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## The intersection between masculinity and health among rural immigrant Latino men

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### Abstract

Latino men experience health disparities in STI/HIV, diabetes, hypertension, and cancer. Gender roles likely play a role in risk behaviors and outcomes; however, there has been little focus on masculinity in Latino men. We conducted 20 semi-structured interviews with Latino men living in North Carolina. The interviews, conducted by a trained bilingual/bicultural Latino male, prompted discussion around work, family, and stress. Four themes were identified: masculine roles of being a family provider and protector, sources of stress, family responsibility and interconnectedness to health, and coping mechanism. For Latino men, masculinity may have both positive and negative influences on health. For example, the role of family provider may contribute to coping and be a stressor simultaneously. Future research should examine masculinity as a positive and a negative health influence and the additional impacts of gender roles on mens' health.

### Keywords

masculinity; machismo; caballerismo; rural; Latino; men

### Literature Review

In the United States, the Latino population has rapidly increased, particularly in the South. Across the nation, from 2000 to 2010, the Latino population grew 43%, while in the South, it grew 57% (Ennis, Ríos-Vargas, & Albert, 2011). Among the nine states where the Latino population has more than doubled from 2000 to 2010, seven were in the South (Passel, Cohn, & Lopez, 2011), including North Carolina where the Latino population increased by 111% (Ennis, et al., 2011). Based on population estimates as of July 1, 2013, Latinos

represent the nation's largest ethnic or racial minority and by 2060 almost one in three US Americans will be Latino (Office of Minority Health and Health Equity, 2015).

Latino populations in the US experience many health disparities, including higher rates of diabetes, multiple forms of cancer, high blood pressure, obesity, HIV, and other sexually transmitted diseases than white men (Vega, Rodriguez, & Gruskin, 2009). Nine percent of Latino men have been diagnosed with diabetes compared to 6.5% of White men (US Department of Health and Human Services Office of Minority Health, 2015b). Liver and stomach cancer death rates among Latino men were nearly twice as high as white men (US Department of Health and Human Services office of Minority Health, 2015a). Latino men are about 3 times more likely than white men to be diagnosed with HIV (Gray, Valverde, Tang, Siddiqi, & Hall, 2015) and heterosexual Latino men are 4–5 times more likely than white counterparts to be diagnosed with HIV in the US (Lansky et al., 2015).

In order to understand and improve Latino men's health, it is important that researchers and practitioners understand the role of masculinity in health and wellbeing for Latinos. Generally masculinity has been pathologized and described as a barrier for men in practicing health-promoting behaviors (Gough, 2013). Masculinity is typically treated as a set of norms, often rigid norms, to which men must adhere to maintain their social status. Furthermore, as demonstrated in the concept of masculine capital, masculinity is not a static trait and may be more important in some situations than in others. For example, when masculinity is threatened behaviors that can reinforce masculine ideals become more likely, which may increase the need to perform risky behaviors such as hazardous drinking, fighting or sexual conquest. For Latinos, much of the research focuses on concepts of *machismo*. Machismo is not well defined, but typically includes social norms that are aggressive, sexist, chauvinistic, and hyper-masculine attitudes and behaviors (Arciniega, Anderson, Tovar-Blank, & Tracey, 2008), similar to descriptions of traditional hegemonic masculine norms. High levels of machismo, have been found to be associated with higher levels of depression (Fragoso & Kashubeck, 2000), relationship satisfaction (Herrera, Owens, & Mallinckrodt, 2013) and heavy drinking, poor diet, and other risky health behaviors (Galanti, 2003). However, it is important to note that within broader definitions, less often used concepts of *machismo* also include aspects of protectiveness, responsibility and hard work. Linked to this, *cabarellismo* (chivalry), although less often cited, highlights the more pro-social aspects of masculinity and includes behaviors such emotional connectedness to family and friends and problem-solving coping (Arciniega et al., 2008; Davis, 2012). However, little to no research has examined how *machismo* and *caballerismo* might interact to influence health behaviors.

