

Health and Disability Among Young Black Men

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Background: Black men experience the highest rate of disability compared to White, Asian, and Hispanic men. Yet, we know little about how Black men with disabilities experience the embodiment of their gender, race, social class, and disability positionalities and how they draw from their cultural backgrounds as they engage in health-seeking behaviors.

Objectives: The purpose of this study was to explore how young Black men experienced the onset of chronic disabling conditions while negotiating health-promoting activities in the context of gender, race, social class, disability positionalities, and culture.

Methods: This descriptive study used hermeneutic phenomenology to achieve study objectives. This study's research questions were answered using audiotaped, one-on-one qualitative interviews, along with detailed field notes. Each participant was interviewed twice at a mutually decided upon location to ensure their privacy and comfort.

Results: In relation to their embodied interactions of self in the context of disability, these men described their health-related decisions using four themes: maintaining manhood, economic constraints, the "risk" of healthcare, and health promotion.

Conclusions: By examining the experiences of young adult Black men living with disabilities, knowledge of their perspectives and experiences at earlier stages in their life course contributes to the understanding of their personal challenges, health needs, and their perspectives of health-promoting strategies.

Key Words: African Americans • disabled persons • hermeneutics • phenomenology • young adult

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When compared to women, men experience poorer health outcomes, which lead to higher morbidity and mortality rates for men around the world (Hawkes & Buse, 2013; Wang et al., 2012). Researchers have attributed these gendered health disparities to dominant constructions of masculinity as these "cultural scripts" that encourage men to engage in behaviors that place their health at risk while simultaneously discouraging them from seeking medical intervention (Courtenay, 2000; Mansfield, Addis, & Mahalik, 2003; Oliffe & Phillips, 2008). Increasingly, researchers are calling for more intersectional approaches to understanding the gender health gap, which recognize that masculinity is constructed and embodied in interaction with other aspects of identity, including race, social class, and disability (Griffith, 2012; Hankivsky, 2012). This article explores how 11 young Black men negotiated health-seeking activities as they experienced the onset and advancement of chronic disabling conditions.

Black men living with disabilities reside at the intersection of major risk factors for poor health outcomes. Among all racial

groups in the United States, Black men experience the highest number of poor health indicators. Black men specifically report a shorter life expectancy than both Black women and non-Hispanic White men (U.S. Department of Health and Human Services, Office of Minority Health, 2012). Black men have the highest incidence and mortality rates for all cancers, including prostate, lung, stomach, and colorectal (U.S. Department of Health and Human Services, Office of Minority Health, 2012). Furthermore, Black men experience more than eight times the AIDS rate and are almost six times as likely to die from HIV/AIDS when compared with non-Hispanic White men (U.S. Department of Health and Human Services, Office of Minority Health, 2012).

Approximately 20% of Black men report living with disability—the highest rate of disability when compared to White, Asian, and Hispanic men (Brault, 2008). As a group, persons living with disabilities also experience poor health outcomes. Americans with disabilities experience low levels of access to quality healthcare, along with high rates of preventable health problems (Goode, Carter-Pokras, Horner-Johnson, & Yee, 2014; Gulley & Altman, 2008). They are found to be more likely to engage in health-damaging behaviors, such as smoking and inactivity (Centers for Disease Control and Prevention, n.d.), with rates often varying with age.

The developmental period known as young adulthood, ages 26–40 years, will provide context for interpreting the results of this study. Researchers characterize those in young

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adulthood as portraying a more stable identity with consistent behaviors than do people in earlier developmental time periods; for instance, as compared to those in emerging adulthood, consisting of people ages 18–25 years. Emerging adulthood, viewed as a time “when little about the future has been decided for certain” (Arnett, 2000, p. 469), is characterized as a period of experimentation and evolving societal and personal expectations for roles and identity formation (Arnett, 2000, 2003). In contrast, young adulthood is a period of stability. Heavily dependent on cultural and societal viewpoints, the explorative and risk-taking behaviors that characterize the emerging adulthood period commonly disappear once young adulthood begins. Beginning in the mid- to late 20s, long-term beliefs form from what are considered “enduring decisions” (Arnett, 2000, p. 473), as self-identities become known and knowable for the individual. The ability to distinguish a disabled identity and adopt sustained health promotion behaviors are “enduring decisions” made during young adulthood.

