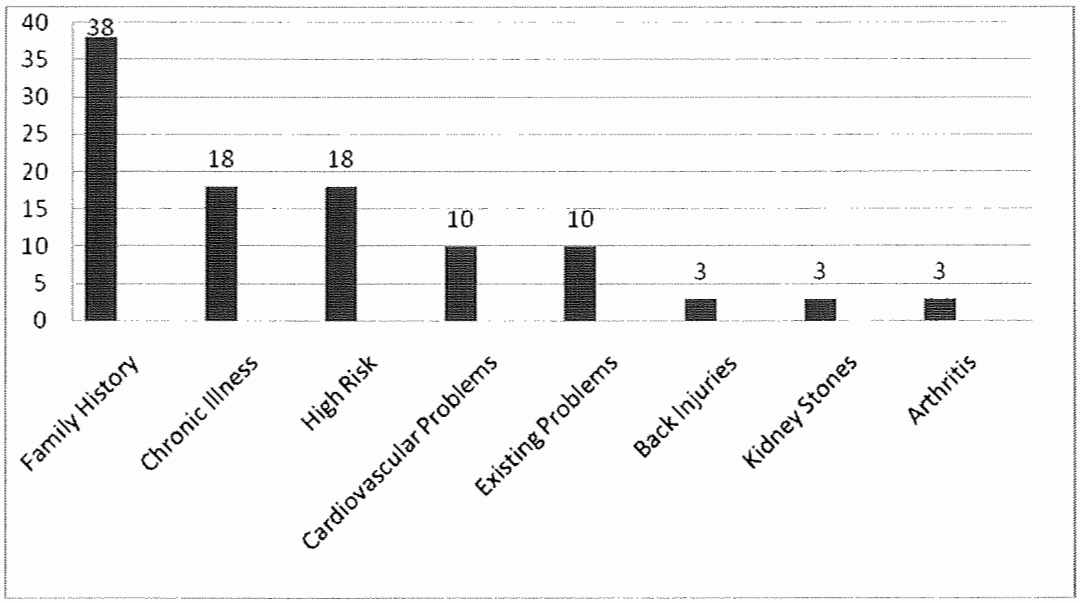

Figure 8. Percentage of question five "what injuries/illnesses/diseases are you worried about getting in the future – when you are 40 years or older?" responses by construct.

Construct #1. 'family history'. 'Family History' was defined as participants' concerns about health problems that run in their families. These participants demonstrated knowledge of their particular family history and were aware that they were at an increased risk for certain diseases. Participants indicated that they had family histories of six different illnesses, which were each identified as sub-constructs. Table 11 indicates the frequency of responses by sub-construct and the percentage of the 'Family History' construct's responses that belong to each sub-construct.

Table 11

'Family History' Responses by Sub-Construct

Sub-Construct	# of responses	% of all construct responses
Heart Problems	5	33
Diabetes	3	20
High Blood Pressure	2	13
Cancer	2	13
Alcoholism	2	13
Liver Problems	1	7
Totals	15	99 [a]

Note.

[a] Percentages for the sub-constructs are rounded to the nearest whole number, which may result in a total percentage unequal to 100.

Figure 9 represents the percentage of total responses for the 'Family History' construct by each sub-construct. A discussion of each sub-construct follows.

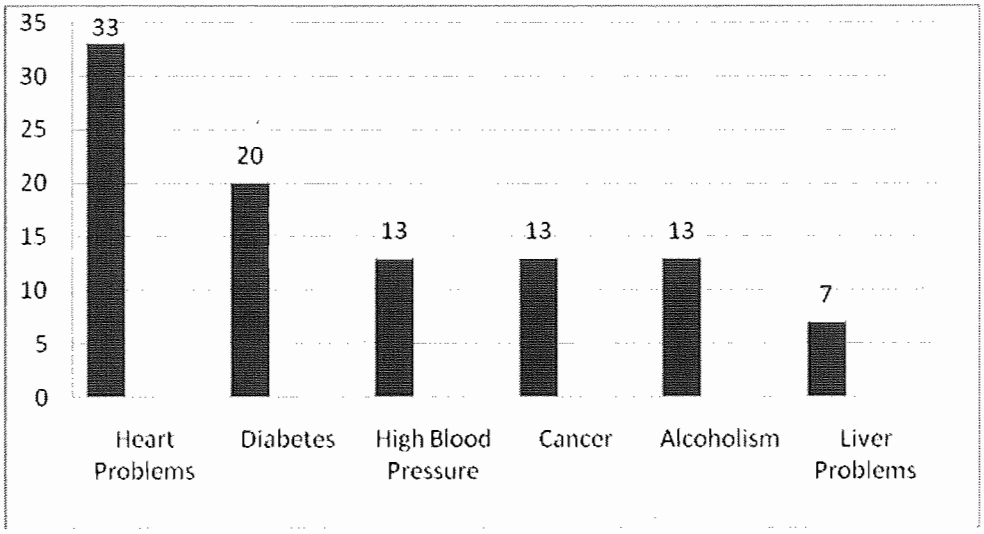

Figure 9. Percentage of 'Family History' responses by sub-construct.

'***Heart problems'.*** Responses indicated a concern for future heart problems. Participants revealed that heart disease ran in their families and that for some individuals, heart problems were present on both sides of their families. A sample response from this sub-construct was:

"I'd also have to say I'm aware of the genetics of my family. Like heart disease."

'***Diabetes'.*** Responses also revealed a concern over getting diabetes in the future because of a family history of the disease. An example of a response included:

"For me it's probably diabetes. Because all of my relatives have diabetes."

'***High blood pressure'.*** Responses indicated a concern over high blood pressure. One response was:

"Possibly blood pressure problems because I know it runs in my family."

'***Cancer'.*** Participants also expressed concern over a family history of cancer.

'***Alcoholism'.*** Two responses were also made about a concern over alcoholism.

'***Liver problems'.*** A family history of liver problems was mentioned in one response. This participant indicated a family history of a disease that affected liver functioning and required testosterone injections.

Construct #2. 'chronic illness'. 'Chronic Illness' was defined as concerns about chronic illnesses. Three chronic illnesses were identified as sub-constructs: 'Cancer', 'Obesity' and 'Diabetes'. Table 12 indicates the frequency of responses by sub-construct and the percentage of the 'Chronic Illness' construct's responses that belong to each sub-construct.

Table 12

'Chronic Illness' Responses by Sub-Construct

Sub-Construct	# of responses	% of all construct responses
Cancer	3	43
Obesity	3	43
Diabetes	1	14
Totals	7	100

Figure 10 represents the percentage of total responses for the 'Chronic Illness' construct by each sub-construct. A discussion of each sub-construct follows.

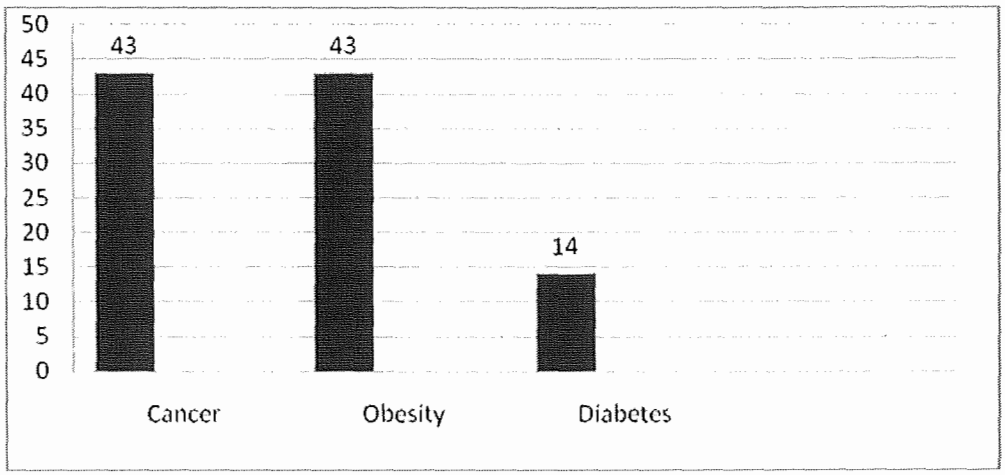

Figure 10. Percentage of 'Chronic Illness' responses by sub-construct.

'Cancer'. Three responses indicated a concern about getting cancer in the future. One of the responses indicated a concern specifically for colon cancer. The other responses did not contain reference to a specific type of cancer.

'Obesity'. Three responses also indicated a concern over obesity. Participants expressed concern over gaining weight and becoming unhealthy.

'Diabetes'. One response indicated a concern about diabetes. The response indicated a concern about developing Type II diabetes due to an unhealthy lifestyle. The participant also expressed a concern over the possibility of having diabetes but not knowing it.

Construct #3. 'high risk'. The construct of 'High Risk' included responses that indicated participants were worried about having an increased risk for certain health problems due to their personal activities or habits. Five sub-constructs were also identified, indicating the specific health problems participants were concerned about contracting due to increased risk. Table 13 indicates the frequency of responses by sub-construct and the percentage of the 'High Risk' construct's responses that belong to each sub-construct.

Table 13

'High Risk' Responses by Sub-Construct

Sub-Construct	# of responses	% of all construct responses
Knee Problems	3	43
Back Problems	1	14
Cataract	1	14
Carpal Tunnel	1	14
Arthritis	1	14
Totals	7	99 [a]

Note.

[a] Percentages for the sub-constructs are rounded to the nearest whole number, which may result in a total percentage unequal to 100.

Figure 11 represents the percentage of total responses for the 'High Risk' construct by each sub-construct. A discussion of each sub-construct follows.

