

Exploring Structural, Sociocultural, and Individual Barriers to Alcohol Abuse Treatment Among Hispanic Men

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Abstract

Hispanic men have poor access to alcohol abuse treatment, low treatment engagement, and low treatment completion rates despite the contrasting burden of alcohol-related consequences they face. The purpose of this study was to examine Hispanic male perspectives regarding alcohol abuse treatment-seeking behaviors and the structural, sociocultural, and individual factors that may influence initiation and continued engagement in treatment in this population. Individual interviews were conducted with a sample of 20 Hispanic men (age: 44.6 ± 11.3 years). Thematic analysis was completed using a hybrid deductive–inductive approach centered in an a priori codebook that was further supplemented with iterative exploration of transcripts. Results suggested treatment-seeking behaviors were highly influenced by (a) structural factors related to poor treatment access, as well as lack of linguistic- and cultural-responsiveness of available treatment; (b) sociocultural factors related to difficulties problematizing alcohol abuse due to lack of community awareness, societal normalization of consumption, and stigmatization of alcohol abuse treatment; and (c) individual factors related to lack of individual knowledge. This work highlights the perceived lack of congruency between available treatment and the linguistic, cultural, and gender norms of Hispanic men. There is need for responsive treatment strategies that comprehensively consider the gendered- and sociocultural-factors that govern treatment seeking and engagement behaviors. Findings also suggest a need for targeted alcohol abuse awareness building efforts in the Hispanic community. Specifically, the detrimental effects of alcohol-related problems and potential benefits of treatment should be addressed in order to diminish social stigma of abuse and of treatment.

Keywords

alcohol use, behavioral issues, cultural sensitivity, general health and wellness, health inequality/disparity, health-care issues, risk behaviors, behavioral issues, masculinity, gender issues and sexual orientation

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Maladaptive patterns of alcohol consumption can lead to clinically significant impairment or distress, and have been established as a partial cause of a wide variety of health conditions, including neuropsychiatric disorders, cardiovascular diseases, hepatic inflammations, certain cancers, and infectious diseases (World Health Organization, 2014). Hispanic men are more likely than Hispanic women and non-Hispanic White (NHW) men to engage in high risk alcohol consumption (Caetano, 2003; Caetano, Ramisetty-Mikler, Floyd, & McGrath, 2006). Hispanic men experience disproportionate levels of adverse health consequences of alcohol abuse when compared to NHW men (Caetano, 2003). Research suggests that Hispanic men present with alcohol-induced liver diseases such as alcohol steatosis

and cirrhosis at significantly younger ages than NHW men (Levy, Catana, Durbin-Johnson, Halsted, & Medici, 2015).

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Inclusively, social consequences of alcohol use disproportionately affect Hispanic men when compared to NHW (Caetano, 2003). Hispanic men have higher incidence rates of alcohol-related intimate partner violence, (Caetano, Galvan, Aguirre-Molina, & Molina, 2001; Morales-Aleman et al., 2014), face disproportionate alcohol use related contact with the criminal justice system, and more severe punitive consequences when compared to NHW men (Iguchi et al., 2002).

Research suggests that when compared to NHW, Hispanic men have poor access to treatment, low treatment engagement, and low completion rates despite the contrasting burden of alcohol-related consequences they face (Campbell & Alexander, 2002; Guerrero, Marsh, Khachikian, Amaro, & Vega, 2013; Marsh, Cao, Guerrero, & Shin, 2009; Wells, Klap, Koike, & Sherbourne, 2001). According to the National Survey on Drug Use and Health (NSDUH, 2012), the following characteristics increase the likelihood of treatment access, engagement, and completion: (a) endorsing NHW race and ethnicity, (b) being female, (c) reporting an age of 40 or older, and (d) having more than a high school education. Consequently, some Hispanic men might face disproportionate challenges when undergoing conventional alcohol abuse treatment.

