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## Younger African American Men's Beliefs and Attitudes Toward Prostate Cancer Screening

Linda Teemer-Baker  
*Walden University*

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# Walden University

College of Psychology and Community Services

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Linda Carol Teemer-Baker

has been found to be complete and satisfactory in all respects,  
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the review committee have been made.

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Walden University  
2025

Abstract

Younger African American Men's Beliefs and Attitudes Toward Prostate Cancer  
Screening

by

Linda Carol Teemer-Baker

MA, Capella University, 2022

BS, University of Phoenix, 2019

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Human Services

Walden University

November 2025

## Abstract

Prostate cancer screening has been a focus of scholars since the late 20th century, as researchers have sought to address persistent disparities in early detection and mortality rates among African American men. Researchers have demonstrated that cultural beliefs, mistrust of the medical system, and limited access to healthcare significantly influence prostate cancer screening behaviors within this population. However, researchers have yet to establish how younger African American men specifically interpret prostate cancer risk and how their beliefs and attitudes shape decisions regarding screening participation. The purpose of this study was to explore the beliefs, perceptions, and attitudes of younger African American men toward prostate cancer screening, and to identify what influenced their screening intentions and behaviors. The Health Belief Model provided a framework to analyze participants' perceptions of susceptibility, risk severity, potential benefits, and barriers associated with screening. Data for this qualitative multiple-case study were collected through detailed semi-structured interviews with three African American men aged thirty-five to forty-five across the southeastern United States, along with archival data related to published information about prostate screening. The findings from the content analysis indicated that cultural norms, fear of diagnosis, masculinity concerns, and limited routine health provider engagement strongly influenced screening attitudes. This study contributes to positive social change by adding information that may enhance efforts to promote screening. Public health practitioners may benefit from these findings by developing culturally responsive outreach initiatives to promote early prostate cancer screening among African American men.

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## Dedication

I dedicated this work to my parents, Mary Alice and Frank Teemer, whose love and encouragement sustained me and my community. I hope this study helps bring awareness and lasting change.

## Acknowledgments

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## Table of Contents

Chapter 1: Introduction to the Study.....	1
Background.....	2
Problem Statement.....	3
Purpose of the Study.....	4
Research Question.....	5
Framework for the Study.....	5
Nature of the Study.....	7
Definitions.....	8
Assumptions.....	11
Scope of Delimitations.....	12
Limitations.....	16
Significance.....	17
Summary.....	20
Chapter 2: Literature Review.....	22
Introduction.....	22
Literature Search Strategy.....	23
Theoretical Foundation.....	25
Health Disparities and Structural Barriers.....	28
Masculinity, Psychological Constructs, and Help-Seeking.....	28
Stigma, Avoidance, and Emotional Barriers.....	29
Cultural Contexts and Intersectionality.....	29

Traditional masculine norms,.....	33
Literature Review Related to Concepts .....	37
Summary and Conclusions .....	74
Chapter 3: Research Method.....	77
Research Design and Rationale .....	77
Role of the Researcher .....	78
Methodology .....	80
Instrumentation .....	83
Procedures for Recruitment, Participation, and Data Collection.....	83
Data Analysis Plan.....	84
Coding Framework .....	86
Ethical Procedures .....	88
Evidence of Trustworthiness.....	90
Summary.....	91
Chapter 4: Results.....	94
Introduction.....	94
Setting.....	94
Demographics .....	95
Data Collection .....	95
Data Analysis .....	96
Open Coding .....	98
Axial Coding.....	98

Evidence of Trustworthiness.....	99
Credibility .....	99
Transferability.....	101
Dependability.....	102
Confirmability.....	103
Results.....	107
Beliefs and Attitudes Toward Screening .....	120
Cultural Norms and Community Influence: Trust and Historical Mistrust .....	121
Knowledge and Health Information Access .....	121
Barriers and Facilitators of Screening.....	122
Summary .....	122
Chapter 5: Discussion, Conclusions, and Recommendations.....	126
Introduction.....	126
Interpretation of the Findings.....	127
Motivations and Barriers Through the Lens of the HBM.....	131
Perceived Susceptibility.....	132
Perceived Severity .....	132
Perceived Benefits .....	133
Self-Efficacy .....	133
Limitations of the Study.....	135
Recommendations.....	136
Recommendations for Practice .....	141

Recommendations for Policy .....	142
Recommendations for Future Research .....	143
Significance of the Recommendations.....	144
Implications.....	145
Theory.....	145
Practice.....	146
Social Change .....	147
Recommendations.....	148
Conclusion .....	149
Discussion.....	155
Masculinity and Gender Role Socialization .....	155
Beliefs and Attitudes Toward Screening .....	155
Cultural Norms and Community Influence.....	156
Trust and Historical Mistrust .....	156
Knowledge and Health Information Access .....	156
Barriers and Facilitators.....	157
Personal Health Practices and Decision-Making.....	157
Recommendations for Outreach .....	158
Current Resources and Public Health: Awareness and Stigma Reduction in the Community.....	162
Final Thoughts and Advice.....	163
References.....	165

Appendix A: Prostate Cancer Interview Questions .....	198
Appendix B: Flyer.....	201
Appendix C: Data Analysis Summary With Conceptual Alignment.....	202
Appendix D: Coding Framework With Case Narratives (P1-P3).....	203
Appendix E: Conceptual Framework Integration .....	206
Appendix F: Comparative Matrix: Study Findings Versus Prior Literature.....	208
Appendix G: Digital Rectal Examination .....	210
Appendix H: Current Resources and Public Health .....	211
Appendix I: Public Health Initiatives Promoting Prostate Cancer Awareness.....	212

## Chapter 1: Introduction to the Study

In the United States, the prostate cancer situation is worse for Black men, with case prevalence and death rates, both of which surpass the figures of other groups, shocking in their aspect, according to the American Cancer Society (ACS, 2023). Despite this, the need for such intervention is demonstrated in the considerable lack of socioeconomic, cultural, and emotional examination of systemic factors centered on screening behaviors, which is mitigated by their understanding of the perception of their own health. Even less attention has been paid to the case of Black men aged 35 to 45; in relation to this issue, there exists a gap in the research (Lateef et al., 2024). Therefore, the guiding research question for this study is “What did men in the region of interest think of early prostate cancer screening, and what are their thoughts, attitudes, and beliefs on the earlier detection of this disease?”

To identify the social construction of masculinity, as well as the process of gender role socialization, uniquely shaped attitudes towards attending and taking care of their own health (see Johnson & Norwitt, 2022). One of the study's goals was also to analyze and overcome the various barriers, such as mistrust, financial issues, lack of knowledge, and fear. To do so, the study also aimed to identify culturally appropriate strategies to raise awareness and, subsequently, participate in the screening. One participant remarked, “Some Black men think being healthy and not seeing a doctor is much easier than going to see a doctor. I hate hospitals.” Another emphasized family obligations, stating, “For my peers and my family, I feel good about it... what I could do to help better my life.”

These perspectives highlighted the tension between traditional masculine norms and the desire to protect family and community well-being (Vyas et al., 2022).

. By focusing on this age group, the study expanded understanding of the factors influencing preventive behaviors and helped develop approaches to reduce prostate cancer disparities. The chapter concludes by summarizing these key elements, thus laying the foundation for the methodological approach described in Chapter 3.

### **Background**

Prostate cancer disproportionately affects African American men in the United States, with incidence and mortality rates surpassing those observed in other racial and ethnic groups (American Cancer Society, 2023; Nyame et al., 2022). This disparity is shaped by factors, including socioeconomic conditions, barriers to healthcare access, and culturally embedded beliefs and norms regarding health and masculinity (Griffith et al., 2022; Okoro et al., 2020). Notably, Buote et al. (2020) emphasized that insufficient participation in regular prostate cancer screening significantly contributes to the elevated mortality risk within this population. Cultural constructions of masculinity, which discourage men from seeking preventive health services, have been identified as a substantial barrier to screening and early detection (Brüggemann, 2021; Buote et al., 2020; Whitten, 2022).

A substantial body of literature demonstrates the influence of gender norms—and, in particular, concepts of masculinity—on health-related decision making, including engagement with preventive practices such as cancer screening (Smith et al., 2022). Researchers have reported that individuals from marginalized communities, especially

men, may be less likely to pursue health-promoting behaviors perceived as challenging to their masculine identity (Brüggemann, 2021).

### **Problem Statement**

The central problem addressed in this research is the marked disparity in prostate cancer outcomes—detectable in higher rates of both diagnosis and mortality—among African American men when compared to other demographic groups in the United States (American Cancer Society, 2023). Despite the availability of effective screening methods, such as the prostate-specific antigen (PSA) test, African American men consistently have lower rates of early screening, contributing to late-stage diagnoses and poorer prognoses (Amin et al., 2025; Joshi & Filson, 2020; Tabei et al., 2020). Centers for Disease Control and Prevention [CDC], 2024b). Systemic challenges—including lack of access to healthcare, medical mistrust, insufficiently tailored healthcare interventions, and cultural norms surrounding masculinity—further exacerbate these disparities (Claeys et al., 2021; Nordin et al., 2024; Qiu, 2024).

Notably, the attitudes, beliefs, and perceptions that inform prostate cancer screening behaviors among younger African American men (ages 35–45) have received limited empirical attention (Svensson et al., 2023). Understanding health behaviors in this age group is essential, as early adulthood is a critical period during which health-related patterns and attitudes are formed, influencing future outcomes (Bynum et al., 2022). By addressing this research gap, the current study aims to generate findings that can inform the development of culturally relevant interventions to support early detection, narrow

disparities in prostate cancer outcomes, and facilitate informed decision-making for this population.

Significantly, the significance of this line of inquiry extends beyond individual or group-level health. The disproportionate burden of prostate cancer among African American communities highlights broader public health and social justice concerns. Griffith et al. (2022) and Shastry et al. (2022) argued that tackling this disparity aligns closely with efforts to advance health equity and address entrenched systemic inequalities in healthcare access and outcomes.

### **Purpose of the Study**

This qualitative multiple-case study sought to examine how younger African American men—those aged 35 to 45—perceive early prostate cancer screening (see Kensler et al., 2020). The goal was not just a surface-level review. Rather, the research aimed to unpack various cultural, social, and psychological factors shaping opinions regarding prostate cancer screening, including the obstacles and potential motivators for early detection (see Griffith et al., 2022). Researchers have focused on pathways such as individual lived experiences, awareness of prostate cancer, and health-seeking behaviors, hoping to pinpoint underlying themes that could support more effective, targeted interventions and health education (Butler et al., 2020; Jain et al., 2023; Mursa et al., 2022).

The study intentionally addressed multiple intersecting factors—concepts of masculinity, longstanding mistrust in healthcare systems, economic barriers, and the influence of one’s community (see Buote et al., 2020; Kensler et al., 2020). It also

examined perceptions of the risks and rewards of testing, knowledge about health disparities, and the impact of family history or peer attitudes on health choices (Dickerson et al., 2020). The research revealed that African American men in this age bracket tend to delay preventive care. Several reasons for this reluctance have emerged: cultural stigma, anxiety about a possible diagnosis, and insufficient recommendations from physicians (ACS, 2023; Griffith et al., 2022). By highlighting these perspectives, the study aimed to guide more culturally responsive public health strategies that might boost prostate cancer screening uptake among African American men (see Kensler et al., 2020).

### **Research Question**

The central question framing this research emerged from a conceptual framework incorporating socialization norms and exploring how the health belief model can shape decision-making. Specifically, the research question was as follows: What are the perceptions, attitudes, and beliefs of African American men, aged 35 to 45 years, about early prostate cancer screening?

### **Framework for the Study**

This research was anchored by a set of interconnected concepts: masculinity, gender role socialization (as outlined in Lopez-Vergara et al., 2021; Nielson et al., 2020), and the health belief model (see Green, 2021). Collectively, these frameworks provided a lens for investigating how the beliefs and attitudes of younger African American men (ages 35–45) shape their participation in early prostate cancer screening. Specifically, the focus on masculinity and gender role socialization allowed for an analysis of how social

and cultural norms influence men's health behaviors (Kuss et al., 2021; Lateef et al., 2024).

Masculine socialization is understood to be contextually driven and varies substantially between cultures; this study concentrated on African American men. Prevalent notions of masculinity often discourage help-seeking and preventive care, framing vulnerability or medical screening as a threat to one's manhood (Adam et al., 2023). By contrast, individuals with more adaptable or androgynous perspectives on gender roles demonstrate greater concern for health maintenance, sometimes motivated by familial responsibilities, increasing openness to early detection (Smith et al., 2022).

Incorporating the health belief model (see Green, 2021; Nganda & Mwithia, 2024; Okoro et al., 2020) further extended this analysis. This framework facilitated examination of how cultural and gender-related influences shape risk perception, the perceived value of prevention, and attitudes toward medical engagement. Green (2021) posited that health behaviors are a function of how individuals perceive their susceptibility to a health threat, the seriousness of that threat, the advantages of acting in a preventive manner, and the obstacles that might impede such actions.

As applied to prostate cancer screening among younger African American men, the health belief model was instrumental in examining beliefs concerning personal risk, perceived efficacy of screening, and various barriers—including cost, apprehension, or distrust in the healthcare system—within the context of prevailing cultural and gender norms (see Zhuang & Guan, 2022). Taken together, these perspectives illustrate the complexity of factors that guide health-related decisions and highlight implications for

interventions addressing disparities in prostate cancer outcomes within this population.

Further explication of these theoretical frameworks is provided in Chapter 2.

### **Nature of the Study**

This study utilized a qualitative multiple-case research methodology to investigate the beliefs and attitudes of African American men aged 35–45 toward prostate cancer screening (see Kensler et al., 2020; Priya, 2020). Semi structured, audio-recorded interviews were conducted with eligible participants to elicit narrative data, allowing for an in-depth exploration of their perspectives and lived experiences. Upon completion, interview recordings were transcribed verbatim and subjected to individual analysis following established case research procedures (see Tasci et al., 2020). The findings consistently highlighted the pronounced influence of cultural norms—particularly perceptions of masculinity and vulnerability—on screening behaviors and health outcomes (see Adams et al., 2023; Kensler et al., 2020).

Given that African American men are disproportionately affected by prostate cancer in terms of both incidence and mortality, the study proceeded on the premise that cultural health beliefs significantly shape participants' perspectives (see Jones et al., 2023; Whitney & Evered, 2022). By elucidating their attitudes, concerns, and decision-making processes, I sought to inform the development of tailored strategies aimed at increasing early screening uptake and reducing persistent health disparities (see Lopez-Vergara et al., 2021; Saldaña & Sterba, 2021).

The selected multiple-case methodology was well-suited for this inquiry, as it provided a mechanism for eliciting rich, contextually grounded accounts of preventive

health behaviors (see Nagel et al., 2023; Thakore et al., 2023). Participants had to be African American men between the ages of 35 and 45 who had, within the past 2 years, considered, discussed, or received information about prostate cancer screening. Gathering personal narratives in this manner generates nuanced insights to inform culturally competent interventions, enhance patient-provider communication, and ultimately improve health outcomes in this high-risk demographic (Bynum et al., 2022; Griffith et al., 2022).

### **Definitions**

Brief definitions of key terms are provided, and further explanation is provided in Chapter 2.

*Autonomy:* Autonomy is the capacity for self-directed decision-making, particularly regarding personal health and life choices (Coleman-Kirumba et al., 2023). As an illustration, a man who has received relevant health information about prostate cancer screening and feels empowered to decide independently may be more inclined to pursue screening. The concept of autonomy is central to this research, providing insight into screening behavior among African American men, especially when trust, respect, and perceived control influence health-related decisions (Coleman-Kirumba et al., 2023).

*Emasculation:* Emasculation encompasses the experience or perception of diminished masculinity or male identity, typically provoked by situations perceived to undermine power, control, or sexual function (Lindqvist et al., 2021). For example, some men may interpret digital rectal exams as emasculating due to their intimate nature and potential implications for sexual integrity. This construct is particularly relevant for

interpreting psychological barriers to screening among African American men, as concerns about masculinity can discourage timely health-seeking behavior and early detection practices (Kirby et al., 2024; Bowie et al., 2020)

*Gender role socialization:* Gender role socialization refers to the process through which individuals learn and internalize cultural expectations for behavior based on gender (Nielson et al., 2020). An example is boys being taught to suppress emotional expression and, as a result, growing up to avoid discussing health issues. This process shapes beliefs and attitudes about preventive healthcare and impacts African American men's responses to prostate cancer screening, as well as their perceptions of masculinity itself (Bowie et al., 2020; Kuss et al., 2021).

*Health belief model (HBM):* The HBM is a theoretical framework for understanding health-related decision-making, based on individuals' perceptions of susceptibility, severity, benefits, barriers, and their belief in their own capacity (self-efficacy) to take action (Khalil et al., 2024; Nganda & Mwithia, 2024). For example, a man with a family history of prostate cancer may recognize his heightened risk, increasing his likelihood of seeking screening. This model is foundational to the present study's approach in understanding how African American men calculate the risks and benefits of prostate cancer screening, which guides their decisions about preventive action or delay (Okoro et al., 2020).

*Health disparities:* Health disparities refer to the persistent differences in health outcomes and access to healthcare between population groups, often rooted in social, economic, and environmental inequities (Lopez-Vergara et al., 2021; Ndugga &

Bloomberg, 2024). For example, African American men have significantly higher mortality rates from prostate cancer compared to other racial groups. In the context of this study, health disparities highlight the disproportionate burden of prostate cancer among African American men and emphasize the necessity of examining the sociocultural and systemic barriers that limit early screening (Ndugga & Bloomberg, 2024).

*Masculinity norms:* Masculinity norms describe socially constructed expectations about male behavior and traits, including strength, self-reliance, emotional restraint, and independence (Kuss et al., 2021). A practical example is a man declining prostate cancer screening because he believes seeking help would be perceived as weakness. These norms are highly relevant to this study because they significantly influence African American men's health behaviors, particularly their willingness to participate in screenings that may confront these gendered expectations (Lindqvist et al., 2021).

*Preventive healthcare:* Preventive healthcare involves medical measures taken to prevent illnesses or detect them early through regular checkups, screenings, and vaccinations (Cleveland Clinic, 2023). Prominent examples include PSA tests and digital rectal exams (DRE) for prostate cancer detection. For African American men, preventive healthcare is particularly significant, as early detection can improve outcomes and address elevated risks for aggressive forms of prostate cancer (ACS, 2025; del Pozo et al., 2022; Tabei et al., 2020)

*Psychological androgyny:* Psychological androgyny refers to integrating traditional masculine and feminine traits within an individual, contributing to greater

behavioral flexibility and emotional resilience (Bem, 1974; Woodhill & Samuels, 2023). For example, an assertive and emotionally expressive man may feel more at ease seeking medical care. In relation to this study, psychological androgyny is noteworthy because it supports health-seeking behaviors among African American men, reducing the perceived tension between masculine identity and engagement in preventive healthcare (Woodhill & Samuels, 2023).

*Traditional masculinity:* Traditional masculinity encompasses culturally ingrained ideals about manhood, such as stoicism, dominance, emotional suppression, and aggression (Barry et al., 2020). For instance, some men may avoid discussing prostate health due to beliefs that acknowledging vulnerability contradicts the masculine ideal. In this context, traditional masculinity impacts how African American men perceive and respond to prostate cancer screening, often reinforcing avoidance because screening may be interpreted as threatening their identity (Kuss et al., 2021).

### **Assumptions**

I conducted this investigation under several assumptions essential to its conceptual framework. I considered these assumptions necessary to ensure that the Participants' beliefs and attitudes of younger African American men toward early prostate cancer screening were effectively addressed. I successfully recruited participants who could share rich, detailed accounts of their beliefs and attitudes regarding prostate cancer screening (see Vapiwala et al., 2021). This assumption was foundational, as the study relied on the depth of participants' narratives to explore themes related to masculinity and health beliefs (see Lindqvist et al., 2021).

I selected participants who provided accurate recollections of their experiences with screening, whether they had undergone the procedure or had considered it (see Butler et al., 2020; Saldaña & Sterba, 2021). The validity of this research depended on the accuracy of these accounts, even though the possibility of memory bias or social desirability bias may influence some responses (see Vince et al., 2022). Despite variability in participants' levels of knowledge, attitudes, and past screening behaviors, common themes and influences related to masculinity and health beliefs would emerge (see Bispo Junior, 2022; Iacoviello et al., 2022). The participants' perceptions, beliefs, and attitudes are grounded in the belief that the African American community's cultural norms and shared experiences significantly shaped health-related behaviors (see Lateef et al., 2024; Svensson et al., 2023). I expected that the willingness of participants to provide detailed and honest accounts would ensure that the data collected would be sufficiently rich to explore the nuances of masculinity, cultural norms, and health beliefs associated with prostate cancer screening. Without the manifestation of these assumptions, the inquiry would have been less capable of uncovering meaningful patterns or informing targeted interventions.

### **Scope of Delimitations**

The respective delimitations established helped define this study's boundaries and focus. These parameters reflected intentional decisions made by the researcher to ensure the study remained aligned with its purpose of exploring the beliefs and attitudes of younger African American men toward early prostate cancer screening. First, I selected participants within a specific age range—35 to 45—rather than including younger or

older individuals. The decisions were based on the rationale that men within this age group were approaching the age at which prostate cancer risk begins to increase, and not yet routinely targeted by current screening campaigns.

Previous research has often focused on older African American men, leaving a gap in understanding how health beliefs and behaviors are shaped earlier in adulthood (Bynum et al., 2022). Second, the study was geographically limited to participants residing in a single metropolitan area in the southeastern United States. While this focus restricted the generalizability of findings to broader populations, it allowed for a more contextually grounded analysis of local cultural norms, healthcare access, and community influences. Similar studies have noted that localized research can reveal important nuances sometimes lost in national-level investigations (Kensler et al., 2020).

Third, I focused exclusively on self-identified African American men, excluding participants from other racial or ethnic backgrounds. This choice was made to ensure cultural specificity, given that African American men face disproportionate rates of prostate cancer incidence and mortality (ACS, 2023). Including other racial groups would have broadened the scope beyond the study's intent to examine this population's unique cultural, social, and psychological influences.

Fourth, the study did not require that participants have a history of prostate cancer screening. Instead, both screened and unscreened individuals were eligible. This approach allowed for a more comprehensive understanding of the factors influencing decision-making, including barriers to initial screening and perceptions among those who had not yet engaged with prostate cancer prevention efforts (see Griffith et al., 2022).

These delimitations were purposefully implemented to maintain a transparent and manageable scope, enabling a focused exploration of the research question. While these decisions inherently limited the breadth of the study, they enhanced its depth by allowing for a detailed examination of a specific population disproportionately affected by prostate cancer.

This analysis aimed to explore the beliefs and attitudes of younger African American men regarding early prostate cancer screening. To ensure a focused and meaningful investigation, specific boundaries were set. I chose to study African American men aged 35 to 45 because this stage of life is important for establishing preventive health habits. Men younger than this were excluded to keep the focus on a group whose screening choices might still be influenced before reaching higher risk ages (see Griffith et al., 2022).

I deliberately chose this age group to fill a gap in the literature, as most studies have focused on older African American men (see Bynum et al., 2022). Geographically, participants draw from accessible communities in a defined region. This localized focus allowed for in-depth qualitative data collection and case-based analysis that captured cultural and contextual factors influencing participants' experiences (Eakin & Gladstone, 2020; Morris et al., 2022). Although the geographic delimitation limited generalizability, it enhanced the depth of insight into community-specific norms and barriers.

Methodologically, the study was delimited by its reliance on qualitative approaches.

It used thematic analysis to explore participants' subjective experiences, avoiding quantitative techniques such as statistical analyses of screening prevalence. The emphasis

on qualitative methods supported a nuanced understanding of the social, cultural, and psychological factors that shaped health behavior (see Smith, 2020). The research was also limited to prostate cancer screening and did not examine attitudes toward other types of cancer or general health screenings. The limitation of prostate cancer screening allowed for a tightly focused investigation centered on a condition that disproportionately affects African American men (see Albertsen, 2020).

This study explored cultural influences on health decisions, particularly how masculinity norms impacted perceptions of vulnerability and health-seeking behavior. It considered both traditional and evolving gender roles and their effects on attitudes toward preventive care (Svensson et al., 2023). I analyzed screening behaviors within a framework of social, psychological, and environmental factors, with the HBM guiding the interpretation of perceived risks, benefits, barriers, and cues to action (see Adams et al., 2023; Jiang et al., 2021).

Additional delimitations included the exclusive focus on self-identified African American men, thereby excluding other racial or ethnic groups facing distinct healthcare challenges (Nyame et al., 2022). The findings were thus culturally specific and not intended to generalize across populations. Moreover, while the study identified potential interventions, their implementation and efficacy testing fell outside the scope of the current research (see Hernandez & Gibb, 2020). These delimitations helped ensure a precise, manageable scope and allowed for deep exploration of an under-researched area. They also acknowledged the boundaries of the study's findings, ensuring that conclusions

were appropriately contextualized while contributing meaningful insights to the literature on prostate cancer disparities.

### **Limitations**

The study also encountered limitations. One of the primary challenges involved recruiting participants who were comfortable discussing the sensitive topic of prostate cancer screening. For some, the subject was either unfamiliar or personally distressing, and the interview process had the potential to trigger psychological discomfort (see Bynum et al., 2022). Another limitation involved variability in the level of detail participants were able or willing to provide.

Those who had recently engaged with or considered prostate cancer screening were more likely to offer rich, detailed accounts of their experiences than those who had not (see Adam et al., 2023; Butler et al., 2020)

. To address these limitations, the study included several mitigation strategies. First, invitational materials emphasized participant confidentiality and the voluntary nature of the study. Potential participants were also informed of the topic's sensitive nature so they could make an informed decision about whether to participate.

Second, before the interviews, participants received a list of free and low-cost counseling services, in case the discussion evoked any distress. These steps ensured that participant well-being was prioritized throughout the research process. (Vyas et al., 2022)

By considering these limitations, the study maintained ethical integrity and rigor. Despite the challenges, the findings contributed valuable insights into the personal and societal factors that shaped health behaviors in this demographic group. These insights

supported broader strategies to identify barriers and facilitators to early cancer detection, ultimately aiding efforts to reduce health disparities in prostate cancer screening (see Griffith et al., 2022).

This study was limited by a small sample size, restricting generalizability. While culturally relevant, the barbershop setting may not reflect experiences in other contexts, such as HBCUs, rural communities, or workplaces. Reliance on self-report introduced potential social desirability bias. The exclusion of family members and healthcare providers limits perspectives on shared decision-making. Finally, the study limited its address of emerging factors such as digital Health and genomic risk stratification.

### **Significance**

This study makes a meaningful contribution to advancing knowledge in public health, health psychology, and cultural studies by exploring critical gaps in understanding how younger African American men aged 35–45 perceive and approach early prostate cancer screening. Its practical implications are major for healthcare providers, policymakers, and community organizations, as it offers valuable insights that can help shape culturally customized interventions aimed at increasing screening rates among this group. Such interventions might include targeted health education campaigns, community outreach initiatives, and culturally sensitive messaging designed to overcome psychological and cultural barriers to screening (Adams et al., 2023; Claeys et al., 2021; Nemesure et al., 2022). Healthcare professionals can use these findings to improve communication with African American male patients and to promote culturally responsive conversations about prostate cancer screening.

The research also supports the development of training programs for healthcare providers to better address issues like cultural stigma, distrust, and historical skepticism towards the healthcare system (see Claeys et al., 2021; Rossi & Bombaci, n.d.). From a policy perspective, the insights gained could guide the creation and implementation of public health initiatives focused on reducing disparities in screening access. Policymakers might use this information to advocate for increased funding for community health programs, preventive education efforts, and expanded access to screening services for prostate cancer (see Bynum et al., 2022; Nemesure et al., 2022). By tackling the cultural and psychological obstacles faced by younger African American men, this research aimed to help narrow healthcare disparities and promote earlier detection in this high-risk group.

Encouraging greater participation in screening could lead to fewer diagnoses at advanced stages and lower mortality rates among African American men. Addressing misconceptions and cultural stigmas around screening may also boost health literacy and promote a greater acceptance of preventive health behaviors. Community leaders, educators, and advocates could use these insights to promote culturally appropriate health initiatives in African American communities. These initiatives might include health fairs, peer-led educational sessions, and support groups that make conversations about prostate cancer screening more normalized.

Besides, the findings have the potential to strengthen trust in the healthcare system by addressing longstanding barriers and improving communication. Open, honest interactions between healthcare providers and African American men can build stronger

relationships and increase engagement with healthcare services (Claeys et al., 2021; Rossi & Bombaci, n.d.). This research also lays the groundwork for future studies, inspiring further investigation into the social, cultural, and structural factors that influence preventive health behaviors among African American men. Besides, it could spark policy advocacy and healthcare reforms aimed at achieving greater health equity across diverse populations.