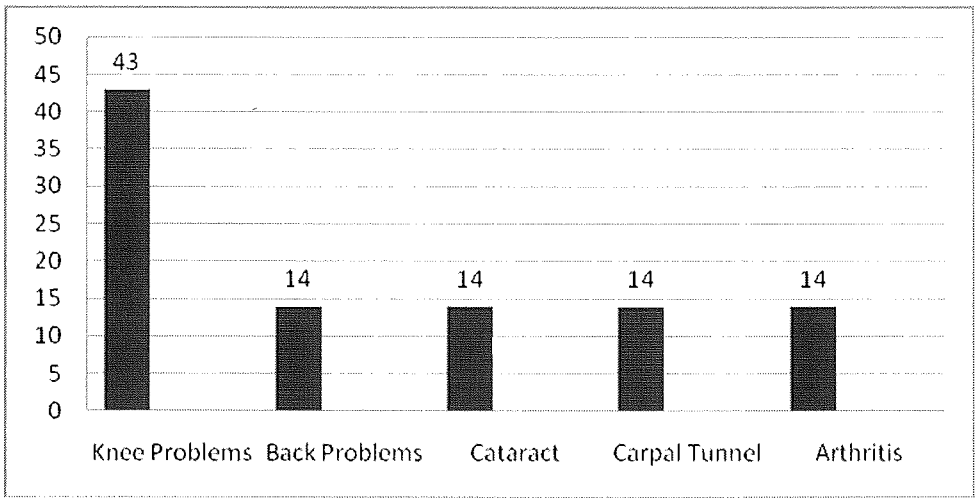

Figure 11. Percentage of 'High Risk' responses by sub-construct.

'***Knee problems'.*** Three responses indicated a concern over developing knee problems in the future. Participants cited this as a concern because of exercising and being active. One participant also responded that he was concerned because he was taller than most people and believed tall people had more problems with their knees. A sample response was:

"I guess knee problems because I do heavy squat twice a week."

'***Back problems'.*** One response indicated a concern about developing back problems in the future. This was cited as a concern because the participant was physically active. The response for this sub-construct was:

"Lower back because I'm fairly active now so it gets a lot of wear and tear."

'***Cataract'.*** One participant responded that he was at a high risk for developing a cataract and had even purchased transition lenses to help with the problem.

'***Carpal tunnel'.*** Carpal Tunnel was cited as a concern by one participant. The participant was concerned that playing video games would lead to this condition.

'***Arthritis'.*** Arthritis was cited as a concern in one response because the participant had a habit of cracking his knuckles.

Construct #4. 'cardiovascular problems'. 'Cardiovascular Problems' consisted of concerns about health problems involving the cardiovascular system. Three specific cardiovascular conditions were identified as sub-constructs. Table 14 indicates the frequency of responses by sub-construct and the percentage of the 'Cardiovascular Problems' construct's responses that belong to each sub-construct.

Table 14

'Cardiovascular Problems' Responses by Sub-Construct

Sub-Construct	# of responses	% of all construct responses
Heart Attack	2	50
High Blood Pressure	1	25
High Cholesterol	1	25
Totals	4	100

Figure 12 represents the percentage of total responses for the 'Cardiovascular Problems' construct by each sub-construct. A discussion of each sub-construct follows.

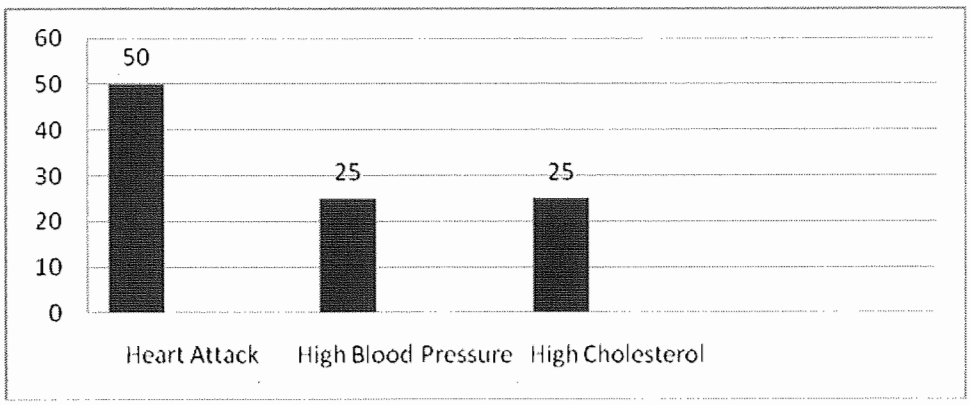

Figure 12. Percentage of 'Cardiovascular Problems' responses by sub-construct.

'Heart attack'. Two responses indicated that participants did not want to experience a heart attack in the future.

'High blood pressure'. There was one response that indicated a concern about developing high blood pressure in the future.

'High cholesterol'. One response also indicated a concern for developing high cholesterol in the future.

Construct #5. 'existing problems'. 'Existing Problems' was defined as concerns about health problems that participants had experienced in the past. Two specific concerns, 'Back Problems' and 'Knee Problems', were identified as sub-constructs. Table 15 indicates the frequency of responses by sub-construct and the percentage of the 'Existing Problems' construct's responses that belong to each sub-construct.

Table 15

'Existing Problems' Responses by Sub-Construct

Sub-Construct	# of responses	% of all construct responses
Back Problems	3	75
Knee Problems	1	25
Totals	4	100

Figure 13 represents the percentage of total responses for the 'Existing Problems' construct by each sub-construct. A discussion of each sub-construct follows.

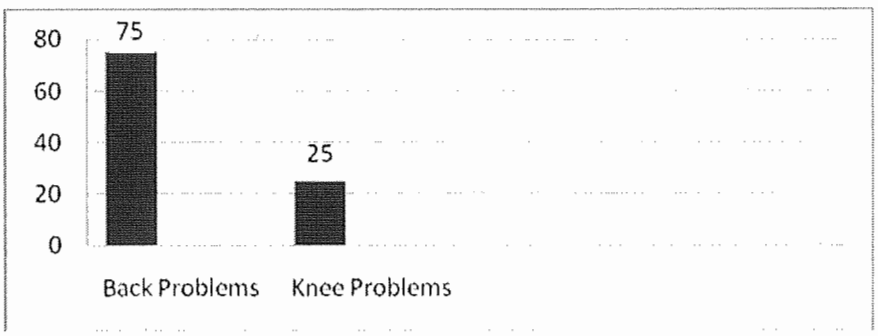

Figure 13. Percentage of 'Existing Problems' responses by sub-construct.

'Back problems'. Three responses indicated a concern about experiencing back problems in the future. Reasons for the concern included already having experienced major back problems and having scoliosis. Sample responses were:

"I've had major back problems and I'm currently trying to prevent surgery."

"I have scoliosis so I worry a lot about that in the future."

'Knee problems'. One participant cited knee problems as a future concern due to having experienced knee problems in the past.

Construct #6. 'back injuries'. One response indicated a concern about experiencing back injuries in the future. No further explanation was given to indicate why this was a concern.

Construct #7. 'kidney stones'. One response also indicated a concern about developing kidney stones. The participant who gave this response did not indicate why this was a concern.

Construct #8. 'arthritis'. Arthritis was also cited as a concern in one response.

Question Six. Violence

Four constructs and a total of 109 responses were identified for this discussion question. The four constructs were 'Witnessing', 'Not Concerned', 'Situational' and 'Opposite Sex Attacks'.

The construct of 'Witnessing' was defined as expressing concern about the impacts of witnessing severe violence. This construct contained 34 responses. The construct 'Not Concerned' included responses that indicated participants were not concerned with violence and were not worried about experiencing or witnessing violent acts. 'Not Concerned' contained 33 responses. 'Situational', which contained 28 responses, was defined by responses that indicated participants were not concerned about experiencing violence because they believed they could avoid situations where violence would occur. The final construct, 'Opposite Sex Attacks',

contained 14 responses and described participants' experiences getting assaulted by women. Table 16 indicates the frequency of responses by construct and the percentage of the question's total responses that belong to each construct. Figure 14 represents the percentage of total responses for the question by each of the four constructs. The following sections further define and discuss each of the four main constructs.

Table 16

Question Six "Violence" Responses by Construct

Construct	# of responses	% of all question six responses
Witnessing	34	31
Not Concerned	33	30
Situational	28	26
Opposite Sex Attacks	14	13
Totals	109	100

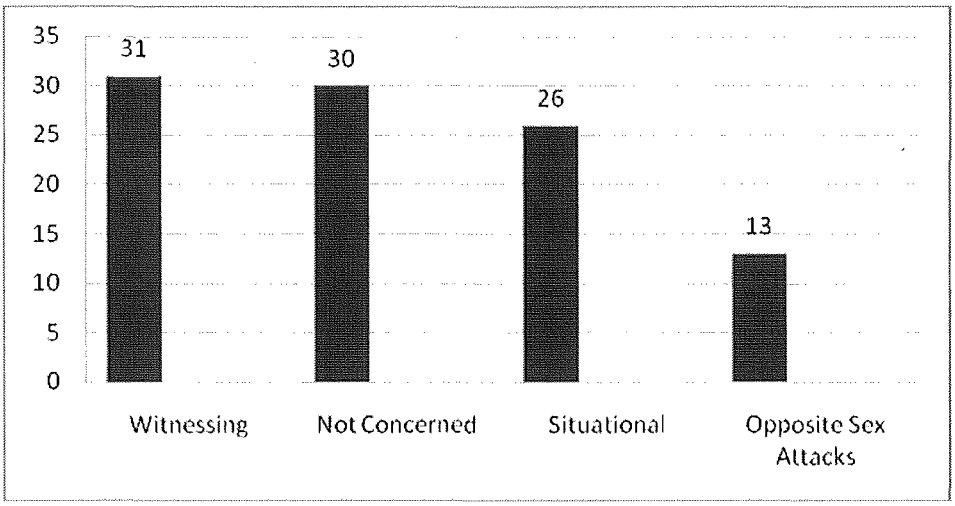

Figure 14. Percentage of question six "violence" responses by construct.

Construct #1. 'witnessing'. The construct of 'Witnessing' was defined as expressing concern about the impacts of witnessing severe violence. Participants expressed concern over

witnessing severe violent acts such as shootings or stabbings or witnessing violent acts that result in someone's death. Participants were also concerned about the effects of witnessing a friend or family member involved in a violent act. There was also a concern about the desensitization that may result from young people witnessing multiple acts of violence. The following are responses from this construct:

> "If I ever saw somebody get shot, I mean that would really affect me."
>
> "As long as people walk away it's all good."
>
> "The desensitization of yourself. If you see enough violence then it becomes the norm and that is a trait you're more likely to pick up."