There is a persistent lack of knowledge about the mechanisms by which adherence to Hispanic gender-bound cultural norms influence treatment-related behaviors in this group (Kissinger et al., 2013; NSDUH, 2012; Ojeda & Liang, 2014; Vega, Alderete, Kolody, & Aguilar-Gaxiola, 1998). Behavior norms believed to express masculinity such as toughness, self-reliance, expressions of strength, and emotional disconnectedness can result in maladaptive coping behaviors that have adverse effects on physical and emotional wellbeing (Courtenay, 2000), particularly in Hispanic men (Arciniega, Anderson, Tovar-Blank, & Tracey, 2008). Although stereotypical in nature, research suggests that some Hispanic men may closely adhere to masculine ideologies (i.e., *machismo*) that exaggerate hyper-masculine behavior and can be detrimental to health (Arciniega et al., 2008; Torres, Solberg, & Carlstrom, 2002). For example, adherence to *machismo* has been associated with higher levels of depression and stress (Fragoso & Kashubeck, 2000) as well as alcohol use and misuse in Hispanic men (Liang, Salcedo, & Miller, 2011). In contrast, *caballerismo*, the positive counterpart of *machismo*, is used to describe behaviors that incorporate displays of respect, care for family, and emotional connectedness that can have protective effects on alcohol and substance misuse-related health behaviors (Arciniega et al., 2008; Liang et al., 2011).

Little is known, however, about how aforementioned individual and sociocultural factors interact with an individual's social context (i.e., neighborhood disadvantage,

differential access to care, economic resources) to influence treatment seeking behaviors among Hispanic males. Understanding barriers to prevention and treatment service utilization by Hispanic men may be hampered by the lack of an approach that embraces the dynamic relationship between external influence and internal responses. Consequently, this work used the *Socio-ecological Model* (Sallis, Owen, & Fisher, 2015) as a heuristic framework to organize and understand barriers to treatment present at different levels of influence; structural, sociocultural, and individual. We used this framework to examine Hispanic male perspectives regarding alcohol abuse treatment-seeking behaviors and the structural, sociocultural, and individual factors that may influence initiation and continued engagement in treatment in this population.

Methods

Twenty in-depth, semistructured interviews with Hispanic men were conducted between January and March 2017. Participants were recruited using informational flyers posted at community health centers, as well as through tabling at community agencies and outdoor marketplaces. Eligibility for participation was determined by an initial telephone or in-person screening. This work used a *purposeful homogeneity* sampling strategy to facilitate the identification and selection of participants that could provide rich data on the phenomenon of interest (Palinkas et al., 2015; Patton, 2005). Eligible participants were self-identified Hispanic males, between the ages of 21–64, who reported previous or current alcohol consumption. *Hispanic* was used here to represent people who identified their ethnicity as Hispanic or Latino. U.S. federal law defines Hispanic or Latino as those as those people who classify themselves as into one of the specified Hispanic or Latino categories listed in the U.S. Census as “Mexican,” “Puerto Rican,” or “Cuban,” “Central or South American”—as well as those who may indicate that they are “Other Spanish, Hispanic, or Latino” (Ramirez & De La Cruz, 2003). A total of 73 men expressed interest in participating and provided contact information. The research team was able to contact 52 of these participants, of which 34 continued to express interest and were scheduled for an interview appointment. Eight participants were unable to attend or reschedule their appointments due to work and time constraints. Another six were lost-to-follow-up leaving a final sample of 20 (Table 1 presents participant characteristics). Participants were informed of all study related procedures verbally and in writing before completing written consent. Recruitment, consent, and all other study materials were available in both English and Spanish and approved by the University of Arizona's Human Subjects Protection Program Internal Review Board (UA IRB

Table 1. Participant Characteristics ($n = 20$).

Characteristics	<i>n</i> /mean	%/ <i>SD</i> (range)
Age (years)	44.6	11.3 (23–64)
Foreign born	15	75%
Years in the United States	29.8	15.4 (6–57)
Currently married or live with domestic partner	15	75%
Employed	20	100%
Income		
<\$29,999	10	50%
\$30,000–59,999	8	40%
>\$60,000	2	10%
Brief Acculturation Scale for Hispanics (BASH)	2.6	1.1 (1–4.75)
The Machismo Caballerismo Scale (TMCS)		
M-Scale (Machismo)	2.7	0.69
C-Scale (Caballerismo)	5.8	0.66
Consumption measures		
Current alcohol use	17	85%
At least once a week	6	35%
Binge drink at least once a month	4	23%
Experience with treatment	9	45%

1701148051). All study-related procedures were carefully explained to participants by study staff before participant consent. Interviews took place in a private and confidential environment located within the University of Arizona's Collaboratory for Metabolic Disease Prevention and Treatment in Tucson, AZ.