Local health agencies and community centers can use these findings to develop culturally sensitive outreach efforts. Regional health departments might apply this knowledge to develop targeted interventions, such as mobile clinics and awareness campaigns. At the national level, organizations like the National Urban League and the National Medical Association could use this research to push for increased funding, community involvement, and public health education. Health educators and social workers can incorporate these insights into training and outreach programs to support early detection and knowledgeable decision-making among African American men. Eventually, healthcare providers, including doctors and nurses, can use these insights to improve culturally sensitive care, build trust, and reduce persistent barriers to prostate cancer screening. This study provides a foundation for future research, offering actionable insights that could inform policy changes, combat cultural stigma, and promote sustainable improvements in healthcare access and prostate cancer outcomes for younger African American men.

## Summary

In Chapter 1, I summarized the existing literature on health disparities in prostate cancer screening, factors that influenced younger African American men's engagement with preventive health services, and the cultural and psychosocial elements that shaped their decision-making. Within the chapter, I delineated the problem statement, emphasizing the lack of research explicitly focused on the beliefs and attitudes of younger African American men toward prostate cancer screening. I outlined the purpose of the study, which centered on understanding the psychosocial influences and cultural perceptions that affected prostate cancer screening behaviors. I presented the central research question to guide the overall inquiry (Svensson et al., 2023). I introduced the conceptual framework—drawing from the HBM and theories of masculinity—to provide a theoretical foundation for understanding how cultural expectations, perceptions of vulnerability, perceived benefits and barriers, and gender norms influenced health behaviors.

These frameworks were well-suited for investigating the multifaceted issues contributing to health disparities and shaping preventive behaviors among younger African American men (Lindqvist et al., 2021). The nature of the research relied on a narrative, case-based methodology to capture individuals' described experiences. The underlying paradigm assumptions of the study included the expectation that participants would be transparent and provide honest, detailed accounts of their experiences, and that their narratives would yield rich insights into their health-related decision-making processes (Butler et al., 2020)

. I delineated the study's focus and delimitations, including the inclusion criteria for participants and an acknowledgment of other theoretical frameworks that were considered but not selected.

I addressed limitations, such as African American men's hesitancy to discuss personal health matters and the influence of limited knowledge about prostate cancer screening. The chapter described how this investigation could contribute to positive social change by informing healthcare policies, clinical practices, and educational strategies aimed at increasing prostate cancer screening participation among younger African American men. Chapter 2 includes an in-depth literature review, detailing the search strategy and providing a comprehensive discussion of the theoretical frameworks. The study highlights key concepts relevant to the research, and the chapter concludes with a summary and a transition into Chapter 3.

## **Chapter 2: Literature Review**

### **Introduction**

Prostate cancer remains the most commonly diagnosed cancer among men in the United States, with African American men facing the highest incidence and mortality rates. According to the ACS (2025), African American men are nearly twice as likely to die from prostate cancer as White men. Despite the availability of practical early detection tools—such as the PSA test and DRE—screening uptake among African American men, particularly those aged 35 to 45, remains disproportionately low (Tabei et al., 2020). This disparity underscores the urgency of exploring the intersecting sociocultural, psychological, and systemic influences shaping their screening behaviors (Amin et al., 2025).

Existing literature has shown that cultural beliefs, medical mistrust, masculinity norms, and limited access to healthcare influence prostate cancer screening decisions. However, little had been written about the beliefs and attitudes toward prostate cancer screening among younger African American men, whose perceptions of health, masculinity, and preventive care might differ significantly from those of older populations. To address this gap in the literature, I explored how younger African American men understood prostate cancer risk, interpreted health information, and made decisions regarding screening participation. In this chapter, I describe the research strategy used to guide the literature review. It included an examination of the theoretical framework guiding this study and the history of prostate cancer screening among African

American men. Despite ongoing public health efforts, younger men's screening beliefs remained underexplored, underscoring the need for this study.

### **Literature Search Strategy**

The literature research strategy I used for this study included Walden University's online library and academic databases such as EBSCOhost, JSTOR Digital Library, ScienceDirect, SAGE Publishing, Google Scholar, and the Thoreau multi-database search tool. I selected these databases because they provided access to peer-reviewed journals, dissertations, and empirical studies relevant to health disparities, cultural beliefs, and cancer prevention behaviors. I used several keywords and Boolean combinations such as *prostate cancer screening*, *African American men*, *health beliefs*, *attitudes toward screening*, *decision-making criteria*, and *preventive health behavior*. I also used additional terms such as *public safety*, *public health*, and *United States health disparities* to access current and historical information related to prostate cancer outcomes and early detection efforts among African American men.

To ensure comprehensive coverage, I reviewed references cited within identified articles to locate additional resources not retrieved through database searches. This strategy helped identify seminal studies and relevant theoretical literature on the Health Belief Model, cultural perceptions, and barriers influencing screening participation (Girman & Ritchey, 2021; Negrin et al., 2022; National Institutes of Health [NIH], n.d.). This systematic approach allowed for a thorough synthesis of existing literature and ensured that the review reflected diverse scholarly perspectives on younger African American men's beliefs and attitudes toward prostate cancer screening. Lastly, I

reviewed references in the literature to gather additional resources not found through the proposed research strategies.

I refined the search strategy iteratively. Boolean operators and conceptual clustering techniques were applied to increase the precision and depth of the results. I prioritized articles published within the past decade, focusing on peer-reviewed studies that explored behavioral health theories such as the HBM and sociocultural determinants of health, including masculinity ideology, stigma, healthcare mistrust, health disparities, and access to care.

The search strategy evolved to integrate emerging themes, such as shared decision-making, perceptions of PSA testing, and psychosocial influences on screening behavior. I employed, in addition, both backward and forward citation tracking to locate foundational and highly cited studies. This approach allowed for a deeper contextual analysis of the barriers and facilitators to prostate cancer screening within the target population.

I paid particular attention to qualitative and mixed-methods research that captured the lived experiences of African American men navigating masculinity, identity, and health-related decision-making. This literature search strategy ensured the review incorporated a comprehensive scope, reflecting scholarly rigor and cultural relevance. I approached the design to remain attuned to the unique sociopolitical and historical contexts that have shaped Black men's engagement with preventive healthcare services.

### **Theoretical Foundation**

The theoretical foundation for this study was grounded in the Health Belief Model (HBM), which has been widely used to explain health-related behaviors and preventive screening practices among diverse populations (see Girman & Ritchey, 2021). The HBM provided a framework for understanding how perceptions of susceptibility, severity, benefits, and barriers influenced individuals' health decisions (National Institutes of Health [NIH], n.d.). In the context of this study, the model helped to interpret how younger African American men perceived prostate cancer risk, evaluated the benefits of early detection, and navigated personal and cultural barriers that affected their willingness to participate in screening. This theoretical lens aligned directly with the study's purpose—to explore younger African American men's beliefs and attitudes toward prostate cancer screening and to identify the sociocultural factors shaping their decision-making processes.

Nganda and Mwithia (2024) informed this investigation, conducted a comprehensive database search to gather literature addressing African American men's beliefs and attitudes toward prostate cancer screening. The HBM served as a guiding theoretical framework, offering a structured lens through which to understand the psychosocial and cultural factors influencing prostate cancer screening engagement (see Khalil et al., 2024). The model's core constructs—perceived susceptibility, perceived severity, perceived benefits, self-efficacy, and cultural competence in healthcare delivery—were used to explore how these elements manifested in the health behaviors of younger African American men aged 35 to 45. Each construct offered insight into the

motivations and barriers shaping decisions about preventive care, particularly concerning early detection of prostate cancer (see Claeys et al., 2021; Fish et al., 2022; Quach, 2022).

*Perceived susceptibility* reflected the extent to which individuals believed they were at risk of developing a particular health condition (Liu et al., 2021). Within the context of prostate cancer screening, this concept addressed whether African American men acknowledged their statistically higher vulnerability to the disease (Lie et al., 2021). A lack of awareness or understanding of this increased risk often contributed to the misconception that prostate cancer was unlikely to affect them personally, resulting in a tendency to postpone or avoid screening altogether (Zhuang & Guan, 2022).

*Perceived severity* refers to individuals' understanding of a health condition's seriousness or potentially life-threatening nature (Devi et al., 2022). The perceived severity component emphasized the importance of recognizing the consequences of undetected or untreated prostate cancer. When African American men viewed the disease as severe, they were more likely to respond urgently and adopt preventive measures, reinforcing that acknowledgment of disease severity played a pivotal role in driving screening behaviors (Taflinger & Sattler, 2024).

*Perceived benefits* encompassed the belief that engaging in a specific health action—such as undergoing prostate cancer screening—could reduce personal health risks or limit the impact of illness (Alyafei & Easton-Carr, 2024; Devi et al., 2022). Among African American men, the perception that the advantages of early detection outweighed potential discomfort, stigma, or distrust of healthcare providers was often a determining factor in whether they pursued screening. This aligned with the broader

HBM framework, positing that individuals evaluate potential gains and losses before committing to health-promoting behaviors (Ekeh, 2022; Leung, 2020).

*Self-efficacy* refers to the belief in one's ability to take meaningful health-related action and manage potential challenges (Devi et al., 2022). In this context, self-efficacy reflected African American men's confidence in navigating the healthcare system, seeking information, and following through with screening procedures. Empowering individuals with the necessary knowledge, resources, and support was essential to strengthening self-efficacy, ultimately encouraging consistent engagement with preventive care (Henderson et al., 2022; Owens et al., 2020; Qin et al., 2022).

Taken together, these constructs provided a comprehensive framework for exploring how perceptions of risk, severity, benefits, and personal agency shaped African American men's decisions regarding early prostate cancer screening. The HBM offered a culturally responsive and psychologically grounded approach to understanding the multifaceted influences that continue to affect screening participation in this underserved population.

This literature review was divided into several sections. The first section reviewed literature discussing the theoretical framework used in this study—Health Disparities and Structural Barriers—to provide context on how systemic inequities influenced prostate cancer outcomes among African American men. The second portion examined research on Masculinity, Psychological Constructs, and Help-Seeking, along with existing knowledge about Stigma, Avoidance, and Emotional Barriers that affected the screening decision-making process (see Negrin et al., 2022).

## **Health Disparities and Structural Barriers**

Health disparities refer to inequitable differences in health outcomes and healthcare access often shaped by systemic, socioeconomic, and environmental disadvantages (Lopez-Vergara et al., 2021; WHO, 2021). For African American men, these disparities manifest in delayed diagnoses, limited access to preventive care, and persistent medical mistrust—factors that contribute directly to their higher prostate cancer mortality (Ndugga & Bloomberg, 2024). Clinical frameworks such as those developed by the National Institute for Health and Care Excellence (NICE, 2019; updated 2021, 2025) advocate for early screening, patient autonomy, and culturally responsive care. These guidelines align with the HBM, which explains health behavior as a function of perceived susceptibility, perceived benefits, and barriers to action (Khalil et al., 2024).

## **Masculinity, Psychological Constructs, and Help-Seeking**

Masculinity norms—social expectations that valorize traits such as stoicism, independence, and dominance—are often internalized during gender role socialization and significantly impact African American men’s willingness to engage in preventive healthcare (Kuss et al., 2021; Nielson et al., 2020). For many, undergoing a DRE may evoke feelings of vulnerability or symbolic emasculation, defined as the perceived loss of masculine identity or control (Lindqvist et al., 2021; Kirby et al., 2024). These feelings are not merely individual reactions but are shaped by cultural narratives around masculinity, race, and bodily autonomy (Bowie et al., 2020)

Autonomy—the capacity for self-governed, informed decision-making—is central to many African American men’s health behaviors (Coleman-Kirumba et al., 2023).

When screening is perceived as coerced, intrusive, or inadequately explained, it may be rejected as a threat to personal dignity. However, when masculinity is reframed to emphasize responsibility, leadership, and family protection, it can motivate proactive health behaviors (Barry et al., 2020; Woodhill & Samuels, 2023). Additionally, the concept of psychological androgyny—the integration of masculine and feminine traits—has been associated with greater emotional flexibility and openness to seeking medical care (Bem, 1974).

### **Stigma, Avoidance, and Emotional Barriers**

Brenner et al. (2020) offered a critical psychological perspective by examining how self-stigma and experiential avoidance inhibit help-seeking behaviors. Drawing from acceptance and commitment therapy (ACT), the study found that individuals who avoid uncomfortable emotions (e.g., shame, fear) are less likely to seek help, even when recognizing its benefits. Among African American men, this dynamic may help explain resistance to prostate cancer screening. Procedures like the DRE or PSA test can provoke fears not only of physical discomfort but of symbolic emasculation, compounding internalized stigma. Brenner et al. (2020) emphasized psychological flexibility as a key intervention point—encouraging individuals to acknowledge discomfort without control, a strategy highly applicable to prostate cancer screening outreach.

### **Cultural Contexts and Intersectionality**

Thompson's (2023) three-group model of masculine identity in African American men adds an important layer of analysis. This framework distinguishes between (a) peer group masculinity, often marked by hypermasculine norms; (b) subcultural masculinity,

emphasizing community unity and emotional openness; and (c) societal masculinity, shaped by dominant Eurocentric ideals. These reference groups profoundly shape how African American men engage with health systems. For instance, hypermasculine peer norms may discourage screening due to associations with weakness, while subcultural norms may provide space for emotional disclosure and collective health promotion. This complexity is further evident in public discourse, such as the media response to the U.S. Secretary of Defense's delayed disclosure of his prostate cancer diagnosis (USA Today, 2024). His silence was widely interpreted as emblematic of broader issues around stigma, masculinity, and racialized expectations of strength. These narratives reflect the tension between vulnerability and identity that many African American men navigate when facing health decisions.

### ***Toward Culturally Responsive Interventions***

To address these disparities, scholars have increasingly called for culturally tailored interventions that affirm rather than undermine masculine identity (Aguilera et al., 2024). Educational messaging should frame screening not as a threat but as an act of strength, self-respect, and responsibility to one's family. Furthermore, strategies should enhance autonomy through shared decision-making, empowering men to take control of their health on their own terms (Coleman-Kirumba et al., 2023). Updated screening technologies—such as multiparametric MRI and refined PSA protocols—and structured decision aids (NICE CKS, 2025), offer opportunities to increase trust and engagement. When implemented in culturally appropriate ways, these innovations can help bridge the gap between guideline-based care and the lived realities of African American men.

The literature has revealed that prostate cancer screening disparities among African American men stem from a complex interplay of structural, psychological, and cultural factors. Health disparities, medical mistrust, masculinity norms, and stigma converge to reduce screening participation, particularly among men aged 35 to 45. However, when masculinity is reframed as a source of strength and autonomy is respected, these same constructs can be mobilized to support health engagement (Bowie et al., 2020). Theoretical models such as HBM and gender role socialization, along with psychological frameworks like experiential avoidance, offer valuable lenses for understanding these dynamics.

### ***Current Resources and Public Health: How Young Men Access Prostate Cancer Information***

Understanding how young African American men access prostate cancer information is essential to addressing early screening disparities. Public health messaging often fails to reach this demographic effectively due to mistrust, stigma, or a lack of culturally relevant communication (Brenner et al., 2020; Ndugga & Bloomberg, 2024). Increasingly, advocacy from public figures and targeted nonprofit campaigns serve as alternative, influential information channels. Montell Jordan—renowned for his 1995 hit *This Is How We Do It*—emerged in 2024 as a prominent advocate for prostate cancer awareness following his own diagnosis and treatment journey.

Partnering with ZERO Prostate Cancer, Jordan aimed to amplify early detection messaging within the Black community, particularly for younger men who may otherwise delay screening due to stigma, masculinity norms, or insufficient knowledge (ZERO

Prostate Cancer, 2024). His story was shared through multiple media outlets and an upcoming documentary, *Sustain*, offering a culturally resonant, personal account that reframes screening as a proactive act of self-preservation and empowerment.

Organizations like ZERO Prostate Cancer have increasingly focused on digital resources, peer testimonials, and community outreach efforts to bridge the gap between healthcare systems and underserved populations. Their platform includes tools tailored for African American men, addressing key barriers such as medical mistrust and lack of symptom awareness, while promoting regular PSA testing as a life-saving measure (ZERO Prostate Cancer, 2024; Tabei et al., 2020). Despite such resources, many young African American men still rely on informal or community-based sources—such as barbershops, social media, and family stories—for health information. These platforms can either reinforce misinformation or, if leveraged effectively, become conduits for trusted public health messaging. Understanding these information pathways remains critical for designing culturally appropriate interventions that resonate with younger audiences.

### ***Cultural Competence in Health Care***

Cultural competence in healthcare delivery significantly shaped health behaviors (Claeys et al., 2021). Trust in the healthcare system remained a pivotal factor for African American men, particularly in light of the historical context of systemic racism and unethical medical practices. The Participants in this study agree that culturally competent care, characterized by authentic, patient-centered communication, establishes trust and increases engagement in healthcare services (Taylor et al., 2023). Longstanding mistrust—rooted in historical injustices—deterred individuals from participating in

routine screenings (Bazargan et al., 2021). However, when healthcare providers addressed patients' cultural, social, and linguistic needs, they fostered environments encouraging African American men to seek preventive care (Patel, 2020).

By promoting cultural competence, providers deliver more personalized and culturally sensitive care, improve patient trust, facilitate open communication, and support health-promoting behaviors such as prostate cancer screening. Tailored interventions that acknowledged and addressed cultural beliefs helped bridge gaps in understanding, empowered patients, and promoted shared decision-making that respected patients' values and preferences (Claeys et al., 2021; Hernandez & Gibb, 2020). Within the framework of the HBM, this study examined how cultural norms, gender role socialization, and systemic barriers intersected to influence prostate cancer screening behaviors (Khalil et al., 2024; Nganda & Mwithia, 2024; Nielson et al., 2020; Okoro et al., 2020). A deeper understanding of these dynamics guided the development of culturally tailored interventions. Insights derived from this framework informed healthcare providers, policymakers, and community organizations in their efforts to reduce disparities and improve health outcomes for this vulnerable population (Dickerson et al., 2020; Richardson-Parry et al., 2023).

### ***Traditional Masculine Norms***

Traditional masculine norms, such as self-reliance and emotional restraint, contributed to delays in African American men's engagement with preventive healthcare services (Lindqvist et al., 2021). Deeply embedded in cultural expectations, these norms emphasized strength, independence, and control (Fluit et al., 2023; Kuss et al., 2021). As

a result, men who adhered to such standards often avoided displaying vulnerability or seeking medical care, which led to postponement of consultations and neglect of symptoms until conditions worsened (Bazargan et al., 2021; Green et al., 2020). Findings from this study suggested a strong correlation between traditional masculinity and medical mistrust. African American men closely identified with conventional masculine roles were more likely to express skepticism toward medical institutions (Adam et al., 2023; Kensler et al., 2024). Medical mistrust amplified historical injustices and contemporary experiences of discrimination in healthcare settings (Bazargan et al., 2021; Lindqvist et al., 2021).

The cultural emphasis on self-reliance—combined with justified wariness of the healthcare system—contributed to reluctance in seeking necessary medical care, even in situations involving significant health risks (Henderson et al., 2022). Conforming to traditional masculine ideals also appeared to heighten stress and depressive symptoms. The expectation to remain stoic and emotionally controlled limited opportunities for emotional expression and help-seeking, which potentially exacerbated mental health challenges (Adam et al., 2023). Mental health interventions designed for African American men, especially when they create environments where vulnerability and help-seeking are normalized (Fish et al., 2022; Whitten, 2022).

### ***Gender Roles and Health***

Gender roles significantly shape health-seeking behaviors and decision-making around prostate cancer screening (Marshall et al., 2023; Smith et al., 2022). Stigma surrounding prostate cancer—often tied to associations with sexual dysfunction and

perceived loss of masculinity—contributed to delays in diagnosis and treatment (Bowie et al., 2020). This stigma, compounded by discomfort with procedures such as DREs, led many African American men to avoid routine screenings, which resulted in later-stage diagnoses and poorer outcomes (Bouras, 2024; Leung, 2020; Smith et al., 2022). Female partners and family members frequently played a pivotal role in motivating men to seek care and adhere to health recommendations. Blok et al. (2021) found that support from family helped men navigate healthcare systems, effectively addressing cultural and structural barriers to timely care.

Bem's (1974) theory of psychological androgyny—which suggested individuals could display both masculine and feminine traits—offered a valuable perspective in this context (as cited in Liu & Damian, 2022; Woodhill & Samuels, 2023). Men who adopted a more androgynous identity appeared to be more receptive to engaging in health-promoting behaviors, including prostate cancer screening. These individuals often balanced traditional masculine traits with those emphasizing emotional openness and self-care (Bem, 1974; Liu & Damian, 2022). In contrast, men who conformed strictly to conventional masculine roles were more likely to perceive screening procedures, such as the DRE, as emasculating, which served as a significant barrier to participation (Bouras, 2024; Treadwell, 2020).

### ***Application of the HBM***

Together with the aforementioned constructs, the HBM provided a valuable framework for understanding the complex behaviors associated with prostate cancer screening. The model allowed for an analysis of how risk perception, perceived severity,

expected benefits, and perceived barriers influenced health-related decisions (Khalil et al., 2024; Nganda & Mwithia, 2024; Okoro et al., 2020). The beliefs held by younger African American men regarding their susceptibility to prostate cancer, the seriousness of the disease, and the perceived effectiveness of screening procedures were central to understanding their decisions (Green, 2021). When combined with cultural definitions of masculinity and gender roles, the HBM offered a structured lens for examining the challenges and motivators that shaped attitudes toward early screening (Khalil et al., 2024; Lindqvist et al., 2021; Nganda & Mwithia, 2024; Okoro et al., 2020). The integration of these elements revealed how risk perception and cost-benefit considerations intersected with self-efficacy to influence decision-making (Getaneh et al., 2020; Yang et al., 2020).

For example, men who perceived themselves to be at risk and acknowledged the severity of prostate cancer were more likely to consider screening—especially if they believed the benefits outweighed the barriers. However, significant obstacles such as stigma, mistrust, or fear of invasive procedures often discouraged action. Cues to action, including public health messages or encouragement from family members, were instrumental in initiating health-seeking behavior, while self-efficacy determined the individual's confidence in acting upon those cues (Bart et al., 2024; Fish et al., 2022; Quach, 2022). These theoretical and cultural constructs offered a comprehensive approach to exploring how masculinity, health beliefs, and systemic barriers intersect to influence preventive health behaviors. This framework laid the foundation for the development of culturally responsive interventions aimed at addressing the unique

challenges faced by younger African American men in accessing and engaging with prostate cancer screening services.

### **Literature Review Related to Concepts**

Kensler et al. (2020) argued that prostate cancer remained a significant health disparity within the United States, disproportionately affecting African American men compared to other racial and ethnic groups. African American men continued to experience higher incidence and mortality rates for prostate cancer than any other demographic group, a pattern well-documented across decades of epidemiological research. Despite this heightened risk, screening participation among African American men remained suboptimal. Researchers attributed this underutilization to a combination of social, cultural, and structural barriers, including limited awareness of screening recommendations, mistrust of the healthcare system, and cultural conceptions of masculinity that discourage preventive health behavior (Bynum et al., 2022; Lindqvist et al., 2021). The existing literature highlighted that these disparities were exacerbated by socioeconomic constraints, systemic healthcare inequities, and cultural beliefs about illness and manhood (Lillard et al., 2022). Younger African American men exhibited lower screening rates shaped by a complex interplay of psychological, cultural, and institutional influences (Adams et al., 2023; Bynum et al., 2022). Among these, the influence of traditional masculinity norms appeared most consistent across the literature. Adams et al. (2023) and Tamir et al. (2024) emphasized that ideals such as stoicism, resilience, and emotional restraint—often viewed as virtues within African American

communities—paradoxically discouraged younger men from engaging in preventive care, including prostate cancer screening.

### ***Stoicism and Health Behavior Avoidance***

Vapiwala et al. (2021) argued that culturally embedded expressions of masculinity, particularly stoicism, played a pivotal role in shaping African American men's health behaviors and decisions regarding preventive care. Stoicism, while historically serving as a coping mechanism that fostered resilience and emotional endurance, was observed to significantly limit participation in life-saving health behaviors, including prostate cancer screening. Though its philosophical roots originated in Hellenistic traditions emphasizing emotional restraint and perseverance, stoicism evolved within African American male communities into cultural expressions of toughness, bravado, and silent suffering. These characteristics were not transmitted through formal instruction but were passed intergenerationally as behavioral expectations that profoundly influenced health-related decision-making. Within this sociocultural context, stoicism functioned as a silent yet powerful barrier to preventive health practices. Conversations about prostate cancer were often absent from family and community discourse, as the topic was regarded as private or taboo. Bekele and Martínez-Hernández (2024) observed that this cultural silence perpetuated stigma and reinforced reluctance to engage in medical screenings that they might perceive as emasculating or revealing vulnerability. Similarly, Fry et al. (2022) found that suppressing health concerns to maintain masculine identity further discouraged early detection behaviors. Collectively,

these dynamics created enduring patterns of avoidance and underutilization of preventive screening, even among African American men who were aware of their elevated risk.

### ***Emotional Suppression and Gender Role Stress***

Adams et al. (2023) argued that intergenerational socialization shaped how African American men internalized emotional restraint and self-reliance as markers of masculine strength. Socialization processes and learned behaviors across generations reinforced cultural narratives emphasizing emotional invulnerability and radical self-reliance. Many African American men reported being raised under messaging such as “a man keeps his pain to himself,” reflecting a deep-seated resistance to seeking help or expressing vulnerability. Transmitted through family and community expectations, these norms became internalized behavioral codes that guided health-related decisions.

Aguilera et al. (2024) agreed that gender role stress—the psychological strain experienced when traditional masculine ideals conflicted with health needs—intensified these tendencies, rendering preventive behaviors such as prostate cancer screening incompatible with established notions of masculinity. As a result, even with strong empirical evidence demonstrating the life-saving benefits of early prostate cancer detection (Albertsen, 2020; Elosua, 2022), many African American men delayed or avoided screening altogether. Moreover, stoic attitudes often hindered open communication between patients and healthcare providers, reducing opportunities for shared decision-making and diminishing trust in clinical relationships (Allen et al., 2022). This communication breakdown posed significant risks by obstructing culturally sensitive

care and perpetuating the systemic disparities that contributed to delayed diagnosis and poorer health outcomes among African American men.

### ***Resilience as a Double-Edged Sword***

Resilience, often celebrated as a defining strength within African American communities, had functioned as both a protective and paradoxical force in men's health behaviors. Historically, resilience emerged as a vital coping mechanism that enabled African American men to endure systemic racism, socioeconomic hardship, and social exclusion. Traditionally defined as the capacity to overcome adversity, resilience fosters endurance, adaptability, and emotional strength. However, this same resilience, when expressed through excessive self-reliance and emotional restraint, frequently discouraged proactive health engagement. Terrana and Al-Delaimy (2023) observed that African American men's emphasis on self-sufficiency diminished their perceived need for preventive healthcare, including prostate cancer screening. The researchers further argued that resilience, while psychologically beneficial, reinforced masculine ideals equating help-seeking with weakness, thus complicating healthcare engagement.

Preventive services, such as prostate-specific antigen (PSA) testing, were particularly vulnerable to being dismissed under these normative frameworks (Joshi & Filson, 2020; Tabei et al., 2020). Health behaviors requiring vulnerability—including expressing fear or uncertainty—were often avoided because they conflicted with dominant masculine expectations. Adams et al. (2023) described cultural scripts, such as “real men do not complain” and “you handle your business in silence,” which normalized the avoidance of medical care even when they know serious health risks. Aguilera et al.

(2024) further asserted that emotional invulnerability and hyper-independence intensified men's reluctance to pursue screening, resulting in delayed diagnoses and poorer outcomes.

Empirical evidence underscored the connection between stoic resilience and the underutilization of preventive health services. Allen et al. (2022) found that reluctance to communicate openly or express concern during medical encounters—behaviors rooted in stoic resilience—frequently hindered shared decision-making and eroded trust in healthcare relationships. Similarly, Bouras (2024) reported substantial disparities in digital rectal examination (DRE) uptake, citing cultural discomfort and perceptions of emasculation as significant barriers among African American men. These findings suggested that masculinity norms discouraging vulnerability and promoting emotional control raised the threshold for seeking medical care, causing early detection practices to be deprioritized despite elevated prostate cancer risk. Collectively, these studies illustrated that resilience, once a critical adaptive resource in the face of structural inequality, had evolved into a behavioral constraint that impeded preventive healthcare. To address these disparities, researchers emphasized the need to reframe resilience not as stoic endurance or silence but as proactive responsibility for one's health and community well-being (Griffith et al., 2022).

### ***Reframing Masculinity in Public Health Interventions***

Adams et al. (2023) and Griffith et al. (2022) argued that while stoicism and resilience had historically served as adaptive mechanisms within African American communities, these traits required reexamination within contemporary public health

frameworks to mitigate unintended consequences. The literature demonstrated that stoicism and self-reliance, once necessary for survival in the face of systemic racism and social exclusion, often became barriers to preventive health behaviors in modern contexts. Recognizing the deep cultural significance of these characteristics, researchers contended that future interventions needed to redefine strength and autonomy in ways that supported, rather than inhibited, proactive engagement with healthcare. Practical approaches benefited from community-based models centered on cultural values while dismantling narratives equating help-seeking with weakness or dependency.

