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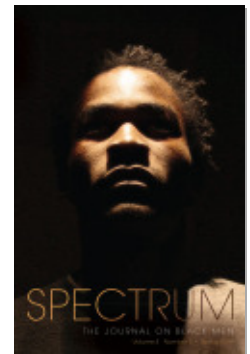
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Spectrum: A Journal on Black Men, Volume 4, Number 2, Spring 2016, pp.  
61-81 (Article)

Published by Indiana University Press



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# Masculinity, Socioeconomic Status, and Self-Reported Health among African American Men

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**Terry L. Thompson, Daphne C. Watkins,  
and Vicki Johnson-Lawrence**

**ABSTRACT:** The purpose of this study was to examine the influence of masculinity and socioeconomic status (i.e., income) on the self-reported health of a sample of African American men. Study participants ( $n = 122$ ) were barbershop patrons from Chicago, Illinois, who ranged in age from 18 to 66. We used logistic regression to assess the relationship between masculinity and self-reported health. Masculinity was measured as the average of responses to a subset of 10 items from the Male Role Norms Inventory and the Male Attitude Norms Inventory II. Self-reported health was measured with a five point Likert scale and dichotomized as excellent versus other health status. Analyses suggested that masculinity, but not socioeconomic status, was positively associated with excellent self-reported health. Such results offer understanding of how masculinity and self-reported health impact health outcomes in African American men.

There are clear gender disparities with regard to health and health behaviors in the United States. For example, national reports suggest that men suffer more severe health-related conditions and have higher mortality rates when compared to women (Woods-Giscombé, 2010). These gender differentials are also evident across various racial and ethnic groups, as research suggests that men of all racial and ethnic

backgrounds engage in fewer preventive health behaviors (Gallant & Dorn, 2001), lack a primary care provider (Bertakis, Azari, Helms, Callahan, & Robbins, 2000), and consume alcohol (Wilsnack, Wilsnack, Kristjanson, Vogelanz-Holm, & Gmel, 2009) and tobacco products (Centers for Disease Control and Prevention, 2014b) at a far greater rate than women. As for the long-term effects of such gender-specific health and health behaviors, the age-adjusted death rate for men is approximately 40% higher than for women, while life expectancy figures show women living on average five years longer than men across all racial and ethnic groups (Arias, 2006).

Just as gender differences in health are apparent in the literature, there are also clear racial/ethnic differences that have implications for poor health outcomes among men, generally, and marginalized men, specifically. For example, when compared to other men in the United States, African American men experience disease at an earlier onset (Go et al., 2013; Quinones, Liang, & Ye, 2012), with a greater frequency, and these diseases are often accompanied by more severe health outcomes (Fiscella & Holt, 2008). Previous research on the health of African American men has documented the various social determinants of health that impact the living and working conditions of African American men (Watkins, 2012; Watkins, Walker, & Griffith, 2010; Xanthos, Treadwell, & Holden, 2010). These social determinants raise concerns about the influence of social and economic capital for African American men, as well as the ways in which they define their own health. Unfortunately, there is sparse and under-developed research in this area. Therefore, the current study sought to examine the effects of masculinity and socioeconomic status (i.e., income) on the self-reported health of African American men.

### Self-Reported Health of African American Men

Despite its subjectivity, self-reported health is a strong predictor of mortality and morbidity (Idler & Benyamini, 1997), well-being, quality of life, and health care service utilization (Miilunpalo, Vuori, Oja, Pasanen, & Urponen, 1997; Ware & Sherbourne, 1992). Self-reports of general health are also useful indicators of an individual's health; though, the comparability of self-reported measures across different racial and ethnic groups has been questioned (Borrell, Kiefe, Diez-Roux, Williams, & Gordon-Larsen, 2013). A major concern with individual self-assessment of health is that respondents have often been adverse to the health assessment scale presented to them. Such phenomenon is especially prevalent among African Americans and other communities of color. Therefore, individuals with the same health status may rate their health differently as a result of different reference points, socioeconomic statuses (SES), and health literacy/knowledge (Matsuyama et al., 2011).

