

Utah State University

DigitalCommons@USU

---

All Graduate Theses and Dissertations, Spring  
1920 to Summer 2023

Graduate Studies

---

5-2014

## The Role of Masculinity, Masculine Capital, and Spousal Social Control on Men's Health Behaviors

Melinda Gean Arnell  
*Utah State University*

Follow this and additional works at: <https://digitalcommons.usu.edu/etd>



Part of the [Medicine and Health Sciences Commons](#)

---

### Recommended Citation

Arnell, Melinda Gean, "The Role of Masculinity, Masculine Capital, and Spousal Social Control on Men's Health Behaviors" (2014). *All Graduate Theses and Dissertations, Spring 1920 to Summer 2023*. 3293.  
<https://digitalcommons.usu.edu/etd/3293>

This Thesis is brought to you for free and open access by the Graduate Studies at DigitalCommons@USU. It has been accepted for inclusion in All Graduate Theses and Dissertations, Spring 1920 to Summer 2023 by an authorized administrator of DigitalCommons@USU. For more information, please contact [digitalcommons@usu.edu](mailto:digitalcommons@usu.edu).



THE ROLE OF MASCULINITY, MASCULINE CAPITAL, AND  
SPOUSAL SOCIAL CONTROL ON MEN'S HEALTH BEHAVIORS

by

Melinda Gean Arnell

A thesis submitted in partial fulfillment  
of the requirements for the degree

of

MASTER OF SCIENCE

in

Health and Human Movement

Approved:

---

Julie Gast, Ph.D.  
Major Professor

---

Phillip Waite, Ph.D.  
Committee Member

---

Reed Geertsen, Ph.D.  
Committee Member

---

Mark McLellan, Ph.D.  
Vice President for Research and  
Dean of the School of Graduate Studies

UTAH STATE UNIVERSITY  
Logan, Utah

2014

Copyright © Melinda Gean Arnell 2014

All Rights Reserved

## ABSTRACT

The Role of Masculinity, Masculine Capital, and  
Spousal Social Control on Men's Health Behaviors

by

Melinda Gean Arnell, Master of Science

Utah State University, 2014

Major Professor: Dr. Julie Gast  
Department: Health, Physical Education, and Recreation

The study of men's health behaviors has received a great deal of attention worldwide. Studies have been conducted to identify determinates related to men's health care usage. Masculinity and spousal control are well accepted determinates of men's health care seeking. However, the concept of masculine capital and how it factors into men's health care seeking has been a relatively new topic of research. The researchers do not believe there has been a study to date that examines the social control wives place on their husbands, and how that social control may influence their spouses' health, how masculinity plays into men's health behaviors, and how men maintain masculine capital in the face of social control, if at all. Therefore, this study sought to examine how masculinity and the social control wives placed on their husbands intersected.

The purpose of this study was twofold. First, the study sought to gain a greater understanding of how wives exert social control over spousal health behaviors. Second, the study sought to examine how men maintain masculinity, specifically masculine

capital in the face of social control that their wives placed on their health behaviors. Focus groups were conducted with married male participants in Cache County, Utah. Umberson's 1987 model of social control was modified to analyze the data. The constructs of masculinity and masculine capital were added to Umberson's original constructs of family relationships, social control, health behaviors, and physical health/mortality. In addition, the construct of social control was substituted for spousal social control.

At the conclusion of the research study, the research team changed the unidirectional arrows leading from the concept of masculinity and masculine capital to bidirectional arrows to reflect the idea that masculinity and masculine capital not only affect the concept of family relationships, spousal social control, and health behaviors, but those elements in turn affect masculinity and masculine capital. The researchers found the updated proposed model to be accurate in that masculinity and masculine capital influence many realms of a man's life and that spousal social control can have a great influence on a man's health-related behaviors and physical health.

(218 pages)

## PUBLIC ABSTRACT

The Role of Masculinity, Masculine Capital, and  
Spousal Social Control on Men's Health Behaviors

Melinda Gean Arnell

Previous research has noted that married men tend to be healthier than single men. And that wives may exert influence on men's health behaviors, both positively and negatively, through social control methods. However, little research has examined how men maintain masculine status when faced with spousal social control efforts. The purpose of this study was twofold. First, the study sought to gain a greater understanding of how wives exert social control over spousal health behaviors. Second, the study sought to examine how men maintain masculinity, specifically masculine capital, when their wives desire to change the health behaviors of their husband's.

Umberson's 1987 model of social control was modified to analyze the focus group data; i.e. masculinity and masculine capital were added to the original constructs of family relationships, social control, health behaviors, and physical health/mortality. The construct of spousal social control replaced Umberson's social control construct. To test this model, a total of five focus groups were conducted with 44 currently married men in Cache Valley, Utah. The benefits of the study explain why spousal social control, masculinity, and masculine capital should each be carefully considered and researched when conducting needs assessments and when planning interventions or health education programs designed to improve men's health behaviors. Findings also indicate that wives' play a significant role in their husbands' health behaviors.

## ACKNOWLEDGMENTS

I would like to express my gratitude to the members of my committee: Dr. Julie Gast, Dr. Phillip Waite, and Dr. Reed Geertsens. Thank you for your expertise, support, time, and encouragement. I would especially like to thank my committee chair, Dr. Julie Gast, for her constant support and encouragement as well as her promptness in making suggestions and revisions. Julie, you have always believed in me and encouraged me to keep writing. I truly appreciate not only your support as an advisor and teacher, but also as a trusted friend. I would also like to thank the HPER department; I have loved working with all of you and appreciate your assistance throughout the years.

Thank you to all of my family and friends, and the local business that helped me recruit participants for the study. I would specifically like to thank Nathan Smith who helped me advertise on USU's campus; your help was instrumental to the project. A special thanks to all of the men who responded to my "Married Men Needed" flyers. I could not have done this without you. I appreciate your time and candidness and I hope the experiences and insights you shared will improve your lives as well as others'.

Thank you to the Women and Gender Research Institute at USU, now called the Center for Women and Gender, for the grant money to help fund this research project. And thank you to Dr. Terry Peak of the SSWA department, and Dr. Julie Gast of the HPER department, for obtaining the grant and allowing me access to it.

Thank you to my family and friends for being supportive and willing to help in whatever way you could. Thank you, Sarah, for your help and support along the way and for letting me share in your journey through college. Extra special thanks to Julie Johns

for the countless hours she spent helping me throughout this process; your enthusiasm throughout this process and friendship means so much to me.

Thank you, Mom and Dad Arnell, for all the support and love you have shown me and for the countless hours you have spent playing with my girls so that I could study.

Mom and Dad, thank you for teaching me how to love learning from a young age and for teaching me to enjoy hard work. Thank you for always telling me I could do it and for telling me “things will work out.”

To my girls: I hope when you are older you will look back on these few years and realize the sacrifices we made as a family were to help you realize the importance your dad and I place on earning an education. We love watching you learn and discover new things and we are excited to see you learn much more as you grow. Find something you love learning about and always keep learning.

To the love of my life, Dallas. Thank you for all of your love and support, and for allowing me to pursue this dream. Thank you for all of the sacrifices you have made for me through this journey and for enduring it with me.

Melinda Gean Arnell



## CONTENTS

	Page
ABSTRACT .....	iii
PUBLIC ABSTRAC .....	v
ACKNOWLEDGMENTS .....	vi
LIST OF TABLES .....	xi
LIST OF FIGURES .....	xii
CHAPTER	
I. INTRODUCTION .....	1
Background of the Problem .....	1
Theoretical Construct .....	5
Purpose of the Study .....	7
Research Aims .....	8
Limitations .....	8
Delimitations .....	9
Assumptions .....	9
Definition of Terms .....	9
Summary .....	11
II. REVIEW OF THE LITERATURE .....	12
Introduction .....	12
Masculinity .....	12
Men and Health Care .....	25
Relationship Between Spouses' Health .....	31
Education Level and Employment Status .....	35
Women's Influence on Men's Health .....	38
Social Relationships and Marital Status .....	39
Social Support/Spousal Support .....	43
Social Control .....	45
Summary .....	48
III. METHODOLOGY .....	49
Overview .....	49
Research Design .....	49

Instrumentation .....	56
Pilot-Testing Procedures .....	58
Data Collection Procedures .....	60
Data Analysis .....	63
Study Participants .....	65
Summary .....	68
IV. RESULTS .....	70
Introduction .....	70
Wives' Use of Social Control to Influence Their Husband's Health	
Behaviors .....	72
How Men Combat Their Wives' Social Control Strategies .....	81
Men's Perception of "Man Card" .....	83
Masculine Capital .....	94
How Men React to Being Ill .....	95
Factors That Influence Men's Health Care Use .....	100
How Men's Feelings of Responsibility Impact Their Health Behaviors .....	102
How Marriage Encourages Men to Engage in Positive Health Behaviors .....	108
How Marriage Discourages Men to Engage in Positive Health Behaviors .....	112
Summary of Research Themes .....	116
Justification for the Updated Model .....	117
Family Relationships .....	119
Spousal Social Control .....	121
Masculinity .....	125
Masculine Capital .....	130
Health Behaviors .....	132
Physical Health/Mortality .....	134
Summary of Justification for Altered Model .....	135
V. DISCUSSION .....	136
Introduction .....	136
Conceptual Model of Spousal Social Control, Masculinity, Masculine	
Capital, and Men's Health .....	137
Family Relationships .....	138
Spousal Social Control .....	141
Masculinity .....	147
Masculine Capital .....	153
Health Behaviors .....	156
Physical Health/Mortality .....	161
Limitations .....	161
Implications for Health Education .....	164
Implications for Further Research .....	167
Summary .....	169

REFERENCES .....	170
APPENDICES .....	186
Appendix A: Discussion Guide .....	187
Appendix B: Informed Consent .....	190
Appendix C: Demographic Questionnaire .....	194
Appendix D: Notice of Cash Received .....	197
Appendix E: Opening Statement .....	199
Appendix F: Table of Research Theme Summaries.....	201
Appendix G: Table of Research Model Summaries .....	204

## LIST OF TABLES

Table	Page
1. Demographic Information .....	67

## LIST OF FIGURES

Figure	Page
1. Conceptual model of social control .....	5
2. Conceptual model of spousal social control, masculinity, masculine capital, and men's health .....	7
3. Conceptual model of spousal social control, masculinity, masculine capital, and men's health based on research results .....	119

# CHAPTER I

## INTRODUCTION

### **Background of the Problem**

According to the National Center for Health Statistics (NCHS), between 2000 and 2010 U.S. death rates were higher for males than females for heart disease, cancer, chronic lower respiratory diseases, diabetes, and unintentional injuries (NCHS, 2014). And in 2012 the World Health Organization (WHO) reported that the life expectancy of women at birth was 81 years and only 76 years for men (WHO, 2013). Many factors may play into the fact that men exceed women in the leading causes of U.S. deaths, including that men visit their physicians less often than women (Farrimond, 2012; Pinkhasov et al., 2010), wait longer to seek medical care than women, do not seek medical attention until their condition(s) become serious (Sayer & Britt, 1996; Seymour-Smith, Wetherell & Phoenix, 2002) and when they do seek medical attention they ask fewer questions than women do (Courtenay, 2000b). Additional factors may include that men visit their dentist less often than women and are more likely to be alcohol drinkers, cigarette smokers, and illicit drug users than women (Pinkhasov et al., 2010). In addition to men's shorter life expectancy and their procrastination in seeking medical attention, men are also becoming more obese in general (Fryar, Carroll, & Ogden, 2012).

The health disparity that exists between men and women has recently become more recognized. In fact, in 2003 the former U.S. Surgeon General, Dr. David Satcher, called for more attention to be paid to men's health, especially men of color, and the W. K. Kellogg Foundation authorized \$3 million for a men's health initiative (1998).

Additionally, the non-profit organization Men's Health Network, was founded in 1992 with a mission to provide prevention messages and tools, screening programs, educational materials, advocacy opportunities, and patient navigation for men of all ages (Men's Health Network, 2013).

Just as more organizations are focusing on the health disparity between men and women, researchers are also trying to key in on the reasons behind men's health disparity. Gast and Peak (2011) believe an examination of masculine gender scripts and gender role socialization could be used to help understand why there is such a difference in male and female response to illness and health disparity. Masculine gender scripts are ways of acting, feeling, and thinking based on socially prescribed norms of masculinity (Burns & Mahalik, 2007). Traditional masculinity ideology, or a system of social beliefs and attitudes toward masculinity and men's roles, give men guidelines and expectations of how they should act or conform to certain socially sanctioned norms. Unfortunately, the traditional social construction of masculinity typically encourages men to avoid health enhancing behaviors such as going to the doctor (Farrimond, 2012) and complying with preventive health care (Springer & Mouzon, 2011). Recent research has shown that not all men adhere to traditional masculine gender scripts (O'Brien, Hunt, & Hart, 2009; Sloan, Gough, & Conner, 2009) and interestingly, men who do not comply with traditional masculine norms may produce masculine capital, or insurance, which can be used to compensate for traditionally non-masculine behavior, in other domains (de Visser, Smith, & McDonnell, 2009).

In the study of men and women's health, research has shown that marriage can have many health enhancing effects. Previous research suggests that marriage affects a

range of health outcomes by reducing many health-related risky behaviors (Wood, Goesling, & Avellar, 2007) and by improving health-promoting behaviors (Koball, Moiduddin, Henderson, Goesling, & Besculides, 2010). And according to data collected from the 1999-2002 National Health Interview Surveys (NHIS), married adults enjoy better physical and mental health than those who are not married (Schoenborn, 2004). Studies focusing on men's health have found that married men have more proactive health beliefs and more proactive health-related behaviors than their single peers (Markey, Markey, Schneider, & Brownlee, 2005)

Some of men's health behaviors have been shown to change once they enter into marriage. For example, one study found that when men marry, their binge drinking and marijuana use noticeably falls when compared to their drinking and marijuana use previous to marriage (Duncan, Wilkerson, & England, 2006). A second study by Eng, Kawachi, Fitzmaurice, and Rimm (2005), also found alcohol consumption was affected with regard to men's marital status. They found men who become widowed increase their alcohol consumption compared to men who stayed married. With regard to men's preventive health behaviors, Markey and colleagues (2005) reported men who are married are more likely to undergo colorectal cancer screening, cholesterol screening, and prostate exams than are men who are single.

A third finding with regard to men's health is that marriage can increase longevity. Kaplan and Kronick (2006) found the death rate for unmarried men was significantly higher than it was for those who were married and living with their spouses. An additional study on longevity was conducted by Murray (2000). He found that



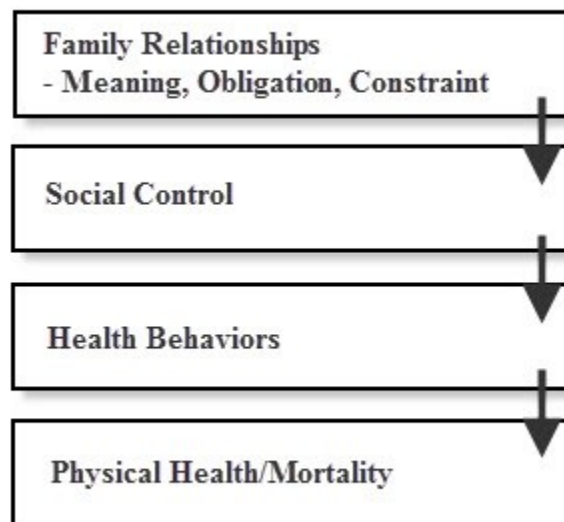
marriage was associated with lower mortality in men even while controlling for health status in adulthood.

Substantial research has shown that men's health can be affected by their spouse. Women can be important health-promoting agents to their spouses by helping to shape their spouse's health beliefs, health behaviors, and health care seeking (Norcross, Ramirez, & Palinkas, 1996; Seymour-Smith et al., 2002). Spouses can encourage or promote health-enhancing behaviors (Koball et al., 2010) and discourage health-harming activities (Wood et al., 2007). This encouragement or discouragement can be defined as social control, or behaviors initiated by one individual to influence or control the behavior of another (Lewis & Rook, 1999; Umberson, 1987). Pierce, Hong, Franks, and Ketterer (2002) stated that social control can take such forms as attempting to suggest, coerce, or force others to behave in a desired manner.

Because spouses play such a unique position of influence to their partners' health behaviors, it is important to examine how wives influence their husband's health through the use of social control. While many studies have examined social control using married participants (August & Sorkin, 2010), the researchers did not believe there had been a study that examined the social control wives place on their husbands and how that social control influenced their spouse's health as well as examining how masculinity plays into men's health behaviors and specifically how men maintain masculine capital in the face of social control, if at all. Therefore, this study sought to examine how masculinity and the social control wives placed on their husbands intersected.

## Theoretical Construct

Umberson's 1987 study illustrated a conceptual model of social control (see Figure 1). The premise of social control is that one individual attempts to control, influence, or regulate the behavior of another in an attempt to keep him or her healthy (Lewis & Rook, 1999; Umberson, 1987, 1992). As Meyler, Stimpson, and Peak (2007) stated, typically it is the wife that attempts to control the husband's behavior. Models provide a framework for how we look at reality, and the concepts within the models are clearly specified ideas derived from it (Silverman, 2006). The social control model illustrates how marital and parental roles affect health behaviors (Umberson, 1987).



*Figure 1.* Conceptual model of social control.

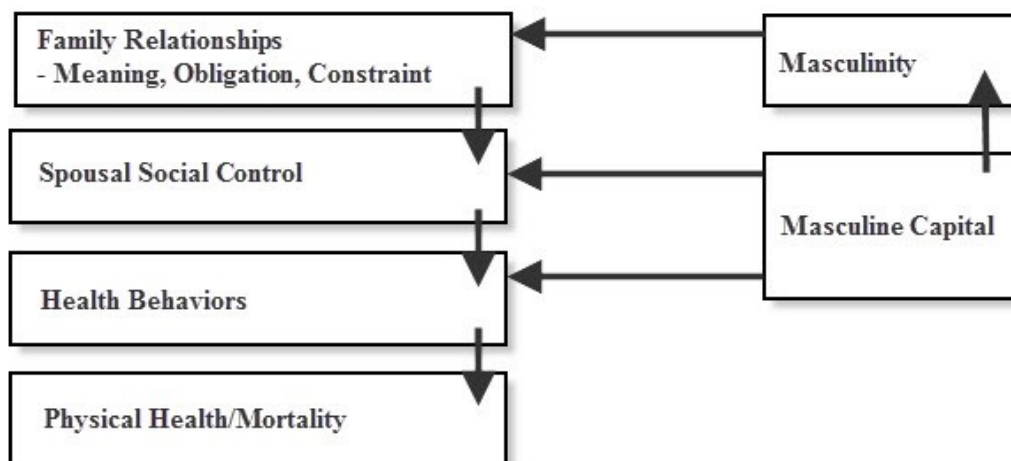
Social control of behaviors can occur in two ways: (a) through internal influence, and (b) through external influence (Umberson, 1987). Internal influence most commonly comes through self enforcement of norms. These individuals internalize norms of

responsibility toward a family member, and as a result, control their own health behaviors. Relationships within a family may serve to regulate or sanction an individual for behavior that could be detrimental to health. This external influence over the individual could come through regulations, sanctions, and physical intervention (Umberson, 1987). The last part of Umberson's model is physical health/mortality. She theorizes that the social control placed upon individuals to change their health behaviors contributes ultimately to mortality. She further states that the absence of control provided through relationships creates a higher probability of an individual engaging in a health-compromising behavior; she also states that with social control present, an individual's longevity would increase due to health-enhancing behaviors (Umberson, 1987).

When applied to the current research study, social control was used to examine the form(s) of social control wives used to influence their husband's health as well as how the husbands perceived it influencing their health behaviors. The concepts of masculinity and masculine capital were also examined in this study and were added to Umberson's 1987 model of social control (see Figure 2).

Traditional masculinity is a system of social beliefs and attitudes toward masculinity and men's roles; it gives men guidelines and expectations of how they should act or conform to certain socially sanctioned masculine behaviors and avoid certain proscribed behaviors (Levant & Richmond, 2007; Levant, Wimer, Williams, Smalley, & Noronha, 2009). With regard to masculinity, the aim of this study was to examine men's perceptions of masculinity and how it impacted their past and current health behaviors, as well as how masculinity possibly interacted with the social control that men's wives exerted on their health behaviors. In addition, the study sought to examine how men

maintained their masculine capital when faced with spousal control and the health behavior change.



*Figure 2.* Conceptual model of spousal social control, masculinity, masculine capital, and men's health

### **Purpose of the Study**

The purpose of this study was twofold. First, the study sought to gain a greater understanding of how wives exert social control over spousal health behaviors. Second, the study sought to examine how men maintain masculinity, specifically masculine capital, in the face of social control that their wives placed on their health behaviors. Umberson's 1987 model of social control was modified to analyze the focus group data. Masculinity and masculine capital were added to the original constructs of family relationships, spousal social control, health behaviors, and physical health/mortality (see Figure 2).

## **Research Aims**

Men living in Cache Valley, Utah were recruited to participate in focus group discussions for this study. The following list was used to guide the focus group discussion and serve as research aims of the study.

1. Explore men's perceptions of how marriage encourages healthy behaviors.
2. Explore men's perceptions of how marriage hinders healthy behaviors.
3. Explore men's perceptions of how their wife influences their health behaviors.
4. Explore how men's feelings of responsibility to their family impact their own health behaviors.
5. Explore how men reconcile with the fact that their wife influences their health decisions.
6. Explore how masculinity is affected when a man's wife persuades him to participate in health enhancing behaviors.
7. Explore strategies men use, if any, to maintain masculine capital in the face of spousal social control.

## **Limitations**

The limitations of this study were as follows:

1. Participants were not selected through a process of random-sampling.
2. Participants were possibly from the state of Utah and thus may limit generalizability to other men.
3. The focus group questions used self-report measures, which may not accurately reflect actual behaviors.

### **Delimitations**

The delimitations of this study were as follows:

1. Participants were all English speaking
2. Participants were currently married at the time of the data collection.
3. Participants were 18 years of age or older.

### **Assumptions**

1. Participants responded honestly.
2. For the purpose of this study, the discussion guide was considered valid and reliable.
3. The instruments utilized in this study accurately measured what they intended to measure.

### **Definition of Terms**

For the purpose of this study the following definitions were used.

*Diet*: Food and drink regularly provided or consumed (Diet, 2012).

*Dieting*: To eat sparingly or according to prescribed rules (Dieting, 2012).

*Exercise*: Bodily exertion for the sake of developing and maintaining physical fitness (Exercise, 2012).

*Health*: The general condition of the body (Health, 2012).

*Health Behavior*: Any activity performed by an individual or considered by an individual for improving their health or for preventing decline (Calasanti, Pietila, Ojala, & King, 2013).

*Health Concordance:* The connection between spouses and their similar health statuses (Meyler et al., 2007).

*Hegemonic Masculinity:* The dominant form of masculinity acceptable within a patriarchal culture. A set of standards and practices within a culture in which men possess stereotypical masculine traits of assertiveness, aggressiveness, heterosexuality, dominance, competitiveness, control, self-reliance, perceived invulnerability, physical strength, and emotional restraint (Connell, 1995; Sloan et al., 2009).

*Masculine Capital:* Credit or insurance which can be used to compensate for traditionally non-masculine behavior in other domains (de Visser et al., 2009).

*Masculinity:* That which is not feminine (Connell, 1995; Messner, 1998).

*Physical Activity:* Any bodily movement produced by skeletal muscles that require energy expenditure (WHO, 2014).

*Social Control:* Behaviors initiated by one individual in an attempt to influence, regulate, or control the behavior of another. Social control can be exercised through the use of suggestions, regulations, sanctions, coercion, and force (Pierce et al., 2002; Umberson, 1987, 1992).

*Social Support:* Attempts to aid and reinforce partner's efforts to sustain needed changes in health behaviors (Franks et al., 2006).

*Traditional Masculinity:* A system of beliefs and attitudes toward masculinity and men's roles. Guidelines and expectations of how men should act and conform to certain socially sanctioned masculine behaviors and should avoid certain proscribed behaviors (Levant & Richmond, 2007; Levant et al., 2009).

## **Summary**

This chapter provided the framework to support the purpose and the process of this study. Also included were limitations, delimitations, assumptions, and definitions of terms. Empirical evidence from published research is presented in the next chapter to further support the value and need for this study. Methodology used for the study is discussed in Chapter III. Chapter IV analyzes the results of the data from the focus group discussions. Chapter V provides a discussion of the findings from the study as it relates to past literature and implications for both future research and health education.



## CHAPTER II

### REVIEW OF THE LITERATURE

#### **Introduction**

The literature review will provide a synopsis of past literature regarding how the following impact men's health: (a) masculinity, (b) men and health care, (c) correlation between spouses' health, (d) education level and employment status, (e) women's influence on men's health, (f) social relationships and marital status, (g) social support/spousal support, and (h) social control. The literature evaluation supported the justification for this research project.

#### **Masculinity**

Masculinity can be simply defined as that which is not feminine (Connell, 1995; Messner, 1998). Connell (1987) stated that masculinity is socially constructed and dependent on a specific historical time, culture, and locale. Evans, Frank, Oliffe, and Gregory (2011) have pointed out that how masculinity is displayed over time changes, and men define and redefine masculinity in response to location, life events, age, and the social context of their experiences throughout their life.

Connell (1995) explained that within any society there can exist a hierarchy of masculinities with the idealized version being dominant or hegemonic. Farrimond (2012) stated that in western culture, contemporary hegemonic masculinity is associated with being white, heterosexual, middle-class, and possessing stereotypical masculine traits of

assertiveness, dominance, control, physical strength, and emotional restraint. Sloan et al. (2009) simplified hegemonic masculinities to be a perceived invulnerability.

In 2000, the World Health Organization (WHO) declared masculinity as a primary factor for men's health disparity. They identified a lack of understanding of the role of "masculinity" in shaping men's expectations and behaviors as a primary causative factor for the health disparity between men and women.

### **Traditional Masculinity Ideology**

Levant et al. (2009) discussed traditional masculinity ideology, or the system of social beliefs and attitudes toward masculinity and men's roles. This ideology gives men guidelines and expectations of how they should act or conform to certain socially sanctioned masculine behaviors; and it also tells men to avoid certain proscribed behaviors (Levant & Richmond, 2007; Levant et al., 2009). The traditional social construction of masculinity encourages men to be self-reliant, stoic, to avoid healthcare (Addis & Mahalik, 2003; Courtenay, 2000b; Helgeson, 1994), and it has been found that men who endorse more traditional masculine norms underutilize healthcare (Helgeson, 1990; Mahalik, Burns, & Syzdek, 2007; Mahalik, Lagan, & Morrison, 2006; Marcell, Ford, Pleck, & Sonenstein, 2007).

Levant (1995) and Levant and Richmond (2007) believe this masculine ideology influences how adults think, feel, and behave. But Levant and colleagues (2009) pointed out that individuals' views may vary in the degree to which they hold their masculine beliefs.

