DOI: 10.1590/S1414-32832013005000024

Effects of psychoeducational intervention on the use of healthcare services by elderly men

Lilian Maria Borges[1]
Eliane Maria Fleury Seidl[2]

[1] Programa de Pós-Graduação Stricto Sensu em Psicologia, Universidade Católica de Brasília. SGAN 916, Módulo B. Avenida W5. Brasília, DF, Brasil. 70790-160. limaborgesg@gmail.com

[2] Instituto de Psicologia, Universidade de Brasília.

This study investigated the effects of a psychoeducational intervention for strengthening self-care among elderly men, with emphasis on seeking and using healthcare services. Thirteen retired married men aged between 62 and 78 years (M = 69.5) participated. The interventions occurred at nine thematic meetings that included dialogue-based presentation and group dynamics. Data were obtained before and after the group sessions, through individual interviews based on a questionnaire that had been developed for investigating self-care behavior and associated factors. The possible effects from the interventions were seen to be greater readiness among the participants to attend consultations and medical examinations. However, the intervention was most beneficial in terms of awareness-raising and maintenance, rather than in relation to changes to healthcare behavior. The need for further investigations focused on the interrelationship between gender, aging and health was emphasized.

Keywords: Men's health. Aged. Masculinity. Psychoeducational group.

Introduction

Brazil has been presenting a notable demographic transition process, with an increasing proportion of elderly people over recent decades. According to the demographic census of the year 2010, people aged 65 years and over presented relative participation in the population of 7.4%, which signifies that the number of elderly people in Brazil is more than 20 million (IBGE, 2011). Life expectancy at birth among Brazilians, which was 71.3 years in 2003, increased to 73.17 years in 2009 (IBGE, 2010a). It has been predicted that in 2020, the country will have 32 million people within this age group, thus making Brazil the sixth biggest country in the world, in terms of the number of elderly people. These demographic changes have been accompanied by changes to the population's epidemiological profile, with reductions in the incidence of infectious and contagious diseases and greater prevalence of chronic and degenerative diseases, which have become the main causes of morbidity and mortality (Veras, 2009; Veras, 2003; Camarano, 2002).

Although old age should not be taken to be synonymous with disease, it is known that the elderly segment of the population presents higher morbidity rates than other age groups. As the aging process advances, people show greater predisposition towards chronic illnesses such as

cardiovascular and osteoarticular diseases (Veras, 2009; Veras, 2003). At the age of 75 years, most people have an average of three to four diseases or incapacities (Tulloch, 2005).

On the other hand, indicators of morbidity and mortality measured according to the demand for healthcare services and through population-based surveys have shown that there are differentiated risks of becoming ill and dying for man and women. These relate both to biological characteristics and to sociocultural processes. Women present chronic diseases and incapacities more often than men do (Redondo-Sendino et al., 2006; Laurenti, Jorge, Gotlieb, 2005; Lunenfeld, 2002). However, in Brazil, men present life expectancy that is around seven years shorter than that of women (Brasil, 2008; IBGE, 2010a).

In analyzing the differences in mortality between the sexes, Abreu, César and França (2009) found that in Brazil from 1983 to 2005, around 32% of deaths among men were avoidable. Thus, the risk of death was greater among men than among women in relation to causes of death that would be avoidable through early diagnosis and treatment, and in relation to ischemic heart disease. These differences became greater with advancing age, particularly after the age of 45 years.

The high incidence of diseases and mortality among the male population indicates that, in comparison with women, men present more types of behavior that present risks to health, engage less in preventive behavior and seek healthcare services less frequently, especially primary care services (Gomes, Nascimento, Araújo, 2007). According to data from the National Household Sampling Survey (Pesquisa Nacional por Amostra de Domicílios, PNAD) of the year 2008, a smaller percentage of the men interviewed (58.8%) had had medical consultations over the last 12 months, in comparison with the women (76.1%). Although the main reason for seeking healthcare service, for both sexes, was that they had been affected by diseases, women sought vaccination or prevention proportionally more often, while men sought these services more than women for treating accidents and injuries (IBGE, 2010b).

Largely due to cultural and educational reasons, men act mainly because of the need to repair problems that already exist and predominantly seek emergency services and pharmacies (Couto et al., 2010; Pinheiro et al., 2002). This male behavioral pattern may lead to loss of important time for making early diagnosis, thereby giving rise to worsened morbidity (Brasil, 2008). This implies greater physical and emotional distress and greater expenditure on healthcare resources (Issa et al., 2006; Lunenfeld, 2002).

