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African American Masculinity and Its Influence on Hypertension-Related Behaviors

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Abstract

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MPH, Armstrong State University, 2009

BS, Savannah State University, 2007

Doctoral Study Submitted in Partial Fulfillment

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Doctor of Public Health

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Abstract

High blood pressure (hypertension) is known to be one of the leading factors that directly contributes to heart disease and stroke, which are the first and third leading causes of disabilities and death in the general U.S. population. The prevalence of high blood pressure among African American men in the United States ranks as one of the highest in the world. Research indicates the roots of this phenomenon are found in physiological, psychosocial, cultural, and socioeconomic factors differentially affecting the African American population. The purpose of this study was to examine the interaction between African American males' masculine perspective and the lifestyle and clinical dictates essential to self-management of hypertension. This qualitative study used social cognitive theory and health service utilization as its theoretical foundation. The research questions that guided the thematic analysis of the qualitative interview data centered on psychosocial/risk factors, sustaining self-management, and common themes gathered from individual interviews with ten African American men ages 40-65 years with a medical diagnosis of hypertension. Responses were transcribed, and data were analysed by using NVivo 10 to identify reoccurring themes. The dominant themes were perceptions of discrimination, lack of trust and miscommunication with providers, and self-care behaviors associated with masculine identity. The results of the study did not necessarily present new findings but support that efforts are needed by professionals to craft innovative approaches to education and support for African American males with chronic diseases. This study influences positive social change by helping health providers grasp a better understanding of how African American males' views of masculinity and race influence hypertension-related behaviors.

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Dedication

First, I would like to give honor to my Heavenly Father who is the Alpha and Omega, the Beginning and the End, the King of all Kings. All I've ever needed was faith as small of a mustard seed, and all the doors that stood before me where opened because of God's Grace and Mercy. Secondly, I want to thank my parents for motivating and loving me unconditionally. Thank you for being my voice of reasoning, my personal cheerleaders, for believing in me when I didn't believe in myself! If I had a million tongues, I couldn't thank you enough! I love you both from the depths of my heart. To Tanessa, Shaunta, Quintena, Kei Shondra, Kirsten and Eukitha, thank you for friendship and most importantly encouraging me throughout this long journey! Auntie Peggy, I love you and thank you for everything! To my husband, Dontrece, you have made me the happiest woman in the world! I look forward to spending the rest of my life with you! This is this only the beginning.

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I would like to personally thank Dr. Ego Onyejekwe for the support, guidance and the encouragement throughout this journey. It's been a long road, but you have stood by me even during hard times. I would like to thank Dr. Catherine Garner for coming in and helping Dr. Ego and I reshape this dissertation and pushing me to see it through. The both of you changed the dynamics of my dissertation committee and made things a lot easier. For that, I am forever grateful! Thank you to New Bethel Baptist Church for allowing me to use your church so that I can conduct each of the interviews. Lastly, thank you to the men that willingly participated in this study. You all made this study rememberable. It was an honor to meet each of you.

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Chapter 1: Introduction to the Study

Introduction

In the United States, approximately one in every three adults, or approximately 75 million adults (29%), have hypertension (Merai et al., 2016). Only slightly more than half (54%) of these people can control their high blood pressure (Merai et al., 2016). This incidence leads to an increased risk of health disease and stroke, which are the leading causes of death for Americans (Yoon, Fryar, & Carroll, 2015). The prevalence of high blood pressure among African Americans in the United States ranks as one of the highest in the world (American Heart Association, 2016). Despite 2 decades of research into both the origins and the prevention of hypertension among African Americans, the high rate of hypertension in this segment of the population remains a significant public health concern. Having a history of strokes or ministrokes, being African American, and having a less than high school education are all characteristics that are associated with lower hypertension knowledge (Bosworth et al., 2006). Research indicates the roots of this phenomenon are in physiological, psychosocial, cultural, and socioeconomic factors, affecting the African American population differently than other populations in the United States (Cuffee, Hargarves, & Allison, 2012).

Despite all efforts (clinical and public health) to decrease the incidence ratings of hypertension and any health-related consequences that are associated with African Americans, a need to focus on African American men who are disproportionately affected is significantly needed. Having extensive knowledge of what hypertension is and how it affects one's body, understanding self-efficacy skills, and being genuinely devoted

to adhering to medication requirements are a few factors that may contribute to successfully managing hypertension levels among African American males (Gbenga et al., 2003). The dynamic interplay of the African American male's view of masculine roles and its influences, concerning either risk reduction for or the self-management of hypertension, has not yet been explored.

In this study, I aimed to understand the African Americans male masculine perspective on hypertension and the health system and how this perspective may explain their lack of treatment or control of hypertension.

Background

African American men are at higher risk for hypertension than any other population in the United States. African American men are reported to develop hypertension earlier in life and have a high incidence of undiagnosed, untreated, and uncontrolled hypertension. Researchers have indicated that African American men endure a disproportional share of the risk for hypertension due to the stress associated with such factors as racial discrimination, poverty, limited employment opportunities, substandard housing, and residing in communities characterized by high crime rates (Cuffee et al., 2012). Data from the Heart Disease and Stroke Prevention (American Heart Association [AHA], 2015) indicated that 43.0% of African American men were hypertensive, in comparison with 45.7% of African American women. Percentages for white men and Hispanic men were 33.9% and 27.8%, respectively, during the same period (AHA, 2015). Data indicate that African American men are less likely than African American women or white men to be aware that they are hypertensive are less

likely to be treated for hypertension even after they are aware of their condition. Research by Hammond (2010) emphasized the role of the documented distrust of the traditional medical care sector in the African American community as causal in diagnosis and treatment disparities between races, whereas gender difference has been attributed to the well-documented difference in medical care service use between men and women.

The legacy of this research has been the development of much community-based social support and health education initiatives designed to curtail the effects of stress and to encourage prevention, diagnosis, and treatment behaviors to both impede and control hypertension in African American communities (Becker et al., 2005; CDC, 2010). The overall effect of these intervention efforts on African American men has been disappointing despite efforts to reach out to African American men in culturally acceptable venues and to tailor programming to African American men in different socioeconomic strata (Centers for Disease Control and Prevention [CDC], 2010). The lack of sustainable success among African American men suggests that the higher rates of hypertension and the lower effectiveness of medical interventions in this subpopulation may be attributable to a disconnect between African American men and the responses themselves. African American men valuing neither the form nor the content of current health education or clinically based support programs is an assertion supported by the CDC's comprehensive review of system-level interventions (CDC, 2010).

One potential source of this disconnectedness is in the distinctively African American male standard of masculinity that not only maintains the traditional male perspective of care seeking as a sign of weakness, but also incorporates a drive to project

a persona of control as a counterpoint to a history of slavery and a lack of social power (CDC, 2010; Karlsen & Nazroo, 2002). This potential is underscored by data that prove that African Americans receive less quality of care their Caucasian (Bach et al., 2004; Mayr et al., 2010). Many of the barriers can be found primarily within the relationship between the African American patient and their physician (Scheppers et al., 2006). Establishing an excellent patient-physician relationship is critical to ensure that quality of care is always rendered.

It is imperative to manage high blood pressure and to improve patient self-management skills and attitudes because such improvement aids in improved precision and frequency of measurement using high blood pressure monitoring, and it enhances adherence to prescribed medications and lifestyle interventions (Uhlig et al., 2012). According to a research conducted by Flynn et al. (2013), hypertension is still a significant health issue within the United States and, consequently, a significant amount of research and work must be done to control this incidence. There is an even greater need to focus on the less-controlled blood pressure observed among African Americans compared with whites (Dickson & Plauschinat, 2008). Dickson and Plauschinat (2008) also stated within their research that African Americans who have been diagnosed with hypertension are more likely to have lower adherence to self-management behaviors compared with their White Americans counterparts.

Problem Statement

According to the National Vital Statistics System (AHA-Circulation, 2017), in 2014, approximately 73,345 deaths were attributed to high blood pressure. The

prevalence of hypertension among African Americans living in the United States is statistically slated as the highest in the world per the American Heart Association (2016). The rates are still increasing. Doctors have known for a long time that African Americans are more prone to hypertension than any other race/ethnicity group. Blacks develop onset of high blood pressure within the early stages of life, and research has shown that the average blood pressure for Blacks is more elevated than whites (Mozafarian et al., 2017). African American males almost double the incidence of hypertension, when compared with their white counterparts. The age-adjusted death attributed to high blood pressure was 19.9 per 100,000 and for non-black Hispanic males 50.1 (Mozafarian et al., 2017). Leading cause of death for Blacks is heart disease all ages at 24.1% (CDC, 2014).

Many researchers have sought to understand why the prevalence of hypertension is much high in African Americans. Doctors have suspected that genetics, as well as environmental and social factors, contribute to the increased incidence of hypertension. Despite a lack of substantial evidence of effective interventions targeting the control of hypertension, a lack of literature exists on how African American males' view of masculinity affects hypertension self-management. Therefore, I aimed to assess strategies such as patient education, self-monitoring, and behavioral counseling addressing African American male health beliefs, medication adherence, and lifestyle modification that affects a patient's ability to control hypertension.

Purpose of the Study

My purpose in this study was to examine knowledge and self-care management practices regarding behaviors needed for hypertension control among African American

males. In this study, I have assisted in developing a theory that masculine identity contributes to decision making regarding self-care management/control of hypertension. This information helped aid in addressing hypertension as a whole for individuals, communities, or general societies that may have similar characteristics to those who are being studied through this research.

Research Questions

To achieve the purpose of the research, in this qualitative study, I addressed the following research questions.

RQ1: What psychosocial factors comprise the African American Male's perspective of masculinity in the African American community?

RQ2: How do African American men view the risk factors for hypertension within the context of their psychosocial experience with their masculinity?

RQ3: How do African American men view the suitability of using medical care services to help guide self-care management of hypertension within the context of their psychosocial experience with their masculinity?

RQ4: How do the commonality of responses amongst those African American Males who were interviewed help to explain how their perception of masculinity affects self-care management of hypertension?

Framework

I used two conceptual frameworks to guide this grounded theory investigation: Bandura's (1960) social cognitive theory and Andersen's (1968) health service utilization model. Both frameworks will make independent and interrelated contributions to data

collection and data assessment. Bandura's (1960) social cognitive theory is a multiconceptual framework for evaluating the form and genesis of psychosocial variables and how a dynamic interplay shapes them with the environment. It is, consequently, fundamental to understanding the psychological variables that constitute the African American Males masculinity perspective.

Social cognitive theory (SCT) describes human behavior as a reciprocal model, inclusive of three factors: behavior factors, personal factors, and environmental factors, in which all three influences are all interrelated (Glanz et al., 2002). These interactions are subdivided into 11 concepts, six of which represent an individual's psychosocial outlook: observational learning, expectations, perceptual situations, expectancies, reinforcements, and emotional coping (Glanz et al., 2002). I used these six variables to gather and evaluate data related to the beliefs, attitudes, and motivations of the target population concerning what it means to be an African American male.

Three additional concepts in SCT, behavioral capability, self-efficacy, and self-control deal primarily with the psychosocial competencies used by individuals to negotiate their social environment. I used these three concepts to organize and interpret data on the African American male sense of self-agency as he evaluates the parameters of the need for personal health-related services through the perceptual lens of African American manhood. According to Bandura and Walters (1959), Bullock and Merrill (1980), and Emmons and Diener (1986), because of behavior and environmental circumstances ability to function bidirectionally, this has allowed social cognitive theorists to consider people as both the products and producers of their environments.

These theorists have determined that people shape their environment through the selection and creation of situations.

The final constructs in the SCT are environment and reciprocal determinism. SCT refers to those objective factors that affect a person's behavior from a social (family or friends) and physical (size or ambiance) aspect as the environment (Glanz et al., 2002). This concept draws attention to the interplay between perceptual reality, as defined by the preceding nine SCT concepts, and the evident components in which an individual's behaviors are embedded. Bandura defines this interplay as *reciprocal determinism* (Glanz et al., 2002). These final two concepts of SCT assessed the facilitators and barriers to accessing and using health care services as experienced by African American Males. To increase content validity, I asked reviewers about the appropriateness of the items regarding the research questions and target population, and their expert opinion on the matters measuring the intended constructs.

I used Andersen's (1968) health service utilization model to identify and understand those variables that directly facilitate or impede public health and health care utilization as defined from the clinical perspective concerning self-care management/control of hypertension. I used this framework to examine the relationship between the African American males' perspective on masculinity and predisposing, enabling, and need criteria for self-care health service use (Wolinsky, 1983). According to Chi (1998), "There are no standard measuring instruments for service utilization in behavioral health literature. Therefore, studies may specify service utilization by basically reporting the general use of services by category, usually without indicating the

frequency or length of service uses" (p. 234). Outcomes and volume of services are often expressed through measures traditionally associated with health services utilization (Donabedian, 1973; Starfield, 1998).

I used SCT to capture the variables associated with perceived need because it represents a more detailed and psychosocially grounded assessment of human cognition. However, Andersen's framework assessed the clinical definition of the signs, symptoms, and risk factors that constitute the professional view of need. This component is missing in SCT. I evaluated the overlap and the divergence between the two perspectives so that any gap between the target population's perceived need for prevention or care relative to hypertension, and the established medical assessment of a need for prevention or care relative to hypertension was adequately characterized.

Andersen's framework further defined the concept of predisposing factors as those social risk factors that affect the inclination of a given individual to seek medical care. Again, this concept both overlaps SCT and adds additional medical care specific variables not accounted for by Bandura. The Andersen variables include education, occupation, ethnicity, age, gender, social networks, social interactions, and culture, health beliefs, attitudes, values, and the knowledge that people have concerning and toward the health care (Andersen, 1995). I used SCT to characterize the variables of culture, beliefs, attitudes, and values as the framework is, again, better suited to the development and understanding of human cognition. The Anderson model, integrated into the SCT, captured the effects of social risk factors.

Andersen's conceptualization of enabling factors represents the medical counterpart to the SCT concepts of environment and reciprocal determination. Enabling factors are defined as factors that allow individuals or a population to change their behavior or situation, for example, resources (income, health insurance), family, societal and community supporters, access to health care personnel and facilities, and others. The SCT captured those environmental and reciprocal relationships outside the interaction with the medical care or health education systems that influence actual utilization, but the Health Services Utilization Model (HSUM) served to capture those variables that are more specific to accessing health care treatment and self-care management/control relative to hypertension.

Andersen's concept of utilization has no counterpart in the SCT. I used this concept to capture information on the psychosocial assessment of the value and outcome of medical or health education encounters directed toward prevention, diagnosis or self-care management/control of hypertension. These concepts, as outlined, meshed Andersen's health service utilization model (1995) with SCT and granted the opportunity to thoroughly examine both the realities of the African American male perspective within the African American culture and within the conventional medical care and public health care educational and clinical environments (Andersen, 1995). Figure 1 presents a model of these interrelated conceptual frameworks (Source: Andersen, 1995).

