

An Exploratory Study of the Impact of Gender on Health Behavior Among African American and Latino Men With Type 2 Diabetes

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Abstract

This study explores gender values and beliefs among Latino and African American men with diabetes and examines how these values and beliefs may influence their health behaviors. Participants were recruited from individuals who participated in one of three Racial and Ethnic Approaches to Community Health Detroit Partnership diabetes self-management interventions. One focus group was conducted with African American men ($n = 10$) and two focus groups were conducted with Latino men ($n = 12$) over a 3-month period. Sessions lasted 90 minutes, were audiotaped, and analyzed using thematic content analysis techniques. Two themes emerged that characterize gender identity and its relationship to health behavior in men: (a) men's beliefs about being men (i.e., key aspects of being a man including having respect for themselves, authority figures, and peers; fulfilling the role as breadwinner; being responsible for serving as the leader of the family; and maintaining a sense of chivalry) and (b) influence of gender values and beliefs on health behavior (i.e., the need to maintain a strong image to the outside world, and the need to maintain control of themselves served as barriers to seeking out and engaging in diabetes self-management behaviors). Results suggest that gender values and beliefs may have implications for how health behaviors among men with diabetes. Future research should study the direct impact masculine identity has on health behaviors among men with diabetes.

Keywords

diabetes, masculinity

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Introduction

Today, 15.5 million men live with diabetes in the United States according to the Centers for Disease Control and Prevention (CDC, 2014). In recent years, the number of men diagnosed with diabetes increased at a faster rate than women and these numbers continue to rise (CDC, 2013). In the past 30 years, the age-adjusted percentage of diagnosed diabetes increased 156% (from 2.7% to 6.9%) for males and 103% (from 2.9% to 5.9%) for females (CDC, 2013). These variations are not only gendered but also vary by race, as African American and Latino men are disproportionately affected by diabetes compared with White men (CDC, 2013). Diabetes also increases the risk for heart disease and stroke, blindness and eye problems, kidney failure,

and lower limb amputation (CDC, 2014). Because African American and Latino men are reported to have lower rates of glycemic control compared with non-Hispanic White men, they are at a higher risk for other health conditions such as heart disease and stroke (Egede, Mueller, Echols, & Gebregziabher, 2010; Liburd, Namageyo-Funa, & Jack, 2007). In order to successfully manage diabetes, men must

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engage in a series of activities to remain healthy, these include regular exercise, healthy diet, adhering to medication regimens, and more frequent physician visits (Boren, 2007; Hearnshaw & Lindenmeyer, 2006). However, diabetes rates continue to rise among African American and Latino men, who more frequently engage in health behaviors that can worsen health outcomes compared with non-Hispanic White men with diabetes (Egede et al., 2010; Suh, Choi, Plauschinat, Kwon, & Baron, 2010).

Research on the influence of gender on men's health behavior has primarily focused on how "hegemonic masculinity" (such as displaying strength) can prompt unhealthy behaviors (such as viewing illness as weakness; Connell & Messerschmidt, 2005; Sloan, Gough, & Conner, 2010). Hegemonic masculinity seeks to describe how and why men maintain dominance over women and other gender identities in society (Connell, 1982). The gendered attitudes derived from hegemonic masculinity can sometimes conflict with health behaviors, for instance, messages men receive emphasizing self-reliance, the commonly held beliefs in mainstream society regarding men, such as autonomy, risk taking, dominance, and the need to suppress pain, can create a barrier to seeking out a health professional, asking for help, relying on others, and following health guidelines given by authority figures (Connell & Messerschmidt, 2005; Courtenay, 2000; Gough & Conner, 2006). In terms of mainstream masculinity, traditional beliefs and values about masculinity for men in the United States can be characterized as a need to maintain independence, demonstrate fearlessness and strength, and a discouragement of displays of emotion (Garfield, Rogers, & Isacco, 2008). More important, men who adhere to more traditional definitions of masculinity have been documented to have poorer health outcomes (Courtenay, 2000; Garfield et al., 2008). The commonly held beliefs and values in mainstream society regarding men, such as promotion of independence, risk taking, dominance, and the need to suppress pain, can adversely affect help seeking and self-management of health conditions (Courtenay, 2000; Garfield et al., 2008).

Dominant sociocultural perspectives on masculine beliefs and values have been developed specifically for Latino and African American men and have key implications for health. Men of color share similar aspects of mainstream male gender beliefs and values. However, they occupy different social spaces and the interplay between race, class, culture, and other factors significantly affects the way masculinity manifests itself among Black men. For instance, Duck (2009) argues that Black men must cope with discrimination in their daily lives and this lack of control can directly conflict with traditional African American and mainstream views of masculinity and result in increased levels of stress and helplessness.

"Cool Pose" refers to the coping response African American men sometimes adopt which involves displaying physical aggression in order to project a powerful image to society (Pierre, Mahalik, & Woodland, 2001), but can interfere with interpersonal relationships and cultural obligations, particularly to significant others and extended family. Furthermore, Pierre et al. (2001) argue that African American men can experience psychological distress as a result of trying to reconcile conceptions of masculinity that are promoted by mainstream society (e.g., aggression, dominance, risk taking, and individual achievement) with aspects of African American culture (such as the promotion of mutual aid, survival, and collective identity), preventing them from realizing a view of masculinity that is more suitable for African American men.

