


Developing Effective Diabetes Programming for Black Men

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Abstract

The purpose of this study is to obtain feedback from 20 men on developing effective programming to reduce the impact of diabetes (t2dm) among Black men. Three focus groups were convened in Des Moines, Iowa. Men were recruited, all either diagnosed with t2dm ($n = 10$), pre-diabetic ($n = 1$), or experienced t2dm through family and friends ($n = 9$). The results highlighted themes related to t2dm knowledge, masculinity, and behavioral health; gender-centered diabetes management education; and family support and functioning. Men provided recommendations for program format and content, desirable facilitator characteristics, and whether to include spouses/partners, relatives, and friends. These results provide guidance and ideas to nurses wishing to enhance t2dm education and patient outcomes for Black men.

Keywords

diabetes, focus groups, gender, masculinity, men's health, minorities, risk

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The risk of type 2 diabetes mellitus (t2dm) among Blacks is more than twice that for Whites (National Diabetes Information Clearinghouse, 2014). There is also considerable disparity in the prevalence of t2dm among Black men when compared with Black women and Whites. In 2011, the age-adjusted prevalence of diagnosed t2dm per 100 individuals was highest among Black men (9.9), followed by Black women (9.0), White men (6.5), and White women (5.4; Centers for Disease Control and Prevention, 2015). After diagnosis, Black men have two to four times the rate of blindness, renal disease, and limb amputations in comparison with Whites (Bell et al., 2010; Liburd, Namageyo-Funa, & Jack, 2007). Although scholars have long studied t2dm, Black men have not been included in many of the studies (Newton, Griffith, Kearney, & Bennett, 2014). This under-representation of Black men is particularly surprising given the prevalence rates of t2dm in this group and the likelihood that disparities in t2dm will persist because of the rising prevalence of obesity (Jack, Gross, & Troutman, 2010; Newton et al., 2014). We therefore conducted the present study to obtain guidance from 20 men on developing effective t2dm programming to reduce the impact of t2dm among Black men. In particular, we wanted to better understand how race and masculinity might intersect to shape the experience of t2dm and inform the creation of programming for Black men. Such information could be helpful to nurses and diabetes nurse practitioners (Seley, Furst, Gray, Jornsay, & Wohl, 1999).

Black Men and Diabetes

It is important to attend to race and masculinity when developing interventions for Black men because the mechanisms associated with successful t2dm risk management and care are likely to be qualitatively different from women (including Black women) and men from other racial groups (Jack, Toston, Jack, & Sims, 2010). Masculinity is defined as a set of traits, behaviors, and roles that are often linked to men and shaped by social context (O'Neil, 2015). Masculine socialization is influenced by culture, so health outcomes for men of different racial backgrounds might also vary (Addis & Mahalik, 2003; American Diabetes Association, 2015; Biddle, Gunnell, Sharp, & Donovan, 2004; David & Brannon, 1976; Galdas, Cheater, & Marshall, 2005). For example, culturally inspired practices (e.g., reliance on home remedies, mistrust of physicians) might lead men to ignore health-screening opportunities and preventive health care and delay help-seeking when problematic symptoms are present (Smith, Braunack-Mayer, & Wittert, 2006). Moreover, socially constructed masculine behaviors and attitudes might negatively influence health behaviors (Jack, Gross, & Troutman, 2010).

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For example, masculine gender roles (e.g., invincibility, protector, provider) might explain why men are less likely than women to engage in proactive health practices (Griffith, Ellis, & Allen, 2013; Jack, Toston, et al., 2010; Newton et al., 2014). The need to be strong and avoid vulnerability (i.e., be a sturdy oak) could encourage men to prioritize fulfillment of gender roles related to family and work more than health-promoting behaviors (e.g., physical activity, good diet, health screenings, annual physical exam) when they experience diabetic symptoms such as increased thirst and pain or numbness in their hands or feet (Addis & Mahalik, 2003; American Diabetes Association, 2015; Biddle et al., 2004; David & Brannon, 1976; Newton et al., 2014; Seawell, Hurt, & Shirley, 2015). Moreover, gender differences in nutritional choices (e.g., preference for soul food) and exercise patterns (e.g., lack of obtaining 30 minutes of exercise daily) are well established in the literature, underscoring the need to separately consider the issues for each gender (Newton et al., 2014). It is thus important to attend to both race and gender in developing interventions for Black men.

Diabetes Intervention Programming

One of the most effective diabetes intervention programs is the Diabetes Prevention Program (DPP). DPP used a sample population at risk of t2dm to demonstrate that an intensive lifestyle intervention focused on diet, nutrition, physical activity, and lifestyle could prevent the onset of t2dm (Diabetes Prevention Program Research Group, 2002). Despite the overwhelming success of this intervention, Black men were found to have poorer outcomes relative to Black women and men from other racial groups (Diabetes Prevention Program Research Group, 2004; Samuel-Hodge, Johnson, Braxton, & Lackey, 2014; West, Prewitt, Bursac, & Felix, 2008). Even at baseline, Black men could be viewed as a group worthy of special attention. They had the highest rates of glycemia and strongest family histories of t2dm (Diabetes Prevention Program Research Group, 1999; Diabetes Prevention Program Research Group, 2000). On closer examination of the DPP results, differential rates of success pertaining to recruitment and retention became apparent. Of a sample of more than 3,200 individuals, only 165 participants were Black men, just 5% of the total sample (Diabetes Prevention Program Research Group, 2000). Given the small number of Black men in the sample and the resulting data analytic challenges, researchers were severely limited in their ability to further explore DPP's impact among Black men, especially as it concerned the rates of conversion to t2dm relative to other racial groups (G. Dwyer, The Diabetes Prevention Program Biostatistics Center, personal communication, April 24, 2015).