The purpose of this study is to examine how Latino men in a new Latino destination state approach their health, especially as it relates to their jobs and families, and how masculine roles influence perceptions of stress and coping. New Latino destination states are defined as those that had small numbers of Latinos before 1990 but have experienced rapid Latino population growth since that time.

## Method

This qualitative study was conducted by a community-based participatory research (CBPR) partnership in North Carolina, which included: researchers and practitioners at Wake Forest School of Medicine and the University of Iowa College of Public Health; community partners working with Latinos; and lay Latino community members in North Carolina. This CBPR partnership has been working on Latino health priorities and needs for over 15 years (Rhodes et al., 2006, 2014; Rhodes et al., 2012).

The 20 men recruited into this study were randomly selected from the pool of men that had recently completed participation in a HIV prevention intervention targeting Latino men living in North Carolina known as HoMBReS Por Un Cambio [Men for Change]. Briefly, this intervention was designed to increase HIV risk reduction behaviors (i.e., condom use and HIV testing) by training lay health advisors from rural recreational soccer teams. These lay health advisors, known as Navegantes, served health advisors, opinion leaders, and community advocates (Rhodes et al., 2012; Sun, Mann, Eng, Downs, & Rhodes, 2015; Wagoner, Downs, Alonzo, Daniel-Ulloa, & Rhodes, 2015).

### The Interview Guide

The interviews followed a semi-structured format of 29 standard open-ended questions with probes. The interviews focused on broad areas, including; demographics, family life, health, work, and stress. The interview guide was reviewed, revised, and approved by members of the CBPR partnership. The interview guide was developed in English by the CBPR partnership and translated into Spanish by trained professional transcribers/translators. The Spanish-language version was reviewed, refined, and approved by the CBPR partnership.

Each interview was conducted one-on-one in Spanish by a bilingual/bicultural native Spanish speaker originally from Nicaragua who had extensive experience working with Latino men. Each interview was audio recorded. Interviews lasted 30 to 60 minutes. After interviews were completed, they were transcribed into written Spanish and then translated into English by trained professional transcribers/translators. The interviews were coded in English.

Each participant provided informed consent and was given \$20 for their participation. Human subjects review and study oversight was provided by the Wake Forest School of Medicine Institutional Review Board (IRB). The study was also conducted with the approval of community partners.

### Interview Data Organization and Coding

The transcripts were analyzed in two stages (Braun & Clarke, 2006; Fereday & Muir-Cochrane, 2006). The first stage of coding was guided by the interview guide. These codes were organized into larger patterns or domains, which were explored in the second phase.

Coding was conducted by two independent raters. Initially, the primary rater read through all the interviews to develop initial codes. The secondary rater coded the first 5 interviews using these initial codes and then the two raters met and compared codes. Between the two raters a

set of codes was developed based on these 5 interviews. Then, the next 5 interviews were coded by both raters independently, and the raters met to discuss codes and resolve discrepancies while allowing for new codes to emerge. Finally, the same procedure was repeated for the last 10 interviews. The codes were then discussed with HoMBReS Por un Cambio staff for confirmation. The staff agreed with the coding scheme.

After completing coding, the raters met to discuss, develop, and refine themes that occurred within and across transcripts and are reported as themes. These themes were shared and discussed with the study staff again, who validated findings and their interpretation.

### Demographic Data

Demographic data were obtained using a standard demographic form and included age, country of origin, age migrated to the US, years living in the US, highest level of education attainment, relationship status, and employment.

## Results

### Participants

All of the participants reported immigrating from Mexico. The current mean age of participants was 31 ( $SD = 7.9$ , range 20–50) years old. All came to the US between the ages of 15 and 25 ( $M = 20$ ,  $SD = 4.8$ ), and they reported having been in the US for an average of 13 ( $SD = 7.8$ , range 3–30) years.

