HEGEMONIC MASCULINITY AS A KEY FACTOR ON HEALTH BELIEFS AND SEEKING HELP IN PUERTO RICAN MEN WITH HYPERTENSION: A QUALITATIVE STUDY

MASCULINIDAD HEGEMÓNICA COMO FACTOR CLAVE EN LAS CREENCIAS DE LA SALUD Y BÚSQUEDA DE AYUDA EN HOMBRES PUERTORRIQUEÑOS CON HIPERTENSIÓN: UN ESTUDIO CUALITATIVO

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ABSTRACT

High blood pressure is a serious heart disease that poses a potential health risk among minority men. Minority populations of Hispanic ethnic background often practice poor preventive behaviors and access to healthcare. In comparison to women, men show difficulties in perceiving threatening signs in their bodies, avoid routine checkups, and have poor adherence to treatment. According to the literature, men's views about health are influenced by their perception of masculinity. The present study examined the experience of 14 Puerto Rican men with hypertension who participated in focus groups. Participants answered questions regarding health, social support, and masculinity. A thematic based coding strategy approach and discourse analyses were used. Protective factors, risk factors, and cultural values for prevention are discussed. The most frequent subthemes that emerged were emotional support based on interpersonal support and spiritual support. The study also found a relationship among the following themes: masculinity and health beliefs; emotional support and health beliefs, and masculinity. These findings provided an opportunity to address risk prevention including adherence to treatment from spouse and partner support as a cultural bridge between men and health in Puerto Rico. Finally, the findings could help to promote research on health psychology in minority populations and the challenges men face with seeking help.

KEYWORDS: Masculinity, hypertension, cultural, seeking help, adherence to treatment

RESUMEN

La hipertensión arterial es una seria enfermedad crónica que plantea un potencial riesgo para la salud entre los hombres de minoría. Las poblaciones minoritarias de origen étnico hispano presentan pobres conductas preventivas. En comparación con las mujeres, los hombres muestran dificultades para percibir signos de amenaza en sus cuerpos, evitan visitas de rutina, y reportan pobre adherencia al tratamiento. De acuerdo con la literatura, las opiniones de los hombres acerca de la salud están basadas en su percepción sobre la masculinidad. El presente estudio examinó la experiencia de 14 hombres puertorriqueños con hipertensión que participaron en grupos focales. Los participantes respondieron a preguntas relacionadas con la salud, el apoyo social, y la masculinidad. Se utilizó como estrategia una codificación basada en temas y análisis de discurso. Se discuten factores de protección, factores de riesgo y los valores culturales para la prevención. Los subtemas más frecuentes que surgieron fueron el apoyo emocional basada en el apoyo interpersonal y apoyo espiritual. El estudio también encontró una relación entre los siguientes temas: la masculinidad y las creencias de salud; apoyo emocional y las creencias de salud, y la masculinidad. Estos hallazgos proporcionan una oportunidad para abordar la prevención de riesgos, incluyendo la adherencia al tratamiento provista por cónyuges y el apoyo de las parejas como un puente cultural entre el hombre y la salud en Puerto Rico. Por último, los resultados podrían ayudar a fomentar la investigación en psicología de la salud orientada a poblaciones de minoría y entender los desafíos que enfrentan los hombres en búsqueda de ayuda.

PALABRAS CLAVE: Masculinidad, hipertension, cultura, busqueda de ayuda, adherencia al tratamiento

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Health disparity among minority populations continues to be a relevant discussion due to the increasing mortality rates in the past few years. According to the Centers for Disease Control and Prevention (2011a), men and woman from Hispanic ethnic background reported a rise in cases across the five top leading causes of death such as chronic heart disease, cancer, respiratory diseases, stroke, and accidents. The report showed an alarming increase among Hispanic men for each cause of death. Chronic heart diseases are the leading cause of death worldwide, and about 9.4 million of the 17 million are caused by high blood pressure, also known as hypertension (World Health Organization, 2013). Hypertension gradually worsens health and should be treated as a chronic disease (Sperry, 2009). In the United States, 68 million adults have high blood pressure and half of them do not comply with treatment. Direct and indirect annual estimated economic burden caused by hypertension is 93.5 billion dollars (Centers for Disease Control and Prevention, 2011b). In Puerto Rico and the United States, one in three adults has high blood pressure (Rodríguez & Marazzi, 2010). Puerto Rican men between 45 to 65 years old are at risk of developing hypertension (Behavioral Risk Factor Surveillance System, 2005).

