Sociocultural considerations in aging men's health: implications and recommendations for the clinician

Keywords

Sociocultural factors

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Abstract

The health of aging men, and the particular health concerns that they confront, are commanding greater attention within clinical medicine. Remnants of the biomedical tradition that examines prevention, diagnosis, and treatment of disease states in isolation from the historical, developmental, and cultural contexts in which they occur still predominate even though their impact on the medical care context is slowly becoming recognized. The relations of sociocultural characteristics to patterns of disease risk, health behaviors, symptom responses, delayed diagnosis, and treatment adherence are less well-documented or understood. Empirical evidence supports the role of sociocultural factors in the understanding and management of health among aging men. The essential features of specific ethno-cultural, psychosocial, socio-demographic, and health system variables can offer practical clinical applications for providers. Awareness and understanding of such characteristics will facilitate culturally competent practices that are more likely to engage men in collaborative educational, disease management, and health maintenance efforts throughout their lifespan.

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An evolving body of evidence regarding the particular health issues confronting populations of aging men is receiving increased recognition from practitioners [1]. Ill-health in later life results from complex multi-factorial processes that originate from a combination of biological, social, and psychological factors, all of which are experienced, interpreted, and responded to within men's sociocultural frameworks. While many practitioners acknowledge the importance of such factors within a bio-psychosocial medical model, the reality of overwhelming clinical demands can prompt a more biomedical approach in practice. This results in a tendency to examine and treat disease with minimized attention to related, but often more ambiguous, factors. Although recent work suggests that gender differences in *self-reported* health may be smaller than previously thought [2], a significant literature implies that while women become disabled with age, men experience acute events [3]. Men die, on average, between 6 and 7 years earlier than women, and have higher death rates at all ages and for most leading causes of death. Such disparities are receiving increasing attention [1,4].

Less well-recognized in clinical practice is the fact that the health issues confronting older men *as well as the characteristics that place them at risk* are unequally distributed across ethnic groups. National United States (U.S.) data describing incidence and mortality for leading killers suggest that African American men are more likely to die of heart disease, most cancers, cerebrovascular disease, and diabetes [5]. Similarly, in comparison to European Americans

(172.9/100 000) and Hispanics (127.6/100 000), African American men (275.3/100 000) have the highest incidence of prostate cancer in the United States [6]. African Americans have more than twice the mortality rate of Whites for prostate cancer [7], and among Hispanics it remains the second leading cause of cancer death [8]. Minority men are more likely to present with metastatic cancer/distant stage cancers [5], reducing both treatment options and survival rates. Compounding this problem is an ongoing tendency to examine individuals from highly heterogeneous backgrounds as if they were similar. So, for example, while many ''African American'' or ''Black'' men have been in the United States for generations, more recent immigrant groups from the Caribbean and Africa were raised, and live in, cultural environments that are near-completely distinct [9].

Characterizing diverse groups of aging men

Broadly speaking, there are three ways in which researchers have conceptualized disparities across groups. The first – that groupings represent biologically distinct sets of individuals with differing disease vulnerabilities – has generally fallen into disfavor. Second, public health and epidemiological traditions suggest that ethnicity serves as a proxy for sociodemographic and environmental disadvantages including lower income, education/social class, insurance coverage, employment characteristics, access to foodstuffs and health resources, environmental exposures and so on. Although important, there are reasons to think that this characterization may oversimplify the nature of ethnic ''belongingness'', not least because research shows that ethnic disparities in behavior and outcome persist even when such variables are controlled.

The third approach is more ethnographic and psychological and encompasses characteristics such as culture, identity, minority status, immigration history, religion, language, kinship, and place of origin [10] as well as more psychological constructs such as normative patterns of relating, emotion and emotion regulation, health beliefs and illness cognitions [11]. In this view, understanding the links between ethnicity and outcome requires that we tease apart the meaning of ethnicity as a variable by identifying the proximal variables through which it impacts outcomes [9]. This view suggests that the way disease, illness, and health-related symptoms develop, occur, and are experienced are shaped by a man's contexts. So, while disease has its origins in biological and developmentally-acquired patterns of exposure and risk, such patterns are socioculturally embedded. For instance, early dietary patterns and neuro-endocrine reactivity that may exacerbate a hereditary predisposition for midlife diabetes onset [12] could be influenced by social and environmental considerations including financial or geographic restrictions in access to healthy foods, caregiver availability for balanced meal preparation, and stress responses to neighborhood violence, domestic traumas, immigration troubles, or unemployment concerns. Cultural or familial beliefs about the urgency of treating ''sugar'' could further delay initial or subsequent presentation for treatment. Symptoms and diseases as well as their management are experienced and interpreted within particular contexts suggesting that engagement with an aging man on the matter of his health requires an understanding and appreciation of where he is coming from.

An important implication of this perspective is that both the health and general functioning of current cohorts of aging men represent the ''culmination'' of a particular set of experiences that have implications for their health. Some experiences are particular to men that are currently old (rather than those who will become old), while some reflect ideas about masculinity or aging more generally. It has been suggested, for example, that persons raised in the United States during the Great Depression spent a powerfully formative period living with economic hardship [3]. Such experiences have likely made them hardier, more stoic and with a belief in the value of work, and more closely linked to their families. Older men tend to have low tolerance for uncertainty or medical intimacy, value independence and control, individualism, and ''toughing it out,'' are often isolated, have poor self care, and are frequently avoidant in managing stressors. Men from under-represented groups are, if anything, ''more masculine'' in these regards; they generally report (even) lower anxiety [13], have reduced health-related self-efficacy [14], and, although gender-specific