Emotional suppression, independence, and invulnerability were deeply embedded within the gender role socialization of African American men. These traits functioned as core components of hegemonic masculinity, shaping men's health behaviors across the lifespan and exerting a powerful influence on prostate cancer screening practices. Researchers identified these constructs as culturally valorized strategies developed to navigate structural racism and maintain social standing within hostile environments (Adams et al., 2023). Emotional suppression, in particular, was observed as a learned behavior in which vulnerability was discouraged as a means of psychological self-protection against discrimination and social scrutiny. Adams et al. (2023) argued that this suppression began early in socialization, where their emotional expression was silenced in boys and replaced with expectations of toughness and control—behaviors that persisted into adulthood and contributed to the avoidance of discussions about illness.

Independence, another defining masculine ideal, further complicates healthcare engagement. Men socialized to value self-reliance often viewed medical care as a private

matter to be managed alone, resulting in delayed or absent engagement with screening and follow-up care (Griffith et al., 2022; Jackson et al., 2023). While independence was traditionally regarded as a strength, its extreme expression frequently led to adverse health outcomes, as men avoided preventive services that required acknowledgment of vulnerability. Invulnerability—a related masculine construct—was similarly detrimental to health engagement. Bowie et al. (2020) found that invulnerability, expressed as denial of physical or emotional weakness, discouraged participation in routine medical procedures, including prostate-specific antigen (PSA) screening. This avoidance was especially concerning given the elevated risk of prostate cancer among African American men (Adam et al., 2023; Joshi & Filson, 2020; Tabei et al., 2020).

Aguilera et al. (2024) highlighted how emotional suppression and expectations surrounding invulnerability generated psychological strain, producing gender role stress that further hindered healthcare participation. These internal conflicts often led to cognitive dissonance when health vulnerabilities conflicted with traditional masculine ideals. For African American men, this tension was compounded by the dual burdens of racialized discrimination and masculine expectations, creating a heightened sense of stigma around illness and care-seeking. The consequences of these intersecting pressures were particularly severe: African American men continued to experience disproportionately high prostate cancer incidence and mortality (Basourakos et al., 2022), yet participation in screening and early detection efforts remained markedly low.

The paradox between cultural definitions of strength and the need for vulnerability in healthcare engagement had been partially attributed to longstanding

beliefs that valorized silence, toughness, and stoicism (Allen et al., 2022; Smith et al., 2022). Though individually adaptive, these traits operated collectively as socially reinforced norms that shaped decision-making and sustained health disparities. Effective public health interventions, therefore, required cultural sensitivity and awareness of these gendered dimensions of avoidance. Programs that successfully reframed strength to include emotional openness, self-advocacy, and proactive health behavior demonstrated promising results in improving screening uptake and advancing health equity among African American men (Adams et al., 2023; Griffith et al., 2022). Such interventions positioned preventive care not as a sign of weakness but as an act of responsibility, courage, and protection—values deeply rooted within African American cultural and masculine identity..

### ***Cultural Masculinity Norms and Shared Decision-Making***

Kirby et al. (2024) and Smith et al. (2022) argued that the complex interplay of stoicism, resilience, and masculinity among African American men had significantly hindered participation in prostate cancer screening. While these traits historically functioned as vital survival mechanisms in response to systemic racism and racialized adversity, their continued expression in contemporary health contexts contributed to preventable disparities. These culturally embedded behaviors, though adaptive in maintaining dignity and control under oppression, inadvertently discouraged help-seeking and open dialogue regarding health. A nuanced understanding of these dynamics proved essential in designing culturally competent interventions aimed at increasing screening participation and reducing the disproportionate burden of prostate cancer among African

American men. The intersection of masculinity, race, and health behavior underscored the urgent need for public health initiatives that disrupted harmful gender norms while promoting culturally grounded models of care. Addressing emotional suppression, reframing help-seeking as a strength, and challenging myths of invulnerability were identified as critical strategies for improving early detection and health outcomes in Black male populations.

Prostate cancer screening, particularly the invasive digital rectal examination (DRE), was frequently perceived as a direct challenge to masculinity and a source of discomfort or embarrassment. Tamir et al. (2024) expanded on this observation, demonstrating that societal stigmas surrounding male vulnerability and bodily exposure exacerbated screening avoidance and perpetuated a culture of silence around prostate health. Despite an awareness of their elevated risk due to longstanding health disparities, many African American men adhered to masculine norms that encouraged emotional control and downplayed susceptibility to illness (Nganda & Mwithia, 2024). Within this framework, preventive care was often viewed as unnecessary, intrusive, or even emasculating—an attitude that reinforced low screening engagement.

Research consistently demonstrated that African American men were more likely to seek healthcare services when they perceived themselves as personally susceptible to prostate cancer, understood its seriousness, and recognized the benefits of early detection (Ekeh, 2022; Fish et al., 2022; Green, 2021; Griffith et al., 2022; Okoro et al., 2020). These findings aligned with the Health Belief Model (HBM), positing that individuals were more likely to engage in preventive behaviors when the perceived benefits

outweighed perceived barriers (Fish et al., 2022; Khalil et al., 2024). Furthermore, self-efficacy—the belief in one’s ability to take practical health actions—emerged as a critical determinant of screening participation. Quach (2022) found that African American men who believed their actions could reduce risk and improve outcomes were more inclined to undergo screening.

These findings highlighted the interconnection between masculinity, perception of control, and health behavior. Interventions that encouraged emotional openness and reframed screening as a demonstration of self-efficacy and responsibility—rather than vulnerability—showed promise in addressing the psychosocial barriers to prostate cancer screening. By aligning messages of prevention with culturally resonant definitions of strength and leadership, healthcare providers and community programs could enhance engagement and promote equity in prostate health outcomes among African American men.

### ***Cultural Beliefs, Mistrust in Health Care Providers and Institutions***

Cultural competence in healthcare delivery was central to improving health outcomes among African American men, as patient-centered and authentic care fostered trust between patients and providers. Claeys et al. (2021) and Zhang et al. (2021) similarly contended that culturally responsive approaches enhanced communication, strengthened relational trust, and improved adherence to screening recommendations. Despite these insights, research continued to show that African American men’s awareness of prostate cancer risks and screening options remained limited. Adam et al. (2023) and Lillard et al. (2022) found that younger African American men often

expressed uncertainty and apprehension about prostate cancer screening, driven by misinformation and fear of potential side effects. Bratt et al. (2023) identified significant knowledge deficits regarding both the nature of prostate cancer and current screening guidelines. Bynum et al. (2022) and Miller et al. (2022) further reported that many younger men underestimated their personal susceptibility to prostate cancer, contributing to their low rates of screening participation. Similarly, Tidd-Johnson et al. (2022) discovered that misconceptions—such as exaggerated fears of complications, pain, or impotence—perpetuated avoidance behaviors and reinforced skepticism toward preventive healthcare. Collectively, these studies underscored the urgent need for culturally tailored education campaigns that addressed misinformation, corrected false beliefs, and promoted informed decision-making among younger African American men.

Beyond limited knowledge, mistrust in healthcare providers and institutions persisted as a powerful deterrent to screening engagement. Bazargan et al. (2021) and Hernandez and Gibb (2020) found that distrust of the medical system, rooted in historical and contemporary experiences of discrimination, significantly reduced participation in preventive care. The legacy of the Tuskegee syphilis study continued to cast a long shadow over African American men's perceptions of healthcare institutions, fostering skepticism, fear, and avoidance (Rose et al., 2022). Herbach et al. (2024) documented that perceived racial bias and discriminatory treatment during medical encounters discouraged many African American men from initiating or completing screening procedures. Rose et al. (2022) further emphasized that inadequate communication and a lack of cultural sensitivity within clinical interactions amplified this mistrust, leading

younger African American men to question the intentions and reliability of healthcare professionals.

This enduring mistrust represented more than individual skepticism—it reflected the intergenerational transmission of cultural memory tied to systemic injustice. The combination of limited knowledge, misinformation, and institutional distrust compounded barriers to prostate cancer screening, particularly for younger African American men navigating healthcare systems perceived as untrustworthy or exclusionary. Addressing these barriers required deliberate efforts to cultivate trust through transparency, cultural humility, and meaningful community engagement. By fostering equitable communication and acknowledging historical trauma, healthcare providers could begin to rebuild credibility and encourage greater participation in preventive screening among African American men.

### ***Epidemiological Urgency and Screening Disparities***

The urgency surrounding prostate cancer screening among African American men intensified due to persistently high incidence and mortality rates. Prostate cancer remained the most frequently diagnosed cancer among African American men and continued to be one of the leading causes of cancer-related deaths within this population. The American Cancer Society (ACS, 2024a) reported that African American men experienced mortality rates more than twice those of White men, illustrating a stark and enduring racial disparity. A heightened genetic predisposition to aggressive and earlier-onset forms of the disease further elevated clinical concern and prompted calls for earlier and more frequent screening interventions.

Leading health organizations, including the Prostate Cancer Foundation (PCF), recommended that African American men begin discussing prostate-specific antigen (PSA) screening between the ages of 40 and 45 to promote earlier detection and intervention (Garraway et al., 2024; Prostate Cancer Foundation, 2024; Tabei et al., 2020). These recommendations were grounded in genomic and epidemiological studies demonstrating that African American men were more likely than other racial groups to be diagnosed at advanced stages and with more aggressive tumor biology (Darst et al., 2021; Dupont et al., 2020). Despite the accumulation of evidence and growing consensus regarding early screening for this high-risk population, screening rates among African American men remained disproportionately low.

This paradox—elevated risk and reduced screening participation—underscored the urgent need for culturally grounded and contextually relevant public health strategies. Researchers emphasized that addressing this gap required more than universal policy changes; it demanded interventions that accounted for the unique sociocultural, historical, and psychological factors influencing African American men’s health behaviors. By integrating community engagement, culturally responsive education, and trust-building practices, healthcare providers and policymakers could begin to bridge the divide between awareness and action, thereby reducing the burden of prostate cancer disparities within this population.

### ***Intergenerational Health Education and HBCU Contexts***

Coughlin et al. (2021) emphasized the importance of culturally tailored education programs to improve prostate cancer screening among Black men, particularly in settings

like Historically Black Colleges and Universities (HBCUs). Understanding the influence of educational contexts on young Black men's health perceptions proved essential for shaping culturally responsive interventions. Coughlin et al. (2021) highlighted the role of these institutions in shaping the health behaviors of students who might not otherwise engage with preventive care. Black male college students frequently demonstrated low levels of prostate health literacy and did not perceive themselves to be at risk. A qualitative study conducted by Lopez et al. (2024) involving 35 Black male students at an HBCU revealed that participants had a limited understanding of prostate anatomy, function, and prostate cancer risk.

While students acknowledged the seriousness of the disease, many failed to perceive themselves as personally vulnerable, revealing a critical gap in health knowledge. These findings supported the applicability of the HBM, which emphasized perceived susceptibility as a core determinant of preventive behavior (Lopez et al., 2024). The study also identified a significant association between traditional masculinity and health beliefs, suggesting that educational programming should address these intersecting factors. Early decision-making during the college years presented a unique opportunity to establish lifelong health-promoting behaviors among African American men. Initiatives grounded in peer-led education, culturally relevant messaging, and trusted community frameworks demonstrated potential to increase engagement with prostate cancer screening guidelines (Coughlin et al., 2021).

### ***Systemic Barriers and Institutional Distrust***

In addition to low health literacy, systemic barriers have significantly impeded the timely diagnosis and effective screening of prostate cancer among African American men. These barriers encompassed longstanding medical mistrust, underrepresentation in clinical trials, and inadequate physician–patient communication, each contributing to the persistence of racial disparities in prostate cancer outcomes (Lillard et al., 2022; Murphy et al., 2024). Medical mistrust, deeply rooted in historical injustices and perpetuated by ongoing inequities in healthcare access and treatment, remained one of the most pervasive obstacles to preventive engagement. Poulson (2022) noted that such mistrust was closely associated with skepticism regarding the fairness, objectivity, and thoroughness of prostate cancer care, often leading African American men to question the motivations of healthcare institutions and providers. This skepticism frequently resulted in delayed screening, reluctance to follow up on abnormal results, and avoidance of participation in clinical research initiatives designed to address these disparities.

Murphy et al. (2024) further observed that African American men’s underrepresentation in clinical and genomic research limited the applicability of emerging diagnostic and treatment innovations to their population. Consequently, evidence-based screening guidelines often failed to reflect the unique genetic, social, and environmental risk factors affecting African American men. Lillard et al. (2022) argued that this exclusion perpetuated a cycle of inequity in which African American men remained both medically underserved and scientifically underrepresented. Inadequate communication between patients and healthcare providers compounded these barriers, as

implicit bias, lack of cultural competence, and insufficient provider training undermined patient trust and satisfaction.

Collectively, these systemic factors created a healthcare environment that discouraged early screening and constrained the development of equitable interventions. Addressing such barriers required structural change—improving representation in research, enhancing communication training for healthcare professionals, and implementing community-based trust-building initiatives. Without confronting these systemic inequities, efforts to improve prostate cancer outcomes among African American men risked remaining superficial, failing to dismantle the institutional roots of mistrust and exclusion that continued to shape screening behaviors.

### ***Underrepresentation in Genomic Research***

Black men remain significantly under-enrolled in genomic and precision medicine studies. This disparity limited the relevance and applicability of emerging evidence-based guidelines to this population. Darst et al. (2021) and Lowder et al. (2022) documented that African American men's exclusion from genomic research restricted the scientific understanding of prostate cancer's biological variations across racial groups. Although genomic and precision medicine advancements had the potential to inform risk stratification, early detection, and individualized treatment planning, African American men's underrepresentation in these studies contributed to persistent gaps in developing equitable care strategies. Yuan et al. (2020) emphasized that this exclusion perpetuated existing health disparities, reinforcing a cycle in which African American men were both underserved in clinical practice and underrepresented in the research shaping clinical

guidelines. The resulting lack of tailored genomic data impeded progress toward personalized medicine approaches that could improve prostate cancer outcomes for high-risk populations.

Murphy et al. (2024) further noted that African American men frequently experienced communication barriers in their interactions with healthcare providers, leading to diminished satisfaction with care and limited opportunities for shared decision-making. These communication challenges extended beyond clinical settings to the research environment, where participants often expressed skepticism about study transparency and data use. Poulson (2022) reported that perceptions of racial bias, inadequate explanation of medical risks and benefits, and limited cultural sensitivity among professionals exacerbated distrust and reduced willingness to participate in clinical and genomic research.

These studies highlighted the intersection between systemic exclusion and interpersonal mistrust as critical barriers to progress in equitable cancer care. The underrepresentation of African American men in genomic studies not only weakened the scientific validity of prostate cancer research but also perpetuated inequities in access to emerging diagnostic and therapeutic innovations. Addressing these gaps required inclusive research designs, culturally responsive communication strategies, and intentional recruitment practices prioritizing transparency and trust-building within African American communities. Without such efforts, the promise of precision medicine risked reinforcing, rather than resolving, racial disparities in prostate cancer outcomes (Nyame et al., 2022).

### *HBCUs as Platforms for Health Equity*

The persistent challenges surrounding prostate cancer awareness and screening engagement, Historically Black Colleges and Universities (HBCUs) have emerged as vital platforms for advancing health equity among African American men. These institutions uniquely promoted culturally grounded health education and preventive behaviors by leveraging community trust and social connectedness within predominantly Black academic environments. Nyame et al. (2022) contended that HBCUs provided ideal settings for implementing community-based outreach and peer education programs, effectively increasing awareness, reducing stigma, and fostering trust between healthcare providers and young Black men. Similarly, Coughlin et al. (2021) found that integrating educational and screening initiatives into HBCU campus life utilized existing institutional trust and peer networks to encourage engagement among students often overlooked by mainstream public health campaigns.

Tailoring screening programs to align with African American cultural and social realities enhanced both participation and comprehension of prostate cancer risks. Garraway et al. (2024) emphasized that transparent, respectful, and consistent communication between healthcare professionals and African American men was critical to rebuilding trust and promoting screening adherence. Within the supportive context of HBCUs, these approaches were particularly effective because they framed health education as part of a broader commitment to community empowerment and academic achievement.

Prostate cancer awareness initiatives embedded within HBCU curricula, student health services, and campus events directly addressed cultural disparities while fostering early intervention. Rylance Prostate Cancer UK Clinical Advisory Group. (2024) report that situating screening education within trusted, identity-affirming spaces, HBCUs helped normalize conversations about men's health, reducing stigma associated with prostate cancer and the digital rectal examination (DRE). These institutions also served as incubators for culturally competent leadership in public health, cultivating future generations of advocates equipped to address racial disparities in cancer prevention and care. Collectively, these efforts demonstrated that HBCUs functioned not only as educational institutions but also as transformative community assets capable of shaping health behaviors and advancing equity in prostate cancer outcomes among younger African American men.

### ***Health Literacy, Risk Perception, and Educational Interventions***

Prostate cancer has continued to disproportionately affect Black men in the United States, particularly through early-onset and aggressive disease forms that contribute to higher mortality rates. Despite these elevated risks, screening uptake among African American men remained consistently low, hindered by systemic barriers, inadequate health education, and enduring distrust of healthcare institutions (Coughlin et al., 2021; Griffith et al., 2022). Addressing these disparities required a multifaceted strategy that combined earlier screening initiation, culturally responsive education, and inclusive research practices tailored to the lived experiences of African American men.

Henderson III et al. (2022) and Okoro et al. (2020) emphasized the influential role of Historically Black Colleges and Universities (HBCUs) in promoting preventive health behaviors and shaping students' perceptions of medical engagement. Centering prostate cancer screening education within HBCU environments offered a culturally grounded approach to health promotion that leveraged institutional trust, community engagement, and peer influence. These settings provided unique opportunities to address the complex social, cultural, and informational barriers younger African American men face. Butler et al. (2020) found that qualitative, narrative-based research approaches were particularly effective in capturing men's lived experiences and identifying the factors influencing their decisions about prostate cancer screening.

Sullivan et al. (2020) noted that systemic barriers—such as limited healthcare access, socioeconomic disparities, and institutional racism—continued to obstruct screening participation, reinforcing a cycle of delayed detection and poorer outcomes. Dickerson et al. (2020) demonstrated that significant reductions in cancer disparities were achieved when system-level interventions directly targeted these structural impediments. Similarly, Kensler et al. (2020) highlighted that improvements in sustainable screening participation depended on systemic transformation and individual-level behavioral change.

Collectively, the literature indicated that improving health literacy and risk perception among younger African American men required interventions that were not only educational but also structural—acknowledging the historical context of mistrust and the sociocultural meanings of masculinity. Comprehensive, culturally responsive

programs that integrated medical knowledge with social empowerment were essential to fostering early detection behaviors and reducing prostate cancer disparities in this high-risk population.

### *Historical Context*

Prostate cancer represented one of the most visible and enduring examples of racial health disparities in the United States. African American men experienced prostate cancer incidence rates 60–70% higher than their White counterparts, with mortality rates more than double those of other racial groups (Lillard et al., 2022; National Cancer Institute, n.d.; Van Blarigan et al., 2025). It remained both the most frequently diagnosed cancer and the second leading cause of cancer-related death among Black men (ACS, 2023). Despite significant medical advancements in detection and treatment, these disparities persisted, primarily driven by lower participation in screening and delayed diagnoses (Allen et al., 2022; Basourakos et al., 2022). Researchers contended that these inequities were deeply rooted in historical and structural injustices—including systemic racism, discrimination, and medical exploitation—that continued to shape African American men’s healthcare behaviors (Bazargan et al., 2022; Vince et al., 2022).

The legacy of the Tuskegee syphilis study (1932–1972), in which African American men were deceived and denied medical treatment, served as a defining source of intergenerational mistrust toward the healthcare system (Miteu et al., 2024; Rose, 2022). Jackson et al. (2023) noted that younger African American men often inherited this skepticism, normalizing avoidance of preventive care, particularly prostate screening. This historical trauma, combined with cultural expectations of masculinity, created

additional barriers to engagement. Though medically routine, the digital rectal examination (DRE) carried intense symbolic weight. Participants in prior studies described it as invasive, embarrassing, and emasculating—a violation of both privacy and masculine identity (Bowie et al., 2020; Smith et al., 2022). These reactions reflected not merely discomfort with the procedure but also centuries of medical exploitation that positioned Black male bodies as subjects of control rather than care.

Participant accounts from qualitative studies illustrated how gender norms and historical mistrust intersected to reinforce avoidance. One participant described fear of ridicule for undergoing the exam, linking the act to a perceived loss of masculinity. Another reframed the screening as demonstrating strength and responsibility, suggesting that proactive health-seeking could coexist with masculine ideals of leadership and provision. This reframing echoed Aguilera et al.'s (2024) findings that traditional masculinity norms often induced gender role stress when men confronted vulnerability. Similarly, while culturally celebrated, resilience sometimes manifests as stoic self-reliance, discouraging engagement in preventive healthcare (Kensler et al., 2020).

Researchers such as Griffith et al. (2022) emphasized that culturally responsive interventions could reduce these barriers by validating men's lived experiences and acknowledging the historical and emotional dimensions of mistrust. Community-based outreach in trusted spaces, including barbershops, churches, and HBCUs, promoted open discussion around prostate health. Prostate cancer screening behaviors were more readily accepted when reframed as acts of familial responsibility and cultural pride. The DRE, therefore, symbolized far more than a diagnostic tool—it represented a crossroads where

masculinity, history, and health converged. Addressing these layered meanings through empathy, education, and cultural awareness was essential to advancing equity in prostate cancer outcomes among African American men.

### ***Community Engagement and Family Support***

Community engagement and family support played a central role in shaping African American men's participation in prostate cancer screening and preventive health behaviors. Family influence—particularly from women—proved pivotal in encouraging men to seek medical evaluation, initiate screening discussions, and overcome cultural hesitancy surrounding prostate cancer (Allen et al., 2022; Bynum et al., 2022). Spouses, partners, and female relatives often served as key motivators, framing screening as an act of love and responsibility toward family well-being. This relational encouragement not only reduced resistance but also reframed health-seeking as a collective rather than individual act.

Henderson III et al. (2022) and Okoro et al. (2020) observed that social support systems enhanced men's participation in health interventions by creating environments where preventive behaviors were socially reinforced. Community networks—particularly those grounded in trusted institutions such as churches, barbershops, and Historically Black Colleges and Universities (HBCUs)—were instrumental in normalizing prostate health discussions. These culturally familiar spaces provided psychological safety, reduced stigma, and facilitated peer-led dialogue that fostered shared accountability for health outcomes.

Buote et al. (2020) and Vapiwala et al. (2021) demonstrated that stigma reduction and peer normalization were among the most effective results of such community-based interventions. When prostate cancer screening was discussed within group contexts, men reported feeling less isolated and more empowered to act. These programs cultivated positive social pressure that encouraged open conversations about health, replacing silence and avoidance with communal responsibility.

Collectively, the literature suggested that community engagement and family support functioned synergistically to counter barriers rooted in mistrust, stigma, and masculinity norms. By leveraging relational networks and culturally resonant settings, interventions not only increased awareness but also strengthened collective health agency among African American men.

### ***Shifting Screening Guidelines/Impact on African American Men***

Changes in prostate cancer screening guidelines had created widespread confusion and disproportionately affected African American men. In 2012, the U.S. Preventive Services Task Force (USPSTF) recommended against routine prostate-specific antigen (PSA) screening for men of any age due to concerns regarding overdiagnosis, unnecessary biopsies, and potential overtreatment (Albertsen, 2020; Nguyen & Mahal, 2020). While intended to minimize medical harm, this recommendation led to a substantial nationwide decline in screening rates, with African American men experiencing the most pronounced reduction—an 11.6% drop between 2012 and 2018, compared to a 9.3% decrease among White men (Kensler et al., 2020).

This decline was particularly concerning because the evidence base that informed the USPSTF's recommendations largely excluded or underrepresented African American men, thereby neglecting their elevated risk profiles and unique health disparities (Basourakos et al., 2022). The result was an unintended widening of racial inequities in early detection and survival outcomes. In response to these challenges, organizations such as the American Cancer Society (ACS, 2023), the American Urological Association, and the National Comprehensive Cancer Network revised their positions, advocating for individualized screening strategies for high-risk populations.

Jain et al. (2023) and Miller et al. (2022) noted that these organizations recommended initiating informed discussions about PSA testing as early as age 45 or younger for men with strong family histories or genetic predispositions. Further, Gong et al. (2024) emphasized that emerging research demonstrated African American men's heightened susceptibility to earlier-onset and more aggressive prostate cancer, reinforcing the urgency for risk-adapted and culturally tailored screening practices.

Recognizing these nuances proved critical to advancing health equity and improving prostate cancer outcomes among African American men. The literature collectively suggested that guideline development must not only be data-driven but also demographically inclusive, ensuring that recommendations reflect the realities of high-risk populations rather than perpetuating structural oversight.

### ***Cultural Coping, Faith, Fatalism, and Health***

Jones (2023) argued that one of the most persistent cultural barriers influencing African American men's participation in prostate cancer screening was the prevalence of

cancer fatalism. This belief system framed cancer as an inevitable and terminal condition, fostering the perception that early detection or medical intervention could not alter one's fate. Green (2021) found that many African American men expressed sentiments such as, "If I am meant to get cancer, there is nothing screening can do," which reflected a deep-seated skepticism about the value of preventive health behaviors. This fatalistic worldview not only diminished motivation for screening but also reinforced avoidance behaviors rooted in fear, mistrust, and resignation.

Vyas et al. (2022) noted that this outlook was often compounded by a culturally embedded present-time orientation, where individuals prioritized immediate well-being and daily survival over long-term health planning. Many Black Americans focused on managing current socioeconomic challenges, viewing preventive screenings as unnecessary unless physical symptoms were present (Griffith et al., 2022). This focus on the present moment, while adaptive in contexts of structural and economic stress, inadvertently limited engagement in proactive health practices such as PSA testing and routine medical consultations.

Collectively, these patterns revealed how cancer fatalism and present-time orientation functioned as intertwined psychological and cultural barriers that reduced the likelihood of early detection. Researchers agreed that addressing these perceptions required culturally responsive health education interventions that reframed screening as a proactive and empowering act rather than a futile one (Green, 2021; Griffith et al., 2022). Efforts that incorporated community-based messaging, spirituality, and family involvement were shown to be most effective in countering fatalistic attitudes and

promoting sustained engagement in prostate cancer screening among African American men.

### ***Spirituality and Religion, and Health Behavior Avoidance***

Spirituality profoundly intersects with African American men's health decision-making, often shaping attitudes toward prostate cancer screening and preventive healthcare. For many, the belief in "leaving it in God's hands" functioned as a coping mechanism and a cultural orientation toward faith over biomedical intervention (Bynum et al., 2022). This reliance on divine will provided psychological comfort and spiritual resilience in the face of uncertainty but sometimes led to delayed screening, as individuals trusted that God—not medical professionals—would determine their health outcomes. While emotionally sustaining, Berger and Miller (2021) noted that this faith-based reliance inadvertently reduced engagement with preventive health behaviors when prayer or spiritual healing was perceived as a sufficient alternative to medical action.

Dunlop (2024) found that spirituality served a dual role—acting as both a source of strength and a potential barrier to early detection. Within Christian traditions, particularly among Baptist, Pentecostal, and African Methodist Episcopal (AME) denominations, illness was frequently interpreted as a divine test of faith, with healing believed to originate from God rather than through human intervention (Griffith et al., 2022). This belief reinforced endurance and hope but could also delay participation in medical screenings when divine healing was prioritized. Beyond Christianity, Islamic traditions and the Nation of Islam emphasized health stewardship, discipline, and bodily sanctity—principles that could encourage preventive care. However, Griffith et al. (2021)

observed that historical medical mistrust among these communities sometimes undermined their willingness to engage in Western medicine.

Additionally, African Traditional Religions (ATRs) and syncretic belief systems emphasized holistic wellness practices, such as herbalism, ancestral healing, and community rituals, which were often preferred over formal healthcare systems. While these spiritual frameworks preserved cultural identity and community cohesion, they sometimes perpetuated avoidance of medical procedures like PSA testing. Collectively, the literature demonstrated that spirituality, though vital for emotional resilience and identity, could delay or discourage early prostate cancer screening when divine intervention or alternative healing was perceived as sufficient.

To address these dynamics, researchers emphasized the need for culturally responsive health education strategies that honored faith traditions while promoting health literacy and empowerment (Berger & Miller, 2021; Bynum et al., 2022). Culturally attuned interventions that framed medical screening as complementary to divine care—rather than contradictory—proved most effective in fostering trust and improving participation among African American men.

### ***Physical and Spiritual Health Avoidance***

Vyas et al. (2022) argued that integrating physical and spiritual health has been increasingly recognized as vital to holistic well-being, particularly among culturally specific populations such as young African American men. Health was not conceptualized solely in biological or medical terms but understood as a multifaceted experience rooted in both physical maintenance and spiritual fulfillment. Physical health

encompasses the body's ability to function optimally through proper nutrition, regular physical activity, and adequate rest (Cleveland Clinic, 2023). Among African American men at heightened risk for prostate cancer, these practices carried significant implications for early detection and prevention (Griffith et al., 2022).

