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An Investigation of Health Management Perceptions and Wellness Behaviors in African American Males in Central Texas

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Abstract

Little is known regarding interventions that incorporate health management perceptions among African American (AA) men, to reduce the risk for developing various medical conditions. Using the Theory of Planned Behavior (TPB), the study objective was to better understand health-care perceptions of AA men by assessing participants' attitudes, subjective norms (SNs), and perceived behavioral control (PBC) regarding health management. AA adult males in Texas were recruited to participate in one of four qualitative focus groups. The TPB was used to assess participants' attitudes (advantages/disadvantages), SNs (approvers/disapprovers), and PBC (enablers/barriers) regarding health management. All four sessions were audiotaped, transcribed, and independently analyzed by researchers to identify major themes. Participants ($n = 23$) were 45.2 $\pm$ 16.2 years of age (range 24–74). Regarding attitudes toward health management, participants viewed increased longevity and avoiding future health problems as advantages; however, increased cost, lack of confidence in health care, and social pressures were disadvantages. Regarding SNs, parents and children were positive influencers, while spouses and coworkers were both positive and negative influencers. For PBC, a support system and health awareness were identified as enablers, while medical mistrust, fear, and culture were barriers. The results convey that health management behaviors in AA males are multifaceted. Health-care providers should seek to understand these factors, discuss these issues with AA males, and integrate treatment strategies that are culturally informed and patient centered. Findings from this study may be used to develop targeted interventions that improve health outcomes for AA males.

Keywords

health management, African American, men's health, theory of planned behavior

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In the United States, life expectancy for men is, on average, 5 years less than that for women (Mimino, 2011; Miniño, Murphy, Xu, & Kochanek, 2011). African American (AA) men have an even lower life expectancy with an average life span of 5.5 to 10.3 years less than their racial and ethnic counterparts (Mimino, 2011). AA men suffer a disproportionate burden of preventable morbidity and mortality in the United States. Indeed, AA men are nearly twice as likely to have a stroke and more likely to die from heart disease than Caucasians are (Centers for Disease Control and Prevention [CDC], 2015a; Mozaffarian et al., 2015). Over the past 15 years, advancements in medical technology and public health initiatives have contributed to a decrease in premature deaths primarily due to decreases in mortality related to heart disease, cancer, and HIV (Shiels et al., 2017). Despite this, AA men still maintain higher rates of death when compared to their White counterparts (Mimino, 2011; Miniño et al., 2011; Shiels et al., 2017). According to the CDC, AAs have the highest death rates from ischemic stroke and hypertension (CDC, 2015b; CDC, 2012–2014). Non-Hispanic Blacks have the second highest age-adjusted

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percentage of individuals with diagnosed diabetes (U.S. Department of Health & Human Services, 2014). AAs have the highest prevalence of obesity than other races/ethnicities at 47.8% (Ogden, Carroll, Kit, & Flegal, 2013). These disparities translate into increased morbidity and mortality rates for AA men.

Health management activities, such as eating healthy, engaging in physical activity, medication adherence, and seeking care, are important to prevent, delay, and/or manage health issues (Pace, Dawkins, Wang, Person, & Shikany, 2008; Thorpe, Bowie, Wilson-Frederick, Coa, & Laveist, 2013). Health management behavioral and lifestyle changes have been effective at reducing adverse health events among minority males (Stuart-Shor, Berra, Kamau, & Kumanyika, 2012; Thorpe, Wilson-Frederick et al., 2013). The literature shows that AA men do not routinely do the following: rely on others, engage in seeking out health information, or follow up on health care appointments (Griffith, Gilbert, Bruce, & Thorpe, 2016; Hooker, Wilcox, Burroughs, Rheaume, & Courtenay, 2012; Parker, Hunte, Ohmit, & Thorpe, 2016; Sanders Thompson, Talley, Caito, & Kreuter, 2009). The literature has shown that AA men perceive several advantages of healthy lifestyle practices (e.g., diet and exercise), including improved overall health and increased productivity (Hooker et al., 2012; Long, Ponder, & Bernard, 2017).

Health management and prevention are impacted largely by patients' attitudes and beliefs about health, particularly what they perceive as advantages and disadvantages of engaging in healthy behaviors (Feldman & Fulwood, 1999; Long et al., 2017; Thorpe et al., 2015). Several qualitative studies have provided insight regarding AA men's health management beliefs, ideology, and attitudes (Feldman & Fulwood, 1999; Long et al., 2017). One study showed that AA males perceived that masculine responsibility and perseverance were related to self-reliance and self-care behaviors, which could contribute to delays in help seeking (Hooker et al., 2012). Other studies indicated that AA men have low perceived illness severity, which can lead to a high threshold for taking action when ill (Long et al., 2017; Pace et al., 2008; Sanders Thompson et al., 2009). Additionally, AA men's perceptions of discrimination in the health-care system negatively affect their health management behaviors (Feldman & Fulwood, 1999; Rickles, Domínguez, & Amaro, 2010). Several studies have identified social support as both a facilitator and barrier to self-care behaviors among urban and rural AAs (Bopp et al., 2006; Dickson, McCarthy, Howe, Schipper, & Katz, 2013; Hooker et al., 2012; Thorpe et al., 2015). One type of social support, spirituality and engagement with religious communities, was shown to influence health behaviors (Bopp et al., 2006). AA men noted that spirituality was an important component of managing their health and that they often sought approval to engage in health-related activities from church and/or communities (Bopp et al., 2006). Other studies showed that AA men identified family and community expectations regarding dietary habits to be a barrier to self-management (Bopp et al., 2006; Dickson et al., 2013; Long et al., 2017). Specifically, culturally embedded expectations and cooking styles (e.g., fried and high-fat foods, sugary desserts) made it difficult to maintain healthy diets (Bopp et al., 2006; Courtenay, McCreary, & Merighi, 2002; Hooker et al., 2012; Long et al., 2017). A better understanding of attitudes and beliefs may facilitate health-care professionals' efforts in working with and improving health outcomes of underserved groups, specifically, AA males.

Although not specifically focused on AA men, studies have identified the following barriers to health management engagement among men: below average socioeconomic level, poor access to health care, and uninsured status (Rickles et al., 2010). Among AA men, discrimination, lack of trust, and low perceived quality of health care have also emerged as barriers to engaging in healthy behaviors (Hooker et al., 2012; Long et al., 2017; Rickles et al., 2010).