They all immigrated to the US to work in areas in which they had a family member already working. Eighty percent of the participants were employed year-round in construction ( $n=8$ ) or manufacturing ( $n=8$ ). Many of the participants reported additional jobs that provided extra money, such as handyman work, copper reclamation, auto work, remodeling, and selling vegetables. Most reported working multiple jobs for 25 to 60+ hours a week.

Several participants reported that they supported families in their home country. Not all the men shared whether they had a family, but 14 of the 20 indicated that they had children and of those 14, and 10 indicated that they lived with their spouse and children. However, it should be noted, that we did not ask directly about living with family and this number could be higher, and it does not mean that they live with all of their children. Nearly three-quarters (72%) reported being in a relationship. More demographic details are presented in Table 1.

Participants reported why they came to the US. The most common reason for coming was the lack of opportunity in their home country and having a friend or relative already working in the US. Most participants had family here in the US.

### Qualitative themes

Four inter-related themes emerged from the qualitative data analysis: (1) the masculine role of being a family provider and protector, (2) sources of stress, (3) the family responsibility and interconnectedness to health, (4) coping mechanisms.

**Theme 1: Masculinity and the role of family provider**—Participants reported that the masculine role of the provider for and protector of the family was important to them and motivated their desire to work, despite health concerns. When sharing what motivates him to work, a participant noted,

“My family. Always my family. It’s because of them that I go to work... so that I can give them the best that I can. Not everything, but the best that I can.” Another participant shared, “To get my family ahead... to have enough money so my family gets ahead in life.”

The participants discussed their need to provide for their family being their primary motivation to work, but many also reported living financially month to month. Fear of any financial setback to their family was a threat to their responsibility to provide and protect. Another participant noted,

“I feel desperate [stressed] because in this country they don’t give anything out for free. If I don’t come home with money, they kick you out. If you don’t pay the rent, they take away the electricity. So you have to work.”

Even if injured, the drive to provide, forces men back to work before they are physically ready. A participant stated,

“Thinking that when I work I can have money and feel satisfied that my family has what they need to be happy, and that they are not lacking anything. Because I knew there was no food at home, the bills kept on coming, we did not have any money in savings. So I wondered what I could do to have money, but since my shoulder was injured all I could do was rest at home. So then after 2 weeks, I called the boss and told him I was fine and so I went... even though I couldn’t do anything for 2 or 3 weeks more”.

**Theme 2: Sources of stress**—Stressors listed by the participants included losing one’s job, lack of job opportunities, instability of work due to season and weather, not having enough money to feed the family or send back to relatives in other countries, fearing for their family when they were at work (e.g., harassment), fear of getting injured at work and losing their jobs, accruing bills (e.g., medical and car repair), not having health insurance, and loneliness. Many commented on stress particular to the US in comparison to Mexico because of the pace of the lifestyle, separation from extended family, and legal status. In addition to stress related to the difficulty of the work day, the perceived threat of becoming unemployed drove participants to work as much as they could, in order to save money for times when they could not work.

Participants were worried about being injured at work and potential illnesses from work exposures. In response to being asked about how work affects his health, a participant, who reporting working in a factory responded,

“Cement has chemicals. I think the smoke that gets locked in the factory could affect us over time. The heavy things that we lift, they are 20 or 30 pounds, maybe even 40 pounds that could affect my back over time.”

These worries went beyond the immediate loss of income from sick days to the long-term concern of losing one's job because of missing too many days at work.

Living in the US was perceived as stressful. Adapting to what the men perceived as the US lifestyle was part of that stress, but worries related to experiencing barriers with language, not having health insurance, and deportation of family members who were not documented immigrants also added stress. In addition, social isolation and weaker family ties perceived as consequences of living in the US were identified as worries. Weaker family ties could be doubly worrisome as most of the men stated that they came or only remain in the US to provide for family members with whom they feel a growing emotional distance. A participant reported,

“Sometimes, you get stressed because it is not your country. It is different here in the US. In the nine years I have been here I have only visited Mexico for a week. It stresses you out that you are not with your mom or your dad... my country is more beautiful to me, I would not want to be here. However, I know that being here I can give my daughter a better future, which I could not do in Mexico. One has to think about his family.”

