

Psychosocial Factors That Influence Health Care Use and Self-Management for African American and Latino Men With Type 2 Diabetes: An Exploratory Study

Journal of Men's Studies
2015, Vol. 23(2) 161–176
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DOI: 10.1177/1060826515582495
men.sagepub.com



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Abstract

The purpose of this study was to explore the psychosocial factors that influence diabetes self-management and health care utilization among men of color with type 2 diabetes. Data were collected from focus groups with African American men ($n = 9$) and Latino men ($n = 13$) who were part of a diabetes intervention. Sessions were analyzed using thematic content analysis techniques. Five themes were discussed in focus groups, including (a) social support as a motivator, (b) patient–provider relationships as facilitators of healthy behaviors, (c) immigration status and access to resources, (d) waiting until symptoms became severe before seeking medical attention, and (e) structural barriers. Public health interventions may need to tailor interventions to address the specific needs of men of color.

Keywords

diabetes, men, gender, health care utilization, self-management

Diabetes affects 25.8 million people of all ages and 8.3% of the U.S. population with an additional 7 million undiagnosed cases (National Institutes of Diabetes and Digestive and Kidney Diseases [NIDDK], 2011). Among men, nationally, 12% (or

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13 million) have a diabetes diagnosis, with the highest prevalence of diabetes found in African American men and Hispanic men compared with non-Hispanic White men, according to the Centers for Disease Control and Prevention (Centers for Disease Control [CDC], 2012, 2013). Despite these statistics, men of color continue to have the poorest health outcomes and often go unnoticed in health care system and in health research (Satcher, 2003; Williams, 2003). Research shows that, in general, African Americans and Latinos are more likely to be diagnosed with diabetes and experience complications related to diabetes such as end-stage renal disease (NIDDK, 2014; Office of Minority Health [OMH], 2014a; 2014b). They are also more likely to be hospitalized for diabetes-related complications and have higher incidence of death as a result of diabetes (OMH, 2014). For certain diabetes-related conditions, men of color are at an even greater risk. For instance, African American and Hispanic men are more likely to be diagnosed with end-stage renal failure related to diabetes compared with women (OMH, 2014). Furthermore, African American and Hispanic men are more likely to die from diabetes than women (OMH, 2014). However, efforts to better understand diabetes self-management and health care use in men of color have been few in number (Sherman, McKyer, Singer, Larke, & Guidry, 2014; Williams, 2003).

Although research remains limited, studies of minority populations with type 2 diabetes suggest that factors such as social support, socioeconomic status, and culture play critical roles in self-management and health care utilization behaviors and health outcomes (Gary, Narayan, Gregg, Beckles, & Saaddine, 2003; Sherman et al., 2014). However, a more focused examination of psychosocial factors related to self-management and health care use among African American and Latino men with diabetes is lacking.

African American and Latino Men, Self-Care, and Health Care Utilization

Diabetes self-management is defined as maintaining control of glucose levels, checking for foot-sores and adhering to physician prescribed medication, exercise, and diet regimens (Lindenmeyer et al., 2006). In terms of health care use for diabetes specifically, persons with a new diagnosis of diabetes should receive an initial evaluation and, moving forward, medical care from an interdisciplinary team including physicians, nurses, mental health professionals, and dieticians (American Diabetes Association, 2010). Furthermore, persons with diabetes should receive a blood glucose test administered by their health care provider every 3 months and should see a physician for a follow-up appointment every 6 months, at a minimum, or more frequently depending on stability of the disease (Turner, Williams, Taichman, & Vijan, 2010).

The relationship between gender and diabetes self-management and health care use has been investigated in the literature, but a dearth of research still remains (Liburd et al., 2007; Sherman et al., 2014). In a study of 19 African American men, Sherman, McKyer, Singer, Larke, and Guidry (2014) found that social support from friends and

family played a critical role in facilitating successful diabetes self-management in adult African American men. Conversely, a lack of social support can serve as a barrier to diabetes self-care in men (Chlebowy, Hood, & LaJoie, 2013). In addition, social support has been found in multiple studies to increase medical care utilization (Broadhead, Gehlbach, & Kaplan, 1989; Kouzis & Eaton, 1998). Research has also found that traditional sex roles can impede the acceptance of social support. For instance, in African American men, the need to maintain autonomy can lead men to set limitations to the type and extent of social support they participate in (Liburd et al., 2007).