Research also suggests that Black masculinity can serve as barriers to African American men attaining optimal health. Liburd et al. (2007) conducted in-depth interviews with 16 African American men with diabetes. Findings suggest that the gender socialization and subsequent behaviors of African American men often contradict recommended diabetes management behaviors. For instance, men reported a desire to maintain control over their bodies and health care at all times and often declined social support offered by family and community networks. Men in the study also engaged in behaviors that increased their risk for diabetes-related complications such as poor dietary habits and alcohol consumption. Liburd et al. (2007) attributed these behaviors to gender values and beliefs, arguing that men viewed themselves as weak if they outwardly revealed any pain associated with illness. Plowden and Young (2003) examined socio-structural factors that influence health behavior among African American men in an urban setting. The study revealed that men sampled encountered significant difficulty in accepting a caring environment, traditionally thought of as feminized practices (e.g., such as emotional support and caregiving), which served as a barrier to seeking care in this population. The findings could be linked to caring environments being a challenge to Black masculine identity that promotes control, independence, and suppression of emotions.

The concept of machismo was created to help explain masculinity in Latino men; however, because Latinos constitute such a diverse group—geographically and in terms of level of acculturation—the study of masculinity poses a unique challenge for researchers. Definitions of machismo vary, with little agreement on a specific definition of the concept, which has been characterized as having multiple and fluid meanings, and is heavily dependent on social context (Courtenay, 2000; Gutmann, 2006; Quintero & Estrada, 1998). Mirande (1997) states machismo (male/masculine identity) can be defined as adherence to a code

of ethics that guide behaviors in Latino men, but emphasizes that Latino men are also a heterogeneous population. For example, migration can influence how masculinity develops as Latino men negotiate cultural definitions of masculinity with mainstream definitions in the United States (Boehm, 2008; R. C. Smith, 2005). Machismo can also be performative: In academic literature, the concept of machismo is sometimes associated with men who are from low-income or rural backgrounds, although machismo has also been used to describe men from other demographic backgrounds (Gutmann, 2006). Because machismo is dependent on an individual's social context, it can also be thought of as performative (Quintero & Estrada, 1998). One study found that machismo was situational among Mexican men whose performances of machismo changed from a street context (e.g., violence and aggression) to a private context (e.g., role as provider for family; Quintero & Estrada, 1998), revealing how this cultural construct can shift based on time and space. Other work argues that masculinity among Latino men is best described by the combination of two concepts: traditional machismo (as described above) and *caballerismo* (Arciniega, Anderson, Tovar-Blank, & Tracey, 2008). *Caballerismo* can be characterized as a need to maintain honor, fairness, and emotional connectedness, and prizes the importance of family and respect for elders (Arciniega et al., 2008).

Research that examines the impact of machismo (and *caballerismo*) on health has not been explored extensively in the literature (Getrich et al., 2012). However, machismo and men's health behavior has garnered more attention with researchers focusing on how machismo influences health behaviors and health in general in Latino men (Hunter, Fernández, Lacy-Martínez, Dunne-Sosa, & Coe, 2007; MacNaughton, 2008; Sobralske, 2006). Research has primarily been focused on conditions that affect men specifically, such as prostate cancer screening and treatment and vasectomies (Erviti, Sánchez, & Castro, 2010; Maliski, Rivera, Connor, López, & Litwin, 2008; Rivera-Ramos & Buki, 2011). In terms of other conditions, colorectal screening and machismo has recently received more attention (Fernandez et al., 2008; Goldman, Diaz, & Kim, 2009; Goodman, Ogdie, Kanamori, Canar, & O'Malley, 2006; Salas-Lopez, Deitrick, Mahady, Gertner, & Sabino, 2011). These studies have helped develop a better understanding of how machismo can serve as a barrier to seeking out health care, specifically by making men reluctant to seek out medical care. While there have been attempts to explain machismo as a concept, the implications for diabetes self-management and health care use have not been explored extensively.

With the exception of Liburd et al. (2007), the role of gender beliefs and values in type 2 diabetes among African American men has not been studied extensively.

The same can be noted about the role of gender beliefs and values in type 2 diabetes among Latino men. In general, there is still limited research, specifically for men of color, regarding how men with a chronic illness conceptualize gender identity and manage diabetes within their own social and cultural context. No published studies were found that sought to discover beliefs about being a man among both African American and Latino men with type 2 diabetes and how these beliefs influence their health behavior.

The academic knowledge base for men's health has expanded with work on men's health issues linking aspects of male gender beliefs and values (i.e., masculinity) to poor health outcomes and risky health behaviors (Courtenay, 2000; White, 2004). This work has brought to light disparities in health outcomes between men and women and the state of men's health, such as men's increased risk for numerous health conditions (i.e., most cancers and obesity). However, most research has focused on diseases that disproportionately affect men such as prostate cancer (Gough & Conner, 2006), with few examining other diseases that also affect men such as diabetes (Hawkins et al., 2015; Seawell, Hurt, & Shirley, 2016) and even fewer focusing specifically on men of color (Hawkins et al., 2015). While the study of men's health has garnered more attention among academics, a dearth of research on impact of gender beliefs and values on health behaviors among men of color with diabetes remains (Gough & Conner, 2006), particularly for men of color.

