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Latino/Hispanic young men and health beliefs, acculturation, and emerging adulthood : an exploratory study

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LATINO / HISPANIC YOUNG MEN AND HEALTH BELIEFS, ACCULTURATION, AND EMERGING ADULTHOOD: AN EXPLORATORY STUDY

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Veronica Mendez-Cruz, Director and the entire past and present staff at the University of New Mexico's El Centro de la Raza.

To the Latino/Hispanic young men who participated in this study

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Latino/Hispanic Young Men and Health Beliefs, Acculturation and Emerging Adulthood: An Exploratory Study

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ABSTRACT

The purpose of the study was to identify factors that influenced health promotion behaviors in Latino/Hispanic men's health, including their experiences and health concerns. Acculturation, emerging adulthood and health were the three key ecological variables used in the study. The sample consisted of 16 Latino/Hispanic young men who were students at a Hispanic-serving university in the Southwestern United States.

The study consisted of two data collection sessions. Session one consisted of a semi-structured individual interview and completion of a demographic questionnaire, two acculturation scales, a health promoting lifestyle scale, and visual analog scales for overall health perceptions and quality of life. Session two consisted of a single focus group interview in which participants were asked to clarify and amplify provisional findings from the individual interviews.

The majority (56.3%) of the young men self-identified as Mexican and 18.8% self-identified as Mexican American ethnicity. The Short Acculturation Scale for Hispanics (SASH) and Acculturation Rating Scale for Mexican Americans-II (ARSMA-II) categorized approximately one quarter to one fifth of participants as acculturated or strongly Anglo oriented. Overall, the SASH

showed stronger correlation with health promotion measures than the ARMSA II. The qualitative results indicated that participants struggled with issues of relationships, work and love.

Any future work with young Latino/Hispanic men must take into consideration how ethnicity influences health promotion choices. In addition, any health promotion intervention must engage the Latino/Hispanic family and community. Participants also believed that any health promotion program must use the internet to deliver a culturally competent message.

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Chapter 1

Introduction

Early adulthood is a crucial period in the lives of individuals. It is a time when they may initiate or decide not to initiate behaviors such as smoking, excessive alcohol consumption, unprotected sex, and poor eating habits, which frequently lead to vital health concerns at a young age and poor health later in life. This is true for all racial and ethnic groups, but especially for young Latino/Hispanic males as they are more likely than their white counterparts to lack both health insurance and adequate access to preventative care (Brown, Ojeda, Wyn & Levan, 2000; Rich & Ro, 2002) that may serve to avert consequences of risky health behaviors. Additionally, they are more likely than other groups to experience low educational attainment (Stoops, 2004). There is a scarcity of investigations that focus on the factors that influence health promotion behaviors in 18 to 25 year old young men in general and Latino/Hispanic young men in particular. Health promotion behaviors established early in life are foundational to maximizing the quality of life through adulthood and contribute to reducing health disparities (CDC, 2006). It is critical for individuals to establish this foundation in young adulthood as they move toward independence as an adult.

The purpose of the study was to identify factors that influenced health promotion behaviors in Latino/Hispanic men's health, including their experiences and health concerns (NINR, 2006). The specific aims of this study were 1) explore and describe the influence of emerging adulthood and acculturation processes on the

meaning of health for young Latino/Hispanic men, 2) identify the consequences of emerging adulthood and acculturation processes in terms of health beliefs and behaviors as perceived by young Latino/Hispanic men and 3) generate hypotheses that can be used to develop and test culturally appropriate measurement and intervention strategies to promote and improve the health of young Latino/Hispanic men.

In particular, I wanted to understand how young Latino/Hispanic men experienced the tasks of emerging adulthood. Arnett (2000, 2004) characterized emerging adulthood as a period of identity explorations in the areas of love, work and worldviews. Emerging adulthood is viewed as a period when young people make decisions about their beliefs and values (Arnett). Identity exploration increases high risk behaviors among young adults. I was interested in understanding how the tasks of emerging adulthood influenced health beliefs and behaviors. I also became interested in how young Latino/Hispanic young men experienced the phenomenon of acculturation and what relationship it had with emerging adulthood and health beliefs and behaviors.

Chapter 2

Review of the Literature

The National Center for Health Statistics (NCHS, 2010) estimated that 44% of men between the ages of 18 and 24 years of age drank five or more alcoholic drinks on at least one day and approximately 24% did so on at least 12 days in the past year; approximately 20% are involved in illicit drug use. High-risk sexual behaviors place many young men at risk for contracting and transmitting HIV/AIDS and other sexually transmitted diseases. Lack of exercise and poor nutrition place young men at risk for developing diabetes, hypertension, and obesity which are considered epidemic in the United States (National Center for Health Statistics, 2005c). By establishing unhealthy behaviors that typically become more difficult to change as they grow older, young men who initiate these behaviors are at risk for developing major risk factors for premature death. Young Latino/Hispanic and African-American men are more likely to die from homicide than young white non-Hispanic men (Diaz, 2006; National Center for Injury Prevention and Control, 2010). They are also more likely to be incarcerated for crimes, including petty theft and drug use, and are less likely to have the means to obtain substantive legal representation (Demuth & Steffensmeier, 2004; Schlesinger, 2005; Steffensmeier & Demuth, 2000). Latino/Hispanic and African American young living in the inner city experience many barriers to obtaining adequate preparation for competing in a changing technological world. Limited educational and economic opportunity impacts their

ability to obtain a job and health insurance. The lack of health insurance forces many young men to forgo health screening and treatment (Callahan, Hickson & Cooper, 2006).

Aside from the lack of job security, another issue that may impact a young man's health status is his perception of masculinity. Young men in general and Latino/Hispanic young men in particular are in many instances socialized into concealing their pain or injuries. Davies et al., (2000) found that young men of college age experienced barriers to seeking health care. These barriers included the need to maintain a strong sense of independence and invulnerability. These researchers found that younger men were more likely to espouse this sense of invulnerability than older men. Their sample, however, consisted of White non-Latino college age men; therefore, the extent to which that extrapolates to Latino/Hispanic young men of college age is uncertain.

Emerging Adulthood. Emerging adulthood is a developmental juncture when individuals are no longer adolescents but are not considered by themselves or their parents to be fully adult (Arnett, 2000; 2004; Nelson, et al., 2007). In addition to the demands of love, work, developing a worldview and mature identity, emerging adulthood is also a period of instability during which relationships are fluid; that is, they may be short term. Emerging adults may date several partners in a given period. They also may not have the familial obligations that their parents had in their 20s. In a very broad sense, emerging adults are in transition, moving from dependence on parents toward

independence that will mark their adult lives (Arnett, 2000; 2004). However, emerging adulthood is also a time when young adults may increasingly engage in high-risk behaviors. Arnett contents that freed from parental supervision, emerging adults experience a new found freedom to engage in drinking, smoking, and high risk sexual behaviors.

Acculturation. A major obstacle in generalizing the concept of emerging adulthood in Latino/Hispanic men is the impact of acculturation and assimilation. Acculturation is a multi-dimensional process (Abraido-Lanza, Armbrister, Flórez & Aguirre, 2006). Padilla and Perez (2003) argue that it may be necessary to re-envision the study of acculturation in terms of social cognition, cultural competence, social identity, social dominance, and social stigma. Social cognition characterizes how human beings give means to social interactions in relation to their goals, motives, and values (Padilla & Perez, 2003). Cultural competence requires that an individual have the tools, skills, or strategies to co-exist in a cultural context. A person must be able to know how to behave in a culturally competent fashion that respects another person's beliefs and values (Padilla & Perez). At the core of cultural competence is social identity, which arises out of collective experiences and is socially constructed. Persons come to self-understanding as individuals and as members of a cultural group. Members of social groups construe their experiences in part through their perceptions of dominant versus non-dominant group characteristics, including who will be in the inside and who will be on the outside. Social dominance, in turn, often results in

stigmatizing the non-dominant group, particularly if its members have a distinguishable attribute such as skin color or an accent viewed negatively by the dominant group.