In addition to the role of social support, studies of gender and diabetes have found that structural barriers can impede prescribed self-care regimens (Cherrington, Ayala, Scarinci, & Corbie-Smith, 2011; Chlebowy et al., 2013). Moreover, for minority populations, a low income can limit access to medical resources (Smedley, Stith, & Nelson, 2009). Differences in diabetes self-care behaviors based on socioeconomic status (or differences in income and employment) have also been recorded for Latinos and African Americans (Figaro, Elasy, BeLue, Speroff, & Dittus, 2009; Levine et al., 2009; Liao et al., 2004). In general, African Americans and Latinos experience higher poverty and unemployment rates and economic barriers than do Whites and other racial/ethnic groups in the United States. (Liao et al., 2004). Specifically, for African American and Latino men, structural aspects of work, such as long work hours and lack of time at work, impeded men's ability to engage in self-care behaviors both on and off the workplace (Cherrington et al., 2011; Chlebowy et al., 2013).

Socioeconomic status (particularly in low-income populations) also created a barrier by limiting access to medications and health care (Liburd et al., 2007; Lynch, Fernandez, Lighthouse, Mendenhall, & Jacobs, 2012). Medical expenditures can range from medication cost, hospitalization, and doctor visits. Medical costs for individuals living with diabetes are 2.3 times higher than for those without the disease, and it is estimated that the total cost of diabetes-related health care will exceed \$174 billion as diabetes rates continue to rise in the United States (American Diabetes Association, 2010). Although the research in this area remains limited for men of color, the current literature reveals that this population faces unique barriers to diabetes self-management that should be explored further. The purpose of this study was to explore the psychosocial factors that influence self-management and health care utilization in African American and Latino men with type 2 diabetes.

Method

REACH Study

Individuals who participated in one of three diabetes intervention phases of the REACH Detroit Partnership (REACH Detroit), between 2002 and 2013, were recruited for the current qualitative study. The intervention was originally developed and implemented with support from the CDC, as part of initial group of Racial and Ethnic

Approaches to Community Health (REACH) initiatives across the country (Giles et al., 2004). The REACH Detroit Partnership aims to reduce disparities in diabetes and related health conditions among low-income Latino and African American living in two communities in Detroit (Kieffer et al., 2004). Each REACH Detroit intervention has been guided by the principles of community-based participatory research (CBPR; Kieffer et al., 2004; Two Feathers et al., 2005; Spencer et al., 2011). Using an empowerment-based approach, community health workers provided participants with diabetes self-management education and regular home visits, and accompanied them to a clinic visit during the intervention period (Two Feathers et al., 2007). For each intervention phase, participants who were at least 18 years of age and had physician-diagnosed type 2 diabetes were recruited from Detroit, Michigan health systems.

Study Sample

The study sample included African American and Latino men, 18 years or older, with a type 2 diabetes diagnosis who had participated in a REACH Detroit intervention were contacted via phone and asked to participate in the focus groups. If a participant agreed to be a part of the focus groups, a formal letter describing the study and location of the focus group was mailed to the participants. The Institutional Review Board at the University of Michigan approved protocols for recruitment and conduction focus groups. 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.

Data Collection

Focus groups are generally comprised 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 min 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 homogeneous group of persons who are not familiar with one another, potentially lowering inhibitions (Krueger, 2009).