The study of vulnerability factors among men with different backgrounds is well documented in research. For minority and marginalized populations, some of these factors are key to help seeking behaviors. Hispanics and African American men are more likely to drop out of school or college compared to women, also they are more likely to be accused as perpetrators in criminal related cases than women and have high unemployment, and experience violent deaths including suicide (Centers for Disease Control and Prevention, 2011b, 2013; Suicide Prevention Resource Center, 2013). Men's poor health behaviors could place them at risk for excessive alcohol consumption or other substance abuse, and more likely to be tobacco smokers and have sexual encounters with more than one partner (Courtenay, 2003). In contrast to men, women are more likely to engage in prevention activities (Courtenay, McCreary, & Merighi, 2002). Men report fewer screening visits, poor social support, and poor adherence to treatment (Courtenay, 2011). Hispanic and Black men are more prone to hospitalizations than other groups, and most are not enrolled in health insurance because they view it as unnecessary (Centers for Disease Control and Prevention, 2011a; Livington, Minushkin, & Cohn, 2008). A similar trend has also been observed in Puerto Rican men for almost every scenario previously described (Instituto de Estadísticas de Puerto Rico, 2009). Despite the available quantitative evidence, further research is needed to fully comprehend the health behaviors of Puerto Rican men. The gap between help seeking behaviors and healthy lifestyles continues to be wider because it has not been fully perceived by men as a risk.

Minority men from different cultural and ethnic backgrounds have reported poor health beliefs in areas such as cancer, heart disease, diabetes, safe sex practices, and HIV, and others as compared to other men (Courtenay, 2002, 2003; Courtenay, McCreary, & Merighi, 2002; Fisher & Fisher, 2000). The traditional and cultural roles associated with masculinity assumed by these men are predominant in their behavior (Galdas, Cheater, & Marshall, 2005; Williams, 2003). Research has suggested that men who endorse traditional male discourses exhibit poor health beliefs and are more prone to high risk behaviors than men who show fewer male traditional discourses (Addis & Cohane, 2005; Brown, Avis, & Hubbard, 2007; Courtenay, 2000; Felicié-Mejías, 2007; Felicié -Mejías & Toro-Alfonso, 2009; Fleming, Lee, & Dworkin, 2014; Levant & Wimer, 2014). Social discourse about role of men in society has coexisted historically across cultures. This discourse, known as hegemonic masculinity, is constantly reinforced and authorized by a patriarchal

society over other possible masculinities that attempt to disrupt the order previously established (Connell, 2005). Any behavior associated with weakness is subject to scrutiny by other peers. Behaviors and attitudes sustained by men are rooted in how they perceive themselves in public and private scenarios through male daily life activities such as social interaction, problem solving, corporal movement, tone of voice, sexual performance, body image, eating, and hygiene habits, just to name a few examples (Courtenay, 2011). Nevertheless, past research has challenged this notion by suggesting that there are multiple masculinities within one culture that are subject to factors such as access to power, education, profession, social status, sexual orientation, race, and ethnic group (Connell, 2005; Kimmel, 1994; Ramírez, 1999; Toro-Alfonso, 2008). Access to power is predominantly a common factor reported in the literature. According to Toro-Alfonso (2009), men not only display power over women, but also use power among their peers as an official discourse of masculinity, also known as hegemonic masculinity. This notion goes beyond the subordination of women by regulating and excluding poor men, minority men (Black and Hispanic or Latino, among others), men within the LBGT community, nonviolent men, men who are single parents, caring men, unemployed men, men with physical or mental disabilities, and men with a current disease. Therefore, the present study aimed to explore how Latino men, specifically Puerto Rican men, perceive a diagnosis of hypertension and its treatment within the social discourse of hegemonic masculinity. The study key questions were: (a) What are the common barriers and challenges of Puerto Rican men who face hypertension? (b) What are the experiences of Puerto Rican men toward the diagnosis of hypertension? and (c) What are the common protective factors that Puerto Rican men with hypertension have during treatment?