Construct #2. 'not concerned'. The construct 'Not Concerned' included responses that indicated participants were not concerned with violence, were not worried about experiencing it or the impacts on them of witnessing violent acts. Participants indicated that they felt safe at UW-Stout and did not think they would ever be involved in a violent act. They also indicated that they were not concerned about the impacts of witnessing violence. Sample responses were:

> "I've walked around late at night on campus and off campus and I've generally found it to be relatively safe."
>
> "Figure things out, what happened, get on with it. Don't dwell on it."

Construct #3. 'situational'. 'Situational' was defined by responses that indicated participants were not concerned about experiencing violence because they believed they could avoid situations where violence would occur. Participants responded that they stayed out of violent situations because of their personality – they were laid back and passive and were not interested in fighting. Participants also responded that they could easily avoid situations where

violence was likely to occur, such as at bars or parties. Examples of responses in this construct were:

> "I'm just too laid back to get into a fight with someone. If someone really wanted to fight me, I wouldn't do it."
>
> "For me, I can stay away from it for sure. I don't really put myself in those situations."

Construct #4. 'opposite sex attacks'. 'Opposite Sex Attacks' described participants' experiences getting assaulted by women. These experiences included getting punched and slapped by women. Participants explained the complications of being assaulted by the opposite sex. Participants felt that it was not appropriate for a man to defend himself against a woman. Men also felt as though they could not report the crime and were worried that the woman would tell the police she was assaulted and the police would believe the woman. Sample responses included:

> "I don't see a guy turning in a girl at all because it could turn right on them like that. They'd always believe the girl."
>
> "I've been slapped before, like five times in a row. Turned the cheek and walked away."
>
> "It's really tough because your natural instinct is to defend yourself. But, I couldn't do it because it was a girl."

Question Seven. Body Image

A total of 46 responses and four constructs were identified for the discussion question. The four constructs were 'Staying in Shape', 'Not Concerned', 'Addressing Concerns' and 'Peers' Experiences'.

'Staying in Shape' indicated that participants were concerned about their body image and had a desire to stay in good physical shape. This construct contained 17 responses. 'Not Concerned' was defined as having no concern about body image. This construct contained 16 responses. The construct 'Addressing Concerns', which contained 10 responses, described how participants dealt with their body image concerns. The final construct, 'Peers' Experiences', consisted of three responses in which participants described their peers' experiences with body image concerns. Table 17 indicates the frequency of responses by construct and the percentage of the question's total responses that belong to each construct. Figure 15 represents the percentage of total responses for the question by each of the four constructs. The following sections further define and discuss each of the four main constructs and present any sub-constructs identified for each.

Table 17

Question Seven "Body Image" Responses by Construct

Construct	# of responses	% of all question seven responses
Staying in Shape	17	37
Not Concerned	16	35
Addressing Concerns	10	22
Peers' Experiences	3	7
Totals	46	101 [a]

Note.

[a] The percentages for the constructs are rounded to the nearest whole number, which may result in a total percentage that is unequal to 100.

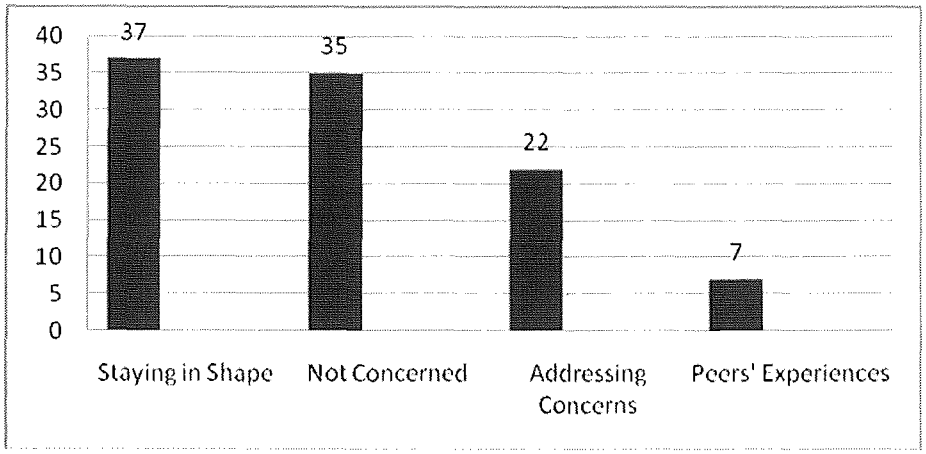

Figure 15. Percentage of question seven "body image" responses by construct.

Construct #1. 'staying in shape'. 'Staying in Shape' indicated that participants were concerned about their body image and had a desire to stay in good physical shape. Some participants were motivated to work out because they had previously been in good shape and wanted to get back to that status. Others responded that they wanted to become stronger and more muscular. Examples of responses from this construct included:

> "I'm definitely aware that I can be in better shape and I can probably look better."
>
> "I would definitely like to be a little bigger, a little stronger, a little more buff."

Construct #2. 'not concerned'. 'Not Concerned' was defined as having no concern about body image. Responses in this construct indicated that concerns about body image did not cause any stress in participants' lives.

Construct #3. 'addressing concerns'. The construct 'Addressing Concerns' described how participants dealt with their body image concerns. Three sub-constructs, 'Healthy Eating', 'Exercise' and 'Hygiene', were identified from these responses. Table 18 indicates the frequency of responses by sub-construct and the percentage of the 'Addressing Concerns' construct's responses that belong to each sub-construct.

Table 18

'Addressing Concerns' Responses by Sub-Construct

Sub-Construct	# of responses	% of all construct responses
Healthy Eating	5	50
Exercise	3	30
Hygiene	2	20
Totals	10	100

Figure 16 represents the percentage of total responses for the 'Addressing Concerns' construct by each sub-construct. A discussion of each sub-construct follows.

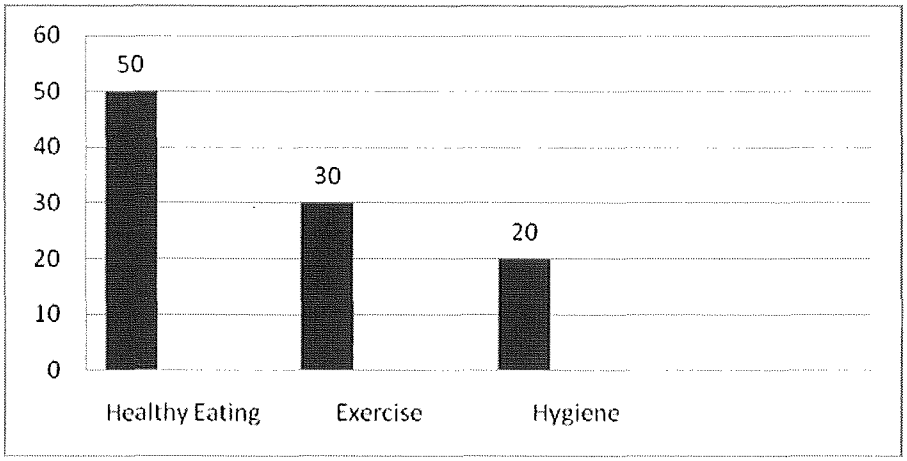

Figure 16. Percentage of 'Addressing Concerns' responses by sub-construct.

'Healthy eating'. Participants indicated that they dealt with body image concerns by practicing healthy eating. Participants ate healthy by limiting their intake of certain foods and increasing their intake of fruits and vegetables. Sample responses from this sub-construct included:

"Got to get your fruits and vegetables in."

"Not getting a Chicken sandwich from the Commons every day."

'Exercise'. Other responses indicated that exercise was used to address concerns with body image. Responses indicated that participants tried to stay active and work out at the gym.

'Hygiene'. Practicing basic hygiene like daily showering was also given as a response for how participants addressed body image concerns.

Construct #4. 'peers' experiences'. 'Peers' Experiences' consisted of three responses in which participants described their peers' experiences with body image concerns. Participants described experiences with peers' obsessions with working out at the gym and taking proteins. They also told stories about peers who were skinny as teenagers and are now concerned with being muscular and about peers who were overweight as teenagers and are now concerned with being thin. Examples of responses in this construct were:

> "I've seen people that are just obsessed with going to the gym and taking proteins and taking Creatine."
>
> "I know a kid who was fat when he was little. Now he's slimmed down, he's like 120 pounds and if he starts feeling fat at all he'll just not eat."
>
> "I've known guys who were the little kids in school. Now they're super heavy built like they're compensating to appease something in their head."

Question Eight. Reproductive Health

Five constructs, with a total of 29 responses, were identified for the discussion question. These five constructs were 'Relationship Stress', 'Testicular Cancer', 'Not Concerned', 'Pregnancy' and 'Erectile Dysfunction'.

The construct of 'Relationship Stress' was defined as concerns over the emotional needs of a romantic relationship. This construct contained 11 responses. 'Testicular Cancer' included responses about testicular cancer and testicular self exams. This construct contained eight

responses. The construct of 'Not Concerned', which consisted of six responses, was defined as not being concerned about any reproductive health issues. 'Pregnancy' was defined as concerns about getting a woman pregnant. There were two responses in the 'Pregnancy' construct. One response was included in the construct of 'STDs', which indicated concern over contracting a sexually transmitted disease. One response was also included in the construct of 'Erectile Dysfunction', which indicated a concern over developing this condition. Table 19 indicates the frequency of responses by construct and the percentage of the question's total responses that belong to each construct. Figure 17 represents the percentage of total responses for the question by each of the six constructs. The following sections further define and discuss the six main constructs.

Table 19

Question Eight "Reproductive Health" Responses by Construct

Construct	# of responses	% of all question eight responses
Relationship Stress	11	38
Testicular Cancer	8	28
Not Concerned	6	21
Pregnancy	2	7
STDs	1	3
Erectile Dysfunction	1	3
Totals	29	100

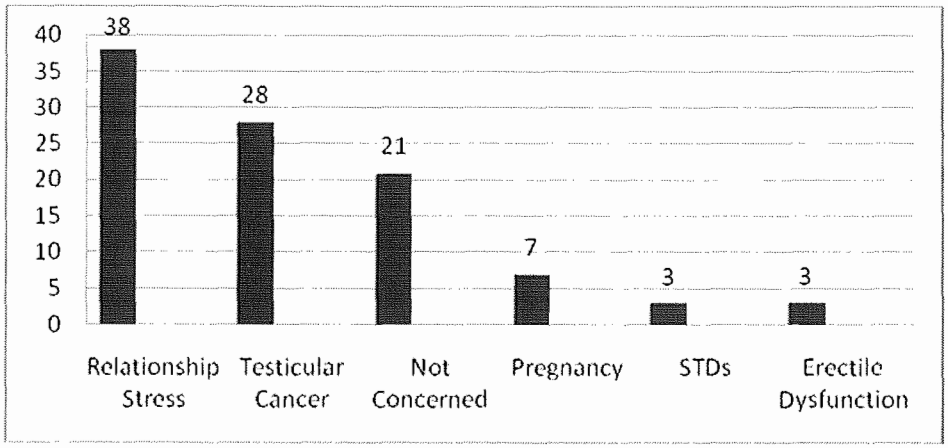

Figure 17. Percentage of question eight "reproductive health" responses by construct.