Engagement in preventive care, such as prostate-specific antigen (PSA) testing, was shaped by more than medical literacy or awareness. Spiritual beliefs and community traditions profoundly influenced men's perceptions of illness, healing, and responsibility for care (CDC, 2024b; Tabei et al., 2020). Spiritual health was often linked to a sense of purpose realized through prayer, faith, meditation, and community involvement (Claeys et al., 2021). Scriptural teachings reinforced this framework, emphasizing that physical care was not merely a medical act but a sacred duty. For instance, 1 Corinthians 6:19-20 described the body as "a temple of the Holy Spirit," while Proverbs 3:7-8 urged wisdom and attentiveness to bodily and spiritual well-being (The Holy Bible, New International Version, 2011). Health became a moral and spiritual responsibility through this lens, resonating deeply within African American religious life.

Griffith et al. (2022) found that neglecting physical health often led to spiritual disconnection, while spiritual disengagement could exacerbate physical and emotional distress. When prostate cancer screening was aligned with values of spiritual stewardship and bodily respect, African American men were more receptive to preventive care. Health education and screening initiatives that were culturally and spiritually tailored proved particularly effective in overcoming distrust and stigma (Claeys et al., 2021; Griffith et al., 2022). Public health professionals were therefore encouraged to collaborate

with faith leaders and embed health messaging within church-based or faith-centered contexts, facilitating trust and engagement (Cleveland Clinic, 2023).

The parallels between spiritually grounded health practices in African American and Muslim communities further demonstrate how religious values shaped preventive health behaviors. Religiosity was positively associated with follow-up screening behaviors, particularly when spiritual life was closely integrated with personal identity (Coughlin et al., 2022). Interventions framed in spiritual language and implemented in faith-based environments—such as churches, mosques, or community centers—encouraged informed decision-making and improved adherence to screening recommendations (Neves et al., 2024). Similarly, values such as cleanliness, self-restraint, and communal accountability, emphasized across Christian and Islamic health traditions, aligned closely with prostate cancer prevention behaviors (Adams et al., 2023; Claeys et al., 2021).

While the perception of illness as a divine test occasionally delayed medical engagement, it also provided opportunities for spiritually informed outreach (Malika et al., 2020). Programs that reframed divine healing as complementary to medical care, rather than a substitute, achieved greater cultural resonance. Even those identifying as spiritual but not religious (SBNR) valued holistic wellness but often resisted invasive medical interventions due to cultural discomfort or mistrust (Griffith et al., 2021). Thus, culturally responsive public health strategies that integrated spirituality, partnered with clergy, and reframed preventive care as both a spiritual and physical act were essential to enhancing prostate cancer screening participation among young African American men

(Bynum et al., 2022; Griffith et al., 2022). Cultural Barriers: Stigma, Silence, and Misinformation

Cultural stigma, silence, and misinformation significantly obstructed prostate cancer screening among African American men. Vapiwala et al. (2021) argued that stigma, misinformation, and silence contributed to the underutilization of screening practices. Many men reported shame or discomfort discussing prostate health, particularly regarding intimate procedures such as the DRE. This discomfort fostered a culture of silence where health concerns were rarely discussed, even among close relatives or friends.

The absence of open dialogue limited peer learning and reinforced avoidance behaviors, creating an environment where misinformation flourished. Some men reported fearing disclosure of a diagnosis to family due to stigma, which further reinforced secrecy (Buote, 2020; Green et al., 2021). These dynamics were closely linked to traditional masculine norms discouraging vulnerability and help-seeking. Expressing concern or undergoing screening was often perceived as challenging masculinity, discouraging men from asking questions or accessing services out of fear of appearing weak or uninformed (Adams et al., 2023; Smith et al., 2022). Misconceptions about screening were common, including the belief that PSA tests caused cancer or that all treatments resulted in impotence, further heightening fear and mistrust (Adams et al., 2023; Kirby et al., 2024).

Younger African American men were particularly susceptible to misinformation and often expressed confusion about screening guidelines, risk factors, and the benefits of early detection (Benedict et al., 2022; Henderson III et al., 2022). Although peer and

family networks were culturally significant sources of support, reliance on these groups for health information sometimes reinforced inaccurate beliefs and skepticism toward formal healthcare (Griffith et al., 2022). Investigating factual inaccuracies, challenging stigma, and promoting open dialogue with trusted community figures were essential to shifting prevailing norms. A sense of shame or embarrassment surrounding prostate exams contributed to a culture of silence, where men avoided discussing prostate health, even in group settings (Vapiwala et al., 2021). One participant described reluctance to disclose a diagnosis to family, highlighting the deep stigma associated with the disease (Buote, 2020; Green et al., 2021). Reinforced by masculine norms discouraging emotional openness, men often avoided help-seeking behaviors, fearing appearing weak or uninformed (Adams et al., 2023; Smith et al., 2022).

### ***Addressing Misinformation and Knowledge Gaps***

Misinformation and lack of awareness had further compounded the challenges surrounding prostate cancer screening among African American men. Many participants reported confusion about what prostate cancer was, how it was screened for, and why early detection was critical to improving survival outcomes. Benedict et al. (2022) and Henderson III et al. (2022) observed that younger African American men, notably, held misconceptions about the screening process and its associated risks. These misunderstandings often stemmed from secondhand accounts, community myths, or incomplete information about medical procedures.

Adams et al. (2023) and Kirby et al. (2024) found that pervasive myths—such as the belief that PSA testing could cause cancer or that surgical treatment inevitably led to

impotence—fueled fear and reinforced avoidance behaviors. These falsehoods perpetuated stigma and mistrust, deterring men from pursuing screening even when aware of their heightened risk. Within many African American communities, informal networks such as family members, peers, and social circles served as primary sources of health information. Although these networks provided emotional support and cultural affirmation, they also circulated inaccurate or outdated information, reinforcing skepticism toward formal medical systems (Griffith et al., 2022).

The influence of community norms further shaped screening behaviors. When health discussions within peer groups dismissed the importance of screening or distrusted medical institutions, individuals were less likely to challenge these prevailing attitudes. Griffith et al. (2022) suggested that this social reinforcement of avoidance created a collective environment in which silence, misinformation, and mistrust discouraged proactive health behaviors.

To address these barriers, researchers emphasized the importance of comprehensive, culturally tailored health education initiatives that provided accurate information and countered misinformation. Effective interventions required dismantling stigma, challenging rigid masculinity norms that equated vulnerability with weakness, and leveraging trusted community figures—such as faith leaders, barbers, and educators—to reshape collective beliefs about prostate cancer screening. By engaging these community influencers and normalizing open health dialogue, public health efforts could help African American men make informed decisions rooted in both medical knowledge and cultural understanding.

### ***Structural Barriers: Access, Cost, and Provider Dynamics***

Structural and systemic barriers significantly limited African American men's access to prostate cancer screening and shaped their outcomes. Chief among these barriers was limited healthcare access: nearly 15% of Black adults in the United States were uninsured compared to under 10% of non-Hispanic Whites, and many did not have a regular source of care (Office of the Assistant Secretary for Planning and Evaluation, 2024). This insurance gap and lack of continuous healthcare relationships reduced opportunities for prostate screening recommendations and created logistical and financial obstacles for men considering screening (Bazargan et al., 2022; Jordan et al., 2024).

As a result, African American men were more likely to receive late-stage diagnoses and experience higher mortality rates (Kensler et al., 2020; Thakore et al., 2023). Even those with healthcare access often face economic stressors. Many men had to weigh medical co-pays, transportation, and time off work—particularly those in labor-intensive jobs or without paid sick leave (Lopez et al., 2024). These burdens contributed to avoiding screenings due to potential financial strain from a cancer diagnosis and treatment (Bamidele et al., 2022). Geographic and infrastructural inequalities, including residing in healthcare “deserts” or lacking transportation, further limited access to routine care (CDC, 2024b).

### ***The Role of Cultural Competence and Self-Efficacy***

In addition to access challenges, African American men often faced poor communication and strained relationships with healthcare providers. Studies indicated that Black men frequently reported their questions being dismissed or poorly explained

during clinical encounters, which diminished trust and engagement (Bazargan et al., 2021; DeRosa et al., 2021). Lack of racial concordance with providers exacerbated discomfort, reduced open dialogue, and compromised shared decision-making (Allen et al., 2022). Black men were among the least likely to report meaningful conversations about PSA screening with providers, despite guidelines emphasizing such discussions (Owens et al., 2020; Tabei et al., 2020)

Systemic racism and implicit bias may have influenced clinical decision-making, with some providers assuming Black men were less compliant or uninterested in screening, resulting in fewer offers for PSA testing (Patel, 2020; Tabei et al., 2020). The underrepresentation of African Americans in medical research contributed to mistrust and resulted in clinical guidelines that were not continually optimized for this population (Lillard et al., 2022; Wieland et al., 2021). Social determinants, including education and income, further influence health behaviors. Lower educational attainment and economic instability contributed to reduced health literacy and limited understanding of prostate cancer risks and options (CDC, 2024b; Lopez et al., 2024).

Even when care was accessible, limited comprehension of medical terminology or difficulty navigating the healthcare system led to non-compliance and missed follow-ups (Bazargan et al., 2021). Quach (2022) emphasized that fatalism, socioeconomic barriers, masculinity norms, and mistrust created a web of psychosocial and structural challenges that deterred preventive care. These structural barriers created a healthcare environment that was difficult for African American men to navigate, even when they wished to seek

care. Reducing disparities in prostate cancer outcomes required both educational and systemic reforms.

### ***Screening Policy and Health System Interventions***

Scholars emphasized the importance of systemic changes to improve prostate cancer outcomes. Miller et al. (2022) advocated early communication, especially targeting men in their 30s, while Basourakos et al. (2022) questioned the benefit-to-harm ratio of current screening practices for Black men. Jones et al. (2023) and Lillard et al. (2022) argued that racial disparities in diagnosis persisted due to limited outreach and ineffective policy enforcement. Institutional efforts by the ACS (2023) and the National Cancer Institute (n.d.) provided screening guidelines but often lacked culturally specific adaptations. Prostate cancer screening among African American men was shaped not only by clinical access but also by a complex interplay of sociocultural influences. A literature synthesis revealed that masculinity norms, cultural identity, family roles, and historical mistrust collectively shaped screening behaviors (Adams et al., 2023; Griffith et al., 2022).

Researchers consistently call for culturally informed interventions that are gender-sensitive and grounded in community engagement (Smith et al., 2022). While current studies have offered important insights, many have been exploratory or descriptive and lacked evaluative outcomes. Future research must test specific, scalable strategies, such as early outreach to younger men, family-centered interventions, and policy frameworks supporting sustainability. These strategies should bridge the gap between awareness and behavior through education, trust-building, and systemic support. Addressing these

multifaceted barriers was critical to designing effective solutions that reduced disparities in prostate cancer outcomes.

This synthesis highlighted that prostate cancer screening among African American men was not merely a clinical matter but a deeply sociocultural one. Masculinity, cultural identity, family dynamics, and institutional trust significantly influenced health behaviors. Emasculation, or the perceived loss of masculine identity, emerged as a key psychosocial barrier to prostate cancer screening among African American men, particularly due to associations with bodily invasion and diminished sexual function linked to the DRE (Kirby et al., 2024; Lindqvist et al., 2021). Conversely, autonomy—the ability to make informed, self-directed health decisions—is valued and often undermined when screening is framed as mandatory or inadequately explained.

The interplay between masculinity and autonomy contributed to delays in screening uptake (Coleman-Kirumba et al., 2023). The literature has strongly supported culturally responsive, gender-sensitive, and community-engaged interventions. These cultural factors shaped coping strategies among younger African American men (Griffith et al., 2022). A nuanced understanding of these factors enabled more inclusive and culturally attuned psychological and emotional support systems. Researchers examined the role of individualistic versus collectivistic values, communication preferences, religious frameworks, and the influence of social networks on stress and help-seeking behaviors (Adams et al., 2023; Claeys et al., 2021; Griffith et al., 2022).

For many young African American men, masculinity was culturally defined by strength, autonomy, and resilience, often limiting emotional expression (Adams et al.,

2023). Therefore, cultural competence in mental health and support services was necessary to ensure that interventions aligned with the lived experiences of African American men (Chu et al., 2022; Kensler et al., 2020). Early outreach was vital, and systemic interventions needed to be scalable, sustainable, and responsive to real-world challenges. Bridging the knowledge-behavior gap required comprehensive efforts involving education, family, community trust, and supportive policies. Addressing these intersecting barriers represented the most promising path toward reducing long-standing disparities in prostate cancer outcomes.

### **Summary and Conclusions**

Prostate cancer has remained a critical health concern for African American men, who experience higher incidence and mortality rates compared to other racial and ethnic groups (Kensler et al., 2020). Despite these risks, younger African American men have continued to exhibit lower screening rates, influenced by cultural, psychological, and systemic factors (Adams et al., 2023; Bynum et al., 2022). Masculinity norms such as stoicism, resilience, and emotional suppression discouraged preventive care (Adams et al., 2023). Procedures like the DRE were perceived as threats to masculinity, contributing to discomfort and avoidance (Bouras, 2024).

Societal stigmas about vulnerability compounded these challenges, creating a culture of avoidance around screening (Rose et al., 2022). The HBM provided a valuable framework for understanding health behaviors. Fish et al. (2022) stated that perceived susceptibility, severity, benefits, and self-efficacy shaped preventive action for African American men, understanding susceptibility required correcting myths and recognizing

the elevated risk (Fish et al., 2022; Zhuang & Guan, 2022). Severity refers to the life-threatening nature of prostate cancer, which encourages early intervention (Taflinger & Sattler, 2024).

The perceived benefits of screening and high self-efficacy, mainly when supported by culturally competent care, also increased participation (Fish et al., 2022; Quach, 2022). African American men underutilize preventive services, including screenings, partly due to fatalism, socioeconomic disadvantage, health misinformation, masculinity beliefs, medical mistrust, and racism (Keller et al., 2021; Lillard et al., 2022; Rao et al., 2023; Singh & Sridhar, 2021). Studies have revealed knowledge deficits about prostate cancer risks and screening among younger African American men. Rose et al. (2022) reported that these men underestimated their risk, while Lühring et al. (2024) found that exaggerated fears of treatment side effects led to hesitancy.

Systemic barriers—including limited access to care, economic inequality, and institutional racism—further exacerbated disparities. Rose et al. (2022) proposed structural solutions to improve access and equity. Kensler et al. (2020) called for comprehensive reforms, including culturally relevant public health strategies and age-specific screening recommendations. These studies concluded that combining systemic and behavioral interventions was essential to achieving sustainable progress in reducing prostate cancer disparities. This narrative case study offered valuable insights into younger African American men's experiences. The selected methodology allowed in-depth exploration of systemic, cultural, and psychological influences on health behavior.

Chapter 3 presents the methodology, rationale, data analysis plan, trustworthiness considerations, and ethical protocols.

### **Chapter 3: Research Method**

The purpose of this narrative, multiple case study was to explore and understand the beliefs, attitudes, and perceptions of younger African American men regarding prostate cancer screening (see Maurer et al., 2023). Specifically, this study explored how cultural norms of masculinity, gender role socialization, historical mistrust of healthcare systems, and knowledge gaps influenced their healthcare-seeking behaviors (see Brüggemann, 2021; Lateef et al., 2024; Rose et al., 2022). This exploration aimed to uncover the described experiences of younger African American men to understand better any barriers and facilitators associated with prostate cancer screening participation (see Kensler et al., 2020). This chapter presents information on methodology, including the research design, participant selection criteria, instruments, data collection procedure, approach to data analysis, role of the researcher, trustworthiness, and ethical guidelines. A summary of the information is provided at the end of the chapter.

#### **Research Design and Rationale**

This inquiry was driven by the central question: What are the perceptions, attitudes, and beliefs of African American men, aged 35 to 45 years, about early prostate cancer screening? The study explored the experiences and beliefs of three to five African American men aged 35–45 (Maurer et al., 2023) by applying a qualitative multiple-case approach incorporating narrative data analysis. Data were collected primarily through in-depth, individual questions guided by a structured interview protocol informed by insights from the literature. This approach followed the method outlined by Yin (2018).

Additionally, relevant artifacts, such as a participant flyer about prostate cancer related to African American men's health, were collected to provide contextual insights (see Covert et al., 2024). The primary objective of case-based inquiry was to describe events and phenomena based on participants' personal experiences (see Priya, 2021). A qualitative multiple-narrative case study complemented this approach by focusing on understanding individual experiences, beliefs, and attitudes (see Yin, 2018). This method involved collecting detailed personal stories through conversations and analyzing these narratives to identify common themes and insights (see Nagel et al., 2023). Narrative analysis was particularly suited for exploring culturally nuanced topics, such as the role of masculinity and gender norms in influencing health behaviors.

### **Role of the Researcher**

The role of the researcher in qualitative inquiry encompasses responsibilities as an open-minded interviewer, examiner, data collector, and analyst (Collins & Stockton, 2022). As the researcher, I engaged with participants as equal contributors to the inquiry process and fostered a collaborative environment to ensure authentic data collection. The researcher served as the primary instrument for gathering, analyzing, and interpreting qualitative data. I identified and selected participants, ensuring high-quality data collection through meetings and observations, transcribing interview data, coding and analyzing the data to identify trends and themes, and ultimately interpreting and reporting findings (Mishra & Dey, 2022; Morris et al., 2022).

In this narrative and case study approach, I intentionally set aside preconceived assumptions to focus entirely on participants' experiences. To maintain objectivity and

ensure the integrity of the data analysis process, I used reflexivity, recognized as a vital component of qualitative research, particularly in studies situated within complex sociocultural and health contexts. According to Olmos-Vega et al. (2022), reflexivity involves intentionally examining and acknowledging the researcher's subjectivities, including how personal, interpersonal, methodological, and contextual factors shape the research process. Rather than viewing subjectivity as a bias to be eliminated, reflexivity embraces it as a strength—allowing researchers to make transparent how their positionalities influence study design, data collection, interpretation, and dissemination.

In the context of this study on African American men's perceptions of prostate cancer screening, reflexivity played a critical role. As the researcher, I continuously reflected on how my identities, assumptions, and sociocultural experiences shaped my engagement with participants and my interpretation of their narratives. This reflexive stance was necessary to ensure that the study remained attuned to participants' lived experiences while acknowledging the influence of broader power structures and cultural dynamics. Aligning with Olmos-Vega et al. (2022), this study incorporated reflexive practices throughout the research process—from developing the interview guide to coding and thematizing data—thereby enhancing methodological coherence and credibility.

By foregrounding reflexivity, the study aimed to center participant voices and critically examine how knowledge about masculinity, race, and health behavior is co-constructed in qualitative inquiry, involving systematic documentation of thoughts, beliefs, and assumptions in a reflective journal. This approach ensured the focus

remained on participants' authentic descriptions of their beliefs and attitudes toward prostate cancer screening. Reflective practices such as journaling provided a framework for documenting and addressing potential biases and assumptions, ensuring that findings were informed by participants' perspectives rather than personal interpretations. Recognizing the need to document my beliefs, I used reflective journaling to uphold transparency and trustworthiness in the study.

My lived experiences, including the recent loss of two older biological brothers who had not undergone early prostate cancer screening, profoundly influenced my motivation for the study. These experiences and my role as a human services professional informed my desire to address concerns of younger African American men. As an African American woman and human services professional, my identity and connections to the target population created a sense of relevance and a need for reflexivity, acknowledging potential biases, which enabled me to intentionally center the participants' authentic narratives and document assumptions in a reflective journal (Ide & Beddoe, 2023).

### **Methodology**

I selected participants based on specific inclusion criteria to ensure alignment with the research purpose and objectives. Eligible individuals self-identified as African American men, aged 35 to 45, to reflect a demographic increasingly diagnosed with advanced-stage prostate cancer despite screening guidelines that typically begin at age 50 (see Kensler et al., 2020). In addition, the study acknowledged the possibility of androgynous gender identity within the participant pool, recognizing that gender identity

and expression may intersect with cultural and social perceptions of masculinity and health behaviors. Androgynous gender identity refers to individuals who embody or express traditionally masculine and feminine traits, whether in self-presentation, roles, or lived experiences (Bem, 1981).

Including the recognition of androgynous identity was significant because individuals who integrated both masculine and feminine traits often demonstrated greater behavioral flexibility than those who adhered strictly to traditional gender roles. Prior research has suggested that androgynous individuals might approach health behaviors with less rigidity, potentially showing greater openness to preventive practices such as cancer screening (Korabik, 2017). In the context of this study, acknowledging androgyny highlighted that health decisions among African American men could not be understood solely through rigid masculine ideals such as toughness and stoicism. Instead, men who identified or expressed themselves in more androgynous ways might negotiate masculinity differently, reframing health-seeking as a personal responsibility and a socially connected act.

This consideration aligned with the gender role socialization framework, which emphasizes that health behaviors are influenced by how individuals navigate cultural and gendered expectations (Smith et al., 2022). By integrating androgynous identity into the conceptual framework, the study extended masculinity theory beyond binary categories and captured a broader spectrum of how African American men construct and express gender concerning health. Such attention to gender variation also acknowledged the

intersection of identity, culture, and social determinants of health, offering a more inclusive lens for understanding prostate cancer screening behaviors.

Participants had considered, discussed, or received information about prostate cancer screening within the past 2 years and were willing to share their beliefs, attitudes, and perceptions through in-depth interviews. Each participant was mentally and legally capable of providing informed consent (see Nikidehaghani et al., 2023). Individuals outside the age range, not identifying as African American, or lacking prior exposure to prostate cancer screening information were excluded. Additionally, individuals unwilling or unable to engage in the interview process were excluded to ensure rich qualitative data generation (see Bazargan et al., 2021).

Each participant's interaction began with an acknowledgment of informed consent. The process collected demographic information and confirmed age, racial identity, gender identity or expression, and awareness of prostate cancer screening, in alignment with guidelines for multiple narrative case-based research (see Yin, 2018). A small, purposeful sample prioritized depth over breadth. I identified participants through flyers and digital announcements in community organizations, clinics, churches, and social networks serving African American communities. Interested individuals initiated contact and received detailed study information and verbal consent. Upon confirmation of consent, a mutually convenient time for a face-to-face interview was arranged (see Oates et al., 2022; Tasci et al., 2020). Each participant received a \$10.00 gift card as a token of appreciation.

## **Instrumentation**

I served as this study's primary data collection and reanalysis instrument, consistent with qualitative research. Cultural competence, trust-building, sensitivity to historical disparities, and open dialogue are essential in engaging African American men regarding prostate cancer screening (Olmsted, 2024). The instrumentation strategy integrated semi-structured questions, field notes, reflective journaling, and artifact analysis. These tools supported comprehensive and context-rich data collection, aligning with the narrative, case-based design, and prioritizing authentic lived experiences (see Kensler et al., 2020; Tomaszewski et al., 2020).

The primary instrument was a semi-structured interview protocol informed by the literature and theoretical frameworks. Open-ended questions allowed participants to share experiences and reflections. Follow-up probes encouraged elaboration, while introductory questions established rapport and verified eligibility. Core questions, as illustrated (see Appendix A), were aligned with the HBM and explored masculinity norms, emotional barriers, healthcare mistrust, and knowledge (see Khalil et al., 2024).

### **Procedures for Recruitment, Participation, and Data Collection**

With consent, conversations were audio-recorded and securely stored on password-protected devices to ensure confidentiality (NCI, n.d.). Field notes captured contextual details during and after interviews, and reflective journaling documented emotional responses, biases, and methodological decisions. Artifact analysis supplemented interviews through healthcare brochures, social media posts, or community health flyers shared by participants or collected publicly. These items enriched the

contextual understanding of participant experiences (see Antunes et al., 2022; Buote et al., 2020; Okoro et al., 2020).

I collected basic demographic information and confirmed the inclusion criteria. Following this, informed consent was initiated. Participants consented with the words "I consent" and received answers to any questions about the form. Data were collected using face-to-face interviews and saved as audio files. Interviews were transcribed in Microsoft Word. Artifact images were saved in a separate file for analysis (see Caronia, 2018).

### **Data Analysis Plan**

I analyzed the data using a three-stage coding process to ensure a rigorous and systematic approach to thematic development. In the first stage, I conducted open coding by performing line-by-line identification of significant words, phrases, and ideas within each transcript. This process allowed me to highlight emerging concepts and initial patterns from participant narratives (see Saldaña, 2021). In the second stage, I employed axial coding, which involved categorizing the initial codes into broader groups and examining the relationships between categories.

The axial coding process provided structure to the data and facilitated a clearer understanding of connections across participants' experiences (see Kensler et al., 2020). In the third stage, I conducted selective coding, refining the categories into overarching themes that captured the essence of participants' perspectives (see Appendix D). Selective coding allowed me to integrate participant voices into meaningful themes aligned with the study's research questions and conceptual framework (see Naeem et al.,

2023). I also used cross-case synthesis to compare narratives across the three participants. This step enabled me to identify similarities and differences in perspectives, enhancing the analysis's depth and richness (see Yin, 2018). To strengthen the credibility of the findings, I integrated data triangulation by drawing from multiple data sources, including interview transcripts, field notes, artifacts, and my reflective journal (see Appendix F). The support of integrated data triangulation ensured the findings by converging lines of evidence (see Elosua, 2022; Rintala et al., 2023). Additionally, I conducted member checking by inviting participants to review and confirm the accuracy of their thematic summaries. This process validated the interpretations and enhanced the study's trustworthiness (see Elosua, 2022).

I incorporated the analysis process guided by the HBM and gender role specialization theory. During open coding, I identified key phrases that reflected HBM constructs such as perceived susceptibility to prostate cancer, perceived severity of the disease, perceived benefits of screening, and perceived barriers to care (see Rosenstock, 1974). Axial coding enabled me to group these concepts into categories reflecting participants' beliefs about personal health risks and their evaluations of preventive behaviors. Selective coding refined these categories into overarching themes demonstrating how individual perceptions and cultural norms shaped participants' health decisions (see Naeem et al., 2023).

The framework of gender role specialization further informed the coding process. I identified codes that reflected traditional masculine norms, such as reluctance to discuss health issues, prioritization of work or provider roles, and the influence of peer networks

on health decisions. These codes were categorized during axial coding to show how gender role expectations intersected with health beliefs. In the selective coding phase, overarching themes emerged that illustrated how masculinity and cultural identity influenced participants' willingness to engage in prostate cancer screening.

By synthesizing the HBM and gender role specialization theory, the data analysis revealed how participants' perceptions of risk, benefits, and barriers were situated within cultural and gendered contexts. This alignment with the conceptual framework provided a deeper understanding of African American men's perspectives on prostate cancer screening.

### **Coding Framework**

This illustrates the three-stage coding process (open, axial, selective). It demonstrates how the emerging themes are aligned with the constructs of the HBM and gender role specialization theory. This visual framework highlights the flow from raw data coding toward refined themes situated within the study's conceptual framework. The data analysis process in this study followed a structured and systematic approach to facilitate a comprehensive understanding of the cultural, social, and emotional factors that influenced prostate cancer screening behaviors among younger African American men.

They incorporate semi-structured question interviews as the primary data source, capturing in-depth narratives reflecting participants' experiences, cultural beliefs, and health-related attitudes. Thematic analysis commenced with transcription, proceeded through open coding to identify significant phrases, and advanced to axial coding to

categorize emerging patterns (see Appendix E). Selective coding was then employed to refine and align themes with the study's research questions (see Naeem et al., 2023; O'Brien et al., 2024).

Microsoft Word (2023) supported the coding process by enabling text searches and manual organization of codes. Discrepant cases—narratives that diverged from dominant themes—were reviewed in full to highlight alternative perspectives or document exceptional findings (see Elosua, 2022). I incorporated the participant prostate cancer flyer to strengthen the analysis. Artifacts and visual materials, such as healthcare brochures, social media posts, and community event flyers, provided insight into how African American men perceived and engaged with health-related messaging (see Caronia, 2018). Recurring themes, symbols, and cultural cues were identified and organized through Microsoft Word content analysis.

The artifact that conveyed the message was inconsistent with the interview data, flagged, and cross-verified to ensure analytical integrity. I addressed inconsistencies or potential biases by comparing data across participant narratives and the related artifact. Integrating semi-structured question interviews, artifacts, and reflective journals enabled methodological data triangulation, which enhanced the credibility and trustworthiness of the findings (see Elosua, 2022; Stokes, 2025). The use of defined coding strategies and digital tools such as Microsoft Word and Excel facilitated a rigorous and comprehensive exploration of the factors shaping African American men's prostate cancer screening decisions (see Isangula et al., 2024; Stacey et al., 2024).

### **Ethical Procedures**

Before data collection, I established all necessary permissions and agreements to ensure ethical compliance and transparency. I secured formal Institutional Review Board (IRB) approval before the initiation of recruitment or any participant interaction. Required documents submitted for IRB review included informed consent forms, the participant interview protocols, and recruitment materials (National Institutes of Health [NIH], n.d.). The study adhered to the ethical standards outlined by the American Psychological Association (APA, 2025). Ethical approval was granted under protocol Walden University's Research Participant Advocate at 612-312-1210 or Walden University's IRB at [IRB@mail.waldenu.edu](mailto:IRB@mail.waldenu.edu). I recruited all participants voluntarily and provided them with written informed consent with information describing the aims of the project, the interview procedures, and their rights as participants.