Several diabetes intervention curricula have been designed to be culturally sensitive for Blacks. These include the Diabetes Coaching Program adapted for Blacks (Steinhardt, Mamerow, Brown, & Jolly, 2009), Fit Body and Soul (Dodani

& Fields, 2010), Project Diabetes Interventions Reaching and Educating Communities Together (Project DIRECT; Engelgau et al., 1998), and the Lifestyle Balance Church Diabetes Prevention Program (Davis-Smith, 2007). These programs addressed ways that Black culture influences behaviors and beliefs relevant to t2dm (e.g., preferences for soul food, which often contain fried foods, breaded meats, and foods high in sugar, starch, or carbohydrates; beliefs about the importance of finishing one's plate at every meal). Although these interventions have helped Blacks to enhance their self-care behaviors, most of the research has focused on Black women (e.g., Centers for Disease Control and Prevention, 2015; McGinnis, McGrady, Cox, & Grower-Dowling, 2005; Norris, Engelgau, & Narayan, 2001), thereby raising a question as to whether the curricula are ecologically valid for men (Jack, 2004; Newton et al., 2014). In sum, though earlier work has reduced t2dm among Blacks (e.g., Diabetes Prevention Program Research Group, 2004; Samuel-Hodge et al., 2014; West et al., 2008), scholars offered little information about how programming was culturally and gender sensitive for Black men.

One study by Treadwell and colleagues (2010) specifically addressed race and gender and tested the impact of Save Our Sons, a six-session group-based intervention program focused on reducing t2dm and obesity among 42 Black men. Prior to delivering Save Our Sons, Treadwell and colleagues (2010) utilized focus groups of Black men to improve recruitment and retention strategies (e.g., including photographs of Black families in program materials, involve community health workers) and learn about men's help-seeking behaviors with respect to health-related concerns (e.g., address challenges Black men face; W. Graves, Community Voices: Healthcare for the Underserved, Morehouse School of Medicine, personal communication, April 27, 2015). The study successfully increased men's knowledge relative to strategies for managing obesity and t2dm, physical activity, and connections with health professionals. These findings represent a promising starting point for developing programming tailored for Black men. To extend this work, we will recruit a different sample of Black men and obtain their feedback about how to attend to gender and culture. We will report on the men's feedback, which was absent from previous publications on the Save Our Sons project.

Building on the Save Our Sons project, we also seek to learn about men's opinions for integrating a family-based approach in t2dm programming. The family unit is a critical resource for men's health promotion (Chesla et al., 2004). Families can help reduce the impact of t2dm through education, reinforcement, and direct assistance (Chesla et al., 2004; Chlebowy, Hula, & LaJoie, 2013; Treadwell et al., 2010). Spouses and relatives manage meal planning and encourage physical activity (Savoca & Miller, 2001). In the Supporting Healthy Activity and eating Right Everyday (SHARE) Study, weight loss was highest in the group in which family and friends actively took part in the intervention (Samuel-Hodge

et al., 2014). Families are absent in intervention work; interventions target individuals and often fail to intervene in the family context in which t2dm develops (Gomersall, Madill, & Summers, 2011). As for Black men, they may be less likely to seek out prevention programming and stay involved in interventions. Focusing on the family may be an important route to increase retention for men. In particular, given the masculine roles noted above, men may be more likely to maintain their health if the goal is to continue to adequately provide for the family rather than simply participate in prevention programs to be healthier. Thus, studies that include family member(s) in preventive interventions may find success not only with recruiting and retaining Black men but also with maximizing intended outcomes (Brody, Kogan, Murry, Chen, & Brown, 2008; Chlebowy et al., 2013; Newton et al., 2014).

Guiding Framework

Recognizing that t2dm is complex and that various factors can differentially shape health outcomes, the Gender-Centered Diabetes Management Education Ecological Framework (Jack, Toston, et al., 2010) was selected for the current study. The model outlines how demographic factors, family functioning (e.g., social support), and masculinity intersect to influence and be influenced by biological health (e.g., weight, body mass index [BMI], glycemia), knowledge and psychological health (e.g., diabetes knowledge, stress), behavioral health (e.g., nutrition, physical activity, health care), and gender-centered diabetes management education (e.g., sensitivity to gender, culture). Each area impacts one's ability to reduce diabetes-related health disparities in the short term (e.g., glycemia, weight) and long term (e.g., quality of life; Jack, Toston, et al., 2010).

