

ADVANCING RACIAL/ETHNIC MINORITY MEN'S HEALTH USING A LIFE COURSE APPROACH

Roland J. Thorpe, Jr, PhD; O. Kenrik Duru, MD, MS; Carl V. Hill, PhD, MPH

Ethn Dis. 2015;25(3):241-244.

Key Words: Minority Men's Health, Life Course, Health Disparities

From the Program for Research on Men's Health, Hopkins Center for Health Disparities Solutions, Johns Hopkins Bloomberg School of Public Health (RJT); the Department of Health Behavior and Society, Johns Hopkins Bloomberg School of Public Health (RJT); Department of Internal Medicine, Division of General Internal Medicine, David Geffen School of Medicine at the University of California, Los Angeles (KD); and Director, Office of Special Populations, National Institute on Aging, National Institutes of Health (CVH).

Address correspondence to Roland J. Thorpe, Jr, PhD; 624 N. Broadway, Ste 708; Baltimore, MD 21205; 410-502-8977; 410-955-7241 (fax); rthorpe@jhu.edu

Marked disparities in health indicators exist between White men and racial/ethnic minority men in the United States. These disparities begin early in life and persist through the life course until advanced ages. Not only do minority men have poor outcomes across a broad variety of health conditions when compared with White men, but they are also less likely to interact and engage with the health care system.¹⁻⁴ Although there is a burgeoning body of literature on men's health, the literature has only a paucity of research focused specifically on the health of minority men. Moreover, advancing the study of men's health disparities requires a shift from merely documenting between-group differences to understanding variations in pathways through environmental, sociocultural, behavioral, psychosocial, and biological factors that create and sustain health disparities for minority men.^{1,5,6}

It is well-documented that minority males in the United States experience life differently from infancy onward compared with White men, largely due to social and structural inequalities at all stages of life.³ Beyond exposure to risks that have a direct and immediate effect on health (eg, HIV status, homicide), the primary pathway to adverse health among minority men is through social disadvantages and stressors that accumulate over the life course beginning at early ages. These stressors compro-

mise physiological systems and lead to early onset of age-related diseases and premature mortality. For this reason, scholars seeking to advance the field must consider minority men's health in a life course framework.

Nearly two decades of health research has utilized life course perspectives and theories that provide some indication of influences on health via socioeconomic status, health behaviors, and labor market outcomes such as unemployment, underemployment, and work conditions, but this scholarship has been noticeably silent on the topic of minority men's health.^{1,7-9} A critical next step is to test prevailing life course hypotheses on minority men's health and health disparities specifically. We may then ultimately be able to identify and prevent or treat mechanisms that lead to the reduction of premature mortality and improvement of the lives of minority men. A better understanding of how and why racial/ethnic disparities emerge among younger men is required to develop strategies and policy-relevant solutions that can attenuate/eliminate disparities among men of all age groups.

A life course perspective offers three key features that are important in understanding minority men's health: 1) the opportunity to identify positive or negative cumulative experiences and examine the impact of those experiences on health outcomes; 2) the timing of significant

experiences in life that might contribute to patterns of health,^{8,10} and 3) the insight to understanding how gendered norms, beliefs, roles, and expectations evolve overtime and at different points in the life course.^{11,12} An implicit assumption of the life course perspective directly relevant to understanding minority men's health is that there is substantial variation in health status within age groups, particularly at upper ages.¹³ Because much of this variability is driven by differential social, psychological, and economic experiences over the life course rather than biological/genetic factors,¹⁴ it is evident that minority men's health is amenable to intervention at multiple levels and at different points in the life course.^{1,5,15-17}

The co-guest editors of this special issue of *Ethnicity & Disease* sought to publish a collection of peer-reviewed articles that would begin a discourse on using the life course perspective to understand the health of minority men. In this issue the topics range from psychosocial stressors to obesity and include the following groups of men: African American, White, Samoan and Tongan. All of the authors' work has moved beyond the mere documentation of the health profile of these groups of men to understanding how earlier life experiences impact health in each of these populations. Each of the nine articles is briefly described below.