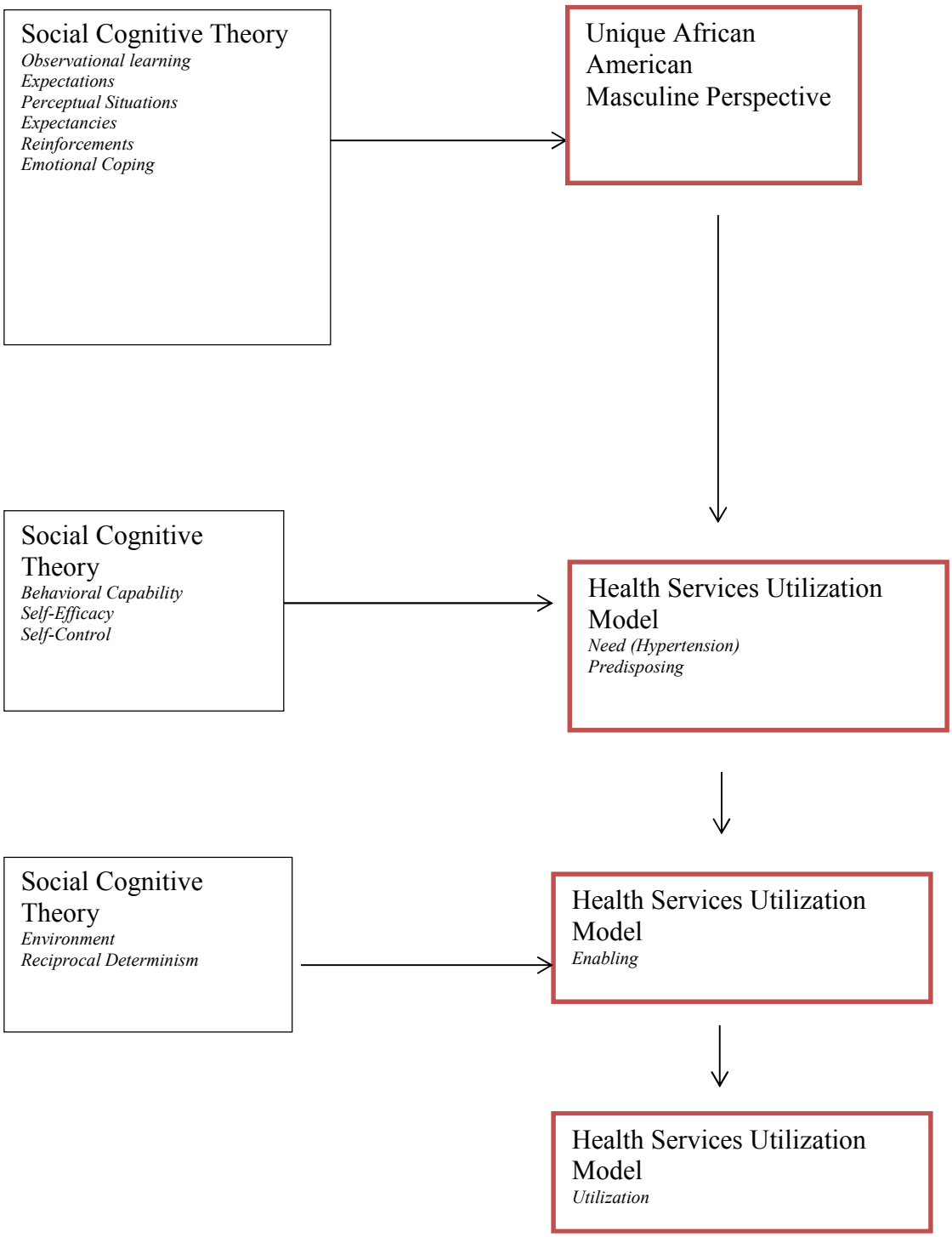

Figure 1 Interrelationship of study conceptual frameworks flowchart.

Nature of the Study

In this qualitative ethnographic study, I assisted in exploring how the views of African American men on masculinity affects self-care management of hypertension. This information helped prove whether there is a correlation between self-care management of hypertension and African American men views of masculinity. I collected data from African American Males who have been diagnosed with clinically significant hypertension. I asked study participants to discuss lived experiences of being African American males living with hypertension. Their responses and perspective granted the opportunity to thoroughly understand the target population's unique thinking patterns regarding masculinity and self-care management/control and points of conflict that could dissuade African American males concerning hypertension. Through these comparisons, in the study process, I was able to detect essential disconnects between the target population and the health care tactics currently used to reach, treat, and ensure compliance with hypertension protocol.

Possible Types and Sources of Information

The study participants were African America Men, ages 40 to 65 years who have been diagnosed with hypertension. I recruited participants from community churches or local male organizations (Masonic Lodges, Fraternity-Alumni Chapters, and All Men Church Ministries) within Wilkinson County Georgia, which consists of six cities: Gordon, Ivy, Irwinton, McIntyre, Toomsboro, and Danville. The presence or absence of a diagnosis of hypertension is an important distinction among study participants, as a labeled illness has been demonstrated to affect both perceptions and behaviors (Calhoun

et al., 2008). One of the goals of this investigation was to determine whether the African American male perspective of masculinity affects hypertension self-care management. The potential exists for other limitations on the final sample, and the literature searched for confounders that can affect inclusion and exclusion criteria. I tape-recorded interview to gather data from the target population.

In this research study, I intended to explore African American males' masculine perspective and its effect on the self-care management of hypertension. This investigation was a qualitative study process in which I conducted interviews to evaluate the psychosocial factors that compose the African American male view of appropriate masculine deportment and encourage study participants to extend and apply that view to the dictates of hypertension prevention, treatment, and self-care management/control.

I conducted in-depth interviews, which consisted of semi structured interview instruments composed of personalized questions and standard questions, in which I aimed to discover new or uncertain survey responses that will connect masculine factors attributed to influencing health decisions about self-care management/control of hypertension. I did not intend for the survey to inform the interview process, but to provide additional data within the analysis phase, just as though the data were sourced elsewhere.

Operational Definition

Following is a compilation of terms and definitions I used throughout this study to gain a more thorough understanding of the research. It is important to know how the research study will operationally define *masculinity* as it relates to African American men

and self-care management/control, specifically their perceptions of hypertension. This information will help determine how the research will capture the theories concepts that are pertinent to overall health overall. According to Griffith, Gunter, and Watkins 2012, "Measures of masculinity tend to categorize masculinity into four key areas: male norms, role conflicts and stressors, masculine conceptions and ideologies, and machismo."

Definitions

African American: Individuals who strongly identify as being non-Hispanic African American.

Blood pressure: *"*Blood forcibly pushing again artery walls as it flows through them" (The American Heritage, 2007)

Hypertension: *"*high blood pressure. A chronic, common asymptomatic to a symptomatic, disorder characterized by a persistently receiving a repeatedly elevated pressure reading that exceeds 140 over 90 mmHg—a systolic pressure above 140 or diastolic pressure over 90" (Mosby, 1994).

Masculinity: Characteristics by or possessing qualities traditionally attributed to men, such as aggressiveness, strength, and boldness.

Self-care management: *"*The education and support offered to people who deal with some form of illness and their families to help them grasp an understanding of the role and responsibility in managing their illness, make informed decisions about care, and engage in healthy behaviors" (Agency for Healthcare Research and Quality, 2016).

Assumptions

I interviewed participants to obtain further information regarding their lived experiences and their perception of masculinity and its association with hypertension-related behaviors primarily self-care management/control. In this study process, I assumed that participants were truthful in the responses that they provide within the interview. I thought that the participants would accurately report that they have been diagnosed with hypertension by a health care provider. I assumed that the social influences of family and friends effected the participants' outlook on masculinity, which can discourage or facilitate hypertension-related behaviors primarily self-care management/control. The assumption that participants' hypertension-related behaviors are associated with their perception of masculinity serves as a foundation for this research study that I conducted.

Scope

In this study, I focused on African American men with hypertension and their views on masculinity. I further explored how their perspectives on hypertension affect self-care management of hypertension. Even though it is evident that hypertension may affect all people regardless of race and or gender, merely being a member of the African American population is a risk factor for hypertension (CDC, 2014). According to the American Heart Association [AHA] (2015), hypertension (HTN) is a significant problem within the black communities, and this is a significant public health concern. Therefore, in this study, I intended to identify whether or not the perspective of masculinity among African American men determines their willingness to engage in self-care management

of hypertension. With this being the focus, in this study I targeted African American men ages 40 to 65 years to interview. I used the American Heart Association standards for hypertension (CDC, 2014) as a guideline in this study.

Limitations

This study was limited to interviews in the rural region of the United States. It may not be representative of a broader population of African American (AA) males. Limitations include not having access to the medical records of those African American participating in the interviews were conducted in English; therefore, only English-speaking African American Men were able to participate in the study.

Significance

This new paradigm will inform further research, and a new perspective of African American males' lived experiences, their views on masculinity, and the intersection with the challenges of prevention, treatment, and self-care management of hypertension. The social significance of the study is to improve health education initiatives targeting African American males to help reduce the documented disparity in diagnosis, treatment, and self-care management/control concerning hypertension. By adequately educating and informing the target population of the different resources that are available within the community can overall assist with improving the incidence of hypertension not only from on an individual level but on a societal level as well. For example, participating in different support groups or different health-related programs (i.e., chronic disease self-management education programs, lifestyle change programs), using health educators or

community health workers that can help share resources and strategies to help manage their chronic conditions, improve their quality of life and lower health costs.

Summary

According to the AHA (2015), approximately one-third of U.S. adults suffer from hypertension and approximately half (54%) of these people with high blood pressure can control their hypertension (Merai et al., 2016). The incidence and prevalence of cardiovascular and renal complications of hypertension are higher than other racial/ethnicity groups. The burden is considerably higher in the African American community, in which the condonation affects 43% of the male population and 45% of the women population (Mozafarian et al., 2015).

In this study, I used interviewers' responses to gain the perspective of African American men views on masculinity and how this perception affects the self-care management of hypertension. The health service utilization model and the social cognitive theory guided this study as I examined the perception masculinity among African American men living with hypertension. I will further discuss in-depth the background information about masculinity and hypertension in Chapter 2.

In Chapter 2, I will explore the study process and various aspects to help explain the social concepts related to masculinity, masculinity ideologies, and help-seeking behaviors among men. In Chapter 3, I will describe the research methodology of the study. I will include an explanation of how I selected participants and how I interviewed them. In Chapter 4, I analyze the interview results, and I will report all data. In Chapter 5, I will summarize an explanation of the findings, and I will make recommendations. In the

discussion, I will provide a breakdown of the information and how it involves social change.

Chapter 2: Literature Review

Chapter Overview

Hypertension is a significant problem Among African Americans because this segment of the populous is inclined toward earlier onset of hypertension and are less responsive with traditional treatments (Viera, Cohen, Madeline-Mitchel, & Sloane, 2008). This literature review consists of numerous subsets that form a dynamic framework, which is intended to aide audiences in identifying the causes and theories that explain the problem. This literature begins synthesizing the issues from a global perspective and then addresses social problems, which may be linked with the issues. I will discuss several theories to lay the foundation for the research question of whether there is a correlation between self-management of hypertension and African American men's views of masculinity.

Following the identification and discussion of the theoretical framework, I will discuss social concepts relative to masculinity, masculine ideologies, and self-management of hypertension among men. I used two conceptual frameworks utilized in this study: the social cognitive theory and health service utilization model. I further outlining differing conceptualizations within the literary review discussing common issues stemming from the subject of masculinity and self-management of hypertension, which then serves as the concluding segment.

Literature Search Strategy

The literature review includes research from several journal articles that encompasses earlier studies regarding African American masculinity and its influence on

self-management as particularly relative to hypertension. I used three primary research databases to include the following sources: EBSCOHost, Emerald, and Proquest databases. Using keywords aides in the identification process of locating articles that discuss findings which have been obtained from the performance of specific research regarding the local study at hand. In this vein, the literature search was conducted using the three databases.

Keywords or phrases used in searching for journal articles that have been sited on the subject included: *African American men and hypertension*, *African American men and hypertension health risks, Gender roles and help-seeking behaviors, African American men and health behaviors barriers, African American men and health promotion initiatives and African American men and self-management*. Where fewer articles were available or identified, the Google search engine was also used to recoup various other journal articles.

Introduction to Men's Health, African Americans' Health, and Masculinity

In the United States, African American men suffer more health-related illnesses and have continuously higher rates of death when matched with other groups of people. Whiteman (2014), in the *Medical News Today* newsletter, stated that

> Life expectancy in the US reaches record high" reported that current statistics show the age-adjusted death rate declined by 1.2% in 2011-12 for non-Hispanic white males, while non-Hispanic African American males saw a 1.1% reduction. African American men's life expectancy is reduced by 6.4 years when matched

with European American men. For European American men, the life expectancy is 75 years, while for African American men the expectancy is 68.6 years. Generally, African American men undergo earlier onset of disease, higher complication rates, and more restricted medical care access as opposed to European American men. Differences in gender in health-related behaviors and attitudes may partially add to health outcome differences (Pleck & O'Donnell, 2001).

Levant, Wimer, Williams, Smalley, and Noronha (2009) researched a total of 385 men between the ages of 18 and 25 years to examine whether specific dimensions of masculinity are associated with psychological help-seeking. This research proved that morbidity differences are somewhat more intricate when analyzing men. An examination of two sets of data from Britain identified health differences as it relates to sex distinctions. These differences occurred concerning the specific health problem being evaluated and with regard, to the life cycle stage of men. Within the US, unintentional injuries, terminal disease, chronic conditions, and infectious diseases all have a higher prevalence rate amongst men than women (Verbrugge & Wingard, 1987). These high morbidity and mortality rates may emerge from men actively participating in more risky practices and having poorer health lifestyle choices than women.

Prevention of Hypertension Among African Americans

According to the American Heart Association (AHA, 2016), the incidence of hypertension within the African-American population is the highest in the world. Currently, there is no proof of a clinically distinctive inherited variant connected to the prevalence of hypertension in African American males and females. In addition to

genetic factors, socio-environmental and lifestyle factors also play a significant role in understanding hypertension in African American males. For example, engaging in an unhealthy lifestyle (using tobacco, lack of physical activity, adapting unhealthy eating habits that consist of high saturated fats, sugars and or salts), social environment (where you live, job, income, education, etc.,) and DNA, genetic make-up, hereditary determinants (family history shares genes, behaviors, and lifestyles) are all contributing factors that high levels of hypertension within the African American community.