Chapter 3

Methods

Research Design. This study used a mixed methods triangulation convergence research design (Creswell, Plano-Clark, Gutman & Hanson, 2003). According to Creswell, et al., the triangulation convergence research design is the most familiar of the mixed methods designs and is used to corroborate or cross validate findings within a single study. The study consisted of two data collection sessions. Session one consisted of a semi-structured interview and completion of a demographic questionnaire, two acculturation scales, a health promoting lifestyle scale, and visual analog scales for overall health perceptions and quality of life. After the individual interview, the young men were invited to participate in a focus group session. The intent of the focus group was to add depth to the responses from the survey instruments and to clarify and interpret qualitative results from the individual interviews (Stewart & Shamdasani, 1990; Stewart, Shamdasani & Rook, 2006).

Sample & Setting. The sample for the study consisted of 16 Latino/Hispanic young men who were students at a Hispanic-serving university in the Southwestern United States. All were between the ages of 18 and 25. Inclusion criteria included: capacity to give informed consent; and willingness to respond to questionnaires and participate in a semi-structured individual interview and a focus group.

The study was approved by the University of New Mexico Health Science Center Human Research Protections Office. Signed, informed consent was obtained from the participants. The director and the staff of a campus organization that provides a myriad of services to Latino/Hispanic students were approached to discuss the study aims and receive permission to post recruitment flyers. The organization provided a meeting space for the individual and focus group modalities of the study.

Measures. The quantitative aspect of the study used several measures to investigate acculturation and health promotion beliefs and behaviors (Appendix A). A demographic questionnaire, developed by the author, asked participants to provide information about their age, gender, racial/ethnic identification, education, and employment status, and asked questions about their health behaviors (e.g., smoking exercise, and whether or not they performed testicular self-exam)(Appendix A). Acculturation was measured with two instruments: the Short Acculturation Scale for Hispanics (SASH) (Marín et al., 1987) and the Acculturation Rating Scale for Mexican-Americans (ARSMA-II) (Cuellar et al., 1995). Health beliefs and behaviors, and self-reported health status were measured using the Health Promoting Lifestyle Profile (HPLP-II) (Walker & Hill-Polerecky, 1996) and the General Health Visual Analog Scale (VAS), Quality of Life VAS and Self-Rated Health Scale (Lorig et al., 1996).

Short Acculturation Scale for Hispanics [SASH]. The SASH (Marín et al., 1987) is a 12-item measure pertaining to language use and media (items 1 through 8),

and ethnic social relations (items 9-12). All items are rated on a 5 point Likert scale (items 1-8: *1 = Only Spanish; 2 = Spanish better than English [or More Spanish than English]; 3 = Both equally; 4 = English better than Spanish [or More English than Spanish]; 5 = Only English. Items 9-12: 1 = All Latinos/Hispanics; 2 = More Latinos than Americans; 3 = About half and half; 4 = More Americans than Latinos; 5 = All Americans).* Although the mid-point of each Likert scale was neutral, the SASH manual (1995) states that the mid-point "should not be construed to represent biculturalism" (p. 1). A score was obtained by summing all the items and dividing by the number of items. Marín et al (1987) reported a .92 Cronbach's alpha coefficient for the scale and that a mean score of 2.99 or higher indicates a respondent is more acculturated.

Acculturation Rating Scale for Mexican-Americans-II (ARSMA-II). The ARSMA-II (Cuellar et al., 1995) is a 48 item measure consisting of two subscales comprised of 30 items measuring cultural orientation: The Anglo Orientation Subscale (AOS; 13 items) and the Mexican Orientation Subscale (MOS; 17 items). Anglo marginality, Mexican marginality, and Mexican American marginality are measured by 6 items each. A marginality scale consists of 18 items that reflect how difficult it is for a person to accept Anglo, Mexican and Mexican-American beliefs and customs (world view).

All items used a 5 point Likert scale (*1 = Not at all; 2 = very little or not very often; 3 = Moderately; 4 = Much or very much; 5 = Extremely often or almost always*). Cuellar et al., (1995) reported an internal consistency of .68 to .91 for the various

subscales and a 1-week test-retest reliability of .72 to .96. The ARSMA-II AOS and MOS subscales are used to calculate a Linear Acculturation Score (LAS) to determine a respondent's acculturation level. Cuellar et al., identified five acculturation levels (Table 1). The LAS is calculated by using the mean scores from the AOS and MOS and subtracting the AOS mean from the MOS mean. The marginality scales are not used in calculating the LAS; they are primarily descriptive, and their use is optional (Cuellar et al.).

Health Promoting Lifestyle Profile-II. The HPLP-II is a 52 item measure developed by Walker and Hill-Polerecky (1996) based on the original Health Promoting Lifestyle Profile (Walker, Sechrist & Pender, 1987). It consists of six subscales that measure physical activity, spiritual growth, health responsibility, interpersonal relations, nutrition, and stress management. It is self-administered and uses a 4 point ordinal scale (1 = never; 2 = sometimes, 3 = often, 4 = routinely), with total scores ranging from 55 to 208. The HPLP-II was found to have a Cronbach's alpha of .94 and a test-retest reliability coefficient of .89 over 3 weeks; subscale alphas range from .79 to .87 (Walker & Hill-Polerecky, 1996). Walker and Hill-Polerecky indicated that reporting the means " rather than the sum of scale items is recommended to retain the 1 to 4 metric of item responses and to allow meaningful comparisons of scores across subscales" (Health Promoting Lifestyle Profile-II Scoring Handout, 1995). The HPLP-II takes about 20-25 minutes to complete.

General Health VAS, Quality of Life VAS & Self-Rated Health Scales. Visual Analogue Scales (VAS) were initially developed to measure subjective phenomenon like pain (Aitken, 1969; Carlsson, 1983; Dixon & Bird, 1981; Gift, 1989; McGuire, 1997; Scott & Huskisson, 1976). The General Health VAS and the Quality of Life VAS (Lorig et al., 1996) were used in this study. Both consisted of a horizontal 100mm line with verbal anchors at either end (Gift, 1989). The verbal anchors for the General Health VAS were *poor health* at the lower end and *excellent health* at the higher end. The verbal anchors for the Quality of Life VAS had *worst possible life* at the lower end and *best possible life* at the higher end. Respondents were asked to make an X to indicate where they fell in a given dimension relative to the anchor instruments. The distance to the mark from the lower anchor was measured. It is crucial that the line be 100 millimeters exactly, and that reproduction of the line is accurate. The author used the same set of rulers to measure the 100 millimeter line to maintain reliability. The Self-Rated Health Scale is a single item scale with scores ranging from 0 to 5, with a higher score indicating poorer health (Lorig et al., 1996). Internal consistency reliability for a single item cannot be determined. The three single-item measures took 1-2 minutes to complete.

Individual Interviews. Participants were asked to participate in a semi-structured interview that explored and described the participants' perceptions of what being healthy meant to them and creating a health promotion program for young Latino men. Informed consent was sought prior to the start of the individual interviews.

The individual interviews included a period during which the participant was asked to respond to the study instruments. The individual interviews lasted approximately forty five minutes.

Focus Group. Following the quantitative and qualitative data analysis the young men were invited to participate in a focus group that sought to clarify and amplify those findings. The participants were asked to elaborate on the key health promotion issues that impacted their day to day lives. Informed consent was sought prior to the start of the focus group. The focus group lasted for approximately two hours.

Data Analysis

Quantitative. The quantitative data were analyzed using SPSS statistical program (Scientific Software Development GmbH, 2006). Demographics and health behaviors were analyzed descriptively. Analysis of responses to the ARSMA-II, SASH, HPLP-II and the two VAS was primarily exploratory, not inferential. Descriptive statistics included frequencies and mean, median, or mode as appropriate for the level of measurement and distribution. Internal consistency of multiple-item scales and subscales were assessed using Cronbach's alpha. Because the sample was small (n = 16), correlations between scales were assessed with Spearman rank order correlation coefficients.