The first article by C. Hill and colleagues presents a new framework that the National Institute on Aging (NIA) will use to assess progress toward supporting research that aims to reduce and ultimately eliminate health disparities. The authors make

a case that research designed to understand, prevent, and ameliorate health disparities should be a public health research priority. Hence, institutions that protect public health by supporting biomedical research should support health disparities research that is very relevant and important for minority men.

McCaskill and coauthors examined life-space mobility among 501 older Black and White male veterans and non-veterans aged ≥ 65 years using data collected during an 8.5 year period from the NIA-funded University of Alabama at Birmingham (UAB) Study of Aging. Race-veteran subgroup analyses revealed significant differences in demographics, comorbidity, cognition, and physical function. Relative to Black veterans, the authors found significantly greater declines in life-space trajectories for White non-veterans, but not for White veterans or Black non-veterans. Other findings revealed significantly greater declines in life-space trajectories for White non-veterans in comparison with other race-veteran subgroups.

Using data from the NIA-funded Baltimore Study of Black Aging (BSBA), L. Hill and coauthors examined the impact of psychosocial factors, such as stress, depression, and perceived control, on pulse pressure, an established marker for cardiovascular risk (CVD). After accounting for age and health status indicators of the middle-to-old age African American male participants, perceived control emerged as a significant predictor of pulse pressure. These findings suggest that greater belief in one's own efficacy is a protective factor for CVD risk among African American men.

Clay and colleagues sought to examine measures that could explain racial differences in lower extremity function and to identify race-specific correlates of lower extremity function among 501 White and African American men aged ≥ 65 years. Using data from the NIA-funded UAB Study of Aging, these investigators reported that African American men had poorer lower extremity functioning—as measured by the Short Physical Performance Battery—than White men after adjusting for age, rural residence, marital status, education, and income difficulty. Racial differences in cognitive functioning accounted for approximately 41% of the race effect on physical function. These findings can provide insight for researchers and clinicians to aid in identifying older men who are at-risk for poor lower extremity function and in planning targeted interventions to help reduce disparities in this understudied population.

Panapasa and colleagues examined the impact of long-standing obesity on health outcomes among Samoan and Tongan men, aged ≥ 18 years in California. Using data from the Pacific Islander Health Study (PIHS), a probability sample modeled after the National Health Interview Survey (NHIS), these investigators reported that the health profile of Samoan and Tongan men in California is uniformly poor and obesity alone does not affect the risks of poor health outcomes.

Griffith presents a commentary that explains how manhood intersects with other determinants of health to shape minority men's stress responses, health behaviors and health outcomes across the life course. Specifically, he

describes that manhood represents an important lens to understand how minority men's identities, goals and priorities impact their health. Further, Griffith acknowledged that the role of manhood in minority men's health is understudied and underdeveloped. However, a life course approach is important to better understand how manhood affects gendered and non-gendered mechanisms and pathways that explain minority men's health over time.

Gilbert and coauthors examined the relationship between life course measures of racial composition of social environments and diagnoses of hypertension among African American men. A unique feature of this study is that it attempts to understand how social ills that result from living in despondent segregation environments affect health of African American men. Using data from African American men seeking health care services in an outpatient primary care clinic serving a medically underserved patient population, these investigators reported that African American men who grew up in mostly Black neighborhoods and worked in mostly Black environments had higher odds of being diagnosed with hypertension than those who did not. Findings suggest exposure to segregated environments during childhood and later adulthood may impact hypertension among African American men over the life course.

In an article by Bruce and colleagues, the researchers present findings based on data from the National Heart, Lung and Blood Institute-funded Jackson Heart Kids Pilot Study, which is an offspring

cohort study examining cardiovascular disease risks among adolescent descendants of Jackson Heart Study participants. This study examined the degree to which weight status has implications for elevated blood pressure among young African American males aged 12-19 years. These authors reported that nearly 49% of adolescent males in the study were overweight or obese. Further, diastolic blood pressure (DBP) for African American boys carrying excess weight was 4.2 mm Hg higher than the DBP of normal weight African American boys, after controlling for age and lifestyle factors including fruit and vegetable consumption, physical activity, and sleep. These findings provide key preliminary evidence for future studies that can address the manner through which excess weight can accelerate the development and progression of CVD-related diseases among African American males over the life course.