For the present study, one focus group was conducted with African American men ($n = 9$) and two focus groups with Latino men ($n = 13$) over a 3-month period. Sessions lasted 90 min and were audio-tape recorded. Focus groups were conducted in community settings (i.e., a community organization and a church) in Detroit, Michigan, and participants received a \$20 cash incentive for their time. Focus groups with Latino men were conducted in Spanish. Focus groups were facilitated by trained focus group moderators experienced with working in Latino and/or African American communities. A research assistant was also present at each focus group to take notes. 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 11-item questionnaire asked, How old are you? Which culture or ethnic group do you

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	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	3	10
No	7	2
Marital status		
Married	6	7
Single/divorced/never married	4	4
Cohabiting	0	1
Number of children		
0	1	1
1-2	4	4
3 or more	5	7
Education		
Less than high school	2	9
High school and above	8	2
Unknown	0	1
Years in the United States ^a		
Less than 15	—	2
15 or more	—	10
Country of origin ^a		
Mexico	—	9
Dominican Republic	—	1
El Salvador	—	1
Nicaragua	—	1
Age settled in Detroit		
Born in Detroit	4	0
1-9 years old	2	0
10-19 years old	3	1
20-29 years old	0	2
30 or older	1	9

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

^aLatino men only.

feel a part of? In what country were you born? How old were you when you first came to live in the United States? How old were you when you first came to live in Detroit?

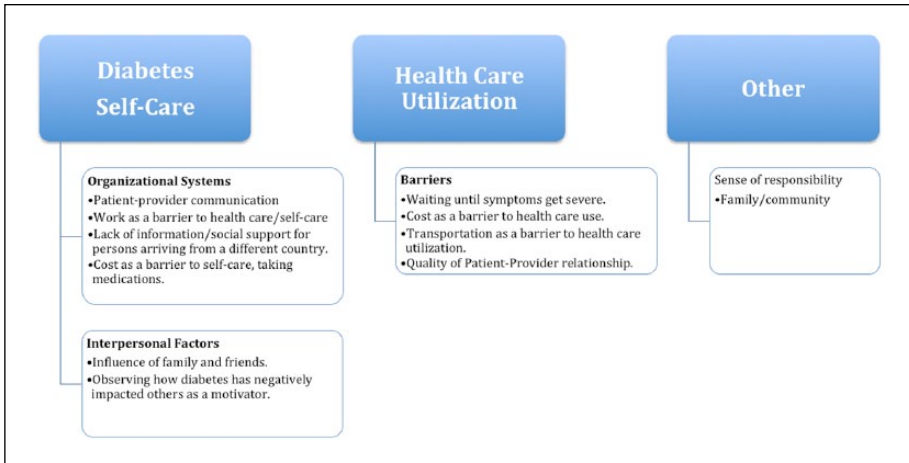


Figure 1. Code and sub-code categories.

What is your marital status? In which language do you feel most comfortable speaking? Which was the last school grade you completed? Do you work for pay outside of your home? How many children do you have? And lastly, how many people live in your home? Specifically, these sections asked, *How has what you learned about being a man from men in your community impacted your decisions about your health?* Men were also asked, *As a man, how do you feel about using diabetes medication? (including insulin and pills)?* For the “health services and health care” section, men in the focus groups were asked, *What could the health care system or your doctor do to make it more likely that men in your community would use the health care services that they offer?*

Data Analysis

Data analysis took place at multiple levels, utilizing a CBPR framework (Minkler & Wallerstein, 2010). 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 group and created a summary document to be used in later analysis. Audio from the sessions were transcribed verbatim, and were analyzed using thematic content analysis techniques. This study identified codes, and engaged in confirming and refining themes using the *rigorous and accelerated data reduction (RADaR)* technique (Watkins, 2014). This technique assisted in coding transcripts for each focus group and in identifying patterns in themes. Furthermore, a codebook was developed that included code definitions and examples (see Figure 1). Finally, code categories were derived from the data (inductive approach) and also from existing literature on men’s health and diabetes (deductive approach; Fortune, Reid, & Miller, 2013).

Results

As stated, a total of 22 African American and Latino men participated in three focus groups conducted in community settings. Code categories and sub-categories emerging from the data can be grouped into three major areas: *diabetes self-care*, *health care utilization*, and *other* (which included what we referred to as “participant initiated points” or “PIP,” in which the participants raised topics that were not asked of them by the focus group facilitators). The PIP had one code “sense of responsibility” with the sub-code of “family/community” (see Figure 1 for codes and sub-codes). Below we report the topics that were the most frequently discussed by the African American and Latino men in the focus groups. Because of the exploratory nature of this study, study themes were generated based on the frequency of the topics discussed. These themes included (a) the role of social support, (b) patient–provider relationships, (c) immigration and access to resources, (d) waiting until symptoms get severe, and (e) structural barriers. Each will be described further below.