Yet, we know little about how Black men with disabilities experience the embodiment of their gender, race, social class, and disability positionalities and how they draw from their cultural backgrounds as they engage in health-seeking behaviors. When race is considered, risk increases, as evidenced by the fact that Black men experience the highest number of health disparities when compared with all other racial and ethnic groups. It is expected that Black men aging with early onset disability, that is, disability prior to the age of 25 years, may be at increased risk for poor health-related outcomes over time (Harrison, Umberson, Lin, & Cheng, 2010). If practitioners are to curtail the problems that may arise over time, further research is needed to understand the health-related decisions and experiences of young adult Black men with disabilities. We posit that if health promotion efforts are to be effective, they must be grounded in the population’s beliefs. Hence, it was our goal to ask two questions: *What is the essence of losing abilities among young Black men in Western societies?* and *What is the context of learning health promotion reported by Black men living with disabilities?*

METHODS

Data presented are drawn from 22 individual, in-depth interviews with 11 self-identified Black men who experienced one or more disabling conditions. We interviewed each participant twice. To describe the unique voice and health promotion experiences of the young adult men who participated in this study, we used hermeneutic phenomenology (Cohen, Kahn, & Steeves, 2000) as our methodology. This guided the data collection, data analysis, and presentation of findings, allowing the investigators to assume that the health-related experiences of young adult Black men was shaped by their embodied life circumstances and was unique to their gender and racial experience.

Recruitment and Sample

Recruitment Participants were recruited using a variety of methods. First, community liaisons were contacted by the investigators and asked if they knew of potential participants; someone they might tell about the study who might be qualified and/or interested in participation. Second, personnel from healthcare and social services agencies that provide services for persons with disabilities who might meet the study’s inclusion criteria were visited, and information flyers and participant return envelopes were left at these sites. Local Black churches, barbershops, and salons were also visited, and flyers were also left at these sites. An incentive of \$50.00 was offered to each participant.

Inclusion/Exclusion Criteria Once a man contacted the first author, he was screened for eligibility. The study inclusion requirements included Black men who reported difficulty or inability to perform a minimum of two of four functional limitations identified in the National Health Interview Survey (NHIS; Pleis, Ward, & Lucas, 2010). These were the following: (a) walk a quarter of a mile; (b) walk up 10 steps without resting; (c) stand for 20 minutes; or (d) stoop, bend, or kneel. The NHIS criteria have been used in other qualitative studies to ensure reviewers that our sample did meet the goal for having an objective degree of functional limitation (Harrison et al., 2013). Their self-appraised ability to meet NHIS criteria provided a starting point for our discussions of what that functional limitation meant in relation to “disability.” These men did not believe their mobility had always been limited; many believed that their impairments were invisible to most others, their individualized pain being the primary limitation on mobility.

Data Collection

In-depth, semistructured, audiotaped interviews were completed by the first author. Each participant was interviewed twice with both audiotaped and nontaped portions of data collection. The goal of the interviews was to gain descriptions of how the men remembered times of socially channeled incapacity—their feelings of embodied removal from mainstream life due to their impairments.

The first author’s time spent with the men while recorders were off was detailed in field notes and described below. These were often those times when first discussing the meeting or coming into the homes while dialogue and observations were first made. These were also times after ending the formal interview, when leaving the home, or viewing something in their immediate environment. The participants were aware that these times were included in the study. Any details that the participants requested we exclude were off limits to the analysis.

As mentioned, two interviews were completed with each participant, which is consistent with phenomenological research approaches aimed at gaining in-depth embodied experience

(Harrison, Angel, & Mann, 2008; Harrison & Stuijbergen, 2005). Although initial interviews could be as short as 30 minutes, subsequent interviews tended to last as long as 2 hours. Interviews were scheduled 2–4 weeks apart unless the participants indicated that more or less time was needed. Interview questions focused on eliciting participants' feelings, perceptions, and experiences surrounding health promotion (Table 1).