Hargrove and Brown present findings from their study, *A life course approach to inequality: examining racial/ethnic differences in the relationship between early life socioeconomic conditions and adult health among men*. Using data from the NIA-funded Health and Retirement Study, Hargrove and Brown incorporate a life course approach to examine racial/ethnic differences in the relationship between early and later life socioeconomic circumstances and self-rated health among 4,147 White, Black, and Mexican American men, aged \geq 50 years. Findings indicate that the association between early life socioeconomic conditions and adult health vary by race/ethnicity. For example, multiple measures of childhood so-

cioeconomic status (SES) predict self-rated health in adulthood for White men, while significantly fewer measures of childhood SES predict self-rated health for Black and Mexican American men. Moreover, among Black and Mexican American men, the health consequences of childhood SES diminish with age. These findings underscore the importance of understanding the unique social determinants of health for men of color in future investigations of, and efforts to reduce/eliminate, health disparities among minority men.

Taken as a whole, the articles in this special issue represent the NIA's broad and comprehensive framework for considering factors that impact health disparities, ranging from environmental and sociocultural influences to individual-level behavioral, psychosocial, and biological factors that influence population health. Several articles establish pathways across different levels of analyses: the Gilbert article linking environmental and sociocultural influences with hypertension among African American men and the L. Hill article linking sociocultural stressors with blood pressure control, specifically pulse pressure, of African American men. A notable absence from each of the quantitative analyses in this special issue is a measure of manhood as a determinant of men's health that may interact with other environmental, sociocultural, behavioral, and biological factors. The Griffith article describes how such a measure would be useful in advancing our understanding of these issues. We believe that the development of such a measure with confirmatory reliability and validity testing in multi-ethnic

male populations, to evaluate in conjunction with other explanatory factors, should be a priority in this field.

Finally, the articles in this edition of *Ethnicity & Disease* underscore that issues related to minority men's health are dynamic and highly complex. Panapasa and colleagues show that long-standing obesity does not necessarily have adverse effects on the health of Samoan and Tongan men, and Hargrove and colleagues note that for African American and Mexican American men, the effects of childhood SES decrease with age as compared with White men. Both of these studies indicate that other key factors are related to poor health in these minority male populations. This special issue is intended to start a discourse on the health of minority men, and will hopefully serve as a catalyst to encourage new research that moves us closer to a better understanding of how and why health equity for minority men in this country remains a distant goal.

ACKNOWLEDGEMENTS

ABOUT THE GUEST EDITORS

Dr. Roland Thorpe is supported by the Program for Research on Men's Health in the Hopkins Center for Health Disparities Solutions (P60MD000214) and National Institute on Aging (R01AG040100). He is an alumnus of the NIA Summer Institute (currently the NIA Butler-Williams Scholars Program) and the Summer Research Program at the Michigan Center for Urban African American Aging Research (MCUAAAR; P30-AG15281). He is a past recipient of the NIH Health Disparities Loan Repayment Program (L60 MD001407) and a graduate of Florida A&M University.

Dr. O. Kenrik Duru is an associate professor of Medicine at UCLA and is the co-leader of the UCLA site for the NIA-funded Resource Centers for Minority Aging Research (RCMAR) (P30 AG021684). He formerly held a pilot award through UCLA RCMAR and is an alumnus of the NIA

Summer Institute (currently the NIA Butler-Williams Scholar Program).

Dr. Carl V. Hill is the director of the National Institute on Aging's (NIA) Office of Special Populations. In this role, he directs the NIA Butler-Williams Scholars Program (formerly the NIA Summer Institute). Dr. Hill is a graduate of Morehouse College in Atlanta, Georgia and graduate of the inaugural class in the master of public health (MPH) program at Morehouse School of Medicine. He was part of the inaugural class of the Centers for Disease Control and Prevention's Public Health Prevention Service and has worked with the National Center on Minority Health and Health Disparities (now the National Institute on Minority Health and Health Disparities) and the *Eunice Kennedy Shriver* National Institute on Child Health and Human Development. He is chairperson of NIA's Minority Working Group, NIH's Special Populations Research Forum, the Trans-NIH American Indian, Alaskan Native, Native Hawaiian Special Interest Group and co-chair of the Interagency Committee on Disability Research's Committee on Health and Health Disparities.