Understanding gender beliefs and values among African American and Latino men is critical to gaining a better understanding of how men of color with a chronic illness manage their health and interact with the health care system. Given the dearth of literature, the current study uses a sample of Midwestern African American and Latino men with type 2 diabetes to explore definitions of masculinity and how these gender-related beliefs and values might influence health behavior in this population.

Method

Study Design

Our study utilized a phenomenological approach to address the aim of the study. The goal of phenomenological research is to systematically explore participants' perception of their personal and social world. This type of study can be used to explore personal perceptions related to specific events or experiences (J. A. Smith & Osborn, 2003). We selected a phenomenological research method to capture how men who shared a common diagnosis of type 2 diabetes, but were heterogeneous in other ways

Table 1. Sociodemographic Characteristics in REACH Sample of Latino and African American Men With Type 2 Diabetes ($N = 22$).

	African American ($n = 10$)	Latino ($n = 12$)
Average age (years)	63	52
Born outside of the United States		
Yes	0	12
No	10	0
Primary language		
Spanish	0	12
English	10	0
Work for pay		
Yes	2	10
No	8	2
Marital status		
Married	6	7
Single/divorced/ never married	4	4
Cohabiting	0	1

Note. REACH = Racial and Ethnic Approaches to Community Health.

(i.e., race, ethnicity, length of time in the United States), experienced and perceived the impact of gender beliefs and values on engaging in health behaviors that have direct consequences for their diabetes self-management. While focus groups were not stratified by other sociodemographic factors (aside from race and language), as stated, each focus group participant shared the same health condition and gender, aligning with the purpose of the present study: To gain a better understanding of how men feel gender values and beliefs may influence their health behaviors.

Study Data

Participants were men who participated in one of three Racial and Ethnic Approaches to Community Health (REACH) Detroit Partnership diabetes self-management intervention studies, conducted between 2002 and 2013 which are described in greater detail elsewhere (Spencer et al., 2011; Two Feathers et al., 2005; Two Feathers et al., 2007). The REACH Detroit studies were designed, implemented, and the data were analyzed using a community-based participatory approach (Minkler & Wallerstein, 2011). Community-based participatory research (CBPR) allows communities to actively participate in research projects from conception to dissemination of results in an effort to change aspects of their community such as health outcomes, policies, and systems (Minkler & Wallerstein, 2011). The Institutional Review Board at the University of Michigan approved the procedures and protocols associated with the REACH Detroit study reported here.

Participant Characteristics

The eligible male ($n = 50$) participants from the REACH Detroit studies were contacted by mail and phone over a 2-month period and asked to participate in the focus groups. Potential participants were mailed a flyer describing the research project and then received a follow-up phone call from a research assistant (either in Spanish or English). A total of 10 African American men and 12 Latino men participated in the present study. The average age of African American men was 63, while Latino men were slightly younger at 52 years. All of the Latino men who participated in the study reported that they were born outside of the United States and that Spanish was their primary language. Two African American male participants and 10 Latino male participants were working for pay at the time of the focus groups. About an equal number of men from both racial groups were married and single. For a description of participants, see Table 1.

Data Collection

This study utilized data from one focus group conducted with 10 African American men and two focus groups conducted with a total of 12 Latino men. Focus groups were chosen because they can assist a group of individuals with meaningful similarities to share ideas in a low-pressure environment (Krueger & Casey, 2002). Focus groups are generally composed of 6 to 10 people who engage in a discussion facilitated by a trained moderator. Moderators are tasked with eliciting different ideas and opinions from group members during the given time period. Focus groups typically last from 45 to 90 minutes and are structured by a guide of predetermined questions. Focus group discussions can produce rich data because they are free flowing and usually involve the participation of a homogenous group of persons who are not familiar with one another, potentially lowering inhibitions (Krueger & Casey, 2002).

For the present study, focus groups were conducted over a 3-month period in 2011. Sessions lasted around 90 minutes and were audiotape recorded. Focus groups were conducted in community settings (i.e., a community organization and a church) in eastside and southwest Detroit, Michigan, and participants received a \$20 cash incentive for their time and received snacks and beverages during the focus group. Focus groups were stratified by race. All of the Latino men who participated in the focus groups reported Spanish as their primary language so their groups were conducted in Spanish.

Focus group moderators with experience working in Latino and/or African American communities facilitated the sessions. Focus group moderators received a 1- to 2-hour training 2 weeks before the first focus group to familiarize them with research protocol and focus group

Table 2. “Men’s Health Care-Related Behaviors and Beliefs” Section of REACH Focus Group Questionnaire.

1. *When you were growing up, what did you learn about being a man from the men in your community?*
 - a. Probe: How are men supposed to act?
 - b. Probe: What are men supposed to do? (in relation to work, family, friends).
2. *How has what you learned about being a man from men in your community affected your decisions about your health?*
 - a. Probe: How serious would a problem need to be to go to the doctor?
 - b. Probe: What keeps you from going to the doctor?

Note. REACH = Racial and Ethnic Approaches to Community Health.

facilitation techniques. Focus group moderators were male and resided in the same community as participants. Moderators were matched for race, gender, and language because research suggests that male research participants may be more comfortable and candid discussing issues of masculinity with male researchers (Sallee & Harris, 2011). Research assistants (matched for language) were also present at each focus group with the primary task of taking notes, and ensuring consent forms were signed and demographic data were collected. Written informed consent was obtained from each participant before each focus group. The focus group moderator read through the informed consent with participants in Spanish or English before signing. Demographic data were collected with an 11-item questionnaire at the beginning of each discussion (in Spanish or English; see Table 1 for selected demographics).