Linhares et al. (2003) found that the clientele attended at the geriatrics outpatient clinic of a university hospital was composed predominantly of women, who accounted for 70% of the participants in the study. Veras (2003) also found that there was consistently lower demand for outpatient services among the men, in interviews conducted with 360 elderly people at the reception desk of an outpatient clinic within the public system. The absence of more significant numbers of elderly men at the outpatient clinic shows that these individuals may have contacted

the healthcare system at a more advanced stage of their diseases, which would lead to treatments that were more onerous and less curative.

The low male demand for healthcare services can be better understood if it is taken into consideration that in men's socialization, self-care and placing value on the body are issues that have little encouragement (Schraiber, Gomes, Couto, 2005). Taking care of health is strongly associated with the idea of femininity, and primary care services are commonly regarded as a space destined for the female public and for children (Figueiredo, 2005; Lunenfeld, 2002). Furthermore, in a general manner, men fear that putting their healthcare needs into words may be interpreted as a demonstration of weakness, fear or insecurity, thus generating suspicion regarding their masculinity (Gomes, Nascimento, Araújo, 2007; Figueiredo, 2005). Women are more encouraged and authorized by society to communicate their afflictions relating to pain and discomfort, and more frequently use strategies such as crying, complaining and seeking healthcare services (Linhares et al., 2003).

Gomes, Nascimento and Araújo (2007) drew attention to the cultural influences involved in this issue and highlighted several factors in order to understand the differentiated patterns of healthcare between men and women, including fear of discovery of a serious disease, embarrassment about exposing the body in front of healthcare professionals and unavailability of programs or activities directed specifically towards the male population. In this regard, it seems that there is a gap between the healthcare needs of the male population and organization of healthcare services and practices (Couto et al., 2010). Consequently, the topic of "men and health" is a recent target of interest within public health and increasing efforts have been made towards identifying the specific features that need to be considered in addressing male health in different phases of the cycle of life.

In Brazil, the National Policy for Comprehensive Men's Healthcare (Política Nacional de Atenção Integral à Saúde do Homem, PNAISH) has been in force since 2009. This recent innovative initiative from the Ministry of Health was launched with the aims of facilitating and expanding the male population's access to healthcare actions and services, and reducing their morbidity and mortality rates. In formulating the principles and guidelines of this policy, the government sought to overcome sociocultural and institutional obstacles that made it difficult for men to undertake preventive measures, and to delineate actions that would contribute towards understanding the singular aspects of male realities and would promote coping with risk factors and stimulation of self-care (Brasil, 2008).

Within this scenario, identification of men's needs becomes an important condition for attaining healthier day-to-day practices among men, with the aim of providing special care strategies that might result in addressing their needs and anxieties better (Figueiredo, 2005; Schraiber, Gomes, Couto, 2005; Loeb, 2003; Quine et al., 2004). Lunenfeld (2002) highlighted the importance of programs that aim to make men better informed about the male aging process, and affirmed that guidance about the impact that preventive care might have in prolonging their lives

and on their quality of life would help to turn them into managers of their own health. Oliffe et al. (2010) advocated that it would be useful to have group spaces in which men would be able to exchange their experiences of becoming ill, model strategies for health maintenance, reinforce the perception that they are not alone and acquire guidance regarding strategies for self-care and its benefits. They also emphasized that other men are capable of strongly influencing male standards regarding issues of health and disease.

Little empirical information is available regarding the efficacy of group interventions among elderly men. However, based on clinical evidence, Thompson et al (2003) advocated that elderly men could benefit from participation in psychoeducational groups that were developed to deal with their needs, preferably as closed groups with few participants, presenting a balance between information, support and coping strategies.

With the aim of promoting and strengthening self-care behavior among elderly men, the authors of the present study developed and implemented a group psychoeducational intervention among individuals attending an old people's social center. Several topics were covered at the meetings, including looking for healthcare services as a measure for disease prevention and control The starting point was the assumption that this type of program could contribute towards developing efficient strategies for attending to specific features of the male world and thus favor a more comprehensive approach towards elderly men's health.

The present article had the aim of presenting the effects of this intervention, starting from verbal indicators referring to the participants' beliefs and behavior in relation to periodically performed preventive medical examinations and opportunely sought healthcare services. This investigation was conducted in the form of a quasi-experimental study, with the following structure: the elderly people participated in individual initial assessments with the aim of surveying the baseline, and then underwent a group intervention, which was followed by two other similar individual assessments after the intervention and a follow-up conducted four months after the end of the group sessions.