Data Collection

Individual interviews were conducted using a semistructured interview guide (Table 2) formulated to elicit perspectives related to alcohol abuse, masculinity, and treatment seeking behaviors. The interview guide used was based on formative work (Valdez et al., 2018) and a brief review of the available literature to identify potential gaps in work with Hispanic men. A bilingual, bicultural male member of the research team conducted all interviews and administered a voluntary questionnaire. The questionnaire was constructed to provide a demographic illustration of this sample and elicited information related to; (a) demographics (age, Hispanic heritage, schooling, employment, income, marital status, and time lived in the United States); (b) machismo/caballerismo (using the *Machismo Caballerismo* scale (TMCS), a self-report instrument that examines the extent to which men identify with two different constructs of machismo; *machismo*/hyper-masculinity and *caballerismo*/positive masculinity (Arciniega et al., 2008); (c) past 12-month alcohol consumption frequency and quantity; and (d) acculturation, using a language use-based scale to indicate level of acculturation (Mills,

Malcarne, Fox, & Sadler, 2014). Both the acculturation and machismo/caballerismo scales have been tested for validity and reliability in the study's target population (Arciniega et al., 2008; Mills et al., 2014).

Data Analysis

Interviews were audio-recorded and transcribed verbatim by trained staff. A hybrid deductive–inductive analysis strategy was used for data assessment. Analysis began with a deductive process using an *a priori* developed codebook based on the objectives of the analysis and the topics included in the interview guide (Table 2). The research team supplemented this initial codebook with themes that emerged during repeated reading of the transcripts. The codebook was completed using ongoing discussion and iterative analysis of each transcript and confirmation of deductive–inductive coding structure. Four randomly selected transcripts were double coded to establish inter-rater reliability of coding strategies, reaching a consensus of approximately 86%, to establish analytic rigor by controlling for individual coder bias and ensuring that all coding was applied consistently. All remaining transcripts were coded by a single member of the research team, however, 10% of each transcript was double coded and any discrepancies were discussed to minimize the potential of analytic drift. Theme saturation was derived by the diminishing variation in coded transcripts, recruitment was halted once saturation of themes was reached. (Patton, 1999). NVivo 13 (QSR International,

Table 2. Semistructured Interview Guide.

Domain and questions

Definition of the problem

- How would you define alcohol abuse?
- What do you think are some of the biggest alcohol-related health problems Latino/Hispanic men in the United States face?
- How do you think alcohol abuse affects the Latino/Hispanic community?
- How do you think alcohol abuse affects Latino/Hispanic men?

Masculinity

- Think of someone you consider manly or a typical man. Describe that person, what makes that person manly?
- How does the idea of manhood influence a man's life?
- How does manhood differ for a Latino/Hispanic man compared to a man of another race?
- How is the idea of manhood influenced by Latino/Hispanic culture or traditions?
- How does the idea of manhood influence health-related behaviors?

Masculinity and alcohol consumption

- How does the idea of manhood influence alcohol consumption in Latino/Hispanic men?
- How do traditional ideas of manhood influence alcohol abuse in Latino/Hispanic men?
- How does this influence change with age?

Treatment-seeking behaviors

- What do you think brings people to seek treatment for problems with alcohol?
- What may be some of the reasons why people who need treatment do not seek it?
- It is known that Hispanic/Latino men have a harder time gaining access to alcohol treatment, can you tell me why you think that might be?

Now, even when men gain access, it is known that Latino/Hispanic males have a harder time successfully completing alcohol abuse treatment, can you tell me why you think that is?

Cambridge, MA) was used to facilitate data organization, management, and analysis. STATA 13 was used to calculate all questionnaire-based demographic statistics.

Results

Demographic Characteristics

Twenty Hispanic, Spanish and English-speaking men participated in semistructured interviews lasting an average of 43 min. Of this sample, 10 completed the interview in Spanish and 10 in English. Mean age of participants was 44.6 (range: 23 to 64; $SD = 11.3$). All men were of Mexican-origin, having been born in Mexico, or were the children or grandchildren of Mexican-born parents/grandparents. Fifteen participants were born outside the United States and reported living in the United States a mean of 29.8 years (range: 6 to 57; $SD = 15.4$). Mean machismo scale and *caballerismo* scale scores were 2.7 ($SD = 0.69$) and 5.8 ($SD = 0.66$) respectively; meaning that our sample showed poor adherence to *machismo*-related traits and high adherence to *caballerismo*-related traits (Arciniega et al., 2008). Mean Brief Acculturation Scale for Hispanics (BASH) score was 2.6 (range: 1 to 4.75; $SD = 1.1$) and ranged from 1 to 4.75 suggesting acculturation was *moderate* for our sample (Norris, Ford, & Bova, 1996). Current alcohol use was reported by 17 (85%) of our participants, 6 (35%) drank at least once a week, 5 (29%) were consuming between 9 and 15 drinks per drinking occasion, and 4 (23%) reported binge drinking at least once a month.