Per Kennedy, Mathis, and Woods (2007), self-management areas for prevention and control consist of reduced dietary sodium and saturated fat, no tobacco use, limited alcohol intake, augmented physical activity and weight control. African Americans demonstrate many challenges in attaining these lifestyle changes. The obesity prevalence (both second and third classes) among all racial groups has been identified as highest in both males and females of African American descent. Complicating the issue of weight is the fact that an estimated 27% of African American males are physically inactive (Musa et al., 2009).

Men's Health and Masculinity Ideology

Per Fischer and Farina (1995), early biological research on sex comparison has signified that girls and boys are socialized to construe physical symptoms in different manners. This research agrees with the literature on masculinity and men which means the ideology of men's masculinity and the normative masculinity prescriptions affect the health behaviors of humans. Elements such as social context, sexual orientation, educational degree, economic status, and ethnicity influence the kind of masculinity

constructed by men and add into the discrepancy risk of health among US men (Lewis, Simon, Uzzell, Howitz, & Casserly, 2010).

Masculine ideology refers to how men accept how culture defines masculinity and the beliefs about obedience to the standards cultural has defined as "male behaviors" (Pleck, Sonenstein, & Ku, 1993). The larger part of masculine ideology research has centered on what has been signified as "conventional" masculinity ideology. Nevertheless, masculinity not only limits men from demonstrating behavior signs or thoughts that may resemble the role of the female, but it also involves a broad range of specific self-perceptions and behaviors to which men strongly abide by (Jarett, Bellamy & Adeyemi, 2007). For instance, traditional masculinity involves traits as restricted affectionate behavior, limited emotionality, sexual and physical violence, competitiveness, and homophobia between men.

Fischer and Farina (1995) explained how limited research had examined the correlation between health-related behaviors and attitudes and masculinity ideology in African American males. In their research study on healthcare compliance, these researchers identified that men of African American descent were more focused on not wanting to seem weak and having and displaying masculine pride, which affected decisions regarding seeking assistance both from friends and family, as well as from professionals. Research studies have evaluated the effect of the ideology of masculinity on the health behaviors of young men (Jarrett, Bellamy & Adeyemi, 2007). The control of a range of psychosocial aspects in these studies leads to the emergence of traditional masculinity as the most powerful determinant of a behavior style or one of taking risks.

Additionally, numerous features were linked with the ideology of conventional masculinity; these aspects consisted of African American ethnicity, lower family income, and lower educational levels.

Per Wade and Rochlen (2012) Per Baldwin and Bell (1985), the research literature proposes that men may try to validate their masculinity by risk-taking practices that result in adverse negative health issues. For African Americans, gender roles are trivialized leading to permissible mainstream methods used to endorse gender roles among men - risk-taking actions imply that these kinds of males can try to ascertain themselves as men. Gender roles are distinct from the African American community dating back to slavery. Where African Americans where in some ways taught that their lives weren't as worthy as others. Black women were only useful for their ability to reproduce whereas men were just as useful as the work that they could do out in the fields. The traditional ideology of masculinity endorses those health-related behaviors and attitudes that threaten the health of men (Jarrett, Bellamy & Adeyemi, 2007).

The Relationship between Health Behaviors and Masculinity

As previously stated, masculinity itself can be of threat to the health of the male gender. This statement aligns with the social perspective of health and masculinity. From the viewpoint of public health, it is significant to evaluate this probability. Most of the time, men use health behaviors within their daily routines to help them convey social power and social status, and these health practices can either undermine or promote health (Griffith et al., 2016). Millar and Houska (2007) explained that there was a large pool of research that revealed the links between health behaviors, masculinity variables,

and attitudes directed toward the treatment of mental disorders. It is vital to review specific literature to interpret the connection between health behaviors and masculinity variables, to recognize the areas where there are knowledge gaps. Additional documentation should also be investigated to address the association between masculinity and attitudes towards requesting medical and psychosomatic help.

When conducting a study to determine if there is a connection between health behaviors and masculinity, researchers have applied several measures connected to the different dimensions of conventional masculinity. These facets consist of gender role conflict, gender role stress, conformity to masculinity beliefs, and traditional masculinity ideology (Millar & Houska 2007). Each aspect has a somehow different focus, although all are founded on the social constructionist perception of masculinity that stresses how gender is culturally and socially (compared with biologically) established and spread. Hence, the literature focus is not the link between men's health interest differences and biological sex, but instead of gender-socialized prototypes of relationship to health and behavior.

Traditional Masculinity Ideology

Researchers have found that characteristics and behaviors are linked to conventional masculinity types of social belief systems: a philosophy concerns the anticipations of the character of men (Fischer & Farina, 1995). The philosophy affects the process of behavior, feeling, and thinking of adults in gender-salient issues about overall positive health and well-being. For instance, a fundamental dimension of the traditional ideology of masculinity is the limitations placed on the expression of emotions.

Supporting this philosophy would lead to the emergence of universal intellectual versus emotional convictions - for instance, men must never publicly show their feelings or cry. Individuals may differ in the level at which they embrace these convictions, and hence, masculinity ideology measures evaluate these differences.

Still, from these research studies, men who supported conventional ideologies of masculinity have been identified as persons who partake in increased use of substances, including tobacco, alcohol, and illegal drugs (Pleck & O'Donnell, 2001). Furthermore, the men who were reported to score higher on the Male Role Attitude Scale were more inclined to participate in increasingly risky sexual behaviors consisting of condom use failure. Men who supported traditional ideologies of masculinity were also identified as having an aptitude to experience increased levels of anger and stress.

Masculinity Theories and their Inferences for Health

Biological Masculinity

Generally, masculinity is understood as the superficial appearances of being a male biologically - this implies that men's 'gender' and their general characteristics and behaviors are correlated with their 'biological sex' (Austin, Carter & Vaux, 1990). This factor alone has a propensity for taking on two associated structures in men's health discussions. The primary discussion connects to the fragility of men genetically giving way to their inclination to poorer health results owing to their XY genetic arrangement or in the very least, the 'Y' component of it. Owing to this, scientists emphasize that the male fetus during pregnancy is at a more significant threat of damage or death from all obstetric misfortunes that can take place before birth. They also postulate the

physiological and anatomical diversities that render a developmental disadvantage to newborn males ranging from four to six weeks when matched with their female counterparts (Millar & Houska, 2007).

Research continues to emphasize that male mortality in the current age surpasses female mortality all through life, connecting 'pre-existing biological weaknesses' to multifaceted social-cultural features. Per Millar and Houska (2007), the second discussion develops on this notion, although it takes a slightly different approach. Instead of social-cultural aspects complicating biological inclination within socio-biology, 'actions' themselves are perceived as biologically compelled. The Y chromosome, as well as associated hormonal pressures (mainly testosterone), is identified as initiating a force towards certain male behaviors. Some of these behaviors have been defined as sexual promiscuity, being territorial, and hunter (breadwinner), which are idioms of evolutionary structures devised to guarantee species survival and the reproduction of the most dynamic genetic pool (Millar & Houska, 2007). Societies (comprising of gender relations) have evolved as an element of this evolutionary structure intended to channel or restrain the worst aspects of these characters from building expressions of them that are more constructive.

Moynihan (1988) identifies that the way men are, or masculinity is, hence, perceived, as an outcome of hormonal/genetic evolutionary processes. Additionally, it is unusual to find this method of modeling masculinity as a sole or single description to explain the current state of men's health overall. However, humorous delineations have been given in a bid to propose that it is frequently implicitly present in the media and

health professionals' explanations of "men's health." A qualitative research study was conducted to identified different health professionals' explaining their perceptions of masculinity where a respondent identified that:

> But while men leave their customary Saturday afternoon beer-swilling and shin-kicking in support of a warm neighborhood center, a group discourse on better foreskin sanitation and a slice of cake? It is highly unlikely. Foolhardiness and aggression are born on the Y chromosome, which means that there is nothing that can be done about it. (Austin, Carter & Vaux, 1990, Pg., 237-244)

Still, controversial questioning has arisen as to whether there is a broad range of health variations that exist between men and women, and the health differentiations between men of diverse geographical regions, social classes, and ethnic groups (Riska, 2006). These variations can be justified only in this constrained biomedical method. Furthermore, viewing such modifications as necessary and predetermined in this method leaves little to no probability for positively reinforced change.

Role Theories and Models of Masculinity'

Sociological and psychological work have inquired these biological-determinist Explanations for a human character, and an early substitute Explanation for comprehending human character in the contemporary society (Pleck & O'Donnell, 2001). This information consists of the variation of characters between the two sexes emerging from the 'role of theory.' A hypothesis adopted by the role concept is that societal expectations regarding an individual's status in the community generate compliance with a specified role and its connected functions. Satisfying these roles has been endorsed

through a variety of explicit or implicit sanctions and rewards that are utilized to allow conformity.

Per Pleck and O'Donnell (2001), challenges nevertheless arise when specific social responsibilities cannot be or are not being fulfilled. For instance, the male sector of society may anticipate that a fundamental element of men's trust is to be an economic provider or the breadwinner for his family. If this perception becomes domesticized by a specific man who may be unemployed, the element of Male Gender Role Strain then becomes its outcome. Hence, the higher the domestication of cultural standards of masculinity responsibilities for a person, the superior the responsibility strains experienced in situations where the individual cannot live up to these stereotypical cultural norms.

This theory is mainly conveyed in the strong expression using two methods that generate a second connection for men. Initially, there is the notion that compliance with conventional male responsibilities is damaging to his health. Prolonged hours, risk-taking, and pressure to succeed among others can generate physical and psychological ill health. Subsequently, the failure to achieve these high-pressure expectations and roles causes strains and pressures that can lead to stress and associated symptoms and feelings of failure (Austin, Carter & Vaux, 1990). The notion of comprehending masculinity using the sex role theory, as well as the constructs of psychological masculinity measures, to evaluate this currently has resulted in a considerable amount of negative impartial criticism. The discussion below outlines some objections attributed to explanations of masculinity regarding the role theory.

Role Theory Criticisms

a. They are Unreservedly Homogenizing

Pleck and O'Donnell (2001) identify that sex roles have been determined to be deficient in historical outlook and, hence, comprehending change. Individuals are recognized as empty vessels during birth that goes through socialization in different ways, or not. In this process, men become homogenized to formulate a standardized perception of masculinity.

b. They Fail to Connect with Power Issues

The center on 'variation' in responsibilities laid the gradations that take place in gender associations that function within power systems (Levant et al., 2009). The multifaceted mechanisms of gender identity, both at the individual and social levels, vanish in sex-role concept, as general opinions regarding 'variation' substitute the concrete, shifting relationship of power between women and men.

c. They Polarize matters through the enhancement of sex variations

In lack of sufficiently dividing biological gender and sex, they are still a significant thinking manner that generates fixed and rigid perceptions concerning gender(sex) variations. As some researchers' outline, sex responsibilities are delineated as reciprocal; polarization acts as an essential element of the theory (Levant et al., 2009). It, consequently, becomes challenging to investigate gender relations in cases where these roles are presented as opposing ends of a scale. This means that the polarization (sex differences and the concentration on differences) aids in confusing other significant identity issues, for instance, race and class.

d. They Disregard framework at the Micro-level

The concentration on the macro elements of socialization decreases the capability to consider subjects of agency and structure within individual encounters. For instance, there is a failure to investigate further the barriers that health service structures or health professionals may present to men's access to them (Robertson, 2009). This means that the micro-level (individual) reasoning's as to why men (not speaking for all) chose to seek professional help are neglected and often time overlooked.

Rational Masculinity Models

Masculinities are perceived as patterns of social processes that are arranged and ordered using specific methods. Significantly, there are masculinity practice sets that are categorized regarding women. Connell (2005) identifies this as hegemonic kind with other sets of practices of masculinity become marginalized from or subordinated to, these more appreciated hegemonic behaviors (Millar & Houska, 2007). This way, gender practice configurations, consisting of masculinities, can be comprehended as natural behaviors that are also prone to transformation in differing or new situations.

Masculinity is, thus, not a personality type or character trait instead that men hold in lesser or greater amounts from their female counterparts. Instead, masculinities are comprehended as being contingent historically, although not necessarily ascertained social actions that are fluid, although, hierarchically arranged with dominant configurations acting cooperatively. Millar and Houska, (2007) add that these traits then become integrated into the social framework of communities and, therefore, replicate themselves. Regarding health, it becomes evident that the method that power shifts within

these differed sets of gendered, social practices influence well-being and health. Per research, a gender relations advance is one that suggests that women's and men's relationships with others, including the situations under which they relate add considerably to health constraints and opportunities (Millar & Houska, 2007).

Compliance to Masculine Norms

Pleck and O'Donnell (2001) confirmed that conventional ideologies of masculinity delineate the standard behavioral patterns and norms linked to traditional masculinity. Those who support these norms are more prone to comply with them. For instance, a man who supports the conventional ideology of masculinity that constrains emotions are more inclined to abide by the norm of not revealing his feelings or vulnerabilities during discussions with others. As identified in ideologies of masculinity, there was a valid link established between alcohol and tobacco use as it relates to masculine norms (Pleck & O'Donnell, 2001). A relationship between binge drinking, marijuana use, and conformity to these norms was also identified in other studies (Pleck & O'Donnell, 2001). Men who were found to show high scores on a compliance measure were also more inclined to account for violent behavior (Pleck & O'Donnell, 2001). Ultimately, responses to a health risk measure were identified as being associated with complying with typical gender roles of masculinity.

The stress of Masculine Gender Roles

Gender role stress implies stress that individuals experience when they can't live up to the roles given to their gender (Lommers-Johnson, 2016). This stress is connected to Gender Role Ideology. Researchers have suggested the endorsement of a man to

traditional ideologies of masculinity can influence his perceptions and appraisals of events. For instance, restraining emotions is vital when aligning to conventional masculinity ideology. Being seen crying can be very worrying to a man who embraces a traditional perception of masculinity. Gender role stress on predicted masculinity augmented feelings and expressions of hostility, anxiety, and anger. Gender role stress on masculinity was also displayed as being established to relate with failing to participate in health-promoting practices and with dangerous health habits.

A study was conducted on the association between blood pressure reactivity and scores on gender role stress on masculinity, where men were subjected to the cold pressor examination were given either masculine challenge instructions or neutral instructions. The neutral instructions involved were merely offering physiological data (Fischer & Farina, 1995). On the other hand, the challenge instructions on masculinity involved being instructed to submit their hands in water that was cold to measure the ability to survive pain, endurance, and strength. For the men involved in the challenge group for masculinity, large reactivity differences were found. In these tests, the men who scored highest showed greater reactivity, including an increase in BP levels. No distinctions were identified among men who were placed in the placebo group with neutral instructions.