To address improved engagement in health management activities and to develop interventions tailored to AA males that may lead to decreases in preventable death in AA men, it is important to understand their attitudes, influencers, and barriers to pursuing health management activities. In light of the factors and issues that have been identified in the literature, the Theory of Planned Behavior (TPB) was selected as a framework for the study objectives, which are to understand the attitudes (advantages/disadvantages), SNs (approve/disapprove), and PBC (enablers/barriers) of managing health among AA men (Ajzen, 1991).

Methods

Sample, Setting, and Recruitment

A convenience sample of adult AA men were recruited from a large central Texas AA Baptist church (>2,500 members). Participants were recruited through leadership in the church, word of mouth, and flyers. This study was approved by The University of Texas at Austin Institutional Review Board. All study participants provided written informed consent.

Focus Group Guide and Brief Survey

This exploratory study utilized qualitative focus group methodology to address the study objectives. A moderator guide was developed using the TPB as a guiding framework (Appendix A). The TPB posits that behavior is determined by a person's attitude (beliefs about the behavior), SNs (important others' opinions), and PBC

(perceived degree of control they have over the behavior) toward that behavior (Ajzen, 1991; Montano & Kasprzyk, 2015). Focus group participants were asked open-ended questions adapted from the TPB to assess their attitudes, SNs, and PBC regarding health management and medication adherence (Ajzen, 2002). Participants were also asked about their attitudes toward and interactions with pharmacists. Finally, participants were asked to complete a brief survey regarding metabolic syndrome–related diagnoses (hypertension, high cholesterol, diabetes) and clinical knowledge of relevant metabolic syndrome values (blood pressure, blood glucose, body mass index, body fat percentage). Only results regarding health management perceptions are presented here. In return for their participation, participants were given a $25 gift card at the conclusion of the focus group.

Data Collection and Analysis

Four focus group sessions were conducted in February 2016 in Austin, Texas. Focus groups were conducted until saturation was observed among responses in focus group sessions. The primary researcher (CAN) moderated each focus group session with a trained assistant moderator and notetaker. The moderator, assistant moderator, and notetaker were all AA males. All sessions were audiotaped and subsequently professional transcribed by a third party. During each focus group session, the moderator and the assistant moderator took brief written notes on the note-taking moderator guide forms to refer back to during the data analysis process. The written notes on participant nonverbal communication were analyzed by CAN and another member of the research team (BAB) and were determined to be consistent with the transcript data. For each topic of open-ended questions, a number of relevant themes identified in the literature were utilized as prompts in the few instances where participants asked for question clarification during the discussion. Using a deductive approach, thematic analysis was used to examine the data and to identify primary themes. CAN and BAB independently analyzed the transcribed data and written notes and compared results. BAB, an AA female and was not involved in facilitating the focus group sessions. Differences were resolved through discussion that continued until consensus was reached over the course of six in-person meetings throughout the coding process. Data were analyzed through multiple reviews of transcripts where recurring concepts were labeled as codes. Similar codes were then grouped into larger categories, which were then analyzed for themes (Attride-Stirling, 2001; Boyatzis, 1998; Braun & Clarke, 2006). The main themes regarding attitudes, SNs, and PBC were documented and the two researchers collectively included and listed the most representative theme.

Table 1. Demographic and Clinical Information ($N = 23$).

Demographics	*N*	%
Age (years), mean (*SD*)	45.2 (16.2)	
18–30	6	26.1
31–45	5	21.7
45–59	6	26.1
60–75	6	26.1
Weight (BMI, kg/m^2; measured[a])		
Normal, 18.5–24.9	7	31.3
Overweight, 25–29.9	10	43.8
Obese Class 1, 30–34.9	6	25.0
Medical conditions (self-reported)[b]		
Hypertension	6	26.1
High cholesterol	3	13.6
Diabetes	2	8.7
Physician visit in 6 months[c]		
Yes	18	82.2
No	4	17.8

Note. BMI = body mass index.
[a]Total may sum to more than 100% due to rounding. [b]Some reported more than one medical condition. [c]Total may not equal 23 due missing responses.

Results

Demographic and Clinical Characteristics

A total of four 90-min focus group sessions ($n = 23$ participants total) were conducted with men who self-identified as Black or AA. Participants ranged from university students to retirees and were between 24 and 74 years with a mean age of 45.2 ± 16.2 years. Almost 70% of the participants were either overweight ($n = 10$; 43.8%) or obese ($n = 6$; 25.0%). Less than 30% of the participants self-reported being diagnosed with hypertension ($n = 6$; 26.1%), high cholesterol ($n = 3$; 13.6%), or diabetes ($n = 2$; 8.7%), and 82% ($n = 18$) of participants had visited a physician in the past 6 months (Table 1). With regard to blood pressure, cholesterol, and blood glucose, overall, Table 2 shows that the majority of participants reported that they did not know their values ([$n = 16$;72.7%]; [$n = 15$; 68.2%]; and [$n = 16$; 69.6%], respectively). Table 2 also shows that approximately one half of participants reported having knowledge of their body mass index ($n = 11$;47.8%) and their body fat percentage ($n = 12$; 52.2%).

Attitudes Regarding Health Management

Table 3 provides a summary of themes and subthemes elicited from the focus groups. Several themes emerged from the focus group sessions regarding attitudes (advantages and disadvantages of managing health), SNs (individuals or groups who would approve or

Table 2. Knowledge of Metabolic Syndrome–Related Clinical Values ($N = 23$).

Clinical measurement	*N*	%
Blood pressure[a]		
Yes	6	27.3
No	16	72.7
Cholesterol[a]		
Yes	7	31.8
No	15	68.2
Blood glucose		
Yes	7	30.4
No	16	69.6
Body mass index		
Yes	11	47.8
No	12	52.2
Body fat percentage		
Yes	12	52.2
No	11	47.8

Note. Question posed: "What was your last <clinical test> result?" Yes = respondent provided a response; No = respondent checked "I don't know."
[a]Total may not equal 23 due missing responses.

disapprove of health management), and PBC (factors or circumstances that would enable or make health management more difficult). Following is a detailed discussion of the findings.