**Theme 3: Family responsibility and health**—Family ties and responsibilities were identified by participants as providing emotional support but were also a source of stress and worry; thus, responsibilities to family and presence of the family provide positive and negative consequences to health in the form of stress and coping.

“I have a family, not only here, but also in Mexico... my mother and father. I have to help them.” Stress was reported from an array of sources linked to not being able to protect family or give dependents what they needed. As another participant noted, “I would become depressed and I would feel bad [if I could not find work]. I would get into trouble, with rent and bills. Long story short, I would feel very bad and stressed.”

Other ways men worried about their responsibilities included providing for sick family not in the US. A participant shared,

“My wife is currently in Mexico. I am currently working, and I miss my family, but I am glad because my daughter is with my mother. They did not know each other. My mother is a little sick, and my wife is there taking care of her. If I did not have a good job, I could not do that”.

Participants also reported being frustrated with their inability to help their children with simple tasks related to adjustment and life in the US. For example, a participant noted that he cannot help his daughter with her school work, noting,

“My daughter sometimes tells me to help her with her homework, but I don't speak English well. So I want to help, but I can't. I see that she needs help, so that does stress me out.”

Finally, participants noted their worry about how to protect family members from harassment from law enforcement. A participant explained, “Sometimes my wife goes to the

supermarket and sometimes she takes a while and if she doesn't have her phone, I start thinking that the police stopped her".

However, at the end of the week, spending time with family and taking them out for the day and being connected to family provided participants with relief and was identified as reaffirming the father's role in the family. Supporting family in the US and in their country of origin requires working as much as possible. Participants reported that it is worth the trouble; however, if their dependents are happy, healthy, and provided for even if the participant cannot see them. These attitudes seem to coincide with their definition of what a man should be doing for his family, as a participant noted, "My children make the stress go away."

**Theme 4: Coping with stress**—Although a few participants stated that they used drugs, alcohol, or sex to alleviate feelings of stress, they stated that many other Latinos participate in these activities, especially those that do not live with their families. In general, participants reported using a number of active coping methods to alleviate stress, including using herbal teas, relaxation techniques, massage, and exercise. Several indicated that having time with their families as the best way to reduce stress.

"When my wife is here, I take my daughter to the farm, since the owners know me. I let my daughter ride on horses or I take them out to eat or I watch TV with a beer. I do that during the weekend. I don't play soccer anymore, but when I used to play soccer we used to go out to eat afterwards."

## Discussion

Little is known about how masculine roles interact with health, work, and family among immigrant Latino men. Much of the research conducted with these men has focused on health outcomes such as HIV prevention (Herbst et al., 2006) or cardiovascular health (Daviglius, Talavera, Avilés-Santa et al., 2012). Research on masculinity is often limited to negative concepts of *machismo*, which are most closely aligned with hegemonic gender roles (Arciniega et al., 2008; Creighton & Oliffe, 2010). This contributes to the overall impression that masculinity in its entirety is a risk factor for morbidity and mortality. Very few studies of Latino men explore more pro-social norms of masculinity or how those norms promote or prevent risky behaviors (Arciniega et al., 2008; Estrada & Arciniega, 2015; Griffith, Gunter, & Watkins, 2012). The results of these interviews suggest that masculine roles, and how men view their responsibilities to work and family, can have both positive and negative impacts on their health behaviors. In particular, pro-social masculine roles of family protector and provider provide the motivation to work, to ignore health problems, or to avoid hazardous work conditions. However, the results suggest that for these men, the stress stemming from anxiety about being able to protect and provide for their families is balanced by the role of father and husband, and spending time with family. This is congruent with aspects of *caballerismo* that suggest connections to family are important (Davis, 2012; Estrada & Arciniega, 2015). Furthermore, how men cope with stress may also be related to concepts of *caballerismo*; specifically linked to problem solving and family connectedness. For example, men in this study suggested that single men, especially men living away from



family would turn to sex and alcohol to cope with stressors. On the other hand men living with family were able to cope with stress in reinforcing connection with family; thus experiencing the positive roles of father and husband provides a coping mechanism that men without families in the US do not have.