Importantly, the framework incorporates masculinity and gender into t2dm education efforts and has been used to guide studies on Black men's health, t2dm, and masculine identity (Jack, 2004; Jack & Griffith, 2013; Jack, Gross, & Troutman, 2010; Jack, Toston, et al., 2010; Sherman, McKyer, Singer, Larke, & Guidry, 2014; Whitaker et al., 2014).

Study Purpose

Considering the existing gaps in the empirical literature and the noted significance of attending to race and masculinity in t2dm education, it is important to consider the perspectives of men with respect to efforts in creating effective t2dm programming (Liburd et al., 2007). Liburd, Namageyo-Funa, Jack, and Gregg (2004) assert that more attention is needed to understand the connections between masculinity, men's health, and t2dm. This study's purpose is to use focus group methodology to guide the development of culturally tailored, gender-sensitive t2dm programs for Black men. We report on three focus groups with community-dwelling men who were queried about developing effective programming to reduce

the impact of t2dm. Focus groups were conducted to explore these issues. Such a method allowed for significant in-depth and cost-effective exploration of diverse perspectives (Huberman & Miles, 1994).

Method

Participants

In June 2013, participants were recruited from the Family and Community Health Study (FACHS). FACHS is a large-scale longitudinal study of more than 800 Black primary caregivers and their 10- to 12-year-old children residing in Iowa and Georgia. FACHS recruitment procedures are described in greater detail elsewhere (Cutrona et al., 2003). We developed a list of eligible men residing in the Des Moines, Iowa metropolitan area, between 2010 and 2012 at FACHS Wave 6, and identified a group of 95 men with ages ranging from 31 to 78 and BMI ranging from 16.3 to 51.5 (four cases with missing data). Most of these men (80%) at Wave 6 did not report having t2dm whereas another 20% were diagnosed with t2dm. After each eligible respondent was mailed a recruitment letter, an undergraduate and graduate student on our research team made follow-up phone calls approximately 3 days later to inquire about the men's interest in participating in the focus groups. All men who agreed to participate in the focus groups were enrolled. Men were assigned to one of three focus groups based on their availability.

The resulting sample size was 20, of whom 19 were Black. Although one man was White, he qualified for inclusion in the larger FACHS project because he was married to a Black woman and thus was eligible to take part in the focus groups. All men in the sample were affected by t2dm. Half were diagnosed with t2dm ($n = 10$), one was pre-diabetic, and the others ($n = 9$) had indirect experience with t2dm through family and friends. All men were currently partnered or married at the time of the focus group meeting, and their average marriage duration was 18 years (range = 4–34 years). The sample's mean age was 49 years (range = 38–63 years), and the mean level of education was some college/technical school (ranging from less than high school to an advanced degree). The mean level of individual income was between US\$40,000 and US\$45,000 (range < US\$10,000–US\$100,000; two refused to provide this information).

Procedures

Two Black men—an undergraduate student and a graduate student—assisted with recruitment and data collection. Enlisting the support of Black men was intended to demonstrate sensitivity to eligible participants by relying on racially and gender concordant staff and awareness of the importance of building trust by connecting with others of similar backgrounds (Cooney, Small, & O'Connor, 2007). A man-to-man

approach was also advocated in earlier work (Treadwell et al., 2010). The undergraduate student called participants to enroll them in the study and facilitated the focus groups; the graduate student only phoned participants to recruit them to the project.

Focus group methodology was used to explore the relevant topics and utilize group dynamics to engage the men in detailed discussion about each topic. The nature of focus groups empowered facilitators with the flexibility to follow up on nuanced or emergent themes. Each group contained six or seven men. The undergraduate facilitator attended a 1-hour training session prior to the focus group meetings to learn about the focus group protocol. Dr. Tera R. Hurt, a Black woman with advanced education in qualitative methods, trained the facilitator. The undergraduate facilitator led two of the three focus groups; Dr. Hurt observed the activity in these two focus groups and played a supportive role of keeping notes and taping the discussions. Because of an unexpected change in the undergraduate facilitator's availability and inability to conduct the third focus group as planned, Dr. Hurt facilitated this focus group in collaboration with a postdoctoral fellow, who was also a Black woman. The women explained this change in staffing to the participating men; no men expressed concern with the adjustment.

On arrival at a private meeting room at a centrally located community center in Des Moines, Iowa, the facilitator and Dr. Hurt introduced themselves to the men and invited them to eat the provided healthy meal. After all men had arrived and were settled, the facilitator called the focus group to order. The facilitator introduced himself or herself and briefly described the desired purpose of the discussion to follow. All procedures in conducting this research were in compliance with Iowa State University's Institutional Review Board requirements as well as general ethical standards. As such, the facilitator then read the informed consent document, asked the men if they had any questions about study procedures, and obtained all their signatures. Guided by the conceptual framework, men completed a demographic questionnaire to document their marital status, income, and education. Dr. Hurt then activated the digital recorders used to document the group discussions. The facilitator asked the men to comment on the meaning of t2dm and their knowledge about t2dm, including its relation to stress, diet, and physical activity. Facilitators invited the men to describe ways to make t2dm programming more appealing for Black men to encourage participation as well as propose marketing strategies for a t2dm program. Facilitators probed the men to ensure programming was sensitive to gender and race by focusing on gender roles and norms, gender role conflict, perceptions of masculinity, and cultural beliefs and attitudes. Men were also asked to brainstorm a list of sites where an education program should be provided, and discuss the pros and cons of including spouses/partners, friends, and children in the program given family norms around health. Each focus group discussion lasted for about 2 hours. At the conclusion

of the focus group discussion, each man was paid US\$50.00 for his participation.