Advantages of health management. Two unique themes emerged as advantages of health management, including longevity and avoiding future health problems. The initial theme that emerged from the interviews was the desire to live a long life. Participants noted that an advantage of health management behaviors was "increased longevity," which enabled them to have "a longer life experience" and to support loved ones and family members. Most participants believed that managing their health enabled them to model good behavior and manage responsibilities with respect to their families.

> *I think it's very evident to do the things that you need to do to be healthy just because you have people in this world who look up to you, you have responsibilities to look out for . . . to take care of all of those things you have on your plate. . . . You want to try to live healthy, lead a healthy life to help other people to be there for other people.*

> *A healthy husband, a healthy father is there to interact with his family in the long run. It's all about benefits to the ones whose lives you affect.*

A second advantage of health management activities that emerged was avoiding future problems. Several participants believed health management could result in decreasing future health-care spending. They also emphasized preventative health management activities, such as "exercising, [getting] enough sleep and enough water," as ways to avoid future health complications. Some participants noted a direct relationship between early or preventative health management and fewer health issues in the future.

> *It's huge to monitor [health] early, catch it early. And that's why I believe in, you know, monitoring and taking care with the doctor because it prevents cost.*

> *Avoiding the cost of having to control or maintain diseases. Less costly for me to exercise now than to, you know, have to take medication every day and pay for that. As well as doctor's visits.*

> *I know I want to minimize a lot of those little things [complications]. I don't have to go to the doctor for high blood pressure and things like that. And that's one thing . . . I try to eat healthier on a daily basis.*

When discussing avoiding future complications, some participants used the context of their family medical history as a motivating factor to engage in preventative health management.

> *I recognize early on, from my watching family members, was my family suffers from diabetes also and overweight and coronary disease, and I recognized early that if I didn't do it [manage my health] that as one of their descendants that that was going to be my consequences. . . . I think, when you recognize that—that something can happen to you, and it has happened to people that you love dearly, and you can avoid it.*

Disadvantages of health management. The following themes emerged as disadvantages of health management: costs associated with improving health and healthy lifestyles; impact of aging on health; lack of confidence in health care and health-care professionals; time constraints; and social pressures. The initial topic of discussion focused on costs and the financial investment required for health management. While the high costs associated with health care were discussed as a disadvantage, participants focused the majority of their discussion on issues associated with the high cost of purchasing healthy foods.

> *The only disadvantages to managing your health would be economics. There are a lot of African Americans that don't have health care, they can't afford to manage their health, they can't afford to buy the fresh vegetables and the fruits and the organic foods and the meats that they aren't filled with steroids and antibodies or whatever they are called.*

Table 3. Major Focus Group Themes and Subthemes Derived From the Theory of Planned Behavior Regarding Health Management.

Major themes	Subthemes
Attitudes	
Advantages of health management	1. Longevity 2. Avoid future health problems
Disadvantages of health management	1. Associated costs 2. Impact of aging on health 3. Lack of confidence in health care and health-care professionals 4. Time constraints 5. Social pressures
Subjective norms	
Individuals who approve of health management	1. Family/loved ones 2. Friends 3. Coworkers
Individuals who disapprove of health management	1. Family/loved ones 2. Friends 3. Coworkers
Perceived behavioral control	
Health management facilitators	1. Support system 2. Provider ethnic concordance 3. Health awareness/knowledge
Health management barriers	1. Competing priorities 2. Access and environment 3. Medical mistrust 4. Fear 5. Culture 6. Youth and aging

They can't afford to eat healthy, they have to eat on the lower end of the food scale. . . . Who has time to think about eating right or managing their health when their number one priority is trying to pay rent and trying to buy food in the best way they can for their family? Disadvantage.

I mean financial. If you go to the store, I mean you should see the candy section. You know three or four dollars can get you three candy bars, but you go to the fruit section, and you're spending $5. So yeah, it is kind of frustrating on the financial aspect of it. Or, if you go to a fast food place, you can get you a little $5 fries, soda, everything for $5. But go somewhere healthy, and you're spending about $10. [It] becomes very expensive. . . . I can get a little bit frustrated with myself. Like how much money I'm spending on my health.

Second, another disadvantage of health management was the impact of aging on health. Participants discussed challenges with reconciling that as they age, more effort may be needed to get similar health results.

I think that if you are unable to meet your standards or some people go through depression because they . . . used to look like this when I was 20 and now I'm like 46, I don't look like that anymore. . . . My mom is a prime example. . . . She's trying to eat healthy, but yet—I mean physically she can't because it's her body and how it is right now.

I think one of the disadvantages and we take it for granted, I know when I was younger I can eat a whole bag of chips and more cookies and not even worry about gaining weight. And then go play a couple of games of basketball and it's gone. Now, I'm older, I can't eat the whole cookie. It is going to be affecting, and you just take it for granted.

The third disadvantage that emerged from the focus groups was lack of confidence in health care and health-care professionals. Participants noted negative experiences when seeking health care where they were either misdiagnosed or they did not receive a diagnosis.

I think the one thing that you missed—is also the disadvantage is lack of confidence in an actual doctor. I mean, I've been to the doctor before and they didn't tell me what was wrong. I had to go back, back, back.

You go and lose confidence in the doctor, I can guess myself what's wrong with me.

Other participants described uncertainty associated with medications: *"Now I'm spending my money, and I'm spending my time, and they may put me on some drugs that may help me, they may not help me, may hurt me."* These experiences created uncertainty regarding

health-care systems, which in turn, negatively impacted health management behaviors.

Fourth, time constraints regarding health management activities were also described as a disadvantage. Participants believed health management activities were time-consuming. Some participants primarily focused on healthy eating and exercise.

> *I think one of the most important things about eating healthy is that you have to cook your own meals and that is time consuming. You have to spend most of Sundays preparing what you're going to eat for the week and then if that doesn't last through the week you have to have time again to prepare more meals. So all of that is very time consuming.*

> *This is like a disadvantage to [managing your health] but there's constraints that people are under, right, and then even when it comes to like working out, eating healthy like that takes time, right, so you only have a certain amount of hours in a day, right, and so you just have to work within those constraints.*

Finally, social pressures were identified as another disadvantage of health management activities. Participants described how engaging in healthy eating habits conflicted with their families. They explained that departure from familial dietary habits resulted in alienation and a "disconnect with family." This loss of social support may have a negative impact on AA men changing their dietary habits.