Upon approval, the IRB number was documented and cited in the final dissertation to demonstrate adherence to the ethical principles of respect for persons, beneficence, and justice, as outlined in the Belmont Report (NIH, n.d). If distress arises, in case of any distress, you can call the National Association for Mental Illness hotline: 1-800-950-NAMI (6264). I appropriately documented the source of the publicly available artifact, such as the participant's prostate cancer screening flyer. I maintained a document analysis log to track distribution dates and relevance, ensuring transparency and accuracy.

The informed consent process ensured participants understood the study's purpose, procedures, risks, and benefits before participation (see Caeymaex et al., 2023).

Before the interview, I presented the consent forms, giving participants time to review and raise questions. I received confirmation of consent verbally and securely stored it in encrypted digital files, separate from the transcripts. Verbal consent was also confirmed during virtual meetings, as Bouras (2024) outlined. Participant protection remained central throughout the study.

The voluntary nature of participation was emphasized in recruitment materials and verbal scripts to minimize perceived coercion (see Girman & Ritchey, 2021). I conducted all interactions via private, face-to-face, or phone calls. I distributed the recruitment materials indirectly by trusted community organizations to reduce coercion risk. As a token of appreciation, participants received a \$10.00 gift card, a modest incentive that did not constitute undue influence (Negrin et al., 2022).

Several safeguards protected participants' privacy and emotional well-being. I used unique identifiers to anonymize participants, and all data—including recordings, transcripts, and artifacts—were stored in encrypted folders with restricted access. Virtual meetings were held in private, neutral spaces to ensure confidentiality. I express to participants their right to pause (take a break) or withdraw at any point.

I made counseling resources available to call the National Association for Mental Illness hotline for those experiencing emotional discomfort (see WHO, 2021). At the conclusion of each interview, participants were thanked and informed about how the study would use their data. They were reminded of their right to withdraw data before the analysis began (see Oates et al., 2022). These procedures aligned with IRB standards and

ethical research practices, ensuring participant protection while maintaining research rigor and integrity (NIH, n.d.).

### **Evidence of Trustworthiness**

I employed multiple strategies to ensure the trustworthiness of the findings, consistent with ethical guidelines for protecting research integrity and participants' rights (National Institutes of Health [NIH], n.d.). I strengthened credibility through careful transcription verification. I audio-recorded each interview with participant consent and transcribed verbatim, as Bouras (2024) outlined. I checked transcripts against the recordings to ensure accuracy and invited participants to review their transcripts to confirm that I represented their perspectives faithfully.

I incorporated clarifications and corrections when provided. Additionally, theme-checking was conducted by sharing preliminary thematic interpretations with participants, allowing them to validate or challenge the researcher's interpretations. This process enhanced the data's accuracy and authenticity (Girman & Ritchey, 2021). Thick descriptions of the study context, participant characteristics, and interview procedures supported Transferability. By offering detailed contextual information and illustrative quotations, I equipped readers to determine the applicability of the findings to other settings.

The depth of the interview data ensured that I conveyed participants' experiences in ways that could resonate beyond the immediate research context (see Negrin et al., 2022). I established dependability by maintaining a detailed audit trail, including field notes, analytic memos, and coding decision logs. I held peer debriefing sessions with

colleagues who reviewed portions of the transcripts and coding structures to ensure that the evidence supported interpretations. This systematic approach ensured transparency and reliability in the analytic process (NIH, n.d.).

I enhanced confirmability through reflexive practices and maintained a reflexive journal to document personal assumptions, biases, and reflections during the interview and analysis process. The record helped monitor the influence of my research perspective and supported neutrality in interpretation. Data triangulation, which included cross-checking transcripts, reflexive notes, and analytic memos, further reduced the likelihood of bias shaping the findings. These practices aligned with ethical research principles outlined in the Belmont Report (NIH, n.d.). Transcription verification, reflexivity in interviewing, and participant validation of emerging themes contributed to the study's credibility, dependability, confirmability, and transferability. These procedures upheld ethical research standards while demonstrating methodological rigor and trustworthiness of the findings (Mishra & Dey, 2022).

### **Summary**

Chapter 3 outlined the methodological framework used to explore the beliefs, attitudes, and perceptions of younger African American men regarding prostate cancer screening. The investigation employed a qualitative, multiple case study design informed by narrative inquiry, which aligned with the HBM and theories of masculinity and gender role socialization. This approach allowed for a culturally grounded and psychologically nuanced examination of the factors influencing prostate cancer screening behaviors. The study design emphasized depth over breadth, utilizing purposive sampling to recruit

African American men aged 35 to 45 who had considered or encountered prostate cancer screening information within the past two years (Campbell et al., 2020).

Recruitment occurred through the Barbershop, a community-based organization, to ensure accessibility and cultural relevance. Instruments included semi-structured question interviews, artifact analysis, and reflective journaling. These tools facilitated the collection of rich, contextualized data reflective of participants' lived experiences. Data collection followed a structured protocol. Interviews were audio-recorded and transcribed for thematic analysis using open, axial, and selective coding. Microsoft Word (2023) supported data organization and cross-source analysis. The analysis integrated various data sources—participant narratives, cultural artifacts, and reflective journal entries—enhancing analytical depth and credibility.

Data triangulation, member checking, reflexivity, and audit trails strengthened trustworthiness across the study. Ethical procedures guided every phase of the research. I received approval from the IRB before participant engagement. I prioritized confidentiality, voluntary participation, informed consent, and participant well-being. I stored data securely and will retain it for 5 years, adhering to data protection and ethical compliance guidelines. The methodological decisions described in this chapter established a rigorous and ethical foundation for exploring a complex and under-researched topic.

These decisions ensured the reliability and validity of findings presented in Chapter 4. The next chapter offers an in-depth analysis of the data, organized around emergent themes, participant narratives, and contextual insights. These measures enhance

the investigator's credibility, transferability, dependability, and confirmability, ensuring the findings are valid, reliable, and trustworthy (see Stokes, 2025). In Chapter 4, I present an analysis of the collected data, including an organized overview of emerging themes, participant narratives, supporting evidence from questions, the artifact, and reflective journal entries. The research questions aligned with this research provide an insightful response to the objectives. Adherence to the methodological rigor established in this chapter ensures that Chapter 4 lays a solid foundation for interpretation, discussion, and application in Chapter 5.

## **Chapter 4: Results**

### **Introduction**

I conducted interviews with three participants for this multiple case study on African American men, resulting in their beliefs, attitudes, and perceptions regarding prostate cancer screening. This qualitative study explored how younger African American men described their health-related decisions about early detection and preventive care. This chapter presents the results organized by themes that emerged from the data. The central research question guided the analysis: What are the perceptions, attitudes, and beliefs of African American men, aged 35 to 45 years, about early prostate cancer screening?

I structured this chapter into three sections. First, I describe the data collection setting, participant demographics, and the recruitment strategy. Next, I outline the data collection procedures and the coding process used for analysis. I organize the results into five themes. Each theme includes direct participant quotes, coded categories, and descriptive results. Finally, this cross-case synthesis highlights similarities and differences across the three participants. This organization allows the results to remain closely tied to the data, and I present them clearly and transparently.

### **Setting**

I conducted a qualitative multiple case study to explore the beliefs, attitudes, and perceptions of African American men regarding prostate cancer screening within the culturally familiar setting of a local barbershop in Central Florida. I chose the barbershop for its cultural relevance and longstanding role as a trusted social space in African

American communities. I met them one after the other on a Sunday afternoon after church. All face-to-face interviews were conducted privately in the barbershop to provide a quiet, trusted, and familiar space conducive to open dialogue. The setting supported the study's aim to access authentic narratives shaped by personal and collective experiences.

### **Demographics**

Three African American men between the ages of 35 and 45 participated in this study. Each participant met the inclusion criteria, which required self-identification as African American, being within the specified age range, and having encountered exposure to information about prostate cancer screening within the past two years. To protect confidentiality, I assigned pseudonyms: Participant 1 (P1), Participant 2 (P2), and Participant 3 (P3). P1 was a small business owner, P2 was a college student, and P3 was a car sales associate. All participants lived in Central Florida and connected strongly to families, churches, and peer networks. These social ties often intersected through the shared cultural space of the barbershop, which grounded the study in a specific socio-cultural and geographic context.

### **Data Collection**

I employed semi-structured interviews as the primary data collection method. I provided participants with three options for participation: telephone, Zoom, or face-to-face. All three participants chose in-person interviews. Each interview was audio-recorded with participant consent, ranging from 45 to 60 minutes. The interviews were conducted privately in the barbershop on a Sunday afternoon after church.

The semi-structured interview protocol followed the five domains identified in Chapter 3: masculinity and gender role socialization, beliefs and attitudes, cultural norms and trust, knowledge, barriers, practices, outreach, and final thoughts. I also presented a supplementary artifact, which was the recruitment flyer, which participants referenced during their interviews (see Appendix B). I took detailed field notes to supplement the interviews to capture tone, pauses, and body language. I also maintained a reflective journal throughout the research process to document my positionality and track evolving insights.

These practices supported the transparency and rigor of the study. The cross-case synthesis integrated the nine themes to demonstrate how masculinity, cultural norms, systemic barriers, and family influence collectively shaped African American men's prostate cancer screening behaviors. While P1 framed masculinity as toughness and avoidance, P2 associated it with procrastination and financial responsibility, and P3 viewed it as leadership and optimization. Family influence consistently emerged as a motivator, while barriers included stigma, cost, and institutional mistrust. Knowledge gaps and a lack of targeted messaging appeared across participants, though trust in providers varied.

### **Data Analysis**

I analyzed the interview data using a systematic three-stage coding process. In the first stage, I conducted open coding by reviewing each transcript line by line. I identified significant words, phrases, and ideas reflecting participants' statements about masculinity, health beliefs, attitudes toward prostate cancer screening, cultural influences,

and decision-making processes (see Appendix C). In the second stage, I applied axial coding by grouping the initial codes into broader categories and examining their relationships. Categories included barriers, facilitators, cultural influences, family roles, knowledge sources, and trust in healthcare providers.

In the third stage, I used selective coding to refine the categories into overarching themes that summarized the findings across all three participants. This process produced nine themes: masculinity and gender role socialization, beliefs and attitudes toward screening, cultural norms and community influence, knowledge and health information access, trust and historical mistrust, barriers and facilitators, personal health practices and decision-making, recommendations for outreach, and final thoughts and advice. I also conducted a cross-case synthesis to compare participants' narratives. This process identified areas of convergence and divergence across the three cases.

To ensure accuracy, I triangulated data across multiple sources, including interview transcripts, field notes, the recruitment flyer, and my reflective journal. I also conducted member checking by providing participants with thematic summaries of their interviews, which they confirmed as accurate. This rigorous process allowed me to identify significant participant insights, categorize relationships among codes, and refine them into overarching themes aligned with the conceptual framework. By grounding the analysis in the HBM and gender role socialization theory, I ensured that the findings were theoretically coherent and reflected the cultural and gendered realities of African American men's health experiences. Importantly, I aligned the ethical acknowledgment

of androgynous expressions of masculinity with the gender role socialization framework, enriching the findings' inclusivity and validity.

### **Open Coding**

In the first stage, I conducted open coding by analyzing each interview transcript line by line. I identified significant words, phrases, and ideas that directly reflected participants' beliefs, attitudes, and perceptions regarding prostate cancer screening. This inductive process enabled the codes to emerge organically from the data rather than being imposed by preconceived categories (Saldaña, 2021). For example, phrases such as "I hate hospitals," "that's the part that frightens me," and "you can't work and provide for your family without being healthy" surfaced as meaningful indicators of how participants linked health behaviors to masculinity, fear, and family responsibility. These initial codes represented the raw insights that formed the foundation of the broader thematic structure.

### **Axial Coding**

In the second stage, I applied axial coding to categorize the initial codes into broader groups and map their interrelationships. This step revealed how participants connected their health knowledge and screening behaviors to cultural contexts and masculine identities (see Whitney & Evered, 2022). For instance, codes related to fear of rectal examinations, mistrust of providers, and financial strain were grouped under "barriers." In contrast, codes related to family support, responsibility, and faith were clustered under "facilitators." The axial coding process also illustrated how masculinity operated as a constraint and motivator. Some participants described masculinity as toughness that discouraged health-seeking, while others reframed it as accountability to

family that encouraged preventive care. By organizing the data into these relational categories, axial coding highlighted the complex ways in which cultural norms, systemic barriers, and individual identities shaped screening behaviors.

### **Evidence of Trustworthiness**

I ensured the trustworthiness of this study by applying the four criteria identified by Stokes (2025): credibility, transferability, dependability, and confirmability. These criteria have remained widely accepted standards for establishing rigor in qualitative research (NIH, n.d.). By intentionally integrating these principles into each stage of the research process, I demonstrated that the findings were valid, reliable, and rooted in the authentic voices of participants. The use of the HBM, gender role socialization theory, and the recognition of androgynous expressions of masculinity strengthened the analytic depth and theoretical grounding of the study, while simultaneously reinforcing its methodological rigor.

### **Credibility**

I enhanced credibility by employing data triangulation, which involved cross-verifying data from multiple sources. I analyzed interview transcripts alongside field notes, participant artifacts, and reflective journals to ensure consistency and convergence of evidence. For example, when a participant described fear of the rectal examination during the interview, I validated this theme with notes from my reflective journal, documenting the participant's tone, hesitation, and pauses. By connecting transcripts with nonverbal and contextual details, I ensured that the interpretation reflected the lived reality of the participants and not merely the textual record.

I also conducted member checking, allowing participants to review their interviews' thematic summaries. Each participant confirmed the accuracy of the interpretations and, in some cases, expanded on their initial responses. For instance, one participant clarified that his mistrust of healthcare systems was not absolute but was moderated by his ability to research providers independently. This feedback strengthened the credibility of the findings by ensuring that interpretations aligned with participants' perspectives.

In addition, I engaged in peer debriefing with a methodological advisor, which provided opportunities to receive critical feedback on coding decisions and thematic development. This process challenged me to reflect on whether my assumptions overly influenced interpretations or whether alternative explanations might exist. These steps enhanced the accuracy and integrity of the findings and reduced potential researcher bias. Integrating the HBM and Gender Role Socialization theory supported credibility by offering structured theoretical lenses for interpreting participant responses. For example, perceived susceptibility and barriers, as outlined in the HBM (Rosenstock, 1974), aligned with participants' fear of procedures and mistrust of providers.

At the same time, masculine norms identified in gender role socialization theory explained participants' reluctance to seek help or disclose vulnerability. Recognizing androgynous expressions of masculinity further strengthened credibility by acknowledging that health behaviors were not bound solely by rigid masculine ideals. Instead, participants who integrated traditionally masculine and feminine traits demonstrated greater flexibility in health decision-making, providing a nuanced

explanation of the data (Bem, 1981). Together, these frameworks ensured that interpretations were credible and theoretically grounded.

### **Transferability**

I established transferability by providing thick, contextual descriptions of participants' experiences, cultural backgrounds, and community settings. Each participant lived in Central Florida and shared strong connections to their communities through churches, barbershops, and peer networks. The choice of the barbershop as the recruitment and interview setting was critical because of its cultural significance within African American communities. Barbershops served as grooming sites and trusted communal hubs where dialogue, mentorship, and solidarity occurred.

By offering detailed accounts of the barbershop context, participants' socioeconomic status, and their family and faith-based affiliations, I enabled readers to determine the applicability of these findings to similar populations and settings (see Drisko, 2024). For example, the description of how P2 consulted his family before making health decisions provided insight into the role of collective decision-making. This dynamic may resonate with other African American communities in similar socioeconomic contexts. The integration of the HBM and gender role socialization theory expanded the transferability of the findings by situating individual participant experiences within broader theoretical frameworks.

HBM constructs such as perceived severity and benefits highlighted the rational calculations that guided screening decisions. At the same time, gender role socialization theory emphasized the cultural norms and gendered expectations that shaped those

decisions (see Smith et al., 202; Stacey et al., 2024). Recognizing androgynous masculinity further supported transferability by demonstrating that health decisions were not uniform across African American men but varied along a spectrum of gender identity and expression. This inclusive perspective allowed readers to consider how the findings apply to populations where men resist or reframe rigid masculine norms.

### **Dependability**

I maintained dependability by developing an audit trail documenting coding decisions, analytic memos, and reflexive notes throughout the research process. This record allowed for transparency and provided a clear rationale for methodological and analytic choices. For example, I documented how codes related to mistrust of providers evolved into a broader theme of historical mistrust, supported by both transcript data and contextual reflections in my journal. By preserving these analytic pathways, I ensured the study's procedures were consistent and replicable (see Laferriere & Bertram, 2024).

I also used systematic coding procedures that enhanced dependability. Open coding identified significant phrases, axial coding grouped categories and mapped relationships, and selective coding refined these into overarching themes. This structured process reduced the potential for inconsistency and ensured that the findings emerged logically from the data. The use of peer debriefing further supported dependability. My methodological advisor critically reviewed my coding decisions and thematic structure, encouraging me to justify interpretations with direct evidence. This process increased consistency and provided external validation of the analytic approach.

By grounding the analysis in both the HBM and gender role socialization theory, I ensured that dependability extended beyond procedural rigor to theoretical alignment. The recognition of androgynous masculinity enriched this alignment by introducing a conceptual category that explained variations in participants' negotiation of masculine norms. For example, participants who blended responsibility to family with openness to preventive care reflected an androgynous orientation that expanded the explanatory power of gender role socialization theory. This integration demonstrated that the findings were dependable across theoretical, methodological, and ethical dimensions.

### **Confirmability**

I established confirmability by practicing bracketing and maintaining a reflexive journal. These strategies enabled me to set aside personal assumptions and biases, foregrounding the authentic voices of participants in the analysis. For example, when a participant expressed mistrust of the healthcare system, I bracketed my assumptions about provider–patient relationships and instead relied on the participant's words and contextual explanations. Through reflexive journaling, I documented my reflections on how my identity, positionality, and prior knowledge might influence the study.

I critically examined my responses to participants' narratives and noted where my perspectives could introduce bias. This transparency supported confirmability by ensuring the findings were rooted in participants' perspectives rather than my predispositions (see Whitney & Evered, 2022). The alignment of ethics and theory also strengthened confirmability. By ethically recognizing androgynous expressions of masculinity, I ensured that binary definitions of gender did not constrain participants.

This acknowledgment reduced the risk of silencing diverse identities and affirmed that the findings authentically represented the participants' lived experiences. At the same time, the integration of HBM and gender role socialization theory provided structured, evidence-based frameworks that anchored the findings in established scholarship. This ethical and theoretical dual grounding reinforced that the interpretations were participant-centered and academically rigorous. Through the combined strategies of credibility, transferability, dependability, and confirmability, I ensured that the findings of this study were trustworthy and rigorous.

The systematic coding process, triangulation of data sources, member checking, peer debriefing, and reflexive practices contributed to methodological integrity. By embedding the analysis in the HBM, the gender role socialization theory, and the acknowledgment of androgynous expressions of masculinity, I captured a comprehensive and inclusive understanding of African American men's beliefs, attitudes, and perceptions toward prostate cancer screening (Svensson et al., 2023). This alignment of theory, ethics, and methodological rigor demonstrated that the findings presented in this chapter were valid, reliable, and transferable to similar contexts, thereby contributing meaningfully to scholarship and practice.

### ***Selective Coding***

In the third stage, I conducted selective coding to refine the categories into overarching themes aligned with the study's conceptual framework. This phase produced nine themes: masculinity and gender role socialization, beliefs and attitudes, cultural norms and community influence, knowledge and information access, trust and historical

mistrust, barriers and facilitators, personal health practices and decision-making, recommendations for outreach, and final thoughts and advice. These synthesized themes illustrated how African American men's health beliefs were shaped not only by perceived risks and barriers but also by broader community expectations and gendered norms (see Naeem et al., 2023). Selective coding also allowed me to incorporate the recognition of androgynous expressions of masculinity as an important conceptual dimension.

Androgyny, the integration of traditionally masculine and feminine traits (Bem, 1981), highlighted the possibility that participants could navigate health behaviors more flexibly than rigid masculine norms typically permitted. For example, while toughness and stoicism were often associated with avoidance of care, androgynous expressions of masculinity allowed for alternative interpretations, such as balancing responsibility to family with self-care and openness to preventive practices.

### ***Cross-Case Synthesis***

I employed this cross-case synthesis to compare narratives across participants, which enabled me to identify shared and divergent perspectives among the three cases (see Yin, 2018). For example, all three participants acknowledged the influence of family on health decision-making, but they diverged in how they interpreted masculinity. P1 described masculinity as toughness that discouraged hospital visits, P2 highlighted financial responsibility that delayed preventive care, and P3 reframed masculinity as leadership that encouraged provider communication. This synthesis deepened the analysis by demonstrating how African American men within the same age range and community context negotiated masculinity differently. It also revealed how cultural norms such as

community silence and generational shifts toward openness intersected with systemic barriers like cost and mistrust. I captured the layered and contextualized realities of prostate cancer screening behaviors by situating these similarities and differences within the conceptual framework.

### ***Ensuring Trustworthiness***

I ensured the trustworthiness of the analysis through several strategies. To enhance credibility, I used triangulation by drawing from multiple data sources, including interview transcripts, field notes, artifacts, and reflective journaling. I also conducted member checking, which allowed participants to review their thematic summaries and confirm accuracy. This process validated my interpretations and ensured the findings authentically represented their voices. To strengthen transferability, I provided thick, contextual descriptions of participants' experiences, demographics, and cultural settings. I created an audit trail to establish dependability that documented coding decisions, memos, and reflective journals. I achieved confirmability by engaging in reflexive journaling, which allowed me to critically examine my assumptions, positionality, and potential biases while foregrounding participants' authentic narratives.

### ***Theoretical Integration***

Guiding the entire analysis were the HBM and gender role socialization theory. Codes aligned with HBM constructs such as perceived susceptibility, severity, benefits, and barriers (see Rosenstock, 1974). At the same time, gender role socialization theory illuminated how masculine norms, provider roles, and peer influence shaped men's openness to screening discussions (see Smith et al., 2022). Importantly, I also aligned the

ethical acknowledgment of androgynous expressions of masculinity with gender role socialization theory. This integration demonstrated that masculinity was not monolithic but existed along a spectrum of expression, where androgyny offered alternative pathways to health-seeking behavior. Recognizing androgynous masculinity reduced the risk of reinforcing binary conceptions of gender and expanded the study's cultural sensitivity by capturing a broader range of identity-based health perspectives. By integrating these frameworks, I provided a comprehensive understanding of how African American men's health decisions were influenced not only by perceptions of risk and systemic barriers but also by the interplay of masculinity, cultural norms, and diverse gender expressions. This alignment of theory and ethics underscored that prostate cancer screening behaviors must be understood through individual and collective identities.

### **Results**

The results of this study revealed that masculinity and gender role socialization played a critical role in shaping African American men's beliefs, attitudes, and behaviors toward prostate cancer screening. Themes that emerged from participant narratives demonstrated that masculinity was perceived both as a constraint and a motivator in decisions regarding health-seeking behaviors. These results are presented below by integrating participant responses, highlighting major themes influencing screening behavior.

#### ***Masculinity and Gender Role Socialization***

Participants consistently described masculinity as a dual influence on health behavior. For some, masculinity discouraged engagement with health services due to its

association with stoicism, emotional suppression, and self-reliance. This theme emerged as a central factor shaping participants' screening decisions. Masculinity was not viewed solely as an individual trait but as a socially reinforced identity constructed through family expectations, peer influence, and cultural norms.

Avoidance of health care emerged as a behavioral expression of masculinity. For example, P1 stated, "Some Black men think being healthy and not seeing a doctor is much easier... I hate hospitals," highlighting stoicism and resistance to medical help. P2 echoed similar concerns: "Some guys look good on the outside, but inside, their organs are rotting," revealing how the performance of outward strength often masked internal vulnerability.

Participants identified the DRE as a particularly sensitive and challenging component of prostate cancer screening. The DRE was described as emotionally, culturally, and symbolically invasive, evoking feelings of embarrassment and emasculation. P2 stated, "Rectal examination—that's the part that frightens me," indicating that the procedure triggered anxiety not just due to its physical nature but because of its cultural implications. This reaction aligned with participants' internalized masculine norms, which emphasized control, invulnerability, and sexual dominance.

Both P1 and P2 noted that embarrassment and fear of emasculation led men to avoid discussing the DRE or to defer screening. These narratives suggested that the DRE symbolized a challenge to masculine identity, particularly in African American communities where masculinity is strongly associated with autonomy and physical strength.

In contrast, P3 provided an alternative framing, suggesting that masculinity could be redefined through proactive health engagement. He shared, “That is an opportunity... to make that area stronger by communicating to your provider,” highlighting how communication and responsibility could be viewed as masculine strengths. This reframing supported the concept of androgynous masculinity, which integrates openness and resilience, enabling preventive health behaviors.

### ***Masculinity, Emasculation, and the DRE***

The results of understanding the intersection of masculinity, perceived emasculation, and prostate cancer screening are essential to addressing health disparities among African American men. One of the most controversial yet medically routine procedures associated with prostate cancer screening is the DRE. Although the DRE is a non-sexual, clinical method for detecting prostate abnormalities, it is often interpreted through cultural and psychological lenses that associate the procedure with vulnerability, invasion of personal boundaries, and even sexual stigma (Griffith et al., 2021; Rose et al., 2022). The perceptions are particularly pronounced among African American men, who may be more likely to equate the procedure with a loss of masculine identity.

As a result, masculinity, as conceptualized within gender role socialization theory, is shaped by cultural teachings that promote emotional stoicism, physical toughness, sexual dominance, and self-reliance (Pleck, 1981; Smith et al., 2022). These internalized norms discourage help-seeking behaviors and reinforce the idea that acknowledging physical discomfort, undergoing intimate procedures, or discussing emotional fears compromises one’s masculinity (Aguilera et al., 2024). Consequently, preventive health

services—especially those requiring bodily exposure, such as the DRE—may be experienced as emasculating or humiliating.

The results of the study maintain that for many African American men, the fear of emasculation serves as a significant deterrent to prostate cancer screening. The results of this fear stem from the physical invasiveness of the DRE and its symbolic challenge to cultural ideals of manhood. The results of the association between the rectum and taboos around same-sex intimacy can further intensify this discomfort, especially in communities where homophobia is prevalent or where masculinity is tightly linked to heterosexual performance and emotional invulnerability (Bowling et al., 2021). The results of participants in multiple studies have expressed reluctance to undergo DRE due to concerns about appearing weak, vulnerable, or effeminate—perceptions that directly conflict with traditional masculine norms (Adams et al., 2023; O'Brien et al., 2024).

Therefore, the results of this internal conflict—commonly referred to as gender role stress—have been shown to influence African American men's reluctance to engage in preventive health behaviors. The DRE becomes not just a clinical procedure, but a symbolic test of one's masculinity (Aguilera et al., 2024). As such, the results of the study mention men who strongly identify with traditional gender norms may experience cognitive dissonance when faced with screening, ultimately opting to delay or avoid care altogether (Smith et al., 2022). The results of this delay have profound implications, given the elevated prostate cancer risks within the African American male population (Basourakos et al., 2022).

However, masculinity is not monolithic. Results of recent studies show that some men reinterpret traditional masculine traits such as strength, resilience, and leadership as motivators for preventive care rather than constraints. For example, when masculinity is framed as accountability, protection, and family leadership, men may view screening not as a threat to their identity but as an act of responsibility and strength (Adams et al., 2023; Bowling et al., 2021). The results from the study highlighted that reframing aligns with androgynous masculinity, a concept introduced by Bem (1981), which incorporates both traditionally masculine traits (e.g., strength, decisiveness) and feminine traits (e.g., openness, communication). Such flexibility allows men to engage with health systems without compromising their masculinity.

As a result, in this context, public health interventions must be sensitive to the symbolic meanings attached to procedures like the DRE. Strategies may include offering alternative screening options such as the PSA test, leveraging trusted community spaces like barbershops and churches to normalize prostate health conversations, and reframing screening as an act of family protection and leadership rather than weakness (Tabei et al., 2020). The results of this study highlight health-seeking as a strong, proactive choice; men may be more willing to overcome emotional and cultural barriers to care (Griffith et al., 2021; Smith et al., 2022).

Ultimately, the results showed that masculinity and gender role socialization play a pivotal role in shaping African American men's perceptions of and engagement with prostate cancer screening. As a result, the DRE, in particular, exemplifies the complex ways cultural norms, emotional vulnerability, and healthcare procedures intersect. By

acknowledging these results and addressing these nuances, researchers and practitioners can design more effective, culturally grounded interventions to promote early detection and reduce disparities in prostate cancer outcomes.

In contrast, the study's results reframed toughness as responsibility and accountability to family and community. The results of the participants' accounts suggested that reconstructing masculinity should emphasize responsibility rather than avoidance. Participants described health-seeking not as weakness but as a proactive behavior, reinforcing their role as a leader and provider. The results of this reinterpretation aligned with broader calls in public health research to reframe masculinity in ways that position preventive health behaviors as signs of strength and accountability.