Data Analysis

As each focus group was conducted, Dr. Hurt carefully listened to the men's insights and experiences. By the time the third focus group was conducted, Dr. Hurt heard participants share similar opinions and answers in response to the focus group questions as in the first and second focus groups. This signaled to Dr. Hurt that saturation was reached because no new or relevant information emerged from the discussions (Morrow, 2007).

All authors carefully listened to the digital recordings, reviewed observational notes, and analyzed the content of the focus group discussions to search for similarities and differences in the men's responses. Using a conventional content-analysis approach to categorize, assess, and interpret the data (Hsieh & Shannon, 2005; Huberman & Miles, 1994), all authors evaluated, compared, and contrasted data and developed a list of emerging data themes. Responses to the questions were entered into a Microsoft Word table. The themes emerged directly from the data. Each analyst developed a list of themes from her review of the focus group data and then compared findings from these independent analyses with each other (Saldaña, 2013). Analysts formed conclusions regarding themes in the data that appeared relevant to strategies for developing an effective t2dm program for Black men. In doing so, the analysts practiced data reduction and focused on data particularly related to the current analyses (Huberman & Miles, 1994). Dr. Hurt and Mrs. O'Connor took the lead on writing up the results; Dr. Seawell reviewed the results presentation to ensure that Dr. Hurt and Mrs. O'Connor adequately reported on the data and accurately documented the participants' perspectives. Dr. Seawell supported the results presented in the following section and added suggestions on how to more fully expound on each theme, where applicable.

Results

Diabetes Knowledge, Masculinity, and Behavioral Health

Facilitators first asked the men, "What does it mean to be diabetic?" In general, the men accurately described the characteristics, symptoms, and consequences of t2dm, that is, they described t2dm as a condition related to one's ability to produce enough insulin to maintain normal blood glucose (sugar). Several men stated, "Diabetes affects the sugar levels in your body." According to the men, when the pancreas does not function correctly, the result is either too much or not enough glucose in the blood. Early signs of t2dm include increased thirst and blurred vision. Furthermore, most men were aware that t2dm might be hereditary. Men outlined several negative

diabetes consequences, including damage to the body and one's organs (e.g., erectile dysfunction, aches and pains, nerve problems, paralysis, difficulty with vision), inability to sleep well, and generally diminished quality of life and overall health. A few men understood that t2dm is a progressive disease; as one's body changes, medicine dosages might need to be adjusted. Only one participant pointed out the difference between type 1 and t2dm.

Men were next asked, "What does it mean for a man to be diabetic?" Men discussed intersections between masculinity and t2dm as well as how t2dm affected their ability to meet the requirements of important roles as husbands and fathers. One man stated, "It affects you being the head of your family. Your family looks to you. You could have a shorter life expectancy or some kind of discomfort." Another man who reflected on his father who worked as a mechanic said, "My Dad became a fraction of himself because of t2dm. You would see him cut the grass and just stumble because of the changes in his legs. He went from Superman to a state of dependence." Another focus group participant offered, "It's like, I cannot protect my family now. I cannot provide for my family."

Another respondent noted the challenges of Black men when changing their diet and lifestyle after a t2dm diagnosis when he shared, "It's like you've got to cut out about 90% of our diet and what we eat." Because of genetics and dietary habits and lifestyles (e.g., high fat, high sugar, processed foods and drinks, large portion sizes; weight gain in middle age; more sedentary lifestyle because of responsibilities of marriage and parenthood), one man said, "It's expected at some point. Black men will be diabetic." Many men concurred with this fatalistic attitude. Another focus group member offered that there was little anyone could do to prevent dying, so he resigned himself to accepting his t2dm diagnosis as just something that occurs with time if you live long enough. "At some point in your life, you're gonna get got." In addition, though there was an expectation that many Blacks would be diagnosed with t2dm, several men asserted that there was still a social stigma about having t2dm.

Gender-Centered Diabetes Management Education

Facilitators then asked the men,

What are some things that would motivate Black men who already have t2dm to participate in a program designed to help them manage their t2dm? What are some things that would motivate Black men to participate in a program designed to help them prevent t2dm (i.e., men who do not have t2dm now)? What should these programs cover?

Although these questions were asked in succession, the responses to them were similar so we combined the results. The men opined that a great many men are not likely to participate

because of aversion to being educated. Another respondent was uncertain as to whether Black men have generally established personal expectations for their quality of life. He said, "So many of us are just focused on working and taking care of our families, I'm not sure if we have had time to make ourselves a priority." Thus, to attract men to the program, it would seem to be best to emphasize a "desire to live longer and achieve a better quality of life" and "enhancing one's quality of life for themselves and their families." It must be stated that "preventative care is an investment in your health" according to one focus group participant. Another man offered, "You have to have a wow factor, like it will add 10 years to your life!" One participant shared, "I know I'm pre-diabetic. If it can happen to me, it can happen to you. I'll ask men, have you had your sugar checked?"