> *When I go home for Thanksgiving or Christmas, I barely eat anything. Because it's like I'm not eating that. And I mean you put the hog maw and the grits and all that stuff like that. I don't eat that kind of stuff anymore. I mean I'll eat it now and then; it will be like small portions. I mean, I can't have this huge plate of food anymore like I did in elementary school, and that's going to disconnect me from my family, now. Oh you went to Austin, now you won't eat our food no more. Things like that. So I mean you won't eat Grandma's greens no more. . . . And so I have a conversation that says I eat like this for a reason. And I mean I see all those pills you have in your cabinet. So that's a disadvantage I have is like the disconnect with family.*

SNs Regarding Health-Care Management

Individuals who approve of health management. Regarding those who would approve of their health management, participants identified family and loved ones, friends, and coworkers and employers. Generally, focus group participants primarily identified their family and loved ones as groups who would approve of their health management. Participants believed that those who they engaged in intimate relationships with approved of their health management because of its potential to prolong their life and achieve a better quality of life.

> *We think about health and we think about family first. Our family wants us to be healthy. Our family wants us to be around.*

> *I would think about the folks who are closest to me who would ultimately have to support me if my health failed. And for those people, I want to keep my health to the best of its possibility, because I know it's—the people who love you the most who are ultimately going to have to deal with you. If you can't function, . . . those people, I'm sure, are encouraging me to be as healthy as possible.*

Participants also identified individual family members who would take a particular interest in their health including their significant others, children, and parents. Specifically, participants described these specific family members as monitors of both good and bad behavior and as individuals who remind them to manage their health more appropriately.

> *I've been dealing with some health issues the last couple of months, and my mother is always like you know make sure you . . . make sure you take them (antibiotics). Make sure you finish them. Make sure you're not drinking—yada yada.*

> *"My fiancé. . . . I work out and have an active lifestyle, but when I met her, she was pretty good about the diet aspect of it, and what is cool is that you know she goes "I don't mean to try and be hard on you, baby, but you know I want you to live long. I want us to live—I want you to live longer." And I respect that, because now it's like okay watch your carbs. Watch the sugar. —I never really read the labels when I eat. . . . But her kind of doing that for me kind of makes me conscious.*

> *My son, he watches me—because I exercise on a regular basis. And he'll even tell me that he sees me going harder at that peach cobbler, but he's like 'Dad, you ate half a peach cobbler," . . . so he'll call me on that. He'll challenge me on that, on my eating habits. . . . So yeah, from a son perspective, my son monitors me. And I appreciate that, too. You know, he monitors—he helps me monitor when I'm getting out of control because sometimes if it's good, I'm going hard, and he'll cut me off.*

Participants described their inner circle of friends as a group that would approve of their health management activities. These friends served as peers in health management activities (e.g., exercising together) and often provided peer support. Some men recounted times when their inner circle of friends promoted their healthy living habits.

> *My friends have a big influence on me, you know, like I have a lot of friends I work out with, you know, like my*

buddy hit me up this morning, like "Hey, let's go to 24 and hit the gym." Most of my guy friends are fairly active, you know, like Saturday I try to play football, we play basketball or something like that, you have peer group, birds of a feather, right, so like it definitely—you don't want to be the scrub in the group who is weak, if your friends are about that life like you're probably going to be about that life. So this thing I also believe you interact with, you know, especially when you're younger like your peer set is important.

I was in the Air Force back in 1983 through 1987 and . . . there were three gentlemen that I was friends with, and we we're still brothers. When we were young airmen, we never talked about health concerns or health issues, it wasn't even a factor. We didn't say to one another "Man did you go to the doctor, did you get your cholesterol checked?" That wasn't our mindset, but now that we're all three still here in Austin and we're all still brothers and we're all about the same age we talk about those things . . . now we're giving each other doctor advice and talking about "Did you get your prostate checked this year?" and "How is your cholesterol? You still taking your pills man?" You know, those are our conversations and we encourage each other to continue to manage our health.

Finally, participants identified their employers and coworkers as individuals and groups who support their health management. This support was typically viewed in terms of a benefit to the coworker or the company. Participants shared that some employers even provide incentives for employees to check their health status for the company's benefit.

Co-workers. If you're not on the job that—how can I put this—requires specific tasks and you're a part of that task, if you are out, somebody working with you is going to have to take up that slack. And they're doing their job plus part of your job, or maybe all of your job. So your co-workers would be, you know, glad you take care of your health because of absences.

Even your employer wants you to manage your health. My company is a huge advocate of health, they've built a gymnasium, two gymnasiums there on campus, walking trails, health checks regularly, in-plant nurse for blood pressure checks whatever you need, eating programs. So they're a huge advocate because it's a benefit to them. A healthy employee is a less expensive employee.

Individuals who disapprove of health management. Interestingly, participants in the focus groups shared a dichotomy about those who disapprove of health management. Participants also identified family and loved ones, friends, and coworkers as groups and individuals who would disapprove of their health management activities. As with individuals who would approve, participants overwhelmingly identified family as a group who would disapprove of their health management activities. Disapproving family members subscribed to a different view of health and healthy behaviors and thus were judgmental of health management activities.

I have other family that would not approve, so much, because they see me as too young to care . . . about it. . . . You know it's my old-school family. (Saying) "Man you need to eat more."

As a kid and young man you know my grandmother would feed me anything sitting on the table that she cooked, but you know now that I've gotten older I realize that a lot of that was bad for me.

Another interesting dichotomy presented by the participants revolved around spouses who would discourage healthy habits of their male partners, due to egocentricity.

I've seen a relationship where somebody was discouraged, you know, their spouse from getting in shape, you know, because they think that they're going to start looking good, feeling good or something and they might leave them, you know, they got some issues. You know, so they ain't on board with it, they try to discourage them like hey, eat some more of this, eat some more of that or some stuff like that.

Participants recounted that friends within their inner circle would act as barriers in their pursuit of daily wellness actions. These barriers involved peer pressure or assertions that personal restraint was not required around their peer group.

In terms of putting other negative things in my body, I would probably say like friends going out drinking . . . yeah there's always a reason to drink more when you're out with your friends. . . . And ultimately you can eat as healthy as you want, but if you go out drinking, all those calories, all that sugar, all that stuff, fills right back into your body.

Notably, coworkers were perceived to act in opposition to the participant's health habits specifically in relation to eating habits in the workplace.