Gender Role Conflict

Per Pleck and O'Donnell (2001), the GRCS (Gender Role Conflict Scale) has been employed most habitually in studies that are inclined to addressing the issues of gender roles in society. The researchers could investigate four specific forms of conflict

which included those between family and work, disputes with the restrictive affectionate conduct of men, restrictive emotionality, and conflicts with the drive for competition, power, and success. According to O'Neil (1981a):

> Conventional male role socialization provides unrealistic and contradictory messages causing internal chaos. It may also result in other negative consequences. Men who attempt to fulfill the expectations of the male gender role, which are both restrictive (e.g., boys don't cry) and contradictory (e.g., be a successful economic provider, but also an involved, sensitive father.), experience high levels of conflict (O'Neil, Helms, Gable, David, & Wrightsman, 1986). O'Neil (1981b) stated that men with higher levels of gender role conflict would have issues with identifying certain feelings, intimacy, and self-disclosure. O'Neil (1981a) stated that there are two likely outcomes when gender conflict ascends and that's, the man will either conform to the cultural norms, or he will deviate from those social constructs. Either outcome will have adverse effects on the man.

O'neil and Denke (2016) suggest that Gender Role Conflict arises within diverse psychological settings: cognitive (thinking about gender roles), behavioral (acting in ways that support gender roles but harm the self or others), emotion (adverse effect resulting from gratifying or failing to exemplify gender role norms) and unconscious (actions and thoughts that are not deliberately articulated). Searching for psychological assistance has been acknowledged as connecting negatively to restrictive emotionality, competition, restrictive affectionate behavior among men, and drive for success (O'Neil,

1981b). If men avoid these "feminine" behaviors, it becomes tough to establish a more intimate and personal relationship with women, but it is even harder to develop this relationship with men due to homophobia (O'Neil, 1981b). Overall, regression analyses signify that only restrictive emotionality and the drive for competition, power, and success predicted adverse perceptions toward seeking psychological assistance (Levant et al., 2009). Conflict in gender roles was also identified to be linked with the Barriers to Help-Seeking Scale (BHSS), which presents as another standard of evaluating attitudes directed toward seeking psychological help (Riska, 2006).

Multiple Measures

Riska (2006) identifies that support of conventional masculinity ideology, compliance to masculine role customs, gender role conflict, and gender role stress have been investigated together concerning the prediction of unsafe health practices. Research studies continue to show that greater support of traditional ideologies of masculinity was linked with increased consumption of alcohol. Higher levels of stressing on masculine gender roles were connected to risk problems related to alcohol. Significant relationships were identified amongst conformity to masculine norms, aggression, and gender-role conflict as a moderating impact of gender-role clashes on the association between aggression and conformity (Levant et al., 2009). Compliance with masculine norms linked adversely with life fulfillment, and conflicts in gender roles connected, negatively with the viewpoint of environmental obstacles to effective community functioning.

Masculinity and Attitudes directed towards Seeking Help

Masculinity negatively impacts attitudes toward help-seeking and decreases help-seeking (Mahalik, Good, & Englar-Carlson, 2003). In most cases, men reject healthy behaviors and healthcare to validate their masculinity (Cole, 2013). When examining the relationship between attitudes toward seeking psychological assistance and masculinity variables, studies have used principles of traditional masculinity ideology, conformity to masculine customs, and gender role conflicts to show the actual connection (Riska, 2006). Men who have traditional views or beliefs about masculinity are less likely to report negative symptoms, accept physical examinations, and more likely to be diagnosed at later stages of disease (Evans et al., 2011). Research also indicates that most men may feel that asking for help or seeking any form of support is viewed as "unmanly behavior" (Davis et al., 2000). If men do decide to reach out and seek help, they are then forced to then reject societal expectations of masculinity (Cole, 2013). The ability to understand why men are willing to seek professional help may help enhance the professional's ability to reach those men who avoid seeking this form of support.

Masculinities and Men Conceptualizing Health

How men conceptualize masculinity, is an essential factor of men's health related to decisions and it's one of the strongest predictors of men's health behaviors (Griffith, 2012). Most men do not think about their health often until something happens and the poor health decisions impairs some part of their lives (i.e., sexual relationships, employment, physical activity) or their roles (i.e., provider, father, significant other) that defined their manhood is questioned by their families, friends, and communities (Griffith,

2012). Robertson (2006) found that men's definition of health may be influenced by their thoughts on what it means to be a man and the roles a man should have within their family and their community. Robertson (2006) found that men associated their perception of health to their overall lifestyle and well-being (i.e., drinking and eating in moderation) and the ability to fulfill roles that society views as necessary (i.e., provider, partner, father). Some men have conceptualized being "healthy" as being able to achieve those roles that society view as appropriate, such as maintaining a job, providing for the family, protecting and teaching their kids, and begin a part of a social network (Griffith, 2012).

Conceptual Framework

Social Cognitive Theory Origin

The roots of Social Cognitive Theory (SCT) are to be found in the learning theories associated with psychological behaviorism, that school of psychological thought that focuses on the obvious environmental influences that drive measurable behavior (Staats, 1994). Early behaviorism focused on understanding stimulus-response behaviors as exemplified by Pavolv's classical conditioning trials where dogs eventually begin to associate the sound of a dinner bell with the act of being fed. Conditioned dogs spontaneously responded to the sound of the neutral stimulus of the dinner bell as though it was identical with the unconditioned stimulus of food, by salivating at the sound of the bell (Pavlov, 1897). These experiments were interpreted as the dogs, having learned that the bell signaled the arrival of food, responded to the bell by displaying the same behavior they would have exhibited upon the arrival of food. This transfer of behavior

from a natural environmental trigger to a paired neutral stimulus was termed as a conditioned response (Pavlov, 1927).

The work of Pavlov was extended by Thorndike and Skinner, both of whom studied the motivating forces of reinforcement and developed the operant conditioning perspective on learning and behavior (Skinner, 1938). Thorndike (1911) introduced the law of effect in which he summed up his research as demonstrating that behavior is most likely to be repeated if it is associated with a pleasant or valued outcome. Skinner's work (1948, 1953, 1961), extended Thorndike's work by demonstrating that behavioral repetition can be motivated by the association that something good will happen, or that something wrong will not happen if a given behavior is repeated under similar circumstances.

The former behavioral association is termed positive reinforcement while the latter association is termed negative reinforcement. Skinner (1961) also experimented with the effect of different patterns of reinforcement on the strength of a behavioral response. Skinner noted that continuous reinforcement, either receiving the anticipated positive outcome or experiencing the lack of adverse outcome every time behavior was repeated, led to the fastest learning curve. While intermittent reinforcement, experiencing the positive or absence of an adverse outcome, only part of the time when the behavior was repeated led to the most enduring stimulus-response behavior; a response association that was difficult to extinguish because the possibility always existed that at any given time the trigger behavior would lead to the valued outcome (Skinner, 1956).

Bandura's early research into learning theory followed in the stimulus-response paradigm of operant conditioning that conceived of all human learning as directly shaped by environmental associations. In Bandura's Bobo doll studies, children either watched a live adult or a videotape of an adult pummeling and yelling at a large inflated clown-like Bobo doll, were more likely to replicate aggressive behavior toward that same doll than children who had not seen the modeled behavior (Bandura, Ross, and Ross, 1961). Bandura termed this form of learning as observational learning and interpreted it as evidence that humans are capable of learning within the social context, as well as in the absence of an obvious reward. This observation marked the beginning of Bandura's movement away from operant conditioning and toward a broader, more complex theory of human learning (Chance, 2009).

Bandura's theoretical interpretation of his research findings begins the development of social learning theory (SLT), the earliest iteration of which relied heavily on concepts from the field of learning theory. These concepts integrated into a framework consistent with his findings on observational learning. The four major SLT concepts of this early model are presented in Table 1.

Table 1

Concepts of SLT

Differential associations	Direct association and interaction with others who engage in certain kinds of behavior or express norms, values, and attitudes supportive of such behavior, as well as the long association and identification with more distant reference groups (family and friends) (Bandura, 1977).
Definitions	An individual's orientation, justifications, attitudes, excuses, and rationalizations that delineate the performance of an act as moderately better or bad, appropriate or inappropriate, justified or unjustified, or right or wrong (religion, moral, and values) (Bandura, 1977).
Differential reinforcement:	The balance of anticipated actual rewards and punishments that follow or are consequences of behavior (Bandura, 1977).
Imitation:	The engagement in behavior after the direct or indirect observation of similar behavior by others (media depictions) (Bandura, 1977).

Per early SLT studies, the learner observes the behavior of others and attaches social meaning to those behaviors through the psychosocial support, or lack of support, by significant others (Differential Association). Further, the learner defines the correctness of the behavior relative to a personal moral code (Definitions). Additionally, the learner observes the rewards or punishments reaped by others who engage in the behavior (Differential Reinforcement). Finally, choosing to imitate the behavior based on the assessment of its social desirability, moral implications, and valued outcomes (imitation) (Bandura, 1977). Imitation became synonymous with observational learning in SLT.

Throughout the 1960s' and 1970s, Bandura continued to extend and refine the SLT by drawing inspiration from psychologists who examined the context and structure of decision making and information processing in the context of learning. Two influential studies were Wolfgang Kohler's investigation into problem-solving in chimpanzees (Rock & Palmer, 1990) and Edward Tolman's study of unreinforced learning in rats (Tolman & Honzik, 1930). Kohler (1925) developed a problem-solving scenario for which a banana was placed just beyond the reach of a caged chimpanzee, and a stick was placed within arm's reach. The chimp first participated in several trial and error attempts to reach the banana by hand, but when these attempts failed the chimpanzee stopped and considered the situation. The chimp appeared to realize the connection between the sick and the goal and used the stick to move the banana close enough to reach it through the bars. Kohler judged that the chimpanzee solved the problem through a flash of insight that was neither dependent on previous trial and error learning, nor on observing behavior modeling by another chimpanzee. Instead, the chimpanzee was motivated to develop a novel solution to reach the end-state goal (Kohler, 1925).

Tolman and Honzik's (1930) maze experiments examined the behavior of rats placed in a maze for the sole purpose of meandering around the layout. Once the rats had had time to explore the maze, Tolman and Honzik begin setting a food reward at the end of the mazes. Once the tortuous rats received the reward (food), they quickly moved through the maze on each subsequent trial to get the food, demonstrating that they had learned the layout of the maze during their unmotivated explorations. Tolman inferred that the rats had formed a mental representation of the maze that he termed a cognitive

map (also known as latent learning) but did not demonstrate this knowledge until they were motivated to use what they had learned (Tolman & Honzik, 1930). Tolman called this phenomenon latent learning (Tolman & Honzik, 1930).

Bandura applied these findings to his framework by noting that observational learning does not require imitation, but instead it can be a product of an encoded symbolic representation of the observed behavior stored in memory and integrated into existing knowledge. Research further solidifies the behavior in memory, so it can be drawn upon when needed. Bandura (1977) explains even further that the integration of encoded behavior with existing knowledge forms the basis of novel applications of learning. Per Bandura (1977), if everyone would learn through and from trial and error, there would be no need to understand the need for human survival. Consequently, Bandura came to view learning as both constructed and vicarious (Bandura, 1997).

As Bandura continued to refine his framework, he established a four-component process: Attention, Retention, Production, and Motivation, by which observational learning takes, place (Bandura 1977). This process is presented in Table 2.

Table 2

The Component Process Underlying Observational Learning

Attention	The observation of the molded behavior, determined by a variety of variables, including the power and attractiveness of the model as well as the conditions under behavior is viewed.
Retention	The learner must be able to remember the details of the behavior.
Production	Involves repeating the desired behavior.
Motivation	Without motivation, there will be no desire to learn or continue the behavior. Aspects of operant conditioning come into play. Reinforcements and punishments help guide the modeling process. Reinforcements increase the likelihood of behavior while punishment decreases the probability of the behavior. Motivation makes learning difficult tasks more likely (Van Wagner, 2010).

Bandura developed the concept of self-efficacy to account for evidence of human agency across the literature (Bandura 1977). Self-efficacy is the confidence that a person can achieve a goal by successfully performing a given behavior. As Bandura's interest in self-regulative capacities and self-efficacy grew, he became more and more distant from the original anti-cognitive stance of the behaviorist tradition (Bandura, 1986). Bandura continued his conceptual development of human agency in which observational learning is but one component of an interactive cycle of self-reflection and self-regulation in which the individual assigns meaning to goals and behaviors based on perceived capabilities and socio-environmental influences (Bandura, 1986). In the end, Bandura

states in the introduction section of his 1986 research, *Social Foundation of Thought and Action: A Social-Cognitive Theory,* that his model had evolved to include concepts from the growing body of motivational and cognitive knowledge. Subsequently, he relabeled his findings as a social cognitive theory.

Social Cognitive Theory

Social Cognitive Theory (SCT) states that an individual's behavior is an outcome of complex interactions between individual characteristics, the environment, and situational contingencies (Bandura 1995). As said before, in SCT, Bandura considers people as both the products and producers of their perceived environment. Individuals affect the nature of their old environment through the selection and creation of situations reflective of their acquired preferences and competencies (Bandura, 1995). Given the complexity of the proposed interactions, Bandura does not impose directional linkages on SCT. Instead, the theory is subdivided into the eleven essential concepts presented in Table 3.

Table 3

Social Cognitive Theory Concepts

Reciprocal determinism	Broad assumption that acknowledges behavior is dynamic and is consequences of continuous interaction between the person, past events, and the current environment.
Environments and situation	The setting is composed of the social environment (i.e., family, friends, peers at work, or in the classroom and the physical environment). *Situation* refers to the person's perception of the environment.
Observational learning	Occurs when a person watches other people's behaviors and the reinforcements associated with those behaviors.
Behavioral capability	An individual's attainment of the knowledge and skills necessary to carry out a behavior. If a person is to perform a behavior, he or she must know what the behavior is (knowledge of the behavior) and have the skills to achieve it.
Reinforcement	Responses which either increases or decreases the probability that a person will repeat a behavior.
Incentive motivation	The use and misuse of rewards and punishments to modify behavior
Outcome expectations	Expectations guides behavior. It is the values a person places on a particular outcome. A person learns that specific outcomes occur in a given situation and expects them to happen when the situation presents itself again, and the person performs. Expectations are learned in four ways: Performance attainment, Vicarious experience, and hearing from other or social persuasion, physiological arousal.
Facilitation	Providing tools, resources, or environmental changes that make new behaviors more comfortable to perform.
Self-efficacy	An essential prerequisite for behavior change. It's the confidence a person feels performing a particular activity.