Based on the transtheoretical model, the participants' motivational stages with regard to actions of seeking healthcare services were analyzed. In this model, behavioral change is understood as a process that involves progression in five stages through which people go, with advances and reversals until they acquire or modify certain living habits: 1. pre-contemplation – the change is not envisaged; 2. contemplation – the change is an intention; 3. preparation – the action for the change is planned; 4. action – specific changes are identified; and 5. maintenance – changes are maintained for at least six months (Prochaska, DiClemente, 1983; Prochaska, Johnson, Lee, 1998).

Method

Participants

Thirteen men aged between 62 and 78 years ($M = 69.5$) were invited to take part in the study and accepted this. These individuals had different schooling levels, religious faiths and family incomes and were recruited among people who were attending an elderly people's social center that was functioning in a private university in the Federal District. All of the participants were retired and had been in a stable conjugal relationship for at least 15 years.

Instruments

The data were gathered by using a questionnaire for assessing elderly men's health that had been prepared for this study. It contained 32 open and closed questions that were structured into five sections: 1. Sociodemographic characterization; 2. Self-assessment of health; 3. Healthcare services sought and used; 4. Preventive behavior and health-promoting behavior; and 5. Definition of health targets. The third part of this instrument forms the focus of the present study and was composed of nine questions that aimed to investigate what healthcare services were accessed, the medical examinations performed and the types of attendance received by the respondent, along with possible obstacles hindering them from undergoing preventive examinations and adhering to the treatments prescribed.

Data-gathering procedures

Firstly, the proposal was presented to the institution at which the study was developed, in order to request approval for implementing it. Thus, it was submitted to a Research Ethics Committee and, after gaining approval (Procedural number CEP/UCB 194/2009), the operational aspects of the intervention were discussed with the coordinators of the social center. The individual assessments on the elderly men who agreed to take part in the study (formalized through signing a free and informed consent statement) took place in rooms that were acoustically insulated and were free from interruptions. At the interviews, which were based on the elderly men's health questionnaire, each respondent was asked to assess his own present state of health and to report on his behavior regarding healthcare services sought and other self-care matters. The researcher carefully read out each question and made an audio recording of the responses given.

Regarding healthcare services sought and used, the main targets defined were to increase the number of preventive examinations undergone and increase the frequency of medical consultations. Group sessions were then started, and these took place every week, with a total of nine sessions each lasting for around 90 minutes. The sessions were thematic, and each of them

had a predefined guiding theme relating to men's health and/or elderly people's health, such as the limits and potentials of aging, the determinants of men's health and prevention of prostate cancer.

According to the planning for each session, the strategies for the group work consisted of obtaining information supplied through oral strategies, with or without support from audiovisual resources; group discussions, with exchanges of information and experiences; use of educational materials in written or video form; messages to reflect on; dramatizations, experiences and group dynamic techniques.

After concluding the group activities, two meetings were held with each participant for new individual assessments, based on using a simplified version of the elderly men's health questionnaire. The aim was to investigate changes in behavior, beliefs and attitudes relating to the intervention. The second set of interviews was started one week after finishing the groups, on days and at times previously agreed with the participants. Four months later, the interviews were repeated. These post-intervention assessments, like the first interviews, were audio-recorded and transcribed.

Data analysis procedures

The participants' verbal reports were subjected to both quantitative and qualitative analysis. The choices between the response alternatives that had been supplied previously, including scales, were accounted in frequency terms for each item evaluated. The information gathered by means of open questions was categorized with regard to reported behavior that was taken to be important for disease prevention, identification or treatment. Some passages from the participants' words are supplied over the course of the results section, followed (in parentheses) by a fictitious name for the interviewee and his age.

Results

Medical consultations attended

Without exception, the elderly men reported that they presented at least one health problem of chronic nature, among which diabetes mellitus and cardiovascular diseases predominated. On average, three health problems per participant were identified, thus showing several states of comorbidities. Over the time period investigated, they went to see general clinicians and physicians within eight specialties for preventive evaluations, diagnostic investigations or follow-ups relating to illnesses. The specialists most often sought were cardiologists and urologists, who were consulted, respectively, by 69.2% and 61.5% of the participants. At lower frequencies, there were reports of visits to endocrinologists, ophthalmologists, orthopedists,

oncologists, neurologists and pulmonologists. Reference was also made to consultations with other healthcare professionals, including dentists (n = 7), nutritionists (n = 2) and physiotherapists (n = 2).