My co-workers. They'll see me like I'll pack a salad or something for lunch, and they are like "Why are you eating salad?" I said "Look, I'm trying to make—I'm trying to be fit." They'll joke about it.

I think in terms of negative eating habits, I think co-workers, because it's almost like if everybody is doing it—then nobody feels guilty about it. . . . So I would say that that's where I most get disapproval and—I would be influenced.

PBC Regarding Health Management

Aspects that enable the management of health. Three unique themes emerged as factors and circumstances that would enable participants to manage their health: support system, provider ethnicity concordance, and health awareness. Most participants reported that they were more inclined to engage in healthy habits when they could rely on a support system that promoted them. Participants emphasized the need for networks of support, outside of health professionals, to inculcate improved health status in men.

> *I want to think having some kind of support system, buddies or friends who have that same condition. Working together supporting each other trying to help yourself get to a better state. Having that definitely helps even mentally. Enabling you and trying to take medications properly or living a better life and helping you or people by you with the same thing. They know what you're going through and so they can support you back and forth and move from there. It's a support group that helps you, I think.*

> *I have to go back again to my wife. Like I said, she's just totally re-arranged, just like, I can't find anything. Matter of fact, I can't find it because it's not there anymore because she totally re-arranged my eating habits.*

A common theme that permeated multiple focus group sessions was the desire to have providers of color or ethnic concordance with their physicians (i.e., AA providers). Participants described an increase in trust and relatability when they engaged with doctors of color. This improved patient–provider relationships, which would then serve as motivation for men to engage in health management.

> *Additionally, this is a high level reason why I'm so regimented with my medications and following my medical advice because my doctor is a man of color and I know that he has my best interest at heart. So he's not going to tell me anything that is not going to benefit me, man of color to man of color. So that adds a level of trust for me.*

> *One of the things that I've found out to allay the fears of going to the physician is finding someone of color. I've got a black general practitioner, and I got a Hispanic, um, coronary doctor that I go to. And – and the way that they explain things. The way that they interact with me – the relationship. I think we have an opportunity to find someone that looks like us, talks like us, give us information like us, so that we can feel more comfortable accepting the information, you know. So I think that's critical.*

Participants also expressed that awareness surrounding diseases that affect AA men and potential outcomes would increase preventative health behaviors and health management behaviors among AA men.

> *Yeah just understanding stuff, right, like maybe your susceptibility to a particular disease and all those things probably play a role and kind of enabling you to manage your health better.*

> *I would say for me, awareness, just knowing stuff ahead of time, allows you to prevent some stuff down the line. So I think that's a big motivator for me just being aware of what could happen. Trying to prevent something from happening allows me to really be proactive with you know what I eat. You know exercise or specific things on what I do, just on a daily basis, in life wherever you input it's got to output. . . . That was real good for me just being aware.*

Aspects that make it difficult to manage health. Competing priorities; access and environment; medical mistrust; fear; culture; and youth and aging were the six unique themes that were identified from participants as factors and circumstances that would make it difficult to manage their health.

When discussing factors that made it difficult to manage their health, participants often highlighted conflicts between managing their health and competing priorities such as school or work. They discussed these competing priorities in relation to time management, finances, and life balance. One participant explained, "So it's just finding time to work out and exercise in addition to diet." In instances when participants were unable to find time, they recounted not following up on basic health care activities due to the significant demands of work life.

> *There have been times when I've postponed dental appointments, postponed eye exams, postponed my doctor's appointment a couple of times because my priorities at work had to be taken care of even though I schedule that time to go to my doctor's appointment. In the real world when I have to get this proposal done and I have a deadline, the government's waiting on me I'm like, you know, I can't go to the doctor.*

> *[I] think for a lot of folks, lose their health consciousness when . . . financial concerns become too much. Like with the work, family, or financial, when you spend most of your time and energy focusing on that.*

> *And the thing is whatever can cause you the most harm the fastest is what you prioritize. So like a job or school, you're going to put that over your health because your health usually leads to harm later in life and—yeah your diet and exercise going to hurt you later in life typically rather than like in the next couple of months. But if you don't do your assignments or do your work the next couple of months*

you're out of job, you're out of school. So it's just delayed versus instant harm.

Focus group members noted that environment and accessibility to health and wellness resources may serve as a barrier to health management for AA men. Participants explained that physical locations and neighborhoods where AA men live and access issues related to provider availability and insurance coverage can prevent health management activities.

I think accessibility to information to our health care period. It has to be accessible and an example of that is, if I call my doctor and they tell me they can't see me for a month, then I might blow it off.

Your level of access to resources, right, you might be in the neighborhood that doesn't have a lot of doctors, you know, or has a hospital that's far away.

Another theme that emerged as a factor making it difficult for participants to manage their health was medical mistrust. Participants viewed health-care providers as interested in money and not in the health of their patients.

Think about why your doctor gives you the medication he gives you. The kickback he gets for giving you that medication. The referrals that he refers you to, the next guy that he gets to kick back.

I think to my experience, not health, but where I went to the dentist, I haven't been to the dentist in a long time. I went to the dentist. There's one dentist that [said] "Hey—your teeth look terrible, and they're going to fall out and you know there's nothing we can do." I'm like wow. And you know but I went to another dentist and [he] said "Hey we can do this for you." So - you know I can understand what he's talking about. You go to the doctor or something, you know. It . . . it does create a trust factor. You're like all right, what are you trying . . . you trying to get more off of like my insurance by trying to help me.

Fear of potential bad news was also highlighted as a factor that makes it difficult for participants to manage their health. Fear was specifically linked to the desire to avoid doctor visits and appointments.

I think the other thing is, like, sometimes you're afraid of what you'll find out. I think that even when you engage with the doctor, you engage with, you know, a health professional or something, they may tell you something that is going to change the rest of your life. I used to work at MD Anderson Cancer Center and I would hear people who were right about to retire, and found out they had cancer. And it's, like, you worked all your life to get here. And, like, to get where you don't have to work anymore, and you find out, like, like, this is about to be the hardest thing you had to do in your life . . . and you're, you know. And so I think . . . I think there's some trepidation with going to a doctor and finding out, like, what . . . what's there.

Fear is one of the biggest contributors—I think is one of the biggest contributors. You don't want to know. And if you don't want to know, then you think everything is okay. . . . But I think fear is one of the biggest contributors to people not wanting to manage—fear and time.