Qualitative. Qualitative data was entered and analyzed using Atlas.ti software (Scientific Software Development GmbH, 2000). Data were coded using

approaches to coding developed by Glaser and Strauss (1967) and Strauss and Corbin (1990, 1998).

Chapter 4

Results

Quantitative

Sixteen young Latino/Hispanic men participated in the study. The majority (56.3%) of the young men self-identified as Mexican while 18.8% self-identified as Mexican American. Three-quarters of the sample self-identified as heterosexual while 18.8% self-identified as questioning. A majority of the participants were unemployed (56,6%) while 37.5 percent has some form of employment. When asked about HIV status 62.5 % (10/16) reported that they were HIV negative and 37.5% (6/16) reported not knowing their HIV status. Table 2 presents the descriptive statistics and Cronbach's alpha for the acculturation scales used in the study. The close proximity of the mean and median indicate that the scores were symmetrically distributed for all of the ARSMA-II subscales. The SASH scores were positively skewed. Table 3 presents the individual mean scores for the Short Acculturation Scale for Hispanics (SASH) used in the study. One quarter of the participants mean scores were at least 2.99 indicating a high degree of acculturation. The remaining three quarters were less acculturated (scores < 2.99). Cuellar et al., (1995) used the ARSMA-II linear acculturation score to identify five levels of acculturation: Level I (very Mexican oriented <-1.33); Level II (Mexican oriented to approximately balanced bicultural ≥ -1.33 and ≤ -.07); Level III (Slightly Anglo oriented bicultural > -.07 and < 1.19); Level IV (Strongly Anglo oriented ≥ 1.19 and < 2.45); and Level V (Very assimilated;

Anglicized >2.45). Table 4 shows the linear acculturation scores for the study sample. Three participants fell within the Level 1 category, 10 fell within the Level II category and three fell within the Level IV category. No participant fell within Levels III or V. The Spearman rank order correlation between the ARSMA-II Linear Acculturation Score and the SASH mean was .57, p = .022 indicating a statistically significant, moderate positive correlation between the two. There was a high level of agreement on how the 2 measures classified individuals (Table 5).

Health promotion was measured using the Health Promoting Lifestyle Profile-II (Walker & Hill-Polerecky, 1996) and the General Health Visual Analogue Scale, Quality of Life Visual Analogue Scale and Self Rated Health Scales (Lorig et.al, 1996). Descriptive statistical analysis was carried out. Table 6 provides the mean, standard deviation and median for the health promotion measures. HPLP-II total mean score and the self-rated health scale were symmetrically distributed. The two VAS items were positively skewed. Spearman rank order correlations among health and acculturation ratings are shown in Table 7.

As previously noted, there was a moderate, positive correlation between the two acculturation scores that was statistically significant. In addition, the SASH correlated moderately and positively with nutrition, spiritual growth, interpersonal relations, stress management and HPLP-II total. However, due to the small sample size only the correlation with nutrition was statistically significant. The LAS correlated moderately and positively with Quality of Life VAS, but the

correlation was not statistically significant. All other correlations between the LAS and the health-related scales were less than r = |.28|.

Among the HPLP II subscales, Nutrition correlated moderately with health responsibility, spiritual growth, interpersonal relationships and stress management. In addition spiritual growth was correlated with stress management.

Qualitative Data

The qualitative piece of this study was guided by two questions: “What does being healthy mean to you”? and “If someone gave us a million dollars to create a health promotion program for young Latino men what should be included”? Please see Appendix C for the interview questions. I conducted 16 individual interviews and one focus group with 6 participants. The analysis showed that the respondents’ concerns centered around three themes: Health Behaviors, Relationships and Sexual and Reproductive Health.

Health Behaviors

Participants defined physical well-being as having the ability to engage in physical activity. Many of the participants were physically active involved in soccer, bicycling and running. Their ability to engage in these activities provided a sense of well-being. A typical response was “I think for me to be healthy means being able to do all activities.” Another participant reported, “Being healthy overall means being in good condition...being in good medical condition like not having

STDs so your physical, sexual and mental health are the most important things." Mental health appeared to be an important issue for several of the respondents. Mental health was equated with living as stress free as possible. Another participant equated mental health with, "being aware of your genetic history" so that "you can know if you are at risk for schizophrenia or depression." This particular participant had an extensive background in the sciences so his perspective was broader than other participants.

Participants were concerned with maintaining a healthy lifestyle. As previously indicated many of the respondents did not have health insurance. The lack of health insurance required that the respondents develop strategies to maintain their health. To overcome the lack of insurance respondents described strategies to maintain health behaviors. Several resorted to *remedios caseros* or home remedies to care for themselves. In one instance one respondent described an incident when he experienced a head injury while playing with friends. He briefly lost consciousness. He related that, "my friends took me home and they sat with me all night to make sure I stayed awake". When I asked why he proceeded in this fashion he responded that he did not have the necessary resources to seek medical attention he turned to his friends who made sure that "I would be okay".

One respondent expressed regret over what he characterized as unhealthy behaviors. He reported that, "I felt really unhealthy about (partying and playing)…I had.. a lot of shame and embarrassment about the way I had been

drinking". For this participant past regrets created the possibility of changing future behaviors.

Despite the admonition to eat healthy several of the young men did not engage in eating nutritious foods. Their fast paced lives did not allow for sitting down and preparing foods in the typical Latino style. A typical response was, "I do not eat healthy, I eat just one meal or eat fast food every day of the week." While not true of all the respondents, it was evident that this group of young men led demanding lives. Engaging in healthy eating was a complex process for many of these young men. Many were socialized in a cultural context that indicated that one has to eat "an enormous amount of food" in order to stay healthy. However, one participant saw this strategy as unhealthy because it led to obesity and diabetes.

Another issue that tied into the being healthy was the impact of culture on choices. One respondent reported that Latino men are usually socialized into not going to the doctor. A visit to the doctor was not a priority for Latino men. He described as, "because of our culture you know being a man means you don't go to the doctor until you are bleeding to death or something. You have to be a man." In addition one participant felt that Americans put too much emphasis on going to see the physician. His perception was that one would go to the physician when it is absolutely necessary. In the meantime one would be practical and use what is at hand. He reported that "mom gives you chicken soup" to deal with the here and now.

Relationships

Many of the respondents expressed concerns about initiating and maintaining relationships, particularly relationships that would lead to intimacy. For instance they were interested in understanding the "nuts and bolts" of how to initiate a relationship with a woman (or in one instance a same sex relationship) and how to maintain it. One participant described it in these words, "I think it was important to [for] me to hear that gay people can have healthy relationships….it is important to bring everything out into the open…no censorship." His belief was that relationships needed to be discussed openly and frankly to maintain a healthy perspective. The heterosexual respondents shared a similar concern about the need to discuss intimate relationships in a safe forum. The college campus allowed them to find a safe place to discuss issues of intimacy and relationship.

Sexual and Reproductive Health

Another key theme that emerged from the data was sexual and reproductive health. Many of the respondents expressed interest in learning more about condom use, pregnancy and fatherhood. However some of the respondents indicated that, "As Hispanics we are closed about the aspects of health and of sexual [and] reproductive issues." This response was echoed by another of the respondents, "Like anything really like STD, HIV…for older men if they have erectile dysfunction or something is wrong, I know that it is like a taboo I think that is why it is harder."

Interventions Suggested by Respondents

When asked the question, " if someone gave us a million dollars to create a health promotion program for young Latino men what should be included" many of the young men appeared to focus for instance, on encouraging exercise and "eating right" to minimize the negative effects of obesity on Latino men. Many of the young men were aware of the changes that occur as they interact with American culture. Some of the respondents came from backgrounds were strenuous work was a daily event. A typical response was, "I think that especially with Latinos we like to ignore the fact that we don't do a lot of exercise a lot of us are immigrants here yet in our countries we ate frijoles fried in *manteca* [lard] but then we go out and work in the fields and work it off." As university students some did not readily engage in regular exercise. The consensus among the respondents was that any health promotion program must include an exercise component.