The participants' accounts collectively illustrate how masculinity is not a static or uniform concept but a dynamic influence that could constrain or motivate health behavior. Participants reflected that, as a result of the traditional, stoic model of masculinity, toughness equated to silence, self-reliance, and avoidance of medical intervention. The results demonstrate how renegotiated masculinity supports preventive behaviors, reframing toughness as the ability to take responsibility for one's health and family well-being (Vyas et al., 2022). The results of this theme underscored the dual role of masculinity in shaping younger African American men's approaches to prostate cancer screening.

The results revealed a critical tension: masculinity could perpetuate health disparities through avoidance, yet it also carried the potential leverage as a motivating

force for early detection and preventive care. P1 explained, “Some Black men think being healthy and not seeing a doctor is much easier... I hate hospitals.” P2 added, “Some guys look good on the outside, but inside organs are rotting.”

In contrast, P3 reframed toughness as responsibility, stating, “That is an opportunity... to make that area stronger by communicating to your provider.”

Masculinity shaped participants’ perspectives in complex ways, discouraging preventive care for some while motivating others toward responsibility. The results illustrated in comparing the five themes from participant narratives (P1–P3) with existing literature. The results highlight points of confirmation, extension, and divergence, demonstrating how this study contributes to the scholarly understanding of African American men’s beliefs, attitudes, and perceptions toward prostate cancer screening.

The results of the study highlighted that gender role socialization behaviors shaped participants’ attitudes, beliefs, and practices surrounding prostate cancer screening. The results of these behaviors reflected deeply embedded cultural messages that African American men had absorbed from family, peers, and community institutions across their life course. Socialization as a result of this study emphasized toughness, independence, and emotional restraint, creating expectations that “real men” remained silent about health concerns and avoided behaviors that might expose vulnerability. It resulted in such expectations that profoundly influenced how participants perceived preventive healthcare, particularly procedures like the rectal examination, which they viewed as threatening to masculine identity.

P1 illustrated this influence when he stated, “Some Black men think being healthy and not seeing a doctor is much easier... I hate hospitals.” His words reflected stoicism, a behavior often socialized as an indicator of strength, which discouraged proactive medical engagement. The study highlighted that avoiding hospitals did not stem from lack of knowledge alone but from a cultural framework that equated help-seeking with weakness. Within this study's results, scholars described this phenomenon as “stoic masculinity,” a pattern in which health behavior avoidance served as a performance of toughness (O’Brien et al., 2024).

P1’s statement is aligned with this cultural script, showing how gender role socialization reinforced reluctance to access preventive care. P2 provided further evidence of how gender role socialization behaviors constrained health decisions. He reflected, “Some guys look good on the outside, but inside, their organs are rotting.” This observation pointed to the behavior of concealing illness to preserve outward strength.

As a result, socialization had encouraged men to suppress signs of vulnerability, resulting in emotional suppression and health neglect. The results of gender role stress—the strain men experienced when they feared failing to meet masculine norms (see Aguilera et al., 2024)—were evident in P2’s account. By prioritizing a façade of toughness, men risked delaying or avoiding prostate cancer screening, even when early detection could save lives.

In contrast, P3 demonstrated and reinterpreted that gender role socialization resulted in behaviors in ways that supported preventive care. He explained, “That is an opportunity... to make that area stronger by communicating to your provider.” His

reframing shifted masculinity away from stoic silence toward responsible action. Rather than viewing health-seeking as emasculating, P3 defined it as an expression of resilience and leadership. His narrative aligned with research that identified reframing masculinity as responsibility—a cultural shift that positioned preventive behaviors as consistent with protecting family and fulfilling provider roles (Adams et al., 2023).

Additionally, central tension emerged across participants, resulting in gender role socialization that simultaneously discouraged and encouraged health behavior. On one hand, the results of behaviors rooted in stoicism and emotional restraint contributed to the avoidance of screening and the heightened embarrassment surrounding rectal examinations, which participants associated with emasculation. The results of masculinity, on the other hand, when framed as protection and responsibility, socialization behaviors motivated men to prioritize health as part of their role as providers and leaders.

These results are aligned with broader scholarship demonstrating that gender norms are not static but negotiated in context. de Loyola González-Salgado et al. (2024) argued that health-promoting behaviors are expressions of masculinity. In this study, the results of African American men's narratives confirmed that these performances could constrain or enable preventive care. The participants' accounts also resonated with Bem's (1974) theory of psychological androgyny, which suggested that incorporating traditionally masculine and feminine traits—such as toughness and openness—could create healthier outcomes. Men who engaged with preventive care demonstrated adaptive

expressions of masculinity that incorporated responsibility, communication, and vulnerability.

This study's results from the rectal examination functioned as a particularly salient barrier to prostate cancer screening among participants because it carried strong symbolic meaning tied to masculinity, vulnerability, and stigma (see Appendix G). The results of the study highlight that while PSA testing could be understood as a routine blood test, the rectal examination required physical exposure and intimate bodily contact that conflicted with socialized masculine norms. The results of the interviews and reflective field notes demonstrated how this procedure elicited discomfort, embarrassment, and even feelings of emasculation among younger African American men. P2 articulated this sentiment directly when he admitted, "Rectal examination—that's the part that frightens me."

His voice softened during this disclosure, and he shifted his posture in the chair, avoiding eye contact. In my field notes, I documented that his arms were folded tightly across his chest, signaling defensiveness. His body language reinforced the sense of unease conveyed by his words. The results of this combination of verbal and nonverbal cues illustrated that his fear was not simply clinical in nature; it was deeply connected to cultural meanings about masculinity and bodily autonomy. Therefore, the perception of embarrassment resulted in reflected long-standing gender role socialization patterns. The study results indicate that within African American communities, and in broader society, men were often taught to equate masculinity with control, invulnerability, and avoidance of behaviors that might compromise a heterosexual or dominant self-image. For P2, the

rectal examination symbolized a forced loss of control that challenged these ideals. Research has supported this interpretation, showing that African American men frequently described the DRE as emasculating, associating it with humiliation or challenges to heterosexual identity (Bouras, 2024; Smith et al., 2022).

P1 also alluded to the social stigma surrounding such procedures, explaining, “You’re getting laughed at.” His statement suggested that embarrassment extended beyond personal feelings into collective expectations. In his account, the results of threat of ridicule by peers and community members amplified his reluctance to undergo screening. This observation aligned with my reflective journal notes. I documented how P1’s tone shifted from matter-of-fact when describing general health habits to noticeably quieter when discussing the possibility of ridicule.

He briefly looked down and shook his head, underscoring the weight of social judgment in shaping his health choices. P3’s perspective offered a contrast. As a result, while he acknowledged the cultural stigma surrounding rectal exams, he reframed the situation by emphasizing communication with providers. He asserted, “That is an opportunity... to make that area stronger by communicating to your provider.”

His choice of words highlighted a redefinition of strength—rather than avoiding the exam, he interpreted proactive engagement as a demonstration of responsibility. My field notes indicated that P3 leaned forward during this part of the conversation, speaking with energy and conviction. His body language communicated confidence rather than discomfort, reinforcing that masculinity could be reconstructed to integrate preventive health behaviors. The results of these narratives revealed how the rectal examination was

not merely a medical procedure but a culturally loaded act that touched upon identity, gender norms, and social expectations.

The study highlights that the exam provoked embarrassment for some participants because it symbolized a loss of bodily control and exposure of vulnerability. For others, particularly P3, it provided an opportunity to redefine masculinity as responsible self-care. This tension illustrated the competing interpretations of masculinity that shaped participants' health behaviors. The results of the sense of emasculation linked to the rectal exam were also tied to broader historical and cultural contexts.

As a result, African American men's historical experiences with invasive medical procedures—often conducted without consent—created layers of mistrust and heightened sensitivity around bodily autonomy (see Bazargan et al., 2021; Rose et al., 2022). As a result, within this context, the rectal examination could evoke both embarrassment and echoes of historical violations of trust, intensifying the reluctance to undergo the procedure. Gender role stress further magnifies these dynamics. Aguilera et al. (2024) argued that when health behaviors conflicted with internalized masculine ideals, men experienced psychological strain. The results of this pattern appeared evident in P2's narrative, where fear of the rectal exam generated visible discomfort. For him, acknowledging fear conflicts with expectations of toughness and emotional control. His statement, "Rectal examination—that's the part that frightens me," represented both a disclosure and a breach of the masculine script that discouraged expressing fear.

Also, the result of the emotional suppression evident in his demeanor underscored how gender role stress translated into concrete avoidance behaviors. At the same time, P3

demonstrated how resilience could function as both a barrier and a facilitator. Results show that on one hand, resilience is aligned with stoicism and self-reliance, discouraging vulnerability and preventive care. On the other hand, when resilience was reframed as responsibility to self and family, it became a motivator for screening.

Subsequently, the result of his insistence on “making that area stronger” by engaging with his provider illustrated how masculine ideals could be reinterpreted rather than discarded. My reflective journal captured this distinction, noting that P3 often used metaphors of strength and repair, language that resonated with masculine ideals but redirected them toward preventive action. As a result, the embarrassment and perceived emasculation tied to rectal examinations carried significant implications for public health interventions (see Appendix I). The results of unaddressed perceptions could perpetuate avoidance and late-stage diagnosis among African American men, contributing to the disparities already well documented in prostate cancer outcomes (Kensler et al., 2020).

However, the results of the participants’ narratives also suggested pathways for reframing the procedure. By integrating messages that positioned screening as an act of responsibility, strength, and protection of the family, interventions could disrupt stigma and reduce embarrassment. For example, framing the rectal exam not as a threat to masculinity but as a demonstration of leadership and care for one’s family aligned with P1’s recognition that “you can’t work and provide for your family without being healthy.” Similarly, community-based conversations in trusted spaces such as barbershops could normalize discussion of prostate exams, reducing the silence and secrecy that reinforced stigma.

However, participants' results also demonstrated that masculinity was reframed as responsibility, creating opportunities for prevention-oriented identities. The results of this study, embedding these insights into public health practice, offered pathways to reduce barriers and increase early detection, ultimately addressing one of the most pressing disparities in African American men's health. Overall, gender role socialization behaviors shaped how participants interpreted susceptibility, severity, and benefits related to prostate cancer screening. For some, these behaviors reinforce silence and avoidance, limiting willingness to seek preventive care.

The study results showed that they motivated responsibility and accountability for others, framing health-seeking as consistent with masculine identity. The complexity of these results underscores the importance of culturally tailored interventions that acknowledge masculinity as a dynamic social construct.

### **Beliefs and Attitudes Toward Screening**

The results of the Participants expressed different beliefs about prostate cancer screening. P1 described how family history shaped his motivation: "My father had prostate cancer... he was only 58." In contrast, P2 revealed fear of the procedure, explaining, "Rectal examination—that's the part that frightens me." P3 demonstrated a preventive orientation, remarking, "If there's an issue, I'd like to be right in front of it." Screening decisions were influenced by family history, fear of invasive procedures, and preventive mindsets. These differing beliefs reflected a complex interplay between familial influence, procedural anxiety, and individual health orientations.

### **Cultural Norms and Community Influence: Trust and Historical Mistrust**

The results of cultural silence about men's health remained a significant factor. P1 reflected, "They want to be strong for their family, but being healthy is more important." P2 explained, "Mostly women are concerned with those things." P3, however, noted a generational shift, stating, "Times are changing... almost no conversation is off the table regarding men's health." As a result, these perspectives revealed that cultural silence persisted, but younger men were increasingly willing to discuss prostate health.

The results of trust in providers varied. P1 expressed confidence, stating, "I trust [my provider] 100%." In contrast, P2 sought privacy, saying, "I'd rather go to another city to ensure confidentiality." P3 balanced trust with self-advocacy, explaining, "I trust them a lot... but I need to be an informed patient." The results of these responses reflected a trust continuum influenced by personal experiences and broader historical mistrust.

### **Knowledge and Health Information Access**

The results showed the participants relied on multiple sources of health information, but confidence varied. P1 trusted his physician and valued preventive checkups. P2 explained, "I relied on Google and barbershops... AI and chats are not always right." P3 admitted limited knowledge, stating, "Not too confident [about prostate cancer]... I am going to do more research now." Additionally, knowledge gaps persisted, but barbershops and other informal spaces were critical in knowledge exchange.

## **Barriers and Facilitators of Screening**

As a result of the study, participants described barriers and facilitators, such as stigma, cost, time constraints, and mistrust. For prostate cancer screening. P1 highlighted stigma, stating, “You’re getting laughed at.” P2 pointed to financial concerns: “You hear the word copay, that turns you away.” P3 emphasized awareness gaps and suggested reminders: “You just don’t know you should... reminders would help.” The results of family encouragement and health system reminders emerged as potential facilitators to overcome stigma, cost, and awareness barriers. Participants described how they made health decisions. P1 emphasized responsibility, stating, “You can’t work and provide for your family without being healthy.” P2 reported that he consulted family and sometimes delayed paying bills to afford health care. P3 explained, “I had to become an expert as best I could.” Participants’ decision-making processes included balancing financial responsibilities, consulting family, and self-advocacy.

### **Summary**

The results in Chapter 4 are from a qualitative, multiple-case study exploring the beliefs, attitudes, and perceptions of younger African American men toward prostate cancer screening. I drew the results from three narrative case studies involving African American men aged 35 to 45. Through rich, in-depth interviews, the study examined how masculinity, cultural expectations, family influence, and systemic barriers intersected to shape screening behaviors. I organized the results into five overarching themes: masculinity and gender role socialization; beliefs and attitudes toward screening; cultural

norms and community influence: trust and historical mistrust, knowledge, and health information access; and barriers and facilitators.

The cases converged on key insights. Masculinity shaped screening behaviors in distinct ways across participants: P1 equated masculinity with toughness and avoidance, P2 with procrastination and financial responsibility, and P3 with leadership and optimization. Despite varied definitions, all participants reflected the profound impact of gender role socialization. The results confirmed that masculinity acted as both a constraint and a motivator, echoing prior research on traditional masculine norms as deterrents to help-seeking (see Griffith et al., 2021). However, the study extended the literature by showing how reframed masculinity—particularly when aligned with family leadership and responsibility—could catalyze proactive health behaviors. Notably, the emergence of androgynous masculinity—combining traditional masculine strength with communication and openness—offered alternative pathways to engagement with healthcare (see Bem, 1981).

Family resulted as the influence consistently emerged as a motivating factor across all participants. P1 cited his father's diagnosis as a motivator, while P2 described familial consultation in making health decisions. P3 emphasized his role as a protector and provider, grounding his health choices in family accountability. The results of the study also uncovered persistent barriers to screening, including stigma, cost, time constraints, and mistrust. P1 identified stigma as a deterrent, P2 referenced financial burden, and P3 highlighted the lack of provider prompts. Despite these challenges,

facilitators such as family support, system reminders, and trusted community settings like barbershops helped foster health engagement.

Additionally, the results of knowledge gaps and the absence of targeted messaging were common across all cases. Participants drew information from various sources—including physicians, barbershops, and the internet—but frequently expressed confusion or incomplete understanding. However, the results identified as trust in healthcare providers varied: P1 reported unconditional trust, P2 expressed confidentiality concerns, and P3 balanced trust with a desire for informed decision-making. These results reinforced literature on historical medical mistrust while demonstrating how I could build trust through personalized, respectful care (see Rose et al., 2022).

The chapter also detailed the results of how cultural silence around men's health remained prevalent, although signs of generational change were evident. P2 observed that health discussions were often seen as "feminine," while P3 noted increased openness among younger men. Participants offered specific recommendations for outreach strategies, including leveraging digital platforms, addressing masculinity directly, and delivering messages through familiar, trusted environments. Moreover, the results of the narratives concluded with final reflections that revealed a shift from hesitancy to advocacy. The overarching results of each participant voiced a desire to protect their families and encourage others to prioritize preventive care, illustrating how lived experience can motivate broader cultural change.

The study employed results of strategies addressing credibility, transferability, dependability, and confirmability to ensure trustworthiness. These actions resulted in how

I enhanced credibility through the triangulation of data sources—three interviews, the participant interview flyer artifacts, and reflective journals—and the results of conducted member checking and peer debriefing with a methodological advisor. I achieved transferability by providing thick descriptions of each participant's context and experience. The results of how I ensured dependability by maintaining an audit trail of coding decisions and methodological memos. The results of confirmability, supported through reflexive journaling and bracketing, allowed me to examine and set aside personal assumptions critically.

The results in Chapter 4 revealed that a complex interplay of masculinity, family responsibility, cultural norms, trust, and systemic access shaped prostate cancer screening behaviors among younger African American men. These results confirmed, extended existing literature, and highlighted the need for more nuanced, culturally responsive outreach strategies. The chapter established a clear foundation for Chapter 5, where I interpret the results through the theoretical frameworks of the HBM and gender role socialization theory. The upcoming discussion will connect participant narratives to broader scholarly discourse and translate insights into actionable implications for practice, policy, and social change aimed at reducing disparities and improving prostate cancer outcomes among African American men.

## **Chapter 5: Discussion, Conclusions, and Recommendations**

### **Introduction**

The purpose of this qualitative multiple-case study is to examine how younger African American men—those aged 35 to 45—perceive early prostate cancer screening (see Kensler et al., 2020). To determine themes that captured younger African American men’s beliefs, attitudes, and perceptions toward prostate cancer screening (Svensson et al., 2023). When reviewing literature on prostate cancer screening, I found a gap in the literature involving screening behavior themes. I addressed this gap by examining the themes highlighted by the ways cultural norms, systemic barriers, family influences, and health literacy intersected to shape participants’ screening behaviors, specifically masculinity.

These themes included taking into account the wants, needs, and concerns of P1, P2, and P3. The results of the participants expressing both hesitancy and advocacy revealed how stigma, financial strain, and mistrust of healthcare systems persisted as barriers, while the results of family support, trusted community spaces, and digital outreach emerged as facilitators. Positioned within the theoretical frameworks of the HBM (see Rosenstock, 1974) and gender role socialization theory (see Smith et al., 2022). This chapter also incorporates the recognition of androgynous masculinity (Bem, 1981) to demonstrate how flexible expressions of gender identity influenced participants’ health practices. By integrating the results of participant narratives with existing scholarship, this interpretation explains how the results confirmed, extended into findings, or challenged prior knowledge. The discussion also emphasizes the findings of

the broader cultural, historical, and systemic contexts that shaped participants' health behaviors and outlines the implications for theory, practice, and social change.

### **Interpretation of the Findings**

This study generated five themes that explained how African American men between the ages of 35 and 45 perceived prostate cancer screening. These findings aligned with prior literature while providing nuanced insights that extended current understanding from the scholarship review. (a) masculinity and gender role socialization, (b) beliefs and attitudes toward screening, (c) cultural norms and community influence participants and trust & historical mistrust, (d) knowledge and health information access, and (e) barriers and facilitators.

Theme 1: Masculinity and gender role socialization. Masculinity shaped both avoidance and responsibility in health behavior. P1 emphasized avoidance, stating, "Some Black men think being healthy and not seeing a doctor is much easier... I hate hospitals." P3 reframed masculinity as responsibility, remarking, "That is an opportunity... to make that area stronger by communicating to your provider." This theme confirmed research on the masculine role norms that often discouraged men from engaging in preventive health care (see Jackson et al., 2023).

However, the study extended knowledge by illustrating how masculinity could also serve as a motivator for proactive health action, reframing toughness as responsible leadership within the family. The dual function of masculinity suggested a more complex role than earlier work, which had primarily emphasized avoidance and stoicism (O'Brien et al., 2024). Theme 2: beliefs and attitudes toward screening. The beliefs about screening

were influenced by family history, fear, and preventive orientation. P1 was motivated by his father's diagnosis, stating, "My father had prostate cancer... he was only 58." P2 expressed fear of the procedure, remarking, "Rectal examination—that's the part that frightens me." In contrast, the finding from P3 adopted a preventive stance, saying, "If there's an issue, I'd like to be right in front of it."

These results confirmed studies documenting fear, stigma, and family history as determinants of screening decisions (see Rossi & Bombaci, n.d.). The outcomes extended knowledge by demonstrating how younger African American men negotiated their fears while simultaneously recognizing the importance of prevention, suggesting opportunities for interventions that highlight family legacy and proactive health behaviors. The theme 3: Cultural Norms and Community Influence, the participants highlighted cultural silence about men's health and noted generational change. P2 remarked, "Mostly women are concerned with those things." P3 explained, "Times are changing... almost no conversation is off the table regarding men's health."

Okoro et al. (2020) supported the conclusion that cultural norms often constrained discussions about men's health. However, the findings of this study contributed new evidence that younger men increasingly challenged these silences, signaling an emerging shift in community discourse that health educators could leverage to normalize conversations about prostate cancer screening. Regarding trust and historical mistrust, perspectives on medical providers ranged along a continuum. P1 expressed complete confidence, stating, "I trust [my provider] 100%." P2 sought anonymity, explaining, "I'd

rather go to another city to ensure confidentiality.” P3 described informed trust, noting, “I trust them a lot... but I need to be an informed patient.”

These perspectives echoed longstanding evidence of medical mistrust among African American men (see Bazargan et al., 2021). However, this study added nuance by showing that trust was not binary but instead ranged from unquestioning faith to cautious engagement. This continuum highlighted the complexity of patient–provider relationships, where mistrust coexisted with emerging forms of patient empowerment. Reflections illustrated how the legacies of distrust, silence, and systemic barriers remained embedded in lived experiences (see Williams et al., 2024).

Moreover, the influence of systemic notions from the Jim Crow era still lingers for African American men. Theme 4: knowledge and health information access. Knowledge about prostate cancer varied among participants, who drew from formal and informal sources. P1 expressed confidence in his physician, while P2 turned to informal spaces and online searches, stating, “AI and chats are not always right.” P3 admitted uncertainty, noting, “Not too confident [about prostate cancer]... I am going to do more research now.”

This theme aligned with earlier research that identified knowledge gaps as a significant barrier to screening (see O’Brien et al., 2024). Moreover, the study expanded this understanding by highlighting the central role of barbershops and community networks as spaces for exchanging health information, consistent with Malika et al. (2020).

Participants also expressed skepticism about emerging digital tools such as artificial intelligence, underscoring the need for reliable, culturally relevant sources of information. Theme 5: barriers and facilitators—participants identified multiple obstacles to screening, including stigma, cost, and lack of awareness. P1 emphasized stigma, noting, “You’re getting laughed at.” P2 identified cost as a barrier, saying, “You hear the word copay, that turns you away.” P3 underscored awareness gaps, stating, “You just don’t know you should... reminders would help.”

These observations confirmed earlier studies that documented stigma and financial costs as barriers to prostate cancer screening (Buote et al., 2021; Getaneh et al., 2020). The study went further by highlighting the potential role of reminder systems and digital outreach as facilitators, offering actionable recommendations to improve screening uptake. Personal health practices and decision-making processes balance family responsibility, financial priorities, and self-advocacy. P1 stressed responsibility: “You can’t work and provide for your family without being healthy.” P2 described consulting his family while delaying bill payments to afford care, while P3 noted, “I had to become an expert as best I could.” The study noted that facilitators included family support, system reminders, and trusted community spaces like barbershops. These insights aligned with HBM constructs of perceived risk, benefits, barriers, and cues to action, and were further contextualized by gender role socialization theory, which highlighted the influence of cultural expectations. Recognition of androgynous masculinity enriched this synthesis by demonstrating how blending masculine and feminine traits created more adaptive pathways to care.

These results confirmed research showing that African American men often consider family and work obligations when making health decisions (see Rogers et al., 2022). The study advanced understanding by demonstrating how younger men increasingly engaged in self-education and advocacy, reflecting a shift toward more active and empowered roles in health management. Regarding recommendations for outreach, participants suggested culturally tailored strategies to promote screening. P1 stated, “That image still needs to be protected.” P2 emphasized the importance of family responsibility, while P3 suggested digital tools, saying, “If social media were pumping screening... text messages would help.”

However, it also expanded knowledge by highlighting generational shifts toward openness, reframing masculinity as responsibility, recognizing the role of barbershops and digital spaces as trusted sources of health information, and documenting a continuum of trust in providers. These insights suggest that effective health promotion strategies must build on cultural strengths, leverage family and community networks, and incorporate digital reminders to encourage prostate cancer screening among African American men. In doing so, the study both confirmed earlier research and contributed new perspectives that expand the field’s understanding of how African American men conceptualize and act upon prostate health in the context of cultural identity, gender norms, and community influence.

### **Motivations and Barriers Through the Lens of the HBM**

Semi-structured interview responses offered rich insight into the motivations and barriers shaping participants’ decisions about preventive care, particularly prostate cancer

screening. The HBM provided a helpful framework for interpreting these results.

Constructs such as perceived susceptibility, perceived severity, perceived benefits, and self-efficacy illuminated how participants assessed personal risk, evaluated potential outcomes, and weighed their capacity to act. This study found that these constructs, combined with participants' lived experiences, revealed how beliefs and attitudes shaped decisions about early detection of prostate cancer (see Claeys et al., 2021; Fish et al., 2022; Quach, 2022).

### **Perceived Susceptibility**

Interview data showed how participants' awareness of their risk for prostate cancer varied, but family history strongly influenced perceived susceptibility. P1 reflected on the impact of his father's illness: "My father had prostate cancer... he was only 58." This acknowledgment underscored how personal and familial experiences heightened risk perception and motivated consideration of screening. Recognition of genetic and familial vulnerability reflected high perceived susceptibility, which often drove health-seeking behavior among African American men at risk (Claeys et al., 2021). By contrast, P3 admitted uncertainty, stating, "Not too confident [about prostate cancer]... I am going to do more research now." His statement illustrated low perceived susceptibility due to limited knowledge, suggesting that gaps in health literacy directly reduced his motivation to act.

### **Perceived Severity**

Participants also expressed differing understandings of the seriousness of prostate cancer and its potential consequences. P2 highlighted the hidden threat of untreated

illness: “Some guys look good on the outside, but inside, their organs are rotting.” His statement reflected an awareness of severity, recognizing that external appearances could mask life-threatening disease. Similarly, P1 noted, “You want to know that you’re healthy to care for your child,” emphasizing how the severity of prostate cancer extended beyond individual health to family responsibilities. These insights aligned with evidence that African American men often evaluate severity regarding personal health outcomes and their ability to fulfill familial and community roles (Fish et al., 2022).

### **Perceived Benefits**

Participants demonstrated an understanding of the benefits of early detection, though the framing of those benefits differed. P3 emphasized the importance of preventive action, explaining, “If there’s an issue, I’d like to be right in front of it.” His proactive stance illustrated how participants viewed screening as an opportunity to control outcomes and maintain strength. P1 also linked screening benefits to family legacy, noting that his father’s diagnosis motivated him to pursue his own health. By contrast, P2 struggled to reconcile the benefits of screening with procedural fears, remarking, “Rectal examination—that’s the part that frightens me.” This statement highlighted how perceived benefits could be overshadowed by perceived barriers, consistent with research showing that stigma and fear often complicate African American men’s cost–benefit evaluations of screening (Quach, 2022).

### **Self-Efficacy**

Participants’ confidence in their ability to take preventive action emerged as a crucial determinant of behavior. P3 demonstrated strong self-efficacy by asserting, “I had

to become an expert as best I could.” His commitment to educating himself reflected empowerment and agency, reinforcing the belief that he could navigate medical decisions effectively. P2, however, revealed limited self-efficacy when he admitted to delaying bills to afford healthcare, reflecting how financial stress eroded his confidence in maintaining consistent care.

P1 displayed moderate self-efficacy, relying on his physician’s guidance but admitting, “I hate hospitals,” which signaled trust and avoidance. These varied expressions of self-efficacy underscore the importance of addressing internal and external barriers to strengthen men’s belief in their capacity to act. Subsequently, the analysis of perceived susceptibility, severity, benefits, and self-efficacy revealed that participants evaluated prostate cancer risk through a lens shaped by family history, cultural masculinity norms, financial pressures, and health literacy. P1’s narrative highlighted how family experiences heightened both susceptibility and severity.

P2’s statements emphasized the tension between recognizing severity and fearing procedures, undermining his acknowledgment of screening benefits. P3 reframed masculinity as responsibility, demonstrating high self-efficacy and a preventive orientation. Collectively, these results confirm that African American men’s preventive health behaviors were influenced not only by HBM constructs but also by broader cultural and systemic contexts. Addressing gaps in knowledge, reducing procedural fears, and reinforcing screening as family protection will be critical to improving engagement with early detection initiatives. While traditional norms often discouraged engagement

with preventive care, participants also showed how redefined masculinity promotes accountability and resilience through health-seeking behaviors.

### **Limitations of the Study**

This study had several limitations that warrant consideration. The first limitation was the small sample size. Only three participants contributed to the study, which limited the breadth of perspectives. However, the small number of participants also functioned as a methodological strength. It enabled me to collect thick, contextualized insights that reflected the lived experiences of each participant in depth. Such detail enhanced the richness of the findings, which may not have been possible with a larger sample (see Althubaiti, 2022).

The second limitation involved the recruitment strategy. I recruited participants primarily through community and faith-based networks, which may have introduced selection bias. Individuals who volunteered to participate may already have been more willing to discuss health issues than those who did not respond. While this strategy helped establish trust and facilitated access to a traditionally hard-to-reach population, it also meant that the sample may not fully represent the diversity of attitudes and beliefs within the broader African American male population (see Althubaiti, 2022).