Construct #1. 'relationship stress'. The construct of 'Relationship Stress' was defined as concerns over the emotional needs of a romantic relationship. Participants indicated that they were distracted and stressed by troubled relationships and were stressed by simply being in relationships with women. Sample responses included:

> "That's the one that I think drives most guys crazy. Once you think you got it figured out, you don't."
>
> "My relationship is not going to good right now. It's kind of stressful. Distracts me in class."

Construct #2. 'testicular cancer'. 'Testicular Cancer' included responses about testicular cancer and testicular self exams. Two responses revealed that participants were concerned about testicular cancer because they had friends and family members who had suffered from the disease. Six other responses revealed that participants were aware of testicular cancer and the importance of self exams, but did not conduct testicular self-exams. Examples of responses were:

> "I think testicular cancer is definitely something I worry about. I had a friend in high school get testicular cancer."

"I'm aware of testicular cancer. Think about it, but I don't do anything to get checked up on."

Construct #3. 'not concerned'. The construct of 'Not Concerned' was defined as not being concerned about any reproductive health issues. Participants indicated that they had no concerns over reproductive issues and also indicated specifically that they were not concerned about testicular cancer.

Construct #4. 'pregnancy'. 'Pregnancy' was defined as concerns about getting a woman pregnant. Responses revealed that participants did not want to father children and were concerned about the availability of Plan B at Student Health Services. Sample responses were:

"I don't want to have a baby either."

"You go to the Student Health Center and they're closed two days a week and you can't get in there and get Plan B."

Construct #5. 'STDs'. One response indicated a concern about contracting a sexually transmitted disease.

Construct #6. 'erectile dysfunction'. One response also indicated a concern about developing erectile dysfunction in the future.

Question Nine. Mental Illness

Four constructs and a total of 39 responses were identified from the discussion question. The four constructs were 'Not Concerned', 'Stress', 'Family History' and 'Onset Age'.

'Not Concerned' indicated that participants were not concerned about mental illness. This construct contained 22 responses. 'Stress' was defined as concerns about suffering from anxiety and stress from academic and daily life responsibilities. 'Stress' contained 11 responses. 'Family History', which contained five responses, was defined as being concerned due to a

family history of mental illness. The construct of 'Onset Age' contained one response and was defined as a concern about the age of onset for mental disorders. Table 20 indicates the frequency of responses by construct and the percentage of the question's total responses that belong to each construct. Figure 18 represents the percentage of total responses for the question by each of the four constructs. The following sections further define and discuss the four main constructs and present sub-constructs identified for each.

Table 20

Question Nine "Mental Illness" Responses by Construct

Construct	# of responses	% of all question nine responses
Not Concerned	22	56
Stress	11	28
Family History	5	13
Onset Age	1	3
Totals	39	100

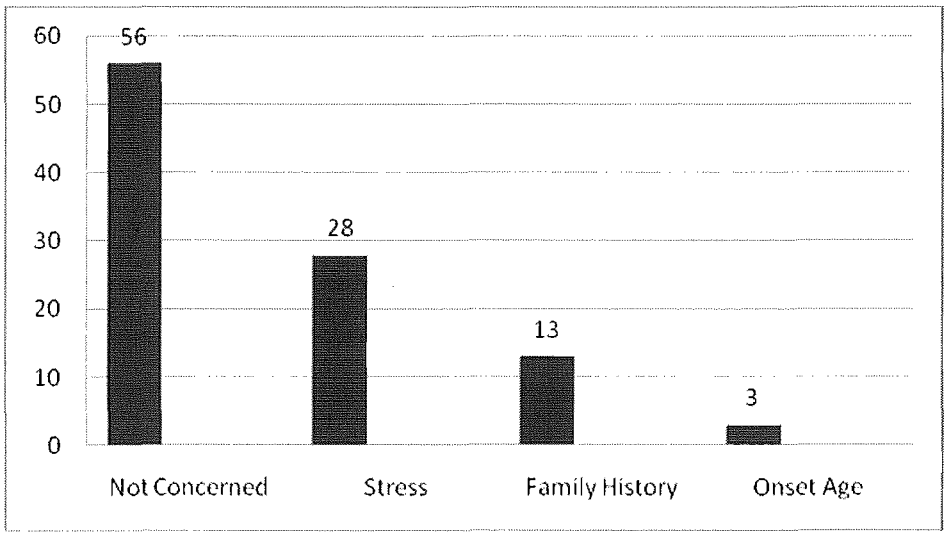

Figure 18. Percentage of question nine "mental illness" responses by construct.

Construct #1. 'not concerned'. 'Not Concerned' indicated that participants were not concerned about mental illness. Participants indicated that they were not concerned about mental illness because they knew how to handle stress. Responses revealed that participants dealt with stress by talking about their feelings, writing poetry and maintaining balance between work and play. Others sought help from their family doctor and the University Counseling Center. Responses included:

> "I think we just all have to balance everything we're doing. Don't focus too much on any one thing."
>
> "I'm not really that kind of guy to get stressed out about anything really."

Construct #2. 'stress'. 'Stress' was defined as concerns about suffering from anxiety and stress from academic and daily life responsibilities. Some responses indicated that participants suffered from anxiety and physical symptoms as a result of stress. Other responses discussed the stress that is felt by students during the end of the semester and finals week when homework and exams increase. Sample responses were:

> "I have to watch anxiety, when stress gets too much it can actually cause physical symptoms."
>
> "It's sometimes really overwhelming if you got a bunch of stuff to do and you have finals to think about."

Construct #3. 'family history'. 'Family History' was defined as being concerned due to a family history of mental illness. The specific mental illnesses that participants mentioned were identified as sub-constructs. Table 21 indicates the frequency of responses by sub-construct and the percentage of the 'Family History' construct's responses that belong to each sub-construct.

Table 21

'Family History' Responses by Sub-Construct

Sub-Construct	# of responses	% of all construct responses
Anxiety	2	40
Insomnia	1	20
Depression	1	20
Bipolar Disorder	1	20
Totals	5	100

Figure 19 represents the percentage of total responses for the 'Family History' construct by each sub-construct. A discussion of each sub-construct follows.

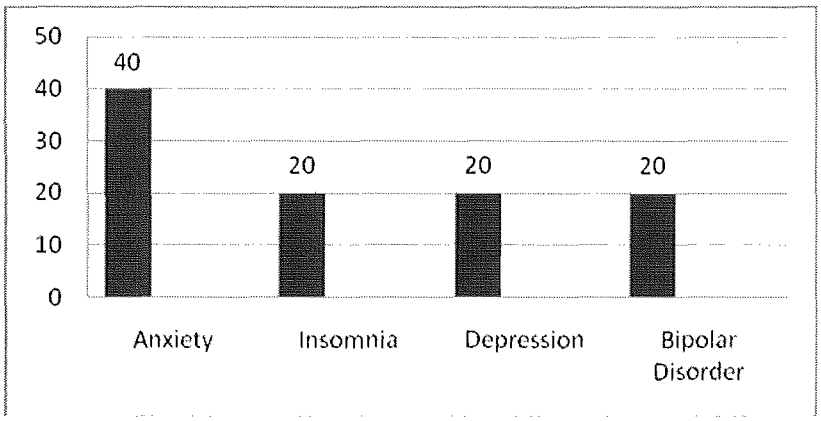

Figure 19. Percentage of 'Family History' responses by sub-construct.

'Anxiety'. Two responses indicated a concern about anxiety. Participants revealed that anxiety ran in their families and they had difficulty handling the stress of academic responsibilities. An example response was:

> "My number one thing is anxiety. It runs in my family. With tests and papers and all the classes we have to do. It's hard for me to keep the anxiety in check."

'Insomnia'. One response indicated a concern over insomnia. Family history included a father and brother with insomnia.

'Depression'. One response was also given indicating a concern about depression because it ran in the participant's family.

'Bipolar disorder'. Bipolar Disorder was indicated as a concern in one response. The participant did not believe he suffered from the disorder but was worried because it was in his family genes.

Construct #4. 'onset age'. The construct of 'Onset Age' was defined as a concern about the age of onset for mental disorders. This response indicated a concern for college students due to the onset age of many mental illnesses being in the early 20's.

Question Ten. As Men, if You Could Create Healthcare on Campus, What Services Would You Offer?

A total of 59 responses and nine constructs were identified for final discussion question. These constructs were 'Convenience', 'Blog', 'Weight Rooms/Gyms', 'Therapist/Trainer', 'Transportation', 'Pamphlets', 'Family History', 'Unaware of SHS' and 'Male Doctor'.

'Convenience' was defined as desiring more convenient healthcare service on campus. This construct contained 23 responses. The construct of 'Blog' contained nine responses describing the desire for an anonymous online blog that students could use to communicate with healthcare professionals. The construct of 'Weight Rooms/Gyms' was defined as improvements in the cost and convenience of these on-campus facilities. This construct contained eight responses. The construct of 'Therapist/Trainer' contained six responses and included responses that indicated a desire for the availability of an on-campus physical therapist or athletic trainer. With four responses, the construct of 'Transportation' was defined as a desire for on-campus

transportation that could take students around campus. 'Pamphlets' described an interest in receiving pamphlets about health-related issues. 'Pamphlets' contained four responses. 'Family History Awareness' consisted of two responses that indicated an interest in receiving information and education about the importance of being aware of your family history. The construct 'Unaware of SHS' included two responses that indicated some students were not aware of Student Health Services. The final construct of 'Male Doctor' contained one response that indicated a desire for a male doctor to be on staff at Student Health Services. Table 22 indicates the frequency of responses by construct and the percentage of the question's total responses that belong to each construct. Figure 20 represents the percentage of total responses for the question by each of the nine constructs. The following sections further define and discuss the nine main constructs and present sub-constructs identified for each.