Qualitative Results

Participants mentioned a variety of hindrances to seeking and accessing treatment. Findings were grouped into three categories reflecting the underlying heuristic framework used for this work: structural barriers, sociocultural barriers, and individual barriers. Table 3 contains quotes selected to provide a contextual illustration of analysis themes using the voices of study participants.

Structural Barriers

Cost and efficacy of treatment. In general, the men believed that alcohol abuse treatment was unobtainable by them and to the Hispanic community for a variety of reasons, the most impactful of which was the inability to afford treatment they perceived to be effective. There was a shared belief that adequate, and consequently, successful treatment, was reserved only for those who could afford it. Some participants shared personal and familial frustration with seeking treatment and being turned away because they could not pay or were not insured, which often only exacerbated alcohol abuse-related problems. The men explained that it would be impossible for most men they knew to enter treatment, even when access was guaranteed, simply because they could not afford to take time off work given they are the primary bread winners and work jobs that do not pay very well.

The men discussed that the treatment that was accessible to them without medical insurance, at a sliding scale, or free of charge was inadequate. While participants explained

Table 3. Select Quotes Illustrating Perspectives and Opinions Regarding Influential Factors of Alcohol Abuse Treatment Seeking Behaviors in Hispanic Males.**Structural barriers**

Good treatment is expensive, okay treatment does not work, and free treatment is a nightmare

- "I think that some of the reasons why some men don't get treatment is because they simply can't. They fear because they are undocumented, or they do not have insurance, or it is too expensive. I imagine that there are programs that can help but, well, I do not know, I guess there is a lack of information."^a

Linguistic and cultural disconnects

- "The problem is that if the psychologist does not understand the cultural aspects, well they're going to focus only on the education that they have received. Maybe a lot of the things they do will not help, although some things might ... Sometimes language is a barrier, not everybody speaks perfect English. Most of these programs are in English."^a

Sociocultural barriers

Normalization makes it difficult to problematize

- "Well it's in our lifestyle, for example, since you're a young man you see it, right? You see that your father drinks excessively, uncles, you understand? All of the people that surround you."^a

Los Consejos del Compadre

- "I guess if it was a friend of mine I really wouldn't know where you could go to get help. I would say, 'Yeah, you know, to AA or just stop drinking, just don't drink anymore.' It's not that easy of course but really, I don't know where somebody could go."

Negative community perceptions of known treatment

- "The help is not really there, I would be good with the help but it's just not 100%, there are too many holes. If somebody like yourself wanted to try to reach out to somebody, I would say to go on but how would you be accepted, you know? How can you be accepted if they don't even know you?"

Individual barriers

El Orgullo Mata (Pride Kills)

- "I think there is too much machismo in the Hispanic culture that they don't look for help. They don't look for that at all. They try to deal with it I guess or they don't deal with it and they keep on with it. I don't know the percentage of people in the Hispanic that are abusers of alcohol. I'm sure it is up there. I just think there is too much machismo for them to look for help in our culture."

Lack of understanding of treatment purpose and goals

- "Because you hear it from one person, you expect to get the same treatments. 'the doctor gave me pills so that the beer won't hit me as hard, or pills so that when I drink it tastes bad' and then everyone expects that type of treatment."^a

Getting Past the Orgullo (Pride)

- "Well, what I meant by that is that a shock to the body, usually a house scare, that will change a man from drinking to stop drinking when you do that. That's why I say a shock to the body, when I say by incident it can be maybe DUI or car accident where alcohol is a contributing factor, of course."

Note. ^aThese quotes were translated from Spanish.

that they were aware that accessible treatment programs may exist, they explained that these programs are not easily found, are difficult to navigate, are overburdened, and ill equipped to treat Hispanic patients. Participants explained that accessible programs have long queues that can take months to gain access.