The third limitation concerned reliance on self-reported narratives. Although I triangulated the data with reflective journals and artifacts, self-reporting remained subject to recall bias and social desirability effects. Participants, for instance, expressed gratitude for their involvement in the study and highlighted the recruitment flyer as a meaningful artifact. The flyer, which contained information about prostate cancer screening, not only

functioned as a tool for recruitment but also shaped participants' reflections during the interviews. Despite these limitations, triangulation enhanced the study's credibility by integrating multiple data sources (see Bazargan et al., 2021).

### **Recommendations**

This study offers valuable insights into African American men's beliefs, attitudes, and behaviors regarding prostate cancer screening. Based on the assumptions that (a) African American men's health decisions are shaped by cultural and gender norms, (b) screening behaviors are influenced by community context, and (c) reducing barriers requires coordinated practice, policy, and research strategies, I developed recommendations for practice, policy, and future research. These recommendations also reflected the HBM, gender role socialization theory, and the broader framework of social determinants of health.

Participants concluded their interviews with advice for others. P1 stressed family responsibility, stating, "You want to know that you're healthy to care for your child." P2 added, "I just wish more young men... would get healthy." P3 urged action, warning, "Do not put it off... bad news is like spoiled milk—it does not get better." These closing reflections demonstrated a shift from hesitancy toward advocacy and calls for early prostate cancer screening. The study demonstrated how African American men's beliefs, attitudes, and perceptions toward prostate cancer screening were shaped by the intersection of masculinity, cultural norms, systemic barriers, and family influences.

Based on the study, I observed that this is a synthesized summary of overarching influences. By integrating participant narratives with theoretical frameworks and existing

literature, the study highlighted persistent challenges and emerging opportunities for intervention. I observed that this reflects the methodological approach and its outcomes—highlighting rather than reporting new empirical findings. Masculinity functioned as a constraint when tied to stoicism and suppression, but as a motivator when reframed as responsibility and leadership.

Masculinity function emerged directly from participant data (e.g., differences between P1 and P3) and reflects a core theme in the analysis. Mistrust of healthcare institutions remained a barrier, yet participants' trust was fostered in community spaces and family networks. Based on participants' responses about trust and mistrust, I found that, especially around providers, barbershops, and family influence. Knowledge gaps persisted, but culturally grounded education offered pathways for change, particularly through HBCUs and barbershops.

The barbershop environment helped establish familiarity and safety, encouraging openness and engagement in participant responses. Barbershops have historically served as central communal spaces, with origins tracing back to ancient civilizations. In societies such as ancient Egypt and medieval Europe, barbers held respected positions not only as groomers but also as healers, advisors, and community figures (Sabhan, 2025). Their roles extended well beyond personal care, often encompassing physical and emotional support within their communities. In the context of African American and other minority communities, barbershops evolved into vital cultural hubs. These spaces provided far more than grooming services—they became informal centers for dialogue, storytelling, and cultural transmission.

Clients and barbers frequently exchanged personal updates, political opinions, and collective concerns, reinforcing a sense of solidarity and shared identity (*Barbershop politics: A social hub for political discourse*, 2024). The décor, music, and artwork within these spaces reflected the cultural heritage and pride of the communities they served. The barbershop also played a significant role in fostering social bonds and long-term relationships. Many clients developed enduring friendships with their barbers, rooted in trust, familiarity, and shared experience.

Over time, the barbershop became a trusted environment where individuals could speak openly about personal issues, including health concerns, without judgment (Blankenship, 2025). Specifically in Black communities, barbershops served as safe havens for cultural expression, activism, and empowerment. Throughout history, they functioned as informal town halls where civil rights initiatives were organized and community advocacy was cultivated. Barbershops helped preserve cultural identity through storytelling, music, and generational traditions (Sabhan, 2025). Even today, the barbershop remains relevant as a community engagement site.

Many contemporary barbershops blend tradition with modernity by hosting health fairs, charity drives, and mentorship programs. These initiatives reinforce community ties and positioned barbers as frontline stakeholders in public health outreach. Moreover, barbershops increasingly embrace diversity and inclusion, offering services and spaces welcoming to all racial, gender, and age groups while honoring the cultural traditions they emerged from (*Barbershop politics: A social hub for political discourse*, 2024). Given this deep-rooted legacy, barbershops continue to represent a powerful,

underutilized asset in community-based health promotion, particularly among African American men. Their established trust, cultural relevance, and social connectedness make them ideal venues for health interventions such as prostate cancer education and screening advocacy.

Historically, barbershops, churches, and HBCUs serve as trusted pillars within African American communities and offer culturally grounded platforms for health promotion. Each of these institutions uniquely contributes to advancing awareness, particularly regarding prostate cancer screening among African American men. Barbershops foster informal, routine conversations that allow men to engage in peer-level dialogue on health topics often stigmatized in clinical settings. These spaces encourage open communication around sensitive procedures, such as the DRE, helping to reduce fear and normalize preventive behaviors without threatening masculine identity (Blankenship, 2025). Their value in this study rested in their cultural resonance and consistent male presence, particularly among those aged 35–45.

Churches provide spiritual leadership and multigenerational reach. Through pastors and health ministries, churches delivered faith-based health messaging that aligned with the values of stewardship and responsibility. Although some traditional church settings have struggled to address sexual health openly, their role in legitimizing health behavior and mobilizing collective action remained significant (Hopgood et al., 2024). Regarding the study, churches offered a trusted space to frame prostate screening as an act of divine responsibility and family protection.

HBCUs contribute by engaging younger African American men in early health education and prevention. As academic institutions, they promote prostate cancer awareness among students and prepare culturally competent future healthcare providers. HBCUs were especially relevant to this study in addressing the underrepresentation of younger African American men in prostate cancer research and promoting early screening literacy (see Lillard et al., 2022). When viewed collectively, these institutions served as complementary channels for outreach—barbershops emphasized trust and routine connection, churches offered moral authority and intergenerational influence, and HBCUs provided education and professional development. Their integration into prostate cancer screening interventions aligned directly with the study’s focus on culturally responsive strategies to reduce disparities and increase screening uptake among African American men (ACS, 2025; Lillard et al., 2022).

HBCUs and barbershops as solutions reflect a partial interpretation or implication. However, based on participant suggestions (those spaces were not mentioned explicitly). The cross-case synthesis underscored that future interventions must be culturally sensitive, family-centered, and attentive to systemic inequities and shifting generational norms. I observed that this is a recommendation based on the synthesis and interpretation of the data. In doing so, this study contributed to scholarship, practice, and policy aimed at reducing prostate cancer disparities among African American men. This is a meta-level comment on the study’s contribution rather than a specific empirical finding.

## **Recommendations for Practice**

I recommended that health care providers adopt culturally responsive communication strategies that reframed prostate cancer screening as an act of strength and family protection rather than vulnerability. For example, P1 remarked, “You can’t work and provide for your family without being healthy.” His statement underscored the central role of family provision in decision-making. Framing screening as a means of safeguarding one’s ability to lead and provide alignment with both the HBM’s construction of perceived benefits (Fish et al., 2022) and gender role socialization theory, which highlighted how masculine identity is tied to responsibility (Smith et al., 2022).

Barbershops and churches emerged as trusted venues for outreach and dialogue. P2 explained that he relied on Google and barbershops for health information, while P3 emphasized that “times are changing... almost no conversation is off the table regarding men’s health.” These findings illustrated that informal and faith-based community spaces reduced stigma and facilitated conversations that might remain silenced. Providers collaborating with barbers and church leaders could expand their influence and normalize prostate cancer screening in culturally relevant ways.

One direct effect of this study was that it inspired a group of young African American men who participated in or heard about the project to begin planning a prostate cancer awareness campaign. They proposed using barbershops and local churches to educate peers about mortality, preventive screenings, and family health responsibility. This outcome reflected the study’s power to generate scholarly knowledge and mobilize community action.

## **Recommendations for Policy**

Policy change was essential for addressing structural barriers identified in the study. Cost and financial strain emerged as significant obstacles. P2 described the impact of copays, saying, “You hear the word copay, that turns you away.” This echoed prior research demonstrating that cost functioned as a critical barrier to prostate cancer screening among African American men (Hooper et al., 2018). Based on this evidence, I recommended that policymakers expand insurance coverage for prostate cancer screening and associated services, particularly for high-risk groups such as African American men aged 35 and older.

Mobile screening clinics in trusted community spaces represented another policy solution. By situating services in barbershops, churches, and recreation centers, policymakers could increase accessibility while reducing logistical and cultural barriers. This strategy aligned with the social determinants of health framework, emphasizing how neighborhood environments, accessibility, and health system design shaped individual health outcomes (Lopez-Vergara et al., 2021). I recommend that the findings from this study also suggest that policy efforts should go beyond clinical access and address systemic mistrust. For example, P2 stated that he preferred to travel to another city to maintain confidentiality, reflecting ongoing mistrust in local systems. Recommendations to address policies that invested in transparency, confidentiality protections, and patient-centered care would directly respond to such concerns. These policy interventions had the potential to increase screening rates and rebuild trust in health systems among African American communities.

## **Recommendations for Future Research**

This study highlighted the need for future research that expanded the sample size to include more diverse demographics of African American men across age groups, geographic regions, and socioeconomic statuses. Although this study included three participants, their insights demonstrated the richness of small-sample qualitative approaches. Future studies should replicate this design with larger, more varied samples to strengthen transferability and representation. Longitudinal research would also be valuable for examining how beliefs, attitudes, and behaviors evolved. For example, P3's recognition that he needed to "do more research now" suggested that prostate cancer awareness was not static but developed across the life course.

A longitudinal design could capture how men shifted from hesitancy to advocacy, as observed in this study, and how life events, such as family illness or aging, influenced screening decisions. Mixed-methods designs could provide further insights by integrating the depth of qualitative data with the generalizability of quantitative findings. For example, surveys could quantify the prevalence of fears associated with rectal exams, while interviews could explore how masculinity reframes those fears as responsibility. This integration would allow researchers to capture both the scope and complexity of prostate cancer screening beliefs among African American men.

One important effect of this study was that it sparked dialogue among young African American men about planning a prostate cancer awareness campaign. Future research could partner with these emerging leaders to evaluate the effectiveness of peer-led interventions. Studies could examine how such initiatives influenced perceived

susceptibility, reduced barriers, and mobilized community support. In doing so, future research would not only build on the HBM and Gender Role Socialization but also demonstrate how community-driven strategies shaped long-term health behaviors.

Participants recommended strategies to increase awareness. P1 suggested protecting masculine identity, stating, “That image still needs to be protected.” P2 emphasized family responsibility as a motivator for men. P3 recommended digital outreach, explaining, “If social media was pumping screening... text messages would help.” Recommendations included reframing masculinity, linking health to family responsibility, and using digital tools to reach men. To reduce prostate cancer mortality among African American men, future research and public health strategies must center on culturally responsive, empowerment-based approaches.

### **Significance of the Recommendations**

These recommendations confirmed existing research on barriers, masculinity, and cultural silence in prostate cancer screening (Malika et al., 2020), while extending knowledge by highlighting generational shifts toward openness, the role of barbershops and churches as culturally resonant venues, and the potential for youth-led campaigns. The study’s integration of the HBM, gender role socialization, community norms, and social determinants of health provided a comprehensive framework for practice, policy, and research. By reframing screening as a strength, reducing structural barriers, and mobilizing culturally grounded outreach, this study contributed to actionable strategies for increasing prostate cancer screening among African American men. Most importantly, it demonstrated how research could spark grassroots community action, as

young African American men began planning to educate their peers about mortality, health responsibility, and the importance of early detection.

### **Implications**

This study will generate important implications for theory, practice, and social change by illuminating how African American men between the ages of 35 and 45 conceptualize and engage with prostate cancer screening. The findings will contribute to scholarly debates on masculinity, inform practice by guiding culturally responsive interventions, and support social change by amplifying the voices of an underrepresented group.

### **Theory**

This study will extend masculinity theory by demonstrating how toughness is reframed as accountability to the family. For example, P3 explained, “That is an opportunity... to make that area stronger by communicating to your provider.” His comment revealed that strength will no longer be defined solely as stoicism or avoidance, but instead will be reconstructed as responsibility for one’s family. Masculinity will be integrated with broader cultural frameworks, suggesting that African American men interpret health behaviors through intersecting lenses of gender, culture, and community.

Future research will use these insights to expand theoretical applications of the HBM and gender role socialization. The HBM will explain how perceived benefits, such as protecting one’s family, will motivate screening decisions. Gender role socialization will highlight how norms of provision and leadership will shape attitudes toward care (Rogers et al., 2022). By integrating masculinity theory with cultural frameworks,

scholars will move beyond deficit-based models of male health behavior to recognize proactive, family-centered interpretations of strength. This expansion will provide a more nuanced understanding of how African American men navigate health decisions in the context of cultural norms, mortality awareness, and social determinants of health.

### **Practice**

Practitioners can use the study's findings to design interventions that embed outreach in trusted community settings such as barbershops and churches. These venues will serve as culturally safe spaces where discussions of prostate cancer screening will become normalized. Providers who partner with community leaders will demonstrate cultural responsiveness and increase participation likelihood. The study will also inform us of practices that encourage collective participation. For example, interventions will invite men to attend appointments with family members, reframing prostate cancer screening as a family responsibility rather than an individual burden. P1 emphasized this perspective when he explained, "You can't work and provide for your family without being healthy." By incorporating family accompaniment, practitioners will leverage cultural values of interdependence and strengthen motivation for preventive care.

Additionally, outreach strategies will employ digital platforms such as text messaging and social media to reach younger African American men. P3 stated, "If social media were pumping screening... text messages would help." These tools will complement traditional outreach by aligning with generational communication preferences. Future practice may therefore combine community-based and digital interventions to ensure that culturally relevant messages reach men across multiple

contexts. Through these strategies, practitioners may move beyond one-size-fits-all approaches and instead implement tailored interventions that reflect masculinity, cultural norms, and trusted community networks.

### **Social Change**

This research may contribute to social change by amplifying the underrepresented voices of younger African American men. Participants in this study shared their perspectives and demonstrated a willingness to educate peers and advocate for earlier awareness of prostate health. One direct outcome of the study was the initiation of conversations about launching a prostate cancer awareness campaign among young African American men in Central Florida. This campaign may promote community-led education on mortality, screening, and family health responsibility. The findings may provide evidence to inform culturally tailored interventions that address stigma, mistrust, and cost barriers. For example, P2 highlighted financial concerns, stating, “You hear the word copay, that turns you away.” Social change may occur when policymakers, practitioners, and community leaders use these insights to reduce financial barriers, implement mobile screenings in trusted spaces, and create confidential, patient-centered care systems.

Furthermore, the research may strengthen trust between communities and healthcare systems. P2’s decision to travel to another city to maintain confidentiality illustrates how mistrust remains a barrier. By grounding outreach in trusted community venues and involving local leaders, future initiatives may rebuild credibility and accountability in healthcare systems. This shift may encourage men to transition from

avoidance to advocacy, as observed when participants concluded with calls to action:

“Do not put it off... bad news is like spoiled milk—it does not get better” (P3).

Ultimately, the study’s position is that African American men are not passive care recipients but are active partners in shaping health education, intervention design, and community awareness. These contributions may ensure prostate cancer screening becomes part of a larger movement for equity in men’s health, rooted in cultural strengths and social justice.

This chapter integrates the study's findings with theoretical frameworks, prior literature, and practical applications. It includes implications for theory, practice, and social change, supported by the conceptual framework diagram, and expands to include the discussion of androgynous expressions of masculinity in health outreach.

### **Recommendations**

The findings also emphasized how androgynous expressions of masculinity might shape health outreach and intervention strategies. Androgynous identity, defined as the integration of traditionally masculine and feminine traits, offered a more flexible framework for health decision-making (Bem, 1981). In this study, acknowledging the role of androgyny extended the analysis beyond binary conceptions of masculinity and reframed how African American men negotiated health-seeking behaviors. Men who embodied more androgynous traits may have been less constrained by traditional masculine norms of toughness or stoicism and more open to preventive practices such as cancer screening (Liu & Damian, 2022).

From an intervention perspective, androgynous expressions created opportunities for tailoring outreach strategies that resonate with a broader identity spectrum. Messaging that emphasized responsibility to family (a traditionally masculine value) and self-care (a value often associated with feminine expression) could appeal to African American men across the gender identity spectrum. For example, integrating community-based outreach in barbershops with digital campaigns that framed screening as an act of strength and self-nurture could engage men who navigate masculinity more fluidly. By situating prostate cancer screening within a framework that validates diverse gender expressions, practitioners could reduce barriers rooted in rigid gender norms and encourage greater participation in preventive health behaviors.

### **Conclusion**

A complex interplay of cultural norms, structural inequalities, and psychological constructs shaped prostate cancer screening among African American men. Feelings of emasculation, threats to autonomy, and conflicting masculinity norms created significant barriers to early screening in shaping young African American men's health behaviors, particularly in the context of prostate cancer screening. Decades of scholarship have highlighted this population's unique challenges, with Thompson's (2023) *An Endangered Species* framing young African American men as a group experiencing declining health outcomes compared to previous generations. African American men continued to experience the shortest life expectancy across all racial and gender groups in the United States, underscoring the urgency of addressing both structural and psychosocial determinants of health disparities (Ndugga & Bloomberg, 2024).

Despite this sobering reality, researchers also identified areas of resilience and culturally grounded strengths. Scholars such as Coleman-Kirumba et al. (2023) demonstrated that young African American men's psychosocial development reflected the burdens of inequality and patterns of resistance and growth. Much of the literature emphasized how masculinity and gender socialization influenced mental health outcomes and health behaviors, often portraying masculinity as a constraint (Kuss et al., 2021). However, more recent frameworks reframed masculinity as a multidimensional construct that could support positive engagement when aligned with values such as leadership, responsibility, and family protection (Woodhill & Samuels, 2023). However, when reframed through values of leadership, family protection, and informed decision-making, these constructs also held potential as engagement facilitators. Culturally competent strategies that respected both autonomy and identity were needed to shift the narrative from avoidance to empowerment, thereby improving prostate cancer outcomes for African American men (Aguilera et al., 2024; Barry et al., 2020; Bowling et al., 2021).

The present study built upon this evolving body of literature by examining how masculinity intersected with cultural norms, social class, and racialized experience to influence young African American men's willingness to engage in preventive health practices, such as prostate cancer screening. Informed by gender role strain theory (O'Neil, 2023), the analysis explored how African American men negotiated their masculine identities across multiple reference groups, including hypermasculine peer environments, more flexible subcultural norms within the Black community, and the dominant societal model shaped by Eurocentric ideals (Franklin, 2025). These identity

negotiations significantly influenced perceptions of bodily vulnerability, stigma, and emotional openness, which affected help-seeking behavior and medical trust.

Screening for prostate cancer, particularly via procedures such as the DRE or PSA testing, emerged as a symbolic site where masculinity, race, and vulnerability converged. For many young African American men, such screenings were not simply medical acts but deeply personal experiences that posed potential threats to their sexual identity, bodily autonomy, and social perception (Kirby et al., 2024; Tabei et al., 2020). While some constructions of masculinity fostered resistance to screening due to associations with weakness or feminization, others—centered on familial duty and protective strength—were shown to motivate engagement when culturally and contextually affirmed (Aguilera et al., 2024; Woodhill & Samuels, 2023).

The literature underscored that masculinity among African American men was neither inherently a barrier nor a static identity. Instead, it functioned as a culturally shaped and contextually negotiated framework that, when properly understood and affirmed, could catalyze health empowerment. The findings of this study aligned with this broader perspective, revealing the importance of designing health interventions and public messaging that move beyond deficit-based portrayals of masculinity. By situating prostate cancer screening within frameworks of strength, legacy, and responsibility, health campaigns could more effectively reach young African American men and address long-standing disparities in prostate cancer outcomes (Basourakos et al., 2024; Bowling et al., 2021).

This qualitative multiple case study examined how cultural norms, family influences, and systemic barriers shaped attitudes toward preventive behaviors. Through semi-structured interviews of young African American men conducted in community-based settings, participants revealed how their beliefs, fears, and lived experiences influenced their decision-making regarding prostate cancer screening. The findings demonstrated that masculinity, cultural silence, family responsibility, and systemic inequities intersected to shape screening behaviors.

The study established that stigma, cost, and mistrust persisted as barriers to screening, yet it also identified significant facilitators. Participants emphasized the role of family support, trusted community spaces, and digital outreach as pathways to increasing awareness and engagement. P1, for example, highlighted the link between health and family provision, while P3 reframed masculinity as responsibility by asserting the importance of communication with providers. These insights illuminated the ways that masculinity could serve as both a barrier and a motivator for health-seeking behaviors.

I ensured the trustworthiness of the findings through credibility, transferability, dependability, and confirmability. Credibility was supported through triangulation of data sources, member checking, and peer debriefing. Transferability was achieved by providing thick, contextual descriptions of the participants' experiences and cultural settings. Dependability was maintained through an audit trail that documented coding decisions, reflective journaling, and analytic memos. Confirmability was established by bracketing assumptions and centering participants' authentic voices. These measures demonstrated that the findings were valid, reliable, and trustworthy.

The implications for theory, practice, and social change highlighted the broader significance of this study. Theoretically, the study extended masculinity theory by reframing toughness as accountability to the family and community. This reconceptualization positioned masculine identity not as avoidance of care but as responsibility for family provision and leadership. Practically, the findings guided recommendations for embedding outreach in trusted venues such as barbershops and churches while encouraging collective participation, including family accompaniment to appointments. Socially, the research amplified the voices of younger African American men who had been underrepresented in previous studies. By integrating their perspectives, this study created a foundation for culturally tailored interventions, policy changes, and community-driven campaigns to reduce disparities in prostate cancer outcomes.

This study made several significant contributions. First, it illuminated generational shifts in openness toward discussing prostate health. Younger African American men were willing to challenge cultural silences and advocate for proactive care. Second, the study identified digital tools such as social media and text messaging as promising outreach strategies for younger demographics. Third, it showed how masculinity could be reframed as responsibility, creating a culturally resonant pathway to promote preventive care. Finally, the study highlighted the potential for community action, as participants expressed interest in launching a prostate cancer awareness campaign to educate peers about mortality, responsibility, and the importance of early detection.

Moreover, the study revealed how masculinity, cultural norms, and social determinants of health intersect to influence prostate cancer screening behaviors among younger African American men. While barriers such as stigma, cost, and mistrust persisted, facilitators such as family support, trusted venues, and digital outreach offered opportunities to improve health outcomes. This study provided actionable strategies for theory, practice, and social change by centering participants' voices and reframing masculinity as a motivator. These contributions advanced knowledge and equity in men's health by laying the groundwork for culturally grounded, family-centered, and structurally responsive interventions. Ultimately, this study affirmed that reducing disparities in prostate cancer screening among African American men may require collaborative efforts that integrate theory, engage communities, and transform healthcare practices.

The study further explored how younger African American men perceive masculinity, gender roles, and prostate cancer screening. The findings reveal how masculinity, cultural norms, family influence, and systemic barriers shape preventive behaviors. Stigma, cost, and mistrust persist, but facilitators such as family support and digital outreach offer promise. I ensured that findings were valid, reliable, and trustworthy through attention to credibility, transferability, dependability, and confirmability. Importantly, I reframe masculinity as a motivator for health-seeking. I centered participants' voices so that the research creates a foundation for practice, policy, and social change to reduce disparities and promote equity in men's health.

## **Discussion**

The further exploration of this study examined the perceptions, attitudes, and beliefs of younger African American men aged 35 to 45 toward early prostate cancer screening. Using the HBM and gender role socialization theory, I interpreted semi-structured interview data to examine how masculinity, cultural norms, systemic barriers, and family influences shaped preventive health behaviors. The five themes presented in Chapter 4 provided a foundation for interpretation.

### **Masculinity and Gender Role Socialization**

Masculinity functioned as both a constraint and a motivator. P1 explained, “Some Black men think being healthy and not seeing a doctor is much easier... I hate hospitals,” reflecting stoicism and health avoidance, consistent with prior research connecting masculine norms to delayed care (see Berry et al., 2021). P2 described, “Some guys look good on the outside, but inside, their organs are rotting,” highlighting emotional suppression and denial. In contrast, P3 reframed toughness as accountability: “That is an opportunity... to make that area stronger by communicating to your provider.” His perspective aligned with recent studies showing that masculinity could be redefined as leadership and responsibility (see Adams et al., 2023).

### **Beliefs and Attitudes Toward Screening**

Beliefs and perceptions of risk directly shaped attitudes. P1, reflecting on his father’s diagnosis, stated, “My father had prostate cancer... he was only 58,” aligning with HBM’s perceived susceptibility construct (see Rosenstock, 1974). P2 admitted, “Rectal examination—that is the part that frightens me,” illustrating how stigma and

procedural fear discouraged screening (Buote et al., 2022). P3 emphasized prevention: “If there is an issue, I would like to be right in front of it,” a belief consistent with perceived benefits motivating health behavior (see Fish et al., 2022).

### **Cultural Norms and Community Influence**

Cultural silence remained a barrier, but generational shifts were evident. P1 reflected, “They want to be strong for their family, but being healthy is more important,” highlighting tension between cultural norms and Health. P2 noted, “Mostly women are concerned with those things,” illustrating gendered health roles documented in earlier studies (see Bazargan et al., 2021). P3 observed, “Times are changing... almost no conversation is off the table regarding men’s health.” His insight echoed findings that younger men increasingly challenge silence and stigma (see Smith et al., 2022).

### **Trust and Historical Mistrust**

Trust reflected a continuum. P1 emphasized, “I trust [my provider] 100%,” diverging from familiar narratives of mistrust. P2 sought privacy: “I’d rather go to another city to ensure confidentiality,” consistent with longstanding historical trauma and systemic inequities (see Bazargan et al., 2021). P3 stated, “I trust them a lot... but I need to be an informed patient,” demonstrating cautious collaboration. These findings mirrored prior evidence of mistrust while extending it by showing how informed self-advocacy served as a middle ground (see Nganda & Mwithia, 2024).

### **Knowledge and Health Information Access**

Knowledge gaps persisted. P1 trusted providers, stating, “I had an appointment yesterday... I get checked every 6 months.” P2 relied on informal sources: “I Google...

but these days AI and chats are not always right,” reflecting uncertainty about credibility. P3 admitted, “Not too confident [about prostate cancer]... I am going to do more research now.” These differences aligned with research showing varied reliance on providers, peers, and digital media (see Griffith et al., 2022). Informal settings such as barbershops emerged as critical knowledge exchange spaces, reinforcing their cultural relevance (Vapiwala et al., 2021).

### **Barriers and Facilitators**

Barriers included stigma, cost, and lack of awareness. P1 said, “You’re getting laughed at.” P2 emphasized, “You hear the word copay, that turns you away.” P3 remarked, “You just don’t know you should... reminders would help.” These narratives reflected structural and psychosocial barriers (see Rogers et al., 2022). Facilitators emerged in family responsibility and cues to action. P1 stressed, “You can’t work and provide for your family without being healthy.” P3 suggested reminders and bundling with physicals, aligning with HBM’s “cues to action” framework (see Fish et al., 2022).

### **Personal Health Practices and Decision-Making**

Decision-making balanced financial constraints, family input, and responsibility. P1 emphasized, “Health is a number one priority... you can’t work and provide for your family without being healthy.” P2 described trade-offs: “I found out I had inflammation... but the medical bills got pushed back.” P3 explained, “I had to become an expert as best I could.” These reflections aligned with research highlighting the role of family consultation, self-efficacy, and financial barriers (see Owens et al., 2020).

### **Recommendations for Outreach**

Participants proposed reframing masculinity, family messaging, and digital outreach. P1 stated, “That image still needs to be protected,” suggesting that health promotion should align with masculine identity. P2 emphasized family responsibility, and P3 recommended, “If social media were pumping screening... text messages would help.” These recommendations reflected literature on culturally resonant interventions and digital outreach strategies (see Griffith et al., 2022).

The rectal examination emerged as one of the most sensitive barriers to prostate cancer screening among participants because it carried cultural, theoretical, and historical weight beyond the medical procedure itself. While the exam was intended as a diagnostic tool, participants consistently framed it as a source of embarrassment, ridicule, and emasculation. Their narratives revealed not only immediate discomfort with bodily exposure but also broader meanings tied to masculinity, stigma, and systemic mistrust. P2 captured this discomfort when he stated, “Rectal examination—that’s the part that frightens me.”

He shifted his posture as he voiced this admission, a nonverbal withdrawal of my field notes highlighted as evidence of vulnerability and avoidance. His reaction reflected what Adams et al. (2023) described as stoicism and emotional suppression in African American men, where fear or vulnerability was culturally discouraged and often silenced. Within the HBM, P2’s fear operated as a perceived barrier, powerful enough to override his awareness of potential benefits (Rosenstock, 1974). P1 linked this discomfort directly to peer ridicule, explaining, “You’re getting laughed at.” His remark illustrated how

gender role socialization reinforced stigma through group policing of masculinity. His account paralleled Aguilera et al. (2024), who found that gender role stress heightened when health behaviors clashed with ideals of toughness or invulnerability. My reflective journal noted P1's lowered gaze as he shared this statement, suggesting internal conflict between his private acknowledgment of health risk and his public adherence to masculine expectations.