Extensive field notes were written after each interview and used to gather information that was unable to be conveyed by interviews alone, such as participant attire, body language, facial expressions, environment, and preliminary interpretations and impressions (Cohen et al., 2000). Participants were notified at the time informed consent was gained that notes on observations such as dress, body language, assistive devices, and environmental details—as well as theoretical observations and documentation of self-evaluations of the interview—were written in the field notes. In phenomenology, saturation is reached when there is sufficient data to depict an experience in its entirety (Cohen, 2000). Recruitment and data collection stopped when field notes showed repetitive patterns of experience and when interviews ceased to provide new perspectives on the experience of health promotion. The investigator recruited two additional participants after saturation was obtained to ensure completion.

Analysis

The conversational, open-ended interviews began after institutional review board approval was provided. The remarks made during the interviews were recorded and transcribed. Demographic data were entered into Statistical Package for the Social Sciences (SPSS) 20.0 for statistical analysis. Descriptive statistics were used to summarize the demographic makeup of the sample. Each participant was provided a pseudonym for identity protection. We do not refer to any of the men in this report by their actual or given names.

The philosophical work of Husserl (1999), Lévinas (1987), and Merleau-Ponty (1962) guided our interpretation. The analysis process of Cohen et al. (2000) and Sultan (2018) guided our pragmatic steps. These steps are guided by an interpretive mindset, which is held steady by referring to the philosophers' words. Along with text, detailed field notes were read both separately and together with transcribed interviews. This

encouraged each component of the interpretation and analysis process to inform the other.

The analysis moved from minute analysis to social contextualization and back again within the hermeneutic circle (Cohen et al., 2000). Being a multidisciplinary team of qualitative scholars, we were able to pull from our strengths to accomplish the aims. The first author began the work by conducting a descriptive interpretation of the men's experiences with disability. The descriptive interpretation was done following Cohen et al. (2000), who suggested reading and re-reading the transcripts, line-by-line coding of meaning units, grouping of meaning units into categories, then grouping categories into complementary and/or common groups to form themes. This analysis type can be found in various qualitative reports (e.g., Harrison & Stuijbergen, 2005).

Next, the second author moved the text into a social analysis of the men's experiences while considering their gender and disability. This phase, done by tagging commonly described phases explained within the text by the participants, provided an authentic movement from descriptive bodily impairment to the social consequences. Kahn (2000) described this as a potential process for creating themes from the raw data or the categories. This process is published in other qualitative reports (e.g., Volker, Kahn, & Penticuff, 2004).

Finally, the third author pulled analyses together into an embodied experience using many of the recommendations of Sultan (2018). This was done through the examination of the “nonlinear, fluid, and flexible” (p. 205) experiences that occurred to the men without forcing them into our preconceived boxes. The independent descriptions of the self/body and the social analysis of their experiences were reread in entirety then set aside allowing time for the experiences and the philosophical theory to be contemplated. The last step was to sketch out how these pulled together in answering the final question: “What is the context of learning health promotion reported by Black men living with disabilities?” as well as the implications of it.

According to Kahn (2000), researchers should undergo recurrent “critical reflection” to minimize potential bias during the research process (p. 86). Critical reflection begins with being open and honest about personal preconceptions, assumptions, and beliefs about how attitudes can potentially influence the research process (Kahn, 2000).

To describe the lived experience of health promotion for young adult Black men with disability, the authors engaged in critical reflection throughout all stages of this study. The first author is an African American woman and nurse without a disability, aware that her assumptions regarding the health promotion experiences of young adult Black men with disabilities were influenced by interactions with Black men in her life. In addition, as a healthcare provider, she has preconceived notions of what health-promoting behaviors and activities look like based on her experiences. The second and third authors

TABLE 1. Sample Interview Questions

1. Tell me about you and what it is like to live with the mobility challenges you have experienced.
2. We do different things to take care of our bodies. What kinds of things do you do daily to take of yours?
3. What was a typical day like before your impairment? What is a typical day like for you now?
4. When you're feeling bad (physically, mentally, or emotionally), what kinds of things do you do to feel better? What leads you to choose those things?

are both White women with disabilities, sensory and physical, respectively. Having interacted with Black men with disabilities postsegregation in the United States, our views were highly influenced by common disability-related barriers found meaningful across racial divides. However, barriers uncommon or unique to the Black community required our combined “eye” for final interpretations with consideration of social justice outcomes (Sultan, 2018).