The present study focuses on questions asked in the first section of the focus group interview guide *Men’s Health Care-Related Behaviors and Beliefs*. The two questions posed in this section were the following: (a) When you were growing up, what did you learn about being a man from the men in your community? and (b) How has what you learned about being a man from men in your community affected your decisions about your health? For a more complete list of focus group questions, see Table 2. Focus group questions were developed in a series of meetings by the REACH Detroit Partnership, which included faculty at a major Midwestern university, the principal investigators of the original intervention studies and community partners. The lead investigator also independently met with a male community partner with experience working with men from the REACH interventions to discuss the appropriateness and relevance of questions asked in the focus group guide.

Data Management and Analysis

Immediately following each of the focus groups, focus group moderators, and note-takers met to compile a list of

topics and themes that emerged from the focus groups and created a summary document to be used in later analysis. Research assistants who were fluent in both Spanish and English transcribed the audio recordings from the sessions verbatim. Organization and analysis of data took place using a team-based approach (Watkins, 2012; Watkins & Gioia, 2015). Initially, the lead investigator and research team engaged in the preliminary steps of content analysis by reading and rereading the focus group transcripts also described as becoming “one with the data” and reviewing the original purpose of the study. Afterward, a procedure informed by Watkins and Gioia (2015) was used to both manage and analyze data. Specifically, the analysis team identified codes, then confirmed and refined themes using the *rigorous and accelerated data reduction* (RADaR) technique (Watkins & Gioia, 2015). This technique assisted in coding transcripts for each focus group and in identification of patterns in themes.

According to Watkins and Gioia (2015), the purpose of the RADaR technique is to “generate data tables that produce qualitative results quickly and rigorously for translation and dissemination to intended audiences” (p. 78). Using RADaR as the primary guide, the first step of management and analysis of the data involved the creation of tables in a word processing program to organize and analyze the focus group transcripts. The tables (or spreadsheet) included the following headings: focus group guide question, text chunk, code, notes, and theme. In accordance with the next step of RADaR, after transcripts were entered into the table, the lead investigator and research team engaged in data reduction to both shorten and focus the data tables on the aim of the current study. The process of data reduction involved reading the data tables to identify common topics both within and across focus groups. Research team members then reviewed the data reduction tables and reached agreement that the quotes and themes were both relevant to the study’s research questions and accurately captured focus group participants’ experiences. For the present study, the data reduction process described above took place in three phases, during which the data reduction tables presented a more succinct representation of the data in relation to our research questions (Watkins, 2012; Watkins & Gioia, 2015). Through the use of an inductive, phenomenological research methodology, themes emerged and a codebook was developed that included code definitions and examples. Findings from this study cannot be generalized to the larger population of Latino and African American men living with type 2 diabetes due to study sample size, geographic location, and complexity involved in defining gender values and beliefs among men.

Using a CBPR Approach to Data Management and Analysis. Producing REACH Detroit outcomes and materials for

broader dissemination involves a close partnership between researchers and community partners. Thus, REACH Detroit study findings must obtain approval from community partners and researchers before dissemination occurs. Both community partners and researchers attended bimonthly meetings to discuss the data and materials for dissemination. The credibility and dependability (Watkins, 2012) of the present study was further enhanced by focus group moderators and a community partner working together to interpret the study results. The community partner and lead author worked in tandem to ensure that the study appropriately conveyed the community. A community partner was involved at every stage of the research process including creation of study research questions and study methodology, data collection, interpretation of data, and manuscript development. Involving the community partner in the present study helped contextualize our findings and enhance our discussion, which otherwise would not have been possible.

Results

This study was exploratory, therefore our focus group questions and analysis focused on learning more about how this specific group defines gender beliefs and values within their own social context and how they felt these beliefs influenced their health behaviors. After discussing how they defined gender beliefs and values, men were asked to comment on how these beliefs and values affected their health behavior. It is important to note that while some beliefs and values mentioned in the first theme may not have been directly related to health behavior by the men in our study, because masculinity is fluid and contextually specific, it was critical to include in a discussion of our first theme—a discussion of how African American and Latino men define gender beliefs and values. In order to interpret this study's findings, it is also important to note that we chose not to stratify our focus groups by sociodemographic factors (such as age, income, or marital status); focus groups were only stratified by race and language. The present study did not stratify focus groups by sociodemographic factors primarily due to an interest in discovering potential intergroup and intragroup differences related to gender beliefs and values and the impact of these beliefs and values on health behaviors. Interestingly, despite differences in country of origin, both Latino and African American appeared to share similar beliefs and values related to what they learned about being a man growing up and how what they learned influenced their health behaviors. One significant demographic difference between the two groups is that African American men were significantly older and mostly retired or unemployed, whereas almost all Latino men were employed