Social Support

The first most frequently reported topic was the role of social support and patient–provider relationships in the men’s diabetes health behaviors. When asked how interpersonal relationships influence their diabetes self-management behaviors, respondents discussed the role of social support from spouses and family members. They stated that support from family, specifically children and spouses, was vital in motivating them to engage in self-care behaviors. Significant others and children frequently checked-in with men regarding their health status, suggested they utilize health care when needed, and provided transportation to health care appointments. In describing his relationship with his wife, one man described,

My wife; she’s the one . . . she said “you know what you got so, we take you to the doctor and let them check you out and we gone stick to what the doctor say.”

Another participant stated,

. . . when I feel bad my son and them take me to the doctor. That’s a blessing that you have somebody like that who look out for you.

In addition to family serving as a positive influence in promoting diabetes self-management, respondents also noted that observing how diabetes has negatively impacted others was a motivator. Several of the respondents had close friends and/or family members who struggled with diabetes and diabetes-related complications. After losing a close family member to diabetes-related health issues, one participant noted, “What motivated me was my family and I’ve seen my father went through it and he died from it through complications . . . so I’m still fighting it.” Similarly, another man stated,

What really motivated me was . . . my mother . . . when she passed away [from diabetes] and when I was diagnosed with this I wanted to make sure that I would do what I needed to do to have it under control.

The role of social support in the men's diabetes care and self-management behaviors demonstrates how the negative health consequences of diabetes can propel men into engaging in their own diabetes health management.

Patient–Provider Relationship

Men also identified aspects of patient–provider communication as central to their engagement in diabetes self-management behaviors. When patients had a bad experience with their physician, it determined whether they continued to utilize care. For instance, a participant stated,

If something ain't right about this doctor like you had a reaction or something then you go to another doctor and find out and he'll tell you "he gave you the wrong stuff."

Another man recalled,

My first doctor that tried to treat me for my diabetes, I blew him off because he had a nonchalant attitude.

Respondents mentioned the quality of patient–provider relationships serving as a facilitator to health care utilization. When a health care provider was able to establish a relationship with a patient, it helped to improve engagement with health care. For instance, one respondent stated,

I met this one doctor and he put it blunt straight to me and he said "why are you wasting my time if you ain't gone do this or do that, or follow up with my prescription don't come because I don't want to see you slow me down so if you ain't gone do what you are supposed to do, leave.

In the focus groups, the ways providers communicated with men regarding their diabetes care played a role in whether or not they engaged with health care.

Immigration and Resources

For the Latino respondents in particular, immigrating to the United States, and to an unfamiliar environment, posed a significant barrier to getting health and health care–related resources. They cited a lack of information about where to seek out health care centers. Focus group participants also reported a lack of social support networks for persons arriving from a different country and a lack of a sense of community in the United States. They stated that both these factors significantly impeded their ability to seek out health care. For example, one participant described,

We need more information, yes? Here, we need more information. Because the people that go to CHASS it is because they take us and we don't know them. And when one arrives here and gets sick, one won't go to the CHASS because we don't know.

Another participant explained, "Here there aren't friends like I give to you and you give back to me, no no, here it's everyone to themselves. That's how it is." This demonstrates how some men feel a sense of isolation after relocating to the United States, which has serious implications for how they engage in diabetes self-care and when they choose to utilize health services.

Waiting Until Symptoms Become Severe

Both Latino and African American men stated that they often would wait until symptoms became severe before seeking medical treatment. One participant admitted that he ignored symptoms of illness, until the illness impacted his ability to work: "I am used to working like a machine nonstop so when I got to a point where I couldn't do that, that's what made me finally go to the doctor." Other participants stated that even when time was not a barrier, they opted to not go in for routine doctor appointments. For example, another participant commented,

I want to say that for me if I'm feeling good I don't go to the doctor, even if I have time, unless I'm feeling really, really sick, but until then, I don't go.