Focus group participants noted that their cultural surroundings related to tradition and disclosure sometimes had a negative impact on healthy behaviors.

You know, you see that in our culture, you know, people eating stuff, putting stuff on there, you know, eating all kind of stuff that—they can make healthier choices and like I said making a lifestyle change is not something that you get on and off the wagon, this is for life.

Because you never know. And like . . . I feel like black people in general, especially my family in Beaumont, they don't talk about their health at all. You know I didn't even know someone had brain cancer and they died. I mean . . . I mean it's just like we need to know these things so we can prevent them or if not be prepared for them when they happen.

Finally, potentially due to the varying participant ages in this exploratory study, two main ideas surrounding age emerged from the focus groups. First, there was a notion that in youth, health is not a concern or focus. Second, older participants shared that aging can sometimes limit physical activity.

At my age I don't really feel like that's [health management] something I should be worried about as much. Whether true or false, it's just kind of my mentality, yeah it's just kind of my mentality, you know.

I remember when I didn't, especially when I was younger. It was like, why? I can go through a brick wall, I'm in perfect health.

I guess as soon as your body breaks down. I mean I like playing tennis. I know when I get older my knees are not going to be like they are now . . . but I mean you have to supplement something. So if I can't play tennis anymore, what can I do to keep my sort of weight down and keeping healthy? And I think we all have to realize that your body will eventually break down, regardless, and we can't continue to do the same thing we're doing . . . and just find another avenue of trying to stay healthy.

Discussion

AA males are at high risk for several health conditions, leading to poor health outcomes. In our study involving the health management of 23 AA males, our four focus group discussions aimed to understand their perceptions, which may provide valuable information regarding health management. The present study adds to the limited qualitative literature regarding AA men. Use of a theoretical model in this study allowed us to holistically capture various beliefs and attitudes of AA men in a single study versus individual aspects throughout several studies. Additionally, the diversity of age (range: 24–74 years) in our sample uniquely contributes an analysis of health management in AA men across phases of life and the age spectrum. This information may be used by health-care providers when interacting with this population of patients. The following is a discussion of the findings.

Attitudes Regarding Health Management

The qualitative data related to attitudes revealed that AA men valued longevity and avoiding future health problems as advantages of health management. The main advantage of engaging in health management activities seemed to stem from their internal desire to fulfill familial responsibilities for the benefit of their loved ones. Our findings contribute to the limited literature reporting positive perceptions of health management related to longevity and avoiding future health problems (Dickson et al., 2013; Griffith, Brinkley-Rubinstein, Bruce, Thorpe, & Metzl, 2015; Hooker et al., 2012; Long et al., 2017). Our results are supported by a study of AA patients (male and female) with heart failure who believed that controlling their condition would enable them to increase their longevity via their health actions (Dickson et al., 2013). A study conducted in Michigan uncovered that AA men's perceived ideal health is codified in the ability to be supportive and accomplished (Griffith et al., 2015). Hooker and colleagues discussed similar themes for AA men, linking longevity to healthy eating and doctor visits in their investigation of masculine identity (Hooker et al., 2012). Further, in the same study and in others, AA men report similar ideas, which link consequences of health management to the possibility of avoiding health-related events (Hooker et al., 2012; Long et al., 2017). Thus, when encountering AA men, health-care professionals may want to inquire about motivators for engaging in healthy behaviors. As a result of the study findings, health-care professionals should consider discussing with AA men how healthy living may increase their chances of having a longer life and supporting their families. Health-care professionals may also convey how taking immediate action is an investment that could help them avoid problems, unnecessary costs, and medical ailments related to their health in the future.

The majority of the discussion involving disadvantages was related to cost, impact on aging, confidence in the health-care system and services, time, and social pressures. While several of these disadvantages, such as cost, time, and trust, have been cited in studies related to engaging in health management in general populations, exploring these disadvantages from the lens of AA males may provide unique insight for health-care professionals, as they are seldom reported (Bopp et al., 2006; Flynn et al., 2013; George, Kolt, Rosenkranz, & Guagliano, 2014). AA men in our study perceived the costs required for optimal health management as a disadvantage and they indicated a higher priority for paying for activities of daily living (e.g., rent, utilities, food). The literature supports the idea that cost can be a barrier for men to engage in healthy activities (Bopp et al., 2006). Health-care professionals should be cognizant of financial barriers and be prepared to recommend a continuum of health-care management options, including those that are low to no cost. Furthermore, from our focus groups, AA men were more likely to believe that aging may have been a barrier in their health management practices. Similarly, Long et al. found that AA men perceived increased susceptibility to poor health in the latter part of life versus when they were younger (Long et al., 2017). Changes to self-perceived masculinity were also linked to age-related health and physical changes (Griffith, Cornish, Bergner, Bruce, & Beech, 2017). Further, men in one study became more health conscious and pursued different health management strategies over time (Hooker et al., 2012). Health-care providers may want to educate AA men on how aging and metabolism can impact health outcomes and they may want to provide age-appropriate recommendations. Additionally, future health promotion research and media initiatives targeted at younger AA men may consider utilizing older AA men to promote prevention and emphasize health management activities in youth.

Having confidence in the health-care system and health-care providers was an important issue for our study participants, who had negative perceptions regarding their providers and prescription drug usefulness. In a study on cardiovascular medications and self-management, negative perceptions of medication use were noted by the male participants because of cultural mistrust (Long et al., 2017). Additionally, another study reported that AA men who experienced discrimination had negative perceptions regarding the quality of care, which negatively impacted their health behavior (Hooker et al., 2012). As such, our results may support the perspective on medical mistrust and its effect on AA male health behaviors. In the present study, lack of confidence was shown through perceptions of a drug's

impact (effectiveness and adverse effects), as well as mistrust of providers regarding "kickbacks." Another disadvantage of managing health was related to time. In our study, there was a pervasive message that healthy behaviors are time-consuming. Similarly, another study of AA men showed that more significance was placed on work and addressing emergent work needs than on engaging in healthy behaviors such as exercise or visiting their health-care providers (George et al., 2014). Finally, regarding disadvantages, our results indicate that there is a disconnect from social networks when participants pursue healthy behaviors. Specifically, traditional family gatherings that include cultural dishes that may be high in fat and sugar, may isolate and alienate AA men trying to adhere to a healthy lifestyle. Other studies have shown that these issues have contributed to social pressures and have challenged personal relationships (Dickson et al., 2013; Long et al., 2017). Interventions may also consider employing tailored messaging that includes and targets spouses, partners, and important others (Friedman, Hooker, Wilcox, Burroughs, & Rheaume, 2012). Health-care providers may encourage AA men to be proactive during these social gatherings by bringing/suggesting a healthier dish; discussing dietary issues with the host prior to the event; or helping the host with portion control and food selection. Additionally, promoting the utility and education of dietitians embedded in AA communities may help to improve the issues associated with diet and health-care trust among AA men. Dietitians in this setting may have increased success if they are trained and have roots in the communities they work in. This may help dietitians understand the competing priorities AA men often face, thus allowing them to incorporate these issues into their dietary recommendations.