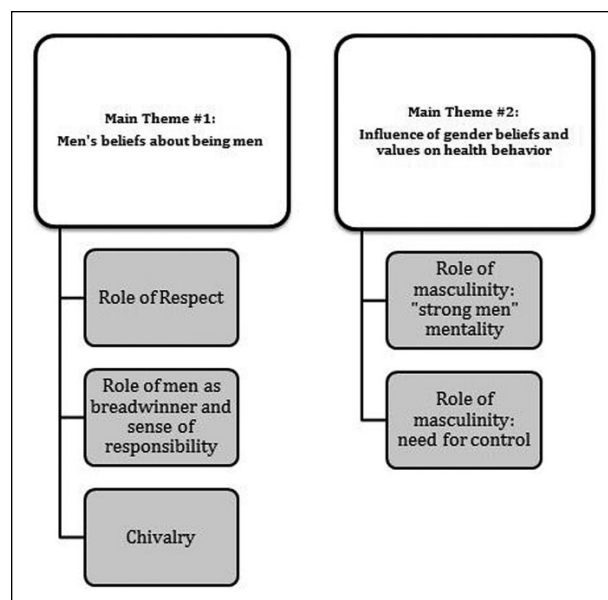


Figure 1. Main theme and subtheme categories.

and younger in age. This fact seemed to not have an impact on their beliefs and values, for instance, both groups of men discuss their dedication to assuming the role of breadwinner of their families. In terms of race, our analysis also revealed differences in terminology related to how men referred to gender beliefs and values, with Latino men referring to male-specific beliefs and values as “machismo” or “machista” beliefs.

This study focuses on two themes and subthemes emerging from the data: The first theme was titled *men's beliefs about being men* with the subthemes of “role of respect,” “role of men as breadwinner and sense of responsibility,” and “chivalry.” The second theme was *perspectives on what you learned about being a man's influence on health decisions* with the subthemes of “role of masculinity: strong men mentality” and “role of masculinity: need for control” (see Figure 1). Each of the themes are described below and accompanied by quotes from the focus groups.

Theme 1: Men's Beliefs About Being Men

Subtheme 1: Role of Respect. Men were asked the following questions: When you were growing up, what did you learn about being a man from the men in your community? When asked how men in their community were encouraged to think and act, focus group participants described the role of respect as a key characteristic of men. Arciniega et al. (2008) argue that masculine beliefs and values among Latino men can be captured by two factors: traditional machismo and caballerismo. One key aspect of caballerismo consists of having respect for

elders (Arciniega et al., 2008). Other studies of Black populations of men have discussed giving and receiving respect from peers and family members as key masculine beliefs (Gibbs, Sikweyiya, & Jewkes, 2014). In the present study, both African American and Latino men emphasized the need for having respect for themselves, authority figures, and peers.

Respect for authority was characterized as not participating in adult conversations and following instructions given by adults. Respect for peers was characterized by treating friends and acquaintances, as one would expect to be treated. There was a general consensus among African American men in the groups as they placed significant value on respect being passed down from generation to generation among groups of men in their community. For example, one African American participant stated:

Well, what I learned is respect and stay out of grown folks business. My daddy always told me "if I tell you to do something once I ain't gone tell you twice" so I learned that and I teach it to my kids . . .

As stated, respect was an equally important aspect of being a man in the Latino groups. While discussing the importance of the role of respect in masculine beliefs and values, one Latino man highlighted how displaying respect for elders had an influence on putting him on the "correct path" as an adolescent:

Well, for me the most important [was] when I started recognizing in my case was the sign of respect. The respect that was given to elders was the primary base to show me how to follow the correct path.

While men in the African American focus groups discussed the importance of a legacy of respect being passed down from generation to generation, they also believed that younger generations of men did not possess the same value for respect, for themselves and for others, as members of older generations of men did. This demonstrates a possible rift in gender values and beliefs based on age between older and young African American men. Previous research on masculinity among African American men has highlighted the importance of taking into account the social location (such as age) of men, arguing that definitions of gender values and beliefs can shift over time and space (Cazenave, 1984); this work can help explain generational differences in definitions of masculinity. For African American focus group participants, this "lack of respect" could be observed in young adults by their lack of regard for issues relating to race and style of dress. For men in the African American focus groups, this was made most apparent by their use of what they

considered racial slurs. For example, one African American man noted:

I hate to say it but my generation stopped teaching the values that we learned. I came up in the 70's but we were taught to respect ourselves because we were trying to break down that racial barrier. . . . There was a lot of respect before. But that's where it stopped at.

For African American men in our focus groups, differences in "respectability" among younger generations of African American men were characterized by differences in the use of specific terms and style of dress. For one African American participant, the use of the derogatory term "nigga" symbolized not only disrespect for him personally but also signaled younger generations of men who use this language tend to engage in a culture that is associated with criminal behavior or "penitentiary mentality" and lack of respectability.

I was raised not to call your friend nigga. Now all of a sudden it's a household word, it's acceptable. You better pull your pants up too when you come in my house. . . . That's a penitentiary mentality. . . . But see I was taught to believe that there was a history with the "N" word so there was no respectful way of saying it to anybody . . .

Subtheme 2: Role of Men as Breadwinner and Sense of Responsibility. According to focus group participants (both Latino and African American), another key aspect of being a man for respondents was fulfilling the role as sole breadwinner for his family. For men in general, being perceived as a breadwinner of the family is a central aspect of hegemonic masculinity (Connell, 1995). Participants commented that the roles for men and women in the household were different: "The woman in the house . . . because the man is in the street . . . with his duty to provide for his family." Specifically, men are charged with the task of supporting the family financially with participants agreeing that ". . . the man is supposed to bring home the bacon."