We identified four major themes that are likely related to masculinity. Several aspects of Latino masculinity could be linked to these themes. The first theme, role of provider and protector, an aspect of *machismo* and *caballerismo* (Arciniega et al., 2008; Davis, 2012), provides the motivation and rationale for these men to be in the US and to work multiple jobs, avoid sick days and work in hazardous conditions. In the second theme, responsibility to family and its interconnectedness to health, suggests that family provides the emotional support necessary to cope with stressful lives of immigrants in the US. However, the reverse is true as well; if they are away from their families they not only miss the support but also worry for them, leading some to cope using alcohol or sex. In the third theme, stress from maintaining the behaviors to providing for and protecting family is necessarily tied to working. The need to work and the worry of being fired was a commonly mentioned stressor. Many expressed worry about injuries or exposure to hazardous materials. They did not worry about themselves or their health, but how that would impact their ability to work and continue bringing home money. Living in the US and adapting to the US lifestyle, was also described as a source of stress as it related to keeping up with family obligations and ability to keep families safe. Finally, some participants talked about how they dealt with stress, which can be tied to problem solving coping, an aspect of *caballerismo*. Family time and activities were the most common strategies employed by participants. A day at the park with their children balances and justifies the working conditions. Thus, living without family reduces access to some more positive adaptive coping strategies and may increase the likelihood of using alcohol or sex for coping.

### Study limitations

This was a small qualitative study of men that had already participated in a health intervention. Their participation in previous research may have sensitized them to issues about their health; however, they may have been more thoughtful because they were primed to think about themselves, their families, and their communities. All of participants were from Mexico and came to the US between 15 and 25 years of age. Furthermore, most of these men lived with their families. These factors limit the generalizability of this work to men with similar attributes, from Mexico.

During the interviews, we did not ask men to specifically consider how masculinity impacted their lives. The interview guide was designed to engage the participants in conversations around issues and concepts that previous research suggested would connect to their self-definitions as men. They were told that we wanted to gather more information about how being a Latino man impacted their daily lives, but were not further prompted to consider masculinity. Although the men did not speak explicitly of their masculine roles, their responses did align with concepts of masculinity. As an exploratory study this method was useful in gathering information about how family and work impacted their lives



providing concrete examples that could be matched to theoretical concepts. Thus this work should be viewed as exploratory and requiring further inquiry.

This study took place in North Carolina, a new destination for Latinos. Less is known about Latinos in new Latino destination states compared to those in communities that have been traditional destination states such as Florida and California. In fact, the experiences of these participants may better reflect the experiences of men living in other new destination states and thus more studies like this need to be conducted to help illuminate how their health, work, and masculinity interact with other new Latino destination states to impact men's health.

### Implications

Research into men's health is gaining traction, however, masculinity continues to be viewed as a risk factor and that men do little to protect their health (Gough 2006). In other words men's health is treated as less than complex. In the case of men of color, research into the intersection of not only masculinity and health, but a deeper examination of how ethnicity and culture interact with that relationship is called for (Griffith, 2015; Griffith et al., 2012). Although exploratory, this study attempts to address serious gaps in the research regarding the positive and negative relationship between masculinity and health for Latino men. The health of men, and especially men of color, has recently gained some importance in research. Although this research is exploratory, it does have several implications. First, the interplay of how Latino men view their responsibilities to family in the US and in Mexico, shows how earning an income becomes important to their ability to reinforce masculinity. Recent work with men suggests that masculinity is not necessarily associated with negative health outcomes (Sloan, Gough, & Conner, 2010). This exploratory study adds to this growing literature base and suggests that masculine roles and norms might have negative and positive impacts on health, depending on how men are able to exhibit masculinity. For example, coping with stress may depend on how Latino men view responsibility to family. These results imply that we need further work to examine how masculinity might be harnessed to aid intervention efforts or identify where it might hamper them.