RESULTS

Participants

The purposive sample consisted of 11 English-speaking, noninstitutionalized Black men between the ages of 25 and 39 years. Our study included one man born in Cameroon who migrated to the United States when he was 17 years old. The men were all residing in a mid-sized metropolitan area of the Southwest. They reported primarily musculoskeletal injuries resulting in conditions such as chronic back, knee, and foot pain. Most participants were single and had never been married (54%). Another 27% reported being married, whereas 19% were living with a significant other or had been divorced. Despite being of working age with complicated work history, half reported having paid employment and the other half were unemployed, receiving disability benefits. Almost all of participants ($n = 10$) had some type of health insurance coverage at the time of the interviews.

Several participants lived with co-occurring conditions, including multiple physical impairments, posttraumatic stress disorder, attention-deficit disorder, and/or clusters of chronic symptoms, which have gone undiagnosed. The average age of the men at time of impairment onset was 21.3 years, whereas the mean age of the participants at the time of the study was 32.4 years. Sports-related injuries contributed to impairment for three of the participants, whereas most were acquired through work-related injuries. One participant's impairments were acquired after being shot. One participant acquired brain injuries after a serious altercation. One participant lives with chronic pain due to complications related to obesity. Finally, one participant sustained permanent injuries after being hit by a car.

Participants' Experiences

The tension caused by gender flanked the men's experiences of health; preventing acceptable and clear pathways to any type of resolution was a key finding. Most participants offered that their disabilities were sustained from permanent injuries in part because they did not seek timely healthcare for those injuries caused by performing manual labor or engaging in athletic sports. The phenomenological essences of their physical and emotional limitations are described in Table 2. According to Dahlberg (2006), “essences are not something that we as researchers explicitly add to the research. They are there

already, in the intentional relationship between the phenomena and us” (p. 12). Phenomenological essences provide a historical and spatial framework for an existential understanding of experiences. The Black man's representative body is flawless in their narratives: athletic, strong, and masculine. The “Black sense of self” was only incapacitated when the Black body was treated as injured by employers, women, and other judges of the body. At that point, they worked to disentangle the self from their Western views of masculinity in order to live a moral life.

When asked to reflect upon why the Black men did not seek healthcare or why they did not follow doctors' prescriptions, these men described their decisions using four themes. First, they discussed wanting to prove their manhood and invulnerability by pushing through their pain. This was their endeavor to be transcendent beings, not broken by the constant or regular bouts of pain. Second, these men described economic constraints that forced them to keep performing manual labor or prevented them from seeking medical care. These activities forced them to feel the pain they worked very hard to transcend. Third, they discussed a sense of distrust toward medical providers that left few alternatives for healthcare. Finally, the men engaged in activities they perceived as health promotion, which integrated spirituality with self-care and self-assuagement. We reviewed below each of the themes surrounding how masculinity couples with the male body to drive health promotion.

Maintaining Manhood Most participants discussed the ways their beliefs about masculinity caused them to avoid seeking healthcare when they first started experiencing pain or to reject doctors' advice to avoid strenuous exercise. Bobby, for example, sustained a disability after returning to sports too soon after an initial injury. Bobby explained how his sense of invulnerability led him to return to the basketball court too soon: “You're invincible, right?...You have an idea like you're superman.”

Ethan lives with a chronic, disabling physical condition and posttraumatic stress disorder, both of which were sustained while serving in the military. Ethan's physical disability was exacerbated after he began running again after his initial injury. When asked why he kept running after being injured, he explained:

Because I'm a soldier. I was in the military. That's what I was taught. You push through things. You push through it. That training doesn't leave you. It doesn't. It'll be a part of your life for the rest of your life.