Regarding program format, one man noted that the program must be offered at a convenient time (e.g., weekends, evenings, times when "the game" is not on). The program should be offered either for free or at a low cost. One respondent asserted, "If money is offered, cash should not be the primary reason for why men enroll, but incentives are helpful and encourage participation when balancing competing demands." In response, laughter erupted, as the men reflected on their motivation for attending the focus group and the fact that being paid for this participation in part inclined them to attend. Men also asserted that the program format should facilitate fellowship and cultivate a sense of "brotherhood" among the men so that they could support one another in their efforts to reduce the impact of t2dm. One man shared, "Men are likely to be more proactive if they have other men challenging them and holding them accountable." Another participant agreed with this sentiment stating, "Each one. Reach one."

Men advocated for the program facilitators to be either Black women or men, but preferably men. One man asserted, "It's very important that the facilitator be Black because of our lifestyles." The facilitators should have varying backgrounds, experiences (especially with t2dm), and personalities because program participants will react differently to each. Facilitators should have the positive intention of serving others (e.g., no representatives from self-interest groups) and should be sure to view program participants as their equals and avoid "talking down" to them.

With respect to program content, the material should not be too complicated; otherwise, men will not actively participate and return for follow-up sessions. The sessions should rather be "interactive, informative, quick, and powerful." The overarching framework for the program should be one of empowerment and recognition that there are consequences for choices individuals make regarding their health (e.g., nutrition). One man advised, "What you eat now will affect your health later." The men recommended that an intervention first focus on t2dm education to dispel the many existing myths about t2dm in the Black community. The facilitators should then describe the consequences of t2dm, note that it is

a progressive disease, and outline medical and technological advances in treatment. Following a t2dm overview, men suggested that the program should next cover diet (e.g., portion sizes, healthy eating without compromising taste and flavor) and exercise alternatives. The men suggested that the curriculum include alternatives for diet and physical activity, taking into account busy schedules and limited resources (e.g., “In trying to maximize my time, I often compromise the quality of the food I eat.”). Programs targeting men diagnosed with t2dm, and therefore focused on improving t2dm management, should provide appropriate support and resources. Each session should provide the men with something tangible to be applied in their daily lives, and give attention to the importance of masculine roles and how the recommendations could increasingly motivate men to meet their family obligations.

Men were also asked, “Which do you think is needed more—a diabetes prevention program for men without diabetes or a management program for men who already have diabetes?” Men were divided on this question. Although men appreciated the benefits of primary prevention, they noted the challenges of reaching young adult men. One man shared, “The 20 to 30 age range is a bad range. They’re [Black men] still trying to find themselves. Oftentimes they’re working jobs with no benefits, including health insurance to cover doctor’s visits.” Another respondent added,

Young men will not go to the doctor’s office without preventative insurance. You might be a college graduate, but still working a job with no benefits. Yes, there’s Obamacare now. I placed my own son on my insurance. He’s got a job. But there was a 3-month gap when he didn’t have insurance, between when he was too old to be on my insurance and when his job offered him insurance.

In summary, the men strongly believed that young adult Black men could benefit from education about diet, exercise, regular health care, and t2dm. One focus group participant shared, “They do not know. Young Black men need to know. They need to go to doctor regularly and get physicals. Most important, they need to listen to what their bodies are telling them.”

Facilitators asked the men, “Where is the best place in your community for a health program?” One man advised, “You need to think outside of the box on this one because this is a big, big problem in the community.” Other men suggested that the program be at an easily accessible location such as a health clinic, church, grocery store, YMCA, or another community center. Some men advised that the program be held at various locations to appeal to different people. One man said, “People feel ‘safe’ in different locations of the city.”

Family Support and Functioning

Facilitators also asked, “Should spouses/partners, friends, and children be encouraged to participate with men?” All the

men supported including spouses/partners, friends, and children because these individuals provide critical assistance to men in encouraging positive health behaviors (e.g., scheduling doctor’s visits, not purchasing unhealthy foods, promoting exercise). One man said, “Black men can be macho, but if everyone in the family changes, it’s not so isolating. It affects everyone.” Another participant offered, “Yes, you need to attack it from a community level, because if only the individual changes, the change really might not be sustained.”

Men with t2dm diagnoses offered personal reflections on how supportive their spouses and families were for them. One man praised his family saying, “My family is supportive. My wife does not purchase items I cannot have. No fried foods. Only baked foods. My wife will get my meter if I get to feeling funny.” Another man who was diagnosed with t2dm and had gastric bypass surgery noted, “My wife is definitely supportive. Since my surgery, if I eat too fast or eat too big of a bite, I will choke. I’ll get to rubbing my head, and she’ll know.” A third man shared,

My weakness is dessert. My wife often says to me, “I’m too young and too fine to be by myself.” I know what I need to do when my blood sugar is low. My co-workers know that I am diabetic and what to do if I need some help. Men, we have to be willing to accept the help.