This point was illustrated by another participant, who stated,

It's a bad habit in the culture. Nobody goes to the doctor until they're actually feeling pain. Until they can't stand the pain anymore Until you're dying.

For these African American and Latino men with type 2 diabetes, the severity of symptoms directly influenced how frequently they utilized health care.

Structural Barriers

Among focus group participants, structural barriers such as their finances, the cost of medical care, and work served as significant barriers to health care use and diabetes self-management. For instance, high medical fees prevented men from seeking medical care when needed. For instance, one participant noted ". . . here in the United States, many times we don't go to the doctor because we are scared of the bill . . ." Another participant stated that he had to choose between buying food for his family or paying medical expenses, which stopped him from obtaining medical care:

. . . we don't go to the doctor because we don't have money to pay. We don't go to the doctor because having an x-ray done because I broke a bone costs the entire months worth of salary. And I am not going to leave my family without food to go and get some x-rays done.

Respondents also identified cost as a barrier to engaging in diabetes self-management, particularly in relation to taking medications. A participant commented that “. . . sometimes people don't check it everyday at home because the strips are really expensive . . . I don't check it every day because I lack the money.” Another respondent stated “. . . It's a big expense to be checking yourself like the doctor asks.” In this case, men identified a lack of resources for purchasing diabetes glucose screening supplies, a critical component of diabetes self-management regimens.

Respondents stated that work could sometimes serve as a barrier to diabetes self-management, particularly in relation to working long hours resulting in a lack of time to complete prescribed health regimens. One focus group participant stated,

I don't get a chance to exercise as much because of the pain and I am on my feet at work anywhere from nine to ten hours and once I get home and get back on my feet, it ain't happening.

In addition to cost, respondents also cited lack of transportation as a barrier to health care utilization. One participant commented “because I don't have my own vehicle, that is why I haven't made many doctor visits.” Overall, structural barriers made it more difficult for men to participate in their diabetes care and self-management in a meaningful way.

Discussion

The purpose of this exploratory study was to identify psychosocial factors that impact diabetes self-management and health care use for African American and Latino men with type 2 diabetes. Our study identified five main themes: the role of social support, patient-provider relationships, immigration and access to resources, waiting until symptoms get severe, and structural barriers. Regarding diabetes self-care, respondents welcome social support from significant others and family members. Similar to previous studies, this finding identifies the critical role social support plays in successful diabetes management (Rosland et al., 2008; Sherman et al., 2014). The findings show that public health interventions targeting men of color with diabetes should include an integration of the family unit into diabetes health care programs and self-care regimens.

Patient-provider relationships were also identified by the men as important psychosocial factors in diabetes self-care and health care utilization. Previous research has shown that continuity of care and successful communication with a provider are two variables that can improve diabetes self-care and increase delivery of preventative care (Heisler, Bouknight, Hayward, Smith, & Kerr, 2002; Mainous, Koopman, Gill, Baker, & Pearson, 2004; Parchman, Pugh, Noël, & Larme, 2002). Although few have investigated gender differences in persons with diabetes, literature suggests in general that African Americans and Latinos encounter difficulty interacting with health care providers (Peek, Wilson, & Chin, 2009; Smedley, Nelson & Stith, 2002), which can result in adverse health outcomes. One study found that African Americans experience less

shared decision-making when compared with non-Hispanic Whites and that physicians who fostered trusting relationships made patients feel more comfortable participating in their medical care (Peek et al., 2009).

The men in our study had a tendency to wait until symptoms got severe before seeking medical attention and actively engaging in their diabetes care (Liburd et al., 2007) and others argue that traditional male sex roles can impede men's ability to adhere to prescribed health care regimens (Boman & Walker, 2010; Courtenay, 2000). Traditional beliefs about masculinity for men in the United States are typically expressed by a need to maintain independence, strength and a lack of emotion (Garfield, 2008). Therefore, the acknowledgment of illness (in this case, diabetes) directly challenges men's notions of manhood (Courtenay, 2000; Liburd et al., 2007), and can lead men to avoid submitting to physicians as authority figures on health issues and a rejection of care (Boman & Walker, 2010). More research is needed to further explore why men delay both seeking and participating in health care and to identify how to address this in health care settings.