Large, national studies that have included self-reported health measures have revealed gender and racial/ethnic group differences. For example, data from

the 2011 National Health Interview Survey (Centers for Disease Control and Prevention, 2012) indicated that 13.0% of non-Hispanic Black men, compared to 9.3% of non-Hispanic White men, reported having fair to poor health. Although interpretations of self-reported health vary by age, gender, culture (Jyhla, Guralnik, Ferrucci, Jokela, & Heikkinen, 1998), and SES (Dowd & Zajacova, 2007), the main determinant of self-reported health remains one's personal knowledge and interpretation of their health status and symptoms (Bratter & Gorman, 2011).

Previous studies examining the relationship between race, gender, and self-reported health suggest that men of all racial/ethnic groups frequently rate their health between "very good" and "fair" (DeSalvo et al., 2009; Dowd & Todd, 2011). Beyond this, however, evidence on the self-reported health patterns of African American men are mixed. On the one hand, some studies suggest that African American men tend to rate their health as higher than men of other racial and ethnic backgrounds (Dowd & Todd, 2011). However, clinical studies have portrayed their health as worse than that of other racial/ethnic groups (Bonhomme & Essun, 2012). Some research has indicated that African American men may be even more likely to report their health as "excellent" to "very good" as a result of cultural socialization and traditional health beliefs (Wade, 2009).

Cultural socialization describes the process of communicating, receiving, and believing verbal and nonverbal messages and behaviors that shape one's sense of identity across one's life span. Research suggests cultural differences and experiences within the same ethnicity as they relate to health behaviors may account for the level of health socialization seen in men (Smith, & Silva, 2011). Such cultural expectancies contribute to socialization behaviors, becoming even more empowering when considering health system mistrust by men, often somewhat prevalent among African American men (Hammond, 2010). As a result of the traditional barriers in health systems' mistrust, it becomes even more important to examine the physical and social environments where African American men live. Such barriers and structural constraints have created a marginalized health society among African American men. The current literature has demonstrated that African American men—as a result of cultural socialization—seek health care/health providers only as a last resort (Hammond, 2010). Meager efforts in this area underscore the importance of examining correlates of self-reported health in African American men, as it offers promise in assessing long-term health outcomes, morbidity, and mortality within this sub-group of men.

### Socioeconomic Status and Self-Reported Health

Socioeconomic status may also influence health expectations. For instance, respondents with lower SES may have general feelings of dissatisfaction with the

health care system, thus leading to lower health ratings than are warranted by objective health. In turn, individuals with higher SES may perceive they should be healthier and rank their own health as high compared to their counterparts. This phenomenon is referred to as a “wishful thinking scenario” (Moesgaard-Iburg, Salomon, Tandon, & Murray, 2002). These differences in health expectations among groups with varying SES result in overestimates of health inequalities. On the other hand, social comparison theory suggests that individuals compare themselves to a reference group of their peers, a phenomenon that has been identified in evaluations across age (Schnittker, 2005). Respondents from higher SES groups may compare themselves with their relatively healthy peers, for instance, resulting in a higher standard for what is considered “excellent” health. Similarly, the expectations of disadvantaged, marginalized groups might be lowered by the lower average health of those around them. Such standards would lead to systematically better health reports for the disadvantaged and an underestimate of health inequalities. Lower SES could also translate into different health ratings given the same health status among SES and environmental peers (Schoeni, Martin, Andreski, & Freedman, 2005).

As with SES, reporting heterogeneity by race/ethnicity may arise from differences in health expectations or peer comparisons or additionally emerge from cultural or linguistic differences in the interpretation of health. Different race/ethnic groups may understand and use the ordinal response scale in systematically different ways, such as the propensity to use extreme categories (Mays, Cochran, & Barnes, 2007). A common finding is that older respondents tend to have a milder view of their health as compared to younger respondents. Thus self-reported health of young and old respondents may not be directly comparable, and the observed decline in self-reported health with age may underestimate the true decline in health (Dunlop, Manheim, Song, & Chang, 2002).