METHOD

Participants

The sample consisted of 14 Puerto Rican men diagnosed with high blood pressure. The participants met the following criteria: Puerto Rican nativity, adults (21 years or older) and received medical treatment for hypertension. The selection criteria was designed to (a) select men from a Puerto Rican nationality, (b) include participants as consenting adults, (c) assess current treatment related to their heart conditions. Puerto Rican men who agreed and met the criteria to participate in the study ranged in age from 36 to 81 years old, with a mean age of 59 years old. The current relationship status was the following: 10 (71%) were married, two (14.3%) were divorced, one (7.1%) was widowed, and one (7.1%) lived with a domestic partner. For participants' academic status, two participants reported unfinished school (14.3%), three had a General Educational Development (GED) or a certificate of High School equivalency (21.4%), three had an associate degree (21.4%), five had a bachelor's degree (35.7%), and one had completed some graduate studies (7.1%). Their current occupational status, one man had a part-time job (7.1%), eight worked full time (57.1%), four were retired (28.6%), and one had a disability (7.1%). Regarding health insurance, 10 participants reported a private health insurance (71.4%), one was insured by the Puerto Rico State Health Coverage (7.1%), two were insured by Medicare (14.3%), and one was not insured (7.1%). The type of support reported by 12 participants mainly consisted of interpersonal support based on emotional support from their partner or spouse (69.6%).

Among men who recently had their blood pressure checked, one reported normal blood pressure (< 120/<80mmHg; 7.1%), one informed having prehypertension (120 to 139/80–89mmHg; 7.1%), and 12 reported having hypertension Phase I (140–159/90–99mmHg; 85.7%). Regarding current

treatment, participants reported the following: eight men had been in treatment for 1 to 5 years (57.1%), four had been in treatment for 6 to 10 years (28.6%), one had been in treatment for 11 to 15 years (7.1%); and one reported being in treatment for 15 years and more (7.1%). Ten men reported a family history of heart conditions including hypertension (71.4%). According to the body mass index (BMI) scale system, participants were obese (M_{BMI} = 30.67, SD_{BMI} = 4.3). Participants reported the following prevention activities: seven had attempted a diet (42.9%), four reported doing exercise, one had reduced alcohol or others substance use (7.1%), and one reported no prevention activities (7.1%). Five men reported past mental health treatment for anxiety (35.7%) and seven for depression (42.9%).

Procedures

The parent current study used a mixed methods approach that included the following measures to assess quality of life (Berberi, Rossignoli, Correr, Fernández-Llimós & Marco de Toni, 2008), health beliefs (Torres-Pagán, 2014), and gender role (Toro-Alfonso & Varas-Díaz, 2003), and also employed focus groups that employed a qualitative methodology. Findings from the above measures are reported in Torres-Pagán, 2014. In other words, this was the qualitative phase of the original study. A thematic coded analysis based on men's health behaviors and gender role was applied using NUDIST NVIVO V.9. The software provided multiple analyses from content categories to reports. A discourse analysis was chosen because hegemonic masculinity is considered a social phenomenon narrative conceived within discursive bodies such as health and gender socialization (Connell, 2005; Kimmel, Hearn & Connell, 2005). This analysis provided the opportunity to obtain a closer look at the participants' experiences and the attributions they have as men facing hypertension. As part of the analysis and transcriptions were reviewed. A category list emerged as a guide through the process, which contained topics related to current health status (physical, emotional and social domains), adherence to treatment, coping strategies, and masculinity. The categories were discussed between the authors including two other graduate students until there was an agreement. The author, as well as two graduate students independently reviewed the transcripts. A preliminary list of categories included areas related to illness perception during treatment, masculinity tension in seeking help, and adherence to treatment. The authors met one last time to discuss and establish a systematic mechanism to review the preliminary list that eventually led to the final categories. Text or quotations for which there was no agreement between judges (authors) was excluded from the final analysis. The agreement rate among researchers after they reviewed the final categories for the first focus group was 91.64% and for the second focus group was 92.58%.