## **Hegemonic Masculinity**

Hegemonic masculinity is a set of standards and practices used to define the dominant form of masculinity acceptable within a patriarchal culture. Often these practices include being self-disciplined, physically tough (Hinojosa, 2010), competitive, aggressive, emotionally contained, self-reliant, heterosexual, not prone to disease or illness, and unconcerned with pain or minor health problems (Connell, 1995; Farrimond, 2012; Levant, 1996). Unfortunately, these practices are often accompanied with unhealthy practices, such as not going to the doctor (Farrimond, 2012), reluctance to seek help (O'Brien, Hunt, & Hart, 2005), violence, risk taking (Hinojosa, 2010), dismissing health needs, legitimizing of themselves as the "stronger" sex (Courtenay, 2000b), and reduced compliance with preventive health care (Springer & Mouzon, 2011). Springer and Mouzon agreed with Calasanti's (2004) findings that aging hegemonic idealist men may enact masculinity through exerting independence and self-reliance by *not* going to the doctor. Dolan (2011) conducted in-depth interviews with 22 men in the UK to learn how working class men construct masculinity and how that construct impacts their health practices. Dolan found men's working environments were consistently portrayed as one of the main arenas in which hegemonic working class masculine identity was constructed and maintained; he also found that the norms and values men associate with working class masculinity, such as being tougher and stronger, could mean a delay in seeking medical attention. Paid employment was found to be a domain in which the men saw themselves in a positive image by being able to fulfill the men-as-provider role. The link Dolan revealed between being male and being healthy was also found to be tied to men's

class position. The more vulnerable position the man was in in the labor market, the more likely he was to conceal health concerns and potentially delay accessing healthcare.

Not all men adopt the usual unhealthy masculine behaviors that typically are in line with hegemonic masculinity. Sloan et al. (2009) sought to find out how ‘healthy’ men account for their health-promoting practices, with a focus on the role of masculinity in framing those healthy practices. Sloan and colleagues’ study comprised interviews from 10 men whom the researchers categorized as pursuing a health-promoting lifestyle. Results showed all the men rejecting a direct interest in talking/thinking about health and instead justified their healthy practices as being autonomous, as talking or thinking about health was construed as excessive and feminine. Sloan and colleagues believe in order for these men to create this autonomous position, they frame their behaviors in ways that maintain hegemonic masculinities. They claim that, if the men had referred explicitly to making conscious health decisions, it would carry the connotation of them being vulnerable. The authors note, “In relation to masculinities, men may shift from positioning themselves as resisting overly rigid guidelines (emphasizing personal autonomy) and complying with sensible health advice (thereby presenting themselves as rational) (Gough & Conner, 2006). What counts as normative and healthy then both shapes and is shaped by hegemonic masculinities” (Sloan et al., 2009. p. 799).

In relation to men who eat healthy and engage in regular physical activity, O’Brien, Hunt, and Hart (2009) found these men could still be seen as masculine due being part of a particular masculine group, such as firefighters, and the healthy behaviors were seen as lifesaving within their work context.

According to de Visser and colleagues (2009), men who oppose hegemonic masculinity must learn to develop viable alternatives to masculine identities. de Visser et al. (2009) studied what alternatives exist for these men who reject or resist hegemonic masculinity. Their study consisted of group discussions among 27 men between the ages of 18-21 years who lived in London. They examined whether men can use competence in key health-related masculine domains to compensate for other non-masculine behaviors. Two major themes emerged in this study. First, the construction of hegemonic masculinity is opposed to femininity and alternative masculinities (i.e., excessive concern with one's appearance is non-masculine, homosexuality is considered less masculine, non-masculine behaviors were labeled to be "gay," and a muscular physique is not necessarily masculine). Second, competence in traditionally masculine health-related domains can produce masculine capital, credit, or insurance that can be used to compensate for traditionally non-masculine behavior in other domains (i.e., sporting prowess allows athletes to abstain from alcohol or seek medical assistance when needed, to maintain current health status). A 2013 study conducted by de Visser and McDonnell found that men who held traditional views were more likely to be concerned about accruing masculine capital as a way to compensate for, or excuse feminine behavior than were men who held more egalitarian views. In de Visser and colleagues' (2009) study, they found masculine capital is limited in what it can be traded for because different masculine and non-masculine behaviors have different values. Connell (2005) believes that although the possibility for trading masculine capital exists, alternative masculinities are inferior to hegemonic masculinity.

Masculinities can work in different health-related situations to both restrict and promote healthy practices. Gough (2013) reviewed 13 papers to reveal themes of how masculine capital can both inhibit and encourage healthy practices in men. He pointed out that any behavior can be endowed with masculine capital. A specific example he cites is that help-seeking, which is traditionally avoided by men, could be reframed as brave and therefore be seen as congruent with valued masculinities rather than be feminized as weakness.

### **Men's Risky Health Behaviors**

As noted above, researchers have found a connection between masculinity and health behaviors in men. For example, a review conducted by Courtenay (2000a) concluded that males engage in over 30 controllable behaviors that increase the risk for disease, injury, and death. Mahalik and colleagues (2007) found that traditional masculine gender socialization and social norms models not only encourage men to put their health at risk, but that masculinity and the perceived normativeness of other men's health behaviors significantly predicted men's own health behaviors beyond those accounted for by socio-demographic variables (e.g., education, income).

Researchers have found men who hold more traditional masculine beliefs report greater substance use, including tobacco (Courtenay, 1998), alcohol (Courtenay, 1998; Pleck, Sonenstein, & Ku, 1994), and illegal drug use (Courtenay, 1998; Courtenay, McCreary, & Merighi, 2002; Pleck et al., 1994); are more likely to engage in high-risk sexual activity (Courtenay, 1998; Pleck et al., 1994); and experience higher levels of stress and anger (Courtenay et al., 2002). In addition, men who score higher at endorsing masculine norms are also more likely to engage in violent behavior, and men who

conform to masculine norms have negative views toward seeking psychological help (Mahalik et al., 2003). With regard to the workplace, Dolan (2011) found that men believe having a strong work ethic, regardless of the potential impact their work could have on their health, is an important aspect of masculinity.

When studying adolescent males and their developmental change in attitudes toward masculinity, Marcell et al. (2007) found those who hold more traditional masculine beliefs are less likely to have a physical examination. Their study, which included 845 adolescent males, also found that men's masculinity attitudes became less traditional between middle adolescence and early adulthood. One interesting finding was that the males who continued to live with their biological fathers between the ages of 18-20 years were more likely to have masculinity attitudes that remained or became relatively more traditional over time, while those adolescent males who stopped living with their fathers during the same ages, were more likely to hold less traditional masculine beliefs.

At the other end of the spectrum, a study of middle-aged men was conducted by Calasanti et al. (2013) in an effort to examine how men maintain masculinity as they age. The men studied reported that middle age inspired them to become more responsible. Calasanti and colleagues found these men from the U.S. and Finland, to view masculine behaviors in terms of individual responsibility, personal choice, and hard physical work. They found that men consider working hard as a key to protecting health and controlling bodily aging and therefore can serve as a way to maintain masculinity in middle-age. The researchers also found men must modify their ideas about masculinity as they age by altering their expectations. They must alter their expectations of their performance in

both physical and mental functioning. For example, instead of men comparing themselves to younger men they compare themselves to peers or men that are older than they are. The most often mentioned strategies of how men tried to maintain their manhood included discipline, routine, and monitoring. For example men would discipline themselves by eating healthier and exercising. They would also establish a routine to follow and monitor their progress in various health behavior areas such as diet, work, play, exercise, cholesterol levels, and blood pressure. All strategies used by men, whether they be an attempt to control their bodies through visible behaviors and/or mental activities, were used in an attempt to forestall aging or as a way to avoid the stigmatized status of old age.

A range of problematic and individual relational variables have been found in individuals who endorse traditional masculinity ideology. These variables include reluctance to discuss condom use, fear of intimacy, lower relationship satisfaction, more negative beliefs about the father's role and lower paternal participation in child care, negative attitudes toward racial diversity and women's equality, attitudes conducive to sexual harassment, self-reports of sexual aggression, lower forgiveness of racial discrimination, and the inability to express emotions (Levant & Richmond, 2007). Levant and Richmond's study providing a summary of findings from research on masculinity ideologies over the past 15 years also found that individuals in lower social classes are more likely to endorse traditional masculinity ideologies.

Findings of traditional masculine ideology producing more risky health behavior in men were contradicted in a study by Levant et al. (2009). This was conducted via a survey of 137 college men. The goal of the study was to compare traditional masculinity



ideology, conformity to masculine norms, and gender role conflict to determine to what degree these masculinity variables are associated with self-reported risky health behaviors and negative attitudes toward seeking psychological help. They found that traditional masculinity ideology was inversely associated with risky health behaviors (i.e., the more traditional beliefs, the less risky health behaviors). Levant et al. also found that masculinity variables as a group significantly predicted health-risk behaviors, accounting for 13.4 % of variance ( $R = .37; p < .001$ ). However, the trend in the research to date has been that traditional masculine beliefs are associated with risky health behaviors.

### **Masculinity and Health Care**

According to the National Center for Health Statistics (NCHS), between 2000 and 2010 U.S. death rates were higher for males than females for heart disease, cancer, chronic lower respiratory diseases, diabetes, and unintentional injuries (NCHS, 2014). Springer and Mouzon (2011) stated this elevated risk of mortality is due to men's greater engagement in preventable health risks including lower rates of seeking health care. Past research has hypothesized that men delay using preventive health services because of traditional social constructions of masculinity (Addis & Mahalik, 2003; Courtenay, 2000b; Helgeson, 1994). Cranshaw (2007) believes that masculinity is to blame for men's lack of interaction with health services and health service professionals. In Levant and colleagues' (2009) survey mentioned above, they found that: (a) endorsement of traditional masculine ideologies, (b) conformity to masculine norms, and (c) a higher degree of gender role conflict, were related to more negative attitudes toward college men seeking psychological help. The study found that conformity to masculine norms was a

unique predictor of these college men's negative attitudes toward seeking psychological help.

One common attitude that defines the masculine ideology is that men need to be tough, and to demonstrate that nothing can hurt them. Getrich et al. (2012) conducted a qualitative study of Mexican and Hispanic men and women in New Mexico to see the masculine norm machismo—a culturally derived masculinity—impacted barriers to colorectal cancer (CRC) screening. The study included interviews from eight medical providers, six staff members from the provider's clinics, and 52 patients. Half of the medical providers were male, all of the clinic staff were female, and half of the patients were male. Participants self-identified as either Hispanic or first-generation Mexicans with the majority of participants identifying themselves as Mexican. Hispanics who can trace their ancestry back to Spanish colonists and who arrived in New Mexico in the late 16<sup>th</sup> century are called Hispanos in this study (Nostrand, 1992). Hispanos emphasize their class-based descent from the original Spanish conquistadors (Oboler, 1999) and are more highly concentrated in the northern half of New Mexico (Nostrand). Hispanics in southern New Mexico typically identify as Mexicano, or Mexican. From the interviews, Getrich et al. found that machismo CRC screening attitudes and behaviors were very apparent among Mexican men, but among Hispano, machismo attitudes were found to be an old-school mentality. Mexican men reacted much more strongly and negatively than Hispano men when a colonoscopy procedure was described to them. Mexican men expressed concern in having a colonoscopy because of its potential transformative and/or stigmatizing affects and that it could cause homosexuality, while Hispanic men viewed

the colonoscopy as strictly a medical procedure and; therefore, less shameful or stigmatizing.

Machismo was found to have a negative effect on health care seeking and prevention in a study conducted by Peak, Gast, and Ahlstrom (2010). They found the Latino men that they interviewed had a strong cultural bias to avoid dealing with their health issues. Focus group participants stated they would wait to seek medical attention until their issue was severe and that they did not actively engage in health promotion activities. Dolan (2011) also found that the norms and values associated with the working class masculinity, such as being tougher, could mean men delaying medical assistance. He illustrates his point by citing two views expressed by working men from the UK. These men viewed the working class male as tall, strong and durable, with the cultural assumption that men should be at work not at a physician's office. Dolan summarizes that because men are in the labor market and because of their position as breadwinner, it can cause them to conceal health problems and delay accessing healthcare. In addition, men in this study had a strong desire to preserve a defined male identity and maintain employment through control and discipline over their bodies.

Galdas (2009) pointed out that help-seeking is characterized by more than just visiting a health professional; but it also includes how individuals become aware of, and respond to, symptoms of ill-health in terms of social norms and cultural practices. Farrimond (2012) extended this definition through her research by asking, "*In what ways [emphasis added] do men visit the doctors (or not), for which illnesses and through which pathways?*" (p. 209). Farrimond interviewed 14 men who were currently working, or had previously worked, in a professional job setting. He found that unlike previous studies,

most of the men constructed their own experiences of health related help-seeking in terms of being responsible, solving their own problems, and being in control. These constructs help make up the male “code” or ideology in which men are supposed to be independent, strong, self-reliant, emotionally restrained, and heterosexual. Farrimond did note that some men saw being ill and seeking help as being associated with being “weak,” feminine, or homosexual, but this view was expressed by the minority of the participants. When explaining ways men do or do not seek help, Farrimond found men in professional occupations had high self-agency and were willing to seek help in order to maintain their current job status. These men in professional jobs were also able to take the time off work to seek help due to their increased financial status. Men in non-professional roles were not able to take time off as readily due to their need to make ends meet financially, their lack of time off, or their being their own employer. Farrimond summarized that the men in her study characterized illness in terms of problem-solving and the construction of symptoms as something to “sort out,” which places a high value on self-efficacy, agency, and taking responsibility. When discussing which illnesses men do seek help for, she found that most men feared illness or disease that would damage their lifestyle or longevity such as heart disease or cancer rather than infectious illness. Gast and Peak (2011) found similar results when conducting their focus group discussions to learn about men’s health beliefs, attitudes, and behaviors. They found men have concerns and fears in regards to contracting a disease or health condition. These fears were linked to concerns about growing older or having a family history of a specific disease.

Other research has found that income and professional status are not necessarily predictors of health care use. Using the Wisconsin Longitudinal Study, Springer and

Mouzon (2011) conducted an analysis of masculinity beliefs and preventive health care use (annual exam, prostate exam, flu shot, and compliance with all three services), including whether the relationship between the two vary by socioeconomic status (SES). They found men's probability of obtaining preventive care decreased as their occupational status, wealth, and/or income increased if the men had strong masculinity beliefs. In fact, the men that showed strong masculinity beliefs were half as likely as men with more moderate masculinity beliefs to have received preventive care regardless of SES, family background, demographics and prior health. Spring and Mouzon speculated that masculinity may be a partial explanation for the paradox of men's lower life expectancy, despite their higher SES when compared to women.

A focus group of men from Scotland discussed why men avoid seeking medical attention and tolerate "minor" health issues. O'Brien et al. (2005) led this group discussion and found that the men felt they may be wasting the doctor's time, or may be seeking help when there is nothing wrong with them. The men in the group saw it as a weakness to pay attention to "minor" symptoms, while the practice of masculinity encourages men to be strong, silent, and endure pain and illness. The younger men in the group stressed that prior to seeking medical attention they felt they needed to be obviously injured, seriously ill, have endured the symptoms to an acceptable threshold, and/or pressured by a spouse to seek attention before they would consider seeking medical attention.

O'Brien and colleagues (2005) also found it interesting that men referred to emotional or mental health problems such as depression as 'stress' rather than admit to the 'unmanly' diagnosis of depression. The men with emotional or mental health issues

were said to be very conscious of the unwelcome scrutiny of their male identities that they felt would result from seeking help for depression.

O'Brien and colleagues (2005) discussed two instances in which seeking medical attention preserved masculinity rather than threatened it. The first instance was among firefighters. The strong masculine identity associated with the occupational role of firefighter gave these men the opportunity to have open discussions about health and even emphasized the importance to consult health professionals for even so-called trivial problems. These men emphasized the importance of preventing health problems to allow them to maintain their health and thus retain their job. The second instance in which seeking medical attention preserved masculinity was if men were having sexual performance issues. These men indicated they would much rather "risk" their masculine status by seeking medical attention than put their sexual health at greater risk by not being able to have sex.

### **Men and Health Care**

Research has shown that men visit their physicians less often than women (Farrimond, 2012) and men wait longer than women to seek needed medical care, and men do not seek medical attention until their condition(s) become serious (Sayer & Britt, 1996; Seymour-Smith et al., 2002). Men have also been found to have fewer dental check-ups, and attend fewer mental health visits than women (CDC, 2004; Corney, 1990; Good, Dell, & Mintz, 1989).

### **Seeking Health Care**

A large amount of men in the U.S. have limited contact with physicians and the health care system; and this lack of contact with doctors means men often do not get the preventive care needed, which places their health at risk (Sandman, Simantov, & An, 2000). In 1998, the Commonwealth Fund conducted a telephone interview of 1,084 adult U.S. men and found that 24% of men did not see a physician in 1997, 33% of men did not have a regular doctor, 24% of men said they would wait as long as possible before seeing a doctor when they were feeling sick or were in pain, and 17% said they would wait at least a week before seeking medical attention. The report found that men's health behaviors such as those mentioned above, and reluctance to seek care, place their health at risk. The authors of the report suggested that married men may benefit from having a concerned spouse and from women's greater inclination to seek health care for themselves (Sandman et al.).

The Commonwealth Fund study also discovered that 28% of men who were living alone did not visit a physician within the year prior to the survey, compared to 21% of men living with a spouse or partner. When examining preventive care, 44% of men living alone sought no preventive care. In addition, 42% of men living alone lacked a regular doctor, while only 27% of married or partnered men lacked a regular physician (Sandman et al., 2000).

Tudiver and Talbot (1999) reported a physician's perspective on why men do not access needed medical care. They identified three themes: (a) support, (b) help seeking, and (c) barriers. Within those themes, they found female partners to be the primary source of support for men's health concerns, and that men delayed or did not seek

medical care due to a perceived vulnerability, fear, or denial of an illness. The traditional social roles of males also inhibited seeking medical care. These social role characteristics included a sense of immunity and immortality, difficulty relinquishing control, the belief that seeking help was unacceptable, and the belief that men did not have an interest in preventing disease. The systematic barriers included lack of time and/or access, having to state the reason for the visit, and not having a male physician.

Marcell, Howard, Plowden, and Watson (2010) also found females to be a good source of support for men's health concerns. Using three focus groups, comprised of adolescent females, young adult females, and adult mothers of sons, Marcell and colleagues explored how to best engage young men in positive sexual and reproductive health practices. They concluded that women may be in the best position to help dispel young men's fears and shed light on the health care experience. One interesting finding was that women found challenges in being the support of young men's reproductive health due to a number of reasons: (a) it was hard to be a trusted source of information, (b) they felt they had a deficiency in knowledge concerning men's reproductive health, (c) they felt uncomfortable talking about certain topics, and (d) they found being a female could be detrimental to male's health promotion, and that young men may prefer and/or benefit more from talking with a male role model. The women in the study felt that when men need to talk to someone concerning their reproductive health, men need to get that information from an expert to "counteract concerns that information provided by a mother may not be taken seriously or true" (Marcell et al., 2010, p. 300). Norcross et al. (1996) also agreed that women can exert an important influence on the decision of men to seek health care. They found that men were 2.7 times more likely than women to be



influenced to seek health care by a member of the opposite sex. A study among elderly couples also found wives play a key role in maintaining their husband's health (Burke, Beeker, Kraft, & Pinsky, 2000). And Padula (1996) found that 52% of couples identified the wife as more influential than the husband in reaching a final health decision. Padula also found that wives were more likely than their husbands to be concerned about their spouse making and keeping medical appointments (16% versus 7%).

### **Health Status and Health Beliefs**

In an effort to understand how marriage and health are associated, Markey et al. (2005) designed a study to observe health status and health beliefs among men and women. Using the Health Belief Model, they examined an individuals' health behavior through the individual's perceived (a) susceptibility to disease or disability, (b) severity of a disease or disability, (c) benefits of health-enhancing behaviors, and (d) barriers to health-enhancing behaviors. They discovered individuals who had low health beliefs (i.e., were less proactive concerning their health maintenance) did not see being actively involved in their health care as important whereas those with high health beliefs saw being actively involved in their health care as being important. Their results concluded that being married, verses being single, was positively associated with men's proactive health beliefs.

### **Health Concordance/Correlation among Spouses**

Similar health status, or health concordance, among spouses began to be recognized around the 1980s (Meyler et al., 2007). Since the 1980s, many studies have been conducted examining the correlation between spousal health. Using longitudinal

data, Falba and Sindelar (2008) conducted a study to examine the degree to which married individual's health habits and use of preventive medical care were influenced by their spouse's behavior. They specifically studied changes in exercising, smoking, drinking, cholesterol screening, and obtaining a flu shot. They found that when one spouse improves his or her behavior, the other spouse is likely to do so too. Although "effects are strongest for behaviors where there might be the most cue-associated behavior (smoking and drinking), and for patient-directed (flu shot) rather than clinician-directed (cholesterol screening) preventive behavior" (p. 112).

With regard to Falba and Sindelar's (2008) results of individual's preventive medical care use, they found that when one spouse starts attending medical screenings the other spouse is likely to start attending screening sessions as well. Homish and Leonard's (2008) study of premarital health behavior discovered that if a wife prior to marriage had regular physical examinations, her husband was more likely to have physical examinations as well during the first four years of marriage. Markey et al. (2005) examination of health beliefs and health status, mentioned above, found that men who were married were more likely to undergo colorectal cancer screening, cholesterol screening, and prostate exams than were men who were single even after controlling for age.

Marital status was a predictor of colorectal screenings in the UK, according to Van Jaarsveld, Miles, Edwards, and Wardle (2006). The researchers found married or cohabiting couples had more positive intentions and higher attendance rates at screenings when compared to non-married or single individuals while adjusting for age, gender and educational level. Although, after adjusting for the marriage effect, invitations to attend

screenings sent to both partners at the same time did not significantly increase screening intentions among men, only among women. Fortunately, actual attendance at screenings significantly increased in both genders when both partners were invited to attend the related screening together.

Efforts are being made to increase men's preventive screening rates. Holland, Bradley, and Khoury (2005) tested five interventions for improving men's preventive screening rates. Of the five interventions, three resulted in significant improvements in men seeking preventive screening. The three that had significant results included: (a) sending a personalized letter/pamphlet to the male educating him concerning the screening along with placing a note in the patients' chart at their physicians office reminding the physician to discuss the screening with the patient, (b) sending only the personalized letter/pamphlet to the male, and (c) sending a loved-one postcard addressed to the female of the household in behalf of the male of the household. Holland and colleagues pointed out that due to unreliable marital status data, the loved-one postcards' positive impact can only be attributed to the fact that the postcard was a point of second contact and should not be attributed to the influence of a female loved one.

Finally, Falba and Sindelar (2008) found that if a spouse continues to get a flu shot, it strongly predicts the other spouse will get vaccinated as well. Husbands whose wives begin getting flu shots have a 60% predicted probability of starting to get flu shots, as opposed to only a 21% predicted probably if the wife does not continue to get a flu shot.

## **Relationship Between Spouses' Health**

Regardless of age, sex, race, education, income, or place of birth, married adults are generally healthier than adults in other marital statuses (Schoenborn, 2004). Using data from the 1999-2002 National Health Interview Surveys (NHIS), Schoenborn found the only negative health indicator in which married adults had a higher prevalence rate was being overweight. Wood et al. (2007) also found that marriage tends to encourage weight gain, reduce physical activity levels, and promote a more sedentary lifestyle. Wood and colleagues examined two major theories to see if the link between marriage and health is a causal one (i.e., if marriage causes better outcomes or simply that people who marry may already be healthier than those who do not marry). They found strong evidence that (a) marriage reduces the prevalence of heavy drinking and marijuana use among young adults; (b) marriage is linked to improvements in mental health, in particular that marriage decreases depressive symptoms (Koball et al., 2010) for both men and women while marital dissolution increases them; and (c) that marriage is associated with lower health care costs among older adults due to the economic advantages provided through marriage such as an increased income and access to a partner's health insurance.

### **Health Concordance within Couples**

Many researchers have found that couples have similar or concordant health statuses. Concordance is the connection between spouses and their similar health statuses. Meyler et al. (2007) identify two primary ways of assessing concordance: (a) researchers can determine the level of correlation of health among spouses or (b) researchers can

investigate whether the health characteristics of one spouse influence the same characteristics of the other spouse.

Several theories have been proposed to explain concordance assortative mating, shared resource hypothesis, social control, and mood convergence or affective contagion (Meyler et al., 2007). Assortative mating can be summarized as individuals marrying people who are much like themselves (Lillard & Panis, 1996). Shared resource hypothesis suggests that people who marry often share the same environment, financial resources, and social network, which translates into shared health behaviors that can be beneficial or detrimental (Smith & Zick, 1994). Social control is much like it says: one spouse will attempt to control the other spouse's behavior to keep him or her healthy (Umberson, 1987, 1992). Mood convergence or affective contagion suggests that by living in co-dependent relationship with a partner, one's emotions are inextricably connected to that partner (Goodman & Shippy, 2002; Joiner & Katz, 1999).

The above theories were examined by Meyler et al. (2007) in terms of how they factored into couples' mental health concordance, physical health concordance, and health behavior concordance. Meyler and colleagues reviewed 103 health concordance research articles examining individuals who were intimate partners, or that were married or in a marriage-like relationships. They found overwhelming evidence to suggest evidence for concordance in mental health, physical health, and health behaviors among couples.

Strong evidence for concordance of mental health within couples, particularly when exploring depressive symptoms, was found by Meyler and colleagues (2007) and Walker and Luszcz (2009). Meyler and colleagues found that the articles they reviewed

were more likely to suggest that spouses experience mental health convergence as a way to explain concordance as compared to assortative mating or shared environment.

However, over half of the mental health concordance articles offered no concordance theory for explanation.

When Meyler and colleagues (2007) analyzed physical health concordance, they found that couples display concordance in their physical health particularly for blood pressure and heart disease. No conclusive evidence was found to explain physical health concordance through shared environment versus assortative mating, although most studies pointed to shared environment (15 of 26) for physical health. Stimpson and Peek's 2005 study of older Mexican American couples also found that when one spouse develops high blood pressure it significantly increases the likelihood of the other spouse developing high blood pressure. They also found this to be true for cancer and arthritis.

Meyler and colleagues' (2007) review found the study of health behavior concordance has received the least attention when compared to studies on mental and physical health. They found that when studies did investigate health behavior concordance, they most commonly examined diet, smoking, alcohol use, and illegal drug use. Stimpson, Masel, Rudkin, and Peek's (2006) study of older Mexican American couples fell into this category which found BMI to be positively associated among couples and the risk of smoking and drinking was higher if the partner had ever smoked or drunk alcohol. Homish and Leonard (2008) found that both men's and women's health behavior prior to marriage was associated with their partner's health behavior over time in both positive and negative behaviors. Meyler et al. overall found evidence to support that health behaviors were concordant, though less overwhelmingly so when compared to

physical and mental health. On the contrary, Padula and Sullivan's (2006) study of older adults in long-term marriages, found low correlations between spouses in term of health promoting behaviors such as health management, injury prevention, stress reduction, rest and relaxation, and exercise and nutrition.