Beyond being the sole breadwinner in his family, another aspect of being a man discussed by focus group participants involved the role of responsibility. In addition to providing financially for their family, men in the focus groups also stated that men were responsible for serving as the leader of their family, in addition to serving as the primary breadwinner. For Latino men, this demonstrates a key value of *caballerismo* or (masculine beliefs and values), which involves prioritizing the importance of family in their lives (Arciniega et al., 2008). Hammond and Mattis (2005) found that among African American men responsibility and accountability emerged as an important aspect of being a man, specifically in terms of taking responsibility for one's family. Accordingly, both

Latino and African American men in the focus groups stated that they saw family as their primary responsibility before all else. For instance, an African American man stated:

Yeah my father. . . . He said “. . . you have to keep your head up and when you become a man you have a family and you have to learn that your family come first.”

Another African American focus group participant described the responsibilities of men as:

The man is supposed to work and take care of this family, support his family, and lead and guide his family the way that he feels so you are supposed to work and support your family.

Taking responsibility for one's actions and holding oneself accountable for thoughts and behaviors can also central aspects of masculine identity (Hammond & Mattis, 2005). For instance, this sentiment was shared by Latino focus groups as well. For instance, a Latino participant explained:

Well I learned from my dad and other guys in the neighborhood that a man takes responsibility for his actions; he don't make excuses “oh it's his fault or their fault” for what happened because of what he did.

Subtheme 3: Sense of Chivalry. In addition to working and familial responsibility, men also mentioned chivalry as a central component to manhood. Maintaining a sense of chivalry can also be a part of masculine gender identity (Day, 2001). Chivalry, as relates to masculine values and beliefs, has been defined as a code of courtesy that dictates how men should behave in interactions with women (Day, 2001; Girouard, 1981). However, a sense of chivalry in men can also be influenced by culture. For Latino men, the concept of *caballerismo* involves “masculinity as affiliation and emotional connectedness as well as respectful manners and gallantry, particularly toward women” (Falicov, 2010, p. 315). Among African American men, some opt to adopt chivalrous self-presentations to counter negative stereotypes of Black men as aggressive and dangerous (Day, 2001).

Similarly, for men in the focus groups, chivalry was defined as being a “gentleman,” primarily displayed through actions such as opening doors for women. Men stated that in the focus groups, in many instances, women would respond with surprise because they were not accustomed to men behaving in a chivalrous way. According to one African American participant:

I could be going into a store or any type of establishment and I stand back and I open the door and some of them will look

at you real funny especially the young ones. They don't know the definition of chivalry.

For the men in this study, key aspects of being a man included need for having respect for themselves, authority figures, and peers; fulfilling the role as breadwinner by supporting their families financially and being responsible for serving as the leader of the family; and maintaining a sense of chivalry. The following subtheme illustrates how some of these beliefs can affect health behavior in Latino and African American men with diabetes.

Theme 2: Influence of Gender Beliefs and Values on Health Behavior

Subtheme 1: Role of Masculinity: Strong Men Mentality. According to focus group participants, definitions of manhood also influence health behavior. They highlighted the role of several gender values and beliefs in hindering acceptance of illness and avoiding utilization of health care until symptoms were severe. Dominant gender norms among men can have an adverse impact on health behaviors (Courtenay, 2000). According to Courtenay (2000, p. 1389) “when a man does experience an illness or disability, the gender ramifications are often great. Illness ‘can reduce a man's status in masculine hierarchies, shift his power relations with women, and raise his self-doubts about masculinity’ (Charmaz, 1995, p. 268).” In our sample, African American and Latino respondents described how the need for men to maintain a “strong” image to the outside world played a key role in preventing them from seeking medical attention when they were ill. According to one African American focus group participant “. . . nobody goes to the doctor until they're actually feeling pain. Until they can't stand the pain anymore.” Another African American focus group member commented:

Well, the way I was raised . . . men are strong and we don't need to go to the doctor—we can take care of ourselves and when I first got diagnosed with diabetes I was still trying to do that on my own without listening to everybody else.

Similar to previous research (Courtenay, 2000), our focus group participants acknowledge that in order to maintain their image as a “strong” man to the outside world, they must demonstrate that they are unconcerned about health matters and also invulnerable to disease.

Latino men discussed some of the same issues, but spoke about them in the context of *machismo* (or Latino masculine ideology). Latino men in the focus groups defined *machismo* as the belief that men should be able to withstand pain, hardship, and failure. For participants, in *machismo* maintaining a strong image was intertwined with putting the needs of one's family and the role as

breadwinner before any physical health needs or what Arciniega et al. (2008) refer to as *caballerismo* (or the presence of emotional connectedness and prioritization of family). In terms of health behaviors, Latino men linked these attitudes to unwillingness among men to utilize health care. One participant stated that:

[In] *machismo* we are taught that the men always had to be strong. . . . The man doesn't cry, the man is the provider of the family, the man shouldn't complain, the man doesn't go to the doctor.

Another commented:

. . . their *machista* beliefs that nothing will affect them; one doesn't get hurt, one doesn't get sick, one doesn't go to the doctor, one shouldn't think of thyself but only of the family.

Similarly, another participant stated:

. . . one . . . wouldn't go to the doctor unless we were about to die . . . [the] *machismo* that we were taught was to be strong, be a man, have a say, and have responsibility . . . one is told that if you go to the doctor it is because you are not a man.