### Self-Reported Health and Masculinity among African American Men

Recent studies on men’s lifestyles have highlighted the association between masculinity constructs and unhealthy behaviors (Levant, Wimer, & Williams, 2011). Generally, men are known to adhere to multiple definitions of masculinity and manhood (termed “masculinities”) at different periods over their life span. Variations in masculinity are often demonstrated through the way that men from different backgrounds work and live within their own social and cultural contexts (Courtenay, 2000). Since African American men have been known to endorse a more traditional form of masculinity than other men (Wade, 2009), self-reports of their health as “excellent” to “very good” may be reflective of their traditional masculinity beliefs and practices that exude toughness, stoicism, and invincibility.

The literature suggests that there are multiple masculine ideologies. However, the masculinity ideology constructs highlighted most in recent research literature has focused on the concept of traditional masculinity ideology (Wade, 2009; Levant, Wimer, & Williams; 2011). Traditional masculinity in these terms encompasses specific behaviors and self-perceptions that men perceive as “being a man.” As such, traditional masculinity often invokes behaviors such as homophobia, competitiveness, physical and sexual violence, restricted emotionality, and restricted affectionate behavior between men (O’Neil, 2008; Wade, 2009). Recent research literature indicates that men who endorse traditional beliefs about masculinity engage in fewer health-promoting behaviors and have greater health risks than those who endorse less traditional beliefs (Courtenay, 2000; Mahalik, Lagan, & Morrison, 2006). The literature suggests that men, in particular African American men, may attempt to prove their manhood through risk-taking, which leads to adverse health outcomes (Bonhomme & Essun, 2012).

For men of color, who are marginalized and often believe that they are not allowed mainstream ways to enact male gender roles, risk-taking behavior provides a way in which they can attempt to establish themselves as men (Courtenay, 2000). Traditional masculinity ideology supports those health-related attitudes and behaviors that put men at risk for poor health (Bonhomme & Essun, 2012). Researchers have shown that men who endorse traditional ideals of masculinity are more likely to engage in unhealthy behaviors and risky lifestyles when compared to men who do not endorse traditional masculinity (Mahalik, Lagan, & Morrison, 2006). African American men are even more likely to report their health as “excellent” to “very good” as a result of cultural socialization, often further endorsed by traditional masculine beliefs of mistrust in the health care system.

Mistrust of the health care system and health care providers has often been associated with less health care compliance and less access and utilization of health care services (Musa et al., 2009). Mistrust becomes even more problematic when examining health care access and utilization of health care services among African Americans. Researchers have linked African Americans’ mistrust of health care systems to both historical content as well as the prevalence of medical malice (Hammond, 2010). Such findings become even more problematic as researchers examine risk behaviors, levels of health services engagement, and health outcomes among African American men. Neighbors and Howard (1987) reported that African American men’s help-seeking behaviors are not mediated by medical severity, thus suggestive of other barriers to engagement. Mistrust of health care providers and the health systems they represent have been identified as strong deterrents to achieving healthy outcomes among African American men. Mansfield, Addis, and Courtenay (2005) further postulate mistrust as a consequence of traditional

masculinity ideology, often seen as “the endorsement and internalization of cultural belief systems that focus on masculinity and the male gender role,” further suggesting African American men’s mistrust issues occur as a result of cultural socialization, mistrust of health care providers, and traditional masculine beliefs.

Levant (2008) identified masculinity as a social construct that characterizes various beliefs and behaviors in men. Men’s health scholars have identified four themes of masculinity: physical strength, toughness, emotional denial, and avoidance of feminine behaviors (Addis & Mahalik, 2003; Thompson, Pleck, & Ferrera, 1992), while studies on masculinity in African American men have underscored their likelihood to project strength, autonomy, and physical aggression as a way to compensate for their lack of emotions, vulnerability, and masculinity (Hammond & Mattis, 2005; Williams & Mohammed, 2009). Such traditional masculinity effects African American men’s health beliefs and lifestyles (Wade, 2009) and has implications for high mortality rates as a result of risk-taking behaviors associated with cultural pressures (Idler, 2003). These social and cultural orientations often combine to increase health risks and the likelihood that African American men would consider seeking help for their health concerns (Bonhomme & Essun, 2012). As such, DeSalvo, Bloser, Reynolds, He, and Muntner (2006) reported that men, particularly African American men, delay using preventive health services as a result of traditional social constructions of masculinity. However, the relationship between self-reported health and masculinity remains unclear, particularly for African American men.