SNs Regarding Health-Care Management

In addition to attitudes, a component of an individual's behavior is also theorized to be influenced by SNs, who are important individuals who may approve or disapprove of the behavior (Ajzen, 1991). Regarding SNs in our study, with the exception of children and parents, all other important individuals emerged as both approving and disapproving. Children, parents, and spouses were the primary influencers. Children were prominent facilitators of health management in AA men because they made their fathers accountable for health choices. A 2012 study on the influences of AA male health behavior identified family, specifically children, as positive influencers to maintain a healthy lifestyle (Hooker et al., 2012). In our study, other enablers included parents, predominantly the mother, as the individual providing constant reminders promoting health-related activities. Health-care providers may want to inquire about and/or elicit support from patients' children or parents when devising health management activities.

Conversely, spouses, friends, coworkers, and family members were identified as both approving and disapproving of healthy behaviors and health management. Regarding spouses, other studies found comparable results, which identified the significant other as commonly perceived to improve and reinforce positive wellness behavior (Allen, Griffith, & Gaines, 2013; Griffith, Ober Allen, & Gunter, 2011). In one of the same studies, researchers discovered that some of the men's significant others could be a hindrance to health management behaviors (Allen et al., 2013). Participants reported how family was regarded as the most invested in their well-being; yet, participants also reported that sometimes family would judge them, as already noted, for not fully participating in traditional or cultural gatherings involving food. These findings are supported in the literature where family was noted as a major resource for health information but also as a source of social alienation when participating in group functions (Griffith, Ober Allen, et al., 2011; Long et al., 2017; Sanders Thompson et al., 2009). Friends were identified as important health behavior influencers for AA men. In our study, friends had expectations that benchmarked the standards for the men to meet. This involved engaging in unhealthy or healthy behavior based on the group dynamics (Jackson, Knight, & Rafferty, 2010; Thorpe, Wilson-Frederick et al., 2013). Our study described that some encounters with friends may result in influencing indulgence in unhealthy food and drink. Similar to our study, other studies have shown healthy encounters where friendly competition served as a motivating factor (George et al., 2014) and where male friends may positively influence health care utilization (Grande, Sherman, & Shaw-Ridley, 2013). Participants also identified coworkers and employers as both approvers and disapprovers. In previous research, AA men reported that employers negatively impact their health management (George et al., 2014). These findings are consistent with the present study where participants noted that some coworkers and employers would create an atmosphere of group isolation if they were to engage in healthy habits at work. However, participants in the present study also believed that some employers and coworkers approved of their health management activities as it would prevent an increase in their own workload. Our finding that employers and coworkers can be approvers of health management in AA men represents a unique contribution to the literature. Employers might consider tailoring specific interventions that leverage the integration of wellness initiatives with income savings and/or successful job performance for AA men. Such interventions may prove particularly successful because of the

significance AA men place on work and in fulfilling familial responsibilities.

With the exception of employers, our study results are congruent with health behavior studies in ethnic minority populations that have examined individuals' approval and disapproval of health management (Allen et al., 2013; Grande et al., 2013; Griffith, Gunter, & Allen, 2011; Griffith, Ober Allen, et al., 2011; Sanders Thompson et al., 2009). Our findings for positive SNs extended beyond the impact of close family and friends to employers. In addition, our study identified that with the exception of children and parents, all other groups could both approve and disapprove. When suggesting individuals for support, it may be prudent to gauge the impact of the individual in question. Interventions to improve health management in AA men may require careful information gathering over assumptions, and recommendations should be tailored to each male's specific group of approvers. Indeed, a systematic review of weight loss in AA men reached similar conclusions, suggesting that interventions and providers should acknowledge the heterogeneity among AA men and tailor interventions to meet the specific needs of patients (Newton et al., 2014).

PBC Regarding Health Management

In addition to attitudes and SNs, PBC, which includes facilitators and barriers, can impact health management behaviors. The qualitative data related to PBC focused on support systems, provider ethnicity concordance, and health awareness as enabling facilitators. Competing priorities, access and environment, medical mistrust, fear, and culture, along with youth and aging were identified as barriers. One facilitator of health management that resonated with our study participants was having a support system. One study showed that having social support in the form of community, church, and family was perceived as vital to health (Ravenell, Johnson, & Whitaker, 2006). Other research in the area revealed that wellness support was associated with the increased ability to take action and mitigate barriers to healthy habits (Allen et al., 2013; Griffith, Gunter, et al., 2011; Griffith, Ober Allen, et al., 2011; Long et al., 2017). Health-care providers should inquire about social support systems and how they influence health behaviors. Another facilitator identified in our study was provider ethnic concordance. Researchers in another study found that perceived quality of care and patient compliance with healthy behaviors was negatively associated with nonethnic concordant providers (Rickles et al., 2010). This is further supported by studies that reveal how providers with AA ethnicity may perceive the perceptions of health care of AA men more accurately (Wallace et al., 2007). The pervading concept of ethnicity concordance may be due to relatability and perceived quality of care, which in turn may contribute to the likelihood of engaging in health-care recommendations or actions. A third facilitator was health awareness. Participants reported that educating AA men about their risk factors and their susceptibility to disease states and long-term complications would enable better health management. Other studies have shown that among AA men, health problems are correlated with a lack of awareness (Bopp et al., 2006; Hooker et al., 2012). During routine health-care visits, providers may want to introduce and reinforce pertinent disease state issues to increase knowledge of factors that could improve and impede optimal outcomes. Providers may also consider offering print and video media to reinforce concepts.