An additional interest area is spousal concordance for overall health risk status and preventive service compliance. Pai, Godboldo-Brooks, and Edington (2010) focused on this area and found statistically significant positive correlations within spouses for both health risk status and preventive service compliance. The researcher's results did not provide direct evidence for gender dominance, but that each spouse exerted comparable influence on the other. On the other hand, they did find that the husband's education level was significantly associated with the wife's health risk status, but the wife's education level was not significantly associated with the husband's health risk status. They also found that a husband's having more health problems were correlated with his wife's worse health risk status.

A model proposed by Lewis et al. (2006) considers why couple dynamics might influence the adoption of risk-reducing health habits. Their model is based on interdependence theory (e.g., understanding the outcomes that partners experience by analyzing how they interact and by understanding each partner's perspective) and communal coping perspectives (e.g., shared assessment of health threats and a shared vision of shared action of how to manage the threat), that explicitly considers dyadic processes as determinants of couple behavior. They suggested that the couple's interference can transform motivation from doing what is in the best interest of the self, to doing selfless actions that are best for the continuation of the relationship. This

transformation can lead to an increased motivation for the couple to cope reciprocally or act cooperatively in adopting health-enhancing behavior change.

### **Education Level and Employment Status**

A great deal of evidence suggests that educational attainment leads to better health including: increased physical functioning, better self-reported health, fewer chronic conditions, a decrease in the age-specific rates of morbidity, disability, and mortality (Lynch, 2003; Ross & Mirowsky, 2010; Schnittker, 2004; Singh-Manoux, Ferrie, Chandola, & Marmot, 2004). Researchers also suggest that less educated individuals have more trouble overcoming obstacles to lead to healthy behaviors (Pampel, Krueger, & Denney, 2010). Additionally, researchers suggest a connection between a wife's education and employment status and their husband's overall well-being. Ross and Mirowsky believe the reason educated people experience better health is because they have healthy lifestyles, and these educated individuals have improved health because they have high levels of personal control as compared to those who are less educated and have less personal control. An additional reason that education may increase health is because it decreases economic hardship (Ross & Mirowsky, 2010). A higher education typically increases income, and Mirowsky and Ross (2003) stated and at the same income level, the better educated have less trouble paying the bills and paying for household food, shelter, and clothing than the poorly educated do. In Mirowsky and Ross's (2003) book, *Education, Social Status, and Health*, they state that educational attainment is a root cause of good health. Ross and Mirowsky hypothesize that education



gives people the resources to control and shape their own lives in a way that protects and fosters health.

Other researchers have reported similar results. Rehkopf, Berkman, Coull, and Krieger (2008) state that income is significantly and positively associated with health. Commodity theory is often used to explain why education and being employed can improve health. This theory focuses on household income and access to medical care and health insurance (Ross & Mirowsky, 2010). Typically the better educated are more likely to be employed and are also earning a higher income (Day & Newburger, 2002) and are therefore able to purchase medical care and health insurance. The following research examines if the educational attainment and employment status of a wife affects her husband's health.

### **Educational Attainment of Men and Their Spouses and How It Affects Men's Health**

While a key predictor of one's own disease and mortality is education, Jafee, Eisenbach, Neumark, and Manor (2006) examined how the educational attainment of one's spouse affects the mortality and cardiovascular disease of the other spouse. They found a wife's educational achievement was a greater predictor of her husband's risk of dying than his own education level. Skalicka and Kunst (2008), in a Norwegian study, also found that a wife's education was a stronger predictor of her husband's risk of dying than his own educational level; in fact, they found a wife's education was not only the strongest predictor of her husband's mortality, but the only predictor of mortality across all causes of death examined, except stroke. They hypothesized the effects of a wife's education might work directly on their husband's behavior or indirectly through the

wife's behavior. In Torssander and Erikson's (2009) study of the 1990 Census comprised of the employed Swedish population, they came to the same conclusion: a woman's education has a substantial effect on the mortality of her husband. Their study examined the effect of mortality of own and partner's positions regarding education, social class, social status and income. Women's education demonstrated a substantial effect on mortality for both themselves and their partners.

While health-related issues are traditionally studied on an individual standpoint, Monden, van Lenthe, de Graff, and Kraaykamp (2003) analyzed the importance of Dutch partner status and partner's education on self-assessed health, smoking and excessive alcohol consumption. For both men and women they observed that having a higher educated partner was associated with lower risks of poor health and smoking, but the influence of the individual's own education was almost twice as important as their partner's education for self-assessed health, and 1.8 times as important concerning smoking. Interestingly they found that men who have only a primary education are more likely to drink alcohol excessively the higher educated their partner is. Monden and colleagues also found that women are more affected by their partner's educational level than men. Women whose partners have low educational attainment report lower self-assessed health and are more likely to smoke.

### **Employment of Men and Their Spouses and How it Affects Men's Health**

The rise in female employment began in the early 1960s in the U.S. (Organisation for Economic Co-operation and Development [OECD], 1999), and the increase in female employment has led to an increase of households where both adults are in paid employment (OCED, 2011). According to the U.S. Census, in 2002 only 7% of all U.S.

households consisted of married couples with children in which only the husband worked, while dual-income families with children made up more than two times as many households and families with two incomes and no children outnumbered the traditional family by almost two to one (AmeriStat, 2003).

With the majority of households having both the husband and wife working it is important to study if women's paid employment has an effect on their husband's health. Springer (2010) studied just that. Her results showed that wives' paid work hours provoked no harmful health affects to their husbands. However Stolzenberg and Williams (2008) found that husbands' overall health is negatively affected if their wife worked greater than 40 hours a week. Torssander and Erikson (2009) discovered that a woman's income from working has a weak or no effect for men's mortality. Stolzenberg and Williams further examined the effect of workers' dissatisfaction with their paid work and their unpaid household work on the health of their spouse. They found that husbands tend to experience reduced health if their wives expressed dissatisfaction or insufficient appreciation for her paid work.

### **Women's Influence on Men's Health**

Men are often portrayed as dependent on females concerning health matters, whether the female be a spouse, partner, or other relative (Norcross et al., 1996; Seymour-Smith et al., 2002). The men in Dolan's (2011) focus group study were generally unanimous in agreement that women were better positioned to access health care due to women's maternal instincts and having the primary role as caretaker for the family. And O'Brien and colleagues (2005) found that some men talked of the role their

wife played in encouraging them to seek medical advice with symptoms the men would have otherwise dismissed as “minor.” Peak et al. (2010) found in their focus group study that Latino men look to women for advice and help about health related problems, and Sobralske (2006a, 2006b) found that Latinas exert a significant influence on which medical practitioner Latino men go to for health care. Norcross et al. and Seymour-Smith et al. also emphasized that women play a key role in persuading men to seek medical help as well as assisting men in interpreting health symptoms and encouraging awareness of health issues. Gast and Peak (2011) discovered that men in their focus groups were willing to overcome traditional masculine gender scripts, seek medical attention, or engage in health-promoting behaviors if they were prompted by a spouse. The men found this to be a bearable loss of masculinity: “Pleasing a wife was perceived as more important than the potential loss of masculinity” (p. 324).

### **Social Relationships and Marital Status**

Social connectedness, or social connection offered by relationships, has proven to have significant effects on health. Social connections or relationships can be measured by the level of social integration or involvement, the quality of the relationship(s), and the social networks or web of social relationships surrounding an individual (Umberson & Montez, 2010).

Research has found adults who are more socially connected are healthier and live longer than their more isolated peers (Umberson, & Montez, 2010). A study conducted by Courtenay (2000a) emphasizes evidence showing individuals with smaller social networks, or fewer less intimate friendships, equates to a risk factor for mortality—

especially for men. Men with less intimate friendships, no close friends, or lower levels of social relationships have (a) a higher likelihood of dying, (b) a decreased chance of survival after heart disease, cancer, and stroke, (c) less positive health practices, (d) lower immune function, (e) higher psychophysiologic responses to stress, and (f) less potential to change unhealthy behaviors.

Umberson and Montez (2010) suggested that marriage may be the most studied social relationship. Marriage shapes a variety of health outcomes including cardiovascular disease, chronic health conditions, mobility limitations, self-rated health, and depression (Hughes & Waite, 2009; Zhang & Hayward, 2006). Cardiovascular risk factors associated with marital status were studied by Maselko, Bates, Avendaño, and Glymour (2009). They found that both men and women who had never been married or were widowed predicted greater cardiovascular risk factors, and that widowed men had the highest risk for both men and women of all marital statuses. Zhang and Hayward (2006) also studied cardiovascular health in regards to marital status. They found that remarried men had a relatively higher risk of cardiovascular disease than continuously married men. About 16.4% of remarried men, 17.7% of divorced men, and 16.5% of widowers report having cardiovascular disease compared to 13.5% of continuously married men. And the risk of cardiovascular disease for never-married men remains about 60% less than for continuously married men. And never-married men and women have comparable or even better cardiovascular health than their continuously married counterpart in late midlife.

Changes in marital status and health were also studied by Williams and Umberson (2004). They discovered that during the transition into first marriage and the transition

into remarriage, men report a self-assessed improvement in their health, but this improvement levels off at some point after three to five years (called the honeymoon effect) and then men's health becomes similar to that of single men in general. They also point out that because of this leveling off, continually married men are no healthier than their never-married or continually divorced counterparts. Another major finding was that transitions out of marriage do not always undermine health and may in some cases improve it, although negative physical health consequences of exiting marriage through divorce or widowhood increase with age.

Researchers have examined if being romantically involved improves health. Markey, Markey, and Gray (2007) found their participants believed their partners to be primarily positive health influences, although women believed their partners to be more influential than did men. Those participants who believed their partners to have a positive health impact tended to be in a relationship that was more loving, understanding, and harmonious than those participants who thought their partners had a relative negative health impact. Stronger emotional and social loneliness was observed in adults whose spouse had health problems, according to Gierveld, Groenou, Hoogendoorn, and Smit (2009). They examined emotional and social loneliness among older people in Amsterdam and how the evaluation of the functioning and quality of marriages plays a role. In addition to higher levels of emotional and social loneliness in individuals who had health problems, they also found stronger emotional and social loneliness in adults who did not often receive emotional support from their spouse, who had infrequent conversations or were in disagreement, or who evaluated their current sex life as not

(very) pleasant or not applicable. Gierveld and colleagues also found distinct social loneliness was characteristic of older men with disabled spouses.

According to data analyzed from the National Health Interview Survey conducted from 1972 to 2003, the self-rated health of the never-married improved over the past three decades (Liu & Umberson, 2008). Results also showed the relative advantage of married over the never-married has decreased for men while the relative advantage in self-rated health of the married over the formerly-married (the divorced, separated, and widowed) has increased (Liu & Umberson, 2008). Muhajarine and Janzen (2006) examined the association between self-rated health and the perceived quality of work, family and community of employed Canadians. They found for men, greater satisfaction with family relationships (other than their partner) was associated with more positive self-perceived health, and the more favorably the men rated the physical quality and social cohesiveness of their neighborhood, the better their self-rated health.

Courtney's (2000a) review of social relationships and health also found several key findings in regards to social support. He found that research consistently shows that men (a) have much smaller social networks than women do; (b) have fewer, and less intimate friendships when compared to women; (c) are less likely to have a close confidante, particularly someone other than a spouse; (d) have social networks that tend to be less multifaceted and less supportive than women's; and (e) are also less likely to seek out social support when they need help.

### **Social Support/Spousal Support**

In their study, Franks and colleagues (2006) defined social support as involving attempts to aid and reinforce partners' efforts to sustain needed changes in health behaviors. Social support has long been recognized to be health protective (Franks et al., 2006). And because men tend to rely on their spouse for social support when it is related to their health (Kandrack, Grant, & Segall, 1991), and because for those who marry, a spouse is one's most likely source of emotional support (Waite & Gallagher, 2000), it is important to know how women's social support influences their husband's health.

Spousal support among cardiac rehabilitation patients was studied by Franks and colleagues (2006). They found spousal support was positively associated with patient health behavior, and prospective analyses of change over 6 months revealed that spouses' support predicted increased patient mental health. Kristofferzon, Löfmark, and Carlsson (2003) also examined social support among cardiac patients. Kristofferzon and colleagues conducted a review examining gender differences in perceptions of coping and social support among patients who had experienced a heart attack. Results showed that women reportedly use more coping strategies than men after experiencing a heart attack, but men were more likely to involve their spouse in their recovery. Men also reported receiving more support from their spouses than did women.

Several researchers have examined social support and its impact on spousal conflict. Heffner, Kiecolt-Glaser, Loving, Glaser, and Malarkey (2004) examined blood pressure and cortisol levels in response to couples' responses to conflict. Newlywed couples demonstrated lower blood pressure after conflict when their spousal support



satisfaction was higher. Older husbands exhibited higher cortisol levels when they were less satisfied with the spousal support they received from their wives.

One study revealed some interesting findings in regards to spousal emotional support. Tower, Kasl, and Darefsky (2002) found that husbands are more likely to live longer if they are perceived by their wife as being a source of emotional support but that the husbands did not view their wife in the same way (i.e., the husbands felt they were emotionally self-sufficient).

A study by Cubbins and Szaflarski (2001) estimated family influence on the self-reported health of Russian wives and husbands. They found that when Russian wives are the chief decision makers in the family, their own health suffers, although their husbands' health is better.

Several studies focusing on support in regard to work have recently been conducted. One was done by Van Daalen, Willemsen, and Sanders (2006). They examined the relationships between sources of social support and the time and strain-based work-to-family and family-to-work conflict among dual-earners. The researchers found men benefitted from social support from both their supervisor and colleagues. Those men who reported having social support from colleagues had a decrease in strain-based family-to-work conflict, and men who reported support from their supervisor had a decrease in their time-based work-to-family conflict. Spousal support was not studied. The second study was conducted by Patulny (2009) who examined the social contact that Australian retired and non-retired men and women had with people outside their household. They found that men rely substantially more on work-based networks for social contact outside their home than women. The researchers suggest that this finding is

detrimental for single and separated/divorced/widowed men who retire because of their lack of partner support and support from family and friends relative to other men.

### **Social Control**

Social control has also been positioned to be health protective because it induces greater compliance with behavioral recommendations and discourages unhealthy behaviors (Umberson, 1987). Social control is similar to social support but involves attempts to induce changes in a health behavior of a partner who has been unable or unwilling to make changes on their own (Franks et al., 2006).

Similar to spousal support and social relationships, men find their spouses to be the most frequent source of social control (August & Sorkin, 2010). In fact, Umberson (1992) reported 80% of men name a spouse as the primary source of social control, whereas only 59% of women name their spouse as the primary source of social control. August and Sorkin also found married men reported receiving social control most often, whereas unmarried men reported receiving social control least often. The researchers asked married and unmarried men and women about the sources and frequency of health-related social control they received. Their results found that men who were married reported the highest levels of both types of social control strategies, persuasion and pressure. The researchers proposed that married men most likely receive the most social control because their wives are reported by married men as being the most common source of social control.

Umberson (1992) summarized data from a national panel survey conducted in 1986 and again in 1989. Results show that: (a) marriage is associated with the receipt of

substantially more efforts to control health for men than women, (b) those who attempt to control the health of others are more likely to be female than male, and (c) there is some support for the social control and health behavior hypothesis among the married. She uses the following theories to explain these marital status differences (a) Men in any unmarried status—whether divorced, widowed, or never-married—report that they experience less social control from others than men who are married; and (b) married persons are most likely to identify a spouse as their primary social control agent, or the person who tries to control their health. Additionally, spousal control efforts have been found to be more effective for men compared to women (Westmaas, Wild, & Ferrence, 2002). Umberson, Chen, House, Hopkins, and Slaten (1996) have endorsed Umberson's (1992) findings in that divorced and never-married men are significantly less likely than their female counterparts to report that others attempt to regulate their health. Of those that are married however, men are much more likely than women to report that others attempt to regulate their health.

One study done by Franks and colleagues (2006) examined spousal support and control as predictors of health behavior and mental health among patients undergoing cardiac rehabilitation. They found evidence was lacking in the support of social control theory (i.e., social control facilitates healthy behaviors and discourages unhealthy behaviors). In fact, through prospective analyses of change over 6 months, they found that spouses' control predicted poor health behavior and poor mental health in the receiving spouse. Their findings did, however, support dual effects hypothesis, which argues that control efforts by one partner to induce behavior change in another may arouse emotional distress in the recipient. Helgeson, Novak, Lepore, and Eton (2004) also

found support for dual effects hypothesis by measuring perceptions of wives' attempts to encourage appropriate health behavior among men with prostate cancer. These wives' attempts to encourage healthy behaviors using social control were not found to produce positive changes in health behavior, but were associated with greater psychological distress. Franks et al. propose these negative health behaviors may be due to the receiving spouse responding to the controlling effort with behavioral and psychological opposition. Franks et al. speculates that this opposition may undercut the receiving spouse's confidence in their ability to change their own unhealthy behaviors.

Women tend to use more coercive strategies when trying to influence their partner than men do (Fekete, Stephens, Druley, & Greene, 2006; Orina, Wood, & Simpson, 2002). Negative control strategies, such as spousal warning, are associated with poorer adherence to a diabetic diet (Stephens, Rook, Franks, Khan, & Iida, 2010), poorer medical adherence, and increased anger in patients over time (Franks et al., 2006; Helgeson et al., 2004; Rook, 1990). On the other hand, when spouses use positively toned and less coercive techniques to influence healthy behaviors, spouses' dietary behavior and disease management was found to be better served, and spouses tended to adhere more to a diabetic diet (Stephens et al., 2010).

One surprising result from Fekete and colleagues (2006) reveals that patients whose spouses used positive control to promote adherence showed decreases in positive affect. Encouragingly, positive control can be associated with more adherence, but only when their spouse provides little problematic support (e.g., changing the topic or telling spouses not to worry).

## Summary

Farrimond (2012) stated that “‘health’ has become an area in which the social values of the Protestant work ethic of self-control, self-denial and individual responsibility can be displayed. Furthermore, this valuation of health is ideologically driven; dividing up the ‘unhealthy’ and thus less morally worthy, from the ‘healthy’ who are socially valued” (p. 211). If this valuation on health continues, as Farrimond proposes, then how do men currently view the impact masculinity has on their health behaviors? In addition, Creighton and Oliffe (2010) reiterated that aggression and risk-taking are considered to be naturally occurring expressions of maleness and that male psyches are ‘hardwired’ to perform behaviors that risk, rather than promote, self-health. The authors further summarize research, stating the importance of understanding how masculinities connect to men’s health, and that this understanding requires a theoretical framework that accounts for the agency of an individual in making the health choice and the social structures that shape those options.

The goal of this proposed study was to do as Creighton and Oliffe (2010) suggested and to better understand how masculinities connected, or influenced, men’s health. In addition, this study sought to evaluate the claims of Norcross et al. (1996) and Seymour-Smith et al. (2002) of the impact women had on men’s health, in particular, the impact women had on their husband’s overall health.

## CHAPTER III

### METHODOLOGY

#### **Overview**

Previous chapters provided the foundation for the purpose and need for the study. This chapter provides an overview of the research design methods used, including sampling methods, instrumentation, pilot-testing, data collection and analysis. Information regarding the advantages and limitations of focus groups is also discussed.

#### **Research Design**

Focus group interviews were used to collect data for the study. Focus group interviews are a form of qualitative research. Qualitative research is situated activity that locates the observer in the world to study things in their natural settings in an attempt to make sense of, or interpret, phenomena in terms of the meanings people bring to them (Denzin & Lincoln, 2005). This field of inquiry can be conducted through observation, participation, interviewing, and ethnography (Denzin & Lincoln, 2005). Qualitative health research is a subdiscipline of qualitative research that focuses on the illness experience including injury, chronicity, birth, death, and dying (Morse, 2010).

Focus groups are often used to explore a specific set of issues through semi-structured discussions (Liamputtong & Ezzy, 2005). These discussions gather information to better understand how people feel or think about a predetermined area of interest, an issue, a product, a program, intervention, research, or service (Krueger & Casey, 2000; Tong, Sainsbury, & Craig, 2007). Participants used in focus groups are

chosen because they possess certain characteristics. The participants provide qualitative data in a focused discussion to help researchers better understand a topic of interest (Krueger & Casey, 2000).

Focus group interviews have many advantages. Focus groups allow for a wide range of ideas or feelings which allows for different perspectives from the groups or categories being studied (Krueger & Casey, 2000). Opportunities for clarification of questions that arise or exploration of unanticipated issues are also possible in focus groups, which allows for more in-depth analysis than quantitative methods (Krueger & Casey, 2009; Stewart & Shamdasani, 1990). An additional advantage of focus groups is that participants tend to feel more relaxed than individuals in traditional interview settings. As a result participants often feel less inhibited during the discussion (Krueger & Casey, 2009).

Limitations are also present when focus groups are used to study a topic of interest. Because focus groups are inquiry based, the participants recruited typically do not receive education or information concerning the topic. Likewise, sensitive information is not as likely to be shared, and when it is shared, it may sometimes be harmful to the individual or group. The environment in focus groups can also become emotionally charged and cause conflict among the group (Krueger & Casey, 2000). An additional disadvantage of focus groups is that they can be impacted negatively by the moderator or an opinionated participant. Participants may also try to portray themselves as more thoughtful and reflective during the discussions than they really are (Krueger & Casey, 2009). A common concern among focus groups is that individuals who choose to participate as volunteers may represent a specific population, thus limiting the

generalizability of the findings (Stewart & Shamdasani, 1990). An additional concern is that focus group discussions involving men may cause men to portray more exaggerated masculine views (Gough, 1998; Pietila, 2008).

A common concern among focus group studies is internal validity and reliability outside of the research setting. Silverman (2006) stated that validity is simply another word for trust. Reliability refers to the degree to which the findings of a study are repeatable and thus independent of the accidental circumstance of their production (Kirk & Miller, 1986).

To maintain internal validity, a research study must ensure the results accurately represent the topic of interest. Type I and type II errors may arise when a researcher proposes a purportedly 'accurate' statement (Silverman, 2006). A type I error is believing a statement is true when it is not. A type II error is rejecting a statement which is in fact true. Silverman explains that in interviews, such as focus groups, validity is called into question as participants' "answers to interview questions do not have a stable relationship to how they behave in naturally occurring situations" (p. 289). A second issue brought up by Silverman (2006) is that "researchers' claims may sometimes be credible merely because they rely on common-sense knowledge which stands in need of explication rather than passive acceptance" (pp. 289-290). Many qualitative researchers claim "they have a 'warrant for their inferences' and that their work is valid" (p. 290). Three issues arise in the validity of qualitative research: (a) the impact of the researcher on the setting, (b) the values of the researcher, and (c) the truth status of a respondent's account. Silverman suggested five ways to create validity within qualitative research: (a) analytic induction – the equivalent of the statistical testing of quantitative associations to see if the



associations that arise are greater than what might be expected at random; (b) the constant comparative method – an attempt a researcher makes to find another case through which to test out a provisional hypothesis; (c) deviant-case analysis – a method by which researchers actively seek out and address deviant cases by analyzing every piece of data until it can be accounted for; (d) comprehensive data treatment – all cases of data are incorporated in the analysis; and (e) appropriate tabulations – the categories being counted are derived from theoretically defined concepts (p. 303).

Reliability is said to be maintained if different researchers could repeatedly conduct the same study and yield the same result. Two ways in which to satisfy reliability in non-quantitative work are suggested by Moisander and Valtonen (2006). One way is to make the research process transparent by describing the research strategy and data analysis methods used. An additional way to satisfy reliability is for the researchers to state the theoretical stance from which the interpretation takes place and show how the stance produces particular interpretations and excludes others. Silverman (2006) has argued that high reliability in qualitative research can be maintained through low-inference descriptors. Low-inference descriptors involve researchers recording observations verbatim and in terms that are as concrete as possible (Seale, 1999). Tape-recording all face-to-face interviews, carefully transcribing the tapes, and presenting long extracts of data in the research can satisfy the need for low-inference descriptors (Silverman).

As this study used focus groups as its method of study, it was important to maintain both internal validity and reliability when reporting responses received from participants. Krueger and Casey (2009) emphasized one crucial way to maintain validity

and reliability is through careful selection of the focus group moderator. They encouraged researchers to consider the moderator's gender, race, age, language, social or economic characteristics, and technical knowledge (Krueger & Casey, 2009. p. 87). The research team determined that it was best to hire a male research assistant as a moderator for the focus group discussions. A male moderator was chosen in hopes that he could provide a more comfortable environment for the male focus-group participants. The research assistant was also chosen because he did not have a stake in the study and could therefore introduce less bias, both suggestions Krueger and Casey have encouraged when choosing a focus group moderator. Asking the moderator to summarize participants' responses at the conclusion of each focus group and then ask participants to clarify or give correction to the summaries was an additional way the researchers sought to maintain validity.

Reliability can also be a problem when careful attention is not paid to the categories used to analyze the text (Silverman, 2006). To reduce this problem, it is important to develop a standardized way of categorizing the data and then have several different coders use these same categories in analyzing the data (Silverman, 2006). Several researchers were utilized to analyze the data received in this study to raise the likelihood that the data and results presented were both valid and reliable. To ensure internal validity was satisfied, two different researchers examined the data to identify themes. External validity was not satisfied in the current study as the purpose of this study was not to generalize results to other populations. To allow further checks on the reliability of this study by others, all research strategies and data analysis methods are described in full detail. The discussions also utilized a digital audio and video recorder to

transcribe participants' responses verbatim. The researchers utilized Umberson's 1987 social control model to examine the form(s) of social control that wives use to influence their husband's health as well as how the husbands perceive it influencing their health behaviors. The concept of masculinity and masculine capital were also examined in this study.

### **Focus Group Size and Number**

A focus group can range in size from 4-12 participants, with a typical group composed of 5-10 participants (Krueger & Casey, 2000). Krueger and Casey stated the ideal size of a focus group is six to eight participants. A group on the smaller side has more advantages than a larger group as it is more conducive to allow everyone to share their opinions. It is important, however, to have enough people in the group to allow for diversity of opinion. Participant selection was based upon predetermined characteristics that each participant must have. These characteristics were determined by the researcher for the purpose of the study. For the proposed study, a minimum of five people was required for each focus group with a maximum of 10. As noted in Chapter I, the inclusion criteria of participants were that all participants had to be male, over the age of 18, and currently married or having been previously married. The exclusion criteria was that all participants had to be English speaking. Group size ranged from eight to ten participants for the present study.

According to Krueger and Casey (2000), the general rule is to conduct three or four focus groups. Once the three or four groups have been conducted, the researchers must determine if the information they have received has become redundant or if new ideas are still emerging. If no new information is being received, the researcher may stop

conducting focus groups, but if new information is being received, the researcher should conduct more groups. A minimum of four focus groups were planned, but due to a high number of interested participants, the researchers decided to hold five focus groups. After the fifth focus group, it was determined that the full range of ideas had been uncovered and no new information was being obtained.