The institutional review board approved the research protocol. Participants were recruited voluntarily from a larger study (N = 115) during the initial research stage. A total of 14 Puerto Rican men (M_{age} = 59.50, SD_{age} = 11.82) agreed to participate in focus groups. Informed consent prior to participation was obtained, and participants received a $10.00 stipend as well as the opportunity to win an 8 GB Apple® iPod Nano in a raffle. Two focus groups were constituted. Audio recordings from each group were obtained. Participants completed demographic questionnaires that included their general information, self-ratings of their health status, and socioeconomic status. Guided questions were based on the literature and assessed by peers and experts in the field before initiating the focus groups. Some of these questions included the following: What changes on your routine have you done due to your illness and how do you feel about them? How do you perceive your family dynamics after your diagnosis? Have you feel less than a man for being ill? Modifications were made by the first author and members of his research

team to adjust the content for participants according to the research objectives.

RESULTS

Three main themes emerged from the qualitative study: (a) *tension between masculinity and health: considerations about masculinity in seeking help*, (b) *experiences toward diagnosis*, and (c) *incongruences between perceived support and masculinity*. Table 1 provides a description for each main theme. A final list of subcategories emerged from the analysis as well, which included participants' health beliefs, unawareness of illness, emotional support, spiritual support, and instrumental support. Each theme is discussed separately. A cluster analysis was used to visualize patterns that share similar attribute values based on Pearson correlation coefficient from -1 (*least similar*) to 1 (*most similar*). Queries by word frequency were also obtained. Both analyses focus on key findings. This section includes quotations translated by the authors because focus groups were conducted in Spanish. A code was provided as an identifier with a number for each participant next to the text (e.g., P1 = Participant 1).

TABLE 1.
Description of the Main Theme Categories.

Main Theme	Description
1.Tension between masculinity and health: Considerations about masculinity in seeking help	Verbalizations about difficulties men face towards health such as health beliefs vs. hegemonic masculinity.
2. Experiences toward diagnosis	Verbalizations about challenges men find in recognizing illness as a threat and self-efficacy.
3. Incongruences between perceived support and masculinity	Verbalizations from men about how they perceived support vs. hegemonic masculinity.

Tension Between Masculinity and Health

Participants exhibited tension associated with masculinity when addressing certain topics related to health and how they perceived it as it shows in their health beliefs. Cluster analysis based on Pearson correlation coefficient suggested a relationship between masculinity and health beliefs (.83). Queries by word frequency for this subtheme also suggested difficulties with *perceived severity* (n = 6) and *cues to action* (n = 8) compared to others health beliefs subthemes by reporting less related words. Responses are categorized as subthemes for each health belief and described below.

When asked what they thought about the diagnosis, some men denied possible symptoms. However, once they perceived it as a real threat, they became aware of how vulnerable they can also be. Men who showed *perceived susceptibility* considered age as an important factor in life. According to some participants, men usually do not recognize how susceptible they are in time to correct their lifestyle. For example, P2 said, "A young person with hypertension does not think about this. Man, this is dangerous. This is not necessarily an old-man disease. I think it is something we caused." Also, P8 stated, "Well, it attacks you at a time when you are more mature. When young, you don't think about getting sick."

Men described their *perceived severity* of the disease with metaphors and its consequences when asked what they thought about prevention related to their condition. Metaphors frequently used by people with chronic diseases might be interpreted as negative and associated with war, inactivity, and death among others (Sontag, 1978; Weiss, 1997). In some responses, metaphors associated with death (e.g., "six feet underground, in position," "ready to be in the soil") and productivity (e.g., "burden; disable or useless") were used. However, they recognized the potential risk of death. Other men placed more value

on death rather than being publicly vulnerable in front of family members.

> Many times, we don't go to the doctor, leaving it for tomorrow, and when you realize it's too late. You are having a stroke. (P11)

> Six feet underground, in position (P14)

> Ready to be buried [en el suelo] (P10)

> I want to share this. The problem with hypertension and strokes are the aftermath if you are alive. If you die, they bury you, but if you remain alive, you have to make someone take care of you and you are useless. (P11)

When asked about possible challenges and limitations with treatment compliance, men described new health behaviors such as assessing positive effects from treatment (e.g., medication), attitude toward life, learning about the disease, and self-care.