Discussion

Data from these focus groups offer guidance as to how to build culturally sensitive and gender-appropriate t2dm programming for Black men. Using Black men’s voices, we provide concrete examples on how to appropriately frame t2dm programming and strategies for effectively delivering such curricula thereby making a contribution to the literature. Although other studies have reduced the impact of t2dm among Blacks (e.g., Diabetes Prevention Program Research Group, 2004; Samuel-Hodge et al., 2014; Treadwell et al., 2010; West et al., 2008), these investigations provide little to no guidance about how programs were modified specifically for Black men, if at all. Thus, though programming might be effective, one wonders about *how* researchers modified t2dm programming to be gender and culturally sensitive. Therefore, this work advances the literature in important ways for nurses desiring to connect with Black men and recognizing the importance of messaging and delivery in reaching Black men and reducing the impact of t2dm. Results highlight concepts underscored in the Gender-Centered Diabetes Management Education Ecological Framework (Jack, Toston, et al., 2010) related to diabetes knowledge, masculinity, behavioral health, gender and culturally sensitive t2dm programming, and family support and functioning.

One way to market a t2dm program to Black men would be to encourage them to first consider impact of their health on the family and their ability to fulfill gender roles. By first

taking care of their own well-being, men will be more assured to be in the good health that is expected of providers and protectors. Toward this goal, the findings recommend a marketing campaign focused on enhancing quality of life and helping men to live longer. The men acknowledged the difficulty of putting one's self first in their roles as husbands and fathers. However, self-care was viewed as a worthwhile, needed goal to optimize one's health. These findings underscore results outlined in earlier work by Liburd et al. (2004), which emphasizes that illness has meaning and our perception of a disease has impact on health outcomes. The focus group results clearly point to the importance of men's gender roles and how they attribute meaning to their roles in the family.

Overall, men were familiar with t2dm and its complications. Men clearly articulated how t2dm might undermine a man's ability to be a good provider. As they aged, men were more focused on responsibilities associated with marriage and fatherhood that negatively affected their behavioral health outcomes, including dietary and lifestyle habits. Busy schedules, in addition to consumption of foods high in fat, sugar, and carbohydrates, contributed to weight gain. Poor diet and family dietary traditions have been noted in earlier work as being important factors to Black men being both obese and diagnosed with t2dm (Liburd et al., 2007; Liburd et al., 2004; Newton et al., 2014).

The men also suggested that the program be free of charge and offered at a convenient time at a local easily accessible community center (Cooney et al., 2007). Sessions should be short, informative, and activity based, and should allow men to engage in fellowship with one another to capitalize on the strength of a brotherhood. Such a social support system could provide Black men with an outlet for expressing health-related emotions and frustrations (Liburd et al., 2007; Liburd et al., 2004). The sessions should focus on t2dm education, t2dm complications, diet, and exercise. Each session should address how to lead a healthier life given the men's busy lifestyles and family responsibilities as well as counteract fatalistic attitudes about t2dm. The men recommended that the facilitator be a Black educator, preferably a man, who viewed program participants as equals (Treadwell et al., 2010). Similar to what has been found in earlier work (Liburd et al., 2007), men advocated for spouses/partners, relatives, and friends to be included in program outreach efforts because they often play a critical role in the men's lifestyle and health care decisions.

Several study limitations are notable. First, the sample size is small and limited to one data collection point. Also, it is not possible to link the quotes presented in the results to specific men. The purpose of focus groups is to provide individuals an opportunity to express their opinions in a group setting and learn about group consensus and diversity of opinions, not to focus on individual opinions (Huberman & Miles, 1994). Focus groups were not employed to record a specific participant's opinion about

an issue. Furthermore, another limitation is that we cannot examine the data by diabetic status (e.g., diabetics vs. non-diabetics vs. pre-diabetic). Even so, the men were fairly consistent in their consensus about the issues discussed. It is also important to note that the one White man who was married to a Black woman and raising Black sons did not express opinions that were markedly different from other participating men.

In conclusion, as nurses work to address the critical disparity between Black men and men from other racial groups and women, greater attention should be paid to ensuring that t2dm programs are culturally tailored and gender sensitive. In comments similar to the results proposed by Liburd et al. (2004), focus group participants acknowledged the high prevalence of t2dm in the Black community and asserted that intervention efforts are warranted. These novel results provide concrete examples and guidance on how to modify such programming for Black men, thereby making a critical contribution to the t2dm literature. Ensuring that programs are revised to meet the needs of Black men and their lifestyles will help to ensure not only ecologically valid programming but also effectiveness in reducing the impact of t2dm. We strongly advocate for a community-based participatory approach to develop and deliver t2dm programming for Black men, counteract fatalistic attitudes, and encourage men to prioritize their health to fulfill gender roles and family responsibilities (O'Fallon & Dearry, 2002). Nurses can capitalize on men's social support networks (e.g., brotherhood, family) to achieve these goals.

Authors' Note

Tera R. Jordan publishes scholarly work using her maiden name, Tera R. Hurt.