Another respondent suggested an important strategy for targeting young men health would be to include the family. He stated, "If you are going to target Latinos for health promotion it is important to target family rather the individual." This particular respondent also indicated that health promotion needed to embrace current technology. He stated, "Also use the popular media such Facebook, Twitter and [other] online resources." Other respondents echoed this sentiment. They felt that in order to reach out to young Latino men it would be necessary to embrace technology that is part of the daily lives.

Another theme that emerged in response to the question of creating a health promotion program focused on sexual and reproductive health. Many were aware of safe sex practices and HIV transmission. However, one participant made that point that some issues are “taboo for men [like] going to the doctor for sexual health.” Discussing sexual health meant, “having an honest conversation with men about pregnancy, STDs, condoms.” Any course that would be created would need to “go in-depth” and tell the “facts rather than trying to scare a guy into not having sex.” The respondents indicated that “Latino men are going to engage in sex so you need to give them simple clear information and not try to make it bland.” They suggested having workshops that provided key information in a safe forum where they “could talk honestly about the issues they are facing as Latino men”. One participant perspective was that, “many Latinos never have the conversation with human sexuality.” The participant felt strongly that any health promotion program must engage the family since it is the family that many times acts to “impede the discussion.” Family should understand that, “there is a psychological and physiological aspect to human sexuality, sexual health [is about] how does your body work.” Any health promotion program should have people who will “answer questions” and not be “like physicians who don’t take time to answer questions.”

A final point that many of the respondents made was that any type of health promotion program had to “take into account their busy lives” and had to make

use of technology. Most of the respondents talked about using “Twitter, Facebook, the Internet” in order to target young Latino men.

Based on the analysis of the individual interviews a focus group interview guide was developed by the PI. The focus group questions were developed around the issues of health behaviors and health promotion, relationships and sexual/reproductive health. The questions (Appendix C) included: How do you teach a young man about taking care of his health? What type of delivery system would be effective with young Latino men? How does a young Latino man negotiate a relationship with a significant other? and How does a young man begin to discuss condom use in a relationship?

The group felt it was necessary to engage young Latino men in the context in which they lived. A fast paced life required that information be readily available and easy to assess. In addition the respondents felt that trying to ‘scare someone into health’ would not work as a strategy. It was necessary for health care providers to be aware of what resources were available to a young man. In addition, the respondents felt that one had to be aware that young men many times are too busy surviving day-to-day to think about long term health issues. They also felt that it was necessary to overcome the reluctance on the part of the family and community to discuss issues of obesity, high blood pressure, diabetes. However, the majority felt that discussing these types of issues may be difficult because young men see it as something remote and in the future. When asked what type of delivery system would be effective with young Latino men

they indicated that any type of delivery system had to take into account how they lived: fast paced and online. As in the individual interviews the majority of the respondents felt that using internet technology was the way of the future. Most saw themselves as connected to technology, less likely to read a newspaper or a pamphlet.

When asked how a young Latino man negotiated a relationship with a significant other most of the participants indicated that there was no magic wand that could make a relationship work. It was an individual negotiating with another individual. However, it was evident from the conversation that some of the participants had more traditional views of relationships than others. There was no clear consensus on how to negotiate a relationship. Some of the respondents felt that family was an important influence on how a young man negotiated a relationship with a significant other, while other felt that one had to take into account modern social mores. They did reach a consensus on distinguishing between a short term or casual relationship and a long term relationship or “those that will go somewhere." They did report understanding that a relationship could be in trouble if either person was not honest with the other. They also indicated that many young Latino men are not taught about relationship how to distinguish between a healthy relationship and a relationship that is headed for major trouble.

Many of the respondents felt that it may be necessary to start this type of discussion in middle school rather than high school. When told that school board

policies could preclude this types of discussion many of the young men responded by saying to take it out of the schools. When it was pointed out to them that a parent might object they indicated that it would be necessary to draw in the family. They saw the family as a key component in any type of discussions about relationships and sexual behaviors. This point was repeated when the discussion turned to negotiating condom use with a potential partner. Again they felt that family was a key component in any type of sexual and reproductive health education. They kept bringing up the point that it may be necessary to move any type of sexual and reproductive health education out of the middle or high school. The respondents felt strongly that in addition to the importance of moving these programs out of the schools, it was necessary to focus more on men so as to understand their point of view. They repeated a point made in the individual interviews that young Latino men are taught not to discuss sexual behavior issues. This they felt contributed to “getting into trouble”. Another point they agreed on was sexual and reproductive information has to be readily available, easily accessible and not hidden under a bunch of papers. They agreed that condoms should be easily accessible and free. Several of respondents agreed that going to the store to buy condoms was embarrassing. At the end of the focus group they reinforced the point that any type of sexual and reproductive information must be available on the internet because it would be allow them to access information in private, thus avoiding intrusions from family. All of the participants had access to internet sources.

Chapter 5

Discussion

This exploratory study was guided by three specific aims: 1) how emerging adulthood and acculturation influences the meaning of health among young Latino men: 2), identifying some of the consequences of emerging adulthood and acculturation on health beliefs and behaviors; and 3) generating hypotheses that could be used to develop and test culturally appropriate intervention strategies to promote and improve young Hispanic/Latino men's health.

I wanted to understand how young Hispanic/Latino men experienced the tasks of emerging adulthood. Arnett (2000, 2004) characterized emerging adulthood as a period of identity explorations in the areas of love, work and worldviews. Emerging adulthood is viewed as a period when young people make decisions about their beliefs and values (Arnett). Identity exploration increases high risk behaviors among young adults. I was interested in understanding how the tasks of emerging adulthood influenced health beliefs and behaviors. I also became interested in how young Hispanic/Latino young men experienced the phenomenon of acculturation and what relationship it had with emerging adulthood and health beliefs and behaviors.

I found that the respondents' belief systems and values influenced how they viewed themselves as Hispanic/Latino. While the acculturation measures were able to place the respondents along an acculturation continuum the majority of

the young men were aware of their cultural heritage. The campus center where they met afforded the respondents the opportunity to meet with other Hispanic/Latino students to discuss issues that impacted their lives as students. Their worldviews and identities were shaped by these discussions. They further defined themselves by the cultural group they grew up in so that they viewed themselves by their cultural group (e.g., as Mexican, Mexican-American, Hispanic New Mexican, Colombian or Ecuadorian.) rather than by race. Unlike previous generations whose identity was forged far from their home countries, the identity of the respondents was forged on multiple borders (Ontai-Grzebik & Raffaelli, 2004). Many had connections to the old country and traveled back and forth. Their socialization was influenced by the multiple worlds (e.g., culture, family and community) they inhabited. Thus, their experience of acculturation was not static but encompassed a more dynamic give and take. They were not entirely assimilated into the dominant culture.

On one hand, I found that the respondents were not much different from what the literature on predominantly non-Hispanic emerging adults would lead one to expect. They were concerned about issues of love, work and a changing worldview. However their concerns of love, work and worldview were influenced by their identity as Latino/Hispanic young men. For example, many of these young men remained connected to their ethnic community. The majority continued to speak Spanish, celebrate ethnic holidays and maintained strong ties to their family. Moreover, Arnett (2007) argues that a mark of emerging adulthood

is the striving for independence from parents. Yet, striving for independence was not entirely evident in the stories of these young Hispanic college students. The needs of the family and the importance of involving family in the discussions of healthy behaviors were not far from the minds of many of the respondents. One young man indicated that he had a need to “look out for his mother and make sure she was taken care of”. In addition several of the participants endorsed the idea that “discussions about health must include the family because family is a strong influence in how young men perceive themselves”.

Marin and Marin (1991) have suggested that Hispanic/Latino communities value a collectivist perspective, that is, the group is more important than the individual. I did not explore the collectivist perspective in depth with the respondents. However, it was evident that a tension existed between the respondents’ individualistic and collectivistic perspectives.