Table 22

Question Ten "As Men, if You Could Create Healthcare on Campus, What Services Would You Offer?" Responses by Construct

Construct	# of responses	% of all question ten responses
Convenience	23	39
Blog	9	15
Weight Rooms/Gyms	8	14
Therapist/Trainer	6	10
Transportation	4	7
Pamphlets	4	7
Family History Awareness	2	3
Unaware of SHS	2	3
Male Doctor	1	2
Totals	59	100

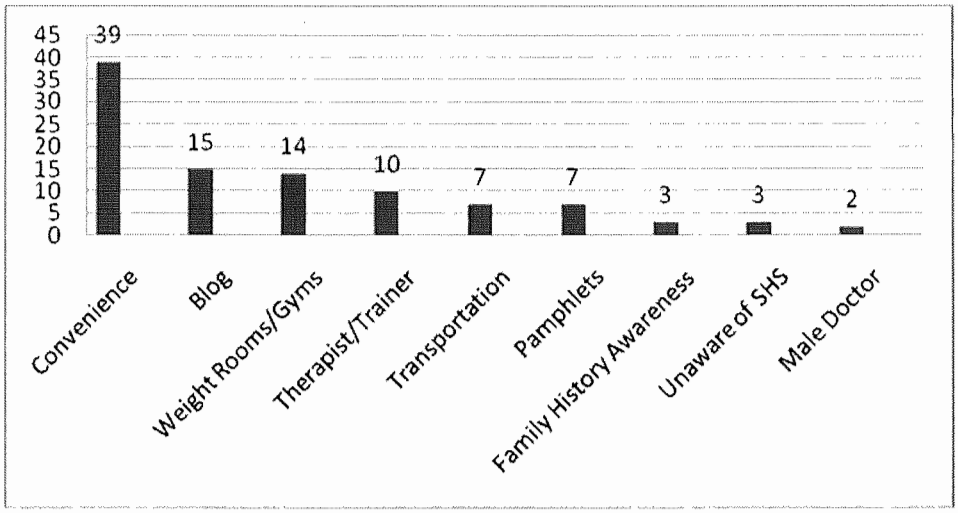

Figure 20. Percentage of question ten "as men, if you could create healthcare on campus, what services would you offer?" responses by construct.

Construct #1. 'convenience'. 'Convenience' was defined as desiring more convenient healthcare service on campus. Participants expressed frustration with Student Health Services' location, hours and efficiency. Participants' suggestions were organized into three sub-constructs. Table 23 indicates the frequency of responses by sub-construct and the percentage of the 'Convenience' construct's responses that belong to each sub-construct.

Table 23

'Convenience' Responses by Sub-Construct

Sub-Construct	# of responses	% of all construct responses
Quicker Service	10	43
Closer Location	8	35
More Hours	5	22
Totals	23	100

Figure 21 represents the percentage of total responses for the 'Convenience' construct by each sub-construct. A discussion of each sub-construct follows.

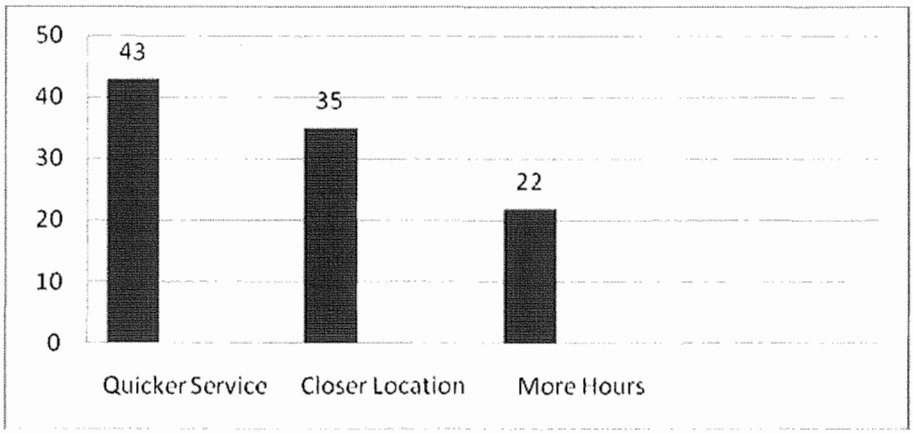

Figure 21. Percentage of 'Convenience' responses by sub-construct.

'Quicker service'. Participants expressed frustration with the efficiency of Student Health Services (SHS) and expressed a desire for quicker healthcare service. Responses indicated that participants had a difficult time getting an appointment at SHS and frequently found that nurses had full schedules. Examples of responses in this sub-construct were:

> "I've found with the nurses there that they always have a full schedule."
>
> "Every time I needed to get in it was always a week or two weeks out."
>
> "It is really hard to get in. They are so busy that it was just really hard to find a time that worked for me and them."

'Closer location'. Responses indicated a problem with the location of Student Health Services. Participants perceived the location to be too far away from the main campus and preferred to have healthcare services located closer to the Memorial Student Center. A sample response was:

"When you're sick and you're trying to get up to north campus, it's a little frustrating."

'More hours'. Participants also requested that Student Health Services be open for more hours each day and be open more days of the week. Participants requested that SHS stay open until 6 or 7 PM or have some hours on Saturdays or Sundays.

Construct #2. 'blog'. The construct of 'Blog' described the desire for an anonymous online blog that students could use to communicate with healthcare professionals. The blog would be used for students to type in questions or symptoms and receive a response from a staff member at Student Health Services. Discussions could also be kept open, so that other students could review previous questions and answers. Responses included:

"I wouldn't mind seeing an anonymous blog in which we could ask a question and then get an answer."

"People can look back on previous discussions and if something is the exact same, use the advice."

Construct #3. 'weight rooms/gyms'. The construct of 'Weight Rooms/Gyms' was defined as improvements in the cost and convenience of these on-campus facilities. Participants expressed difficulty in affording the cost of membership for weight room facilities or gyms. They wanted to see lower fees for using these facilities. Participants also wanted to see better quality gyms in dormitories because they believed students would prefer to use these instead of paying for membership in an off-campus gym. Examples of responses in this construct were:

"Maybe a better gym in the dorms. Because it's hard to toss out a hundred dollars to work at the gym."

Construct #4. 'therapist/ trainer'. The construct of 'Therapist/Trainer' included responses that indicated a desire for the availability of an on-campus physical therapist or athletic trainer. Responses revealed that students were only able to use these resources if they participated in a varsity sport. Participants who played other sports, such as rugby, or who were simply active with rollerblading, biking, long boarding and weight lifting wanted access to a therapist or trainer. Participants expressed a desire to use such services to learn about proper weight lifting techniques and to get treated for knee and back problems. Responses included:

> "Physical therapy would help if you got knee problems, back issues. Someone here on campus so I don't have to go make appointments across town and leave."
>
> "I've tried when I played rugby to go see the trainers, but they would say unless you play a varsity sport you can't use this."

Construct #5. 'transportation'. 'Transportation' was defined as a desire for on-campus transportation that could take students around campus. This was suggested as a helpful way to get to Student Health Services on North Campus and could also be used as a safety measure to transport students late at night who do not feel comfortable walking alone.

Construct #6. 'pamphlets'. 'Pamphlets' described an interest in receiving pamphlets about health-related issues. Responses indicated students would be interested in receiving the pamphlets or posters of information in their dormitories. Three sub-constructs were identified that indicated the specific information participants would like to see in pamphlets. Table 24 indicates the frequency of responses by sub-construct and the percentage of the 'Pamphlets' construct's responses that belong to each sub-construct.

Table 24

'Pamphlets' Responses by Sub-Construct

Sub-Construct	# of responses	% of all construct responses
Minor Injury Care	2	50
Illness Symptoms	1	25
Healthy Eating	1	25
Totals	4	100

Figure 22 represents the percentage of total responses for the 'Pamphlets' construct by each sub-construct. A discussion of each sub-construct follows.

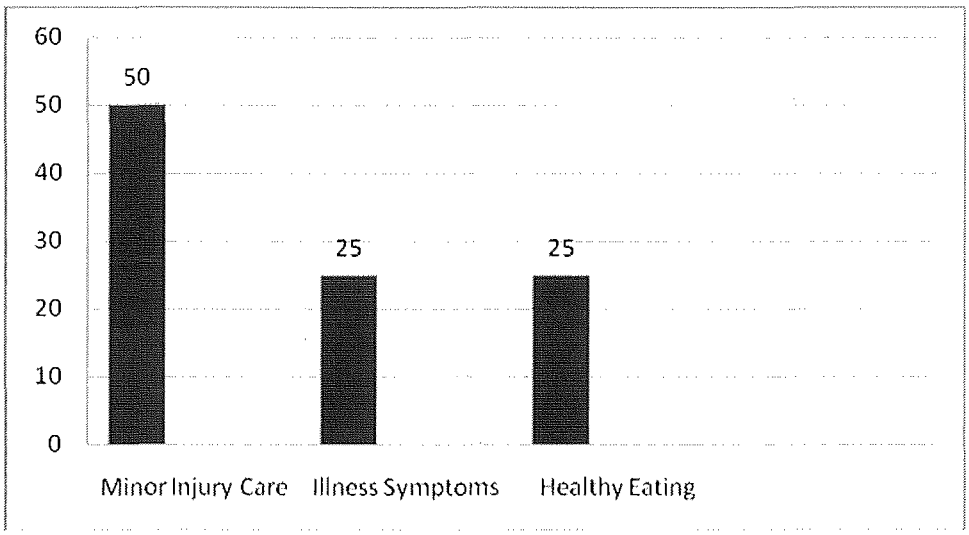

Figure 22. Percentage of 'Pamphlets' responses by sub-construct.

'Minor injury care'. Two responses indicated an interest in receiving pamphlets about minor injury care. Participants were interested in receiving information on how to treat a minor bruise, scrape or sprain.

'Illness symptoms'. One response showed an interest in receiving information on the beginning symptoms of common illnesses, such as mono. This information could be presented in a pamphlet or on a poster displayed in the dormitories.

'Healthy eating'. One response was also given regarding a pamphlet that would provide information on foods that can boost the immune system.