### Socioeconomic Status, Masculinity, and Self-Reported Health among African American Men

While some studies have demonstrated that SES is a moderator for health behaviors among all men, others suggest that there is something unique about the experiences of African American men; that an association exists between masculinity and self-reported health by SES (Courtenay, 2000). Research from the mid-1990s demonstrated that socioeconomic status, race, and ethnicity account for much of the variability in health among minority and non-Hispanic white men, particularly among African American men (Krieger, 1993; Williams, Yu, & Jackson, 1997). More recent studies suggest that though SES continues to be a strong predictor of health outcomes in African American men (Williams & Mohammed, 2009), it still does not explain the relationship between race and self-reported health.

Research on the influence of SES on health outcomes for African American men is mixed. While some studies suggest that African American men from low-income groups experience higher mortality rates compared to men from other

racial groups with similarly low incomes (Dowd & Zajacova, 2007), findings from other studies suggest that African American men with lower socioeconomic statuses are disproportionately experiencing poorer health outcomes and engage in riskier behaviors compared to non-Hispanic White men from lower SES groups (Williams, 2003). These findings are striking, as many scholars have noted the economic challenges faced by African American men, who traditionally experience lower income and educational levels than non-Hispanic White men (Williams & Mohammed, 2009), higher unemployment rates than non-Hispanic White men (Williams, 2003), and a disproportionate likelihood of exposure to poverty over their life course (Lillie-Blanton & Hoffman, 2005; Watkins, 2012; Watkins & Neighbors, 2012).

Men's health experts have reported that African American men with low socioeconomic statuses who also report non-adherence to traditional masculine norms may be more likely to seek health care because they acknowledge their physical limitations (Griffith, Gunter, & Watkins, 2012). In contrast, African American men with high socioeconomic statuses may report higher masculinity scores to over-emphasize the benefits of SES they have achieved, given that higher SES is associated with increased access to high quality (and potentially costly) health care. Though African American men with high SES and lower adherence to traditional masculine norms may report a greater willingness to seek and receive high quality medical care. Considerable evidence also suggests that African American men with low socioeconomic statuses may report higher levels of traditional masculine norms to over-compensate for their lack of resources (Levant & Majors, 1997; Wade, 2009). Yet, efforts to distinguish the masculine characteristics that men identify with at the intersection of their self-reported health and socioeconomic statuses are limited. Therefore, the purpose of this study is to determine the effects of masculinity and SES on self-reported health among a sample of African American men.

## METHOD

### Study Design

This study sought to examine the associations between masculinity and health among male African American barbershop patrons aged 18 to 69 years in Chicago, Illinois. Researchers have reported barbershops are established "comfort zones" (Hammond, Matthews, Mohottige, Agyemang, & Corbie-Smith, 2010) for African American men to receive health messages (Baker et al., 2012). This becomes very important when we examine issues of mistrust and barriers to health messages among African American men. This is also relevant to health researchers



who want to study African American men but may have difficulty accessing this sub-group. The barbershop location referenced in this study was located in a racially diverse (34% African American; 51% non-Hispanic White) inner-city community with an average annual income greater than \$50,000. The barbershop maintained a large customer base (>600 customer visits per month) with a predominantly African American male patronage (>90%). This study was approved and administered under the guidelines of the Institutional Review Board of Central Michigan University. This study satisfied all criteria for the ethical treatment of human participants.

### Data Collection

All study participants were provided with verbal instructions on the informed consent process and each participant provided written consent prior to participating in this study. Power analyses suggested at least 90 participant responses were required to detect significant associations between masculinity and self-rated health, with 80% power and  $\alpha = 0.05$ . Participants were recruited via convenience sampling methods (fliers and word of mouth). Surveys were administered on the busiest days of barbershop operation (Thursday, Friday, and Saturday during normal business hours of 7:00 AM–7:00 PM) to achieve the desired sample size. The study sample consisted of 124 African American men aged 20 to 66 years—Mean ( $M$ ) = 39 years, Standard Deviation ( $SD$ ) = 9.2 years—who frequented the barbershop. Two individuals did not respond to the income ( $n = 1$ ) and self-reported health ( $n = 1$ ) survey questions and were excluded from the final analyses.