In the assessments that preceded the psychoeducational sessions, the elderly men reported their participation in 52 medical consultations over the previous 12 months, which corresponded to a mean of approximately four consultations per month. In subsequent evaluations, a relative increase in the mean number of visits to medical consultations offices was observed over the three months that followed the first interviews, which became a rate of six consultations per month. During the follow-up, the mean number of consultations attended between the second and third evaluations was 4.75. Over the total time interval included in the assessments, relating to 19 months, a mean of 6.8 consultations per participant was calculated. Comparison of the monthly mean numbers of consultations showed that the number of medical visits increased to ten during the post-intervention phase.

Seven participants declared that they had a private healthcare insurance plan and used private medical services exclusively (n = 4) or preferentially (n = 3), while the other elderly men reported that they made use of public healthcare services. Seven elderly men said that they had sought attendance at healthcare centers or units, including consultations with general clinicians and guidance in groups for people with diabetes or arterial hypertension. Immunizations were also constantly practiced among the participants, and all of them stated that they had recently undergone this primary prevention measure. In addition to clinical or outpatient medical attendance, three participants reported that they had been attended as emergency cases.

Berilo's behavior was characterized by avoidance of medical consultations and use of natural medicines to treat symptoms. Seeking this type of consultation was a target established for him in the intervention. He was therefore at the pre-contemplation stage, with a lack of recognition of the need to change his current behavioral pattern. In his words: "[...] and I don't go, I don't do. It's stupid, it's ignorance. I admit it. But I'm feeling well, you know". He demonstrated the belief that cultivation of healthy habits and practicing physical exercise acted as compensatory measures for the lack of medical consultations.

"The health that I have today, I have to conserve it. How? By walking, doing hydrogymnastics, eating food with low salt levels and not eating sweet things as far as possible. So in my head, I think this is enough and so I feel relaxed". (Berilo, 75 years)

In addition, he fed the belief that going to consultations would lead to discovery of diseases.

"I'm healthy and I go to the doctor: I'm going to come back ill. He's going to do tests for this or that [...]. I'm not feeling anything. I'm afraid of going to the doctor and coming back ill, because I'm old. If they look, they're going to find something". (Berilo, 75 years)

For this elderly man, the strategies used in the group consisted of questioning his dysfunctional beliefs about medical consultations, which were justified as an important measure for health preservation. After the intervention, he showed an advance to the stage of contemplation, since he said at the subsequent interviews that he might well seek consultations in the near future, thus showing revision of his beliefs in response to his experiences from the group:

"I see other people saying they 'have to do a check-up or have to go to the doctor'. Here as well, hearing each other in this group, I'm starting to imagine like this that I'll certainly also do it... I think I'll do it. I don't know. I'm thinking. [...] I'm plucking up courage". (Berilo, 75 years)

For three other participants, an increase in the frequency of preventive medical consultations was outlined as a target for the intervention. These elderly men had been postponing seeking consultations and were only resorting to medical assessments when symptoms appeared or worsened:

"I only go when it's necessary. This is how I sort out the problem, when I see that something isn't too good. For example, if I'm not urinating enough or I'm feeling pain. So I feel I have to go there to do some tests". (Franco, 78 years)

"I go to the emergency service. [...] Sometimes I can't hold on very much. I twisted my foot and I didn't go. I spent four months with a painful foot. I think it'll be OK. I'll give it some time". (Fausto, 66 years)

The initial stage shown by these elderly men was therefore a pre-contemplation stage, with little recognition of the importance of preventive assessments and guidance, which resulted in postponement of seeking consultations. By way of example: "I'm bad about going to the doctor. I only go when I really need to. Just like when you're hungry: I only eat when I'm hungry" (Amadeu, 76 years). The associated belief was consequently that people should only seek medical help if they are experiencing specific symptoms and if there is a need for a drug prescription. It was also observed that these individuals habitually used natural medicines, self-diagnosis or self-medication in situations of feeling ill, as exemplified by the following reports: "I think it's better to be at home, drinking that water with bark and things like that" (Amadeu, 76 years); "When I'm not feeling well, I go there, take a pressure pill and that's that" (Franco, 78 years).

The strategy used in the group was to raise awareness regarding the benefits of preventive consultations. At the end, although Amadeu and Franco continued to correlate the need to visit the doctor with the presence of symptoms, they reported that they had attended new consultations. For example: "Just now, in the last few days, I had a check-up, all the way from my toenails to my hair: everything" (Amadeu, 76 years). Fausto showed that he remained in the pre-contemplation stage, since he continued to delay seeking consultations: "I haven't gone with such frequency, going for anything [...]. I go rarely because when I get there, the doctor doesn't want to prescribe anything. He says that everything's OK" (Fausto, 66 years). This behavioral pattern seemed to be partly related to the participants' belief that their healthy eating routine and their knowledge about prevention were sufficient to keep them healthy.