Subtheme 2: Role of Masculinity: Need for Control. A need to maintain control over their actions also posed a barrier to seeking care for health problems. One participant commented that men want to be in control and that this can impede their ability to follow health advice from family, friends, and health care professionals. Another focus group participant explained: ". . . us men just [want] to be in control . . . I didn't want to listen to the doctors or anybody else . . ." Within medical institutions, Courtenay (2000) argues that men can sometimes view interactions with physicians as a challenge to their masculine beliefs and values, particularly the need to sustain emotional and physical control. In medical settings, men perceive physicians, who in many medical settings are predominately men, as having power and control over their bodies because they themselves are not physicians (Courtenay, 2000).

Discussion

The aim of this study was to explore gender values and beliefs among Latino and African American men with type 2 diabetes and to examine how their definitions of masculinity intersected with their health behaviors. Based on the responses of the men who participated in these focus groups, one might conclude that certain aspects of masculinity, as defined by African American and Latino men, can sometimes have a detrimental effect on practicing health behaviors that have direct implications for

diabetes management. The results revealed two main themes. The first theme involved men's beliefs about being men. For participants in our study, key aspects of being a man included a need for having respect for themselves, authority figures, and peers; fulfilling the role as breadwinner by supporting their families financially and being responsible for serving as the leader of the family; and maintaining a sense of chivalry. The second theme addressed how beliefs about being a man influenced health behavior. Men reported that two aspects of masculinity served as barriers to healthy behaviors, specifically, the need to maintain a strong image to the outside world and the need to maintain control of their own actions. For Latino men, in an effort to uphold *machismo*, they take on the responsibility of being a provider, which becomes more important than seeking medical attention and equates sickness with weakness. Our study is supported by previous research on diabetes and other chronic illness (e.g., Getrich et al., 2012; Liburd et al., 2007), which indicates that the way African American and Latino men define and experience masculinity can affect their management of chronic conditions (e.g., diabetes and colorectal cancer) and health care use.

For men in our focus groups, regardless of their racial/ethnic identities, showing respect to elders and fulfilling the role of breadwinner in the family were two key values that emerged in discussions. The men felt that family was their primary responsibility, sometimes putting the needs of their families above their own, even when it came to matters involving their health. An implication of needing to be the primary breadwinner could result in long work hours or assuming other time consuming work-related responsibilities that may negatively affect a man's ability to carry out healthy behaviors (such as diet and exercise) which could have serious implications for diabetes self-management.

Additionally, another definition described by the men in our study, "working hard," is linked to traditionally masculine beliefs (i.e., physical strength, breadwinner, etc.) among men (Connell, 1982; O'Hara, Gough, Seymour-Smith, & Watts, 2013). Our results are supported by previous research, which shows that the prioritization of work over medical issues can lead to poor diet, low rates of exercise, and obesity (Heraclides, Chandola, Witte, & Brunner, 2011). Prioritizing work could also lead to work-related psychosocial stress, which has been linked to the development of type 2 diabetes and other chronic conditions such as heart disease and metabolic syndrome (Heraclides et al., 2011). Because the men in our study continued to work while avoiding or ignoring symptoms of illness, more research should be conducted on both the consequences of ignoring signs of illness and also ways to encourage men to seek medical care in a way that does not challenge their masculinity and definitions of manhood.

Another barrier to seeking medical attention when faced with physical symptoms of illness that was identified by our study participants was the need for men to maintain a “strong” image to the outside world, which prevented men from seeking medical care until symptoms were severe and from accepting support from family members. This finding has been confirmed elsewhere in the men’s health literature (Courtenay, 2000). Plowden and Young (2003) examined sociostructural factors that influence health behavior among African American men in an urban setting. The study revealed that men encountered significant difficulty in accepting social support from others, which served as a barrier to seeking care in this population. For persons living with diabetes, a blood glucose test must be delivered every 3 months or more frequently depending on severity of symptoms and health care is typically delivered by an interdisciplinary team (such as dieticians and nurses) requiring additional medical visits (Hearnshaw & Lindenmeyer, 2006). Because utilization of health care is so critical for diabetes self-management, gender values, and beliefs as a barrier to health care utilization should be further studied among Latino and African American men.

Another aspect of masculinity that men reported as a barrier to healthy behaviors was the need to maintain control over their actions, and to not have that control impeded by a health care professional telling them what to do. Previous literature supports this finding (Courtenay, 2000). Liburd et al. (2007) conducted in-depth interviews with 16 African American men with diabetes. Findings suggest that the gender socialization and subsequent behaviors of African American men often contradict recommended diabetes self-management behaviors. Men in the study also engaged in behaviors that increased their risk for diabetes-related complications such as poor dietary habits and alcohol consumption. Liburd et al. (2007) attributed this to gender socialization and the idea, argued by other Black masculinity scholars, that it is weak to show pain and cowardly to run from danger. Similarly, men in our study reported a desire to maintain control over their bodies and interactions with health care at all times and avoided utilizing health care until symptoms were severe.

For Latino men, gender values and beliefs were expressed through the concepts of *machismo* and *caballerismo*. Among Latino men, these two concepts are often used to help explain masculinity (Mirande, 1997; Quintero & Estrada, 1998). In our study, machismo led to delays in seeking medical care until symptoms of illness became severe primarily stemming from a need to maintain and strong image to the outside world. As stated research on masculine identity and its influence on chronic illness among Latinos has mostly focused on male-specific illnesses (such as prostate cancer, vasectomies) and (Ervti

et al., 2010; Rivera-Ramos & Buki, 2011) and also on colorectal cancer (Fernandez et al., 2008; Goldman et al., 2009; Goodman et al., 2006; Salas-Lopez et al., 2011). While these studies helped develop a better understanding of how machismo may serve as a barrier to healthy behaviors among men with chronic illness, the implications of gender beliefs and values among Latino men with diabetes have not been explored extensively.