### Measures

Self-reported health (SRH) was based on the response to the question “how would you rate your health?” Respondents were asked to rate their health status using a 5-point Likert scale: (5) excellent, (4) very good, (3) good, (2) fair, and (1) poor. For the analyses, the measure was dichotomized as excellent/very good/good compared to fair/poor health. This single question has been used in multiple national studies to assess SRH, including the Medical Expenditure Panel Survey (MEPS, 2008), the National Health Interview Survey (Centers for Disease Control and Prevention, 2014a), and in other published literature (DeSalvo et al., 2006; McGee, Liao, Cao, & Cooper, 1999; Zajacova & Johnson-Lawrence, 2012).

Masculinity was measured using a total of 10 items: three (questions 21, 41, and 42) were extracted from the Male Role Norms Inventory (MRNI; Cronbach's  $\alpha = .87$ ) (Hall, Morales, Coyne-Beasley, & St Lawrence, 2012) and seven items (questions 2, 3, 5, 20, 22, 23, and 27) from the Male Attitude Norms Inventory (MANI-II; Cronbach's  $\alpha = .77$ ) (Luyt, 2005), both of which reflect masculine

ideology from a social constructionist perspective. The MRNI is a 57-item scale that assesses traditional Westernized masculinity based on questions of traditional masculine behaviors and gender roles of men across different races and ethnicities with eight theoretically derived scales: avoidance of femininity, fear and hatred of homosexuals, self-reliance, aggression, achievement/status, non-relational attitudes toward sexuality, and restrictive emotionality, all of which measure traditional norms and non-traditional attitudes toward masculinity (Hall et al., 2012; Levant, Majors, & Kelley, 1998).

The MANI-II is a 40-item scale that captures masculine ideology. The scale reflected three subscales: toughness, control, and sexuality. With the exception of item 23 (which reflected control), the other six selected items from the MANI-II included in these analyses were part of the toughness subscale (Appendix 1). Respondents were asked to rate their level of agreement with these items using a 4-point Likert scale, ranging from strongly disagree (1) to strongly agree (4), and their responses were summed and averaged to produce a total masculinity score for each participant (Cronbach's  $\alpha = .87$ ). Stronger agreement with these items was associated with higher levels of masculinity.

Socioeconomic status (SES) was based on responses to the self-reported annual income question. Annual income (in dollars) was assessed categorically in the survey and was divided into four groups: \$0–11,999, \$12,000–24,999, \$26,000–50,999, \$51,000–74,999, and \$75,000+. The survey also asked the respondents to report their age in years, and is shown in 10-year age bands. For analyses, age was categorized into tertiles.

### Data Analysis

Descriptive characteristics for the sample were calculated using means and standard deviations for continuous variables and frequencies and percentages for categorical variables. Logistic regression models were performed to evaluate the association between masculinity and SRH as in previous research (Hammond et al., 2010). Odds ratios (OR) and 95% confidence intervals (CI) were provided to denote the point estimate and variability of the estimates. Confidence intervals that exclude 1 represent statistically significant findings at a type I error rate of 0.05. Given the variability in self-reported health ratings, which have considered excellent compared to any other ratings (Krieger, Kosheleva, Waterman, Chen, & Koenen, 2011), as well as excellent/very good compared to any other ratings within African American samples in previous research (DeSalvo et al., 2009), we performed two multivariable logistic regression analyses to address the sensitivity of our findings and to allow comparability to the existing literature. In Model 1, self-reported health was dichotomized as excellent compared to all other responses; in Model 2,

the measure was dichotomized as excellent/very good compared to all other responses. These models allow us to assess the sensitivity of the model results to individual self-reports given the highly subjective nature of the measure. Models included masculinity, age (in tertiles), and SES based on income. All analyses were performed in SPSS version 22 (IBM Corp. Released 2013).