Intimate relationships were an important issue in the lives of the respondents. They expressed concerns about finding the ‘right’ partner, of starting but also ending a relationship. According to Arnett (2000, 2004) a mark of emerging adulthood is exploring intimacy until one can narrow down one’s choice. Initiating and terminating relationships was a key factor in this exploration.

The meaning of health encompassed being aware of risks and avoiding taking risks that could injure their health. As with many of their contemporaries respondents were aware of HIV transmission and prevention. Yet nearly 40% of the respondents were not aware of their HIV status.. This is cause for concern

because the respondents are educated men who are constantly exposed to the HIV prevention messages.

Many of the respondents were aware of the consequences of the poor diet and lack of exercise. They were aware that the Latino community was at high risk for obesity and its sequelae. A participant indicated that “it may be necessary to get families to stop cooking with *manteca* (lard) but that is hard because food made with *manteca* has a more appetizing taste than food prepared with cooking oil”. Many had family members with cardiovascular disease and diabetes and/or were themselves at risk for developing these diseases. The respondents made efforts to address these issues by engaging in exercising and eating adequately. However they were also subject to the pressures of being in a mobile society. Despite learning about diet and exercise they lived a fast paced life and like many of their contemporaries had to eat on the run. One participant reported, “many times I do not have time to sit down and have a good meal. I eat what is available”. A walk of the campus shows that there are a variety of ‘fast food’ places to eat. The respondents, like their contemporaries, find themselves frequently on the run, and this limits their options for eating regular nutritious meals.

The internet was a major factor in the lives of these respondents. Most if not all carried cell phones and or laptops. The student union building and the university library provided access to computers, so information was readily available. In addition the university requires students to have computer access to participate

in class. They were not strangers to technology and were comfortable accessing the information and sharing it with each other. The development of health promotion programs will have to take into account the use of technology. I found that most of the respondents were forceful in their endorsement of using technology to convey a health message. In addition the respondents felt that any health promotion program must include the family in developing and delivering the health message.

Another factor that impacted the respondents' health status was the lack of health insurance. Many of the respondents lacked the necessary resources to seek health insurance. Health insurance is not a requirement for enrolling at the university. The student insurance has two options: a) preferred and b) limited. The former costs $1427.00 and the latter $808.00 per academic year. In some instances these costs can create a burden that can overwhelm a student's resources. It may mean increasing the amount of a student loan thus discouraging a student from purchasing student insurance. The burden forced some respondents to find creative solutions to the lack of access to healthcare. Most if not all monitored their health. They sought support from family and friends to stay active and eat well. They were also aware that the emergency room was available in the event it was needed. However, the emergency room was the last resort because it would cause a financial burden for those who did not have the necessary financial resources.

In summary, respondents shared concerns about love, work and worldview with other emerging adults. However, an added dimension for this group of young Hispanic/Latino men was cultural. They were influenced by their Hispanic/Latino ethnicity. They were concerned about health issues that impacted their lives. They also expressed the need to use contemporary technology to convey a health promotion message. In addition they felt that the health promotion message must engage the Hispanic/Latino family and community.

Limitations of the study

A limitation of this study was the use of a convenience sample. The small sample, and the fact that the study was conducted on a university campus, limit generalizability to the population of young Hispanic/Latino men in general. For example, all university students have ready access to the internet, social media, and information technology services. Outside of an academic setting, such access may be more limited. In addition the small sample size did not allow for exploring a wider range of acculturation levels as described by Cuellar et al. (1995) although it was adequate for classifying respondents as more or less acculturated.

Future Research

I found only one of the two acculturation measures, the SASH, was correlated to any meaningful degree with the health constructs measured by the HPLP-II, even though both acculturation measures were moderately correlated and agreed in

terms of classifying individuals. It is not clear why one measure is moderately correlated with health constructs while the other is not. But an implication of those results would be, in any future study of acculturation in relation to health among young Hispanic/Latino young men, that the SASH would be a more appropriate measure of acculturation in terms of sensitivity to health concerns.

Another finding that warrants further exploration is why young Latino men do not seek HIV testing. Using interviews would allow for exploring what factors would interfere with testing among young Hispanic/Latino men. Developing a sexual and reproductive health promotion program using a community based participatory research methodology would be another avenue of research.

Conclusion

In summary, while this group of young Hispanic/Latino young men experienced emerging adulthood in ways similar to other non-Hispanic/Latino emerging adult men an added dimension that should be considered is the influence of their ethnicity on that experience. In addition, the development of health promotion programs targeting young Hispanic/Latino men should take into consideration contemporary technology and the involvement of the Hispanic/Latino family and community.

Tables

Table 1 ARSMA-II Acculturation Levels and Corresponding Acculturation Score

Acculturation Level	Description	ARSMA-II Acculturation Score
Level I	Very Mexican Oriented	<-1.33
Level II	Mexican oriented to approximately balanced bicultural	≥-1.33 and ≤-.07
Level III	Slightly Anglo oriented bicultural	>.07 and <1.19
Level IV	Strongly Anglo oriented	≥1.19 and <2.45
Level V	Very assimilated; Anglicized	>2.45

Table 2 Participants' Acculturation Scales Descriptive Statistics & Cronbach's Alpha.

	Mean	SD	Median	Mode	Min	Max	Percentiles	
							25	75
ARSMA Anglo Orientation Scale (α= .72)	3.4	.05	3.4	2.8[a]	2.7	4.5	3.0	3.7
ARSMA Mexican Orientation Scale (α=.92)	4.0	0.8	4.2	4.0[a]	2.3	4.9	3.7	4.5
ARSMA Anglo Marginality Scale (α=.93)	16.0	6.2	16.0	7.0[a]	6.0	26.0	11.5	21.8
ARSMA Mexican Marginality Scale (α=.91)	15.8	5.8	15.5	20.0	7.0	27.0	11.3	20.0
ARSMA Mexican American Marginality Scale (α=.93)	14.4	6.0	13.0	11.0	6.0	26.0	11.0	19.3
SASH Total 12 Item (α=.90)	34.2	8.4	30.5	28.0	26.0	53.0	28.0	39.5

ARSMA=Acculturation Scale for Mexican American-II
SASH=Short Acculturation Scale for Hispanics
Superscript a indicates multiple modes exist. The smallest value is shown

Table 3 Study Participants' Short Acculturation Scale for Mexican Americans Mean (SASH) Scores

Mean Score	Frequency	%	
2.17	1	6.3	Less Acculturated
2.33	4	25.0	
2.42	1	6.3	
2.50	2	12.5	
2.58	1	6.3	
2.75*	1	6.3	
2.83	1	6.3	
2.92	1	6.3	
3.42	2	12.5	More Acculturated
4.33	1	6.3	
4.42	1	6.3	
Total	16	100.00	

*Median

Table 4 Study Participants' ARSMA-II Linear Acculturation Scores

Score	Frequency	%	Acculturation Level*
-1.62	1	6.3	**I**
-1.43	1	6.3	
-1.42	1	6.3	
-1.10	1	6.3	**II**
-1.03	1	6.3	
-.99	1	6.3	
-.99	1	6.3	
-.92	1	6.3	
-.91	1	6.3	
-.86	1	6.3	
-.82	1	6.3	
-.43	1	6.3	
-.31	1	6.3	
1.24	1	6.3	**IV**
1.48	1	6.3	
1.59	1	6.3	
Total	16	100.0	

*See Table 1 for Acculturation Level descriptions

Table 5 Study Participants' Cross tabulation LAS Category and SASH Category

LAS Category	SASH Category		Total
	less acculturated (≤ 2.99)	more acculturated (> 2.99)	
Level I: Very Mexican Oriented (<-1.33)	3	0	3
Level II: Mexican oriented to approximately balanced bicultural (≥ -1.33 and ≤ -.07)	10	0	10
Level III: Slightly Anglo oriented –bicultural (> -.07 and < 1.19)	0	0	0
Level IV: Strongly Anglo oriented (≥ 1.19 and < 2.45)	0	3	3
Level V: Very Assimilated; Anglicized (> 2.45)	0	0	0
Total	13	3	16