Thus, Ethan's training in the hypermasculinized institution of the military magnified his commitment to masculine stoicism in the face of pain.

Wayne was injured after falling through a floor while working on a construction site. His back injury became permanent

TABLE 2. Phenomenological Essences

Theme	Essential description	Textual examples
Seeking to survive	After the injuries, the men sought a fair and balanced reorientation in which to view and be viewed within the world. Their past self-desires and goals remained.	“Like I said, it’s like going to lawyers. If they can’t get you off, why go? You can’t even get well going to a doctor. If anything, you get sicker. Why do we even patronize them?” “You know because you know poverty scared me more than anything. You know what I’m saying? Being sent back home. So, you know that’s why I stay away.”
Risking the body to preserve the self	Despite understanding the needs of their injured bodies, the men described putting their “bodies” second when the ‘self’ needed social gratification.	“A man gets things done. It’s not because somebody makes you feel that way, but because your condition makes you feel that way.”
Disconnecting threads of the new body to the old self	The remnants of the old self, coupled with the broken body, created havoc and limited the man’s abilities. They slowly let go of less productive beliefs that harmed the self.	“I grew up with this thing, I just had to get you back if you did me wrong. And honestly, all it did was eventually hurt me because it started causing me health problems like chest pains and, you know just always being stressed. Just wanting to do this because I wanna prove that person wrong.” “If you are in a situation where you cannot do any of that, you feel less of a man.”
Presenting the moral self with a renewed consciousness	The ongoing presentation of self and body to a world of variable kindness demands a moral stance. They eventually sought to release control to God.	“So I’m just really to the point where now I’m just trying to like really, really stay away from like a lot of beautiful women because, for some reason, I’m blossoming more now. Now I’m evolving more into like the man that God wanted me to be.” “But I do know that in this part of my life I can’t do it without God, you know what I’m saying?”

after he refused to seek healthcare intervention. Wayne explained that a sense of being young and invulnerable contributed to his decision to avoid healthcare.

I neglected it to tell you the truth. I kept on working. I got a moving job and, yeah, I was determined that I was going to beat this. I’m young and I can do this, and I didn’t want to hear anything.

Though masculine values of stoicism and invulnerability are common themes in the literature on men’s health seeking, these values appear to be particularly poignant for these young Black men. Terrance sustained permanent disabilities after being shot multiple times. He reflected upon how values of masculinity are particularly salient in shaping young Black men’s reluctance to seek healthcare.

I think...us young African American men, we do care about our health. But we just afraid of showing it, you know what I mean? We’re just afraid of letting people know that we care, because we got this persona that, you know...we can handle anything. You know, we hard and all that, you know?...If we get sick and get a flu...we’ll just be like, “Cough that off. It’s all good. I ain’t taking no medicine. I’m good. I’m gangsta.”

Scholars have documented how values about masculinity are particularly powerful forces shaping the self-presentation of Black and Latino boys and young men in low-income, urban contexts (Majors & Billson, 1993; Rios, 2011). Majors and Billson (1993), for example, developed the concept of the “cool pose” to explain why many Black young men in these social contexts adopt a street style, exuding toughness and aloofness. Others have suggested this particular masculine performance is likely to discourage these young men from seeking healthcare (Courtenay, 2000). Our findings suggest the “cool pose” can contribute to the onset of permanent impairments, as these young men tried to live with their pain or self-medicate. They feared being viewed as vulnerable more than they feared not receiving care for their injuries or pain.

Economic Constraints Although these men often discussed masculinity as a driving force in their avoidance of seeking healthcare, they also discussed their decisions as practical ones rooted in their positions as poor and working class men. Several of these men described why they returned to strenuous labor after being advised by doctors not to do so. In short, without access to professional jobs, these men’s livelihoods depended upon the exertion of their bodies in physical labor.