The other participants ($n = 9$) reported that they were making periodic visits to doctors for preventive assessments and to follow up their clinical conditions. In these cases, the participants showed that they were at the stage of action or maintenance, since they stated that they were already attending consultations with medium or high regularity. There was evidence of a belief in the usefulness of preventive consultations and the importance of being pro-active in their interactions with the professional, through giving information, describing symptoms and clarifying doubts. The main strategy used in the intervention consisted of reinforcement of these behavioral patterns. At subsequent interviews, these elderly men continued to place value on and affirm initiatives relating to seeking medical consultations routinely. All of them mentioned the importance of being informed about how their own organism functions, so as to obtain guidance and, if necessary, therapeutic measures.

Undergoing medical tests

In relation to undergoing preventive or diagnostic procedures, the types of tests that the elderly men had undergone over the 12-month period prior to the baseline interview were surveyed, along with tests performed during the months between the start of the psychoeducational interventions and the final interviews. The participants stated that during each period investigated, they had undergone between one and eleven preventive tests or clinical follow-up tests. Arterial blood pressure and blood glucose concentration measurements predominated. All of the elderly men underwent at least one of these two tests, mostly as a follow-up measure for their conditions of hypertension and diabetes.

The elderly men also mentioned laboratory tests, especially hemograms and tests on feces and urine. Most of the elderly men underwent prostate examinations, and more of them did the prostate-specific antigen (PSA) test than the digital rectal examination. Other procedures mentioned by smaller numbers of the participants included imaging examinations, tests for cardiac assessment, echographs, ophthalmological examinations, HIV tests, endoscopic examinations and prostate biopsies.

At the baseline, the reports indicated that over the 12-month period, the number of types of tests undergone ranged from three to eight, with a mean of 6.2 types per participant. At the subsequent assessments, the number of tests undergone over the seven-month period ranged from one to eleven, with a mean of 4.8. In general, the participants stated that they underwent examinations periodically and highlighted the importance of preventive actions as a means of identifying and treating diseases in a timely manner. Oscar gave an example of the importance of undergoing these examinations through telling how firstly a carcinoma was discovered and then diabetes later on, without any signs or symptoms presented in either of the cases.

"So I said "I'm going to have a check-up to see whether I'm OK inside". [...] I went to see a urologist and found when I got there that I had carcinoma, so then I had surgery, I hadn't felt anything. I went for a preventive check-up and it appeared". (Oscar, 70 years)

Three of the elderly men indicated that there had been a decrease in the frequency of undergoing tests over the time period between the start of the sessions and the follow-up interviews. This was explained through the large number of commitments taken on during this period, which compromised their availability for this type of care. Nonetheless, this participant and another two emphasized that they intended to have new consultations and examinations over the coming months. For example: "I'm now waiting for retirement to have a check-up. Firstly for a clinical check-up and then my heart, gastric system and there's another one too... nutritionist. I have to go through all of these" (Eusébio, 63 years).

The digital rectal examination to detect prostate cancer was seen to be the one most feared by the participants, and seven of them said that it was the most difficult examination to undergo. On the other hand, four of the elderly men said that they did not have any difficulties in undergoing any type of medical examination, as was the case of Mário (72 years): "If the doctor thinks it's necessary, I'll put up with anything. None of this business of I don't like this or that. Look, what I like is to be healthy".

Berilo and Fausto said that they had seldom or never had any preventive tests other than routine tests on blood pressure and blood glucose. One of the targets drawn up for these two participants was to promote undergoing the digital rectal examination, since they had been refusing to undergo this. Thus, the initial stage was pre-contemplation, as shown by the following words: "I want to avoid it. I've been doing this (avoiding it). [...] I'm unwilling to do this" (Berilo, 75 years).

The digital rectal examination was presented as an intervention strategy and as an important measure for early detection of prostate cancer, with encouragement to seek the examination. The final behavioral pattern continued to be pre-contemplation in the case of Berilo, as shown by his report: "I'm aware. I'm sure I've had the guidance I need, but I won't say this. In this matter I'm old-fashioned" (Berilo, 75 years). In turn, Fausto showed that he had moved

forward to the contemplation stage, with openness towards undergoing the examination: "I'm willing, because you can't leave what has to be done for another day, because it will be too late" (Fausto, 66 years).