LAS = Linear Acculturation Score from ARSMA-II
SASH = Short Acculturation Scale for Hispanics

Table 6 Study Participants' Mean/Standard Deviations Health Promotion Measures (n=16)

	Mean	SD	Median	Mode	Minimum	Maximum	Percentiles 25	Percentiles 75
VAS Health	25.3	16.2	19.0	17.0	8.0	65.0	14.0	39.0
Self-Health	2.3	0.7	2.0	2.0	1.0	4.0	2.0	3.0
VAS Quality	26.6	11.1	26.0	25.0	6.0	49.0	20.5	32.0
HPLP-II Total Mean (α=91)	2.8	.33	2.7	1.90	1.90	3.23	2.5	2.9
Health Responsibility* (α=.79)	2.0	0.6	2.0	2.3	1.2	2.9	1.4	2.5
Physical Activity* (α=.74)	2.7	0.8	2.6	2.3	1.6	5.0	2.3	3.1
Nutrition* (α=.76)	2.4	0.5	2.4	1.8	1.7	3.1	2.0	2.9
Spiritual Growth*(α=81)	3.3	0.4	3.4	3.6	2.2	4.0	3.0	3.6
Interpersonal Relations* (α=78)	3.1	0.5	3.0	2.9	2.4	4.0	2.9	3.5
Stress Management* (α=.58)	2.5	0.4	2.6	2.4	1.5	3.1	2.3	2.9

VAS Heal= General Health Visual Analogue Scale
Self-Health = Self-Reported Health Scale
VAS Quality = Quality of Life Visual Analogue Scale
HPLP-II = Health Promoting Lifestyle Profile-II
*HPLP-II Subscales

Table 7 Correlational Matrix HPLP-II, VAS Health, Self Heal VAS Quality SASH &LAS (n=16)

		1	2	3	4	5	6	7	8	9	10	11
1.	VAS Heal											
2.	Self-Health	.434										
3.	VAS Quality	.028	-.317									
4.	Health Responsibility*	-.295	-.137	.167								
5.	Physical Activity*	.005	-.322	.176	.200							
6.	Nutrition*	-.406	-.175	-.327	**.522**	-.035						
7.	Spiritual Growth*	.030	.061	-.428	.411	.007	***.676***					
8.	Interpersonal Relations*	-.176	**-.500**	-.082	.498	-.019	***.640***	.401				
9.	Stress Management*t	-.080	-.176	-.183	.272	-.219	**.610**	**.508**	**.615**			
10.	HPLPII_Total_52items_mean	-.212	-.193	-.019	***.839***	.328	***.780***	**.605**	***.667***	**.534**		
11.	SASH_Total_12items	-.340	-.315	-.230	.296	.010	**.550**	.422	.417	.441	.447	
12.	Linear Acculturation Score	-.153	-.239	.408	.160	.095	.049	.108	-.030	.272	.197	**.567**

Bold=Correlation is significant at the 0.05 level
Bold Italics=Correlation is significant at the 0.01 level
HPLP-II Health Promoting Lifestyle Profile II
*Denotes HPLP-II Subscales
VAS Health=General Health Visual Analogue Scale
Self-Health=Self-Reported Health Scale
VAS Quality=Quality of Life Visual Analogue Scale
SASH=Short Acculturation Scale for Hispanics
LAS=Linear Acculturation Score ARSMA-II

Appendix A

CONFIDENTIAL DEMOGRAPHIC QUESTIONNARE

Participant Code_____

Your Responses Are Entirely Voluntary

1) Age_____

2) Male ☐

3) Race

White ☐
African-American/Black☐
Native American☐ Tribal Affiliation_____
Asian/Pacific Islander☐ Ethnic Group_____

Ethnicity

Hispanic /Latino:

New Mexican Spanish descent☐
Mexican ☐
Mexican-American; Chicano ☐
Puerto Rican☐
Cuban; Cuban-American☐
Central American ☐ Country of Origin_____
South American ☐ Country of Origin_____

4) Sexual Orientation

Heterosexual☐ Bisexual ☐ Questioning ☐ Gay ☐

5) Education:

High School Graduate Yes☐ No ☐

GED Yes ☐ No ☐

College/University:

Freshman ☐ Sophomore ☐ Junior ☐ Senior ☐

Major_____ Minor_____

Participant Code_____

6) Employment:

Work Study ☐

Off Campus Employment ☐

Unemployed ☐

7) Health Insurance:

a) Do you currently carry student health insurance Yes ☐ No ☐

b) If you answer no to 7a are you covered by your parents or guardian insurance Yes ☐ No ☐

8) Where do you receive health care services?

UNM Student Health Services ☐
Private Healthcare provider ☐
Health Maintenance Organization or HMO ☐
Emergency Room ☐

HIV Status

Negative ☐
Positive ☐
Unknown ☐

Have you been vaccinated for

Hepatitis A Yes ☐ No ☐
Hepatitis B Yes ☐ No ☐

Participant Code_____

Do you smoke? Yes ☐ No ☐ Packs per day _____

In a typical week how much alcohol (beer, wine, liquor) do you drink?

Do not Drink ☐
1-2 drinks ☐
3-4 drinks ☐
5-6 drinks ☐
6+ drinks ☐

Has anyone (for example a health care provider) discussed or demonstrated examining your testicles for lumps? Yes ☐ No ☐

Do you currently perform testicular self-exam? Yes ☐ No☐

English Version **Cuellar, Arnold, & Maldonado (1995) ARSMA-II USED WITH PERMISSION**

Name: _____

Age: _____

Marital Status: _____

What is your religious preference:

(a) Last grade you completed in school: Circle your choice

1. = Elementary—6
2. = 7—8
3. = 9—12
4. = 1-2 years of college
5. = 3—4 years of college
6. = College graduate or higher

(b) In what country? _____

Circle generation that best applies to you. Circle only one.

1. 1st generation = You were born in Mexico or some other country.

2. 2nd generation = You were born in the USA, either parent born in Mexico or other country.

3. 3rd generation = You were born in USA, both parents born in USA and all grandparents born in Mexico or other country.

4. 4th generation = You and your parents born in the USA and at least one grandparent born in Mexico or other country with remainder born in the USA.

5. 5th generation = You and your parents born in the USA and all grandparents born in the USA

Scale 1—English Version

	Not at all	Very little or not very often or	Moderately	Much or very much	Extremely often or almost always
1. I speak Spanish	1	2	3	4	5
2. I speak English	1	2	3	4	5
3. I enjoy speaking Spanish	1	2	3	4	5
4. I associate with Anglos	1	2	3	4	5
5. I associate with Mexicans and Mexican Americans	1	2	3	4	5

6. I enjoy listening to Spanish language music	1	2	3	4	5
7. I enjoy listening to English language music	1	2	3	4	5

	Not at all	Very little or not very often or	Moderately	Much or very much	Extremely often or almost always
8. I enjoy Spanish language TV	1	2	3	4	5
9. I enjoy English language TV	1	2	3	4	5
10. I enjoy English language movies	1	2	3	4	5
11. I enjoy Spanish language movies	1	2	3	4	5
12. I enjoy reading (e.g. books in Spanish)	1	2	3	4	5
13. I enjoy reading (e.g. books in English)	1	2	3	4	5
14. I write (e.g. letters in Spanish)	1	2	3	4	5
15. I write (e.g. letters in English)	1	2	3	4	5
16. My thinking is done in English language	1	2	3	4	5
17. My thinking is done in Spanish language	1	2	3	4	5
18. My contact with Mexico has been	1	2	3	4	5
19. My contact with the USA has been	1	2	3	4	5
20. My father identifies or identified himself as 'Mexicano'	1	2	3	4	5
21. My mother identifies or identified as 'Mexicana'	1	2	3	4	5
22. My friends, while I was growing up were of Mexican origin	1	2	3	4	5
23. My friends, while I was growing up were of Anglo origin	1	2	3	4	5
24. My family cooks Mexican food	1	2	3	4	5
25. My friends now are of Anglo origin	1	2	3	4	5
26. My friends now are of Mexican origin	1	2	3	4	5
27 I like to identify myself as an Anglo	1	2	3	4	5