A general lack of cultural competency. The presence of linguistic and cultural barriers associated with free treatment also were discussed. Participants reported difficulties finding services that were available in Spanish, adding that when help is offered in Spanish there are long waits and not enough linguistically competent staff to meet their needs. Participants who had accessed treatment in the past spoke about how they did not feel comfortable receiving treatment because they felt misunderstood due to linguistic and cultural disconnects. The men reported that a provider's inability to speak their language hindered an understanding of their experiences

and ability provide adequate advice. Importantly, participants reported that misunderstandings due to cultural incompetency can cause dissatisfaction with treatment providers, claiming that they feel providers can be invasive, and ask too many personal and uncomfortable questions upon initiation of treatment; linguistic disconnects make it difficult to establish rapport. Notably, participants added that one bad experience can drive Hispanic men to deprecate treatment forever.

Sociocultural Barriers

Normalization makes it difficult to problematize. There were a variety of sociocultural hindrances to treatment seeking that were reported. The most common barrier presented was a perceived cultural normalization of alcohol overconsumption in their social circles. The men reported that the ubiquity of overconsumption begets a culture of normalization in which alcohol abuse is not

readily perceived as a problem. Participants explained that high-risk drinking is seen as a phase of youth, and an inescapable habit for Hispanic men. Thus, early signs of problems with alcohol are easily overlooked by family and individuals alike. The men discussed that because alcohol use is not perceived to be a problem, that treatment is not perceived as necessary until they face grave consequences of their alcohol abuse, such as serious health problems, loss of family, or driving under the influence (DUI) convictions.

Los consejos del compadre (a buddy's advice). The normalization of alcohol abuse compounded by *macho*-driven self-reliance generates a peer-to-peer environment that can exacerbate problems with alcohol and deter individuals from treatment. Participants mentioned that most men will reach out to their closest drinking companions for advice when problems with alcohol abuse arise. If a man is having problems becoming violent when he is drunk, then friends suggest he take up smoking marijuana to stay calm; if he is experiencing blackouts men suggest that he use cocaine to stay alert; if he is having trouble keeping up with work in the mornings after drinking, he is encouraged to have a beer in the morning to curb his hangover. The men shared that the topic of seeking treatment is scarcely mentioned, adding that most men who have not had experiences with treatment would not be aware of where to go, or who to ask for help.

Negative perceptions of known treatment. Participants shared that speaking of the topic of alcohol abuse treatment with friends or family is taboo. Participants clarified that they know help can be found at places like Alcoholics Anonymous (AA) or religious organizations. There was a generalized sentiment, however, that only people with extreme drinking problems or those with underlying behavioral health issues need to seek help. As such, the men reported the existence of a stigma of peer-to-peer programs or religious organization-based assistance with alcohol-related issues. Participants described that stigma is rooted in two myths; (a) men that voluntarily seek help at AA must have behavioral health issues, or (b) a prevalent belief that alcoholism is a behavioral flaw and that one only seeks care when they are fundamentally incapable of remedying the problem on their own.

El orgullo mata (pride kills). It was mentioned that in order to seek treatment, men have to admit a loss of control, a vulnerability to alcohol, and a consequential loss of self-reliance. Participants added that an admission of loss of control is perceived as emasculating. Men are often too proud to admit they need help even when their health is at risk and when their lives are falling apart. Participants added that pride keeps most men in need of help away

from treatment and in a self-imposed cyclical battle with alcohol that ebbs and flows with periods of abuse and periods of self-initiated abstinence. Participants explained that due to the intersected barriers, Hispanic men must experience a pivotal, potentially life changing event that outweighs their pervasive pride and self-reliance. Importantly the men clarified that the consequences that override normalization and may drive men to seek help were largely related to a man's ability to provide for their family such as losing their driving privileges due to a D.U.I. conviction, a serious health problem, or job loss. The men explained that when a man loses his ability to provide for his family that is when he may realize the need to seek help.

Individual Barriers

Lack of individual understanding of treatment purpose and goals. The men reported that alcohol-related treatment is considered something to be fearful of. They perceive that "real" help (i.e., not AA or religious organizations) will involve clinical intervention. The general perception of conventional treatment was that it needs to be based on the medical model; that one would need to be hospitalized for effective treatment, which would take a large amount of time and resources. The potential of an inpatient experience makes the treatment-seeking that much more daunting to them, as they fear the unknown interventions they will be subjected to and the loss of work they will have to undertake during their impending stay.