Among the other participants, the target was to increase or maintain the frequency of undergoing diagnostic prostate examinations. They were undergoing the main preventive examinations for prostate cancer, in accordance with medical indications, even though they were averse to the digital rectal procedure. For example: "The rectal examination is really annoying, but what can you do? You do it as often as needed" (Oscar, 70 years). The strategies used in the group consisted of reinforcement towards seeking preventive prostate examinations and revision of myths and beliefs about doing them.

At the end, it was seen that the participants were continuing to undergo the examinations periodically, and they showed less emotional discomfort in undergoing digital rectal examination: "I was very timid. Showing my body to a doctor was the worst thing, I thought. But more recently, from what I've seen, I'm more willing" (Franco, 78 years). More evident signs of anxiety about the need to undergo the digital rectal examination were only seen to continue in the report from Gastão (62 years): "Now I have to do a prostate examination. [...] I do it every year, but it makes me nervous. But you have to do it, don't you? What can you do?"

Discussion

In relation to the participants' morbidity profile, it was observed that the diseases with greatest incidence were arterial hypertension, diabetes and heart diseases, which are among the illnesses most frequently diagnosed among men over the age of 50 years (Issa et al., 2006; Laurenti, Jorge, Gotlieb, 2005). These are non-transmittable health problems: they are largely related to living habits and, as such, can be prevented, identified early on and clinically controlled. There were also several cases of comorbidities, thus showing that in old age, it is common for one chronic condition to be associated with the development of others. Healthcare professionals are thus faced with the challenge of assessing and treating multiple problems (Ferrucci, Giallauria, Guralnik, 2008).

This is worrying with regard to healthcare for the elderly population, considering that chronic diseases increase the risks of functional incapacity, dependence and diminished quality of life (Bryant, Altpeter, Whitelaw, 2006). However, the participants generally showed good control over their clinical conditions, with preservation of their physical functions and social roles. According to Veras (2009), elderly people who maintain their functional capacity, i.e. who have preserved their physical and mental abilities to lead an independent and autonomous life, should be considered to be healthy individuals, even if they are affected by diseases.

Prostate problems constituted current problems or problems within the medical histories of six participants, which reinforces the need for prevention and treatment of prostate problems among elderly men. Thus, they should be encouraged to undergo diagnostic examinations and be made prepared to deal with the effects resulting from the disease and its treatment. However, it was observed that the participants were engaged in seeking a variety of types of healthcare that are generally considered to be infrequent among men. Thus, there were reports on using primary healthcare services, having high frequency of medical consultations and undergoing preventive examinations on a regular basis. Although prostate evaluations, and especially the digital rectal examination, were referred to as sources of embarrassment and anxiety, they were done relatively regularly. This was in line with the findings of Loeb (2003), who observed among 135 elderly men that they underwent an average of four healthcare examinations during the preceding year, comprising mainly blood pressure measurements, physical examinations and prostate examinations.

The results showed that the interventions helped to expand or strengthen awareness of the importance of seeking and regularly using a variety of healthcare services. In the case of Berilo, who was the participant presenting greatest personal barriers against attending consultations and examinations, it was understood from his testimonies that the interventions had led to revision of his belief that consultations would lead to discovery of diseases and that healthy habits on their own would ensure disease prevention, such that a behavioral intension of seeking medical consultation would be favored. However, this elderly man continued to refuse to undergo examinations for diagnosing prostate disorders. Factors that may have contributed towards maintaining his avoidance included his perceived low susceptibility to diseases and his self-assessment that he was healthy, which he expressed thus: "I look at myself and it's as if I didn't have any need" (Berilo, 75 years).

A decision to undergo a preventive or diagnostic examination is more likely if the person presents a state of psychological readiness, which will depend on how susceptible the individual feels towards contracting the condition in question and on his perception of the severity of the consequences of this condition for his health. It also depends on the absence of psychological barriers against taking action (Pavão, Coeli, 2008). Berilo's avoidance of going to the doctor and undergoing examinations was not linked to any lack of information or encouragement for this, as he himself recognized. The type of intervention undertaken was shown not to have been sufficient to provide him with appropriate strategies for facing up to a situation that caused him anxiety over the long term. The group reinforced the benefits of these preventive practices, rather than their costs, and provided him with models for dealing with the situation. However, greater advances in his change process would require more particular attention, through individual interventions.