28. I like to identify myself as a Mexican American	1	2	3	4	5
29. I like to identify myself as Mexican	1	2	3	4	5
30. I like to identify myself as American	1	2	3	4	5

Scale 2 English Version					
	Not at all	**Very little or not very often or**	**Moderately**	**Much or very much**	**Extremely often or almost always**
1. I have difficulty accepting some ideas	1	2	3	4	5
2. I have difficulty accepting certain attitudes held by Anglos	1	2	3	4	5
3. I have difficulty accepting some behaviors exhibited by Anglos	1	2	3	4	5
4. I have difficulty accepting some values held by some Anglos	1	2	3	4	5
5. I have difficulty accepting certain practices and customs commonly found in some Anglos	1	2	3	4	5
6. I have, or think I would have difficulty accepting Anglos as close personal friends	1	2	3	4	5
7. I have difficulty accepting ideas held by some Mexicans	1	2	3	4	5
8. I have difficulty accepting certain attitudes held by Mexicans	1	2	3	4	5
9. I have difficulty accepting some behaviors exhibited by Mexicans	1	2	3	4	5
10. I have difficulty accepting some values held by some Mexicans	1	2	3	4	5
11. I have difficulty accepting certain practices and customs commonly found in some Mexicans	1	2	3	4	5
12. I have, or think I	1	2	3	4	5

would have, difficulty accepting Mexicans as close personal friends					
13. I have difficulty accepting ideas held by some Mexican Americans	1	2	3	4	5
14. I have difficulty accepting certain attitudes held by Mexican Americans	1	2	3	4	5
15. I have difficulty accepting some behaviors exhibited by Mexican Americans	1	2	3	4	5
	Not at all	**Very little or not very often or**	**Moderately**	**Much or very much**	**Extremely often or almost always**
16. I have difficulty accepting some values held by Mexican Americans	1	2	3	4	5
17. I have difficulty accepting certain practices and customs commonly found in some Mexican Americans	1	2	3	4	5
18. I have, or think I would have, difficulty accepting Mexican Americans as close personal friends	1	2	3	4	5

Cuellar, Arnold, & Maldonado (1995) ARSMA-II USED WITH PERMISSION

SASH-English Version Marín, Sabogal, Marín, Otero-Sabogal, & Perez-Stable (1987) USED WITH PERMSSION

1. In general, what language(s) do you read and speak?

1	2	3	4	5
Only Spanish	**Spanish better than English**	**Both equally**	**English better than Spanish**	**Only English**

2. What was the language(s) you used as a child?

1	2	3	4	5
Only Spanish	**More Spanish better than English**	**Both equally**	**More English better than Spanish**	**Only English**

3. What language(s) do you usually speak at home?

1	2	3	4	5
Only Spanish	**More Spanish better than English**	**Both equally**	**More English better than Spanish**	**Only English**

4. In which language(s) do you usually think?

1	2	3	4	5
Only Spanish	**More Spanish better than English**	**Both equally**	**More English better than Spanish**	**Only English**

5. What language(s) do you usually speak with your friends?

1	2	3	4	5
Only Spanish	**More Spanish better than English**	**Both equally**	**More English better than Spanish**	**Only English**

6. In what language(s) are the TV programs you usually watch?

1	2	3	4	5
Only Spanish	**More Spanish better than English**	**Both equally**	**More English better than Spanish**	**Only English**

7. In what language(s) are the radio programs you usually listen to?

1 Only Spanish	**2 More Spanish better than English**	**3 Both equally**	**4 More English better than Spanish**	**5 Only English**

8. In general, in what language(s) are the movies, TV, and radio programs you prefer to watch and listen to?

1 Only Spanish	**2 More Spanish better than English**	**3 Both equally**	**4 More English better than Spanish**	**5 Only English**

9. Your close friends are:

1 All Latino/Hispanics	**2 More Latinos than Americans**	**3 About half and half**	**4 More Americans than Latinos**	**5 All Americans**

10. Your prefer going to social gatherings/parties at which people are:

1 All Latino/Hispanics	**2 More Latinos than Americans**	**3 About half and half**	**4 More Americans than Latinos**	**5 All Americans**

11. The persons you visit or who visit you are:

1 All Latino/Hispanics	**2 More Latinos than Americans**	**3 About half and half**	**4 More Americans than Latinos**	**5 All Americans**

12. If you could choose your children's friends, you would want them to be:

1 All Latino/Hispanics	**2 More Latinos than Americans**	**3 About half and half**	**4 More Americans than Latinos**	**5 All Americans**

SASH-English Version Marín, Sabogal, Marín, Otero-Sabogal, & Perez-Stable

(1987) USED WITH PERMISSION

Participant Code_____

General Health Visual Analogue Scale (VAS)

Please mark an “X” on the line below to describe your general health in the **recent past**.

Best Health | Worst Health

Self-Rated Health

In general, would you say your health is (circle one)

Excellent ……..	1
Very Good……..	2
Good……..	3
Fair……..	4
Poor……..	5

Quality of Life Visual Analogue Scale (VAS)

Take a moment and think of the best possible life and the worst possible life. Now, on the line below, place an “X” to indicate where your life is now.

Best Possible Life | Worst Possible Life

Lorig, Stewart, Ritter, González, Laurent & Lynch (1996)
USED WITH PERMISSION

Appendix B

Guiding Questions Individual Interviews

What does being healthy mean to you?

If someone gave us a million dollars to create a health promotion program for young Latino men what should be included?

Guiding Questions Focus Group

How do you teach a young man about taking care of his health?

What type of delivery system would be effective with young Latino men?

How does a young Latino man negotiate a relationship with a significant other?

How does a young man begin to discuss condom use in a relationship?

Appendix C

The University of New Mexico Health Sciences Center
Consent to Participate in Research

Latino/Hispanic Young Men and Health Beliefs, Acculturation and Emerging Adulthood: A Mixed Methods Study

Introduction

You are being asked to participate in a research study that is being done by Peter Andrew Guarnero, PhD, MN, RN who is the Principal Investigator from the University of New Mexico HSC College of Nursing. This research is studying the factors that influence health behaviors among Latino/Hispanic young men between the ages of 18-25 years old.

Little is known about the health beliefs and practices of this population as well as what factors are important in influencing the health beliefs and behaviors of Latino/Hispanic young men.

You are being asked to participate in this study because you are a Latino/Hispanic young man between the ages of 18-25 years old. Approximately 20 Latino/Hispanic young men will take part in this study at the University of New Mexico.

This form will explain the research study, and will also explain the possible risks as well as the possible benefits to you. We encourage you to talk with your family and friends before you decide to take part in this research study. If you have any questions, please ask one of the study investigators.

What will happen if I decide to participate?

If you agree to participate, the following things will happen:

- You must undergo a screening interview to determine if you are eligible to participate in the study.
- If you participate in the in-person screening interview you will be read the inclusion criteria. If you meet the criteria you will be invited to set up an appointment for the individual interview. If you choose not to participate in the in person screening interview, the interview will stop and all materials gathered to this point will be destroyed.
- The study interview will consist of a) responding to a series of questions that will ask you to discuss your beliefs about health, the issues that can have a negative or positive impact on your health and issues of access to health care and b) responding to six (6) questionnaires that will ask you about your age, racial/ethnic identity, sexual orientation, HIV status, education, employment, and health behaviors (for example, smoking, exercise). You will also be asked to respond to questions about language use (Spanish versus English), television and radio use, how comfortable you are with being Latino/Hispanic man. You will be asked questions about physical activity, relationship and how you manage stress. You will be asked to respond to questions about general

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health, quality of life and self-rated health. The questionnaires should take approximately 55 minutes to fill out. The individual interview should take approximately 45-50 minutes to complete.