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References

- Addis, M. E., & Mahalik, J. R. (2003). Men, masculinity, and the contexts of help seeking. *American Psychologist*, *58*, 1–14.
- American Diabetes Association. (2015). *Symptoms*. Retrieved from <http://www.diabetes.org/diabetes-basics/symptoms/?loc=db-slabnav>
- Bell, R., Bertoni, A., Calles, J., Hairston, K., Hunter, J., Mount, D., & Whitt-Glover, M. (2010). The epidemiology of diabetes in African Americans. In L. Jack Jr. (Ed.), *Diabetes in Black America: Public health and clinical solutions to a national crisis* (pp. 5–25). Roscoe, IL: Hilton Publishing.
- Biddle, L., Gunnell, D., Sharp, D., & Donovan, J. L. (2004). Factors influencing help seeking in mentally distressed young adults: A Cross-Sectional Survey. *The British Journal of General Practice*, *54*, 248–253.
- Brody, G. H., Kogan, S. M., Murry, V. M., Chen, Y.-f., & Brown, A. C. (2008). Psychological functioning support for self-management, and glycemic control among rural African American adults with diabetes mellitus Type 2. *Health Psychology*, *27*(Suppl. 1), S83–S90.
- Centers for Disease Control and Prevention. (2015). Age-adjusted incidence of End-Stage Renal Disease related to Diabetes Mellitus (ESRD-DM) per 100,000 diabetic population, by race, ethnicity, and sex, United States, 1980–2008. Retrieved from <http://www.cdc.gov/diabetes/statistics/esrd/fig5.htm>
- Chesla, C. A., Fisher, L., Mullan, J. T., Skaff, M. M., Gardiner, P., Chun, K., & Kantner, R. (2004). Family and disease management in African-American patients with type 2 diabetes. *Diabetes Care*, *27*, 2850–2855.
- Chlebowy, D. O., Hula, S., & LaJoie, A. S. (2013). Gender differences in diabetes self-management among African American adults. *Western Journal of Nursing Research*, *35*, 703–721.
- Cooney, S. M., Small, S. A., & O'Connor, C. (2007). *Strategies for recruiting and retaining participants in prevention programs* (What Works, Wisconsin Research to Practice Series No. 2). Madison: University of Wisconsin-Madison/Extension.
- Cutrona, C. E., Russell, D. W., Abraham, W. T., Gardner, K. A., Melby, J. N., Bryant, C., & Conger, R. D. (2003). Neighborhood context and financial strain as predictors of marital interaction and marital quality in African American couples. *Personal Relationships*, *10*, 389–409.
- David, D. S., & Brannon, R. (1976). *The forty-nine percent majority: The male sex role*. Boston, MA: Addison-Wesley.
- Davis-Smith, M. (2007). Implementing a diabetes prevention program in a rural African-American church. *Journal of the National Medical Association*, *99*, 440–446.
- Diabetes Prevention Program Research Group. (1999). The Diabetes Prevention Program: Design and methods for a clinical trial in the prevention of type 2 diabetes. *Diabetes Care*, *22*, 623–634.
- Diabetes Prevention Program Research Group. (2000). The DPP: Baseline characteristics of the randomized cohort. *Diabetes Care*, *23*, 1619–1629.
- Diabetes Prevention Program Research Group. (2002). Reduction in the incidence of type 2 diabetes with lifestyle intervention or metformin. *The New England Journal of Medicine*, *346*, 393–403.
- Diabetes Prevention Program Research Group. (2004). Achieving weight and activity goals among diabetes prevention program lifestyle program participants. *Obesity Research*, *12*, 1426–1434.
- Dodani, S., & Fields, J. Z. (2010). Implementation of the fit body and soul, a church-based lifestyle program for diabetes prevention in high-risk African Americans a feasibility study. *The Diabetes Educator*, *36*, 465–472.
- Engelgau, M. M., Narayan, K. M., Geiss, L. S., Thompson, T. J., Beckles, G. L., Lopez, L., Hartwell, T., Visscher, W., & Liburd, L. (1998). A project to reduce the burden of diabetes in the African-American community: Project DIRECT. *Journal of the National Medical Association*, *90*, 605–613.
- Galdas, P. M., Cheater, F., & Marshall, P. (2005). Men and health help-seeking behavior: Literature review. *Journal of Advanced Nursing*, *49*, 616–623.
- Gomersall, T., Madill, A., & Summers, L. K. (2011). A metasynthesis of the self-management of type 2 diabetes. *Qualitative Health Research*, *21*, 853–871.
- Griffith, D. M., Ellis, K. R., & Allen, J. O. (2013). An intersectional approach to social determinants of stress for African American men: Men's and women's perspectives. *American Journal of Men's Health*, *7*(4 Suppl.), 19S–30S.
- Hsieh, H., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research*, *15*, 1277–1288.
- Huberman, M. A., & Miles, M. B. (1994). Data management and analysis methods. In N. K. Denzin & Y. S. Lincoln (Eds.), *The handbook of qualitative research* (pp. 428–444). Thousand Oaks, CA: SAGE.
- Jack, L., Jr. (2004). Diabetes and men's health issues. *Diabetes Spectrum*, *17*, 206–208.
- Jack, L., Jr., & Griffith, D. M. (2013). The health of African American men implications for research and practice. *American Journal of Men's Health*, *7*, 5S–7S.
- Jack, L., Jr., Gross, T., & Troutman, A. (2010). Exploring masculinity and the social context: Research and practice implications for Black men living with diabetes. In L. Jack Jr. (Ed.), *Diabetes in Black America: Public health and clinical solutions to a national crisis* (pp. 130–145). Roscoe, IL: Hilton Publishing.
- Jack, L., Jr., Toston, T., Jack, N. H., & Sims, N. (2010). A gender-centered ecological framework targeting Black men living with diabetes: Integrating a “masculinity” perspective in diabetes management and education research. *American Journal of Men's Health*, *4*, 7–15.
- Liburd, L. C., Namageyo-Funa, A., Jack, L., Jr., & Gregg, E. (2004). Views from within and beyond: Illness narratives of African-American men with type 2 diabetes. *Diabetes Spectrum*, *17*, 219–224.
- Liburd, L. C., Namageyo-Funa, A., & Jack, L., Jr. (2007). Understanding “masculinity” and the challenges of managing type-2 diabetes among African American men. *Journal of the National Medication Association*, *99*, 550–558.
- McGinnis, R. A., McGrady, A., Cox, S. A., & Grower-Dowling, K. A. (2005). Biofeedback-assisted relaxation in type 2 diabetes. *Diabetes Care*, *28*, 2145–2149.
- Morrow, S. L. (2007). Qualitative research in counseling psychology: Conceptual foundations. *The Counseling Psychologist*, *35*, 209–235. doi:10.1177/0011000006286990
- National Diabetes Information Clearinghouse. (2014). *Diabetes in America* (2nd ed.). Retrieved from <http://diabetes.niddk.nih.gov/dm/pubs/america/index.aspx>
- Newton, R. L., Jr., Griffith, D. M., Kearney, W. B., & Bennett, G. G. (2014). A systematic review of weight loss, physical activity, and dietary interventions involving African American men. *Obesity Reviews*, *15*(Suppl. 4), 93–106.