Construct #7. 'family history awareness'. 'Family History Awareness' consisted of responses that indicated an interest in receiving information and education about the importance of being aware of your family history. Participants felt it would be helpful to be educated on the importance of knowing your own personal family history and the illnesses and diseases that you have a greater risk of getting. This education was also seen as important because measures to prevent these family history illnesses or diseases could then begin earlier. The responses in this construct were:

> "Making people aware of the specifics of their families and the diseases that are actually more predetermined to occur could be helpful."
>
> "It took me a long time to become aware of my family's genetic diseases. Just an awareness to recognize those and maybe start earlier of preventing would have helped."

Construct #8. 'unaware of SHS'. The construct 'Unaware of SHS' included responses that indicated some students were not aware of Student Health Services. One part-time, nontraditional student indicated that the focus group discussion was the first time he had heard about Student Health Services. Another response indicated a desire for Student Health Services to advertise more.

Construct #9. 'male doctor'. The final construct of 'Male Doctor' contained one response that indicated a desire for a male doctor to be on staff at Student Health Services.

Chapter V: Discussion

This study was done to determine which health issues concern male students at UW-Stout. Administrators at SHS requested the study in an effort to learn more about the needs of the male population they serve. SHS administrators planned on using the information gained from this study as a basis for development of a related but more generalizable future survey based study. Ultimately, SHS planned to use the information gained from this study and the future survey-based study to improve the on-campus healthcare services offered to men.

Limitations

As stated earlier, a major limitation of the study was the small sample size (N = 24). Another limitation was the nonrandom selection of participants, specifically focus group participants self-selected to be in the study. Due to this nonrandom- self-selection, results cannot be generalized to the entire male student population at UW-Stout. For example, participants were not representative of the entire male student population in race or class status. Almost all of the participants (96 %) were Caucasian and a majority (58%) were freshmen.[1] Only one graduate student participated in the focus groups. Finally, each focus group session lasted only one hour, which did not provide enough time to explore comments in great depth and detail. The data analysis is also a limitation. Qualitative analysis has the potential for subjective biases due to the inductive method used. Inductive reasoning begins with specific observations and measures and uses these to detect patterns and develop conclusions. In qualitative analysis, the

[1] The large number of freshmen participants was a consequence of using SONA Systems as a recruitment method. SONA Systems is used to fill a course requirement for General Psychology classes, which consist mainly of first-year undergraduate students.

researcher identifies the themes present in the data and determines how the individual data points fit with the overarching themes (Rothwell, 2010). This method of analysis is subjective because two different researchers could examine the same data and identify different themes and reach different conclusions.

Conclusions

Violence. Participants gave the most responses to an item querying the topic of violence. Yet, this does not indicate that men were more concerned about violence than they were about other health issues. In fact, 30% of responses to this question belonged to the construct 'Not Concerned'. Another 26% of responses belonged to the construct 'Situational', which indicated that men were not concerned about violence because they were able to avoid violent situations.

This particular question simply invoked more conversation than other questions. Several participants contributed to the conversation by telling personal stories about their experiences with violence. Other participants commented on these stories, resulting in a large number of responses. Some participants responded to this question by speaking about their experiences as the victims of violence.

Interestingly, even though the literature indicates that the most common type of violence involves male victims and male perpetrators (Brooks, 2001), participants spoke about experiences with female perpetrators. These responses reveal that men are confused about how to act when they are attacked by a woman. Men feel that it is not acceptable to defend themselves or use physical force against a woman. They are also hesitant to report the assault because they worry that the female will claim she was the victim and the male was the perpetrator. Studies with college students have shown that females are more likely than males to

be the perpetrators of physical violence. In a survey of students at the University of Florida and the University of South Carolina, 32% of women, compared with 24% of men, reported being perpetrators of physical violence against intimate partners (Keen, 2006). Another survey of undergraduate students found that 19% of women and 14.6% of men reported perpetrating relationship violence. Differences were found in the type of violence however: men were more likely than women to report perpetrating sexual violence, and women were more likely than men to report perpetrating physical violence (Forke, Myers, Catallozzi & Schwarz, 2008).

Participants mentioned that they were concerned about the effects of witnessing severe violence. Participants worried about the impacts of witnessing shootings, stabbings or violent acts that result in someone's death. The men in the focus groups also mentioned that they were concerned about the impacts of witnessing a friend or family member involved in a violent act. There is no literature on how witnessing violence affects adults. However, research has been done on how witnessing violence affects children. Witnessing violence is positively associated with child psychological trauma symptoms of anxiety, depression, anger and posttraumatic stress (Kennedy, 2009; Flannery, 2004). Exposure to violence is also associated with increased aggressive and antisocial behavior in children (Salzinger, 2008; Weaver, 2008; Guerra, 2003). It is possible that exposure to violence may also be associated with psychological trauma and increased aggression in adults.

Reproductive health. Participants provided the fewest responses to a question focused on reproductive health concerns. Twenty-one percent of responses indicated that participants were not concerned about any reproductive health issues. Only two responses indicated a concern for testicular cancer, as most participants appeared simply not concerned. Some men are aware that they are at a high risk of getting testicular cancer due to their age. They are also

aware of the importance of conducting testicular self-examinations. However, this awareness appeared not to lead to action. Even when men were aware of testicular cancer, they reported not practicing self-examinations or consulting a physician for an exam or screening. These findings agree with the literature, which reveals low rates of self-examination in both college males and the general male population (Courtenay, 1998; 2000a).

The most popular response to Question 8 was a concern over relationship stress. Men reported experiencing stress due to the emotional needs of a romantic relationship. Healthcare professionals may want to pay particular attention to this concern. According to Schofield et al. (2000), men are not likely to discuss emotional issues with their healthcare provider and may be reluctant to reveal concerns about a relationship. Healthcare providers should be prepared to bring up the topic and ask men if they are experiencing any relationship stress.

Treating illnesses/injuries. The most popular construct for the question, "What do you do when you are ill?" was 'Severity'. These responses showed that college men seek care from a medical professional only when their symptoms are severe. Men choose to treat illnesses and injuries with self-care unless they are experiencing symptoms like severe pain, bleeding or vomiting. This finding agrees with the literature, which states that men are reluctant to seek care (Courtenay, 1998). Self-care was mentioned in 41% of responses. Participants indicated that they treated illnesses and injuries by taking over-the-counter medications and vitamins, drinking fluids and resting. The 'Severity' construct might also explain the finding that men's health problems are often serious when they visit a healthcare provider (Courtenay, 2000a) and the fact that college men make fewer medical visits than college women (Courtenay, 1998). Male undergraduates in focus groups implemented by Davies et al. (2000) also reported a reluctance to

seek help for medical or emotional problems unless they were in extreme physical or emotional pain.

Although only a minority, in response to Question 1, some men reported that they did not take any action to treat an illness or injury. These men did not seek care from a medical professional or practice self-care; instead, they chose to simply wait until their health improved. This finding could also explain why college men make fewer medical visits than college women (Courtenay, 1998).

Staying healthy. When discussing the question "How do you stay healthy?", participants' most popular answer, with 16 responses, was nutrition. These responses reveal that the college men in this study make a conscious effort to eat a balanced diet. Participants reported that they practice healthy eating by limiting their intake of alcohol and soda and choosing foods that are nutrient-dense like fruits and vegetables. This finding is surprising, given the research showing that compared to women, men have less healthy diets. Research shows that men eat less fiber and fewer fruits and vegetables (Courtenay, 2000a). Research also shows that college men have less healthy diets than college women. College men eat more fried foods, red meat, salt, sugar and high-fat foods (Courtenay, 2000a; Courtenay et al., 2002). This finding suggests that some college men at the university in question are making an effort to eat a healthy diet. The present study did not include women, so it is not possible to determine if college men still have less healthy diets than college women. It is possible that this finding is due to social desirability bias in the focus groups (Nederhof, 1985). Since healthy eating is seen as a socially desirable behavior, participants may have felt uncomfortable admitting to any unhealthy eating habits. Participants may have responded that they engaged in healthy eating so they would appear to be more socially desirable to other people present during the focus groups. Past studies

which found men to have poor diets gathered information with anonymous surveys (Courtenay, 1998; 2000a; Courtenay et al., 2002). When individuals are able to respond anonymously, they are less likely to be influenced by social desirability.

Participants also discussed the topic of screenings. Participants indicated that they do not obtain regular screenings, physicals or check-ups. These men obtain physicals and screenings only when required, as in participation for athletics or employment. This finding agrees with the literature. Courtenay (1998) stated that men are less likely than women to obtain preventative screenings and check-ups. The literature also reports that men are less likely than women to have their cholesterol levels checked (Courtenay, 2000a) and that college men are less likely than college women to have their blood pressure checked every year, to have yearly physical and dental exams (Courtenay et al., 2002).

Hygiene was also discussed, but at lower frequency than for nutrition and screening. Hand-washing was only identified as a way to stay healthy in two responses. Given the current focus on hand-washing and sanitizing that resulted from the H1N1 outbreak, this finding is surprising. Since the outbreak, health officials have been encouraging people to limit the spread of the virus through practicing basic hygiene. The low number of responses in this construct may be due to the timing of the study. The focus groups were held during April 2009, at the beginning of the H1N1 outbreak, when hygiene was not promoted as often as it is currently.

Health information. Half of all responses to "How do you learn about health issues?" referred to the Internet. Men choose to learn about health issues by looking at websites like Google and WebMD. In contrast, just 6% of responses indicated that participants learned about health issues from medical experts. From these responses, college men appear to be more comfortable with reading information online than they are with talking to a health professional.

One response indicated that reading was the manly, independent way to gain information. This finding is supported by the literature, as men tend to conceal their vulnerability and are reluctant to ask for help (Courtenay, 1998). A previous study of undergraduate males found that a need to conceal vulnerability was the most frequently cited barrier to seeking health services (Davies et al., 2000). By reading, men can learn about health issues without having to reveal their vulnerability or ask for help.