Self-control of performance (self-regulation)	The key is the ability of individuals to engage in behavior to achieve a goal: Goal-setting. Planning. Monitoring tasks that an individual use to achieve behavior change Excessive emotional arousal inhibits learning. (*table continues*)
Management of emotional arousal	Moral disengagement: Ways of thinking about harmful behaviors and the people who are harmed that make the infliction of suffering acceptable by disengaging self-regulatory moral standards.

Researchers have used SCT to conceptualize and understand the human thought process and ensuing behavior. The theory has also been used to achieve behavior change and develop health behavior interventions (Bandura, 2001). Both applications of SCT have relevance to this investigation. The recent literature in each of these application areas is presented below.

SCT and Cognitive Constraints

Griffith, King, and Allen (2012) investigated the influence of male peers on senior men's motivation to partake in physical activity (PA) specifically within the African American population. Using SCT, the researchers determined that African American Males viewed their motivation to engage in PA as a reflection of social support and modeling behaviors of their peers rather than a reflection of personal agency (Griffith, King, & Allen, 2012). Team sports or male exercise partners were cited as primary motivators. The men also cited the influence of the social setting as potentially motivating. Men who frequented environments in which the other men made fitness a priority were driven to improve their fitness level even if it meant engaging in an individual fitness regimen while in the company of other men involved in the same pursuit. The older study population interpreted their decline in physical activity in their

later years as a function of the change in their social circumstances. Study participants noted that they were no longer surrounded by men engaging in age-appropriate physical activity and they felt little motivation to participate in the exercise as a solitary activity. The researchers interpreted their findings as evidence that African American men associate health regarding a social environment to include their communities, families and social and cultural roles (Griffith, King, and Allen, 2012).

Ferrari, Robinson, and Yasnitsky (2010) conducted a historical review of influential frameworks dedicated to unifying the biological, social, and cultural facets of human consciousness. This practical angle proved that social development could be defined as the process of shaping human behaviors at a much broader spectrum, to achieve more profound results while enhancing the utilization of human awareness. The independent research and conceptual modeling of Wilhelm Wundt, Lev Vygotsky, and Albert Bandura (Ferrari, Robinson & Yasnitsky (2010)) were compared and contrasted to highlight the recurring failure of reductionist biology to explain the complexities of human awareness adequately. Bandura's SCT was examined for its unique genesis in the reductionist field of behaviorism and its evolution into a framework acknowledging the personal agency and the reciprocal interaction between humans and their social environment. The current value of Bandura's SCT is interpreted as clarifying human consciousness as an emergent process that defies attempts to cast humankind as little more than the total of the biochemical routines and sub-routines encoded in the brain. Bandura directs our attention to the human capacity to self-direct and self- regulate despite environmental and biological constraints. This precept of the SCT underlies both

its popularity and usefulness among those attempting to understand and modify health behaviors.

Bandura (2001) conducted a thorough investigation, researching Social Cognitive Theory and how it distinguishes amongst three identified modes of agency: personal, proxy and collecting. Personal agency is trained personally, and in this method, a person affects what he or she can control directly. A proxy agency is an indirect influence, people depend on others to do the work from them to secure desired outcomes, and collective agency is enacted when likeminded people who share common beliefs act as one to produce effects by collective actions. The research enabled Bandura (2001) to reveal how SCT approves the dominant role of mature elements in human changes and adaptation, which develops information processing structures that offer the capability for attributes that are uniquely human (symbolic communication, reflective self-consciousness, evaluative self-regulation, forethought, and generative symbolization).

Strachan and Brawley (2008) investigation reviewed the correlation between Identity and Social Cognitive Theories. This research focused on identity and suggested that individualities may be the active role in comprehending health behavior guideline. This study displayed the role of self as being the psychological tool that allows organisms to think intentionally about themselves (Contrada & Ashmore, 1999). Strachan and Brawley (2008) explain that SCT (Bandura, 1997) adds to the Identity theory by hypothesizing and measuring a few social insights that allegedly motivates the self-regulatory procedures which impact individuals to self-regulate.

Christy, Mosher, and Rawl, (2013) investigation reviewed how masculinity and gender role conflict influences health promoting and risk behaviors which overall helps understand Colorectal Cancer (CRC) screening behaviors in men. The researchers applied SCT to study CRC screening in men, which reveals that masculinity norms and health care behaviors, attributes to why men tend to avoid expressing thoughts and behaviors that may be thought of as "feminine." This investigation helps to understand why men view certain health care screenings as challenging masculinity norms and their overall health-related experience.

Janicke and Finney (2003) conducted a study to assess social cognitive influences parent-decision making processes regarding children's health care use. The researchers analyzed parent's stress and self-efficacy as critical variables in parent's decision making to use pediatric primary care. The research investigation proved that with self-efficacy being a vital factor that contributed to the parent's stress, there was a correlation between Social Cognitive theory and its influence on health care use. This element of SCT helps to understand how incorporating Self-efficacy can help focus on one's thought process that can ultimately shape a person's future behavior.

SCT and Health Promotion

Georgiadis (2013) research utilized SCT to increase self-efficacy through demonstrating as opposed to telling the marked audience the mechanism for requesting action, affecting attitudes towards obesity, and eventually motivating change in behaviors. The author analyzed how health messages, communicated through consistent trendy campaigns, for a specific target audience, motive and impact some form of change

in the intended behavior. The Let's Move! Campaign is an example of showing instead of telling. The Let's Move! Campaign focused on childhood obesity and the promotion of youth engaging in physical activity as an even more pressing priority (Huhman, Potter, Duke, Judkins, Heitzler & Wong, 2007). Results disclosed noticeably decreased rates in the incidence of obesity which aligned with the awareness and education provided through the campaign. This research suggests that increasing self-efficacy through SCT can influence the health behavior intended to change.

Hooker, Harmon, Burroughs, Rheaume, and Wilcox (2011), investigated the desire to promote physical activity (PA) for midlife and older men within the African America (AA) population. The overall research proved that if AA men would incorporate some form of regular physical activity into their everyday routine, this could decrease that high rating of acute chronic physical and mental conditions (Hooker et al., 2011). Hooker et al., (2011), was able to show positive changes for moderate to vigorous intensity PA and overall all PA, Self-efficacy for PA, social support for PA from family and friends, self-regulation for planning and goal setting and each fitness component. These findings confirm that you can successfully engage middle-aged AA men.

Andersen's health Service Utilization Model

Origins

James Andersen's model was initially used to evaluate whether there were similarities or differences in factors predictive of health services utilization for elderly African Americans compared to Whites. It was also used to explain utilization differences among families (Andersen, 1968), but Andersen redirected the model to

evaluate health service utilization decisions at the individual level and is now solely credited with what has proven to be a more robust application of the two original concepts (Andersen, 1995).

Andersen (1968) developed a model of health care utilization, which looks at three categories of determinants: predisposing characteristics; enabling characteristics; and need-based characteristics. Predisposing characteristics are those variables that prime individuals to access health care services. These characteristics encompass demographics, social structures and health beliefs (Aday & Andersen 1974). Enabling characteristics to facilitate or impede health care use and include personal, family, and community resources. Need characteristics can be broken into two dimensions - Perceived and Clinically Evaluated. Perceived need is the individual's assessment of the need for medical services, while the Clinically Evaluated need is the physicians' professional reference for accessing health care services (*Figure 1.1*).

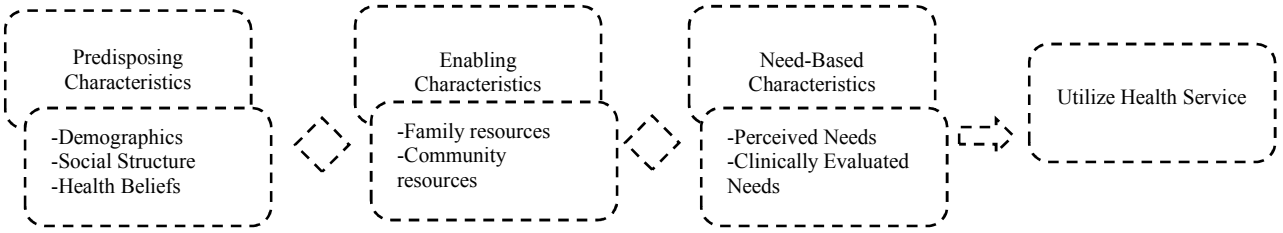

Figure 1.1 Andersen's Behavioral Model of Health Services Utilization (adapted from Wolinsky, 1988b)

As years progressed, Andersen's model was expanded and refined to include the health care system (Figure 1.2) which included health policy, resources, and organization, and the changes made within those areas over time. Per the revised model, the way in which an organization (health care system) disseminates its resources, whether specific

health care services are being utilized and the frequency in which a function is used, will have different elements based on characteristics of the population and the health services (Andersen, 1995; Andersen & Newman, 2005). *Figure 1.2* is an example of Andersen's 1970 model.

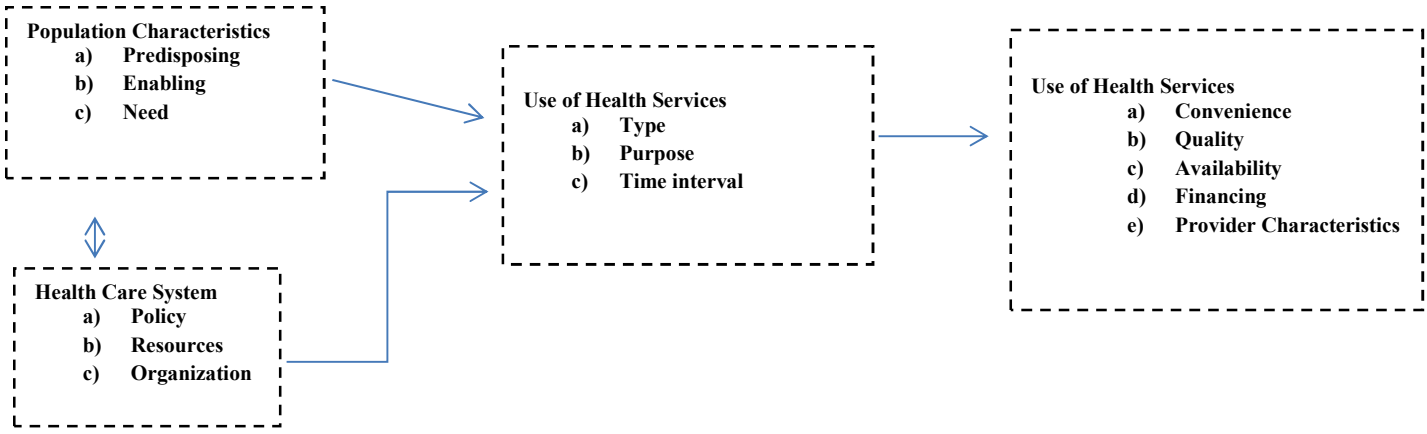

Figure 1.2 Andersen's Behavioral Model of Health Services Utilization (adapted from Wolinsky, 1988b)

In the 1980s Andersen's model was revised again. This time, it was changed to encompass three components with a linear relationship: primary determinants; health behaviors; and health outcomes (*Figure 1.3*). Primary determinants are noted as the direct cause of health behaviors (demographics, resources, and organization, political, physical and economic influences of utilization) (Andersen, 1995). Health behaviors are personal health practices and the use of health services (Andersen, 1995). Health outcomes are perceived health status, evaluated health status, and consumer satisfaction (Andersen, 1995). The components of the model are presented below in *Figure 1.3*.

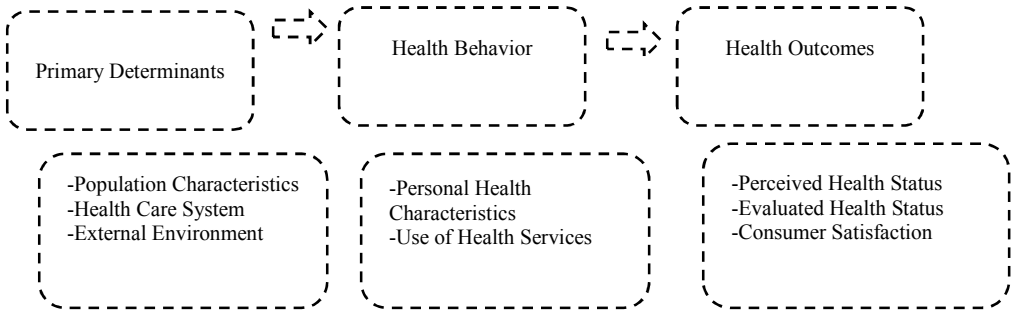

Figure 1.3 Andersen's Phase-3 Model of Health Services Utilization (adapted from Andersen, 1995)

Andersen's model went through a fourth transformation during the 1990s to include individual's access to and the use of health services which was a revision to the three initial factors: Predisposing Factors; Enabling Factors; and Need Factors (Andersen, 1995). The newly revised model exemplified the causation to examine health services and health status disparities amongst various populations. *Figure 1.4* explains the 90's version of Andersen's Model.

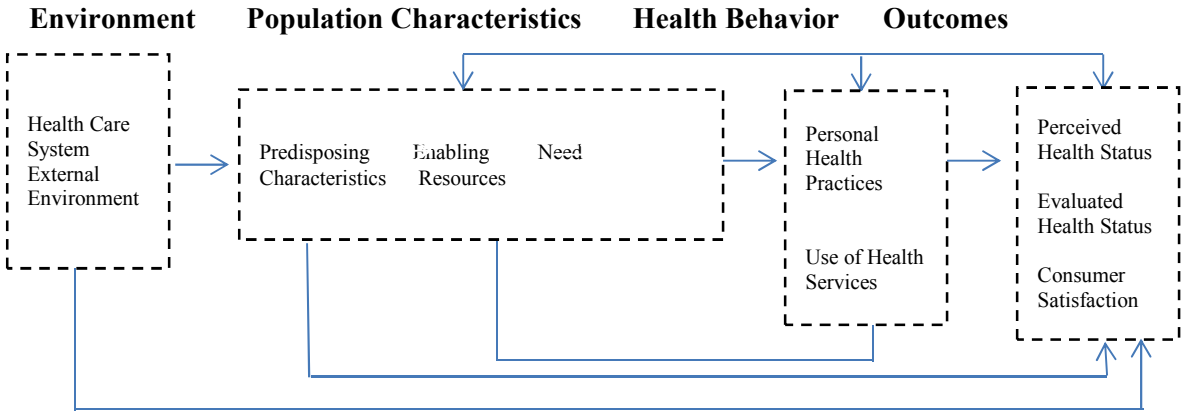

Figure 1.4 Andersen's Phase-4 Model of Health Services Utilization (adapted from Andersen, 1995).