Discussion

The purpose of this study was to examine Hispanic male perspectives regarding alcohol abuse treatment-seeking behaviors and the structural, sociocultural, and individual factors that may influence initiation and continued engagement in treatment in this population. Findings suggest that treatment seeking behaviors are highly influenced by (a) structural factors related to treatment accessibility, and linguistic and cultural-responsiveness of available treatment, (b) sociocultural factors related to difficulties problematizing alcohol abuse due to lack of community awareness and cultural normalization of consumption, and societal stigmatization of alcohol abuse treatment, and (c) individual factors related to a lack of knowledge.

Study data suggest the presence of complex and compounded effects of the socioeconomic status of Hispanic males that beget decreased access to adequate services. Primary structural hindrances to treatment cited by study participants were the high costs of effective treatment and the lack of insurance to subsidize it. Lack of economic resources has been reported to have detrimental effects to

service access and completion that affects minority populations, particularly Hispanics and African Americans, at increased rates when compared to NHW (Alegría et al., 2006; Jacobson, Robinson, & Bluthenthal, 2007). Present study findings highlight the need to consider socioeconomic status-related structural barriers to health for Hispanic men, specifically regarding work- and income-related constraints that keep men from seeking treatment. Prevention and treatment programs should account for the broader socioeconomic context of participants as part of comprehensive treatment plans. Interventions can be supplemented by the improvement of individual socioeconomic status as a focused outcome of comprehensive alcohol abuse treatment. For example, programs can include components focused on effective job placement, continuing education, or job and skills training; strategies that have proven efficacious in parallel populations (Jason et al., 2013).

Participants highlighted the perceived inadequacy of the treatment available to them. Efficacious treatment was seen to be out of their reach, leaving them with inadequate treatment choices. This is congruent with literature indicating that Hispanics consistently report dissatisfaction with treatment when compared to NHW (Alegría et al., 2006). Dissatisfaction with treatment as perceived by this study's sample was centered in; (a) deprecation created by poor experiences with treatment begetting distrust of sliding-scale and free treatment, and (b) the lack of appropriate linguistically and culturally responsive communication between patient and provider. Evidence highlights the scarcity of Spanish-speaking treatment providers, resulting in a lack of linguistically appropriate services that continue to be a major barrier to seeking and using alcohol abuse treatment for Hispanics (Amaro & Aguiar, 1998; Ornelas, Allen, Vaughan, Williams, & Negi, 2015; Pagano, 2014). It is imperative that treatment efforts consider the preferred language of clientele from outreach to completion as this can make efforts more effective with this population. Findings from Ornelas et al. (2015) indicate that some Hispanic men prefer to discuss their alcohol use in Spanish with trusted providers and have therefore suggested the use of *promotores* as a viable strategy. *Promotores* are community health advisors that often share sociodemographic, linguistic, and cultural characteristics with the people they serve and have been demonstrated to enhance participant comfort and trust making intervention communication more efficacious (Ornelas et al., 2015).

Beyond language, considerations of the broad sociocultural environment and social context of individuals are imperative to patient-provider communication and understanding. For instance, Holmes (2012), proposes that social and economic structures in health care drive professionals from seeing the social and cultural determinants of client

health outcomes, a phenomenon which, in part, can be attributed to the economic, pay-per-client, structure of care. Consequently, Holmes posits that rushed, confusing, and blaming interactions with providers can lead individuals to frown on service provision and discount treatment (Holmes, 2012). This was parallel to present findings indicating that one bad experience with treatment can drive men to deprecate treatment indefinitely, which is problematic given that men may find themselves temporarily willing to enter treatment and they are inexplicitly turned away. It is vital for treatment programs working with this population to consider the effects of each client's social context and its potential effect on treatment-related behavior. For instance, Lee et al. (2013), assessed the effectiveness of a motivational interview intervention ($n = 53$, 54% male) to decrease heavy drinking in a Hispanic sample in which interviewers accounted for the influences of poverty, perceived discrimination, historical trauma, and employment status. Authors found that improved communication between providers and participants had a significant influence in reducing participants' drinking patterns at follow-up, suggesting that approaches that consider a broader social context may be more efficacious for this population (Lee et al., 2013; Valdez et al., 2018).