> I do find it hard to take the medication and follow treatment because I'm reluctant to take any medication. But I'm taking it because it's working. Every change counts, you know. (P5)

> I am slowing down. Back then, I used to rush things, but now I'm not concerned about what it's not possible to do. I changed my attitude toward things, and that has helped me a lot, which means less stress. (P2)

> Taking the pills and taking care of me. Learning a little more about the disease. Also, now I'm more aware that I need to exercise. (P8)

There were also some negative responses about medication as well. Among the most commonly *perceived barriers* to treatment expressed by men were medication's side effects (damage to other organs of the body, urinary frequency, diarrhea, and dependency), medical expenses, and reliability in treatment.

> I take the medication religiously. I don't want to have a problem. But I have a concern if I have Panadol or anything else other than hypertension. The effect that eventually, after 5 years, 10 years, 20 years. What will happen to my liver, and my kidney? [head nods and verbal in agreement among participants]. I've seen a few ads of medicine that have more dangerous side effects. (P2)

> In my case, I take Losartan [blood pressure medication] for $50 and paid enough. It was a generic but still expensive. (P7)

> It bothers me going to the bathroom so much [laughs among participants]. If I go to the mall, I have to find a bathroom, If I'm going away . . . to the bathroom. Look, change the pill that has no diuretic. (P4)

In addition, a group of men expressed different views about medications through metaphors when asked how they perceived themselves in compliance with medication. Some of their views were associated with rituals interpreted as negative, where men must follow a medication protocol, and for others, the body was presented as a mechanical entity. Metaphors commonly used by physicians and patients with heart disease were described within a discourse of production related to an assembly line, control, motor or machine related (Weiss, 1997). These men pointed to malfunction, poor maintenance, and performance as key aspects related to production. The statements suggested that participants were not passive recipient on their view of the body. Instead, these men actively engaged in cultural and historical exchange on what does the body represents and what kind of body they need as proposed by Toro-Alfonso, 2007. Men from the focus group in the present study described how they experienced medication regimens and frequently used some of the metaphors illustrated in Table 2.

TABLE 2.
Metaphors and Quotes from Men Toward Medication Protocols.

Participant ID Code	Metaphors and Quotations
P8	*"Doesn't smell like a new car"*
P6	*"My body no longer works as it used to"*
P2	*"This is slavery for life"*
P7	*"It's a process of life"*
P4	*"I'm getting old"*
P5	*"It reminds me of the calendar"*
P9	*"It's not a 100%, now is like 60%"*
P3	*"What's already is broken, mess everything"*

Additionally, men described difficulties in identifying or recognizing body signs as *cues to action* when asked about their decision to seek help. Participants indicated that they engaged in high-risk behaviors such as the use of alcohol, stressful activities, and poor preventive behaviors. Most of the men failed to obtained early medical care. The following responses described some challenges men experience toward a diagnosis.

> Well, I was in college with a lot of stress and additionally I was working. I was having headaches, and most of the time I was feeling like a pressure over my chest. One day, I visited a nurse at my college. She said: 'Mmm, you have high blood pressure. It's better if we sent you to the hospital right away!' (P7)

> I felt the symptoms, but I did not feel bad. Some dizziness and kept on working. At work, I had a one-time checkup routine. I realized I have my pressure off to the skies, close to a stroke. (P5)

Moreover, participants made important contributions about external cues to action such as media or information accessibility about the disease as difficulties inherent for health promotion.

> Although there are circumstances that you hear from other patients, friends, or family. Do you feel that way? They too, but they are giving me this [medication] and why do they give you that? And then one starts to do his own research. (P7)

> Also, I heard something on the radio station. (P6)

> The ones on TV. I'm not really interested. (P1)

> Publicity, promotion? There is none. (P8)

> We search for information on our own. (P3)

> They should give more concise information, less commercial, more orientation for people awareness. People need to learn, regardless of whether they have it or not. (P1)

Experiences Toward Diagnosis

After men have been diagnosed and treated for hypertension, topics related to awareness and healthy cognitive schemes were noted in their responses. The comments by these men showed the important role of self-efficacy and of preventive behaviors when asked about their experience during treatment.