Brandon has chronic and severe back pain due to an injury he sustained in the military. Yet, he continued to work two part-time jobs, one as a nurse's assistant and the second as a cashier at a large discount chain. Both jobs required high levels of physical stamina, and both jobs intensified Brandon's pain levels. Yet, Brandon explained that he could not stop working these jobs because they were his only means of financially supporting himself.

I tell you, I'm finding it very rough. I may not speak it, because, you know, sometimes you bear with things. Because, look, who is out there going to help you? If you say, "Well, my back hurts"...who is going to feed you?

Wayne sustained a permanent back injury while working a construction job. Despite doctors' recommendations, he continued to work physically demanding jobs such as with a moving company. This work worsened the severity of his injury. Wayne discussed how the thought of not working felt like a challenge to an essential part of his identity.

I think the pride part was with them telling me, "Don't do any more work. No heavy lifting. Maybe sign up for some disability." And I said, "Oh, no, no, no, no, no." You know, I always worked. I love to work, and that's when the pride part came in.

For Wayne, pursuing manual labor even with a back injury was a decision he made resulting from both his values about masculinity and his position as a working class man. Wayne's pride as a man was bound up with his identity as a hard worker; yet, this pride in work was also rooted in the ability to perform physically demanding, working class jobs. Without a college degree that could land him less physically demanding work, the loss of his physical strength meant that Wayne would lose his identity as a worker. In addition, even with his disability, Wayne continued to seek out temporary jobs "under the table" as he defined them. He explained, "Whatever I can find, I'm going to go ahead and do, just to take and make that money."

In addition to the constraints imposed by the need to perform manual labor, some participants discussed avoiding healthcare because of financial constraints. Wayne, for example, stopped attending therapy sessions for his back because the copay increased.

I was going to do therapy maybe like once a week or so...They'd like tie me up, and...this machine...would stretch my back out...So, I was enjoying those, and those were only \$10.00. So, all of a sudden the hospital went up on their copays. So, I was like, man, you know, I can't afford that...The money I was making wouldn't suffice enough for me to continue to do those treatments like that.

When discussing why Black people might avoid seeking preventative healthcare, Terrance also pointed to the fear of acquiring costly diagnoses.

And we afraid of the price, you know what I mean? Paying those bills, you know, those hospital bills—all that stuff, you know? You're like, "Man, I got bills already I gotta pay."

The "Risk" of Healthcare The dominant model in health research is to define healthcare avoidance as risky behavior. Yet, most participants defined seeking healthcare as risking their bodies or quality of life. Participants often argued that healthcare providers were not to be trusted, as they were motivated by profit. They also frequently asserted that healthcare procedures and medications posed more of a risk to their untreated conditions. Finally, they argued preventative healthcare would only add to their already stressful lives if unknown conditions were diagnosed.

Franklin lives with chronic pain as the result of complications related to obesity. At the time of his interview, Franklin had joined a chapter of a weight loss company. He stated he was happy with this community, but he discussed his disappointment in seeking professional help to lose weight prior to joining. "People [healthcare providers] only help you so far, and most of them are in it for the money," he argued. "They're not really concerned about you."

Most of the participants also believed that seeking healthcare in formal settings posed a greater risk to their bodies than avoiding healthcare procedures. Several participants avoided major surgeries to relieve their pain or correct their conditions out of fear their impairments would only be rendered more severe by the procedures. Jacob, for example, has avoided a surgery to correct a chronic condition. He explained this decision.

It's really, they ain't gonna do nothing...You can't even get well going to a doctor. If anything, you get sicker. Why do we even patronize them?

This sense of distrust was generated at the intersection of race and social class. Bobby was the only participant who had a professional career, which afforded him access to private health insurance. Bobby discussed his health-seeking decisions with great detail. He was the only participant to identify different surgeons by name and to discuss the strengths and weaknesses of each surgeon. Bobby's private health insurance likely afforded him the opportunity to cultivate consistent relationships with doctors and specialists. By contrast, other participants often felt that they received lower quality care as a result of relying on public programs or having no health insurance.

Jacob asserted that the source of this distrust was rooted at the intersection of racial and economic prejudice from within

healthcare institutions. Jacob argued that he would receive better treatment if he were an upperclass Black man.