Stigma related to participation in peer to peer support and church-based treatment programs was frequently cited. Participants attributed this stigma to ignorance about the problems that arise from alcohol abuse, unfamiliarity of behavioral health issues often intersected with these problems, and inexperience with the benefits of treatment. Research suggests that stigmatization of alcoholism itself keeps people from seeking treatment (Fortney et al., 2004; Keyes et al., 2010); stigma that exists at higher rates among Hispanics (Smith, Dawson, Goldstein, & Grant, 2010). Stigma may be exacerbated by lack of knowledge and recent findings that suggest some Hispanic men may have limited knowledge about how to seek help or change alcohol misuse-related behaviors (Ornelas et al., 2015). Participants in the present study attributed both the social stigma and self-stigmatization to a lack of understanding of alcohol abuse and treatment. These findings illustrate a critical need for education, perhaps through wide-reaching campaigns, on the health and social consequences related to alcohol abuse for Hispanic men. In addition to lowering stigma, information regarding complex origins of alcohol abuse can emphasize the early symptoms of alcoholism and the benefits of treatment, helping Hispanic men become aware of when they may need to seek help.

Help seeking-related research with men also has proposed that men are least likely to seek help with a problem is perceived as *ego central* (Addis & Mahalik, 2003). Ego-central problems are those perceived to be reflective of an important individual quality; such as intelligence in

academics or physical strength in athletes (Addis & Mahalik, 2003). In the present sample, seeking help was perceived as a vulnerability to alcohol and an admission of a personal flaw which can threaten masculinity, self-esteem, and social standing, which are often coupled with *machismo*-bound traits (Arciniega et al., 2008). Nevertheless, there was a larger identification with *caballerismo* than *machismo* in the present sample, a notion that may be used to better formulate interventions for this population. Positive masculinity can be leveraged to create intervention and health communication strategies that consider and individual's adherence to positive masculine ideals and lead to constructive health-related behaviors. Considering the perceived *ego centrality* of a problem with alcohol; a man who generally identifies with *machismo*/hyper-masculine norms may be likely to feel that seeking help is a threat to his self-reliance. If the same man however, perceives himself as unable to solve a problem on his own, he may be guided to seek help and characterize his choice as one of taking control and not succumbing to the problem. Further, health communication strategies also could be based on a man's accountability to providing and caring for his family. For example, if a man sees his ability to provide for his family as central to his masculine identity, health messages can be framed to transmit that not reducing alcohol misuse may lead to health and social problems that create a *loss* of his ability to provide for his family. Conversely, messages can posit that a reduction in alcohol-misuse can lead to *gain* of efficiency at work, which in turn may increase the income that a man can provide his family. Strategically leveraging these concepts in intervention related communication could motivate men to make constructive behavior changes for the sake of the health and wellbeing of their families.

Strengths and Limitations

These findings have the potential to build upon currently available treatment strategies using specified community-based suggestions for improving treatment outreach and participant engagement that can positively impact treatment outcomes for Hispanic males. The ethnic homogeneity of this sample provides rich insight of the distinct sociocultural and contextual factors that influence treatment seeking behaviors specific to Mexican origin Hispanic men. Conversely, the results of this work need to be approached with caution as the racial and ethnic homogeneity of this sample limits the generalizability of these findings to only a subset of Hispanic males. Nearly all participants in this sample consumed alcohol with regularity at the time of the study, however, only a fraction of these reported a binge drinking event in the last month, potentially limiting

perspectives regarding alcohol abuse and treatment seeking. Nevertheless, nearly half of the sample had past experience with treatment or treatment seeking, including the 3 participants that were not current drinkers, all of which attributed their abstinence to past treatment. As a result, the variety in experiences with alcohol and treatment seeking offered valuable *internal* and *external* perspectives to the phenomenology this study explored, which is a strength of this study. Lastly, while study participants were all self-identified males, we used a heteronormative lens for data collection and analysis that limited analysis away from consideration of barriers to treatment experienced by queer, bisexual, and trans self-identified Hispanic men.

Conclusion

Given the rapidly expanding Hispanic population in the United States and the high cost of alcohol-related health and social problems, it is imperative to identify treatment barriers and accessible alcohol abuse recovery resources for this population. These findings point to the need for treatment providers to disseminate accurate information about treatment availability and eligibility, and the treatment process. This work also illustrates the need to for consciousness building efforts targeting the Hispanic male community regarding the detrimental effects of alcohol-related problems and treatment in order to diminish stigma. Increased or redistributed funding for linguistically and culturally responsive programs also is needed in communities with large Hispanic populations in order to meet a growing demand, particularly for the uninsured. Further research is needed to identify alternative potential barriers and recovery resources for this population and other Hispanic subgroups in distinct parts of the United States.

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