AUTHOR CONTRIBUTIONS

Research concept and design: Thorpe, Duru, Hill

Acquisition of data: Hill

Data analysis and interpretation: Thorpe, Duru, Hill

Manuscript draft: Thorpe, Duru, Hill

Statistical expertise: Thorpe

Administrative: Thorpe, Duru, Hill

Supervision: Thorpe, Hill

REFERENCES

1. Thorpe RJ Jr, Richard P, Bowie JV, LaVeist TA, Gaskin DJ. Economic burden of men's health disparities in the United States. *Int J Mens Health*. 2013;12(3):195-212. <http://dx.doi.org/10.3149/jmh.1203.195>.
2. Thorpe RJ Jr, Wilson-Frederick SM, Bowie JV, et al. Health behaviors and all-cause mortality in African American Men. *Am J Men Health*. 2013;7(4 Suppl):8S-18S. <http://dx.doi.org/10.1177/1557988313487552>.
3. Williams DR. The health of men: structured inequalities and opportunities. *Am J Public Health*. 2003;93(5):724-731. <http://dx.doi.org/10.2105/AJPH.93.5.724>. PMID:12721133.
4. Bonhomme J, Young A. The health status of Black men. In: Braithwaite RL, Taylor SE, Treadwell HM, eds. *Health Issues in the Black Community*. 3rd ed. Jossey-Bass; 2009:73-94.

5. Hill C, Perez-Stable E, Anderson N, & Bernard M. The National Institute on Aging Health Disparities Research Framework. *Ethn Dis*. 2015;25(3):in issue.
6. Anderson NB. Levels of analysis in health science. A framework for integrating sociobehavioral and biomedical research. *Ann N Y Acad Sci*. 1998;840(1):563-576. <http://dx.doi.org/10.1111/j.1749-6632.1998.tb09595.x>. PMID:9629283.
7. Ben-Shlomo Y, Kuh D. A life course approach to chronic disease epidemiology: conceptual models, empirical challenges and interdisciplinary perspectives. *Int J Epidemiol*. 2002;31(2):285-293. <http://dx.doi.org/10.1093/ije/31.2.285>. PMID:11980781.
8. Thorpe Jr, RJ, & Kelley-Moore, JA. Life course theories of race disparities. *Race, Ethnicity, and Health: A Public Health Reader*. 2013; 355.
9. Theorell T. Working conditions and health. In: Berkman LF, Kawachi I, eds. *Social Epidemiology*. Oxford University Press; 2000:95-117.
10. George LK. What life-course perspectives offer the study of aging and health. In: Settersten RA Jr, ed. *Invitation to the Life Course: Toward New Understandings of Later Life*. Amityville, NY: Baywood; 2002:161-188.
11. Griffith DM, Thorpe RJ Jr. Men's physical health and health behaviors. In: Wong JY, Wester SR, eds. *Handbook of the Psychology of Men and Masculinities*. Washington, DC: American Psychological Association; in press.
12. Watkins DC. Depression over the adult life course for African American men: toward a framework for research and practice. *Am J Men Health*. 2012;6(3):194-210. <http://dx.doi.org/10.1177/1557988311424072>. PMID:22105067.
13. Kelley-Moore JA, Lin J. Widening the view: capturing "unobserved" heterogeneity in studies of age and the life course. In: *Handbook of Sociology of Aging*. New York: Springer; 2011:51-68. http://dx.doi.org/10.1007/978-1-4419-7374-0_4.
14. Dannefer D and Kelley-Moore JA. Theorizing the life course: new twists in the paths. In: V. Bengtson V, Gans D, Putney N, Silverstein, M, eds. *Handbook of Theories of Aging*. New York: Springer Publishing, 2009: 389-411.
15. Kuh D, Ben-Shlomo Y. *A Life Course Approach To Chronic Disease Epidemiology*. New York: Oxford University Press; 1997.
16. Kuh D, Ben-Shlomo Y, Lynch J, Hallqvist J, Power C. Life course epidemiology. *J Epidemiol Community Health*. 2003;57(10):778-783. <http://dx.doi.org/10.1136/jech.57.10.778>. PMID:14573579.
17. Lynch SM. Race, socioeconomic status, and health in life-course perspective: introduction to a special issue. *Res Aging*. 2008;30(2):127-136. <http://dx.doi.org/10.1177/0164027507312086>.