### **Sample Selection**

A total of 44 married males participated in this study. To obtain the volunteer sample, recruitment was done through printed flyers and digital displays posted in various buildings on the Utah State University campus in Logan, Utah. Flyers were also posted at multiple local businesses, employment centers, and the Cache County Senior Citizen center. Emails were sent to the student researcher's friends and family members asking for volunteers as well as a posting on Facebook. Word of mouth was also used for recruitment.

Volunteers contacted the researcher via email, phone, or text message. During the initial contact, participants were made aware of the overall goal of the study and what they could expect to take place during the focus group discussion. After the initial contact, time preference and availability were obtained from each participant to assist the researchers in choosing times, dates, and locations of the focus group discussions. After the research team set dates for the focus group discussions, the researcher contacted each participant with a list of when and where the focus groups would take place. An online survey tool was utilized to allow participants that were emailed to choose all of the dates that they would be available to participate. This tool aided the researchers in assigning the male participants to one of the five focus group discussions so that the groups would

have at least eight participants and no more than ten. Participants were then contacted, informing them of their assigned date and time. Based on participants' preferred method of contact, a reminder email, phone call, or text message was made several days prior to each event with directions to the focus group location as well as parking information. As incentives, a light meal was provided at each focus group, as well as \$20 cash. Parking validation was also offered to participants as all five discussion groups were held on a college campus that had limited parking.

### **Instrumentation**

A discussion guide (see Appendix A) was developed for the focus groups. This guide set an agenda for the moderator to follow throughout the focus groups (Stewart & Shamdasani, 1990). The guide was formed by tailoring the research questions for the study using the following considerations recommended by Stewart and Shamdasani (1990): (a) Typical focus group questions should provide conversation to help create and maintain a comfortable, informal environment; (b) Questions should also use language that is unpretentious, clear, and easy for the moderator to say. These questions are typically short, open-ended, one-dimensional, and include well-thought out directions (Krueger & Casey, 2000). A male graduate student research assistant, not affiliated with this study, acted as moderator during the focus groups. The moderator was trained by the researchers and the pilot study also acted as a training mechanism for the research assistant. The moderator used the developed discussion guide (see Appendix A) to ask open-ended questions. When needed, the moderator asked follow-up questions for the purpose of seeking clarification or elaboration. The focus group discussions ranged

between one-and-a-half to two-and-a-half hours in length. Each discussion was audio recorded and video recorded.

Prior to conducting the focus groups, participants were given a letter of informed consent (see Appendix B). This letter gave participants information regarding the general purpose of the study, their rights as a research participant, as well as information stating that their responses would remain confidential and that publication of this paper would not include their real names.

Immediately following the administration of the letter of informed consent, the moderator handed out a demographic questionnaire (see Appendix C). The demographic questionnaire asked for the participant's age, occupation, employment and student status, highest level of attained education, race, ethnicity, current marital status, religious affiliation, and number of marriages. The questionnaire also asked several questions about the male participant's wife, including her employment status and her highest level of attained education. The questionnaire took approximately five minutes for participants to complete.

At the conclusion of the focus group discussion, participants were given the opportunity to write down any additional comments or ideas they had that they did not feel comfortable sharing with the group. As participants exited the discussion, each was asked to complete a Notice of Cash Received form (see Appendix D) stating they had received the \$20 cash incentive and parking validation as applicable. Only one participant declined the cash incentive.

### **Pilot-Testing Procedures**

Approval for pilot testing and study procedures were obtained from the Utah State University Institutional Review Board (IRB) prior to conducting this study. A pilot test was conducted prior to the formal study. The purpose of the pilot test was to determine the effectiveness of the proposed discussion guide as well as to assess if the guide was an appropriate length for the focus groups. The pilot test also allowed the moderator to refine his interviewing skills prior to conducting the focus groups. Data collected during the pilot test was not used for final data analysis.

There were six participants in the pilot test. Five of the six participants resided in Cache County, Utah. The age of the male participants ranged from 24 to 76 years and the length of marriage ranged from 1 year to 46 years. All participants identified themselves as white, all were currently in their first marriage, and all participants were of the same religious affiliation, members of The Church of Jesus Christ of Latter-day Saints (Church of Jesus Christ). Two participants were enrolled in school full-time and worked part-time; two participants worked full-time; one was self-employed; and one was retired. Two participants had completed some college, two were college graduates, and two had completed a post-college graduate degree. Two of the six participant's wives worked for an income. Two participants responded that their wife had completed some college; three responded their wife had graduated from college; and one responded that his wife had a post college degree.

These pilot group participants were recruited by word of mouth. They received a phone call to confirm interest and to notify them of the time and location of the pilot focus group. All of the participants were recruited through their wives.

Pilot group participants were provided with refreshments as well as a \$20 cash incentive. Parking validation was not needed by any of the participants as the pilot test took place off campus.

After pilot participants arrived and were seated, the moderator began by passing out a letter of informed consent (see Appendix B), followed by a demographic questionnaire (see Appendix C). After all participants had completed both documents, the moderator read an opening statement (see Appendix E). Following the opening statement, the moderator began the pilot study by introducing himself and then asking for participants to introduce themselves. The moderator followed the discussion guide to its conclusion. At the conclusion of the discussion questions, the moderator asked the pilot participants for feedback concerning their experience in the study and their thoughts on how to improve the discussion. Several participants proposed that a brief introduction was needed explaining the study prior to handing out the informed consent. Another suggestion was that a PowerPoint displaying each discussion question would help participants concentrate and stay on topic. After the pilot participants' feedback, each participant was thanked for their contribution, and upon receiving \$20, signed a Notice of Cash Received form (see Appendix D). The pilot study took approximately 70 minutes.

Results of the pilot study indicated that the discussion guide questions were easily understood by participants. The researchers concluded that although the questions were easily understood by participants, the questions did not adequately address all key issues this study was seeking to explore. Therefore, the discussion guide was expanded. The researchers also decided to implement the changes suggested by participants at the pilot study. These changes included creating a PowerPoint with a brief overview of the study,



a breakdown of the opening statement, and a slide for each discussion question. After reviewing the updated discussion guide, the researchers came across a video clip they felt would help male participants visualize the idea of how some men maintain their masculine capital, also referred to as their man card in the study, in the face of spousal social control.

The video clip is a short commercial showing a man in a stadium parking lot surrounded by other tailgating sports fans. The man retrieves a box from his cooler to find his wife has packed him quinoa vegetable burgers, instead of his usual red meat. He groans in disgust thinking to himself, “why does she pack these things?” He then remembers that he ate a quinoa burger by accident at a previous sporting event and his team won. He has an internal conflict that the burger “tastes like a dirty old tree branch,” but the burger may be good luck. The man then confidently throws the healthy burger on the grill thinking “this is for first place!” This video clip was added to the PowerPoint.

### **Data Collection Procedures**

Focus groups were held on five separate dates during the months of September and October 2013. The discussions took place in one of two conference rooms on the campus of Utah State University in Logan, Utah. Both of these conference rooms were chosen for their close location to a campus parking terrace for which parking validation was supplied to participants if it was needed. Each discussion lasted between an hour-and-a-half to two-and-a-half hours.

At the beginning of each focus group, participants were welcomed by the moderator and invited to obtain a plate of refreshment and take a seat at their name plate

placed on a conference table. After all participants were seated around the conference table, the moderator formally welcomed the group to the study and followed the prompts provided on the PowerPoint. The prompts included a brief introduction of himself as moderator and his role in leading the discussion followed by an introduction to the two research assistants; Dr. Julie Gast as note taker and Melinda Arnell, who managed the audio and video recording equipment. Dr. Gast acted as note taker in all but one session, in which Melinda acted as both note taker and equipment manager. Following these introductions, the male participants were given a short overview of what the focus group discussion was seeking to examine as well as a definition of what a focus group discussion was. The requirements for participation were reiterated at this point to ensure all males were currently married, at least 18 years old, could both speak and understand English, and would be able to stay the length of the discussion. Several housekeeping items were then addressed including asking participants to turn off cell phones, asking for consideration of each other's thoughts, asking for complete honesty in their responses, asking for both negative and positive comments, and informing participants that they would receive their cash incentive at the conclusion of the discussion as well as parking validation if it was needed.

At the conclusion of the housekeeping items, the moderator handed out two letters of explanation/informed consent forms to each participant (see Appendix B). The participants were then asked to read the letter and sign and date one copy and return it to the moderator and keep the second copy for their personal records. This letter explained the purpose of the study, potential risks and benefits of the study, and the voluntary nature of the study. The letter also explained that participants could withdraw from the

study at any time without consequence and that all responses would be kept confidential. The moderator answered any questions participants had concerning the form and informed the group their names would not be included on the final report to aid confidentiality. To further maintain participant confidentiality, the participants were asked to not share information that was shared in the focus group discussion outside of the day's discussion.

After he handed out the letter of informed consent, the moderator handed out a brief anonymous demographic questionnaire (see Appendix C), as noted above, for participants to complete. Participants were reminded to not put their name on the questionnaire.

After all questionnaires were collected, the moderator reminded participants that the session would be both audio and video recorded to aid in transcription and data analysis. Participants were also asked to speak clearly and loudly enough so that they could be heard and understood and to state their name before speaking to aid in transcription. The assistant then began the audio and video recordings. After the recordings had started, the moderator began the discussion by asking the introductory question. The moderator followed the discussion guide (see Appendix A) in its entirety in all five discussion groups. In each discussion, the moderator used various prompting techniques to further discussion and to seek more detail if needed. At the conclusion of the discussion questions, the note taker summarized the participant's responses as a validity check. The participants were encouraged to clarify and/or add to the note taker's summary. Following the note taker's summary and validity check, participants were allowed to anonymously write down any additional information or comments they

wanted to share that they had not previously shared in the group. Only one person did so out of the 44 participants, indicating that sexual intimacy was an important variable in his overall health.

At the conclusion of each discussion, the moderator ended the session by thanking participants for their time and passing out a Notice of Cash Received form (see Appendix D) for participants to initial and sign if they had received the cash incentive and/or parking validation.

The research team met after the fifth focus group discussion took place, and it was determined that overall no new information or themes were being shared and therefore no additional focus groups would be held.

### **Data Analysis**

Data analysis for the focus group interviews involved several steps. To begin analyzing the data obtained from the focus group discussions, first the script had to be transcribed. The recordings were transcribed verbatim through analysis of both audio and video recordings by an external transcriptionist not connected to the study. Upon completion of the external transcriptionist's work, the student researcher conducted a validity check of the transcriptionist's work by listening to all the audio recordings and comparing them to the transcriptionist's work. Minor errors were discovered and corrected. The student researcher also compared her hand written notes, taken during each discussion, to ensure all information was captured in the typed transcript.

Following the student researcher's verification of the transcript's validity, the student researcher followed the classic approach to begin data analysis. As Krueger and

Casey (2009) suggested, each of the five focus group word document transcripts were given a unique border, and line numbers were also applied to each transcript. Following this formatting, the student researcher cut each transcript apart and then placed participants' responses into folders as they related to the discussion questions (see Appendix A). The student researcher utilized a current word processing software program to assist this cut and paste approach. After organizing the transcript by discussion question, the student researcher went back through the data and highlighted information of importance and separated out unessential dialogue. After grouping the data by discussion question, the research team decided it best to then organize the data into themes according to the original research aims. This was done by rereading the dialogue and cutting and pasting the information into an electronic table according to the research aims found in Chapter I. The researcher used the classic approach to analyze the data received from the discussion groups. This approach allows for identification of themes and categories and is recommended for people who are doing their first qualitative analysis (Krueger & Casey, 2009). This approach is a visual and concrete process in which the transcripts are cut apart into individual quotes and then placed into themes and categories. Both the student researcher and another member of the research team reviewed the transcripts for internal validity of found themes. Krueger and Casey (2009) recommend asking four questions when analyzing the transcribed data: (a) Did the participant answer the question that was asked? (b) Does the comment answer a different question in the focus group? (c) Does the comment say something of importance about the topic? (d) Is it like something that has been said earlier? Using the above questions the data was placed into categories and then descriptive summaries were written

summarizing the data received. Krueger and Casey stated that during the summarizing process, a researcher must decide how much weight or emphasis to give comments or themes that arise. To aid in this decision they suggest a researcher look at several factors: (1) frequency, (2) specificity, (3) emotion, and (4) extensiveness. Written summaries were made of each category along with any differences that were found between groups. The summaries included a description of what participants said in response to the discussion questions asked. Themes that arose are discussed in Chapter IV. The analysis sought to find information centered on both the research questions in Chapter I and Umberson's social control model (1987) also proposed in Chapter I.

Validity for the data obtained was checked throughout each discussion group as the moderator attempted to clarify any comments made by participants. An additional validity check was performed at the conclusion of each focus group when the note taker summarized the groups' responses to each focus group discussion question. Participants were also allowed, and encouraged, to add or clarify any information they felt necessary during the note taker's summary. Participants were also encouraged to write any additional notes on an anonymous piece of paper at the conclusion of the session to be turned in for analysis. Reliability was maintained as two researchers reviewed the data for thematic elements.

### **Study Participants**

A total of forty-four males participated in the study (see Table 1). The number of participants in each of the five focus groups varied from eight to ten participants. Participants' ages ranged from 21-82 years, with the mean age of participants being 32

and the median age of participants being 27.5 years. An additional characteristic that was asked of participants during their introductions was added to Table 1. This addition was the length participants had been married. Nearly 30% of participants reported to have been married less than a year, and an additional 30% reported to have been married between one and five years. Of the remaining participants, 18% reported to have been married between six and 10, 14% reported to have been married between 11 and 20 years, and the remaining 9% reported to have been married 21 years or more. Of the participants, 18 were employed part-time, 20 employed full-time, five were unemployed, and one was retired. Of the 44 participants, 5 responded that they were enrolled in school part-time, 23 said they were full-time, and the remaining 16 were not enrolled in school. All participants reported to have completed high school, while 20 reported having attended some college, 10 reported having completed a bachelor's degree, and 8 reported having completed some type of post-college degree. Two participants reported to be Asian, 40 reported to be white or non-Hispanic, one reported to be Navajo and Black, and one participant reported to be Hispanic. In terms of religious affiliation, thirty-six participants (82%) affiliated with The Church of Jesus Christ of Latter-day Saints (Church of Jesus Christ) while one reported being Baptist, another to be Catholic, and another Muslim; four did not affiliate with any religion, and one reported being affiliated with both the Church of Jesus Christ and of Presbyterianism. Only two men reported having been married before and they were both currently in their second marriage. More than half of the men ( $n = 25$ ) reported their wife currently worked. In regards to participants reporting their wife's highest level of completed education, only one participant reported his current wife to have only completed some high school or less.

Eleven participants' wives were reported to have completed high school, 16 participants' wives were reported to have completed some college, 15 participants' wives completed a college degree, and one participant reported his wife to have completed a post-college degree.

Table 1

*Demographic Information*  
(*N* = 44)

Demographic	<i>N</i>	Percentage
Age		
20-29	25	57
30-39	14	32
40-49	1	2
50-59	1	2
60-69	2	5
80-89	1	2
Length of Marriage		
Less than 1 year	13	30
1-5 years	13	30
6-10 years	8	18
11-20 years	6	14
21 + years	4	9
Employment Status		
Employed part-time	18	41
Employed full-time	20	45
Unemployed	5	11
Retired	1	2
Student Status		
Enrolled in school part-time	5	11
Enrolled in school full-time	23	52
Not enrolled in school	16	36
Highest Level of Education Completed		
High school graduate	6	14
Some college (Associates Degree, Voc., etc.)	20	45
College graduate (Bachelors Degree)	10	23
Post-college graduate (Masters Degree, PhD)	8	18
Race		
Asian	2	5
White	40	90
Other	2	5



Table 1 (*continued*)

Demographic	<i>N</i>	Percentage
Ethnicity		
Hispanic/Latino	2	5
Not Hispanic/Latino	40	91
Left Answer Blank	2	5
Religious Affiliation		
Baptist	1	2
Catholic	1	2
The Church of Jesus Christ of Latter-day Saints	36	82
Muslim	1	2
The Church of Jesus Christ ... & Presbyterian	1	2
No religious affiliation	4	9
Have you been previously married?		
No	42	95
Yes	2	5
Number of marriages		
1	41	85
2	2	5
Left answer blank	1	2
Does your current wife work for an income?		
Yes	25	57
No	19	43
Highest level of education your current wife has completed		
Some high school or less	1	2
High school graduate	11	25
Some college (Associate Degree, Voc., etc.)	16	36
College graduate (Bachelors Degree)	15	34
Post-college graduate (Masters Degree, PhD)	1	2

*Note.* Due to rounding, totals may not equal 100.

### Summary

The purpose of this chapter was to discuss the methodology of the study. These procedures included the research design, sampling methods, instrumentation, and pilot-testing, data collection, and data analysis. Future chapters will present the results that emerged from the analysis conducted. Chapter IV highlights the themes found within each research question. Chapter V highlights those same themes but is organized

according to Umberson's (1987) social control model as well as a discussion of these results.

## CHAPTER IV

### RESULTS

#### **Introduction**

This chapter discusses the data collected for the study. A classic analysis strategy was used to sort, categorize, and compare and contrast the data using the original research questions found in Chapter I. This strategy allowed for identification of the nine themes which emerged from the data. These themes included: (a) wives' use of social control to influence their husband's health behaviors, (b) how men combat their wives' social control strategies, (c) men's perception of 'man card', (d) masculine capital, (e) how men react to being ill, (f) factors that influence men's health care use, (g) how men's feelings of responsibility to their family impact their health behaviors, (h) how marriage encourages men to engage in healthy behaviors, and (i) how marriage discourages men from engaging in healthy behaviors.

Overall, analysis of the data revealed a great deal of overlap and consistency among participants' responses and experiences to the questions. However, reported social control strategies which wives used in an attempt to change their husband's health behaviors varied. And men's responses to these strategies were inconsistent. Specifically, data indicated inconsistency among men in how they viewed the degree to which social control from wives influenced their diet and mental/emotional well being.

Participants did agree on the definition of what a man card is and how it is lost or maintained. Data analysis also found that men take advantage of the concept of masculine capital. Men agreed that seeing a doctor when they were ill was not a first resort and that

finances and family responsibilities greatly impacted their health-care seeking behaviors. Men consistently reported their change from bachelorhood to family-man created a change in perspective overall. This change in perspective encouraged them, or provided motivation for them, to become better providers and to become healthier for their family. However, this same perspective made many men avoid seeking health care.

Overall, men perceive their wives as very nurturing towards them when they are ill, and they also report that their wives encourage them to seek medical care much sooner than they would on their own. Data indicated consistency among male participants in that marriage disrupts their health-related routine (when compared to when they were single), promotes selflessness, discourages risky physical activities, and provides a more spirituality centered lifestyle.

All discovered themes are presented below with supporting participant comments validating the inclusion of each theme. The data presented below is based upon the discovered themes found from the research aims. The research aims helped develop a rationale for the study; however, the classic method of analysis focused on thematic outcomes. The information presented below is organized according to these thematic outcomes. See Appendix F for a summary of research theme findings.

Following the presentation of the themes and participants' supporting comments is a presentation of the data as it relates to the proposed model with justification for the validity of the researchers' revised model of social control. See Appendix G for a summary of research model findings.

### **Wives' Use of Social Control to Influence Their Husband's Health Behaviors**

Participants were also asked how their wives had changed or attempted to change their health behaviors. Men reported their wives influencing their diet and physical activity in both negative and positive ways. Men were also asked to think of specific strategies their wives had used in an attempt to promote change. Wives' use of social control included encouragement, subtle reminders/guilt, repetition/persistence, making the change into a team effort, and using coercion.

Wives' use of social control to influence their husband's health behaviors were addressed by asking participants how their wives react to them when they are ill. Overall, wives encouraged their husbands to rest, let them take care of them, and seek medical attention if needed.

### **How Wife Has – or Has Tried to – Change Her Husband's Health Behaviors**

Participants were asked how their wives had changed or attempted to change their health behaviors. Men gave examples of their wives influencing their diet and exercise habits. The moderator followed up this question to see what specific strategies the men had noticed their wives using as a form of social control. Forms of social control strategies utilized by men's spouses included positive messages or encouragement, repetition, making the change into a competition or combined effort, giving rewards, using coercion, and subtle everyday changes or occurrences.

**Diet.** Many men reported their eating habits have become less healthy since becoming married. Stewart, married 11 years, reflected on one exchange he had with his wife:

Early on in our marriage, again, I was far one side [diet conscious], and she was far the other way, like it didn't seem like she even cared too much what we were eating, and she was in charge of making meals, and stuff like that, so it seemed like to me, my perception was that she was always trying to change my eating habits, and trying to get me say, "It's okay to eat the way she wants to."

Stewart eventually told his wife: "You're just trying to fatten me up so I won't be attractive to anyone else." Stewart explained that his comment seemed to wake up his wife to the fact that he likes to eat healthier than how she was preparing food.

A similar experience was shared by Dustin, married 7 years.

Every time we go out, she'll always expect me to eat her half of her food. . . . And then even when we're home and she's cooking, my plates always bigger than her plate. That's just the way she portions it out. The last six months, I've been telling her "no" and she kind of argues with me that I won't eat her extra food.

Several men shared agreement to how they have picked up on their wives' unhealthy eating habits.

*Jensen (married 3 years):* She loves shakes and ice creams, and I never really . . . I mean I like them, I like ice cream, but we eat them more because it is something that she likes, not necessarily as a bad thing, to have one every once in a while, but you know, something I wouldn't normally eat.

*Brian (married 7 years):* She has zero will power when there's sweets around, like she will eat until she's sick (Laughter) and I don't understand that . . . I've never gotten sick. Maybe I have a stronger stomach but ah, um, but ya, so I fall into that too. She'll bring out the bag of M&Ms and I'm there eating with her.

*Justin (married 14 years):* I never drank pop when I was a kid, and when I got married to her, I started drinking pop.

Several men expressed that they wished their wives cooked healthier. Stewart, married 11 years, expressed a desire for his wife to substitute fruit smoothies into their family meals instead of her usual kool-aid. Jacob, married nine years, recounted how his wife grew up eating meat and potatoes and garden vegetables and she believes that is the best was to eat. Jacob on the other hand grew up eating fresh seafood and a variety of

foods. He wished his wife would cook with more variety. Allen, married four years, shared how his wife tried to institute “Meatless Mondays.” He stated that his wife would cook meals that consisted of just pasta and marinara sauce. Allen stated that he had tried to encourage his wife to cook additional side dishes with those type of meals such as a vegetable or some protein.

A handful of men shared how their wives had encouraged healthy eating habits. One participant shared an experience he had with his wife while they were dating. “I was dating my wife and um, she took me into a dark hallway once, and was like ‘Do you like vegetables?’ I was like, ‘I think they’re okay, yeah.’ She’s like, ‘Okay you pass.’ She later told me that if I had said ‘No’, she wouldn’t have married me.”

Stanley, married just 6 months, shared how his wife has already encouraged him to eat healthier:

We have whole wheat flour, wheat bread, wheat pasta. She chooses recipes for us to cook and they’ve had less meat, more vegetables, more healthy ingredients. And so, she hasn’t done a whole lot to, like, strictly change my diet but a lot of subtle small things to steer me more in a better direction than I would by myself. I was a big white bread fan, but now I instinctively go to the grocery store and I pick up the wheat bread without even thinking.

George, married just nine months, reported that his wife will cook meals she knows he enjoys, but she will slip additional ‘healthy’ ingredients into those meals.

**Physical Activity.** Participants noted that it is easy to follow their wives’ example of physical activity, especially if it means a lack of physical activity.

*Dustin (married 7 years):* Due to my wife’s lack of exercise . . . it makes me not want to exercise as much and I’ll spend an extra hour in bed on Saturday morning opposed to going out and go running, where before I used to like to be more active. But she could sit and we can watch a movie at night and it’s just kind of easier to follow her plan than what I used to do.

*Shawn (married 6 months):* I have early morning classes and I like to have my workouts in the morning, and she wants to sleep, so it's hard to get up and get out of bed when she's holding on to you and keeping you in bed.

*Melvin (married 3 years):* If I want to get up in the morning time, at 4 o'clock in the morning and go run, and work out, man she's "more power to you, but I'd much rather you stay here and snuggle with me." . . . you know . . . "I would much rather you stay here with me, and be with me than go out and exercise, or go out and mountain bike, or be out . . ."

A handful of men reported how their wives try to encourage them to exercise more. Some men reported their wives help them exercise by simply encouraging them or inviting them to exercise with them. Dustin, married 7 years, could only think of one time when his wife had a positive influence on his physical activity. It was after she had one of their children and she started exercising and challenged him to lose 10 pounds with her.

Early on in Steven's marriage, he said his wife realized the need for them to exercise because neither one of them exercised very much. Subsequently, they went and bought bikes and exercised on them together. Steven's wife helps him find exercises that he could do even though he is missing a tendon in his knee, which limits the types of physical activities he can engage in.

### **Social Control Strategies Wives Use to Change Husband's Health Behaviors**

An area of focus in the research was to discover the social control strategies husbands perceived their wives using as ways to change or control their health behaviors. Male participants were asked to think of examples when their wives used social control and what strategies they employed. Participants reported their wives using various forms of spousal support or encouragement and forms of spousal control.

**Spousal support.** Spousal support was reported by participants to come in the form of encouragement and of their wife making the healthy behavior into a team effort.



**Encouragement.**

*Nick (married 4 years):* She'll encourage me, like "Oh, go ride your bike, or go hiking with your friends, or doing something like that."

*Jeremy (married 7 years):* She really doesn't try to change me, you know, proactively. She never says anything explicit, like, "Oh, you need to stop eating that garbage," or "You need to exercise more," or she's never said anything, I think, however, ah, what works is when I make a choice on my own. You now, to start eating healthier, I'll mention to her, you know, "Hey, I didn't have any soda today," or "I'm done with drinking pop," or whatever, and then she'll be really positive, and she'll say, "That's really good," you know. "I'm sure you'll see dividends from that, and you'll start feeling better." So, positive reinforcement, so she'll kind of let me make the decision on my own, and when she sees that I do something healthy, she's been really good at just being positive.

**Team effort.**

*Melvin (married 3 years):* Because of my line of work, I had to cut 20 pounds in 3 months, and so there was some extreme dieting going on, and she made it kind of a little competition. She was like, "By May 1, by the end of the spring semester, we're going to make these goals and we're going to work toward them." She kind of knew that competition would keep me going. I don't know for sure if she really wanted to lose the weight herself, but it was a way for her to help me accomplish my goal, and so even if she didn't lose as much weight as she wanted to, she knew that I was accomplishing my goal, and because of that, she was okay with it.

**Spousal control.** Spousal control was reported by participants to come in the form of guilt, repetition or persistence, and coercion.

**Guilt.**

*Jim (married 2 years):* She'll always ask when we're in the grocery store, "Do you really need that?" or, if I'm eating a bag of chips [she'll say], "I'm going to save some of that for later." Because I can go through a bag of chips in one sitting. So, she'll just ask questions like that, that will make me feel a little guilty,

*Melvin (married 3 years):* It's an everyday occurrence . . . she'll send those subtle little, "Hey, you know, you probably shouldn't go back for that third plate, or that fourth plate . . ."