I ain't gonna lie, man. If I was Wayne Brady, I wouldn't mind...If I was one of those Black people that they liked man, I'd go.

Having little faith in medical institutions, most participants felt that seeking preventative healthcare would offer only dismal news without any promise of healing. For poor and working class men who were already shouldering high levels of stress, visiting doctors who would offer only life-threatening diagnoses without certainty of healing did not seem to be a worthwhile calculation. Referring to Black people as a group, Terrence explained:

Most of us don't wanna go to the doctor, man. We're afraid of what they're gonna tell us. It's almost like, man, if we go, we know for sure we're gonna get diagnosed with something. So, oh well, I might as well just live my life and just die not knowing there's something.

Health Promotion Most of these men described multiple pressures that discouraged them from engaging with healthcare providers to promote their health. These factors included beliefs about masculine stoicism, economic pressures including work and the cost of healthcare, and a sense of distrust of healthcare providers. Some of these men also discussed engaging in actions that diminished their health, including smoking cigarettes and marijuana. Yet, despite these constraints, these men also discussed steps they took to protect and promote their health. For example, Brandon defied doctors' recommendations and continued to work in physically demanding jobs because he felt he had no other viable economic options. Although within this context of economic constraint, Brandon found ways to try to care for his body. He wore special shoe inserts and a back brace while working to protect his back and feet from further injury. He also tried to set boundaries with his employer to keep the hours he worked on the floor limited to a manageable number.

Attention to diet was a topic that frequently emerged in the interviews. Most of the participants discussed intentions to improve their diets; however, they often discussed how comfort foods sometimes won out over their best intentions. Wayne discussed how he has made a concerted effort to improve his diet.

I don't know if that would have prevented what happened to me, but I eat a lot more healthier now...I'm still not Jack LaLanne or nothing like that. I ain't there yet, but it's definitely a big improvement from where I used to be.

After a car hit him, Chris said he changed his outlook on health. Although he once felt invincible, he has come to

recognize that taking care of one's health offers some protection from the health vulnerabilities people experience.

I realize now that I have to start taking care of myself. Because if I don't, then I'm going to like end up with cancer and diabetes and prostate cancer. Colon cancer if I eat too much red meat. Diabetes if I eat too much sugar and starch. You know, cancer if I smoke too many cigarettes. I mean, it's just like you have to realize that, you know, you could be worse off, or you could be better off depending on your choices.

Franklin, whose obesity was perceived to have intensified his disabilities, joined a weight loss group, which he said was one of the most important steps taken to promote his health. As he explained, "I wanted to do it for me. It was nothing that I was pressured into."

Some participants also discussed the importance of being self-educated, particularly when interacting with healthcare providers. In the first author's field notes, written while leaving an interview, Andre asserted:

In order for a Black man in general to get better treatment, really that's all they can do is really inform themselves, and just be knowledgeable of their health situation.

Finally, 9 of the 11 participants identified their religious beliefs and spirituality as an essential component of their health promotion. When asked what they do to promote their health, participants most frequently discussed relying on regular prayer and meditation, reading the Bible, and attending church as important mechanisms that keep them focused on living a healthy life and avoiding past activities that they defined as diminishing their health. They frequently said they rely on God and reading the Bible to help them through moments when past traumatic experiences come to the surface.

Terrance discussed the strategies he employs to manage the trauma he carries from the gunshot wound he experienced. Interweaving both a reliance on spirituality with both risk-taking and risk-avoiding maneuvers, Terrance's coping strategies exemplify those of most men in the sample.

If I may be real with you...Sometimes I like smoke weed a little bit and listen to music, you know? I read the Bible. I go for walks...go out to eat. Sometimes that kinda makes me feel better, you know?...I actually like—I read also, like, affirmations, kinda giving me a sense of purpose for the day or something that enlightens me.

There were participants who found a sense of purpose in their experiences of pain and suffering by understanding their experiences through a spiritual framework. Jacob had the following to say:

They say God looks after all the little animals. He definitely has looked after me; changed the way I

was thinking. I quit being so angry at everybody and everything, and just started being like it is what it is. I started really being able to see God in everything, how things worked out.