- Norris, S. L., Engelgau, M. M., & Narayan, K. M. (2001). Effectiveness of self-management training in type 2 diabetes: A systematic review of randomized controlled trials. *Diabetes Care, 24*, 561–587.
- O’Fallon, L. R., & Dearry, A. (2002). Community-based participatory research as a tool to advance environmental health sciences. *Environmental Health Perspectives, 110*(Suppl. 2), 155–159.
- O’Neil, J. M. (2015). Men’s gender role conflict: Psychological costs, consequences, and an agenda for change. Washington, DC: American Psychological Association.
- Saldaña, J. (2013). *The coding manual for qualitative researchers*. Thousand Oaks, CA: SAGE.
- Samuel-Hodge, C. D., Johnson, C. M., Braxton, D. F., & Lackey, M. (2014). Effectiveness of diabetes prevention program translations among African Americans. *Obesity Reviews, 15*, 107–124.
- Savoca, M. R., & Miller, C. K. (2001). Food selection and eating patterns: Themes found among women with type 2 diabetes mellitus. *Journal of Nutrition Education, 33*, 224–233.
- Seawell, A. H., Hurt, T. R., & Shirley, M. C. (2015). The influence of stress on diabetes prevention and management in Black men: A qualitative analysis. *American Journal of Men’s Health*. Advance online publication. doi: 10.1177/1557988315580132.
- Seley, J. J., Furst, P., Gray, T., Jornsay, D., & Wohl, N. R. (1999). The diabetes nurse practitioner: Promoting partnerships in care. *Diabetes Spectrum, 12*, 113–117.
- Sherman, L. D., McKyer, E. L., Singer, J. N., Larke, A., & Guidry, J. J. (2014). Understanding the essence and lived experience of self-care management among African-American men living with type 2 diabetes. *Journal of Social Health and Diabetes, 2*, 96–104.
- Smith, J. A., Braunack-Mayer, A., & Wittert, G. (2006). What do we know about men’s help-seeking and health service use? *Medical Journal of Australia, 184*, 81–83.
- Steinhardt, M. A., Mamerow, M. M., Brown, S. A., & Jolly, C. A. (2009). A resilience intervention in African American adults with type 2 diabetes: A pilot study of efficacy. *The Diabetes Educator, 35*, 274–284.
- Treadwell, H., Holden, K., Hubbard, R., Harper, F., Wright, F., Ferrer, M., Blanks, S.H., Villani, G., Thomas, A., Washington, F., & Kim, E. K. (2010). Addressing obesity and diabetes among African American men: Examination of a community-based model of prevention. *Journal of the National Medical Association, 102*, 794–802.
- West, D. S., Prewitt, T. E., Bursac, Z., & Felix, H. C. (2008). Weight loss of Black, White, and Hispanic men and women in the Diabetes Prevention Program. *Obesity, 16*, 1413–1420.
- Whitaker, S. M., Bowie, J. V., McCleary, R., Gaskin, D. J., LaVeist, T. A., & Thorpe, R. J. (2014). The association between educational attainment and diabetes among men in the United States. *American Journal of Men’s Health, 8*, 349–356.

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