*Seth (married 1 year):* When we were dating, then I was actually a pack a day smoker, and would usually be in the bars about two nights a week . . . but ah, I'll have one pipe a week, maybe, and that's it, so I don't know if there's an application in the word tried but success isn't there, but I chalk that one entirely up to her, just occasionally reminding me that, "Hey, you're going through a pack a day." "Oh, I know. Thanks." And she would remind me like that.

***Repetition/Persistence.***

*Jed (married 10 months):* I think one of the strategies that she uses is patiently persevering. (laughter) Cause she knows me well enough now that eventually, if she keeps on me, eventually, I'm going to give in and do it.

*Harold (married 7 years):* Repeat it, repeat it, repeat it, repeat it. . . .My wife has probably learned to repeat it, because that's how she knows she'll get results.

*Dwight (married 7 years):* She just keeps saying, "Do it, do it" until my ears get plugged, so . . . I think that works best for me.

Kevin says that he doesn't like to take ibuprofen for pain relief, but she persists until he finally gives in just so she'll get off his back and leave him alone.

Phillip, married 24 years, shared that his wife kept insisting that he seek medical attention for a possible sleep disorder. He stated that it took him a couple years of her prodding before he conceded and sought help. He admitted that she had been correct in her diagnosis.

***Coercion.*** A second participant shared how his wife helped him reduce the amount of cigarettes he was smoking.

*Roy (married 3 years):* Thank goodness to her for doing it. I was really bad for about, almost 10 years, I was smoking cigarettes really bad. I was going thru like 3 packs a day, just constantly, one after, I was a chain smoker. And, one day she decided she was going to . . . she wanted me to stop . . . I wouldn't stop, so she went and decided to start breaking up all the cigarettes. Started crunching the packs, and she's like, "Either you do this, if you're so focused for the marriage, and you'll be wanting to start stopping . . ." and she'd crunch another pack. She'd take all the money out of my wallet just to make sure I don't go sneaking off to get another pack. She's like . . . "You're going to stop!" And I'm like, "If you stop me cold turkey, it's going to start [a] war between us." So then she went and got me one of these E-cigarettes . . . thank God . . . I love that thing to this day. I wouldn't put it down. . . . But she tore up my cigarettes in my, and my face was in the dirt, crying my eyes out, "Please, no!" But then she found a way to go from this to now to the E-cigarettes. From there I've worked all the way down . . . now I don't (unintelligible) . . . sometimes I smoke an E-cigarette, but once in a great while.

*Jim (married 2 years):* She really wants me to have a healthy relationship with my family, with my siblings, my parents, so she'll always ask me, "Have you called your family this week?" and I'll say "No" and she'll say "well are you going to do it this week?" and I'll say "Yes". So when she makes those suggestions my reaction is usually procrastination. I'll just put it off until she sits me down and makes me do it.

*Chris (married 3 months):* The strategy my wife uses, and I'm sure everyone's wife has used it, is to um give benefits when you do what she wants you to do health wise, whether it's sexual or otherwise. My wife knows that rewards drive behavior very well and a good example of that is my wife . . . gets a solid 8 hours [of sleep], . . .and she's starting to get me to get that same sleep schedule by the rewards basis (laughter).

### **Husbands Want Encouragement and Support to Make Healthy Changes**

Participants overwhelmingly agreed that they wished their wives would encourage them to exercise and eat healthier. Shawn wished his wife would exercise with him and kick him out of bed instead of hold him in bed. Melvin expressed similar sentiments.

So I wish that she would be a little more supportive of me when . . . I've got to get up, I've got to go work out. . . I wish that she would be a little more assertive when she's like "no, you need to go [exercise]."

*Russell (married 6 months):* Just kind of hold the fire to my feet more . . . be a little more deliberate with inviting me to change.

*Brian (married 7 years):* Someone mentioned that there's a little bit of accountability [to exercise] because of their wife. I don't feel that, really, at all . . . she's not really encouraging me to exercise more, I don't feel. And I think that I would if she did.

*Neal (married 9 years):* I wish just once she's say, "Hey, you're a fat ass, do something!" you know. But she doesn't. She's just the total opposite, you know, and it's frustrating because I need motivation myself. It would help if I had some support, some, you know, some dietary monitoring, you know? . . .If she could just be supportive, at all, like care about it. I've begged her to, 'cause obviously I don't have the self-will to do it myself, but it definitely would make a difference

if she would help me to get into a routine, and encourage me along a routine, or monitor what I eat and how much I eat, and encourage me to go exercise.

Men also mentioned it would be helpful if their wives would make healthy changes with them.

*Allen (married 4 years):* It's hard to do something by yourself, and if you have somebody there that's willing to make the same sacrifice as you are, to do the same things you're doing, you know, even if we did different activities, at least if we living the same healthy lifestyle, we're living, we're exercising, we're doing other things, that would definitely help.

*Dustin (married 7 years):* I think if my wife just worked out, or if she ran, like if she enjoyed to run or do more activities, um, I would be in awesome shape, cause it's just too tempting to stay home with her, or if she wants to hang out and cuddle, you know, that's always going to win.

### **How Wives React When Husband Is Ill**

Participants were asked how they handle illness and how their wives react to them being ill. Men repeatedly stated that their wives wanted them to rest and let them nurture them back to health. Wives also reportedly encourage their husbands to seek medical attention.

**Wife as nurturing and encouraging husband to seek medical attention.** Roy, married 3 years, stated that his wife wants to be the one who is right there at his side nurturing him back to health when he gets sick. Melvin, also married 3 years, reported his wife encouraging him to stay home and rest when he is ill; 'Just stay home, I'll take care of you . . . let me get you some soup,' she'll say. Melvin followed up by mentioning his wife will tell him that they will figure out some other way to earn the money he would miss earning by staying home from work. Several participants laughed after Melvin's

comment further supporting men's view that they still need to provide for their families even while ill.

Some wives seemed to be more concerned about their husband's health than the husbands were. Morris, married just 2 months, relayed this incident:

I was doing a rope swing, and it caught on a branch, and it dropped me right on a rock, and split my heel. [It] pretty much took the whole callus off the bottom of my foot. My wife was like freaking out about that. But like the foot doctor [who happened to be there], "Oh, you're good, you'll be fine it just took the callous off." And I'm like, "Oh, all right." She was like "No, we're going [to see a doctor] right now!" I'm like "It's not a big deal." I'm like just laughing about it, and my friends are laughing about it, and she's like, "That's not something to laugh about!" and I said, "Oh, okay."

In addition to wives encouraging their spouses to rest to get over their illness, wives reportedly encouraged their husbands to seek medical attention. Anthony, married 58 years, stated, "She encourages me [to go to the doctor/seek medical attention], but if I'm ill I'm not as excited about going as she is excited about me going. (laughter)

*Morris (married 2 months):* I think the thing that affects me going to the doctor is if my wife is really concerned, that's the only reason I've gone is because she's, "You really need to get that checked out. I'm worried that that's going to be something serious." But that's really like the only reason why I go get stuff checked out if she's really concerned . . . kind of to calm her mind and give her some peace. I don't really care as much; I can tough it out, but if it means that it will give her a little bit more peace of mind, then I'll go get it checked out.

*Jim (married 2 years):* If I've got sickish, it's just a minor cold, and so, if I feel something coming on, my wife's, "You need to go see someone so you can get on medication, so you can get through this." "No I'll be fine." That's my . . . I'll always be fine. In my mind, I'll be okay, nothing' ever serious is going to happen . . . is how I think, I guess.

*Larry (married 2 years):* When I get sick my wife's always throwing Vitamin C pills at me, which, if they taste good, I'm okay with.

*Ken (married 9 months):* I don't know how long it's been since I've been to a dentist, and . . . since we've been married, it's kind of been her goal to get me in to a dentist, and so, like, she brings it up, a lot of times, and you know, her and my mom kind of work together on it, but I've started flossing on a semi-regular

basis, so almost (someone claps), maybe, 5 times a week. . . . So she's made some attempts and I think she's being a little successful.

### **How Men Combat Their Wives' Social Control Strategies**

One major focus of this study was to understand how wives' use of social control affected men. Did the wives' social control strategies influence them, or call the men to action? As demonstrated above, several individuals severely reduced the amount of cigarettes they were consuming due to their wives' influence. The focus group participants illustrated various ways that they deal with their wives' social control strategies including procrastination, encouraging their wife to make the health behavior change with him, and sincerely trying to implement their wives' suggestions.

#### **Procrastination**

As Phillip mentioned above, his wife wanted him to seek medical attention for a possible sleep disorder, and he stated that he finally did go, but it took years of her asking him to go before he finally did go. Stanley, married just 6 months, stated that he also procrastinated making changes suggested by his wife:

Every time my wife gives suggestions, either unwelcomed or welcomed, I always try best just to take it . . . I always want suggestions . . . I always just try to take it and if she gives a suggestion I know she's in my best interest so I always try and do it. Sometimes, you know, I'm a natural male I procrastinate things, BUT, I always try.

#### **Encouraging Wife to Make Changes with Them**

As mentioned earlier, participants wished their wives would make healthy changes right along with them to motivate them. Below are several examples of how men combat their wives' social control strategies.

*Allen (married 4 years):* I'm bad at this . . . I throw it right back in her face. . . I'm like "Why do you want me to do it? Why don't you do it?" . . . I'm like, I'm not going to do it. I'll do it with you if you want to try it but you've got to do it with me. It's too hard to do it by myself. And so I throw it back, all the time, say, "You don't do it, why should I do it?"

### **Sincerely Trying to Implement Wives' Suggestions**

The majority of men reported to take their wives health behavior suggestions to heart, as expressed by Nick, married 4 years.

I feel like, to a certain degree, it's "The guilty taketh the truth to be hard!" Like your wife's calling you, "Chubby!" I think it's pretty hard to take, but at the same time, just like thinking about it, I would rather hear it from my wife than from my brother, or my parents, or someone, like a friend, so I know to a certain degree, I feel like, as hard as it is to hear it, it's a call to work out and start taking better care of yourself. Cause if my brother says to me, I'm just going to hate him. (Laughter) I'm not going to think, "Oh, maybe he's right."

*Jensen (married 3 years):* When she'd make the suggestions, it's more like with my portion sizes, and when I'm snacking, and when, and you know at first, I handled it, I'll admit, I'd get a little offended, just because, I'm just, "I'm not the biggest guy, ever, I'm not." I wouldn't consider myself large or anything. But then I'd kind of step back and go, "You're probably right, I don't need to pound a whole bag of Chex Mix," or, you know, something to that level. Like, I can cut back, and I know that she does it, not for like her selfish reason to have a husband that looks good or anything, she does it for my health, and so, when I step back and look at it from that perspective, it's easier to understand where she's coming from.

*Joe (married 1 year):* I feel [her suggestions are] welcome, almost ah, you know, I do want to do that, I do want to do this for you . . . when something happens and we're like, "Let's do this" I'm on board with it almost all the time.

*Stanley (6 months):* Every time my wife gives suggestions, either unwelcomed or welcomed, I always try best just to take it . . . I always just try to take it and if she gives a suggestion I know she's in my best interest so I always try and do it.

*Justin (married 14 years):* Suggestions about health pretty much don't bother me. . . I've never really felt like any suggestion she's had for my health has been for a negative impact in my life. It's always been for the best and I'm very open to that.

### Men's Perception of "Man Card"

One of the key research areas aimed to explore how men maintain their masculinity—and specifically masculine capital—in the face of spousal social control. To assist the moderator in illustrating the idea of masculine capital to the male participants, the idea of man card was illustrated by showing a 31 second commercial advertising a type of beer. At the conclusion of the commercial the moderator asked the study participants to describe how the man in the commercial maintained his man card. Some responses were as follows:

*Brian (married 7 months):* Logical arguments, his team won when he ate it, so it's doing the right thing.

*Ken (married 9 months):* He was doing it for his team. Like, he was, he was willing to take one for the team. You know. I'll do, I'll eat this Quino if it means my team will win.

*Jensen (married 3 years):* He justifies his, you know, giving in and eating the all-veggie burger to helping his sports team win. Right? So that's how, he's saying, "Well, if I eat this horrible burger, that my wife wants me to eat, at least the Eagles are going to go home with a victory . . . and that makes me a man."

*Kevin (married 4 months):* He chose to do anything that it takes to maintain that man card. I think that is kind of what a man card kind of is, is do what it takes.

*Joe (married 1 year):* He was standing up for his principles, which was "My team's going to win! Because I'm going to eat this tree branch!" That is not man card revocability; that is . . . *Justin interrupts:* Commitment!

### Trading Your Man Card in for an Adult Card

At the conclusion of the male participants' discussion, of how the actor in the commercial maintained his man card, the moderator asked participants to describe their views of what a man card was. Justin, married 14 years, expressed his view:



[It's when you're] doing it for [your] goal, for [your] purpose, and that is like if your kids are sick then, that's your purpose, "I'm a husband, I'm a father; I have to do this for my team." I think that's what it is, but when your team, like if you're a bachelor, the team is the male gender.

*Dennis (married 5 months):* I would use the word "sacrifice". You know if a man is willing to sacrifice one thing for something better, for a greater good, then that's when he adds points to his man card.

*Rob (married 9 months):* It's all about owning your decision.

The idea of losing your man card when your wife asked you to do things or change your health behavior was addressed. The following comment by Justin illustrated how doing what your wife asks does not necessarily affect your man card. Respondents illustrated that if you do what your wife asks, you are doing it for the greater good of your relationship and/or your family.

I think it's what's for the greater good? And the greater good is your marriage. I think if your wife is saying, "Justin, please don't walk out that door [dressed like that] . . . because it just doesn't look good" that's not losing your man card; that's making sure you walk out of the house with respect, and not looking like an idiot. You know what I mean?

### **I Don't Care about My Man Card**

Overwhelmingly, focus group participants brought up the idea that they are no longer concerned about their man card. Reasons included not having to appear as masculine to impress their spouse now that they are married, changing their views about what being a man is which according to participants is being happy and having a happy wife, and simply not caring what other people think.

#### **Now that I'm married, I don't have to worry about appearing feminine.**

Jeremy, married 7 years, explained that he worried a lot about appearing feminine prior to being married, but ever since he has been married he does not care.

Ever since I've been married, I don't care. I'll wear a pink shirt, and . . . I won't pop the collar . . . But I'll wear a pink shirt if my wife wants me to. But, and I don't know why that is, maybe it's because I, I mean I guess it's before you're married, you think appearing masculine is attractive to the opposite sex, where being feminine is not going to attract them. Maybe that's part of it, I'm sure it is.

*Rob (married 9 months):* I think the . . . worry about being feminine, once you get married, goes out the window, because, you're just like, you know what, I married a girl. She's pretty feminine; I'm having to take on some of those likes and dislikes of hers . . .

**Happy wife, happy life.** Men expressed that they are now more concerned about having a happy relationship with their wife and not as concerned about appearing masculine. They reported, if they had a happy wife and were looking out for their family, that meant they were real men. When Jeremy, married 7 years, was asked to describe his view of what a man card was, he replied.

To some people if you keep your man card, you're really just being a bastard! Where, to other people, if you keep your man card, you are actually doing what your wife wants you to do, right? Let's say you're on an outing, right, and you're hanging out with your buddies, and your wife texts you and says, "Daughter's sick and I need you to come home and help out." Maybe to society, keeping your man card is like, "Put your woman in her place:" "No, I'm hanging out with my buddies." But really being a man would be going home and helping out.

*Stewart (married 11 years):* When I was first married, it seems like, I felt like a man if I could provide for my family, for my wife, you know all those things that we needed. And so it was more physical or tangible type of "Am I a man if we have a house and bills paid?" and those kinds of things. Um, and at times, whether it be health, or anything else, if she wanted to use something against me, that's the part that she would attack, was you know, "We don't have sufficient for our needs," and those kind of things. And over time, I've come to change that and my man card is that, I feel like I'm a man if my wife is happy, and so . . . as long as she feels she's content, or I feel she's content, or she says that she is, then I feel like I maintain that man card . . .

*Melvin interrupts:* Happy wife, happy life.

*Stewart continues:* If mama ain't happy, nobody is happy!

### **I don't care what other people think.**

*Justin (married 14 years):* I can honestly say after 14 years, does it really bother me to sit down and watch a chick flick, like I hear my buddies say, "Oh, I have to go home and I have to watch Sandra Bullock in some stupid movie." I'm like,

“I’ve probably seen it six times.” (laughter) And it makes my wife happy, and honestly, “Happy wife, happy life.” So . . . I mean seriously, it’s not a loss of man card, and it’s not appearing or wanting to be feminine, it’s just, you know what: I think you reach a point in time in your relationship, and in your life, where the depth of the relationship is more important than what outside influence can give to you or provide for you. ‘Cause I really don’t care about what any of you think about me, even if I knew you, I wouldn’t care, (Laughter) because I don’t go home to you every night. You’re not the one I can reach over and can grab her arm and it doesn’t really matter, because that’s the person that matters, that’s the person that makes or breaks the way I have a good day or a bad day.

*Justin continues:* I hold my wife’s purse at the grocery store. Hell I’ve carried it in from the car. . . . It doesn’t bother me, and I see guys, look at me like, “Ah, I’m taking your man card!” and I’m like, “You’re not touching my man card. I’m man enough to hold this purse. (Laughter) I’m man enough to wear PINK!” (Laughter) . . . I really don’t care, like. You can look at me and say, “I’m revoking that man card,” and I’m like, “Well, I don’t really care. You can try, but you’d better bring an army if you think you’re going to take my man card . . . because you’re going to have to deal with this,” you know what I mean?

*Larry (married 2 years):* I don’t really care about my man card, really. I drive a mini-van, [I] don’t have a motorcycle, [I] have a scooter. . . . As long as I’m happy, I don’t care what other people think, really. I just, as long as I’m happy, that’s how I maintain my man card.

*Harold (married 7 years):* I feel pretty secure in my masculinity. I don’t think there’s anything that I have to prove to my wife, or anyone else.

*Neal (married 9 years):* I feel like I’m pretty secure in my manhood, I’ll wear a pink tutu. . . .It doesn’t define who I am, . . . honestly, I don’t feel like I have to maintain masculinity. I don’t think I have anything to prove any longer.

Charles, married 2 years, shared the follow experience of when he realized that he no longer worried about displaying his masculinity.

[I went] with some friends from work during our lunch break one day. We decided to go up Green Canyon here, go on a run up a trail for about a mile. There was four of us and we just started running up hill on this trail. I hadn’t really . . . I wasn’t really in shape but the other guys were just really doing well. After about maybe 10 minutes of running, seven minutes or so, I just had to just give up and start walking up, and the rest of the guys just kept on going, and I guess I didn’t really try to push myself farther than what I thought I could, and I felt a little embarrassed that man, all the rest of these guys, and some of them were older than me, were outrunning me really well. But at the end of the day, I thought about it . . .it really didn’t affect me that much. More than anything, it kind of made

me realize, maybe I should get, become more healthy. But, I don't think I was really humiliated, so it kind of makes me think, maybe I'm not as concerned about the way . . . how masculine I am. It didn't push me to a point to hurt myself and try to keep up with them.

After a rather lengthy discussion on the topic of man card, Bill, married 41 years, chimed in with "It sounds to me like some people have or are trading in their man card for an adult card." The group of men unanimously nodded their heads in agreement, and some also gave several responses in the affirmative.

### **How to Lose Your Man Card**

Following the discussion of defining what a man card was, the question was raised of how men can lose their man card, or lose man points. Justin, married 14 years, commented that doing things that are contrary to your purpose or the greater good causes your man card to be revoked. Dennis, married 5 months, stated that if a man tried to coddle himself, or protect himself like a child, his man points were taken away from his man card.

Men consistently referred to the fact that a man card can be revoked or lose points if a man engages in non-masculine behaviors or shows weakness.

#### **Engaging in non-masculine behaviors.**

*Justin (married 14 years):* I took somebody's [man card] away from them the other day. Because they acted like a girl . . . We were at the beach over in Bear Lake, . . . and [this man] put on a wet suit to go out in the water to play with his kid. And so I officially, in front of everybody, said . . . I'm taking your man card; you no longer can have it because that is ridiculous. I said, "Man up, get some balls, and go out in the water without a wetsuit on. It was just like ridiculous. So he lost his man card and I can't remember if I gave it back to him or not.

#### **Food Choices.**

*Brian (married 7 years):* I'm just going to say, I cannot order chicken at a restaurant. Because I do not want to appear feminine . . .

*Kevin (3 months):* I tend to . . . especially when I'm with my friends, . . . or with my wife . . . I tend to try to eat a lot of food, cause I don't want to be the type of . . . cause I feel like it's kind of feminine to ah . . . leave food on your plate, and box it up to go, because that's just what my wife has always done.

*Joseph (3 years):* Every time we've had like a family get together with food, it is always like, the guys are always having an eating competition. You never want to be the one that doesn't eat as much as the other.

Brandon, married just 1 month, shared how trying to appear masculine shaped his behavior around coworkers:

I worked over the summer, we always have like a steak day on Fridays, and everybody goes and we'll go get like the biggest steak they can find and they'll all just eat this massive steak for lunch, and they always make fun of you if you don't get a huge steak, and eat just a huge ton of meat. And I was thin and they'd always like, "Oh you're such a girl; you can't eat all [that] meat," or whatever, and so, every Friday I would go get a big steak even though I hated it. I didn't want to eat that much, I want, you know, something other than a steak, a little bit, because you just feel sick, you get the meat sweats, and whatever. And, you don't feel good for the rest of the day. You want to puke . . .

Seth had a similar example to Brandon's in how he altered his beverage of choice to appear masculine:

*Seth (married 1 year):* I've never ordered a light beer whenever I'm with other people. If I'm on my own at the store, I'll buy it, if I'm at home, then I will make like, Mai Tai's, or mixed drinks that have like pieces of fruit in them and they're bright pink, or whatever. If other people are around, it's Rum and Coke, or Sam Adams, and THAT'S IT . . . And I've never thought about that before.

Like Seth, Jensen hid the fact that he enjoyed diet soda because he felt it would appear feminine. To go along with the earlier idea, that once men are married they no longer are concerned about appearing feminine, Jensen's comment confirmed that mentality.

People say, "Oh you're a soccer mom because you drink Diet Coke." It's okay now, I have no problem with it, but in the beginning, I wouldn't drink it around her. I would stay away from it and I just never wanted to let it on.

**Exercise routine.** Stewart, married 11 years, shared how he tried one of his wife's exercise videos and altered it slightly to make the workout more masculine:

One of the [videos my wife tried] was the 30 Day Shred . . . [and] that has been my health regime for three years now. I do it three times a week and I work out with Jillian, you know, and kind of try to save face a little at the beginning, you know this is kind of a girlie workout, but, so I got 15 pound dumb bells, and I do it with 15, you know. So, you know, that could be considered shaping my health behavior. . . . I got weights to do it with rather than just doing the neck circles and stuff like that.

**Employment.** Roy and Chris expressed how they try to hide the fact that they earn money through stereotypical feminine ways:

*Roy (married 3 years):* [Something] I don't like to be shown, and my wife is always telling people about, is I can crochet, and it's really feminine, and I don't know why, but I picked it up just like this, and, what she's went on and told people that I can crochet certain items, and now I get phone calls from people saying, "Can you crochet this, can you crochet that, I'll pay you for this." I'm like, I don't like showing this part of me. This is the worst part to show.

*Chris (married 3 months):* I'm in the military, and whenever I have that conversation with anyone, I always say, I'm in the military, and leave it at that. Because in an effort not to appear feminine . . . my job in the military, I'm a cook, and like half of the people in my family know what I do in the military. They just know I'm in the military because that's a really masculine thing, but I don't tell them what my real job is in the military . . . ever! (snickers)

**Showing Weakness.** Overwhelmingly men stated that to maintain their masculinity they could not show weakness or injury:

*Harold (married 7 years):* When you've done something really stupid, and you've hurt yourself, but you don't want to show that you've hurt yourself because that would be showing weakness, and especially if it's in front of your male children  
*Morris interrupts:* Especially when your wife told you not to do it the first place.

*Melvin (married 3 years):* I crashed hard [on my mountain bike] last week—just busted my knee up—and I was coming home, and my wife was, "Are you all right?" because my knee was all bloody, and things like that. And I'm, "Oh, yeah, I'm fine." You know, as I'm limping into the house. I've got to maintain, you know. I've got to be that man, you know, "I'm fine don't worry about it," but secretly, inside, I was like, "Oh my gosh, This hurts so bad. This hurts so bad.

What have I done . . . ? Like I am an idiot.” But no, like I can’t . . . nah, I got to be tough, whatever, you know. Gotta have that stupid mentality, but hey.

Shawn, married just 6 months, shared how he participated in a fight night even though he had a severely injured wrist from a motorcycle crash.

My brother-in-law was having . . . I guess he called it a fight-night. We just went and boxed all night, got drunk and boxed. . . . And so I went and boxed, which made it a lot worse . . . because I didn’t want to seem like a woman. I kept hitting with my wrist, and like I said, it messed it up, and so . . . . Obviously, it’s really bad, the way I do stuff.

Pete and Joseph shared experiences of how they injured themselves years ago.

When the injury occurred they ignored the pain and years later they are still suffering from the injury.

*Pete (married 4 years):* I was playing dodge-ball . . . and I hurt my shoulder throwing the balls, and I didn’t stop. I kept throwing harder, and I kept throwing harder, and I knew my shoulder was hurt, but I didn’t stop, and actually, it’s been eight years now, and I still have problems with my shoulder because I did the damage, really, uh, really well . . . to try to stay on top, to try and be the hot shot.

*Joseph (married 3 years):* When I was in high school, um . . . I broke my ankle playing basketball, and I just didn’t want to not play basketball, so I just didn’t go get it checked out or anything, and just, “Oh, it’s a sprain.” And so after the season there really wasn’t much they could do. And so even to this day, my ankle, like when I wake up in the mornings, will hurt and it has definitely affected my health in a negative way. Kind of being that, trying to be the tough guy, and can do whatever, and go through, play through pain, and all those things.

**Not Being Able to Provide for Family.** Several men shared experiences they had while working and how the pressure to be the breadwinner and keep working through illness or injury harmed their bodies.

*Seth (married 1 year):* I was pushing really hard for a promotion. . . . I was doing a lot of like heavy lifting that I probably shouldn’t have been, given that I’m kind of out of shape. But, [my now wife] started noticing . . . every time I coughed I was doubling over a little bit. I was like “Ah, whatever it’s just a cough,” and then we found out like two weeks before we got married that I’d given myself a reasonably severe hernia, because I was, you know, just “I’m the man, I have to keep doing the job and get the promotion, and I don’t go to the doctor,” and ah,

yeah, shot myself in the foot on that one. Thoroughly enjoying the masculinity that comes with paying off medical bills now.