DISCUSSION

Though health researchers have long recognized that orientation to health promotion is deeply gendered, there exists a need to contextualize these gendered processes within interacting dynamics and themes generated at the intersection of gender, race, and socioeconomic status. This article responds to recent calls for gender health scholars to take more intersectional perspectives in their gender analyses (Griffith, 2012; Hankivsky, 2012).

When these men reflected about why they often did not seek healthcare intervention when they first experienced symptoms, they named values of masculine stoicism and invulnerability as a driving force in their avoidance. This common theme has been widely documented in the literature on men's health-seeking decisions (Courtenay, 2000; Mansfield et al., 2003; Oliffe & Phillips, 2008) and may have particularly salient effects on young Black men living in poor neighborhoods. Gender values were not the sole force driving these men's avoidance of healthcare or health promotion, however. With only one exception, these men worked in low-wage, physically demanding jobs prior to the onset of their disabilities. Even when these men sought healthcare evaluations, they often did not comply with the recommendations of healthcare professionals because their livelihoods depended upon their physical exertion in low-wage work. Finally, given their low wages, some of these men had to stop healthcare interventions because they could not afford the cost.

These men also frequently expressed a sense of distrust of medical professionals and in medicine in general. This distrust was produced at the intersection of race and social class. Scholarship on patient trust in medical providers and medical institutions has documented pervasive racial disparities in Black peoples' feelings of trust in medicine compared to Whites (Armstrong et al., 2008, 2013). Blacks express far lower levels of trust in healthcare than Whites, patterns rooted in historic legacies of exploitation of Black people for medical research (Feagin & Bennefield, 2014) and continued patterns of racial bias (Armstrong et al., 2008, 2013). In addition, several men felt that medical professionals would not treat them with the same care and concern as they would upper-class patients, even those wealthier individuals who were Black. Given their lack of faith in medical institutions, the financial and emotional costs involved in seeking healthcare did not appear to be a sound calculation. Taken together, our data suggest that racial inequality, socioeconomic status, and gender interacted to generate a social context and particular perceptions that often discouraged these men from seeking healthcare, continuing treatments, or following the advice of medical professionals.

Despite these constraints, study participants did find ways to protect their health. Even as they engaged in actions thought to be harmful to health, these men made efforts to protect their bodies at work and to eat healthier. This is an important finding for practitioners, as the ways these men promoted their health could easily be missed when running through a laundry list of negative behaviors with patients. Thus, asking the question, "What kinds of things do you do to protect your health?" might be an important question to ask as healthcare providers interact with patients. Practitioners may be better able to foster effective, long-term health-promoting behaviors as they gain understanding of the healthcare needs, experiences, and desires of young adult Black men with disabling conditions.

The study has several limitations to be considered in future research. First, although this sample size with repeated, in-depth interviews is of ample size for a phenomenological study (Morse, 2000), it does not provide a generalizable sample. It is a purposeful sample with a vulnerable and seldom studied group in disability/health promotion literature. Their background was studied to provide transferability. Second, we had a mixed sample of 10 men who were born in the United States and one who was not. This man was not interviewed as a negative case; he was integrated into the full analysis. It is understandable that his life history is not the same as those who spent time with families in the United States. However, we believe that Black men are a special group, deserving singular attention in American history, social justice, and healthcare (Sultan, 2018).

Conclusion

This study makes an important contribution to our understanding of men's health-seeking patterns. By examining the health-related decisions of 11 Black men living with disabilities, it is clear that gender alone does not explain why men do not seek healthcare intervention as often as women. Racial and economic inequalities, along with gendered beliefs, generated contexts in which seeking healthcare intervention and complying with the advice of medical professionals became too costly.

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All study procedures followed were in accordance with the ethical standards of the institutional review board of the University of Texas at Austin. Informed consent was obtained from all study participants prior to their enrollment in this study. The study protocol (2011-10-0109) was approved by the institutional review board of the University of Texas at Austin.

The authors declare no conflicts of interest.

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