In post-intervention evaluations, although Amadeu and Franco continued to show the belief that seeking medical assistance should be contingent on presenting specific symptoms, they subsequently began to report greater recognition of the need to undergo preventive examinations. The other elderly men reaffirmed their beliefs regarding the importance of preventive measures,

follow-up and control over their health problems, and some of them showed satisfaction in knowing that they were "on the right path". For some of the elderly men, the barriers against adopting preventive practices consisted of factors that had already been observed in other studies, such as fear of discovery of a severe disease and embarrassment about exposing the body in front of the professional (Gomes, Nascimento, Araújo, 2007). However, unlike in some other studies, it could not be confirmed that these difficulties were associated with factors such as lack of time, low value attributed to self-care and incipient concern regarding health (Figueiredo, 2005; Schraiber, Gomes, Couto, 2005; Loeb, 2003).

The results from this study show that men can form the subjects of their own care. It is important to highlight, as discussed by Couto et al. (2010), that men's invisibility in healthcare services is often reinforced by the professionals' expectations. The stereotype assumed is that men do not take care of themselves and do not seek services, such that professionals do not encourage them to practice prevention through health promotion actions.

Final remarks

The dataset revealed that the psychoeducational intervention was useful for raising the participants' awareness regarding the advantages of implementing actions towards preventing or controlling diseases. However, the experiences within the group acted more towards reinforcing healthy practices or raising the participants' awareness regarding new and desirable changes. The intervention was insufficient to change habits associated with dysfunctional beliefs, even if intentions to change had been shown.

The group format, including the diversity of topics and the number of participants, did not favor a more direct approach towards the particular difficulties of the elderly men. When psychological barriers to change are present, it may be necessary to undertake individual interventions in association with the group interventions, so as to help participants to revise their beliefs, manage emotional responses and learn new repertoires of responses to stressful situations.

Elderly men may benefit, in educational contacts with professionals and with their peers, from the opportunity to exchange experiences and knowledge, which boosts maintenance of self-care and raises awareness towards changing behavior that is harmful to health. Although it can be considered that men are more likely to deny than to discuss health and disease issues, the results from this study strengthen the possibility that men, just as much as women, can become involved in group educational processes and may value a commitment towards topics relating to the health-disease process.

Lastly, it is emphasized that health promotion work among men cannot be based on the assumption of a set of equal characteristics that lead to interpretation as a group composed of generalizable common values and behavioral patterns. Men's healthcare practices depend on

demographic, personal and cultural factors and, as such, are diverse. Thus, in addition to looking for differences between men and women, it is necessary to identify differences among men in particular, thereby making it possible to deal with different ways and styles of being a man.

Collaborators

Lilian Maria Borges was in charge of preparation of article, Eliane Maria Fleury Seidl was in charge of the planning and final revision of the paper.

References

ABREU, D.M.X.; CÉSAR, C.C.; FRANÇA, E.B. Diferenciais entre homens e mulheres na mortalidade evitável no Brasil (1983-2005). **Cad. Saude Publica**, v.25, n.12, p.2672-82, 2009.

BRASIL. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Ações Programáticas Estratégicas. **Política Nacional de Atenção Integral à Saúde do Homem**: princípios e diretrizes. Brasília: MS, 2008. Disponível em: <http://dtr2001.saude.gov.br/sas/PORTARIAS/Port2008/PT-09-CONS.pdf>. Acesso em: 7 jul. 2009.

BRYANT, L.L.; ALTPETER, M.; WHITELAW, N.A. Evaluation of health promotion programs for older adults: an introduction. **J. Appl. Gerontol.**, v.25, n.3, p.197-213, 2006.

CAMARANO, A.M. Envelhecimento da população brasileira: uma contribuição demográfica. In: Freitas, E.V. et. al. (Orgs.). **Tratado de Geriatria e Gerontologia**. Rio de Janeiro: Guanabara Koogan, 2002. p.58-71.

COUTO, M.T. et al. O homem na atenção primária à saúde: discutindo (in)visibilidade a partir da perspectiva de gênero. **Interface (Botucatu)**, v.14, n.33, p.257-70, 2010.

FERRUCCI, L.; GIALLAURIA, F.; GURALNIK, J.M. Epidemiology of aging. **Radiol. Clin. North Am.**, v.46, n.4, p.643-52, 2008.

FIGUEIREDO, W. Assistência à saúde dos homens: um desafio para os serviços de atenção primária. **Cienc. Saude Colet.**, v.10, n.1, p.105-9, 2005.

GOMES, R.; NASCIMENTO, E.F.; ARAÚJO, F.C. Por que os homens buscam menos os serviços de saúde do que as mulheres? As explicações de homens com baixa escolaridade e homens com Ensino Superior. **Cad. Saude Publica**, v.23, n.3, p.565-74, 2007.