Present concerns. One of the goals of this study was to discover which illnesses concern college men. In answering "What injuries/illnesses/diseases are you worried about getting now – while you are in college?", men responded that their greatest concern while in college is contracting a common illness. Men are most concerned about getting sick with a cold, the flu, meningitis, pink eye and mono. This finding may be due to the large number of freshman participants. Freshmen are more likely than upperclassmen to live in dormitories, where illnesses spread quickly. Concern about catching common illnesses may be even greater currently, following the outbreak of the H1N1 flu. Yet, this study took place in April 2009, at the beginning of the outbreak and H1N1 was not mentioned in any response.

Participants were also concerned about catching sexually-transmitted diseases. This concern seems appropriate given that men engage in a number of risky behaviors that increase their risk of getting STDs (Courtenay, 2000a). College men are more likely than college women to be sexually active, to have a greater number of sexual partners and to be non-monogamous (Campbell et al., 1992; Helweg-Larson & Collins, 1994; Prince & Bernard, 1998; Reinisch et al., 1992; Wiley et al., 1997). Male students are also more likely than female students to use alcohol or other drugs before engaging in sexual activity (Wiley et al., 1997). In addition, male college

students appear to engage in unprotected sex. Specifically, one study found that 55% of college men did not use a condom during their most recent sexual encounter (Wiley et al., 1997).

Another concern involved injuries. Participants were concerned about becoming injured from athletics and high-risk activities. The literature shows that men are more likely than women to participate in risky sports and recreational activities (Courtenay, 2000a). Men also have a greater risk of being injured at work or in an automobile crash and are more likely to die form a self-inflicted injury (CDC, 2004; Courtenay, 2000a; Heron et al., 2009; "Masculinity and Men's Health", 2008).

Future concerns. Responses to "What injuries/illnesses/diseases are you worried about getting in the future – when you are 40 years or older?" indicated an awareness of family history. Most responses indicated that participants are concerned about health problems that run in their families. The men in the focus groups demonstrated that they are aware of their family histories and are aware that they are at an increased risk for certain illnesses. Davies et al. (2000) also found that male college students were aware of their family medical histories.

Participants also responded with concerns about chronic illnesses, such as cancer, obesity and diabetes. These concerns seem appropriate since more men than women are overweight or obese and more men than women get cancer (Courtenay, 2000a; DHHS, 2009; Nicholas, 2000).

Body image. The responses to an item concerning body image show that the college men in this study have some concerns about body image, but these concerns do not cause them to take unhealthy actions. The most responses, 37%, belonged to the construct 'Staying in Shape'. These responses indicated that participants were concerned about staying in good physical shape and wanted to be stronger or more muscular. Another 35% of responses belonged to 'Not Concerned', which indicated that college men were not stressed about body image concerns.

The men in the focus groups reported that they deal with body image concerns by exercising and practicing healthy eating and basic hygiene. These men did not report using any unhealthy behaviors related to body image concerns (e.g. taking steroids or ingesting other chemicals to build muscle mass, severely restricting calories or purging to control weight).

The fewest number of responses were made about peers' experiences with body image concerns. There were only three responses in the 'Peers' Experiences' construct, which described unhealthy reactions to body image concerns.

Taken together, the above findings regarding body image conflict with data reported in the literature. In a study by Davies et al. (2000), the second most discussed topic was concerns over body image. Specifically, men were concerned about their physical appearance and maintaining a desired weight. They were also concerned about the effects that physical inactivity had on their appearance (Davies et al., 2000). Men in the present study did not list body image as a major concern. Yet, men in these two studies do seem to have similar concerns. Participants in both studies discussed concerns over the effects of physical inactivity on their appearance and a desire to maintain a certain weight (Davies et al., 2000).

Mental illness. Over half of responses to a question regarding mental illness belonged to the construct 'Not Concerned'. This finding indicated that participants were not concerned about mental illness or stress. Men reported that they know how to handle stress effectively, by talking about their feelings, writing poetry and maintaining a balance between work and play. The literature, however, shows that men choose unhealthy strategies to cope with stress. Davies et al. (2000) found that, among male undergraduates, more than 50% of the strategies used to cope with stress were less than desirable. These strategies appeared to focus on how to escape from feeling stress rather than how to deal with it effectively.

Although a majority of responses belonged to 'Not Concerned', 28% of responses did indicate that participants were concerned about stress and anxiety. Participants discussed feeling stressed from daily life and academic responsibilities – particularly during the end of the academic semester and finals week. Male college students in a study by Davies et al. (2000) cited school workload as the most frequent cause of stress.

Participants also demonstrated an awareness of family history in responses to Question 9. Some men are concerned about certain mental illnesses, like anxiety and depression, because these conditions run in their families.

Suggestions for SHS. The final question asked participants, "As men, if you could create healthcare on campus, what services would you offer?" In response to this question, participants discussed their concerns with SHS and suggested several changes SHS could make to improve their services. The most popular suggestion was for SHS to be more convenient. These students in this study feel that is too difficult to get an appointment because providers' schedules are always full. Students describe SHS as being too far away from the main campus and express that they find it challenging to get to the location on North Campus, especially when they are sick or injured. One suggestion was that SHS improve services by having more hours, such as staying open into the evenings or having some hours on Saturdays or Sundays.

Men also suggested that SHS develop an anonymous phone line that students could use to speak to a nurse. Through this phone line, men could explain any unusual symptoms and get a diagnosis or receive advice on whether or not they should visit a healthcare provider. Men in the focus groups also expressed interest in the development of an online system that would be similar to the phone line. A chat line or blog could be set up so students could anonymously post questions for a healthcare professional. The professional's answers would also be posted online.

One suggestion was that other students should be able to view these postings in case they have a concern that is similar to one that has already been posted.

Both the telephone line and the online blog have been suggested in the literature as techniques that college health professionals can use to reach men and make them more comfortable with seeking care (Courtenay, 1998; 2004; Davies et al., 2000). Telephone lines are already being used as a part of tele-health, which helps doctors communicate with patients across distances and allows doctors to monitor patients at home (Masic, 2008). Primiani and Castillo (2009) reported that the use of tele-health in cancer patients' homes reduced the frequency of hospital admissions, urgent care visits and clinic visits, and improved the quality of life for patients and their families (Primiani & Castillo, 2009). Tele-health has also been used to provide healthcare to rural communities. Specifically, the University of Arizona used telemedicine to provide services to medically underserved populations, to increase access to medical specialty services and to improve public health in rural communities (Lopez, Avery, Krupinksi, Lazarus & Weinstein, 2005). Surveys found high levels of patient satisfaction with the tele-health consultations and a majority of patients indicated that the care they received through telemedicine was as good as care received face to face. The majority of patients also indicated that care was more accessible or easier because of telemedicine (Lopez et al., 2005).

Several participants also mentioned a desire for an on-campus physical therapist or athletic trainer that could provide services to students who are not in varsity sports. Students wanted therapists or trainers to assist with certain injuries or to teach proper weight-lifting techniques. Weight-lifting was also mentioned when students indicated a need for cheaper weight room facilities on campus. The focus group participants stated they have difficulty affording the cost of a gym membership and report that if the facilities in dormitories were

improved, more students would use them instead of purchasing a membership in a gym off campus.

Summary of Findings

Responses from the focus groups provided information on male UW-Stout students' health needs and concerns, care-seeking behaviors and desires for on-campus healthcare. The main findings show that these students are most concerned about catching common illnesses. They are also concerned about catching sexually-transmitted diseases. Students are also aware of their family histories and are concerned about the mental and physical illnesses that run in their families. Findings on participants' behaviors show that male college students do not obtain regular check-ups, physicals or screenings and do not practice testicular self-exams. They prefer to practice self-care and visit a healthcare provider only when symptoms are severe. They also prefer to learn about health issues by looking up information on the Internet. Participants suggested that SHS could improve services by expanding clinic hours and providing transportation to the clinic. Male students also want SHS to develop a telephone line and online blog, to hire a physical therapist or athletic trainer and to improve weight room facilities.

Recommendations

The main recommendation for SHS is to continue this research by implementing a larger study. A new study could address the present study's limitations of a small, non-representative sample. Plans call for the development and implementation of a survey that will gather quantitative data on this subject from a larger, random sample of male students. Information from this survey will give SHS a more accurate representation of what male students at UW-Stout are looking for in healthcare. The survey can provide more in-depth information that was not able to be gathered during the present study due to time constraints. The new study should

expand on the current study by focusing on the same main topics of present health concerns and suggestions for on-campus healthcare. Survey questions could focus on male students' opinions of SHS and suggestions for improvement. The survey could also be used to ask a larger sample for their opinions on suggestions from the focus groups. For example, one question could ask how likely the men would be to use an online blog established by SHS. Overall, the new study would provide more accurate data on the health concerns of male students at UW-Stout.

The findings from this study have revealed several ways that SHS can improve existing healthcare services for men. First, more initiative should be put into place to encourage men to take preventive action to protect their health. Men should be encouraged to get screenings and routine physicals and check-ups. No literature has been found on any such initiatives aimed at college men. However, in April 2008, the U.S. Agency for Healthcare Research and Quality (AHRQ), along with the Advertising Council, launched the "Real Men Wear Gowns" public service campaign to raise awareness among middle-aged men about the importance of preventive screenings. The goal of "Real Men Wear Gowns" was to show men over the age of 40 the importance of prevention and working with their health care providers to stay healthy. The campaign included television, radio, print and web advertising. It encouraged men to visit the AHRQ website for a list of recommended screenings and when they should be conducted, tips for talking with a doctor and other health-related resources ("New Campaign", 2008). The ads incorporated the idea of masculinity by showing that "real men" take care of themselves and their health in order to be there for their families and in the future (Higgins, 2008). Unfortunately, no evaluation studies were found in the literature to the effectiveness of this campaign in increasing health screening behavior by men.

When educating students about family history awareness, healthcare providers should also include information about taking action with screenings and check-ups. It's important for men to not only be aware of their health risks, but also to take action to reduce these risks. Because of the increased testicular cancer risk in males aged twenty-plus years, (Courtenay, 2000a), college men should also be encouraged to practice testicular self-examinations. SHS staff can discuss the importance of exams with students who visit the clinic and can provide pamphlets to provide information on how to practice self-exams. These pamphlets and posters about testicular cancer and self-exams could also be placed around campus and in dormitories.

SHS can promote screenings by reaching students when they visit the clinic. Providers should review patients' family histories and suggest specific screenings based on their risks. SHS could also educate students by creating posters about the importance of screenings for cholesterol, blood pressure or cancer. Posters could be placed around campus: in dorms, the student union and classroom buildings. SHS has already created posters to encourage students to get cholesterol screenings. SHS could also work with professors to include information on screenings in health and science courses.