The latest version of Andersen's model was developed in 2000. This version includes Andersen's acknowledgments of the model's continuing strength at an individual's level. This acknowledgment was explained by deconstructing and reconfiguring the environment, system, and population's levels into an aggregated version of the chief explanatory into three variables. These variables are: predisposing; enabling; and need (Andersen, 2008). Additionally, Andersen broke out the process of medical care from the broader category of health behaviors. This change encouraged researchers to use the model to examine anyone, or any combination of intermediate outcomes to include the use of personal health care practices, both individually and culturally determined; use of health care providers; and use of health care technology and other health care services. This version of the model is characterized by the degree of specificity it contributes to previously broadly conceived categories (Andersen, 2008). *Figure 1.5* explains this version.

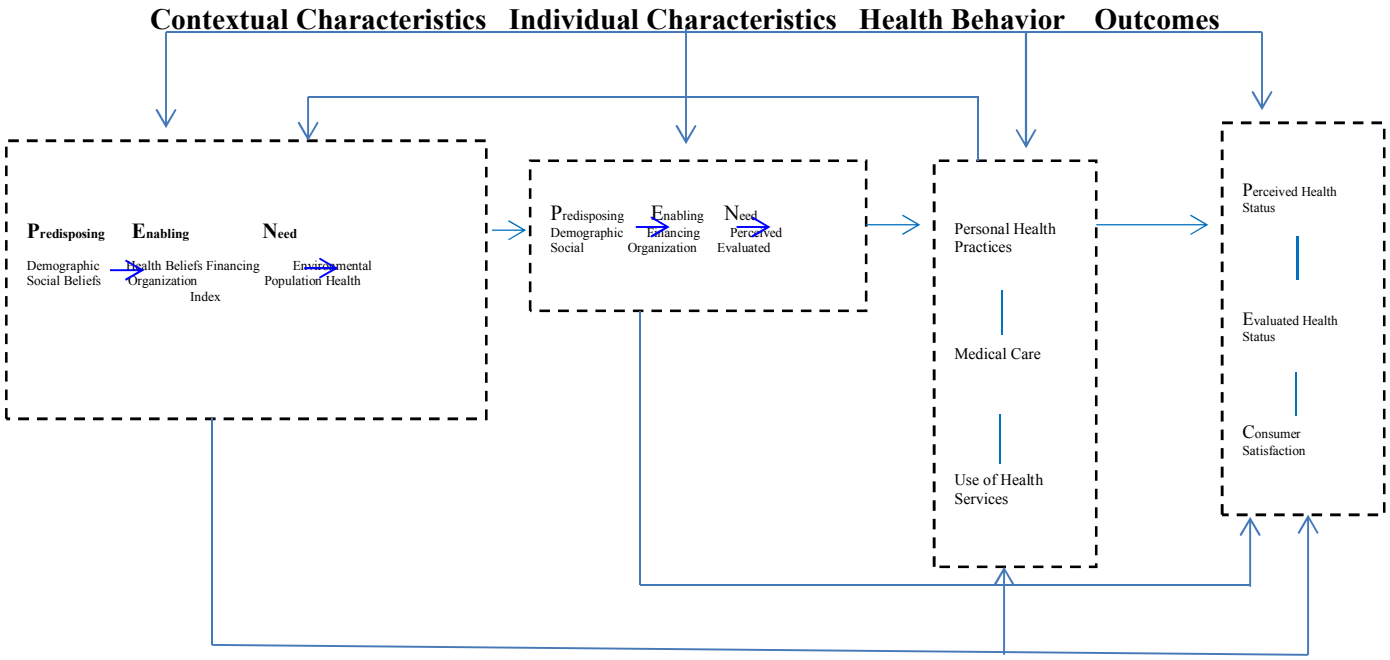

Figure 1.5 Andersen's Phase-5 Model of Health Services Utilization (adapted from Andersen, 2008).

Overall, Andersen's model has evolved into a developing theory that's more knowledge-based, and there's a greater appreciation of the distinctions among the complex array of factors that ultimately influence service utilization and health outcomes (Andersen, 2008). Each amendment to this model exemplifies ways in which Andersen responds to critics seeking a more comprehensive conceptualization of determinants of individual and population health outcomes. A review of the most recent literature using the Andersen's Model illustrates how researchers have employed the model in a manageable form.

Recent Literature

Derose, Gresenz & Ringel (2011), research study examined how racial and ethnic minorities, as well as some underserved populations, handle disparities and how these populations focus on individual-level factors such as demographics, personal health beliefs, and health insurance status. Using Andersen's model through this study, the researchers could show how health outcomes as indicators of health care access (Andersen, 2008). Utilizing Andersen's latest model Andersen (2008) had a more direct focus than any of the earlier models. The focus was primarily on monitoring access, including equity of access, whether the difference in use and outcome among groups is the result of financial or other barriers to care (Andersen, 2008). The researcher's results from the study indicate ways to implement emerging procedures that are targeted at

guaranteeing access to health care and positively influencing and improving population health outcomes.

Al-Ghanim (2004) research study examined the variables which were thought to predict the utilization of public and private primary health care (PHC) services incorporating several individuals and provider-related variables that are believed to influence the use of these services. The study highlights the significant factors, which prompt patients to utilize private outpatient clinics despite the availability of free public PHC centers in Saudi Arabia. Through descriptive statistics and multivariate analyses, it showed that a variety of individual and provider variables strongly influenced the choice of site for the provision of health care. Using Andersen's model allows the researcher to operationalize the complex and multi-dimensional issues of health services and facilities use.

Schoenberger (2012) investigated the reasons why men with Acute Coronary Syndromes (ACS) specifically, delay seeking treatment in a study to include non-health-seeking behavior, knowledge deficit/self-diagnosis, presence of external modifiers, and choice of action in a revised version of Andersen's model to predict health-seeking behavior of men (Schoenberger, 2012). While conducting this research, the investigator could show different challenges that the public faced due to their lack of understanding the presenting symptoms, their ability or inability to precisely notice the conditions, and their preparedness to seek help. This study helps to recognize the psychosocial and economic factors that effects when, where and how I try to access health care (Schoenberger, 2012).

In conclusion, several research studies have used Andersen's model for investigating health care service utilization. The articles presented are engaging Andersen's model as their theoretical framework. The research will assist with identifying and understanding those variables that directly facilitate or impede health and health care utilization as defined from the clinical perspective.

Ignorance and Literacy

Davis (2011) identifies that literacy performs emancipator roles when fitted to offer people with the options required to take part in all sociocultural organizations and or to reconstruct society. Literacy operates in a manner known as oppressive (unjustly inflicting hardship and constraint). This occurs when educational philosophies and curricular materials are collected to teach a theory that belittles a cluster or constricts knowledge access that would facilitate the group or individual taking part in sociocultural institutions (Davis, 2011). Literacy skills are analyzed when evaluating an individual's health status. A person's education level, ethnic/racial group, employment status, income, and age are all looked at when trying to understand a person's competency level. Health literacy has been defined as "the level at which people can comprehend, process and attain information related to health services and their ability to make adequate health decisions" (Davis, 2011 Pg. 176-186).

In this vein, as patients, constrained literacy becomes significantly problematic, particularly, in the African American community since an estimated 50% of the population of adult males and females are presumed functionally illiterate. This illiteracy has been reported within English lingual skills while possessing limited literacy

capabilities, reading at or beneath a fifth-grade level. Additionally, they undergo difficulty in writing, speaking, reading, and ability in applying basic arithmetic skills in daily life circumstances. Most material related to health is written during the 10th grade level of reading or even above (Huntley & Heady, 2013). Therefore, African Americans that have low literacy skills are at a severe disadvantage. Health literacy is increasingly identified as a crucial element influencing communication across the scale of heart health care among African Americans. It delineates the necessary skills to handle efficiently the health care structure, consisting of numeracy and reading skills (Davis, 2011).

Deficiency of health literacy frequently manifests as a limited ability to comprehend and read necessary health-related information, appointment slips, and prescription bottles, with patients identifying that they cannot understand medical instructions. These instructions are needed to operate as a patient successfully (Myers, 2009). The account of the association between the medical profession and African Americans is prevalent of mistrust. Often, African Americans delineate perceived and real examples of misuse to endorse their mistrust of medical researchers.

Consequently, recruiting patients of African American descent into clinical trials happens to be increasingly challenging (Myers, 2009). Furthermore, given the account of misleading research, the practice of continuous relationships between community needs and physicians should be investigated further. It should then be incorporated into the methods and principles of community participation in health problems of minority communities. Researchers (Huntley & Heady, 2013) have linked low literacy in health issues to constrain health vocabulary. The same researchers also found through their

investigation that patients favor reception of health information using verbal channels as opposed to written forms (Huntley & Heady, 2013). This means that targeting health messages directed towards African American men implies identifying an oral tradition culture in health literacy contextualization.

Health Disparities among African Americans

The African American male population are often at a strangely high-risk for hypertension as a result of increased sensitivity and salt intake, high-stress levels, and diabetes. While high BP can habitually be controlled using lifestyle changes, medication, or diet, it is an enduring asymptomatic health condition (Huntley & Heady, 2013). Multifaceted with this predicament is health discrepancies whereas African Americans and other racial and ethnic US minorities frequently attain lower care quality when compared to their white colleagues. Health discrepancies are distinctions in the prevalence, mortality, incidences, disease burden, and other adverse health conditions that subsist among specific US populations. In the year 2010, a health campaign commenced seeking to reduce the discrepancies in six disciplines of health status gone through by ethnic and racial communities. These areas include immunizations, AIDS/HIV Infection, diabetes, cardiovascular disease, cancer screening and management, and infant mortality.

Nevertheless, as studies show (Myers, 2009), little is being performed to offer care access to ethnically and racially diverse groups experiencing cardiovascular disease and hypertension. Furthermore, there is a knowledge paucity among African American men on life's fragility and the significance of taking improved personal care during the

early phases of their lives. Many instances have been demonstrated to show the death of African American men at younger ages owing to an inability or unwillingness to seek constant medical attention as well as lack of knowledge concerning their family medical history (Huntley & Heady, 2013). The necessity for education among African American men, their community and diet and nutrition and the risk features linked to conventional diets of high-cholesterol of high fat is the motivation for health literacy programs. The dialectic between healthy cuisines and traditional soul food establishes an intertextual discourse of dueling accounts whereby, health literacy divulges a critical consciousness occasion (Riska, 2006).

Discrimination cannot be ignored in its impacts on the populous of African American men's health. Even though the socioeconomic status affects health effects, cultural racism is the most accountable for low health conditions of African Americans. For several years, inadequate housing and segregation have been identified as primary reasons for deprived African American health (Huntley & Heady, 2013). As it relates to the targeted population, African American men, politics and nature differences merged with racist ideas of their inferiority have resulted in discriminatory attitudes, stereotyping, and biases that may hinder their quality of care medically.

Summary

Chapter 2 focused on reviewing literature that explored frameworks and prior research that addressed African American Males views on Masculinity, health care, self-management, and hypertension. The literature review supports the statement that African Masculinity influences self-management of hypertension. The literature contained many

qualitative and quantitative studies as it related directly to African American males and psychosocial factors; however, often the literature excluded African American that was recently diagnosed with Hypertension. The proposed research was qualitative, which granted the opportunity to grasp a better understanding of factors that influence hypertension-related behaviors among African American men. The next chapter provides an outline for gathering data that helped identify barriers and weaknesses that are associated with different aspects of masculinity and how this information can be utilized to enhance better health among African American Men.

Chapter 3: Research Method

Introduction

In the previous chapter, I displayed research that emphasized frameworks and prior research that addressed African American masculinity and its influence on self-management related to hypertension. Within this methodology section, I worked to obtain answers to the research questions by gathering in-depth, thorough answers that address awareness and provide a profound understanding and insight into the lives of the targeted population. I also worked to find solutions to what factors influence the targeted population's attitudes towards masculinity and behaviors that contribute to the prevalence of hypertension. In this chapter, I will provide a detailed explanation of the research study design, the roles of the researcher, the selection methods of the participants, sampling procedures, data collection, analysis, and ethical issues.

Study Design and Approach

Regarding behavioral sciences, employing some form of qualitative research is vital, primarily because the overall objective usually is to determine the underlying intentions of human behavior (Oliver, 2010). Due to the nature of this exploratory study, the desire to understand the how African American views of Masculinity effects self-management of hypertension. Therefore, a new qualitative research design will be used in this analysis.

In this qualitative research, I aimed to explore the perspectives and experiences of the targeted population. The initial step to create this research design is to grasp a clear understanding of who the target population is and begin developing strategies to

adequately engage this audience in obtaining pertinent information needed for this research study. It is important to note that as an exploratory study, therefore there should be some form of flexibility to gage the researchers on-going understanding of the phenomenon and to engage different paths of analysis as needed actively. Hence, the overarching research questions may evolve throughout this study.

In this research, I used a descriptive study format in which I evaluated the awareness of hypertension-related behaviours and attitudes toward masculinity relative to self-management of hypertension. There is no formal statistical hypothesis testing, and the sample size will be based upon the response rate. As new perspectives emerge, or new theories are developed during the research, the researcher captured detailed responses to analyse the data to reflect what has already been learned.

I collected primary data by conducting interviews (using semistructured questions) with ten (10). African American men that were recruited from community churches and local male organizations. The interviews allowed me to obtain exhaustive qualitative information that will answer the research questions, but also essential to the prevention, treatment, and control of hypertension associated with the targeted population. It will also grant the research the opportunity to gather personal observations and examine the perceptions and attitudes of all participants at once. This study will also allow the opportunity to explore and clarify complex topics by interviewing each of the participants. With this information, the research will be able to develop a model of the African American male's psychosocial concept of masculinity and extend that model to an understanding of how it affects self-management of hypertension.

Research Questions

This study was exploratory in nature; it's seeking in-depth knowledge about African American men and masculinity. This investigation utilized four questions to guide the semi-structured interviews. These questions helped develop questions that elicited points of views of the participants lived experience as males with hypertension:

RQ1: What psychosocial factors comprise the African American Males perspective of masculinity in the African American community?

RQ2: How do African American men view the risk factors for hypertension within the context of their psychosocial experience with their masculinity?

RQ3: How do African American men view the suitability of using medical care services to guide self-management of hypertension within the context of their psychosocial experience with their masculinity?

RQ4: How do the themes mentioned by African American Males help to explain how their perception of masculinity affects self-management of hypertension?

Research Strategy

I chose the research strategy based upon the research questions, which aligns with the framework that will be utilized during the study. The research strategy that was employed by this research study was phenomenology - qualitative research. Using the phenomenology approach allowed the researcher the opportunity to gather a more in-depth description of the occurrence that is discovered through associations, relationships, and patterns found within the focus topic regarding the targeted population. This approach helped explore how African American males view masculine traits impacting

their own, as well as other African American male's self-management behaviors related to hypertension.