## RESULTS

### Sample Characteristics

Table 1 shows the sample demographic characteristics. Most of the African American male respondents were aged 30–39 (29.8%) and 40–49 (30%) years. Over 40% reported annual incomes greater than \$75,000 and reported excellent

**Table 1. Sample Characteristics (N = 122)**

		N	%
Age (years)	20–29	21	21
	30–39	30	29.8
	40–49	30	30
	50–59	13	12.9
	60–69	5	4.8
Income (\$)	\$0–11,999	2	1.6
	\$12,000–25,999	12	9.7
	\$26,000–50,999	27	21.8
	\$51,000–75,000	29	23.4
	\$75,000+	53	42.7
Self-Reported Health	Excellent	44	35.8
	Very Good	48	39
	Good	25	20.3
	Fair	5	4.1
	Poor	1	0.8
		<u>Mean</u>	<u>SD</u>
Masculinity Scores <sup>a</sup> (10 items)		2.83	0.59

<sup>a</sup>Scores determined by three items from the Male Role Norms Inventory (MRNI) and seven items from the Male Attitude Norms Inventory (MANI-II).

(35.8%) or very good (39%) health. The average masculinity score was 2.83 (SD = 0.59; range = 1–4), which indicates that on average respondents reported less traditional masculine beliefs.

### Logistic Regression Results

Results of the multivariable logistic regression models of the association between masculinity, SES, and SRH are shown in Table 2. Results of Model 1, which evaluated “excellent/very good” compared to “good/fair/poor” health, showed no significant relationship between masculinity and “excellent/very good health”—odds ratio (OR) = 1.74, 95% confidence interval (CI) = 0.81–3.72. Incomes less than \$50,000 was not associated with “excellent/very good health” (OR = 0.37, 95% CI = 0.11–1.24), but incomes between \$50,000 and \$74,999 were associated with decreased odds of “excellent/very good” health (OR = 0.23, 95% CI = 0.07–0.68). Age was not statistically associated with the odds of “excellent/very good health” (OR 20–33 vs 44+ yrs = 1.49, 95 % CI = 0.46–4.82; OR 34–43 vs 44+ yrs = 1.68, 95% CI = 0.56–5.07).

**Table 2. Logistic Regression Models of Self-Reported Health by Masculinity, Income, and Age**

	Model 1: Excellent/ Very Good vs Good/ Fair/Poor Health		Model 2: Excellent vs Very Good/ Good/Fair/ Poor Health	
	OR	95% CI	OR	95% CI
Masculinity	1.74	(0.81–3.72)	3.10	(1.39–6.94)
Income (in \$)				
Income \$0–49,999	0.37	(0.11–1.24)	0.44	(0.15–1.23)
Income \$50–74,999	0.23	(0.07–0.68)	0.39	(0.13–1.17)
Income \$75K+	<i>referent</i>		<i>referent</i>	
Age Tertiles				
Tertile 1 (20–33 yrs.)	1.49	(0.46–4.82)	2.68	(0.88–8.19)
Tertile 2 (34–43 yrs.)	1.68	(0.56–5.07)	1.56	(0.54–4.42)
Tertile 3 (44–66 yrs.)	<i>referent</i>		<i>referent</i>	
–2 Log Likelihood	128.54		145.56	

OR = Odds ratio; CI = Confidence Interval

The results of Model 2, which evaluated “excellent” compared to “very good/good/fair/poor” health, indicated that greater masculinity was associated with increased odds of reporting “excellent” health (OR = 3.10, 95% CI = 1.39–6.94) for the men in our sample. Income (OR \$0–49,999 vs \$75,000 = 0.44, 95% CI = 0.15–1.23; OR \$50,000–74,999 vs \$75,000 = 0.39, 95% CI = 0.13–1.17) and age (OR 20–33 vs 44+ yrs = 2.68, 95% CI = 0.88–8.19; OR 34–43 vs 44+ yrs = 1.56, 95% CI = 0.54–4.42) were not associated with the odds of reporting “excellent” health for the African American men in our sample.