*Steven (married 2 years):* Last semester I was working 60-hours between three jobs, and on top of that I was doing research for one of the professors on campus and doing full-time school, and I was sleeping six, five hours a night? And so, I just started shutting down randomly in the day. I would just zone off for hours. . . . I did this for like three, four months. Almost the whole semester, I just kept doing it, because I just didn't want to say anything, because this is just what I'm supposed to do if I want to get, you know, into grad school, and different things. I'm like, this is just what I'm supposed to do, and I'm not going to complain because that's not what guys do . . . I don't complain. And so, I just shut up and kept doing it, and it was pretty bad for my health. I ended up getting pretty sick. . . . My wife just kept saying "You need to slow down. You need to do this." But I was like, "No, I'm fine. It's, it's all good." And, but, overall, trying to say that I was fine was really just a show.

**Peer pressure.** Steven, married 2 years, shared an experience he had while working as an arborist cutting down trees.

So on our crew it was who can lift those [stumps or logs] . . . I ended up slipping a disc in my back and my leg went numb. . . we went on break and [when I tried to] get up and I can't walk and my boss was like, "Something's going on—you are limping?" . . . I was like, "Yeah. No, I'm good." I worked for like another month and like every time I [stood] up my leg wouldn't work and then, I start walking and eventually it would quit hurting. And uh, now I realize I'm never lifting things like that again, uh just because that's what everyone was doing, you know, who can lift the biggest one.

*Dustin (married 7 years):* I was with a couple of guys who were in college, who weren't married, and they said, "Let's go cliff jumping into the lake," and I'm afraid of heights, like, ten feet up scares me to death. But there was this moment, and again, a couple of things enter my mind: "I've got a kid, I have got a wife." Even though I was afraid of heights before, I'd do stupid things, but now all of a sudden there's more saying, "Don't jump!" and try, I guess, to appear not to be the scared one, I . . . they were cheering me on, and I jumped, and I did it a couple of times, again, because they kept, "Come on, you've got to do it again . . . got to do it again." So I totally fell into that, but I hit the bottom every time, so it wasn't the smartest thing I've ever done (Laughter).



### **Maintain Masculinity to be Perceived as Sexually Attractive**

Men stated that it was very important to not show weakness or to maintain their masculine traits in front of a girl they were trying to impress. Neal, married nine years, shared the following thought: “There was a reason I worked out for hours before I got married. It was obviously to try to increase my masculine points and appeal to the ladies.” Kevin, married 4 months, shared how he tried to appear masculine to impress his now wife.

When I met my wife, I was down on Lake Powell and I was always trying to do the heavy work, like lift the big heavy coolers, or um . . . jump off the highest cliffs in Lake Powell and appear not to be afraid and stuff like that. And she did notice me; I don’t know if that helped me at all but she definitely did notice me.

Steven, married 2 years, shared that he tried to show his masculinity in his ability to do physical things, even if it meant pushing himself way past what he should do. He relayed an event when he and his wife were biking up a fairly steep and long hill.

. . . my wife was just dying. She was in like first gear and was [thinking] “I can’t do this anymore” and me, to show my masculinity, I held in any deep breaths that I had and I was like “Hey, it’s good”, and even though I was feeling really tired too.

Steven continued to state how he had been working to decrease the amount of time it took him to bike to school. “[I’ll push myself] every day to the point of almost killing myself, just so I can come home and say, ‘Hey I got there in ten minutes.’”

Ken, married under a year, shared what he would do to try and impress his wife.

I’m on a male softball team . . . [and I] have a really bad left knee, and my right shoulder isn’t all that great, either. So playing softball isn’t the best, the best choice, but when she’s there at the games I’m much more aware I guess of my masculinity, at least when I’m performing things that a man should do well at. And so in those instances, and this instance in particular, even though I know I probably shouldn’t try to throw it to home from where I’m at, because I know it’s going to hurt my shoulder, and my knee as I’m planting my foot, but I’m more

likely to do it if she's there. So I think I'm more likely to put my health at risk, I guess, to maintain that masculinity, and man card . . .

*Harold (married 7 years) interrupts:* It's not just the masculinity; it's about being perceived as sexually attractive by your wife.

### **Universal Man Card Expectations**

At the conclusion of one of the focus group discussions, participants clarified the idea of how some men may not feel they are losing man points, or giving up their man points by engaging in some behaviors. Participants agreed that even though these men may believe their actions do not lead to their man card being revoked, their actions or behaviors do indeed qualify as breaking a 'universal man card expectation or rule' and therefore their man card was revoked. The following dialogue illustrates.

*Joe:* You [maintain your man card when you] are taking responsibility, you're taking ownership of your decision.

*Justin:* Except in the case of my buddy who put a wet suit on.

*Jeremy:* He might have owned [his decision to wear a wet suit] but it doesn't matter. (laughter)

*Justin:* There's still very universal expectations.

*Jeremy:* And then, yeah.

*Justin:* But yeah, you're right, Joe you're right.

*Jeremy:* The universal exceptions that that does not cover.

Joe, married 1 year, shared more insight into the universal man card rules.

I listen to a radio program from the Seattle area . . . called 'The Men's Room,' and they had men's room rules, and it's just certain rules like you can't drink beer with a straw, or (laughter) you can't stare at someone while you're using the urinal next to them, just things like that aren't manly behaviors (laughter).

The men in this group overwhelmingly agreed that these men's room rules were universal man card rules and must be upheld for men to maintain their man card.

## Masculine Capital

A theme interwoven throughout study participant responses was men's use of masculine capital. Men justified engaging in non-masculine behaviors because they had credit or insurance in another masculine area. As mentioned earlier, focus group participants overwhelmingly began to engage in more positive health behaviors once they became married so that they could better perform in their role of provider. The following comments demonstrate additional remarks made by participants that illustrate how they utilized masculine capital.

*Chris (married 3 months):* I do a lot of things for my wife, and with my wife, that would take away my man card any other time. Ah, but I kind of, I guess, fix it, make up for it, by doing all the, you know . . . I go out and fix the car, and go make sure it's got all . . . the fluids up-to-date, or go out and, you know, do the heavy lifting, do the dirty chores, you know, dig a trench or something. Basically, try to cover up the fact that I'm not as masculine as I used to be by doing something masculine.

*Brandon (married 1 month):* I'll let [my wife] win, like, the little battles, as long as I can win the big war. (Laughter) Does that make sense? I'll give up some things that are less important to me, as long as I can get the one thing that's really important to me every once in a while. You know, it doesn't have to be, like, every day, but, enough that I'm happy, you know. So, compromise a little bit, and kind of giving up things that are of less value to me.

*Neal (married 9 years) interjects:* I'm the same way. And you cash in every once in a while, you know, for the Jeep or a boat or something

*Brandon continues:* Yeah, you've got to get out there and be a man.

*Jim (married 2 years):* I think, in my marriage, um, I'm very willing to watch a chick flick, or to do something that my wife wants to do because I know that she's totally okay with me setting aside a couple hours a week to watch football or to watch a sporting event. So there's just a balance in our marriage, and so I'm happy to do stuff with my wife that other people would maybe consider taking my man card.

*Seth (married 1 year):* You guys have me feeling like a complete and total pushover, at this point (laughter). My red, 2-door sports car is gone, red meat is

mostly out of my diet now. When I'm stressed, I thrive on a war movie collection, and like I mentioned earlier, I will still smoke a pipe or cigarette, like, once a week, and that's my moment where I think, okay, here I am primal, masculine, controlling, fire with phallic symbols (laughter) and that's where I get back in touch with my, yes, I am man and being man is good.

Most participants agreed that they maintain their man card by engaging in traditional masculine activities such as buying a bigger TV, working on cars, shooting guns, doing the heavy lifting around home, etc. These activities were suggested that they help men show that they are still masculine even though marriage has brought about more feminine type activities. Participants still contended that they are not as concerned about appearing masculine, or feminine, as they were previous to becoming married.

### **How Men React to Being Ill**

Several of the discussion guide questions focused on how men react to being ill. Overwhelmingly, men reported that they do not get sick, but when they do get sick they try to tough it out and continue on with their normal routine, because real men tough it out. Multiple men agreed that when they are too sick to work, they believe sleep was the best remedy, not going to see a Doctor. Most men agreed that they would not see a doctor unless they had passed out.

#### **I Don't Get Sick**

When men were asked to describe how they reacted when becoming ill, many of them stated that they don't get sick.

*Rob (married 9 months):* I haven't felt sick enough to need to miss, you know, school or work for probably 10 years now.

*Justin (married 14 years):* I've had colds, I've had head issues, I feel like crap, but I . . . when I say sick, in bed, 3 times in 14 years, I don't get sick . . . verses

my wife taking 7-8 days off of work a month for her headaches or migraines. But we definitely perceive illness completely different. I'll go to work unless I'm on death's bed and that's been only 3 times.

As Justin illustrated he will continue to go to work unless he is on his death bed.

### **Real Men Tough It Out**

Many men agreed with Justin's comment that men should just work through illness and tough it out.

*George (married 9 months):* I would rather tough it out, you know, like you said, if you die, you die.

*Pete (married 4 years):* I think it matters whether it's a minor illness or something more severe. In my case, if it's minor, I'm most likely to just plow my way through it, forget that it's even there, and go about my life.

A handful of participants alluded to the idea that real men do not go to the doctor.

Melvin, married three years, shared his thoughts on how his upbringing influenced his idea that that men do not go to the doctor.

*Melvin (married 3 years):* "Men don't go to the doctor." You know, you just tough it out, you know, if you're hurt, just push through it, you know, whatever. That's kind of how I was raised, you know.

One participant shared his experience of trying to go off anti-depressants and the stigma of illness. He tells how his wife helped him with his decision and how it affected his masculinity.

*Charles (married 2 years):* I take an anti-depressant and for a while I decided that I didn't want to take this pill anymore. I don't want to feel like I'm dependent on it. And so I slowly weaned myself off of it . . . it was about a year ago . . . and I was off of it for about 3 months. And I really tried to keep going, and my wife noticed that I just wasn't dealing with stress as well. I'd go for a couple of days, and she'd said, "You know, that's just not necessary, I think you should go back on it. It doesn't really change you, there aren't any side effects, you just seem generally that you are able to handle stressful situations better." And so it was kind of hard for me. It felt like kind of a loss in that way, like I wasn't . . . I didn't have what it takes to, you know, in my mind, to take care of things myself, and be

a man and just get over it. I'm back on it, 'cause she suggested it and I think it was a good choice ultimately.

A transaction between two group members illustrates how one man views macho-ism and how it factors into seeking medical attention.

*Melvin (married 3 years):* As far as like this, this macho-ism, and things like that in my life, it's been very apparent, just because men don't go to the doctor. Men provide for the women, you know. Women are the ones, who, you know, if they get sick, need to go to the doctor, I guess. That is kind of how my mentality is, you know. Just, you know, if you're, In my case, it's like, man, if you get a little cut, you cut your hand open, just you know, whatever, stop the . . .

*Stewart interrupts:* Super glue it.

*Melvin continues:* . . . bleeding. . . yeah, super glue it you know. Why go to the doctor when you know, you can fix it yourself, kind of thing. So, that's kind of mentality that I was raised with, you know, and for a lot of the people that I know, it's pretty similar. . . Men avoid going to the doctor. I'm not sick . . . if it's not broken, why fix it.

### **When I Do Get Sick, Sleep Is the Best Remedy**

In line with Pete's comment above, most men expressed that if they were severely ill, they believed sleeping was the best remedy. As Jay, married 14 years expressed:

I don't get sick very often, but when I do, I feel like my whole life needs to stop. I need to just take a day or so in bed.

*Edward (married 13 years):* I just like to take the time out for however many hours, 12 hours, just to sleep, get the fluids, mostly water, into my system, and just sleep it out.

*Neal (married 9 years):* [I have the opinion of] just let me lay here and get better or die.

Jeremy, married 7 years, shared his suspicion that women view their husbands as wimps because they stay in bed when they are sick. He commented, "I probably am [a wimp] so I think I agree."

Jacob retorted, "I perceive that when I'm sick and I go to bed, I'm not a wimp, I'm just smart. . . And I get over it fast. I'll be miserable for a couple of days and then, boom back off to the races, you know . . . my body's healed up enough. . . ."

I'd rather suffer for two days, and be totally useless . . . rather than fairly useless, you know at 70% capacity over five days.

### **I Don't See Doctors**

Most men agreed that they do not readily seek medical attention. Harold, who had been married 7 years, shared the following experience:

I don't go see doctors. The last time I went to see my doctor was like three years ago. The time before that was three years before that, and when I showed up on that last one, he said, "Are you one of my patients?" Because I had actually not been to see him for so long that he actually didn't know who I was, and he had to go back and look at the records to confirm that I was actually one of his patients,

*Harold continues:* My mother, and a bunch of my aunts, sister in laws, are all nurses. And so at our house, the doctor is never a first resort. The first resort is, if you're sick and then it's okay, but if you're sick for X amount of time, then you call the family nurse and get her opinion as to whether or not you should go to the hospital, which in our case is generally my mother.

Justin, married 14 years, shared his views of a Comedy Central clip he saw:

[The comedian] was talking about how different things are. Everybody goes to the doctor for bumps, scrapes, and bruises. [I thought] it would literally take an act of God to get me to [go see a doctor for something like that].

Nick and Derek shared how their views of when it is okay to seek medical attention differed from their wife's views:

*Nick (married 4 years):* She seeks help, like crazy fast, and I'm a little more hesitant. I won't go to the doctor even if I feel or know I'm sick, because all they're going to do is tell me I'm sick and I'm paying money to do that.

*Derek (married 38 years):* My wife's a nurse and if I get sick and I don't go to the doctor, she's upset. She says, "For Heaven sake, go get it taken care of!" where I would rather wait and see what happens, and only go if I have to.

### **You Can Take Me to the Doctor When I Pass Out**

Participants gave the following examples of what extreme situations they believed justified seeking medical attention.

*Dennis (married 5 months):* I'd say that I avoid going to the doctor at all costs. I believe that the body can take care of itself, and that you can take me to the doctor when I pass out. Actually, last semester, I was doing a lot of running and it was hurting my shins a lot, and they'd get worse, and they'd get worse, and they'd get worse, and my wife kept telling me, "You need to go to the doctor and get it taken care of." "No, no. I'm not going to the doctor; I'm not going to the doctor." And eventually, it got to the point where I couldn't even stand up; I'd get out of bed and I couldn't even stand up, because it's, it's, I had just pushed myself so hard, so bad, that I go to the doctor.

*Allen (married 4 years):* Last year, I had my knee surgery [because] I couldn't walk; my leg was stuck in a bent position. There was no other option, but that's like the first time I've been to the doctor since I can remember.

One participant shared how he had a hard time seeking medical attention while suffering from a penile fracture.

*Justin (married 14 years):* I'm just going to give you an example of how much it takes to go to the doctor. One morning I woke up and I had an extremely hard erection, and it was, and I reached down and kind of adjusted it and felt like a pop. Anyway, so when I heard that pop I flipped, and it hurt so bad and my wife's like, "You've got to go to the doctor, you've got to go to the doctor." And I'm like, "No, no, it will be okay; I'll just walk it off." (Unanimous objections from the panel members) Seriously, three days later, I couldn't get an erection. I started freaking out, but I still wouldn't go to the doctor because I thought, I thought, "Oh, my God, it's going to be a situation where it's never going to work again." But even with something that excruciating and that important to me, I still didn't want to go. And there were factors . . . I was embarrassed; I didn't know what had gone on. But it just hurt, and hurt, and hurt. And finally, [my wife was] like, "I'm taking you." I didn't miss anything, though. I didn't miss school. I didn't miss work. I still went about my day, but it really takes a lot for me personally, and I think as a man to say, "Okay, I need to go." . . . you know . . . I mean that's a very extreme example, . . . everything ended up fine. It was literally just something that happens.

As illustrated above, men will seek medical attention, but many will only seek medical care in extreme situations.

*Edward (married 13 years):* I'll watch something and it's really got to be fairly debilitating before I'll be like, "All right, I'll go in."

*Justin (married 14 years):* I go when necessary. I don't just go to go. If it's important enough that I feel it's important, I go.



## Factors That Influence Men's Health Care Use

When the male participants were asked what factors influence their health care use they mentioned upbringing, family history, and finances.

### Upbringing and Family History

A recurring theme of why men do not seek medical attention as readily as most women do was reported to be influenced by the men's upbringing as illustrated by the dialogue below.

*Stewart (married 11 years):* I think a lot of mine and my wife's reaction to health has a lot to do with how we were raised. I came from a very large family, never had any health care, so if we got sick, you tough it out. You don't go, you don't take anything, but you know . . . if you die, you die. (laughter) My wife was ultra the other direction. Any time you had a snuffle, pump them full of some you know, whatever over-the-counter medicine you can get. And so when we came together, it's kind of like give-and-take, how do we navigate around this.

*Steven (married 2 years):* I grew up in a really small town. . . .[If] I split my head open, [we would use] a butterfly bandage, or super glue. . . . That's just how we did things, and we never went to the doctor, and so I feel the same way. I'm like, well, what's the point. I've done other things . . . I'm fine. I guess if I had health care it would be different. That's the big thing . . . it's like not having the financial means of doing it.

*Allen (married 4 years):* I was raised in kind of a small town, country town, . . . [if] you got sick you toughed it out, you got hurt, put a band aid on it, you know, and keep working, until you absolutely can't.

*Rob (married 9 months):* Where, I grew up, "Slap some mud on that thing and you're fine."

*George (married 9 months):* I think that one other thing he mentioned was, well, one, how you were raised, but I think that ties into if you have a family history of something. So if you know that a lot of people in your family have something, then anything that looks like it might be possibly be related to something. For example, my dad has skin cancer, so I'm a lot more likely to . . . every time I see a bump or a mark or a freckle, or something . . . I'm a lot more likely to look at that and say (gestures) than I ever was before. I'm a lot more likely to run to the doctor now for a (looks at skin on arm), "Could you make sure than I'm not

dying, please?” . . . than I was before, and I think that ties into any number of sort of illnesses. The second something like that happens to you, you feel a lot more worried about it.

## **Finances**

As mentioned earlier, finances and the lack of health care play a large role in whether men seek medical care. Several men emphasized that the cost of seeking medical care was not in their budget. One participant responded that he would not go to the doctor even if he felt or knew he was sick, because “all they’re going to do is tell me I’m sick and I’m paying money to do that.”

*Charles (married 2 years):* I don’t like to go, mostly because I just don’t want to spend the money. If I feel like I can just get over it, I hate spending money on something like that.

*Edward (married 13 years):* I don’t see a doctor. I just don’t like paying their bills, telling me, “Yep, you got a little bit of something, there, oh and here’s your \$500 bill, on the way out.”

Because many of the male participants were in their first few years of marriage and college students, having or affording health insurance was an issue in seeking medical care.

*Steven (married 2 years):* I guess if I had health care it would be different. That’s the big thing . . . it’s like not having the financial means of doing it

Charles, married 2 years, followed up on Steven’s comment stating, “Even so, with health insurance, you still don’t want to pay \$30 bucks or whatever it is.” Joe, who has been married a year and a half, shared his experience seeking medical care while having health insurance.

My wife and I pay out the nose for amazing health insurance, and I am getting to the point where I am actually okay going to the doctor. I’m willing to drop \$50 to go ahead and you know . . . do full blood work and do all this, go ahead and see if I have any type of cancers, . . . you know . . . anything flowing through my

system. I'm willing to do that for \$50. I'm like, "Yeh, I'm okay with that." It's just afterwards, I'm just like, okay, so I've gone ahead and done this and my insurance covers X and so forth, but if I had no insurance I would honestly wait until I passed out on the side of the road before I was able to go.

Derek, a 64-year-old, married for 38 years, emphasized that seeking medical care takes time away from a man's earning potential:

It's always the time that I have to take away from work. When I'm earning money, to go to the doctor – you know – it's tough to ever make that back up because I'm a blue collar worker and you lose a lot of money when you're gone, and sometimes you never do make it back up.

### **How Men's Feelings of Responsibility Impact Their Health Behaviors**

Participants demonstrated that marriage at times created added stress to their mental state. This stress can come from the responsibility to provide for and take care of families. This added responsibility was shown to impact men's health behaviors in several positive ways: it created the desire for them to become healthier physically, it made them less inclined to participate in risky behaviors, and it provided motivation for them to become more financially stable. However, this added stress caused men to not seek medical care. Participants reported not seeking medical attention for themselves primarily for the reason that doing so took away needed finances from their family. However, men would seek medical attention if their ailment impeded their ability to fulfill their role as provider.

### **Healthier Behaviors to Be Able to Provide for Family**

Participants discussed that once they married, they began to realize the need to stay healthy so that they could provide for their family. Additional reasons men stated the

need to be healthier was so they would be able to keep up physically with their children and grandchildren.

*Rob (married 9 months):* [Marriage] definitely helps my ambitions to be more healthy, you know, live longer so I can see my grandkids, and hopefully even great-grandkids, [to] be there to always provide for my wife.

*Phillip (married 24 years):* Making good diet decisions, and those kinds of things that can impact your health, it certainly makes you think about, well, I can't be stupid about these kinds of things, . . . I've got a family.

*Alex (married 3 months):* I'm more responsible and careful . . . now days, I kind of decrease the amount of drinking, and days of drinking. . . I'm thinking about my health now . . . and if something happens with me, what's she going to do?

*Dustin (married 7 years):* Now that I've got a kid and he's running around, I've realized physically . . . even though I feel like I'm in good physical condition, . . . I need to get more in shape, and more active and especially with more kids, I've got to stay in my prime for longer. That's helped me be a lot more active: my kids, and having a family.

*Judd (married 16 years):* You have to really think about the long term effects of what you're doing, or if you're not exercising, or those types of things, because that's just not you anymore; it's, you have other people that are depending on you now so . . . It puts some pressure on you. Make sure you're trying to be healthy.

*Jacob (married 9 years):* I want to be a dad that can play with his teenage kids without a lot of problem. . . I care about being there for my kids, as an active parent rather than [a] sitting-on-the-couch parent.

*Allen (married 4 years):* I would do anything for my little boy. I want to be there to coach him in sports. I want to do all the stuff with him, and that's why I've been working on losing weight and all of that stuff, because, you know, I don't want to be that guy that's like waddling back and forth, and out of breath, his kids are out wandering out . . . they want me to go out and play . . . and I'm just too tired, I'm too hot. I don't want to make those excuses, I want to be out there and be active with them. So it definitely affects my choices.

## Risk Aversion

Overwhelmingly, the men interviewed agreed that marriage encouraged them to be less risky in their activities to avoid injury that could have impeded their ability to provide for their families.

*Bill (married 41 years):* The health aspect that I recognized in our early years, was a change in willingness to engage in risky behaviors, willingness to, you know, become suddenly become unhealthy to the detriment of your marriage or to your family. Once you become financially responsible for other people, and personally responsible for raising little ones . . . .It's taking risks yourself that put other people at risk, that become an important decision factor. Once they're out of the nest. Then the things that you put off . . . .I once thought I wanted to try hang-gliding . . .you know, then the kids came along and that didn't seem prudent, and now that the kids are grown up hang-gliding doesn't seem prudent to me at all.

*Derek (married 38 years):* When I was single, the things I liked to do, I would do them 100%. For instance, I loved to snow mobile, and since I've been married and I have children, I'll watch the other guys do the high marking and jumping off the cliffs, and things, because I know if I get injured, I'm sunk. I can't then provide for my family, so the way I do activities and things changed greatly from when I was single to when I had a family. You just can't do those things anymore because you can't risk the possibility of injury.

*Pete (married 4 years):* I got rid of my motorcycle, . . . we took out life insurance policies . . . I even opted for additional accidental death and dismemberment because I have a job that's inherently risky. . . . It impacts my health behaviors dramatically, to be married. It matters to me that I should be around for my family, and . . . healthy enough to play with my kids, and healthy enough to work until, until I die, I hope.

*Chris (married 3 months):* The last summer before my wife and I got married, I must have gone cliff jumping, like, 300 times. I haven't been cliff jumping since I starting dating the girl I married, and a hundred other things . . . I take a lot more caution when I go hunting, and I take a lot more caution when I go hiking, and I take a lot more caution . . . just because I know that it's not just me. I mean, one, if I get messed up, if I like broke a limb or something, she'd be the one taking care of me, . . .Or if I died, like, she's not only got to deal with the burden of me being gone, but the financial burden, and you know, a hundred other burdens that before I didn't care, because they weren't really placed on anyone, exactly.

*Justin (married 14 years):* I was just more willing to risk things that probably didn't need to be risked. And I look now and I have my wife, I have my kids, my step-kids, grand-kids, I've got two grandsons . . . .I want to live to be 85, 90 if I

could, you know . . . because I want to see them grow up and I want to see them have families of their own, and I think that I'm much, much less willing to go out and do things that are risky. . . . I really want to go and jump out of the plane when I get to Hawaii. My wife doesn't want me to do it; she doesn't think it's a good idea. And looking at it from a perspective of, could there be something that would happen that could risk my not being able to be with my grandsons, is it worth it? . . . It's not anymore.

*Jed (married 10 months):* I always need to tell myself that you know everything you're doing now, you know, it's not going to affect just you, you know. It's going to affect your wife; you can't maybe do some of the extreme things you used to do in high school, when you were invincible, and you just need to remember that she's also relying on you to take care of her.

### **Change in Perspective**

As mentioned above, a lot of the motivation for men to be risk averse was so that they could continue to provide financially for their families. Many men felt their responsibility to provide for their families provided motivation to work harder and study harder. Chris, married three months, reflected on his change in perspective.

Overall, marriage has severely increased my health. The emotional health, the spiritual health, the mental health has all been severely boosted, and my motivation for physical health is higher because I want to . . . do better at my job, so that I can get a promotion.

Alex, a university student who has been married for 3 months, had similar thoughts concerning his need to be more motivated to work in his job, as well as work harder in his educational studies.

The financial burden of being the bread winner was a frequent stressor brought up in the discussions as illustrated below:

*Morris (married 2 months):* Now that I'm married, I have more responsibility. I have to make sure that my first responsibility is making sure I provide for my family.

*Pete (married 4 years):* I got rid of my motorcycle, . . . we took out life insurance policies . . . I even opted for additional accidental death and dismemberment

because I have a job that's inherently risky. . . . It impacts my health behaviors dramatically, to be married. It matters to me that I should be around for my family, and . . . healthy enough to play with my kids, and healthy enough to work until, until I die, I hope.

*Melvin (married 3 years):* Before I was married, I wasn't as worried about finances, I wasn't as worried about those kind of things, because if something happened I could always just be really frugal and just whatever, like I could just either spend all my time working and not have to worry about another person like wanting to spend time with me or whatnot I was like hey I'm dropping everything else, I'm not going to try dating anymore, I'm not going to try doing this anymore, I just need to work. But, with a wife or a kid you can't really just do that. You have a little like, kind of limitations a little bit that you've got to be spend time in other areas. And, so now like, with me, like . . . mentally it's become more stressful, getting married, because you have so many more responsibilities put on your shoulders that it's not just you you have to worry about.

Melvin continued to emphasize his rationale for putting his physical health on the backburner to provide for his family:

I would feel more at ease with my conscience knowing that my family was taken care of. You know, knowing that, you know, my kids were, you know had a roof over their head, and they were fed, than me going and running 6 miles you know, and getting in shape and things like that. I'm okay with that compromise if I know that my family is taken care of and fed and clothed.