Regarding barriers to health management engagement, competing priorities and access to health-care resources emerged as salient themes in our study. The participants noted how work priorities, the lack of access to health care, and the decreased ability to obtain medical resources served as constant barriers. In a study of AA men with heart failure, insufficient health-care access was noted as a primary factor, making it difficult for the men to manage their complicated medication regimens and obtain proper information (Dickson et al., 2013). Also, two studies of the U.S. Department of Veterans Affairs (VA) health system reported that access limitations such as a socioeconomic status, medical knowledge, and information sources exist and are potential causes for health-care disparities (Rickles et al., 2010; Somnath, Freeman, Toure, Tippens, & Weeks, 2007). Regarding competing priorities, the men in our focus group discussed how work, family, school, or financial obligations would regularly supersede any scheduled health-care appointment or exams. This has been found in other studies where men have reported that they prioritize community, work, and family responsibilities over self-care (George et al., 2014; Griffith, Gunter, et al., 2011; Hooker et al., 2012). As a result, AA men may be limited by the resources in their environment as well as conditioned to fulfill the demands of the family provider or the traditional masculine role, which can limit their ability to engage in optimal health management. The AA men from our focus group were uncertain about the benefits of health actions due to fear and medical mistrust, recounting how they were concerned about the malicious or misguided intentions of their physician. This theme was echoed in a report on health information seeking among AA men, where the men described a low level of health-care trust (Griffith, Ober Allen, et al., 2011; Hammond, Matthews, Mohottige, Agyemang, & Corbie-Smith, 2010). In addition, a review of VA health systems found among minority patients, lack of cultural similarities between themselves and their provider, accompanied by personally

experienced discrimination contribute to a lack of trust and skepticism of medical interventions made on their behalf (Saha et al., 2008). This suggests a need for increased awareness among health-care providers regarding the unique issues AA men face, and it further provides support for increasing the number of ethnically diverse health-care providers. Patient trust has been linked to good communication and relationship building in general populations and specifically in AA men (Hawkins & Mitchell, 2018; Fiscella et al., 2004; Thom, 2000, 2001). Providers and future interventions may consider focusing on improving communication by listening, emphasizing empathy, providing direct answers, and giving patients opportunities to talk openly about their health (Hawkins & Mitchell, 2018; Fiscella et al., 2004; Thom, 2000, 2001). Access and environment along with youth and aging were also identified as barriers. These barriers have been discussed previously in this section and have also been identified in other studies. In our study and others, AA men's view of lower susceptibility to disease at a young age seemed to persist as they aged (Dickson et al., 2013; Hooker et al., 2012; Long et al., 2017; Sanders Thompson et al., 2009). Health-care providers may consider educating AA men about how aging impacts disease conditions and health.

Our findings contribute to the limited literature regarding AA men's attitudes, SNs, and PBC regarding health management. Through the use of a theoretical model, findings from this study captured the various beliefs and attitudes of AA men that have otherwise been dispersed throughout the literature. Additionally, this study extended the literature by providing unique insight regarding the potential positive influence of employers and coworkers on AA men's health management. Findings from this study may serve as potential targets for interventions with AA men. Given the high priority men place on work and its relation to fulfilling masculine roles, leaders of interventions might consider partnering with employers to leverage AA men's views of coworkers and employers as supporters of a healthy lifestyle. These interventions might also emphasize longevity and prevention as advantages that promote masculine identity and enable AA men to fulfill their familial responsibilities.

Limitations

Several limitations should be considered in the interpretation of the present study's findings. This qualitative research study employed methods and data analysis techniques, which employed procedures to capture the most salient and common themes; thus, unique perspectives voiced by only one or two respondents may have been excluded from our results. Additionally, participants were primarily recruited from a church. It is possible that those who attend church have an external locus of control, which may significantly impact how they view health and ways to manage their health. Future studies may consider exploring locus of control in a similar sample and may also consider recruiting AA men from other institutions or places. Further, as noted by our results on personal self-care (Tables 1 and 2), the high rate of our focus group participants reporting frequent health activity and behavior may have resulted in a more proactive and healthier group of AA men, which may have impacted our findings. It is possible that a sample containing AA men with less frequent health activity and behavior would report different views than those that were expressed by our sample. Finally, qualitative data coding and interpretation is subjective by nature. In an effort to reduce the impact of this risk, data were independently coded by two members of the research team.

Conclusion

AA men are often cited for their suboptimal health outcomes compared to other groups. The findings of this exploratory study reveal attitudes, SNs, and PBC perceptions of health management among AA men. The results convey that health management behaviors in AA males are multifaceted with factors that motivate (e.g., children and parents, social networks) and hinder (e.g., competing priorities and mistrust) wellness behaviors. Health-care providers should seek to understand these factors, discuss these issues with AA males, and integrate treatment strategies that are culturally informed and patient centered. These actions may encourage AA men to more fully engage practitioners who acknowledge their unique cultural and situational norms, which may, in turn, facilitate optimal health management.

Appendix A: Moderator Guide Key Questions

Attitudes

1. What do you believe are the ***advantages*** of managing your health condition?
2. What do you believe are the ***advantages*** of taking your medications as prescribed by your health-care professional?
3. What do you believe are the ***disadvantages*** of managing your health condition?
4. What do you believe are the ***disadvantages*** of taking your medications as prescribed by your health-care professional?
5. What else comes to mind when you think about the topic of health management and taking medications?

Subjective Norms

6. Are there any individuals or groups who would ***approve*** of you managing your health condition?
7. Are there any individuals or groups who would ***approve*** of you taking your medications as prescribed?
8. Are there any individuals or groups who would ***disapprove*** of you managing your health condition?
9. Are there any individuals or groups who would ***disapprove*** of you taking your medications as prescribed?
10. Are there ***any other*** individuals or groups who would approve or disapprove of your managing your health condition or taking your medications as prescribed?

Perceived Behavioral Control

11. What circumstances would ***enable*** you to manage your health condition?
12. What circumstances would ***enable*** you to take your medications as prescribed?
13. What circumstances would make it ***difficult*** for you to manage your health condition?
14. What circumstances would make it ***difficult*** for you to take your medications as prescribed?
15. Are th ere any other factors that come to mind when you think about you managing your health condition or taking your medications as prescribed?

Conclusion and Summary—We have covered the desired topics today. Does anyone have anything that he or she would like to add? Or does anyone have any final observations or comments?

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