In contrast, P3 reframed masculinity as responsibility, offering an alternative perspective: "That is an opportunity... to make that area stronger by communicating to your provider." He challenged the association between rectal exams and emasculation by repositioning openness with providers as consistent with strength, leadership, and family accountability. His account reflected both self-efficacy within the HBM and Bem's (1974) theory of psychological androgyny, which emphasized the integration of traditionally masculine and feminine traits. By embracing communication, self-care, and responsibility alongside toughness, P3 embodied an androgynous expression of masculinity that supported preventive health.

The stigma surrounding the rectal exam also drew from historical memory. As described in Chapter 2, systemic injustices such as the Tuskegee syphilis study (1932–1972) created intergenerational mistrust toward invasive medical procedures (Miteu et al., 2024; Rose, 2022). This history was not distant for African American men, but they lived in the cultural narratives shaping medical decisions. P2's hesitation and P1's reference to ridicule reflected not only embarrassment but also a protective skepticism toward institutions that had historically devalued Black male bodies. Bazargan et al.

(2021) and Brüggemann (2021) confirmed that medical mistrust amplified stigma, compounding reluctance to engage in preventive screening.

Gender role socialization compounded this mistrust. Traditional masculine norms such as stoicism, resilience, and invulnerability were internalized as cultural coping strategies in response to systemic racism (Adams et al., 2023). However, in the context of health, these norms functioned as barriers. P2's reluctance to undergo a rectal exam illustrated how originally adaptive stoicism became maladaptive when it discouraged life-saving preventive care.

At the same time, resilience operated as a double-edged sword (Terrana & Al-Delaimy, 2023). While resilience empowered men to endure adversity, it also fostered self-reliance that diminished perceived need for screening. P3's narrative, however, showed how resilience could be reframed as responsibility, turning the same trait into a facilitator of preventive behavior. From a theoretical perspective, the participants' narratives illustrated how the HBM constructs intersected with cultural masculinity norms.

Perceived susceptibility was heightened for P1 due to family history ("My father had prostate cancer"), yet perceived barriers (fear of ridicule, stigma) delayed action. For P2, perceived severity was acknowledged ("organs are rotting"), but the fear of the rectal exam overshadowed both perceived benefits and self-efficacy. P3 embodied the integration of all four constructs—recognizing susceptibility, acknowledging severity, perceiving benefits, and exercising high self-efficacy by proactively seeking screening.

These findings also extended the Gender Role Socialization theory by demonstrating that masculinity was not a uniform barrier but a contested space.

For some, masculinity constrained openness, and fostered avoidance; for others, it motivated responsibility, accountability, and proactive care. P3's stance aligns with research suggesting that reframing masculinity as protection and provision could motivate health-seeking behaviors (Foster et al., 2023). The participants' words confirmed prior research that identified the DRE as a uniquely stigmatized barrier for African American men (Bouras, 2024; Smith et al., 2022). However, their narratives also extended the literature by showing how individual men negotiated this stigma differently: P1 through resignation to ridicule, P2 through avoidance rooted in fear and mistrust, and P3 through reframing masculinity as responsibility.

My reflective notes emphasized that the most productive interview moments occurred when participants felt their discomfort was acknowledged rather than dismissed. This suggested that empathetic, culturally competent dialogue was central to building trust. Embarrassment and emasculation surrounding the rectal exam illustrated how masculinity, stigma, and history intersected to shape preventive behaviors. While some participants experienced the exam as a violation of cultural norms, others demonstrated that masculinity could be reinterpreted to support health promotion. Recognizing these tensions—and integrating historical awareness and theoretical frameworks—was essential for designing culturally sensitive interventions that reframed preventive screening as consistent with strength, leadership, and family responsibility.

## **Current Resources and Public Health: Awareness and Stigma Reduction in the Community**

In recent years, national organizations such as ZERO Prostate Cancer have launched targeted efforts to address the disproportionate impact of prostate cancer on African American men. Their public awareness campaigns, including digital infographics and social outreach, deliver culturally responsive, fact-based information about screening, risk, and survivorship (ZERO Prostate Cancer, 2024). These resources align with ongoing public health strategies to reduce stigma, increase screening uptake, and normalize preventive care in high-risk communities (see Appendix H).

For example, participant P3 acknowledged limited knowledge about prostate cancer but expressed a desire to “do more research now,” which reflected the importance of accessible educational resources. Campaigns like those by ZERO offer downloadable guides, FAQs, and videos tailored explicitly for Black men, helping to fill the informational gap that P3 identified.

Similarly, P1 highlighted family history as a primary motivator for screening. He noted, “My father had prostate cancer... he was only 58.” This aligns with the messaging in ZERO’s outreach, emphasizing family history and early detection as key motivators for proactive health behavior. These materials validate P1’s experience and reinforce health messaging that could resonate with others in similar situations.

Public figures like Montell Jordan have also emerged as advocates for early detection. After being diagnosed with Stage 1 prostate cancer following routine PSA screenings, Jordan used his platform to speak openly about his diagnosis and treatment

journey. His collaboration with ZERO and the release of his upcoming documentary, *Sustain*, aim to shift cultural norms by presenting prostate cancer screening as an act of strength, not vulnerability (ZERO Prostate Cancer, 2024). This narrative directly resonates with P2, who admitted fear surrounding the DRE and sought privacy in care. Public testimonies from trusted Black male figures help reduce the psychological barriers associated with emasculation, shame, and stigma—concerns that were clearly articulated by P2.

Together, these public health campaigns and real-life testimonies provide critical cultural counter-narratives. They reinforce the value of early detection, promote autonomy in health decisions, and foster environments—both online and offline—where men feel empowered to talk openly about prostate health. As participants P1, P2, and P3 demonstrated, access to reliable information, peer support, and role models is essential in shaping beliefs, attitudes, and perceptions toward prostate cancer screening.

### **Final Thoughts and Advice**

Closing reflections revealed advocacy and calls for early detection. P1 stressed, “You want to know that you are healthy to care for your child.” P2 added, “I wish more young men... would get healthy.” P3 warned, “Do not put it off... bad news is like spoiled milk—it does not get better.” These reflections demonstrated a shift from avoidance toward proactive advocacy, reinforcing the importance of reframing masculinity as responsibility and care provision (see Adams et al., 2023).

The findings revealed that masculinity, mistrust, stigma, and systemic barriers continued to shape African American men’s decisions about early prostate cancer

screening, while family responsibility, preventive orientation, and reframed masculinity offered pathways to engagement. This study confirmed existing literature on mistrust and barriers but extended it by documenting generational shifts toward openness and responsibility. Addressing these dynamics through culturally competent, community-grounded interventions remains essential to reducing disparities and improving health outcomes for younger African American men.

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## Appendix A: Prostate Cancer Interview Questions

### Inclusion Criteria

Thanks for agreeing to participate in this interview. During the next 45 minutes to an hour, I will ask you some questions, and I would appreciate it if you answered them as fully and honestly as possible. If there is a question you do not want to answer, say Next question:

First, I want to assure you that you:

1. Self-identify as an African American man?
2. Are you between the ages of 35 and 45?
3. Are you willing to share some of your beliefs, attitudes, and perceptions about your health and health care?
4. Great, I want to confirm that you read the consent form and consent to participate in this study.

---

#### 1. Masculinity and Gender Role Socialization

- What does being a young Black man mean to you, especially concerning your health and healthcare?
- How do you feel about discussing health care with your peers or family?
- Some boys are raised to believe that expressing vulnerability is a sign of weakness. It may be less likely that they seek medical help as adults, including preventive screenings like prostate cancer tests. In what ways do you think traditional male roles affect how African American men approach healthcare or medical screening?
- In other words, do you think being perceived as “strong” or “tough” affects whether men seek medical help?

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#### 2. Beliefs and Attitudes Toward Prostate Cancer Screening

- What are your thoughts or feelings when you hear the words “prostate cancer screening”?
- How familiar are you with PSA testing or other types of prostate cancer screening?

Have you ever considered getting screened for prostate cancer? Why or why not?

- What influences your decision to get screened or not get screened?
- 

### 3. Cultural Norms and Community Influence

- What experience or observation of your peers or other men in your community have you had with them talking about going to the doctor or getting screened for cancer?
  - What messages about health and masculinity did you hear growing up in your family, community, or church?
  - Are there particular cultural values or community attitudes that you think affect how Black men view prostate cancer screening?
- 

### 4. Knowledge and Health Information Access

- Where do you usually get your health information? —
  - How confident do you feel in your knowledge about prostate cancer?
  - How confident do you feel about your knowledge of prostate cancer and screening?
  - Have you ever received information (e.g., flyers, ads, social media content) about prostate cancer targeted to African American men? What stood out to you?
- 

### 5. Trust and Historical Mistrust in Healthcare

- How much do you trust your healthcare providers regarding your care?
- 

### 6. Barriers and Facilitators to Screening

- What are some reasons that might stop a younger African American man like yourself from getting screened for prostate cancer?

- What might make it easier or more likely for someone like you to get screened?
  - How serious do you think cost, time, or privacy concerns play a role in the decision to get tested?
- 

#### 7. Personal Health Practices and Decision-Making

- Can you describe a recent experience where you had to make an important health-related decision?
  - Who do you usually consult or talk to before making a health decision?
  - How serious are you about balancing your concerns about health with other responsibilities (e.g., work, family)?
- 

#### 8. Recommendations for Outreach and Engagement

- What messages about prostate cancer screening would resonate with men your age?
  - What would make you or your peers pay attention to a health campaign?
  - What role should community leaders, churches, or barbershops play in raising awareness about prostate cancer?
- 

#### 9. Final Thoughts

- What advice would you give other young African American men about caring for their health?
- Is there anything else you would like to share about your views on prostate cancer screening, masculinity, or healthcare?

## Appendix B: Flyer



**Perceptions of  
Younger  
African-American  
Men about  
Prostate Cancer  
Screening**

**Share your story about  
Prostate Cancer Screening**

**About the Study:**

-  One up to 60 minute Phone or Zoom Interview that will be audio recorded
-  You would receive a \$10.00 Visa gift card as a thank you
-  To protect your privacy, the published study will not share any names or details that could identify you

**Volunteers must meet these requirements:**

- ✓ Be 35 - 45 years old
- ✓ Have some knowledge about prostate cancer screening

**To volunteer contact:**

Linda Teemer-Baker, MPhil



This Interview is part of the doctoral study for Linda Teemer-Baker, MPhil a PhD student at Walen University. Interviews will take place in July 2025

### Appendix C: Data Analysis Summary With Conceptual Alignment

This document visually represents the three-stage coding process—open, axial, and selective coding—and its alignment with the Health Belief Model (HBM) and Gender Role Specialization theory. The diagram illustrates how line-by-line codes were developed, organized into categories, and refined into overarching themes while grounded in the study’s conceptual framework.

#### Three-Stage Coding Process Aligned with HBM and Gender Role Specialization

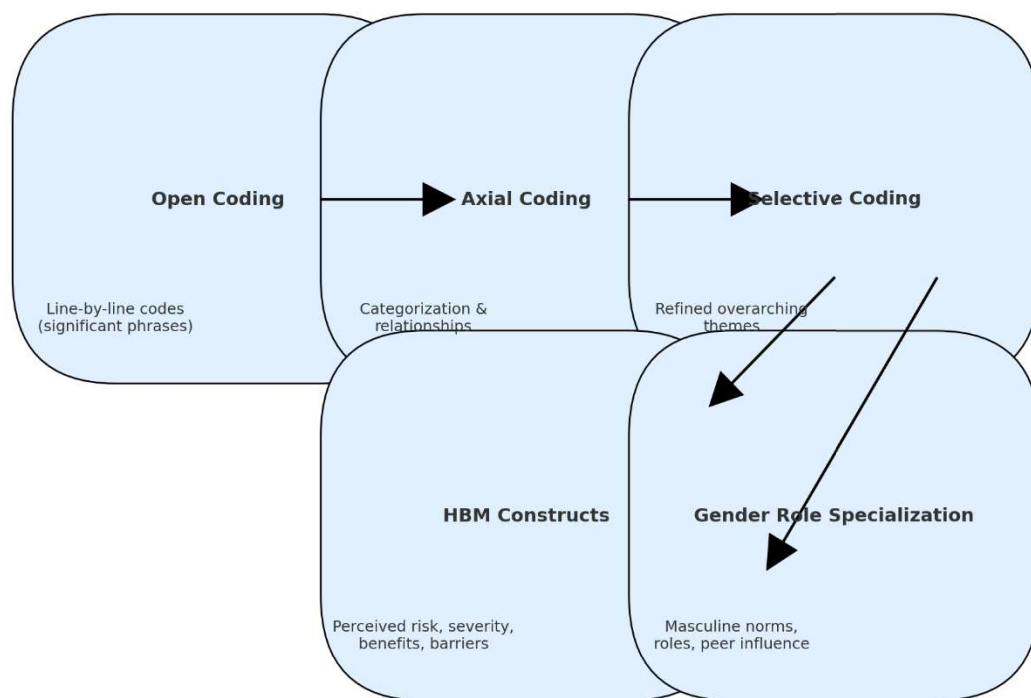


Figure 1

Three-stage coding process aligned with the Health Belief Model (HBM) and Gender Role Specialization theory.

## Appendix D: Coding Framework With Case Narratives (P1-P3)

This appendix presents the coding framework used to analyze data from Participants (P1, P2, P3). Each theme includes representative codes, verbatim excerpts, and analytic memo notes. This format ensures transparency, demonstrates the analytic process, and supports the trustworthiness of findings.

## P1 Coding Matrix

<b>Theme subheading</b>	<b>Codes Column B</b>	<b>Excerpt (verbatim) Column C</b>	<b>Memo Column D</b>
<b>Masculinity &amp; Gender Role Socialization</b>	toughness; avoidance; family influence; stigma	“Some Black men think being healthy and not seeing a doctor is much easier than going to see a doctor. I hate hospitals.”	P1 valued family health discussions but admitted to hating hospitals, highlighting cultural expectations of toughness.
<b>Beliefs &amp; Attitudes Toward Screening</b>	awareness; prevention; family history; motivation	“My father had prostate cancer... he was only 58. I want to be able to be checked.”	Personal family loss transformed fear into motivation for screening.
<b>Cultural Norms &amp; Community Influence Trust &amp; Historical Mistrust</b>	masculinity; cultural silence; family history  provider trust	“A lot of Black men think it is a mess of masculinity... but being healthy is more important.”  “For me, I trust [my provider] 100%.”	P1 highlighted the tension between masculine ideals and prioritizing health.  P1 diverged from familiar distrust narratives in Black communities.
<b>Knowledge &amp; Health Information Access</b>	trusted sources; partial knowledge; confidence in care	“I had an appointment yesterday... I get checked every six months.”	P1 actively engaged with healthcare providers, showing higher confidence.

<b>Barriers &amp; Facilitators</b>	stigma; peer influence; family support	“You’re getting laughed at... If I had someone to go with me, like my father or an uncle, I’d do it.”	Stigma was a barrier; companionship facilitated action.
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## P2 Coding Matrix

<b>Theme Subheading</b>	<b>Codes Column B</b>	<b>Excerpt (verbatim) Column C</b>	<b>Memo Notes Column D</b>
<b>Masculinity &amp; Gender Role Socialization</b>	procrastination; cost barrier; inconsistency; toughness façade	“A lot of us don’t [go to the doctor]. We find ourselves in crisis when we reach out for medical attention.”	P2 emphasized financial responsibility and procrastination over toughness.
<b>Beliefs &amp; Attitudes Toward Screening</b>	fear of procedure; limited familiarity; prevention awareness	“Rectal examination—that’s the part that frightens me.”	Fear of the procedure overshadowed preventive awareness.
<b>Cultural Norms &amp; Community Influence</b>	procrastination; women as health advocates; unhealthy diet	“Mostly women are concerned with those things.”	Women were identified as health advocates while men stayed silent.
<b>Trust &amp; Historical Mistrust</b>	trust with caution; confidentiality concern	“I’d rather go to another city just to ensure confidentiality.”	Trust paired with confidentiality concerns about local providers.
<b>Knowledge &amp; Health Information Access</b>	internet reliance; limited confidence; barbershop influence; lack of targeted messaging	“I Google... but these days AI and chats aren’t always right.”	Highlighted reliance on informal sources, with low confidence.
<b>Barriers &amp; Facilitators</b>	insurance; copay costs; competing financial responsibilities	“Insurance, maybe—that’s the main thing... you hear the word copay, that turns you away.”	Structural financial barriers outweighed cultural factors.

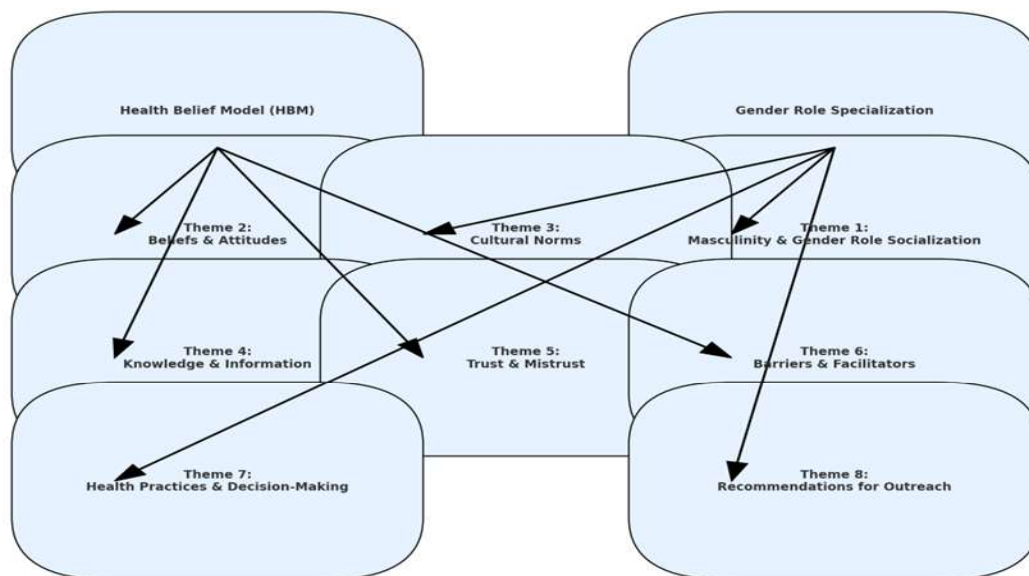
P3 Coding Matrix

<b>Theme Subheading</b>	<b>Codes Column B</b>	<b>Excerpt (verbatim) Column C</b>	<b>Memo Notes Column D</b>
<b>&amp; Gender Role Socialization</b>	strength/toughness; vulnerability reframed; leadership; optimization	“We don’t like to communicate weakness... that’s an opportunity to make that area stronger by communicating to your provider.”	Reframed masculinity as optimizing health by addressing weaknesses.
<b>Beliefs &amp; Attitudes Toward Screening</b>	prevention mindset; anti-procrastination; limited test familiarity; anxiety reduction	“If there’s an issue, I’d like to be right in front of it... procrastinate and I have more anxiety.”	Saw screening as anxiety management and proactive prevention.
<b>Cultural Norms &amp; Community Influence</b>	community silence; emerging openness; wellness culture	“Almost zero... I haven’t heard it in conversation in passing.”	Acknowledged historical silence but sensed cultural transition.
<b>Trust &amp; Historical Mistrust</b>	provider trust; self- advocacy; shared decision-making	“I trust them a lot... However, I need to be an informed patient.”	Exemplified collaborative trust with self-advocacy
<b>Knowledge &amp; Health Information Access</b>	provider as trusted source; digital media; self-education; low confidence	“I get my health information directly from my healthcare providers... and I’ll do my independent research.”	Balanced provider trust with digital research but admitted low prostate-specific knowledge.
<b>Barriers &amp; Facilitators of Screening</b>	awareness gap; invulnerability; time constraints; reminders; integration	“You just don’t know you should... If this were part of an annual physical... reminders would help.”	Saw systemic fixes (reminders, bundling) as facilitators.

### Appendix E: Conceptual Framework Integration

The chapter integrates the study's findings with theoretical frameworks, prior literature, and practical applications. It includes implications for theory, practice, and social change, supported by the conceptual framework diagram, and expands to include the discussion of androgynous expressions of masculinity in health outreach. The conceptual framework diagram below illustrates how the eight themes generated from this study aligned with the Health Belief Model (HBM) and Gender Role Socialization theory. The framework demonstrated how masculinity, community norms, knowledge, trust, and social determinants of health intersected to shape African American men's beliefs and behaviors regarding prostate cancer screening. This visual integration underscored how the study's findings were situated within established theoretical perspectives while extending them.

**Conceptual Integration of Themes with Health Belief Model and Gender Role Socialization**



## Figure 1

Three-stage coding process aligned with the Health Belief Model (HBM) and Gender Role Socialization theory.

Note. This figure illustrates how open coding identified significant phrases, axial coding grouped categories and mapped relationships, and selective coding refined these into overarching themes (Mishra & Dey, 2022). The alignment with HBM constructs (perceived susceptibility, perceived severity, perceived benefits, and perceived barriers) and Gender Role Socialization theory (masculine norms, provider roles, peer influence, and androgynous expressions of masculinity) demonstrated how participants' health perceptions and behaviors intersected with cultural expectations and diverse gender identities.

### Appendix F: Comparative Matrix: Study Findings Versus Prior Literature

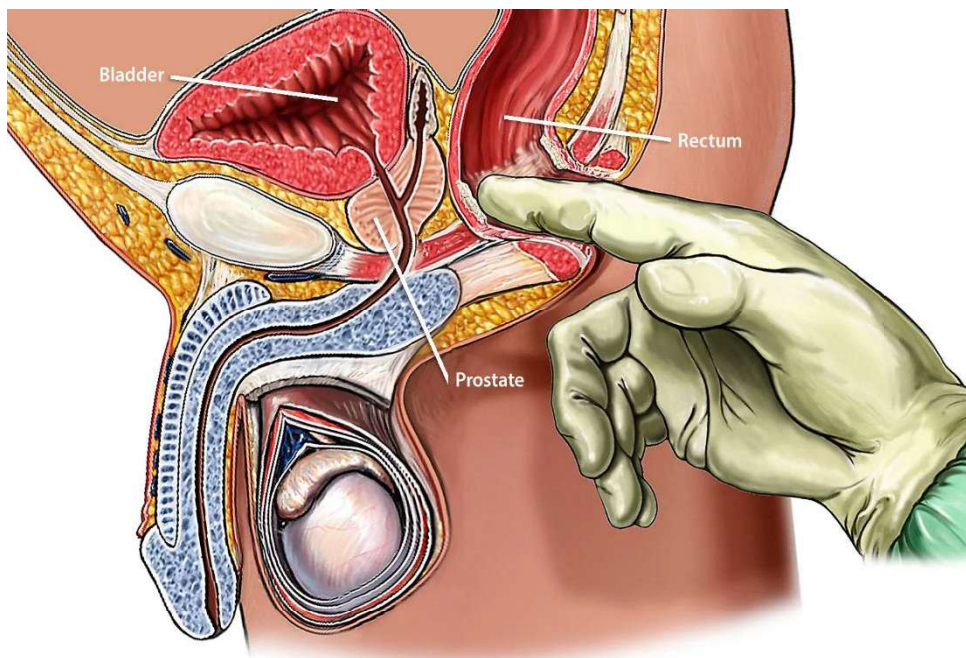
This table compares the nine themes from participant narratives (P1–P3) with existing literature. It highlights points of confirmation, extension, and divergence, demonstrating how this study contributes to the scholarly understanding of African American men’s beliefs, attitudes, and perceptions toward prostate cancer screening.

Theme	Findings from Current Study (P1–P3)	Alignment with Literature
Masculinity & Gender Role Socialization	Masculinity acted as a constraint (P1, P2: avoidance, stoicism, procrastination) and a motivator (P3: reframed as accountability).	Confirms Adams et al. (2023); Extends Adams et al. (2023) by documenting generational shifts toward reframed masculinity.
Beliefs & Attitudes Toward Screening	Family history (P1) heightened susceptibility, fear of rectal exam deterred P2, while P3 adopted a preventive orientation.	Confirms Fish et al. (2022) on susceptibility. Confirms Buote et al. (2022) on procedural fear. Extends Quach (2022) with a preventive orientation in younger men.
Cultural Norms & Community Influence  Trust & Historical Mistrust	Cultural silence persisted (P1, P2), but P3 emphasized generational openness to men’s health discussions.  P1 trusted the provider fully, P2 sought confidentiality outside the city, and P3 balanced trust with informed self-advocacy.	Confirms Okoro et al. (2020) on cultural silence. Extends Marshall et al. (2023) with evidence of generational change.  Confirms Bazargan et al. (2021) and Rose et al. (2022) on mistrust. Extends Griffith et al. (2021) on protective skepticism.
Knowledge & Health Information Access	Varied literacy: P1 trusted providers, P2 relied on Google/barbershops, P3 blended digital + provider input but admitted limited confidence.	Confirms Benedict et al. (2022) and Bratt et al. (2023) on knowledge gaps. Extends with insight into AI/digital mistrust.

Barriers & Facilitators to Screening	Barriers: stigma (P1), cost (P2), awareness gaps (P3). Facilitators: family support, provider reminders, trusted spaces.	Confirms Vapiwala et al. (2021) on stigma. Confirms Jordan et al. (2024) on Financial barriers. Extends Buote et al. (2020) on trusted spaces as facilitators.
Personal Health Practices & Decision-Making	P1 tied health to family provision, P2 consulted family but delayed due to bills, and P3 sought multiple opinions/self-advocacy.	Confirms Blok et al. (2021) on family influence. Extends Griffith et al. (2022) with multi-opinion, self-advocacy strategies.
Recommendations for Outreach	P1: protect masculine identity, P2: emphasize family responsibility, P3: digital outreach/social media campaigns.	Confirms Smith et al. (2022) on reframing masculinity. Extends Coughlin et al. (2021) on HBCU/digital outreach contexts.
Final Thoughts & Advice	P1: family responsibility, P2: advocacy for men's health, P3: urgency with vivid metaphors (bad news like spoiled milk).	Confirms Fish et al. (2022) on family motivators. Extends Adams et al. (2023) by framing urgency through metaphors.

### Appendix G: Digital Rectal Examination

The Digital Rectal Examination (DRE) in prostate cancer screening is a primary diagnostic tool historically utilized, along with the Prostate-Specific Antigen (PSA) blood test. The DRE involved a gloved, lubricated finger inserted into the rectum to palpate the prostate gland and detect abnormalities such as hard nodules, asymmetry, or enlargement.



DRE



PSA blood test.

## Current Resources and Public Health; How Young Men Access Prostate Cancer Information

Understanding how young African American men access prostate cancer information is essential to addressing early screening disparities. Public health messaging often fails to reach this demographic effectively due to mistrust, stigma, or a lack of culturally relevant communication (Ndugga & Bloomberg, 2024; Brenner et al., 2020).

### Montell Jordan

Partnered with ZERO Prostate Cancer to raise awareness of early detection in the Black community—targeting younger men at risk of delaying screening.

Shared a culturally resonant experience through media and an upcoming documentary, *Sustain*.

Organizations like ZERO Prostate Cancer have focused on digital resources and community outreach.



**ZERO**  
Prostate Cancer

Organizations like ZERO Prostate Cancer have focused on digital resources and community outreach. However, many young men still rely on informal or community-based sources for health information.

### Appendix I: Public Health Initiatives Promoting Prostate Cancer Awareness

The following table outlines key public health initiatives and community-based efforts that aim to reduce stigma and promote awareness about prostate cancer among African American men. These efforts are informed by recent literature and participant perspectives (P1, P2, P3) from qualitative interviews.

Initiative	Description	Target Audience	Stigma Reduction Strategy	Participant Perspective
ZERO Prostate Cancer Campaign	National awareness initiative promoting early detection and education.	Black men aged 40+	Features personal stories like Montell Jordan's to normalize screening.	P1 mentioned learning from celebrity experiences and feeling encouraged to get screened.
Faith-Based Health Workshops	Church-sponsored programs discussing men's health in a spiritual context.	African American male congregants	Uses trusted religious figures to frame health as stewardship.	P2 noted openness to health conversations in faith settings when led by respected leaders.
HBCU Health Outreach Events	On-campus campaigns engaging young Black men in health education.	Black college students (18–30)	Combines academic resources with peer-led discussions to reduce stigma.	P3 highlighted the value of early education and peer dialogue at his college.
Barbershop-Based Screenings	Health professionals collaborate with barbers to provide education and screenings.	Working-class Black men	Creates a relaxed, familiar setting for candid conversations.	P1 described barbershops as trusted spaces for open dialogue about men's health.
Digital Media and PSA Tools	Online platforms and AI tools are offering accessible prostate health information.	Digitally connected Black men	Delivers anonymous, judgment-free access to facts and personal stories.	P2 admitted using Google and online chats but stressed the need for trusted sources.