### **Seeking Medical Attention/Illness**

As noted in Chapter II, there is much research focusing on men and their aversion to seeking medical care. During the focus group discussions, questions were asked about how men viewed health and illness. Several themes arose from the men's responses to the questions. One factor that was mentioned repeatedly was men's responsibility to their family to be healthy and provide financially.

**Finances.** Because of the financial pressures men feel, men generally do not seek medical attention because they feel when they do, they are taking away needed finances

from their families. Finances play a major role in men's decisions as to whether to seek medical assistance, as illustrated below:

*Dwight (married 7 years):* In our world culture, men have the biggest responsibility of taking care of their families, to provide for their wife and kids, so I was always told that men, they need to stay healthy and they have the responsibility to save some money, like insurance, and insurance for everybody. So that needs to be there, and he needs to be staying healthy, but it's not meaning that when you have a cold or fever that we go to a doctor, or cut your finger you need go to the doctor.

*Stewart (married 11 years):* If I go [to the doctor], then that's taking away from something that I could be providing for my wife and kids, Why would I put my needs above theirs.

Many participants shared Stewart's view of not wanting to spend money on themselves if it took away needed finances from their families.

*Morris (married 2 months):* A lot of times people put things off because, "Well, I know my knee is bad, or, I know my jaw pops, or I know this happens, and I know I should get it checked out, but we can't afford it right now." And usually, it's the guys that kind of earn the money, most of the money, or provides for the family, or like manages the money, a lot of times, so, they are like, "Well, I don't need to go to the doctor, because we can't afford it."

Many fathers in the group admitted to trying to change their wives' eagerness to send their children to the doctor for what seemed to be a minor ailment. Jacob (married 9 years) recounted the following exchange he and his wife had one night.

My kid got sick the other night, came up stairs, coughing, and so my wife [says], "Should we take him to [the] emergency [room,]?" I was like, "Crap, he doesn't have like . . . his head's not green, or growing a second nose, or something. Why would we ever take him to [the] emergency? . . . Do you know how expensive that is?" And so, "Google it . . . and done . . . I know what's wrong. Nah, we're fine." And so that's sort of my mentality with myself, I would very much avoid going, one because the expense of it, two because the information is really accessible for most things, and like that, so . . .

Even though comments like this were common, upon follow up, many men admitted they are much quicker to encourage their child or wife to seek a doctor's



assistance than they themselves would be. They also stated that they do not worry about the cost of the visit for other family members as much as they do for themselves.

*Stewart (married 11 years):* I had a kidney stone one time, and that was the most pain that I've ever had, and I was sitting there trying to tough it out (laughter) the best I could, for hours, and finally I had to break down, and my wife's like, "Just go to the hospital you stubborn . . .", you know. And I was like, "Fine, take me, I'm going to die." I didn't, I really didn't know what was going on. I felt like an idiot afterwards. They told me it was a kidney stone, and I thought, "Am I a pansy?" you know, because I should have been able to take that. And so we got the bill from that, and I thought, "Really? I'm never going again. Never! I don't care how much pain it is."

As the participants emphasized the importance of finances and providing for their families, men agreed that they will seek medical attention if it impedes their ability to provide for their family. Melvin, who had been married 3 years, told a story of when he injured his ankle:

It got to the point where I couldn't walk anymore, and then I was like, "Well, I'd better go get it fixed, because if I can't walk on it, I can't work, I can't go to school, I can't provide for my family."

Alex, married three months shared Melvin's view:

I usually think . . . "If I'm sick I should be at home." And I couldn't study or work and I will be behind for my pace, . . . I'm thinking, I am like in a foreign country, I am the only guy who is gaining money, who is bringing it home, so I should not be sick. I should be at work. So I am more worried, not for me but for my family [and the concern that they may be sick]. I [also think I] should be at work [so that I can provide food for my family]. . . .If you are sick no one pays you.

### **How Marriage Encourages Men to Engage in Positive Health Behaviors**

To begin the focus group discussion questions, the first research question asked was how marriage encourages healthy behaviors. Overall participants felt that marriage had encouraged them to become less selfish and increased their spirituality which

positively impacted their mental health. Participants had mixed responses in how marriage had encouraged positive health behaviors in the areas of mental/emotional well-being and diet. The following sections illustrate participant's feelings of how marriage encouraged positive health behaviors.

### **Selflessness**

Participants overall agreed that marriage and having a family promoted a less selfish lifestyle or focus, as illustrated by the following comments:

*Stewart (married 11 years):* I remember thinking when I was younger, that I had it all together, that I knew what life was all about, and I was fairly confident in myself and what not. And then getting married, it's like . . . I was very immature, I was very self-centered, I was very, you know, who I was . . . I no longer care to ever be that person again and I hope in ten years I'm a lot different than I am now, because of being married to someone that will help me work out those kinks, and that I can help as well.

*Nick (married 4 years):* I feel like when you first get married, it's kind of like there's kind of a road block and it's . . . and the best way I can describe it is, is learning to quit being so selfish, like that's that was my biggest thing when we first got married. Once you get over that hump of realizing that you're a team, you work together, I feel like it's, it kind of just gets better from there.

*Alex (married 3 months):* Before . . . I was feeling like more selfish, like if you [were to] compare now . . . and before marriage.

Anthony and Derek expressed how having children also increases a less selfish lifestyle:

*Anthony (married 58 years):* [I began to be less selfish and have] greater concern for my wife, and when the children came, for them, [I] forgot about myself a little bit, and it actually improved my health.

*Derek (married 38 years):* You have little kids . . . and you know, it changes your life a lot because it's not so self-centered.

## Increased Spirituality

Many participants agreed that marriage encouraged a more spirituality centered life. The following comments are typical of many comments related to spiritual health.

*Joseph (married 3 years):* As far as spiritual health, I've seen nothing but good things from it; . . . I think my wife does a great job spiritually, because she is definitely the one that kind of gives you the motivation to always do the things you are supposed to spiritually, even when you feel like you don't have time or energy to do them, she definitely does a great job focusing on that, and making it a priority, and giving me motivation.

*Melvin (married 3 years):* My wife definitely has an impact on me. . . .I'm like, "Man!, three hours of church? Just sleep. Come on." My wife says, "No, come on, we've got to go to church." "Gosh really, come on now." But I do it and it recharges me for the week, you know, it helps me, and it allows me to become a better person for my kids and for my wife. . . .So my wife definitely has an impact on my spiritual health because she's always pulling me by the short hairs to come to church and things like that. . . .Even though sometimes I'm just like "man, why do I need to go to church again?" It definitely has helped, helped me keep on that strait and narrow. It definitely has helped . . .

## Mental/Emotional Well-being

Participants were willing and able to talk not just about physical health, but also about spiritual and mental/emotional health. Having a spouse created a more consistent source of emotional support for some participants. The following dialogue illustrates several discussion group members' thoughts of how having one constant companion to talk to encouraged a healthier mental status.

*Jensen (married 3 years ):* Now I . . . have a companion that I get to talk to. I think . . . how I am emotionally . . . that health is a lot better than it was before . . . just because I have that companionship.

*Russell (married 6 months):* Just having somebody that you report to constantly. Like, we're both interested in how we're feeling emotionally, physically, spiritually . . . and so, we'll ask often, and so knowing that we will likely talk about it, is more motivation to have something good to report about, whether it's something spiritually healthy or mentally healthy. And especially just open communication, so that would be, I guess, mental or emotional health has

improved a lot, just making sure that all communication is deliberate and open, and honest.

*George (married 9 months):* I think there has been better benefits in emotional health, not having to go home and fight with your roommates every night because someone uses the cookie sheet and then flips it over and cooks on the back without cleaning either side (laughter). You don't have problems like that. . . .So I think, you know . . . a lot of stress has been relieved and stuff like that.

*Phillip (married 24 years):* Marriage put me on a much more stable course. . . .I think just the emotional base is probably, for me, is the core of it, is there all the time, and so it's, I think I'm probably much better off with that respect emotionally and spiritually with being married.

Several men emphasized how their wives support them through their unwavering support and unfailing forgiveness.

*Joseph (married 3 years):* I think overall happiness is a lot more when you're married, just because you have one stable person that you can rely on. It's not this friend and then you guys go different ways, and this friend. It's like, you know that she will always love you and always stick by your side no matter what, and that is just really comforting to know, especially for your emotional health, and everything.

*Derek (married 38 years):* I think that a lot of times you do stupid things and you'll think, "Oh, boy why did I do such a dumb thing," and yet you'll go home and your wife will still love you and be there with you and back you up, and it's amazing. You wonder why sometimes, but they do.

## **Diet**

Male participants had mixed feelings on if their diet had improved while being married. The following comments were given by men who viewed marriage as having improved their eating habits:

*Matt (married 13 years):* Being married, my wife has helped me eat healthier foods. I was eating out all the time because if I stayed at home I would have no meals.

*Jensen (married 3 years):* I could eat a whole bag or bowl of chips, if she'd let me, but that's the thing she's trying to change is my impulsive eating.

*Charles (married 2 years):* I really hate eating vegetables, (chuckles) and my wife makes sure that I eat vegetables, so she's taught me to like, to enjoy cooked carrots and even peas which I used to hate, but, so she's done a good job kind of helping me to realize that they can be okay . . . still not good but tolerable.

### **How Marriage Discourages Men to Engage in Positive Health Behaviors**

An additional research question focused on how marriage discourages men to engage in positive health behaviors. Overall, participants felt that marriage had interrupted their previous routines and free time. A lack of routine and having less free time, due to married, reportedly impeded on the participants' time to exercise. Additional unhealthy behaviors that were reported by participants included a less healthy diet and a less stable mental status.

#### **Loss of Routine/Time**

Participants consistently expressed that marriage interrupted their routine that they were used to while still a bachelor. This loss of routine was demonstrated in the following comments.

*Alex (married 3 months):* Before I had a lot of time, for exercise, for study.

*Melvin (married 3 years):* When you get married . . . you have to get innovative because your time is divided. You know, cause when you're single you can spend 100% of your time on 100% of yourself. When you get married you have to split that, 50 and 50, you know. And when you have kids, you've got to split it again and so . . . your time becomes extremely limited once you get married.

*Dwight (married 7 years):* You have limited time for yourself, that's for sure, and especially if you have kids, and work.

*Neal (married 9 years):* I just struggle to even do homework. I can't . . . I have to lock my door and keep my wife out just so I can stay focused, if I'm trying to do something, because I just, I just can't put the attention into it that I need to. And so, for me, it negatively, it impacts it by having my routine messed with, and the fact that I can't get into a routine, and can't stay focused long enough.

*Nick (married 4 years):* My wife and I just had twins two months ago, and I feel like that, that routine I had, it's long gone (Laughter). Although at the same time, like, in an effort to rebuild a new routine . . . if it ever will become such . . . it's also started squeezing out some of my extracurriculars that were completely useless, like watching TV, or you know, doing things that, like, have no worth at all. And so, that's kind of helped me, but at the same time, that struggle to find a routine . . . somewhat similar to Neal . . . I cannot study in my house to save my life. I cannot keep focused on things like that, and that's been kind of a real struggle, especially with this semester starting, is my mind is not anywhere near my homework, if I'm . . . if I'm at home. That's been, like a huge struggle with my wife and I because, I watch the kids while she works . . . she works from home . . . so we're both there, and she gets super frustrated with me because she's like, "You're not studying, you're not getting anything accomplished. All you're doing is like doing little to-dos around the house like laundry," Because I'm trying to stay productive, because if I try to do my homework, I will literally stare at the screen, or the paper, and I can't . . . I can't get anything done. And I feel like my time is wasted by sitting there. So it's had a huge impact, and I'm sure it will continue to have an impact.

### **Physical Activity**

As mentioned previously, participants reported marriage disrupted their routine.

This lack of routine impeded on their exercise habits.

*Jensen (married 3 years):* Losing that routine, where I'd be running a lot more before I was married, because I could . . . [I] had a lot of free time. You know . . . that was a negative effect.

*Phillip (married 24 years):* One of the things that I definitely noticed after I got married, and then when we started having children, was that my time to exercise disappeared, and I resented it. You know, this was my time, and I admit I resented it for awhile, and I just had to get over it. And I still had to find time, and so, and that's probably one of the reasons that I like to exercise at night because there were times when I would find myself out running at one o'clock in the morning, 'cause that was when I had time to do it. So it, you know, it's not your time so much anymore.

*Joseph (married 3 months):* Time wise, exercise gets harder, finding the time for exercise. Times to be alone, different things like that.

## Diet

As mentioned earlier, participants reported mixed feelings on if their diet had improved while being married. The following comments came from participants who viewed marriage as detrimental to their diet.

*Jensen (married 3 years):* I never really liked sweet candies, like Starbursts, or things like that. Those are her preferred candies, right, and she loves shakes and ice creams, and I never really . . . I mean I like ‘em, I like ice cream, but we eat them more because it is something that she likes, not necessary as a bad thing, to have one every once in a while, but you know, something I wouldn’t normally eat

*Brian (married 7 years):* [My wife] has zero will power when there’s sweets around, like she will eat until she’s sick (Laughter). . . I fall into that too. She’ll bring out the bag of M&Ms and I’m there eating with her.

## Mental/Emotional Health

Participants’ views differed on how marriage affected mental or emotional health. Participants noted that marriage creates added stress due to loss of time, lack of routine, difficulty adapting to the responsibilities associated with marriage, and difficulty coping with their wives’ emotions. The following dialogue illustrates discussion group members’ thoughts:

*Joseph (married 3 years):* I very rarely get time to myself to do things that break stress down, and so that kind of . . . weighs on me a little bit with health. . . If I want to sit down and watch TV, it gets kind of hard on my wife and my kid, my daughter, because they just like, “Well, I haven’t seen you for so long, I just want to be with you.” And so that stress just gets really amped up and I can’t find good ways to release it, or having time to find a good way to release it makes my emotional health really, sometimes, suffer quite a bit.

*Allen (married 4 years):* I never realized how hard it would be, because my wife is a stay-at-home mom, so I’m the sole provider, and I’m going to school full time, and it’s straining me. It is very stressful, very detrimental to my health. You know, I don’t, I leave at 7 in the morning, come home at 8 at night, see my kid for about an hour, put him to bed, and then I’m doing homework again. You know, it’s hard to find time to exercise and do all that too.

*Dennis (married 5 months):* It [takes] a lot more sacrifice and it definitely produces a lot more stress. I'll admit, I've never been as stressed in my life as I have been in this, in this mess that I'm in right now, but I hope I live through it.

A common stressor among men was the added responsibility of being a husband and or father:

*Jed (married 10 months):* It hurts [your mental well-being] in a way because there's also a lot more responsibility placed on your back.

*Morris (married 2 months):* Mentally it's become more stressful, getting married, because you have so many more responsibilities put on your shoulders that it's not just you, you have to worry about.

Several men, married less than a year, expressed the challenges of understanding their new wife's emotions.

*Ken (married 9 months):* Just the added stress kind of takes a little bit of a toll on your mental health, and I don't know if it's the same with you guys, but my wife is so much different than I am, and I'm still in that "been married 9 months," . . . I know her, but then I don't understand her. . . . So I guess with my mental health. That's kind of, like I don't know what's going on there, I don't understand, or know what I did. . . . Not necessarily all the time, but sometimes you feel like you're living in a perpetual state of caution.

*Kevin (married 4 months):* For being married only 4 months, . . . if she gets emotional, she cries, and . . . that brings me stress and confusion, so that's something maybe that I'm just not used to at this moment.

*Morris (married 2 months):* I can't understand that at times. Is this night ever going to end if she's crying all night? And you don't know why.

Derek, who had been married for 38 years, discussed the emotional highs and lows that can come from marriage and family life:

I think in a marriage, and especially with kids, you have the very highest of highs that you can get. When your kids succeed and when things are going good, you're really on top. And then sometimes when things don't go as well as you think they should, or you have problems, then they can be as low as you can get. I think as a single person . . . I don't remember ever having the highs and lows . . . as I've had when I've been married because you experience the two extremes. If you and your wife aren't getting along or you're having a disagreement, it's as low about



as you can get. Or if your kids are having troubles, you're really low. . . .On the other side, when things go great, it's as high as you can get.

### **Summary of Research Themes**

Similar themes were consistent among all groups. Overall, marriage encouraged selflessness and increased spirituality. Mixed responses were given whether marriage promoted a healthy mental/emotional status for men or discourages a healthy mental/emotional well-being. Men's feelings of responsibility to their family did encourage them to put their family's needs above their own when seeking health care, but it often discouraged them from seeking medical attention for themselves. The role of provider did encourage men to be risk averse and provided motivation for them to perform better in their studies and at work. The participants also felt that marriage and having a family encouraged them to maintain a healthier lifestyle because men felt a greater desire to be able to keep up with their children and live longer to see their children and grandchildren grow.

Wives played a significant role in influencing their husband's health behaviors. Overall, wives influenced their husband's diet and physical activity both positively and negatively. The men in this study reported their wives using many forms of social control strategies such as encouragement, guilt, repetition, and coercion. The men dealt with these social control strategies by procrastinating, encouraging their wife to make healthy changes with them, and simply trying out their wives' suggested changes.

How men react to illness was a major theme in this research study. Men reported that their upbringing, family history, and finances as the major factors that influenced their use of medical resources. Men report their wives as being one of the strongest

factors in encouraging them to seek medical attention, although they consistently were not eager to seek medical attention. Overwhelmingly, men agreed that they do not get ill very often, and if they were ill, they believed they should continue to work through illness and tough it out. When men did get extremely ill, they believed rest was the best remedy and seeing a doctor for illness or injury was a last resort.

Masculinity and the perception of man card were discussed in great detail.

Universal man card expectations were discussed, and the men agreed that if a man breaks one of the universal man card expectations, it causes that man to lose his man card. Men consistently agreed that men can maintain their man card by engaging in masculine behaviors, but participants also agreed that once men were married, their concern to appear masculine diminished dramatically or disappeared.

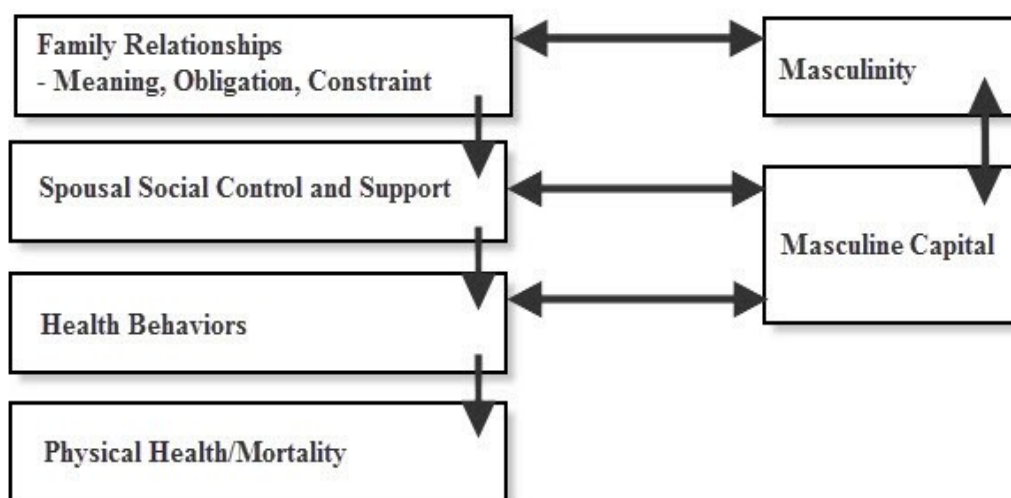
### **Justification for the Updated Model**

Umberson's 1987 Conceptual Model of Social Control was utilized (see Chapter I, Figure 1) to seek a better understanding of how wives influence their husband's health behaviors using social control strategies as well as how husbands perceive those strategies influencing their health behaviors. Umberson's model consists of four elements: family relationships, social control, health behaviors, and physical health/mortality. These elements are placed in a hierarchy with family relationships placed at the beginning of the model according to Umberson. Family relationships influence social control, social control influences health behaviors, and health behaviors influence physical health/mortality. Two additional elements were added to Umberson's model for the current study. These elements included masculine capital and masculinity.

These elements were added to see how they intersected with Umberson's existing model (see Chapter I, Figure 2). The researchers also modified the model to specifically examine spousal social control on men's health. The three elements of spousal social control, masculinity, and masculine capital, and how they related to each other in the model, were utilized to construct the research aims.

At the conclusion of the present study, the research team provided further alterations to Umberson's social control model. The research team changed the unidirectional arrows leading from the concept of masculinity and masculine capital to bidirectional arrows to reflect the idea that masculinity and masculine not only affect the concept of family relationships, spousal social control, and health behaviors, but that those elements also affect masculinity and masculine capital (see Figure 3 below). Masculine capital also appears to influence health behaviors, and so with the final alternation of bidirectional arrows, all of the elements intersect at some level.

With the addition of the bidirectional arrows, we found our model to be accurate in that masculinity and masculine capital influences many realms of a man's life and that spousal social control can have a great influence on a man's health related behaviors and physical health. Each element of the model is presented below. In addition, major findings found within each component of the model are noted.



*Figure 3.* Conceptual model of spousal social control, masculinity, masculine capital, and men's health based on research results.

### **Family Relationships**

Participants reported that once they entered into marriage, they experienced a change in perspective that subsequently provided them with more motivation to become a successful provider. This finding added more insight about how masculinity was defined by the men in this study. For example, men defined success in this study as being able to provide financially for their families and as a central role in being a man. Prior to marriage, men did not feel this role expectation as part of their identity as a man. This change in perspective caused these men to be more motivated in their school work and to work harder in their career or to seek better employment with the goal of being able to provide better for their families, confirming that family relationships were of primary importance, as Umberson's model suggests.

**Risk Averse**

Family relationships, as measured by marriage in this study, encouraged men to become less selfish and more risk averse. One note of interest was that when men referred to risk taking, they specifically mentioned physical activities such as playing sports, or activities such as cliff-jumping, snowmobiling, and base jumping; not overeating or drinking too much. Risk aversion was seen as a way to maintain provider status and to avoid injury and possible death associated with risk taking.

**Selfless Lifestyle**

As our results indicated, men consistently reported that having a family encouraged a more selfless lifestyle. Participants in the current study who were in their first few months or years of marriage also reported that marriage is a constant work in progress and requires a conscious effort of trying to understand their spouse's point of view and needs.

**Motivation to Become Healthier**

An additional reported outcome in the present study came from men who were fathers. These fathers reported that having children motivated them to become healthier so they could keep up physically with their children. Several participants noted that this desire to become healthier was so that they could live longer to see their children and grandchildren grow up.

**Motivation/Strain to Become a Better Provider**

Men in our study reported that when they first entered into marriage, they felt the additional strain of providing for their families. Men reported that prior to marriage they

only had the concern to provide and take care of themselves, but that once they were married, they had to look to the future and how their decisions would impact their families. Men linked this change in perspective to encouragement to work harder in their careers or to get better educational training to better provide for their families.

Upon entering into marriage, participants reported feeling added responsibilities which could be a form of indirect social control that occurs through the self-enforcement of norms. These men could be internalizing norms dictated by both religious and family norms about their responsibility toward their children and/or a spouse, and those religious and family norms in essence control their health behaviors. In Umberson's 1987 study, she reported that "family ties involve elements of meaning and obligation which contribute to social control; that social control is a mechanism by which social relationships affect health behaviors; and that health behaviors affect health outcomes" (p. 309). As our results showed, married men did internalize norms of responsibility toward their family, and those norms appeared to reinforce the obligation men felt to provide for their family; those norms in turn acted as a form of social control. That social control then influenced married men's health behaviors, which in turn influenced their overall health outcomes.

### **Spousal Social Control**

The second element proposed in Umberson's model is social control. This element was adapted for this research study to examine the perceived social control from wives as it related specifically to health behaviors. Our study found that men's wives influenced their husbands in various health-enhancing and health deterrent behaviors

through the internalization of norms. Wives also influence their husband's health behaviors through various social control strategies such as regulations, sanctions, and physical intervention. These will be discussed below.

### **How Wives Influence Their Husband's Health Behaviors**

Our research found that wives influence their husband's health by encouraging them to seek medical attention, and eat healthier and by providing mental/emotional support. Wives' influence on their husband's health also deterred some men from eating as healthy as they did prior to marriage, and some men's mental/emotional state was reported to be less stable now that they were married.

**Wife as motivator to seek medical attention.** Men in all five focus groups reported their wives encouraging them to seek medical attention, typically much sooner than these men would do on their own. Several men in the study reported that they went to the doctor to appease their wife.

**Wife as influencer of diet.** A second well mentioned finding in the current study, was how husbands saw their wives influencing their eating habits. Some men reported their diets had been enhanced since marriage and others reported their diets had gotten worse since marriage. As our participants illustrated, they easily partook of food their wife enjoyed, even though the men acknowledge that their wives' indulgences were something they would not typically eat.

An interesting finding throughout all focus groups was how the majority of men reported the desire to become healthier and that many of them said they wanted to improve their health through a change in diet. Overwhelmingly, men expressed the desire for their wives to cook healthier and for their wives to become healthier with them.

**Wife as contributor of mental stability/support.** An additional impact wives had on their husbands' health in the present study was in mental wellness. Some participants indicated that their wives provided them with increased mental or emotional stability and support. One individual in our group mentioned that marriage created more mental stability, but he subsequently attributed that mental stability to the fact that he and his wife had a healthy relationship. He postulated that if he did not have a healthy relationship with his spouse, his mental health would not be as stable or as healthy.

In summary, men in the present study seemed to rely on their wives for support and appreciated the mental health stability marriage provided. Many of the men in the study were newly married; had the sample consisted of men married for longer periods, results may have been different. In addition, neither the mental health of the men in the study nor the mental health of their wives were the focus of the study, and yet men brought up these aspects of marriage independent of the research questions asked.

### **Spousal Social Control and Support Strategies**

Participants in our study reported their wives using both social control and social support strategies to aid their husbands in making health behavior changes. Reported social control strategies from participants in this study included guilt, repetition/persistence, and coercion. Reported social support strategies from participants in this study included positive encouragement and support where the wife joins her husband in making the change into a team effort.

**Spousal control.** Participants in our study reported their wives using guilt, repetition or persistence, and coercion as forms of spousal control. One man shared how his wife used force to encourage him to stop smoking. He reported that she threw away



his cigarettes and took all money from his wallet so he could not purchase cigarettes. This man reacted to his wife's use of force by praising her for caring about him, and he concluded his story by stating that she eventually bought him an e-cigarette which he also praised her for. He stated that she has tried to take the e-cigarette away from him now too, but he refuses to let her take it away. Another man shared how his wife will use persistence and nag him until he finally gives in and does what she wants. A third participant shared how his wife will reward him with sexual benefits if he caves to her requests.