Adhering to this research strategy and conducting interviews, the researcher was able to develop a model that explains the African American Males psychosocial concept of masculinity and extend that model to an understanding of how it impacts self-management of hypertension. The interviews captured the essence of African American male's experiences and enlightened the researcher about the points of views of the participants without the assumption of the researcher's thoughts contaminating the research itself (Patton, 2002).

Role of the Researcher

As the researcher, I investigated the psychosocial factors that comprise the African American Males view of appropriate masculine deportment and apply that view to the dictates of self-management of hypertension. This process aided in obtaining a more complete and synergistic utilization of the data collected and analyzed. I was also able to collect and analyze qualitative data. For this qualitative exploration, interviews, specifically for this research, were utilized to gather information on attitudes and behaviors and analyze/interpret the views of a group of people from a target population (Mathers, Fox & Hunn, 2009).

My role as a researcher was to observe, participate, listen, and interpret the information that I gather from the participants of the study and document it appropriately. I have not established any personal relationship with the participants because I wanted to get their first response and pre-established views as a researcher. Nevertheless, before

conducting interviews, I ensured that I created a favorable rapport between myself and the participants to gain the maximum results from the study. Additionally, my role also involved framing the right questions to propose while using the right tone to ensure that the research questions and objectives of the study have been met accordingly. Any biases were avoided through interviews (using semi-structured questions) that required the respondents to document their experiences themselves. The process of coding facilitated the elimination of any prejudices.

I also ensured that I address the ethical concerns of the study. According to Creswell (2007), it is necessary to incorporate ethics when conducting research studies. Ethics increase the credibility of the study's findings and validates that the study truly reflects the intent of the investigation. This research study firmly adhered to following all ethical and legal policies and procedures. There were no forms of plagiarism, the use of copyrighted materials belonging to other researchers and scholars were acknowledged and cited adequately.

The privacy of the respondents to the survey questions used during the interviews was protected by ensuring that the data collected was purely used for this research and this research only. The researcher also informed the participants of this as well. The findings of the study were disseminated appropriately and communicated to Walden University just for its review.

Population

In this study, the targeted population/participants are African American men who have been diagnosed with hypertension. Eleven African American men were recruited

from community churches or local male organizations (Masonic Lodges, Fraternity-Alumni Chapters, and All Men Church Ministries) in Wilkinson County, Georgia, which consists of 6 cities: Gordon, Ivy, Irwinton, McIntyre, Toomsboro, and Danville. Flyers will be placed on the churches and local male organizations communications board. The researcher asked that the flyers are read during the announcements at church and meetings with the local male organizations. The age range for the participants were 40 to 65 years of age with varying educational and skill set backgrounds and marital status (single, married, divorced, or widowed). The interviews were done face-to-face with a digital device or tape recorder used (with participant's permission) during the interview.

Sampling Techniques

Purposive or purposeful sampling was the sampling method utilized in the study. This is a technique that is most used in qualitative research studies to enhance the ability to identify and chose rich and credible information when dealing with limited resources (Patton, 2002). This method aids selection process where one can carefully identify and chose a person or a group of people who are incredibly knowledgeable of experience in the subject you're interested in studying (Creswell and Plano Clark 2011). This sampling model granted the opportunity to identify individuals with first-hand knowledge of the study's focus which also meet the inclusion criteria.

One of the goals of this investigation was to determine if the African American perspective of masculinity affects self-management of hypertension. This perspective was analyzed by sampling African American men who have been diagnosed with

hypertension. Ten (10) African American men were sampled from the population to participate in interviews.

Data Collection and Instrumentation

The primary data was obtained by conducting interviews with African American men who have been diagnosed with hypertension. These interviews integrated a variety of semi-structured questions, questions that the researcher developed to assess the target population's views on masculinity fully and those views influence self-management of hypertension This information was pertinent as it enhances the researchers' chances to identify barriers and weakness that are associated with different aspects of masculinity and how this information can be utilized to improve better health among African American Men.

Data Collection Procedures

In this study, interviews were the most appropriate since the intent is to obtain a qualitative view of the problem. The interviews consisted of semi-structured questions that explored general perspectives of masculinity per African American males and its influence on self-management of hypertension. This approach allowed the participants the opportunity to give additional information about their experiences.

Data Analysis

This phenomenological study collected answers based on the participant’s responses to the interviews. This method allowed the researcher the opportunity to achieve the research objectives of the research study. After attaining the data from the interviews, the study explored the opinions, views and the feelings of individuals. This

investigation involved collecting qualitative exploratory data, analyzing the information, and using the findings to determine whether the perspectives of masculinity, according to African American males, influences self-management of hypertension are relative to the historical studies conducted in previous research.

NVivo 10 is software from QSR International that is used to analyse data that has been attained qualitatively. I used this software for the analysis, to assist with the facilitation of the coding process for this research. Line by line analyses assisted with generating these codes which helped with the development of concepts. The concepts also assisted with further categorization to better understand the different factors that aid African American males' perspective of masculinity and how that perception affects the self-management of hypertension. The researcher was able to make sense of the phenomenon through the emergence of the common themes. The researcher was responsible for transcribing the responses from those who participated in the interviews through an online translation service, TranscribeMe! I used this software to analyze the context and afterward, the information was uploaded in NVivo 10. Once the dissertation process is complete and has been approved, all active Participants involved in this process will be given a PDF copy of the overall results.

Ethical Consideration

Those who voluntarily participate signed informed consent forms once they agreed to participate (Appendix C). The participants were not asked to disclose any identifying characteristics such as name or address for this study. I used a pseudonym if a name was needed during the presentation of the data. Therefore, the risk of exposure if

any, as it relates to the interviewers, was minimal. The location of each interview, recordings, and transcripts will be kept private and password protected on a flash drive with the location known only by the interviewer and the designated Walden University review panel.

Summary

Chapter 3 reviewed the strategy of data collection. The phenomenological investigation used interviews (semi-structured questions) to determine if African American Males perception of masculinity influences self-management of hypertension. Also, included in this chapter are the research questions and the role of the researcher in exploring the use of phenomenology as a methodological approach to data collection, as well as a prelude to data analysis. The chapter also discussed the research design, the sample size and setting used to obtain this data. Lastly, the chapter addressed the ethical concerns of data collection and participation.

Chapter 4: Results

Introduction to the Chapter

This chapter discussed the results that emerged from qualitative interviews highlighting the element of African American masculinity and its influence on hypertension-related behaviors. Data were collected and analyzed utilizing the NVivo Software. There were common themes that emerged from the interview data: *lack of trust and miscommunication, discrimination, and self-care management*. Each of these themes were mentioned through discussion with the participants about how they perceived their family's reaction to them having hypertension, their stress levels, feelings regarding racism and discrimination, their preferences on the race and providers, experiences that affected their mistrust towards healthcare systems, and the factors that adversely influenced miscommunication with family, friends, and doctor-patient communication. These particular themes may provide insights into the hypertension-related behaviors of African American male patients for providers.

Rationale of the Study

The purpose of the study was to examine the knowledge and self-care management practices needed for hypertension control among African American males. This chapter is structured around the research questions that were designed to determine what psychosocial factors comprised the African American male's perspective of masculinity, the ways in which African American men view the risk factors for hypertension, the ways in which African American men view the suitability of using

medical care services to guide self-care management of hypertension, and the common themes amongst those African American males who were interviewed.

The participants were African America men, ages 40-65 who were diagnosed with hypertension. Recruitment flyers were posted in community churches, barbershops, local stores and local male organizations (Masonic Lodges, Fraternity-Alumni Chapters, and All Men Church Ministries) within a rural area of Georgia. The flyer directed the willing participants to contact the researcher via phone or email to participate in the interviews. The interviews were held at New Bethel Baptist Church in their kitchen annex. Snacks and beverages were available for all participants that participated in the study., One on one interviews were conducted with ten (10) African American men who self-identified as being medically diagnosed with hypertension from April through August 2018.

Each participant received a written and an oral explanation of the informed consent (Appendix C) and was provided with a copy of the informed consent for their personal files. The consent contained the purpose of the study, the procedures, risks, benefits, the extent of confidentiality, inclusion criteria, freedom to withdraw and approval of research. Contact details were also included if further information was required. It also included the Walden University's Internal Review Board (IRB) approval number. Also, each participant was assigned an identifier code for confidentiality purposes. The interviews were semi-structured, allowing the researcher to obtain exhaustive qualitative information that will answer the research questions. This structure also allows the researcher the freedom to probe interesting areas that occurred during the interview (Smith, 1995). The conversations were recorded.

All the dialogues were transcribed using Transcribe Me into Microsoft Word documents. Each interview was given its file and then analyzed using *NVivo 10* qualitative software. The data that was gathered through the interviews were strategically placed in a document to organize the data, filter through the data, and categorize the data to narrow down potential themes. Notes were taken to capture the way in which the data was analyzed. All records where placed on file to ensure that all vital information was saved, secured, and could be referenced later if necessary. The major themes that emerged from the analysis are *lack of trust and miscommunication, discrimination & self-care management*. The creation of these themes helped narrow down specific key topics the participants mentioned were contributors to the lack of trust towards healthcare systems. The themes also pinpoint how the lack of trust affects their communication with their families, friends, and their doctors, and their ability to self-manage their hypertension. The next section will focus on explaining the themes according to the research questions.

Data Analysis Themes

Lack of Trust and Miscommunication

On several occasions throughout the interview, many of the participants indicated how the lack of trust due to miscommunication was a strong contributor to the lack of trust that they have with healthcare systems. The participants believed that their providers did not provide adequate information related to their hypertension at times nor did the physician communicate efficiently in a way that they (the patients) were able to understand the message they were trying to convey. Most of the participants believed that

this was a result of them being African American. For instance, one participant explained why he began to lose faith in his provider and no longer trusted that the provider was working in his best interest. This participant also explained how Caucasian providers would misconstrue their responses to questions that were asked and when they tried to tell what was meant, the providers would dismiss the answers as if they were ignoring them. The participants felt that because their providers were all men, they should have been able to connect as men at the least. Assisting the patient in understanding the information they were trying to convey. As a result of the disconnect in communication, the participants began to become resistant to the information given and eventually lose trust in their providers. According to one participant,

> I am not sure why, but from the beginning, I felt as though my doctor didn't care about my overall well-being. He was always in a rush and never addressed my concerns. He barely even spoke to me. The walls in the office are extremely thin, so I could hear his interaction with other patients, patients that I knew were a different color than me. Even though I was upset when he would enter the rooms, I tried to give him the benefit of the doubt but once again, it appeared like my issue was downplayed and ignored, and I was merely told that was I felt was unreal, and that it was something else, even though I knew better. At that moment I felt as though either he had an issue with people my color or he had an issue with just me.

Discrimination

Discrimination is defined differently by different sources. For this research study, the definition that was referenced was defined as differential treatment of members of a group by both individuals and social institutions (Williams & Mohammed, 2009). A few of the participants mentioned that they believed that they were discriminated against due to the color of their skin and that they noticeable saw how providers treated them versus the Caucasian patients. There was one participant that mentioned that often when he leaves his provider's office, he left severely dissatisfied and, most of all, not valued and respected. As men, they demanded respect from others, but could not quite figure out how to demand that respect from their medical providers. One participant stated that he knew that he could not and would not receive better services elsewhere, so he mainly just dealt with the treatment and never complained about it. There was one participant that mentioned how dissatisfied he was with a provider who was also African American.

> You would think that having an African American provider would be better, simply because you would think they would understand you better. Not for me. My provider makes me feel like he thinks he is better than me. He is so quick to tell me that I'm not doing this and doing that but won't listen to the reasons why I do certain things. You would think that he would be able to identify with me, but he doesn't. I guess we are from two different sides of the track if you know what I mean.

Even though there were a few participants who complained about having an African American provider, there were some that favored having an African

American provider versus a Caucasian provider. Those that indicated this stated that having an African American provider allowed them an opportunity to identify with someone, primarily as a man who understood their background, ethically and culturally. This level of understanding, in turn, allowed a better provider to patient relationship. The African American provider could pinpoint ways in which the participant could improve their overall health status, due to lived experiences that too had encountered before.

Self-Care Management

Self-care management approaches depend on drawing on patient judgment and values within the context of daily living to inform how the comprehensive treatment plan can best be agreed and implemented (Goldstein, 2002). Most of the participants indicated that they are complying with taking their medication, but they do not eat healthy diets, nor do they exercise. A few stated that they try to exercise more to stay healthy, and they are complying with their medication requirements. Others indicated that they did not eat healthy diets, were not taking their medication and not exercising. Those who stated that they were not complying with the doctor's orders indicated that they did not believe in taking medication; that once you started to take medications and change your lifestyle that's when things begin to go wrong. One participant stated

> It's the same way when you begin taking medication for cancer, you get sick, and most of the time you don't recover from that. But before you find out that you were sick, you weren't taken any medication, eating how you want and living life. You weren't sick, but as soon as you changed things

and started doing what the doctor tells you, you get sick and sad to say, you die. I'd rather not do that and live my life like I am.

Most all the participants stated that they experienced some form of stress daily, whether it was work related, due to family and or friends, or just life in general. They also stated that most of the time, their family members were supportive and tried to keep them on the right track regarding their eating habits and exercising, while others stated that their family and friends acted as if they never told them that they were diagnosed with hypertension. A few participants said that they have never disclosed this information to their family or friends and did not plan to tell them at all due to the possibility of making them feel helpless, which in turn would begin to make them feel less than a man.

As a result of these stressors, sometimes their focus was not always on managing their hypertension. If money was an issue and it became a choice to pay a bill or purchase their medication, they would most definitely pay a bill and not purchase their medicine. As men, they see themselves as providers, and it is their role and responsibility to make sure that they take care of the people that they depend upon them. A few men mentioned that they would love to get healthier but the food that their wives or family members prepare for them is extremely unhealthy, and they cannot ask them to change the habits that they are used to accommodate their health issues. For instance, one participant indicated that he is the only male of six sisters, and they all cook for him and, when they do, it is s never anything healthy. Most unhealthy foods are from recipes that have been passed down from generation to generation. He also mentioned that his wife cooks

unhealthy foods as well and, as the man of the family, he eats what is prepared and does not complain.

A few of the men did mention that they participate in daily activities that can at least keep them moving in the right direction of becoming or staying as healthy as they can be. Even those that stated this mentioned that at times it was hard to remain committed to this when they have other things that may come about that are more important than exercising. For example, doing things for their families or their kids, working, and one man even started watching sports. And as a man, and primarily as the man of the family, they are obligated to uphold those roles and responsibilities.