## DISCUSSION

This study sought to determine the effects of masculinity on health outcomes in African American men using self-reported health ratings. As noted by previous researchers (Courtenay, 2000; Hammond & Mattis, 2005), men’s health behaviors and a deeper understanding of their health status is mediated by social determinants of health (e.g., SES, education, marital status, etc.). Factors such as these may have accounted for the unexplained variance in the current study; though, we did not directly include these variables in our analysis. Despite this, however, it is likely that our results do explain why African American men, while differing by socioeconomic status, reported similar patterns of masculinity when asked about their health status. This line of thinking becomes even more important when addressing health literacy, the onset of disease, and the time between first diagnosis and initial treatment. In addition, this study supports the need for exploring the potential for cultural and gender specific tools that could be used during health assessments to initiate a meaningful dialogue between African American men and their health care providers (Borrell & Dallo, 2008; Read & Gorman, 2006; Swami, Stanistreet, & Payne, 2008).

Previous studies have shown that African American men suffer disproportionately higher morbidity and mortality rates, often lack regular sources of care, and visit a health provider less frequently than non-Hispanic White males. While some studies link traditional masculine norms with poorer health, others have suggested that African American men who adhere to more traditional masculine norms tend to report improved personal wellness (Wade, 2009). This is aligned with our findings. One explanation for this outcome may exist. For example, perhaps the African American men from our sample who reported more traditional masculine norms tend to engage in healthier behaviors than the men who reported less traditional masculine norms. Similarly, we found that men who reported more traditional masculine norms also reported a more pronounced usual source of care, which was also influenced by their higher SES. This finding supports previous

literature that underscores the association between higher SES and greater access to health care. Greater access would then translate into a more favorable self-reported health status. Therefore, any explanation that suggests difference in access to health care between men who report more traditional masculine norms versus those who report less traditional masculine norms may be influenced by SES.

Our study also found differences in self-reported health for our African American male sample, which varied by masculine norms. One explanation for this could be that our respondents who were more likely to report traditional masculine norms may have also been more inclined to report a better health status than the men who reported less traditional masculine norms. Though we did not examine the association between health status and displays of “toughness,” we would urge future researchers to think about the association between masculinity and health status, particularly for African American men who may view being touched as a sign of weakness. This explanation is supported by masculinity studies by other researchers (Levant et al., 1998), who suggest that men who adhere to more traditional masculine norms are more likely to agree that, “to be a man, you need to be tough” than low masculine men. However, we do not examine this relationship in this study and would encourage future researchers to explore this area further.

Given our findings that men self-report their health in ways that are reflective of traditional masculinity beliefs (Farrimond, 2011), we further postulate that risky health behaviors can be mediated by low and high levels of masculinity even when SES challenges exist. Such findings are further supported by results that have shown the presence of community pressures of conformity to expected male behaviors, such as risk-taking, unprotected sex, along with unhealthy lifestyles (Hammond et al., 2010). African American men are more negatively perceived with regard to the previously stated domain (Griffith et al., 2012). Given this, we posit that future research, using a more diverse respondent pool with a more diverse SES, would be an important next step in this area of inquiry. We suspect that additional research that explores these and other social determinants of self-reported health for African American men will reveal a pattern of results consistent with our findings and further delve into the role of masculinity (e.g., positive or negative) in self-reported health among African American men.

Previous research has demonstrated that SES plays an important role in influencing masculine role norms and perceptions of African American men. As such, we recognize that a major determinant of SES (i.e., education) was not measured and that the sole measure used to determine SES for this study was self-reported income. Previous study results have revealed strong correlations between education, SES, and health status. In addition, studies have shown, among men of all racial and ethnic backgrounds, there exists a strong correlation between

higher educational attainment and good health. Such associations have been demonstrated among African American men as well (Williams, 2003). Research has demonstrated strong correlations between education, socioeconomic status, and usual sources of care among African American men (Lillie-Blanton & Hoffman, 2005). Educational levels have also been shown to correlate with less risky health behaviors among men.

SES is one the strongest known determinants in health (LaVeist, 1996; Williams et al., 1997). Men in all SES groups are disadvantaged when health status is compared with women, but low SES men are particularly vulnerable. However, the picture in the African American community is far more devastating. African American males display elevated health risks that persist at all levels of socioeconomic status. Our research findings highlighted the variable SES and its impact on health status in young affluent African American males. These young males revealed high levels of masculinity accompanied by good to excellent health status. Therefore, the significant predictor of health status in this research study was not age or masculinity; it appears to have been the SES of the individuals. Based on our findings, we suggest that future research focuses on African American men of varying employment statuses, as well as those across the masculinity continuum. Doing so will reveal that masculinity has a positive effect on self-reported health status. However, in the under-employed, masculinity can also have a negative effect when displayed in an aggressive manner, as seen in males of low socioeconomic status.