Interestingly, respondents stated that observing how diabetes has negatively impacted others was a motivator. In previous studies, men have expressed concern about the possibility of retinopathy, dialysis, and limb amputation (Liburd et al., 2007; Sherman et al., 2014). Our study shows that seeing friends and family members with these diabetes-related health conditions can actually serve as a motivator to engaging in self-care regimens and utilizing health care. This finding should be explored further and potentially calls for a need to educate men in public health interventions and the health care system about the health consequences of untreated diabetes as a motivator to participate in self-care behaviors.

Cost was also identified as a barrier for both African American and Latino men. African Americans and Latinos in the United States are more likely to lack health insurance and a usual source of care, which can have adverse consequences for self-care practices and health care use (Liao et al., 2004; Smedley et al., 2002). For persons with a diabetes diagnosis, medical expenditures can range from medication cost and doctor visits to hospitalization. Because diabetes can result in considerable economic burden, especially for individuals without health insurance, more affordable treatments should be identified for low-income men in need.

Men also identified a desire to work with other family and community members as diabetes health advocates in an effort to share information about diabetes prevention and treatment. Previous work has found that peer-to-peer health programs targeting men can lead to an increase in positive health behaviors and health outcomes (Holt et al., 2012). Public health interventions targeting African American and Latino men with diabetes should consider incorporating men into the design of the intervention as a strategy for sharing health information.

Race and culture are important factors to include in the development of education programs for men of color. In particular, for the Latino men in our study, immigration status and connection with resources were also identified as barriers to self-care and health care use. Prior research has shown that for newly immigrated Latinos, access to and knowledge of resources can play a key role in self-care behaviors and health care

use (Abraído-Lanza, Chao, & Flórez, 2005; Chong, 2002). Studies of minority populations demonstrate a lack of diabetes knowledge, which may potentially negatively influence adherence to regimens and utilization of care potentially compounding the effects of a lack of resources (Cullen & Buzek, 2009; Sherman et al., 2014; Skelly et al., 2006). Interventions and health care professionals targeting Latino men specifically should consider the role of immigration when treating men for diabetes.

Limitations

In this study, qualitative methodology was used to help enhance our understanding of the psychosocial factors that influence diabetes self-management and health care use among African American and Latino men with type 2 diabetes in a Midwestern urban setting. Although these findings may potentially be applicable to other urban, Midwestern men of color, it is not possible to generalize on a national level. However, the findings in this study should be used as a springboard for future research to develop a more comprehensive picture of psychosocial factors that influence diabetes self-management and health care use in men of color. In addition, while the purpose of this study was to explore psychosocial factors for men of color, future studies may benefit from disaggregating by race/ethnicity to explore the racial and cultural indicators of psychosocial factors that influence health care utilization and self-management in men of color.

Conclusion

Our findings strongly suggest that men of color with type 2 diabetes encounter significant challenges to maintaining optimal health. The present study helps to elucidate some of these challenges but also highlights key mechanisms that help to facilitate diabetes health management behaviors in an at-risk group of men. To successfully address the psychosocial factors that both impede and facilitate African American and Latino men's ability to manage their diabetes and to utilize health care, public health interventions for men living with type 2 diabetes should consider tailoring programs to the specific and unique needs of men of color. Education programs perhaps using a peer-to-peer model may serve as an efficient way to communicate health information.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This research was supported by the National Institute of Diabetes and Digestive and Kidney Disease (Grant R18DK0785501A1), Centers for Disease Control and Prevention (Cooperative Agreement No. U50/CCU417409), the Michigan Diabetes

Research and Training Center (NIH Grant 5P60-DK20572), and the Robert Wood Johnson Foundation Clinical Scholars Program.

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Edith Kieffer, MPH, PhD, professor, School of Social Work, University of Michigan, conducts community-based participatory research (CBPR) addressing health and health care disparities.

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