Both displaying a strong image and the need to maintain control in African American and Latino men with diabetes can also impede healthy behaviors. Our findings suggest that help seeking, specifically visiting physicians, may pose a challenge to masculine identity that promotes control, independence, and suppression of emotions. More research is needed to discover ways to encourage men to seek social support and medical attention that do not directly challenge their masculinity. In an effort to help men feel more in control of their health care and health decisions, one way to combat masculine identity may lie in the use of a collaborative approach by medical professionals that involves encouraging them to play a more active role, and thus maintaining control over their health. Previous research shows that patient participation in medical decision making may result in better glycemic control (Heisler, Cole, Weir, Kerr, & Hayward, 2007).

Findings from this study have implications for the health and diabetes self-management behaviors of men of color. First, the methods employed in the present study, though focused exclusively on African American and Latino men, use approaches that are transferable to men of other racial and ethnic groups. For instance, there is value in using qualitative data collection techniques to learn about the social and cultural contexts and health needs of men of color. Using such research methods can help capture variations across race, culture, and other social determinants of health and can be used to tailor, implement, and evaluate type 2 diabetes interventions specifically for men of color who may experience challenges with managing their diabetes-related health behaviors.

Second, the findings from this study call for a more nuanced exploration of masculinities. As stated, men in our study sought out health services by virtue of participating in the intervention and, while they waited until symptoms were severe, some men did report that they did ultimately seek medical attention when ill. These findings highlight the fact that masculinity is fluid and contextually specific such that men can act in what could be seen as “unmasculine” ways (e.g., seeking out health services) in pursuance of other approved masculine behaviors (e.g., providing for a family and remaining in employment). Past research has found that men can manage masculine capital and illness precisely because they need to fulfill their role as breadwinner and head of household (Peak & Gast, 2014). Thus, it is critical to

acknowledge that how gender is socially constructed in men depends on a complex intersection of variables such as ethnicity, economic status, educational level, sexual orientation, geography, social context, and power relations (Duck, 2009; Garfield et al., 2008; Marriott, 1996). While beyond the scope of our study, more research is needed to discover how health care professionals can integrate the direct impact of masculine identity into practice, modifying their approaches to delivering care to men living with chronic illness accordingly. Additionally, this study did not focus on how masculine beliefs and values could positively or negatively affect diabetes-specific behaviors. However, because men in our study stated that gender-related beliefs and values influenced their health behaviors, this calls for more research regarding how gender identity (i.e., being the primary breadwinner, maintaining a strong image) can conflict with diabetes management specifically and to identify ways to incorporate problem-solving strategies for these conflicts among Latino and African American men with diabetes.

Finally, it is important to note that the willingness of African American and Latino men to participate in the REACH intervention appeared to go against traditional masculine beliefs and values—specifically, the idea that men are less likely to seek medical care because it challenges masculine beliefs and values (Courtenay, 2000). However, it is important to note that while men did engage in help seeking by volunteering for the intervention, this fact did not preclude them from facing barriers to actively engaging in key parts of the intervention. A study that evaluated gender differences in participation in the intervention found that men were more likely to withdraw and had lower participation rates compared with women (Hawkins et al., 2013). Given what we know from the literature regarding the tendency of men to have fewer interactions with health care, the findings from this study warrant a deeper exploration into whether men face unique barriers to participating in health care due to gender values and beliefs. It is also important to note that a majority of men in the focus groups participated in the REACH intervention several years prior to participating in the present study's focus groups, which may or may not have an impact on our studies' findings.

Limitations

The findings from this study should be interpreted in light of a few limitations. First, while these findings may be transferable (Watkins, 2012) to other urban, Midwestern men of color, of similar communities and backgrounds, it was not our intention to make generalizations from our findings on a broader level. However, the findings in this study could be used as a springboard for future quantitative research with larger numbers of African American

and Latino men to develop a more comprehensive picture of factors associated with gender values and beliefs and their influence on health behavior. Second, the men in our study were participants in a (community health worker) CHW-led diabetes lifestyle intervention. Men were recruited for the intervention from medical records and had some level of access to health care prior to the intervention. Thus, our results are specific to men who have access to health care and may not apply to men who do not. A majority of the men in our sample were 40 years of age or older, which may make our conclusions less applicable to younger men with type 2 diabetes. In light of these limitations, this exploratory study is an initial step in deepening the science on African American and Latino men's diabetes self-management.

Conclusions

The findings from this study contribute to the existing literature by elucidating possible mechanisms through which masculine identity might influence health behaviors between African American and Latino men with diabetes. Results from the focus groups held with African American and Latino men with type 2 diabetes suggested that men's beliefs about being men negatively affected health behaviors. While we included both Latino and African American men in the same study, our findings also call for a need to separate these two groups in analysis to get to the nuanced understanding about work, family, age, class, ethnicity, and race in relation to the performance of masculinity in the context of chronic illness. These findings also support a need for more tailored diabetes self-management approaches and treatments for Latino and African American men with type 2 diabetes.

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