Current research has suggested conflict arising from threats to masculinity may increase risky behaviors that reinforce masculine norms and self-definitions. Recent work with men (de Visser & McDonnell, 2013; Gough, 2013) found a relationship between having manhood questioned by oneself or others resulted in a need to even the scale or earn back "man points". To gain back "man points" men had to publically perform behaviors related to hyper-masculinity, e.g. drinking, driving fast, fighting, and other behaviors that express dominance. Whichever definition of masculinity is used, threats to masculinity may be balanced by roles as family provider, taking the family to the park, or watching a movie together. In any anti-immigrant, anti-Latino sentiment community, fear of police harassment or discrimination may keep men in their homes, taking these positive roles from them as well. This resulting conflict may contribute to avoidant coping techniques and increased stress, leading to poor health directly from chronic stress and from avoidant coping behaviors (e.g., alcohol or drugs use and intimate partner violence). This might imply that interventions that increase opportunities to fulfill masculine roles, like family outings,

dinners and entertainment may serve to both help Latino men cope with stress and to allow them to assert their masculinity simultaneously.

As Griffith (2015) argues, to impact the health of men of color, examining their individual health behaviors in a broader societal context is important. A common stressor reported by these men, is fear for the family from local law enforcement. This study took place in North Carolina, which is known to have discriminatory immigration policies and the impact of these policies on health are well documented (Mann et al., 2016; Manshad, 2015; Rhodes et al., 2015). The results of these interviews suggest that the masculine roles may exacerbate the chronic stress associated with immigration policies in states like North Carolina. Thus, policy level interventions to reduce discriminatory law enforcement practices and the formation of Sanctuary cities, could reduce chronic stress experienced by Latino men and their families. Sanctuary cities are those cities or states that limit cooperation between local agencies and federal immigration agencies (Iten, Jacobs, Lahiff, & Fernández, 2014), specifically, they normally do not permit police or municipal employees to inquire about a person's immigration status.

## Conclusions

As Latinos have become the largest group of non-whites in the US, and the Latino populations are growing rapidly, especially in areas they have not traditionally settled (Askim-Lovseth MK & Aldana A, 2010; Elder, Ayala, Parra-Medina, & Talavera, 2009; Kandel & Cromartie, 2011), not understanding the factors that contribute to health disparities among this group will have broader implications to the US as a whole. Currently, research on masculinity and health for Latino men is minimal and as this group grows in size and by generation, these disparities will continue to grow if their needs are not fully understood and attended to. This exploratory study hints at some of the issues that need to be considered to address current and future disparities experienced by Latino men. For many Latino men living as an immigrant, with or without documentation is stressful, but having access to family and contributing to family health and well-being can help buffer these stressors, if the opportunity exists and can be facilitated. Thus, working to protect and keep families together can have important implications to the health of this growing community. Furthermore, mental and physical health practitioners and researchers must be prepared to understand that masculinity in itself is not a risk factor, but how it interacts within particular social environments might be. Much more work into how both aspects of masculinity contribute to the experience and perception of stressors and coping is needed.

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**Table 1**

## Demographic characteristics of participants

<b>Participant characteristic</b>	<b>M ± SD or n (%) as appropriate</b>
Age (year)	31 ± 7.9
Age migrated to the US (year)	20 ± 4.8
Length in the US (year)	13 ± 7.8
Completed at least high school	7 (35)
Monogamous relationship	13 (72)
Employed year round	16 (80)