SHS can also address men's concerns by providing information on how to self-treat minor illnesses and injuries. College men would benefit from this information since they are most concerned about minor illnesses and appear to rely on self-care, preferring to treat an illness by themselves instead of visiting a healthcare professional. SHS could also educate men on how to avoid catching common illnesses and how to prevent spreading an illness if they do catch one. SHS has already developed a series of self-care pamphlets, which describe the symptoms and treatments for common illnesses. The pamphlets are placed at SHS and healthcare providers distribute the pamphlets to patients that seek treatment in the clinic. The information in the

pamphlets is also posted online and can be reached by visiting SHS's website. However, it appears that most male students are not aware that these pamphlets exist. To increase awareness, SHS could place the pamphlets in other locations on campus, such as dormitories, weight room facilities and the student union. SHS could also advertise these pamphlets by putting a message about their availability in the monthly health newsletter or the campus' daily E-mails. Advertising would be needed especially during fall and winter, when common illnesses like colds and flues are more prevalent.

SHS could also inform men when they should seek care from a medical professional. Research has shown that men worry about seeking care too soon and being seen as less masculine (Armstrong et al., 1999; Davies et al., 2000). By providing this information, SHS would make men feel more comfortable and confident that they are not seeking care unnecessarily.

SHS could get this information out to men by using technology. Information could be disseminated through online resources, such as a website or E-mail. The men in the focus groups indicated that they are more comfortable reading information online than they are with talking to a health professional. Recommendations on when to seek care could also be given through a phone line or online blog. Both of these methods were suggested by men in the focus groups. SHS already has a phone line. When students call SHS, they can choose to speak directly to a triage nurse. Students can describe their symptoms to the nurse and receive a recommendation of whether or not to seek care. The nurse can also provide information on how to self-treat in illness or injury. Male students seem to be unaware that this system already exists. The phone line needs to be advertised, but before they can advertise, SHS needs ensure that the system is

properly staffed. If the current triage nurse would be unable to handle an increased number of calls, additional staff members may need to work on the phone line.

SHS also has an online system set up, where students can send a question to a "health mailbox". However, the system was set up to answer general questions about SHS, rather than to provide medical advice. This system would need to be changed into the blog format that was suggested during the focus groups. SHS would also need to ensure that a staff member would be able to check the blog and respond to students' questions daily.

Both the phone line and the online chat line need to be advertised to students. Advertising can be done through SHS' website or campus E-mails. The self-care pamphlets can also contain a message about the phone line and blog services.

Finally, SHS could improve men's healthcare by expanding services. To address these concerns, SHS could investigate various operational changes. One change would be the possibility of providing services in a more convenient location for students or providing transportation to the facility. SHS could also investigate the possibility of expanding hours, by staying open into the evenings a couple nights a week or by having some weekend hours.

Men in the focus groups also suggested that SHS provide physical therapy or athletic training. Before this study was implemented, SHS administrators had already proposed the idea of hiring a physical trainer or family practitioner to focus on sports medicine. Based on the findings of this study, SHS should continue to advocate for the addition of a physical therapist or athletic trainer that can provide services to students that are not involved in varsity sports.

Summary of Recommendations

This study has revealed several ways that SHS can improve existing healthcare services for men. First, SHS should encourage male students to take preventive action, such as

conducting self-examinations and going to the doctor for screenings, routine check-ups and physicals. SHS can address current health concerns by providing male students with information on how to self-treat common illnesses and injuries. This information can be released through various methods – in person at the clinic, online through a website, blog or e-mail, through a phone line or on printed pamphlets and posters. SHS has already created self-care pamphlets and established a phone line, but the clinic needs to focus on advertising these services so more students become aware of their availability. Finally, SHS can improve men's healthcare by expanding services. Clinic administrators could investigate the possibility of moving services to a more convenient location or expanding operating hours. SHS should also continue to advocate for the addition of a physical therapist or athletic trainer that can treat students who are not involved in varsity sports.

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Appendix A: Invitation E-mail

- Do you like free food?
- Could you use an extra $50?

If you answered **YES** to either of these questions, **please keep reading…**

You are invited to join a discussion group of UW-Stout males to talk about health concerns and campus healthcare. Your comments will be used to improve the healthcare services offered to men at UW-Stout. Women are usually the center of attention in healthcare, so this is your chance to bring men into the spotlight and have your opinions heard!

- Discussions will last 1 hour
- Groups will consist of 6 male students
- Groups will also be led by a male student – no women will be present!

- Lunch will be provided
- $50 Wal-Mart gift cards will be given to 2 lucky winners (taken from a pool of 24 participants)
  -Winners of the random drawing will be notified by E-mail

If you are interested in participating, please reply to this E-mail and indicate all sessions that you are available. You will be placed into one session.

Session 1 – Tuesday; 3:30-4:30 pm
Session 2 – Wednesday; 1:25-2:20 pm
Session 3 – Wednesday; 3:30-4:30 pm

If you are selected to participate (based on your availability) you will be contacted soon.

Thank you for your time!

Sincerely,

Jenna Simon

"This research has been approved by the UW-Stout IRB as required by the Code of Federal regulations Title 45 Part 46."

Appendix B: Confirmation E-mail

Thank you for volunteering to join the discussion about men's health.

Your discussion group is scheduled for:

Wednesday, April 8th
12:20 – 1:15 P.M.
Maplewood Room of Memorial Student Center

Your lunch will be available about 15 minutes before your group is scheduled to begin. Please arrive around noon so your group can begin on time.

Thank you for your participation. Please make every effort to attend – the groups are small and your input is greatly appreciated!

If you have any questions or need to reschedule your focus group time, please contact me at simonje@uwstout.edu or 232-2555.

Sincerely,

Jenna Simon

Appendix C: Reminder E-mail

Just a reminder:

Your discussion group on men's health is meeting **today** at **12:20 P.M.** in the **Maplewood Room** of the Memorial Student Center.

Please arrive around noon so the groups can begin on time.

Thank you!

Sincerely,

Jenna Simon

Appendix D: Consent Form

Consent to Participate in UW-Stout Approved Research

Title: Health Concerns of UW-Stout Males

Investigators:
Jenna Simon
SHS Room 123
(715) 232-2555
simonje@uwstout.edu

Dr. Lynn Murel
SHS Room 106
(715) 232-1163
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Research Sponsor:
Dr. Kristina Gorbatenko-Roth
304 McCalmont Hall
(715) 232-2451
gorbatenkok@uwstout.edu

Description:
The objective of this study is to identify the health concerns, needs and behaviors of college males. Healthcare has traditionally focused on females and existing information on the health needs of college males is limited. The results of this study will be used by administrators at Student Health Services to improve the programming offered to males. Student Health Services will also use these results to develop a survey focusing on the health needs of college males. Participants will provide information by attending a discussion on men's health facilitated by a male graduate student.

Risks and Benefits:
There are no major risks associated with participating in this research. However, due to the personal nature of the topic, feelings of discomfort may occur if the participant feels that a particular question or comment made during the focus group is distressing. Participants will be given information for Student Health Services and the Counseling Center and will be encouraged to contact these organizations if they experience distress as a result of the discussion. As a benefit, those who participate in the study will be provided with a complimentary lunch and will also be entered into a drawing to win a $50 Wal-Mart gift card. The investigator and Student Health Services will use this information to gain a better understanding of college males' health concerns, needs and behaviors. The administrators at Student Health Services will use this information to improve programming to better serve the male student population. This study will also be providing information about a population that has not been thoroughly examined.

Time Commitment and Payment:
Completion of the focus group is expected to take 1 hour. Food will be provided and participants will have the chance to win a $50 Wal-Mart gift card.

Confidentiality:
To ensure confidentiality, no identifying information will be attached to comments/responses given during the discussion. Responses will be anonymous and it will not be possible to identify

the source of a response. This informed consent will be stored separately from the other documents completed with this project.

Right to Withdraw:
Your participation in this study is entirely voluntary. You may choose not to participate without adverse consequences to you. You are free to leave at any time and will not be required to comment on any topic you are uncomfortable discussing.

IRB Approval:
This study has been reviewed and approved by the University of Wisconsin-Stout's Institutional Review Board (IRB). The IRB has determined that this study meets the ethical obligations required by federal law and University policies. If you have questions or concerns regarding this study please contact the Investigator or Advisor. If you have any questions, concerns, or reports regarding your rights as a research subject, please contact the IRB Administrator.

Investigator:
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Dr. Lynn Murel
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IRB Administrator
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Advisor:
Dr. Kristina Gorbatenko-Roth
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gorbatenkok@uwstout.edu

Statement of Consent:
By signing this consent form you agree to participate in the project entitled Health Concerns of UW-Stout Males.

_____ _____

Signature.....Date

Appendix E: Prize Winner E-mail

Congratulations!

You have been selected as the winner of the **$50 Wal-Mart gift card**!

You can claim your prize at the front desk of Student Health Services – Monday through Friday, between 8 am and 4:30 pm. You must claim your prize by **May 15**. Please bring your student ID with you.

Thank you for participating in the discussion group on men's health on April 8. Your input is appreciated.

Currently, the results of the focus groups are being summarized and analyzed. A copy of the final report will be sent to you if you indicated that you were interested in receiving one. If you did not fill out the contact information for this at your focus group, but would still like to receive a copy of the report, please contact me at simonje@uwstout.edu or 232-2555.

All of the information you provided will be kept confidential.

If you have any questions or concerns, feel free to contact me at the E-mail address or phone number provided above.

Sincerely,

Jenna Simon

Appendix F: Thank You E-mail

Thank you for participating in the discussion group on men's health on April 8. Your input is appreciated. Unfortunately, your name was not picked as a winner of the $50 Wal-Mart gift card.

Currently, the results of the focus groups are being summarized and analyzed. A copy of the final report will be sent to you if you indicated that you were interested in receiving one. If you did not fill out the contact information for this at your focus group, but would still like to receive a copy of the report, please contact me at simonje@uwstout.edu or 232-2555.

All of the information you provided will be kept confidential.

If you have any questions or concerns, feel free to contact me at the E-mail address or phone number provided above.

Sincerely,

Jenna Simon