> The most important thing is to be aware of your condition and how you identify all those elements and situations that unbalance you. Once you recognize this, you can protect yourself. Because the high pressure is like a very serious disease and, if you do not realize, it could be your end. (P10)

> I did not fool around. You only live once, thank God. If I would continue with my drinking and fooling around, I would be dead now. (P11)

> The problem is that, most of the time, men are in denial when a symptom appears, and they won't pay too much attention. This shows that he is a man. (P14)

Incongruences Between Perceived Support and Masculinity

Spouse and partner support perceived by participants played an important role in adherence to treatment when asked about their family. In addition, the ways the spouses and partners were involved in men's health suggested a cultural value known as "marianismo." According to López-Baez, (1999), the ideal woman should be devoted, strong, and loyal toward men. Spousal and partner support described by participants also exhibited traits such as nurturing and self-sacrifice. Nevertheless, participant perceptions about spousal and partner support seemed to question their manhood and challenge the current "status quo" regulated by the hegemonic masculinity discourse. Cluster analysis based on Pearson correlation coefficient supported these findings and suggested a relationship between emotional support and health beliefs (.82), and masculinity (.69). For instance, P3 stated, "Peace…she is taking care of me. They are more concern than usual". Also P9 said, "More aware of what we do…how we feel, but it feels like we are a burden".

Participants pointed out the importance of *spiritual support* during the course of treatment as a coping mechanism. According to literature, people with chronic diseases consider spiritual support to be associated with culture as a coping strategy (Adegbola, 2006; Büssing & Koenig, 2010; Pajewski & Enriquez, 1996). They also noted that spiritual support contributes to a better quality of life in patients. Casas (1995) argued that African Americans and Latinos largely favor spiritual support in their lives.

> Well, my friends and brothers at the church. Also, the spiritual support has helped me a lot. (P7)

> And the spiritual aspect. I feel an incredible peace, I really do. Whoever thinks that religion is not a psychological aspect, practice and you will see it's good. (P2)

> Now, I'm more aware of what I have, [disease] and when I'm in stress, I have religion. Please Lord, help me with my health. I'm not concerned about other things, but keep me in control. (P5)

Most participants' perceived *emotional support* by spouses and partners to be mainly for adherence to treatment, which included diet and medication regime. The results were consistent with literature that has stated that men with partners are less at risk of developing serious health problems (Courtenay, 2003). Dyer and Beck (2007) suggested that couples have a leading role in the quality of life of people with heart disease. Cultural values linked to partners and spouses or family has also been documented in research as a protective factor such as "familismo" (Alderete, Vega, Kolody, & Aguilar-Gaxiola, 2000; Marín & Triandis, 1985). Among Latinos, immediate and extended families are important for decision making in different scenarios that include medical decisions, treatment, or plans. However, traditional discourse among men such as masculinity within prevention may also place them in a position perceived as weak. Some men deal with that tension through humor or sarcasm. According to Brandes (1991), metaphors illustrated through humor are used frequently, in part, because they provide some acceptance and security between men when they share their anxieties and concerns. Conversations among men show the prevalent tension between hegemonic masculinity and challenged masculinity. Some of these men have agreed to allow the spouse or partner to help them with treatment, but others still struggle with the idea. They also feel infantilized when their spouse or partner address issues of treatment, particularly with regard to medications.

> My wife is the one who reminds me about the medication. (P10)

> To scold you [laughs among participants]. (P11)

> For me, my wife selects what I eat. She keeps an eye on my diet and whether or not I taken my medication. (P14)

> She [wife] is the one who's concerned about the pills, always telling me to take them. I take it If I want to [laughs among participants] (P12)

Table 3 includes a brief summary of themes, subthemes, and main quotes.

TABLE 3.
Brief Summary of Main Themes, Subthemes, and Main Quotes.