INSTITUTO BRASILEIRO DE GEOGRAFIA E ESTATÍSTICA – IBGE. **Sinopse do Censo Demográfico 2010**. Rio de Janeiro: IBGE, 2011. Disponível em: <http://www.ibge.gov.br/home/estatistica/populacao/censo2010/sinopse.pdf>. Acesso em: 16 jun. 2011.

_____. **Observações sobre a evolução da mortalidade no Brasil**: o passado, o presente e perspectivas. Rio de Janeiro: IBGE, 2010a. Disponível em: <http://www.ibge.gov.br/home/estatistica/populacao/tabuadevida/2009/notastecnicas.pdf>. Acesso em: 27 maio 2011.

_____. **Pesquisa Nacional por Amostra de Domicílios (PNAD 2008)**. Um panorama da Saúde no Brasil: acesso e utilização dos serviços, condições de saúde e fatores de risco e proteção à saúde. Rio de Janeiro: IBGE, 2010b. Disponível em: <http://biblioteca.ibge.gov.br/visualizacao/monografias/GEBIS%20-%20RJ/panorama.pdf>. Acesso em: 23 maio 2013.

ISSA, M.M. et al. Assessment of the diagnosed prevalence of diseases in men 50 years of age or older. **Am. J. Manag. Care**, v.12, n.4, p.S83-9, 2006.

LAURENTI, R.; JORGE, M.H.P.M.; GOTLIEB, S.L.D. Perfil epidemiológico da morbi-mortalidade masculina. **Cienc. Saude Colet.**, v.10, n.1, p.35-46, 2005.

LINHARES, C.R.C. et al. Perfil da clientela de um ambulatório de geriatria do Distrito Federal. **Psicol. Refl. Crit.**, v.16, n.2, p.319-26, 2003.

LOEB, S.J. The older men's health program and screening inventory: a tool for assessing health practices and beliefs. **Geriatr. Nurs.**, v.24, n.5, p.278-85, 2003.

LUNENFELD, B. The ageing male: demographics and challenges. **World J. Urol.**, v.20, n.1, p.11-6, 2002.

OLIFFE, J.L. et al. Health promotion and illness demotion at prostate cancer support groups. **Health Promot. Pract.**, v.11, n.4, p.562-71, 2010.

PAVÃO, A.L.B.; COELI, C.M. Modelos teóricos do uso de serviços de saúde: conceitos e revisão. **Cad. Saude Colet.**, v.16, n.3, p.471-82, 2008.

PINHEIRO, R.S. et al. Gênero, morbidade, acesso e utilização de serviços de saúde no Brasil. **Cienc. Saude Colet.**, v.7, n.4, p.687-707, 2002.

PROCHASKA, J.Q.; DICLEMENTE, C.C. Stages and processes of self-change of smoking: toward an integrative model of change. **J. Consult. Clin. Psychol.**, v.51, n.3, p.390-5, 1983.

PROCHASKA, J.O.; JOHNSON, S.S.; LEE, P. The transtheoretical model of behavior change. In: SCHUMAKER, S.A. et al. (Orgs.). **The handbook of health behavior change**. 2.ed. New York: Springer Publishing Company, 1998. p.59-84.

QUINE, S. et al. Health promotion for socially disadvantaged groups: the case of homeless older men in Australia. **Health Promot. Int.**, v.19, n.2, p.157-65, 2004.

REDONDO-SENDINO, A. et al. Gender differences in the utilization of health-care services among the older adult population of Spain. **BMC Public Health**, v.6, n.1, p.155-63, 2006.

SCHRAIBER, L.B.; GOMES, R.; COUTO, M.T. Homens e saúde na pauta da saúde coletiva. **Cienc. Saude Colet.**, v.10, n.1, p.7-17, 2005.

THOMPSON, L.W. et al. Terceira idade. In: WHITE, J.R.; FREEMAN, A.S. (Orgs.). **Terapia cognitivo-comportamental em grupo para populações e problemas específicos**. São Paulo: Roca, 2003. p.269-99.

TULLOCH, A.J. Effectiveness of preventive care programmes in the elderly. **Age Ageing**, v.34, n.3, p.203-4, 2005.

VERAS, R. Envelhecimento populacional contemporâneo: demandas, desafios e inovações. **Rev. Saude Publica**, v.43, n.3, p.548-54, 2009.

_____. Em busca de uma assistência adequada à saúde do idoso: revisão da literatura e aplicação de um instrumento de detecção precoce e de previsibilidade de agravos. **Cad. Saude Publica**, v.19, n.3, p.705-15, 2003.

Translated by David Elliff