Summary

The analysis of data gathered from the interviews is intended to address the research questions that were designed to determine what psychosocial factors comprised the African American male's perspective of masculinity. It was also intended to discover how African American men view the risk factors for hypertension and how African American men see the suitability of using medical care services to guide self-care management of hypertension. The participants truly valued being respected as men, whether it was being respected as a black man seeking medical attention from their providers or if it was being respected as the man of the family. They all wanted to be respected a man no matter what.

Most of the participants were aware of the risk factors that were associated with hypertension. Nevertheless, there were still some participants who admitted their willingness to even engage in activities that could affect their hypertension levels. For

instance, eating unhealthy meals, not exercising, and lack of medication adherence. Others were actively trying to understand hypertension and truly self-manage their hypertension levels by educating themselves, knowing what resources are available, exercising, adhering to medication, and choosing healthier food options. The lack of information provided and the lack of trust and communication from providers were contributors to the lack of motivation for managing hypertension. Chapter Five will provide a more thorough interpretation of the findings, discuss limitations and provide recommendations for future research.

Chapter 5: Conclusion

This study was intended to explore African-American masculinity and its influence on hypertension-related behaviors and self-care management of hypertension. Individual interviews were conducted with ten (10) African American males aged 40-65 who had been diagnosed with hypertension. The study was located in a rural community in the southeastern United States. Several different concepts were emerging from the findings: *lack of trust and communication, discrimination, and self-care decisions*.

Interpretation of Findings

The following themes help to address the research questions that were developed for this study. It also helps to determine what psychosocial factors comprised the African American male's perspective of masculinity, how African American men view the risk factors for hypertension, and how African American men see the suitability of using medical care services to guide self-care management of hypertension. Each of these themes emphasizes why the views of masculinity influences health-care decision. Particularly regarding African American men and Hypertension.

Lack of Trust and Miscommunication

The negative impact of communication between doctor and patient emerged in the interviews. When the respondents conversed about adverse experiences concerning communication with providers, they often identified that they did not feel that the providers listened to them appropriately. They also added that the providers appeared to have always been short of time when conversing with them and that during those brief periods, they did not let the patients speak about the issues that they were experiencing.

When the respondents underwent the experiences of not being sufficiently listened to by the providers, their desire to take part in their treatment was decreased, which directly affected the adherence to their treatment regimens.

A doctor's misuse of medical terminology can interfere with the patient's ability to comprehend and to fully engage in conversations about their health with their medical providers (Huntley & Heady, 2013). As mentioned earlier in the study, health literacy is increasingly identified as a crucial element influencing communication across the scale of heart health care among African Americans (Davis, 2011). As a result, the patient may not be fully involved in the treatment of their potential health conditions. This information further confirms studies that stress the critical knowledge and how literacy is problematic within the African American community (David, 2011). As mentioned in Chapter 2 of the study, health literacy is defined as the "level at which people are to comprehend, process and attain information related to health services and their ability to make adequate health decision (David, 2011). This chapter also addresses the reason why the deficiency of health literacy manifests as a limited ability to comprehend, especially if providers are using medical terminology that patients, particularly African American patients, cannot comprehend (Myers, 2009). Miscommunication leads to the lack of trust that the participates alluded to in their interviews.

Discrimination

The issue of perceived or real discrimination impacts African American men's trust and self-management health behaviors. Feeling discriminated against can trigger several different emotions which could lead to potentially overlooking or ignoring

assistance, particularly health-related assistance. Prior literature states that discrimination and health outcomes are highly related. As mentioned in Chapter 2 of this research study, cultural racism is the most responsible factor for poor health conditions of African Americans (Huntley & Heady, 2013). As it relates to the targeted population, African American men they associate discrimination with respect for their masculinity. The finding from this study future supports why African American Men are more reluctant to seek medical attention than women. As the literature states in Chapter 2, controversial questioning has arisen as to whether there is a broad range of health variations that exist between men and women, and the health differentiations between men of diverse geographical regions, social classes, and ethnic groups (Riska, 2006).

Self-care Behaviors

Different theories attempt to explain the element of masculinity among not only the African American men but also in society as a whole. As mentioned in Chapter 2 of this research study, the notion of comprehending masculinity using sex role theory, as well as the constructs of psychological masculinity measures, to evaluate this currently has resulted in a significant amount of negative impartial criticism (Austin, Carter & Vaux, 1990). The relationship between masculinity and the conceptualization of health and changing health behaviors is a significant element in this study. When asked the meaning of health, an air of anxiety occurred in the accounts of men. They conveyed the perception that men usually do not think or care about their health. This information evolved into a narrative about health being the business of women, resulting in men not seeking medical help as often as women do. For some of the men who do wish to seek

medical help, they depend on the women in their lives to make appointments for them. They also depend on the women to ensure that they are going to their appointments and adhering to their medication etc. This information relates to the perception of gender roles and masculine concepts, which means that the men remain silent, uncomplaining, and secure in issues linked to well-being and health. Optimal self-care involves having specific concerns with overall health and positive engagement with health providers. This study supports the hypothesis that the concept of masculinity impacts self-care behaviors. Some of the men have allowed the perception of masculinity to affect hypertension self-care management negatively.

Limitations

The African American men that participated in this study were limited to rural southeast Georgia. Therefore, the findings may not apply to other African American men in urban parts of Georgia or other regions of the country. The experiences of those African American men interviewed could be completely different from other African men in different areas.

The recruitment was limited as well. Flyers were placed in barbershops, stores, churches, Masonic halls, etc. in certain places one county in Georgia. This area of Georgia has limited transportation which could have decreased the number of African American Men who were indeed able to view the flyers and participate. This particular area is rural, and most people travel outside of the county to shop, attend church and even participant in activities. Word of mouth or snowball sampling could have possibly been a better recruiting mechanism to reach the targeted population.

Recommendations

This study suggests that a lack of trust and miscommunication, and feelings of discrimination were significant factors that contribute to the lack of self-care management for hypertension. Building or even rebuilding the trust between providers and patients would be the ideal first step. Having providers attend professional development trainings to enhance their customer service skills could assist with communication. Providers could also participate in cultural awareness trainings to learn how to interact with patients of different races, culture, ethnicity, etc. This level of training could decrease the sense of discrimination that some participants indicated experiencing, particularly in rural areas where diversity of providers is scarce.

One recommendation is to include the partners in the plan of treatment to off-set the timid nature of men in relationships. Agricultural outreach programs and churches can host nutrition education classes for women and men about cooking healthy for their families. There are several experimental cooking programs for low-income families, healthy cooking courses at local churches, or even hands-on cooking courses at local recreational facilities that women or families could attend. Attending the programs as a family could allow everyone to learn the importance of eating healthy and learn how to enjoy cooking as a family.

The information gathered through the interviews showed a definite correlation between self-care management and how African American men view their masculine roles. Lack of trust, miscommunication, and discrimination were critical factors that contributed to the participants not feeling respected as men. Whenever they mentioned

not feeling respected as men, they became resistant and defensive, especially as it related to hypertension-related self-management behaviors. Most all participants mentioned numerous times that they valued how their family and friend's perception of them as men. If that perception did not align with the participants' views of masculinity, this would stand in the way of them being compliant with their medication as well as properly self-managing their hypertension with exercise and diet. Additional research is needed to analyze the perspective of African American males' lived experiences, their views on masculinity, and the intersection with the challenges of prevention, treatment and self-care management of hypertension.

Implications

This research will provide additional information for principles of community social change and empowerment that support health promotion within the African American population, specifically African American men. Ultimately, the social change would be to identify cognitive barriers related to concepts of African American masculinity as it relates hypertension and the influence on self-care management. In turn, this social change may help reduce the documented disparity in diagnosis, treatment and self-care management of hypertension within the African American male community.

Conclusion

This study explored different topics that focused on factors how the views of masculinity may affect African American males' decisions to seek medical attention for hypertension and their choices regarding self-care management. The results of the study did not necessarily present new findings but support that efforts are needed to

professionals and to craft innovative approaches to education and support for African American males with chronic diseases. This information can help guide further research and interventions that can improve African American men both diagnosed and at risk for hypertension, as well as other chronic diseases requiring substantial changes in health behaviors.

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Appendix A: Flyer

Research Study Participants Needed!

A research study is being completed within our community to help understand the views of African American Men as it relates to masculinity and how it affects those with hypertension. If you have been told by a health professional that have hypertension, you are invited to participate in an interview or a survey/questionnaire to share your thoughts and opinions. This is your chance to help our community develop programs that are specific to hypertension.

If you want to participate in the study, you must be 40 to 85 years of age

During the interview of within the questionnaire/survey process, please expect the following types of questions:

- Are you able to discuss your health issue openly with your family?
- Have you shared your hypertension issues with your friends?
- How has hypertension affected your life?
- Prior to the realization that you have hypertension, did you trust the healthcare system? If no, what were your initial reasons?
- Are you currently managing your hypertension on your own?

The interview or survey/questionnaire will take place in a public location of your choosing. Please allow at least an hour to complete the interview.

If you want to participate, please contact Tangee Thomas at 478-XXX-XXXX or tangee.thomas@waldenu.edu.

Thank you for your time!!

Appendix B: Interview Survey/Questionnaire

Questionnaire on African American Masculinity and Its Influence on Hypertension-Related Behaviors.

This questionnaire is intended to gather data from African American respondents regarding hypertension and some of the behaviors that influenced the diagnosis. The questionnaire contains open-ended questionnaires to identify the perceptions of the African American men on issues related to hypertension. Thank you for agreeing to take part in this research interview or survey/questionnaire.

SECTION A: INTRODUCTION QUESTIONS
Please tick (√) in the appropriate space below.
Where does your age lie in the options below?

[] 20-35 Years [] 36-45 Years
[] 46-55 Years [] 56-65 Years
[] 66-75 Years [] Above 75 Years

What is your employment status?

[] Employed [] Unemployed
[] Retired

What is your education background?

[] High School [] College Education
[] Under-graduate [] Post-graduate

What is your marital status?

[] Single [] Married
[] Divorced [] In a Relationship

SECTION B: AFRICAN AMERICAN MEN'S PERCEPTIONS

According to your medical report, you were diagnosed with hypertension, how has this affected you and daily life?

Are you able to discuss your health issue openly with your family? If yes, how has your marital status influenced your well-being as an individual with hypertension?

Has your family reaction to your hypertension been positive? If not, how has been influenced your wellbeing as a person that needs support from loved ones?

Have you shared your hypertension issue with your friends? If yes, how have they reacted to this information? In addition, have they taken the initiative to find out more about hypertension?

Does your hypertension affect your capability to mingle well with your peers and friends?

How has your education background facilitated your willingness to search for current information on self-management of hypertension?

Do you experience any stress at home, work or within the community that you currently live in? If so, please explain?

Do you think these stressors contribute to your hypertension?

How do you try to overcome this stress?

Do you participate in drinking or smoking? If yes, do you think that these activities can affect your hypertension negatively?

Do you ensure that you visit the doctor regularly for checkups? If yes, according to his diagnosis, do you think that you may develop these serious conditions from hypertension in the future?

SECTION C: AFRICAN AMERICAN MEN MASCULINITY

Prior to the realization that you have hypertension, did you trust the healthcare system? If no, what were your initial reasons?

Have you ever experienced racism within the health care system? If yes, has this element been an obstacle to seeking help about your hypertension?

Apart from racism, what are some other obstacles that could deter African Americans with hypertension to seek medical help?

How would you define self-management of hypertension?

Are you currently doing anything to management your hypertension? If so, what?

How often do you engage in recreational activities?
Do you prioritize your health as an important component of your life? If yes, how do you ensure that you award it the right form of priority?

Do you think your provider can adequately assist you with lower your blood-pressure outside of prescribing medication? Why or Why not?

Have you tried talking to your doctor about ways to self-manage your hypertension?

Appendix C: Informed Consent

Informed Consent for Participants

in Research Involving Human Subjects

Title of Project _____
Investigator _____

I. Purpose of this Research/Project

The purpose of the study is to examine the interaction between African American Males masculine perspective and the lifestyle and clinical dictates essential to the prevention, treatment and control of hypertension.

II. Procedures

The interview will take place at the participant's chosen location. If the volunteer agrees to participate, they will be expected to participate in an audio recorded interview that will be transcribed. The interview will take about an hour. No names will be used in the transcription process.

III. Risks

There is a minimal risk as it relates to the participants of this study. The location of the interview recording, and transcripts will be known solely by the researcher and the designated Walden University committee. A copy of this informed consent form will be provided to the participant.

IV. Benefits

It is hopeful that the information gained from the study, it will lead to positive social change by providing local public health workers an increased understanding African American masculinity and its influence on hypertension related behaviors.

Any additional information about hypertension can be obtain from Wilkinson County Health Department (478-946-2226).

V. Extent of Confidentiality

Any information collected from those who participate in the interviews will not include any identifying information. Names and other identifying characteristics will not be included in the interview transcripts. If a name should be used it will be a pseudonym.

VI. Inclusion Criteria

Participants will volunteer to participate in the research. Participants will not be asked personal questions about their living status, mental capacities, nor their emotional capacities. Any information that is involuntarily offered will not impact the study nor will it be revealed in any data analysis. Participants are selected solely on the criteria of being an African American Male, having hypertension and between the age of 40-85 residing in Wilkinson County, Georgia and whether or not they can successfully answer the qualifying questions.

VII. Compensation

N/A

VIII. Freedom to Withdraw

The participant is not bound to the research study and is free to withdraw from the study whenever he/ she desires to. Participation is strictly voluntary.

IX. Approval of Research

This research study is approved, as required, by Walden University's dissertation guidelines. If you have any questions about this research, you can contact Tangee Thomas [Tangee.Thomas@waldenu.edu], researcher, and/or [egondu.onyejekwe@waldenu.edu], research chairperson.

If you have any questions about your rights as a participant, you can contact the Walden representative at irb@waldenu.edu.

IRB Approval Date:

_____ _____

Researcher Participant

Appendix D: Permission to Post Flyer Letter

To Whom It May Concern:

My name is Tangee Thomas and I am a candidate for the PhD program in Public Health – Community Health Education at Walden University. To satisfy my educational requirements, I am completing my dissertation, entitled, "African American Masculinity and its Influence on Hypertension-related Behaviors in Wilkinson County, Georgia". I will be conducting interviews with African American Men with Hypertension. I would like for you to assist me in my efforts of gaining participants by displaying my recruitment flyer in your office and recommending qualified potential participants to my study. Your support will help lead to positive social change by providing local public health workers an increased understanding African American masculinity and its influence on hypertension related behaviors.

Thank you in advance for responding with your approval or disapproval of displaying my flyer at your business location. If you have further questions, please contact me at 478-XXX-XXXX.

Sincerely,

Tangee D. Thomas

Tangee D. Thomas

THANK YOU

Thank you for completing this questionnaire, and for contributing to this major research project.