### Limitations

The findings of this study should be interpreted in light of some limitations. First, our sample of urban, African American men is unique from most other samples of African American men in the existing literature, as most samples have lower incomes, higher unemployment rates than non-Hispanic White men, and are more likely to experience poverty throughout their life course. African American men with lower SES have poorer health outcomes, riskier behaviors, and “fair” to “poor” SRH compared to non-Hispanic White men. In general, however, African American men, compared to non-Hispanic White men, often self-rate their health higher (“excellent” to “very good”) and report more traditionally masculine beliefs of toughness and invincibility. The extent to which these masculinity and health-related characteristics persist among African American men of higher SES is unclear.

Next, we omitted the socioeconomic variable of marital status. Historical research has often highlighted the effects of marital status on health outcomes, health behaviors, in addition to health care access (Thoits, 2010). Researchers have also reported marital status affecting mortality rates in men of all races and ethnicities (Zheng & Thomas, 2013). This phenomenon is especially relevant

when reporting mortality rates among African American men (Schwandt, Coresh, & Hindin, 2010). The literature has also demonstrated that among African American men the issue of mistrust impacts health care access (Hammond et al., 2010), while the presence of a spouse often acting as a buffer to the outside environment greatly enhances access and utilization of health services. Marital status has also been shown to impact the establishment of a usual source of care among African American men (Shor, Roelfs, Bugyi, & Schwartz, 2012). Another limitation is with regard to our analyses. While we demonstrated statistical significance, many of the correlations were small, thus leaving a great deal of variance among the findings. With only 8% of the variation in self-rated health explained by the model, we acknowledge the need for the consideration of other variables mediating health status effects. Despite these limitations, the current study further demonstrates the need for future studies examining health status and health behaviors among men.

## CONCLUSION

While research studies focusing on health status have been undertaken in the past, this study, with its unique participants, offers exciting new possibilities for the expansion of future research. The current study contributes to the literature in two distinct ways. First, this is a study where respondents were young, affluent, African American men with high levels of masculinity who self-reported their health status. Traditional masculinity would suggest that individuals who possess high levels of masculinity would report a health status of very good to excellent. To report a status of fair to poor health would indicate a sign of weakness. Secondly, high masculine men had a usual source of care, which is seen with men of high socioeconomic status. Therefore, the expected results indicate possible correlations between high masculine men, SES, and health status. Such results duplicate Williams, Yu, and Jackson's (1997) model of race and health.

While our initial hypothesis predicted a negative effect of masculinity on health status, study results revealed that among young, affluent, African American males, low and high masculine men comparable in socioeconomic status, visit a health care provider with the same frequency, and both tend to have a usual source of care. However, research literature examining social constructions of masculinity have demonstrated that men's health perceptions shape their health behaviors over their life course (Chao, Lao, Hao, & Lin, 2012). While age-related masculinity research is not as abundant as research studies highlighting young men, the researchers in this study realize a need for added studies that target high masculinity, health status, and health behaviors in men of varying ages. Moreover, male-centered age-specific health interventions should be undertaken to determine if there exist



correlations between traditional masculinity and health perceptions. Such research could also add value to risk behaviors and health messaging targeting African American men.

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## APPENDIX 1

### Masculinity Assessment Items

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#### Item<sup>a</sup>

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1. If a man hurts himself, he should not let others see he is in pain.
  2. Men who cry in public are weak.
  3. To be a man, you need to be tough.
  4. If a man is frightened, he should try and not let others see it.
  5. Men should be prepared to fight their way out of a bad situation.
  6. A man should take the lead when something needs to be done.
  7. A man's decision should not be questioned.
  8. It is important for a man to take risks, even if he might get hurt.
  9. Men should be detached in emotionally charged situations.
  10. A man should always be the boss.
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<sup>a</sup>Scores determined by three items from the Male Role Norms Inventory (MRNI) and seven items from the Male Attitude Norms Inventory (MANI-II).

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