- The interviews will be audio taped and you will have the choice not to respond to an interview question or the questionnaires. The order of questionnaire administration and individual interview will be balanced by a random start, that is, the first participant will answer the questionnaires first and then participate in the interview, the second participant will participate in the interview first and then answer the questionnaires, the third will revert to the questionnaire first interview second and so forth.
- You may be asked to participate in a focus group interview. You will be asked to consent to being contacted by the PI to participate in the focus group.

May I contact you for participating in a focus group: Yes__ No__

How may we contact you: email__ Phone__

- If you are invited to participate in the focus group will be asked to discuss and clarify issues that arose from the analysis of the individual interviews and questionnaires. The focus group(s) will consist of 5-6 members and will take approximately 90 minutes to complete. The focus group will be audio-taped and no proper names will be used. Each participant will be designated "Participant 1", Participant 2, Participant 3 and so forth.

How long will I be in this study?

Participation in this study will take a total of four (4) hours over the period of the individual interview, answering the questionnaires and participating in the focus group.

What are the risks or side effects of being in this study?

- There are some risks involved in participating in this study, primarily the possible loss of confidentiality. Consent forms will be kept separate from the transcribed interviews and questionnaires. No names will be used during the individual interviews and focus group(s). Each interview and questionnaire will be assigned a unique number thus minimizing the need to use identifying data. In addition, you will be informed that the interviews will be audio-taped and that you may decline to respond to any interview question or questionnaire if answering makes you uncomfortable.
- A potential risk may be psychological distress at discussing health beliefs, acculturation and the tasks of emerging adulthood. While psychological distress may be a possibility the probability is minimal given that the interview/focus group questions would not be particularly sensitive. Risk will be minimized since the interview and questions will be de-identified. Any screening information collected will be kept separate from the transcriptions and questionnaires in a locked file cabinet in the PI office which is also locked.
- In addition you make become anxious or depressed by discussing the issues you face as young Latino/Hispanic man. In the event you become anxious you should first contact Dr. Guarnero. You

may be referred to the University of New Mexico Student Health Services or the University of New Mexico Hospital's Emergency Department. In addition, in the event you would to report a sexually transmitted disease you would be referred to the Bernalillo Country Depart of Health STD Clinic on the UNMHSC campus.

- There are risks of stress, emotional distress, inconvenience and possible loss of privacy and confidentiality associated with participating in a research study.

For more information about risks and side effects, ask Dr. Guarnero.

What are the benefits to being in this study?

There may or may not be benefit to you from participating in this study. However discussing issues faced by young Latino/Hispanic men may give you information that may help you stay healthy. It is hoped that the information gained from this study will help in the development of culturally appropriate services for young Latino/Hispanic men.

What other choices do I have if I do not want to be in this study?

The alternative choice is not to participate in this study.

How will my information be kept confidential?

Dr. Peter Andrew Guarnero will take measures to protect your privacy and the security of all your personal information, but Dr. Guarnero cannot guarantee confidentiality of all study data.

Dr. Guarnero will maintain your first name, telephone number and email address in order to contact for participating in the focus group. This information will be kept separate from the consent forms, questionnaires and transcriptions. Upon completion of the focus group(s) this information will be destroyed.

Consent forms will be kept separate from the transcribed interviews and questionnaires. No names will be used during the individual interviews and focus group(s). Each interview and questionnaire will be assigned a unique number thus minimizing the need to use identifying data. In addition, participants will be informed that the interviews will be audio-taped and that they may decline to respond to any interview question or questionnaire if answering makes them uncomfortable. The study data (interviews/questionnaires) and audio-tapes will be kept for a period of 5 years and will then be destroyed. The interviews, questionnaires and audio-tapes will kept in a locked file cabinet in Dr. Guarnero's office.

The PI will not use proper names during the interviews or focus group(s). The tapes and transcriptions will be labeled with a unique number (e.g., 200901). During the focus group each participant will be

referred by 'Participant 1", "Participant 2", "Participant 3" etc. The focus group will be labeled "Focus Group 1" and "Focus Group 2". Thus the PI will avoid using proper names to identify the participants. The PI's thesis committee of studies will have access to the transcriptions and statistical data.

Information contained in your study records is used by study staff. The University of New Mexico Health Sciences Center Human Research Review Committee (HRRC) that oversees human subject research, Dr. Guarnero's Thesis Committee, and the Interim Dean of Research at the University of New Mexico College of Nursing will be permitted to access your records. There may be times when we are required by law to share your information. However, your name will not be used in any published reports about this study. A copy of this consent form will be kept in your medical record.

What are the costs of taking part in this study?

There is no cost to you for taking part in this study.

What will happen if I am injured or become sick because I took part in this study?

No commitment is made by the University of New Mexico Health Sciences Center (UNMHSC) to provide free medical care or money for injuries to participants in this study. If you are injured or become sick as a result of this study, UNMHSC will provide you with emergency treatment, at your cost. It is important for you to tell Dr. Guarnero immediately if you have been injured or become sick because of taking part in this study. If you have any questions about these issues, or believe that you have been treated carelessly in the study, please contact the Human Research Review Committee (HRRC) at the University of New Mexico Health Sciences Center, Albuquerque, New Mexico 87131, (505) 272-1129 for more information.

Will I be paid for taking part in this study?

In return for your time and the inconvenience of participating in this study, you will be paid $15.00 dollars at the end of the individual interview and $10.00 at the end of the focus group interview. You will be paid in cash.

How will I know if you learn something new that may change my mind about participating?

You will be informed of any significant new findings that become available during the course of the study, such as changes in the risks or benefits resulting from participating in the research or new alternatives to participation that might change your mind about participating.

Can I stop being in the study once I begin?

Your participation in this study is completely voluntary. You have the right to choose not to participate or to withdraw your participation at any point in this study without affecting your future health care or other services to which you are entitled. If you choose to withdraw from the study you may request that any information collected on you be destroyed.

The PI may end your participation in the study if you experience overwhelming psychological distress such panic attacks or the desire to hurt yourself or others. If you become anxious or depressed by discussing the issues you face as young Latino/Hispanic man, you may be referred to the University of New Mexico Student Health Services or the University of New Mexico Hospital's Emergency Department. In addition, in the event you would to report a sexually transmitted disease you would be referred to the Bernalillo Country Depart of Health STD Clinic on the UNMHSC campus.

Whom can I call with questions or complaints about this study?

If you have any questions, concerns or complaints at any time about the research study, Peter Andrew Guarnero, PhD, MN, RN, will be glad to answer them at 505-272-8846 Monday through Friday 8:00 am to 5:00 pm. If you need to contact someone after business hours or on weekends, please call 505-272-8846 and ask for Dr. Guarnero. If you would like to speak with someone other than the research team, you may call the UNMHSC HRRC at (505) 272-1129.

Whom can I call with questions about my rights as a research subject?

If you have questions regarding your rights as a research subject, you may call the UNMHSC HRRC at (505) 272-1129. The HRRC is a group of people from UNM and the community who provide independent oversight of safety and ethical issues related to research involving human subjects. For more information, you may also access the HRRC website at http://hsc.unm.edu/som/research/hrrc/.

CONSENT

You are making a decision whether to participate in this study. Your signature below indicates that you read the information provided (or the information was read to you). By signing this consent form, you are not waiving any of your legal rights as a research subject.

I have had an opportunity to ask questions and all questions have been answered to my satisfaction. By signing this consent form, I agree to participate in this study. A copy of this consent form will be provided to you.

_____	_____	_____
Name of Adult Subject (print)	Signature of Adult Subject	Date

"INVESTIGATOR SIGNATURE

I have explained the research to the subject or his/her legal representative and answered all of his/her questions. I believe that he/she understands the information described in this consent form and freely consents to participate.

_____

Name of Investigator/ Research Team Member (type or print)

_____	_____
(Signature of Investigator/ Research Team Member)	Date

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