Main Theme	Subtheme	Main Quotes
Tension between masculinity and health: considerations about masculinity in seeking help.	Health Beliefs	
	• Perceived Susceptibility	"A young person with hypertension does not think about this…man this is dangerous. This is not necessary an old man disease. I think it something we caused".
	• Perceived Severity	"I want to share this…the problem with hypertension and stroke is the aftermath if you are alive. If you die, they buried you, but it you are still alive, you have to make someone to take care of you and you useless…"
	• Perceived Benefits	"Taking care of me… getting to know a little about the illness. Most important, being more aware of exercise or being active".
	• Perceived Barriers	*Relating to medication:* "This is slavery for life"; "Doesn't smell like new car"; "I'm getting old"; "What is already broke, mess everything" "I felt the symptoms, but I did not feel bad…some dizziness and kept on working. At work, one checkup routine. I realized I have my pressure off to the skies…close to a stroke".
	• Cues to Action	"Although there are circumstances that you hear from other patients, friends or family. Do you feel that way? They too, but they are giving me this [medication] and why do they give you that? ... And then one starts to do his own research"
Experiences toward diagnosis	Not being aware of illness	"…the problem is that most of the time men are on denial when a symptom appears and when they won't give too much attention…showing he is the man".
Incongruence's between Perceived Support and Masculinity	Emotional Support	"They are more concern than usual. More aware of what we do…how we feel, but it feels like we are a burden".
	Spiritual Support	"Now I'm more aware of what I have [illness]…and when I'm in stress I have religion: Please Lord, help me with my health, I'm not concern about other things, but keep me in control".
	Instrumental Support	"She [wife] is the one who's concern about the pills, always telling me to take them…"

DISCUSSION

The hegemonic masculinity discourse remains important and a strong narrative as evidenced in some of the themes and cultural elements found in the literature with Latinos in the United States. The current study was one of the few, or perhaps the only one conducted with Puerto Rican men with hypertension living on the Island. As such, it makes an important contribution to the emerging literature on the hegemonic masculinity discourse and health psychology among Puerto Rican men. The present study explored the participants' health, considering cultural elements that account for risk and protective factors through a qualitative approach. A number of risk factors were identified. These included side effects of medication, difficulties in identifying symptoms, poor preventive behaviors, and anxiety. Protective factors reported by participants were age, emotional support, lifestyle, and spiritual support. Some protective factors were also associated with cultural values commonly observed by Latinos such as "familismo," "marianismo," and "religion or spirituality." Although, Latinos share these cultural values as protective factors, they still face socioeconomic and health limitations as the fastest growing ethnic group in the United States (Alderete et al., 2000). Although Puerto Rican men share a Latino cultural legacy, they also remain at risk as Latino men. The findings suggested the presence of a masculinity discourse in men's daily life stories. Metaphors as well as humor were frequently used to channel tension in vulnerable scenarios when masculinity was threatened.

The current study had some limitations that should be considered in future research on masculinity and seeking help behaviors. First, the results cannot be generalized to other groups or contexts due to the small size of the sample and the characteristics of the participants. The results should be considered with caution when studying hypertension in men. Second, some challenges associated with recruitment limited the sample representation due to availability and poor access to primary care facilities, despite the outreach efforts toward physicians and staff. Some of these challenges were probably related to the lack of knowledge with regard to the role of the psychologist in health care settings such as primary care facilities. Therefore, there is a need to establish a bridge between primary care facilities' staff personal and health psychologists that would be essential to improve adherence to treatment with patients in Puerto Rico. The third limitation was the issue related to "group thinking" that has been reported to occur in focus groups studies. This can result in themes that might not emerge as frequently if individual interviews were conducted (Seal, Bogart, & Ehrhardt, 1998). Fourth, responses might have also been affected by social desirability among men. According to research, study participants tend to perform or show themselves differently when they are alone than when they are observed by others (Crowne & Marlowe, 1960; Thompson & Phua, 2005). Some research has suggested that social desirability is manifested mostly in Latinos, particularly among Puerto Ricans due to their history and cultural context (Porrata, 1995). Fifth, transcriptions from focus groups might lose some cultural context after translation from Spanish to English. Sixth, group facilitators at the time were graduate students representing an academic institution, which might have influenced the group process and type of information disclosed by participants.

Despite the study limitations, the findings pointed to the importance of future research on help seeking behaviors of Puerto Rican men in health care settings. Spousal and partner support were the key features related to seeking help and adherence to treatment. Findings from the present research suggested the need for future studies of other venues such as exploring the voices of primary caretakers. Focus groups or semi structured individual interviews as a pilot

study for spousal and partner support may allow examining other possible barriers and challenges such as gender role, family cohesion and adaptability, and couple satisfaction. Acknowledging gender role discourse, family, and culture would allow health psychologists and healthcare personnel to provide better support toward men when it comes to prevention and health care including seeking help behaviors and adherence to treatment. These efforts may help identify early symptoms and improve treatment acceptance that could have a direct impact in decreasing emergency room visits, medical expenses, and turnovers at work, comorbid conditions, and mortality.

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