Focus group participants illustrated various ways that they deal with their wives' social control strategies including procrastination, encouraging their wife to make the change with them, and sincerely trying to implement their wives' suggestions. Although men in this study admitted to procrastinating when their wives made suggestions, most of them eventually did what their wives wanted them to do or at least tried to implement the behavior change she suggested. One older participant noted that whether his wife's suggestion is unwelcome or welcome, he always tries her suggestion out because he believes she has his—and their family's—best interest in mind. Another man noted that his wife may make suggestions that he finds hard to hear, but he believes if it hurts him to hear what she says, she is probably right. He said that although suggestions may be hard to take, he would rather have his wife tell him he needs to become healthier than someone else. Overwhelmingly, participants reported their wives' use of social control motivated them to become healthier overall.

**Spousal support.** Our study found that wives not only used social control strategies to influence their husbands' health, but also successfully used spousal support

strategies. Men reported their wives encouraging them to make healthy behavior changes or providing verbal praise for the changes they were making.

A final theme that was consistent in all focus group discussions was how men did not want their wives to be hypocritical in telling them to improve a health behavior, while they themselves did not do what they were suggesting. One participant noted that he would throw his wife's hypocrisy right back in her face and tell her "You don't do it; why should I do it?"

### **How Husbands Perceive Social Control Strategies Influencing Them**

Happily, most men in the present study wanted social support and encouragement from their wives to make healthy changes in their lives. Although men reported procrastination in making those healthy changes, most men reported that they have sincerely tried to implement their wives' suggestions and had encouraged their wives to make changes with them.

Multiple men in our study mentioned that they believed a concordant change would help improve their health behaviors. When men were asked how they react to their wives' use of social control, some men stated that they listen to her advice or suggestion and if they think the idea makes sense, they may try and implement the behavior change.

### **Masculinity**

The concept of masculinity and how it has influenced our participants' lives was interwoven throughout each discussion group. As mentioned above, when men entered into marriage, their perspective shifted to the future, which provided motivation for them to become a better provider for their families. In the present study, masculinity was

shown to influence much of our participants' lives in affecting their upbringing and the choices they have made. A common theme among participants was the pressure they felt to act masculine in front of their peers and in front of the opposite gender. Being masculine seemed to be a very public act for men in our study and many men were able to relay stories or experience they had of when they were trying to be seen as masculine, or instances in which they were trying to not appear feminine. Masculinity also played a large role in men's view of health care use as well as how they react to being ill. Marriage also played a large role in men's view of health care use as well.

### **Peer Pressure**

Multiple participants shared stories of times when they tried to act more masculine in front of their peers. Men told of how they would overexert themselves physically when trying to lift a heavy object or participating in a sporting event. Several men admitted to competing in sporting events all while having severely injured or broken limbs.

A second interesting theme found in the present study was that men in our study overwhelmingly had a desire to eat healthier; unfortunately, several participants viewed eating healthy in public as a non-masculine behavior. Participants reported that they ate more than normal and ate different foods (e.g., steak), or drank harder liquors in public so as to not appear feminine, but when in a private setting these men ate smaller portions, drank less or drank diet sodas, and opted for light cigarettes

Alternatively, some participants shared stories of when they rejected traditional masculine norms. For example, one participant shared how he and several co-workers went running during their lunch break. This participant stated that he got winded quickly

and stopped running while the others continued. He recounted the incident and shared that it did not bother him that he could not keep up with his co-workers and that he did not try to exert himself beyond his capabilities.

### **Impressing Women**

Many of our participants were relative newlyweds, and these men often shared stories of how they tried to appear masculine to impress a woman they were dating prior to becoming married. One man shared how he purposefully lifted heavy objects in front of his now wife and jumped off of high cliffs so that he could impress her. Two other men shared experiences of when they tried to show off when in sporting competitions so that they could impress a female. Another discussed his body building practices were in part to attract women.

### **Factors That Influence Men's Health Care Use**

The present study found some additional insight into how masculinity can play a role in men's health care usage. Participants reported several factors that influenced their health care use, all of which had strong links to masculinity: upbringing, family history, and finances.

**Tough it out.** Multiple men relayed stories of how their families seldom went to the doctor and how their fathers never went to the doctor. This socialization and modeling appeared to make men feel that they should not seek health care because it was either not necessary because it was not an extreme situation, or because they saw their father as toughing it out and so they too felt they needed to do the same.

**Family history.** Several participants reported they would seek help more readily if they had a family history of illness or disease. One man stated his father had skin cancer and that this family history of cancer caused him to quickly seek medical attention when he noticed slight changes in a freckle or mole.

**Finances.** An additional predictor of men seeking medical attention was if they had medical insurance and/or the financial resources to pay for the visit. The vast majority of participants indicated that they were reluctant to seek medical attention because of the cost, the possibility of missing work and the lost earning potential. The issue of cost was an overwhelming theme among participants.

Financial strain was mentioned by two self-identified blue-collar workers who emphasized the difficulty they had taking time off work to seek medical attention. As the majority of study participants were college men working side-jobs, we project they too are in a vulnerable position and had less job security than men in a professional career.

**Role of provider.** As mentioned in Chapter II, there is much research focusing on men and their aversion to seeking medical care. During the focus group discussions, our study participants repeatedly noted the stress they feel to maintain their breadwinner status and provide for their families. Because of the financial pressures men felt, most men in our study did not seek medical attention because they felt that when they did, they were taking away needed finances from their families. Even though men were not eager to seek medical attention, many men admitted they were much quicker to encourage their child or wife to see a doctor than to go themselves. Some men stated that they did not worry about the cost of a medical visit for other family members as much as they did for

themselves, but other men admitted to trying to change their wives' eagerness to send their children to a doctor for what seemed to be minor ailments.

**Barriers to seeking medical care.** As mentioned above, men listed several factors or barriers that prevented them from seeking medical attention. Our study participants identified three barriers to seeking medical care: feeling a sense of immunity and immortality, difficulty relinquishing control, and a belief that seeking help was not an accepted behavior for men.

### **How Men React to Being Ill**

Several of the discussion guide questions in this study focused on how men react to being ill. Men overwhelmingly reported that they did not get sick very often, and that even if they were ill, they continued on with their normal routine. In addition, study participants also stated that they did not feel they were sick unless they missed work or school, and still they were reluctant to do either even when they were ill or injured. Many participants self-defined as healthy, which makes sense because most of the participants were younger and probably had not experienced major health issues.

**Tough it out.** A second theme that was mentioned above was participants' strong belief that real men do not go to the doctor; they tough it out.

**If it's severe, I'll go.** Study participants did not seek medical attention for minor issues as they saw their wives frequently doing, but they did seek medical attention if they believed their illness was severe or serious. For example, one man stated that his wife could take him to the doctor only when he had passed out.

**I'll go if it impedes my ability to provide.** An additional setting in which men would seek medical attention was if their illness impeded their ability to provide for their

family. Men justified their use of medical services in these situations because they felt it was imperative for them to seek medical attention so they could maintain their role as provider.

### **Masculine Capital**

A handful of men reported that they believed masculinity, or gender scripts, varied by generation, by the way you were raised, and by your environment. Participants noted they were less concerned or no longer concerned about appearing masculine once they got married, and that they were more concerned about having a healthy relationship with their wife and family.

An additional aim of the study was to examine men's views of masculine gender scripts. Overall, men agreed that masculine gender scripts can be shown by engaging in hegemonic, non-feminine behaviors. These masculine gender scripts can be compromised if men do not comply with "universal man care expectations."

### **Now That I'm Married I Don't Care About Appearing Masculine**

Participants stated that once they married, they were no longer overly concerned about appearing masculine. They stated they felt a shift in their focus from wanting to be seen as a physically strong masculine male, to wanting to be seen as a male that can provide for his family. This shift was discussed and several participants contemplated on whether men felt this shift was due to the fact that they no longer had to impress or be physically impressive to the opposite gender now that they had a partner. Men also noted that once they got married, they felt they did not worry as much about appearing masculine, or trying not to appear feminine.

### **I'm More Concerned about Having a Happy Family Relationship Than Being Masculine**

In line with men stating that they are no longer overly concerned about appearing masculine, men stated that they are now more concerned about having a happy cohesive relationship with their wife than they are about appearing masculine.

### **Masculine Gender Scripts**

One item of interest in the current study was how men viewed characteristics of masculine gender scripts. Overall, men agreed that masculine gender scripts can be shown by engaging in hegemonic, non-feminine behaviors. These hegemonic masculine characteristics include men being competitive, aggressive, emotionally contained, self-reliant, and heterosexual. Participants in the present study also agreed that no other person or man can take your man card without your consent, but that any man can lose his man card if he breaks a universal man card expectation. For example, one participant said he proudly wears pink. He stated that if we were to ask his brothers and father if he had a man card, they would tell us no because he has fashion sense. This man believes he still has a man card because he can hunt, he can fish, and yet he still has fashion sense. This competence in the traditionally masculine behaviors of hunting and fishing was used to compensate for his traditionally un-masculine behavior of dressing well. A different participant shared how he could leave a guys night out early to help his wife who was home with sick children. He stated that some men may perceive his actions as un-masculine, but he perceived leaving early as maintaining his man card because he in turn was being a good husband and father. This man's behavior of helping out his family was endowed with masculine capital.



Masculine capital can be at times credited as a way of encouraging healthy behaviors in men. As mentioned earlier, men in our study stated that after they were married they avoided or ceased to participate in risky physical activities. They claimed they avoided or ceased to participate in risky physical activities to limit the likelihood of injury and therefore maintain their masculine role as breadwinner.

### **Health Behaviors**

Marriage can encourage some healthy behaviors and encourage some unhealthy behaviors. It appears, from our research that wives can significantly impact men's eating habits, physical activity, and mental health status. Men's behaviors can be influenced not only through spousal support or control but also through their wife's example and knowledge in the area or interest.

#### **Eating Habits**

Wives can impact their husbands' eating habits by cooking or providing healthy or unhealthy foods for their husbands. Some men reported their wives encouraging them to eat healthy, implementing healthy eating habits, and cooking healthy foods for them. One participant shared how his wife introduced whole wheat into his diet and how he now instinctively purchases whole wheat products instead of his white bachelor bread. Other men reported their wives as being an unhealthy influence on their eating habits. Some men shared how their wives ate poorly and it was very easy to simply eat unhealthy food along with her. An additional reason participants believed their wives discouraged healthy eating habits had to do with their wife's lack of knowledge and their wife's lack of willpower. Several men noted that their own college degrees were in health related

fields and from their studies, they knew what was healthy and what was not, but their wives did not have that same knowledge base. Other participants in the current study reported their spouses studying nutrition or dietetics. These men stated their wives seemed to constantly analyze food which made these men exhausted to even think about food and led some of them to the point that they didn't want to eat the food their wife suggested.

### **Physical Activity**

Men in the current study reported that once they entered into marriage, their physical activity levels declined. Some attributed this decline to a lack of personal alone time, a lack of motivation to look physically fit because they had already found a wife, and a lack of time due to having children. Participants reported assigning family responsibilities, setting aside family time, and being a provider for their family as priorities over physical activity or physical exercise.

Only a few men reported their wives encouraging them to exercise, while numerous men stated that they wished their wives would encourage them to exercise or join them in exercising. These men that desired their wives to exercise with them believed it would dramatically increase their physical activity level. However, a handful of men that did report their wives inviting them to exercise with them stated they declined their wife's invitation. Interestingly, women who discouraged their husbands from exercising for reasons such as wanting more cuddling time succeeded in their efforts to keep their husbands home and thus decreased their husband's time for exercise.

### **Mental Health**

When focus group participants were asked if marriage had helped or hindered their health, participants' beliefs varied as to whether marriage helped or hindered their mental state. Some newly married men believed the added stress of learning to understand their wife and her emotions, and the responsibility that comes with marriage, hindered their mental health. One such participant explained that he felt he was in a consistent state of caution with his new wife for fear of upsetting her. Other participants reported that having a consistent companion from marriage enhanced their mental well-being and emotional status.

### **Physical Health/Mortality**

Although men in our study highlighted the negative impact marriage had on their eating patterns and physical activity levels, overall they believed they were better off being married and that the pros of marriage outweighed the cons of marriage. The present study also found that social control and spousal support from wives lead to men having a healthier lifestyle. A consistent finding throughout all groups was that marriage improved men's spiritual well-being. This study also found that the responsibility that comes with marriage encouraged men to engage in health protective behaviors and encouraged men to quit engaging in unhealthy habits, the avoidance of which should lead to a longer mortality.

### **Summary of Justification for Altered Model**

The research team changed the unidirectional arrows leading from the concept of masculinity and masculine capital to bidirectional arrows to reflect the idea that masculinity and masculine capital not only affect the concept of family relationships, spousal social control, and health behaviors, but those elements also affect masculinity and masculine capital. With the addition of the bidirectional arrows, we found our model to be accurate in that masculinity and masculine capital influences many realms of a man's life and that spousal social control can have a great influence in a man's health-related behaviors and physical health.

## CHAPTER V

### DISCUSSION

#### **Introduction**

This chapter will provide conclusions regarding the results of the data analysis presented in the previous chapter. The focus group discussions provided valuable insight into how wives exerted social control over their husband's health, what social control strategies wives used, and how men perceived that social control influencing their health behaviors. This study provided an additional insight about how men perceived masculinity and how it impacted their health behaviors. And finally, this study was designed to examine how masculinity interacted with the social control, in the form of masculine capital, that men's wives exerted on their health behaviors.

Past research has suggested a variety of the health benefits provided to men that marry (Duncan et al., 2006; Eng et al., 2005; Kaplan & Kronick, 2006; Markey et al., 2005; Murray, 2000). And substantial research has shown that men's health can be affected by their spouse (Koball et al., 2010; Norcross et al., 1996; Seymour-Smith et al., 2002; Wood et al., 2007). While many studies have examined social control using married participants (August & Sorkin, 2010), the researchers did not believe there had been a study to date that examined the social control wives place on their husbands and how that social control influence their spouse's health or how masculinity plays into men's health behaviors. The researchers also wanted to examine how men maintain masculine capital in the face of social control, if at all.

Umberson's 1987 Conceptual Model of Social Control was utilized (see Chapter I, figure 1) to seek a better understanding of how wives influenced their husband's health behaviors using social control strategies as well as how husbands perceive those strategies influencing their health behaviors. Two additional elements were added to Umberson's model for the current study. These elements included masculine capital and masculinity. These elements were added to see how they intersected with Umberson's existing model (see Chapter I, Figure 2) and were utilized to construct the research aims and subsequent discussion questions for the present study.

With the addition of the bidirectional arrows, we found our model to be accurate in that masculinity and masculine capital influence many realms of a man's life and that spousal social control can have a great influence on a man's health related behaviors and physical health. The following will illustrate how we found our model to be a good illustration of how these elements interact based on the data collected in the present study as well as how our findings within each concept of the model relates to past research. This chapter will also present limitations of the current study, as well as implications for health education, and further research.

### **Conceptual Model of Spousal Social Control, Masculinity, Masculine Capital, and Men's Health**

As mentioned above, Umberson's Conceptual Model of Social Control (1987) consists of four elements: family relationships, social control, health behaviors, and physical health/mortality. In the model family relationships are illustrated as influencing social control, social control in turn influencing health behaviors, and health behaviors

influencing physical health/mortality. We added masculinity and masculine capital to indicate that masculinity influences masculine capital and family relationships and that masculine capital influences social control, or as we've named it, *spousal* social control. In our model masculine capital is also implied to influence health behaviors. And with the final alternation of bidirectional arrows, all of the elements subsequently intersect at some level.

### **Family Relationships**

Participants reported that marriage caused a change in perspective which subsequently provided them with more motivation to become a successful provider for their families. This change in perspective caused these men to be more motivated in their school work and to work harder in their career or to seek better employment with the goal of being able to provide better for their families; this confirmed that family relationships were of primary importance as Umberson's model suggests.

Family relationships, as measured in this study by marriage, encouraged men to become less selfish and more risk averse. One note of interest was that when men referred to risk taking, they specifically mentioned physical activities such as playing sports, or activities such as cliff-jumping, snowmobiling, and base jumping; not overeating or drinking too much. Men in this study saw risk aversion as a way to maintain their provider status and avoid injury and possible death associated with risk taking. This aversion to risk taking is contrary to traditional hegemonic masculinity traits where men are risk takers (Courtenay, 2000b; Hinojosa, 2010) but consistent with findings from Duncan et al. (2006) in that marriage causes greater reductions in risky

behaviors, particularly among men. Our findings were also consistent with Umberson's 1987 article where she stated "the simple existence of family ties may indirectly facilitate health behaviors or deter risk-taking" (p. 309).

An additional finding in the study was that marriage reportedly encouraged participants to be less selfish. This was conducive to Lewis and colleagues' (2006) findings that having a spouse can help transform motivation from doing what is in the best interest of the self to doing selfless actions that are for the continuation of the relationship.

Fathers in the study reported that having children motivated them to become healthier so they could keep up physically with their children. These findings were congruent with Umberson's (1987) hypothesis that family relationships can encourage healthful behaviors "by providing a model to be emulated or by leading an individual to set an example for his or her children" (p. 310). These findings could also be related to Duncan and colleagues' (2006) theory that social definitions or norms associated with marriage encourage men to "clean up their act" as Duncan and colleagues state, or in our study, encourage them to become healthier when necessary and be more responsible.

A final major finding in the concept of family relationships was that participants said they felt additional strain of providing for their families when they first entered into marriage. These findings may have been apparent because the majority of the study participants (57%) were under the age of 30 and enrolled in school full-time, which is the stage of life when many men begin their career path. Another factor that may explain why participants emphasized this pressure to provide for their families was because many of the men were young and relative newlyweds (nearly 60% of participants had been



married for less than five years), still working on earning an undergraduate degree, and subsequently did not have professional paying employment yet. The participants in this study were also found to be young when compared to the national average. According to the American Community Survey (2012), the estimated average age for men to get married in the state of Utah was 26.2 and for females it was 24.1 in the year 2012, compared to the U.S. average of 29.1 and 27.1 respectively. A possible reason these young men were married at a younger age, and report this added pressure, may be because the majority of participants (84%) were members of the predominate religion in the state of Utah, The Church of Jesus Christ of Latter-day Saints (Church of Jesus Christ) (2008) which emphasizes its members remaining sexually abstinent before marriage. The pressure these young men feel to provide for their families may also be due to their religion's emphasis that husbands are responsible for providing the necessities of life for their families (Church of Jesus Christ, 1995). As the Church of Jesus Christ emphasizes a man's role as provider and a woman's role as nurturer, it would be expected these men felt pressure to provide for their family and possibly be the sole provider for the family. However, a single income in any family, regardless of religious affiliation, could potentially cause financial strain.

The added responsibility participants reported feeling upon entering into marriage can be a form of indirect social control that occurs through the self-enforcement of norms. These men could be internalizing norms of responsibility, dictated by both religious and family norms, toward their children and/or a spouse, and these norms in essence are controlling their health behaviors. In Umberson's 1987 study, she reported "family ties involve elements of meaning and obligation which contribute to social

control.” She continued to state that “social control is a mechanism by which social relationships affect health behaviors; and that health behaviors affect health outcomes” (p. 309). As our results showed, married men did internalize norms of responsibility toward their family, and those norms appeared to reinforce the obligation men had to provide for their family; those norms in turn acted as a form of social control. That social control then influenced married men’s health behaviors which in turn influenced their overall health outcomes. Upon examination of participants in this study that affiliated themselves with the Church of Jesus Christ, 59% of men reported their wives work either inside or outside the home for an income; therefore, the majority of these men live in a dual earner household. However, the men in this study may still have felt added pressure of trying to live up to the norm of being the primary breadwinner, especially if there were children in the home or they anticipated having children.

### **Spousal Social Control**

The concept of spousal social control was adapted for this research study to examine the perceived social control from wives as it related specifically to their husband’s health behavior. We found our results to be consistent with Umberson’s hypothesis that social control from wives occurs both directly and indirectly. Our study found men’s wives indirectly influenced their husbands in various health enhancing and health deterrent behaviors through the internalization of norms. Men’s wives also influence their husband’s health behaviors directly through various social control strategies such as regulations, sanctions, and physical intervention.

Consistent with past research, men in our study reported their wives as a motivator to seek medical attention (Davidson, 2013; Marcell et al., 2010; Norcross et al., 1996; O'Brien et al., 2005; Sandman et al., 2000; Seymour-Smith et al., 2002; Tudiver & Talbot, 1999). This behavior is also known as 'the nag and drag syndrome' (Davidson, 2013) which is consistent with findings from Gast and Peak (2011) that found men seek medical attention more readily if their wife encourages them to go. However, Robertson (2003) believes promoting men's health through female relatives only reinforces the impression that real men are not concerned about health. He proposes that, rather than men being unwilling to go to the doctor, men may need a means of legitimizing their visit so they can maintain face, or keep their male identity intact, by claiming to be pressured into attending. Wives can provide this "out" Robertson was referring to by allowing men to state that their wife ordered him to seek medical attention.

Study participants' reports of how their wives influence their diets varied. Some men reported their diets had been enhanced since marriage and others reported their diets had gotten worse since marriage. Although our study did not focus on premarital health behaviors and habits as Homish and Leonard's 2008 study did, our findings were congruent in that there was an association between partners' eating patterns. As mentioned in Chapter IV, participants overwhelmingly expressed the desire for their wives to cook healthier, and for their wives to become healthier with them. This finding is encouraging for men's health as several studies have found the more support wives provide their husband, in regards to eating a low-fat diet, the greater the men achieved their goals of lowering the fat in their diet (Beverly, Miller, & Wray, 2008; Bovbjerg et al., 1995). The issue then for wives is not only encouraging their husband's healthy habits

or lifestyle, but also making the healthy changes along with their husbands. Past research that may support this theory has been conducted by Matsuo et al. (2010). Matsuo and colleagues found that weight loss and a decrease in food consumption in wives correlated significantly with their husband's weight loss and decrease in food consumption.

However, Beverly and colleagues found that men who relied on their wives to maintain a healthy diet exhibited lower self-control or felt they had a lack of control in making their own dietary changes. The study also found that a lack of spousal support appeared to contribute to negative health behavior changes such as adopting less healthful eating patterns, whereas positive reinforcement from a spouse increased dietary self-efficacy associated with health behaviors. Combining results from Beverly and colleagues' findings and our own study's findings, we conclude that men should not rely solely on their wives to cook healthy food, but men could encourage their wives to cook healthy food and learn how to cook healthy food themselves. It may also be helpful for wives to provide positive reinforcement to their husbands when they make healthy changes to increase their husband's self-efficacy around healthy eating behaviors. And as Social Cognitive Theory proposes, self-efficacy is a strong influence in the power an individual has to face challenges and strongly predicts the choices an individual is likely to make (Bandura, 2001).

An additional component of spousal control was how men reported their wives brought them mental stability and/or support. This is encouraging as Horwitz, McLaughlin, and White (1998) found that individuals with supportive partners report less depression, and those with more problematic partners report more depression. It should be noted that Tower and Kasl (1995) found this could be problematic for men in

particular because being close to their spouse was seen to increase vulnerability to depressive concordance, but the authors did not speculate/investigate why this was.

In summary, men in the present study seemed to rely on their wives for support and appreciated the mental health stability marriage provided. Again, many of the men in the study were newly married, and had the sample consisted of men married for longer, results may have been different. In addition, the mental health of the men in the study nor the mental health of their wives was the focus of the study, and yet, men brought up these aspects of marriage independent of the research questions asked.

### **Spousal Social Control and Support Strategies**

Participants in our study reported their wives using both social control and social support strategies to aid their husbands in making health behavior changes. Participants in our study reported their wives using coercion, guilt, and repetition or persistence as forms of spousal control. The reported use of coercion or force as a strategy spouses use when trying to influence them is consistent with past research findings (Fekete et al., 2006; Orina et al., 2002). Negative control strategies such as force are typically associated with poor adherence. Stephens et al. (2010) found negative control strategies were associated with poorer adherence to a diabetic diet, and other researchers have found negative control can cause poorer medical adherence and cause patients to become angrier over time (Franks et al., 2006; Helgeson et al., 2004; Rook, 1990). Findings in the current study did not support past research in the area of social control. In fact, participants in the present study reported their wife's use of social control helped motivate them to become healthier overall. Perhaps the rationale behind many of our participants' reactions to their spouse's use of social control is explained by Rook,

August, Stephens, and Franks (2011). They examined behavioral and emotional responses to spousal social control involving patients with type 2 diabetes. Overall, they found patients who had high expectations for spousal involvement did not react negatively to social control, whereas those who had low expectations for spousal involvement reacted with hostility to social control. Men's behavioral reactions to their spouse's social control attempts were largely unaffected because men typically see their wife's involvement in their health as normal. They found that men did not react negatively to their wife's use of social control, even when a wife used stern tactics such as warnings or tried to restrict her husband's behavior. Furthermore, patients reacted with greater feelings of appreciation for control attempts in their diabetes management if they expected greater spousal involvement (Rook et al., 2011). Our study may build support for Rook and colleagues' findings because several men in the current study stated that their wives make suggestions that are hard to hear, but that when she makes those suggestions, she is usually right.

Participants in the current study also reported receiving various forms of spousal support. Past research has found that if spouses use support, or positively toned and less coercive techniques, to influence healthy behaviors, spouse's dietary behavior and disease management was found to be better served, and support was associated with better adherence to a diabetic diet (Stephens et al., 2010). Further research, in the area of spousal social support, has predicted increased patient mental health among cardiac rehabilitation patients (Franks et al., 2006). We found our study to be consistent with past research findings. Men reported their wives encouraging them to make healthy behavior changes or providing verbal praise for the changes they were making. None of our

participants specifically noted how they reacted to spousal support as the discussion guide for the study focused on social control strategies, but it is encouraging to note that they were receiving support from their wives as studies have shown that spousal support can encourage lower cortisol levels and lower blood pressure readings in response to conflict (Heffner et al., 2004).

When men were asked how they believed their wives could help them become healthier, many mentioned that they believed a concordant change would help improve their health behaviors, which is in line with Falba and Sindelar (2008) that when one spouse improves his or her exercising behavior, the other spouse's exercise activity is also positively affected. Pettee et al. (2006) also found that in spousal pairs, compared with men in the low active group, highly active men were almost three times as likely to have a similarly activity spouse. This information further supports our study participants' beliefs that if their wives made healthy changes it would encourage them to make healthy changes as well.

When men were asked how they reacted to their wife's use of social control, some men stated that they would listen to her advice or suggestion and if they thought the idea made sense, they would try and implement the behavior change. This view is aligned with Sloan and colleagues' (2009) findings that if the men see themselves as complying with sensible health advice, they view themselves as rational (Gough & Conner, 2006) instead of being vulnerable (Sloan et al., 2009).

## **Masculinity**

A key component of the present research model was the concept of masculinity. During focus group discussions, participants reported that they believed masculinity, or gender scripts, varied by generation, by the way they were raised, and by their environment. This view is in line with Connell's (1987) statement that masculinity is socially constructed and dependent on a specific historical time, culture, and locale.

While investigating the concept of masculinity, several themes arose, including how masculinity influenced husbands' role as provider, pressure to appear masculine in front of peers and women, and health care use. In addition to the concept of masculinity, the present study examined male gender scripts and how they are inhibited or maintained.

As mentioned earlier, when men entered into marriage their perspective shifted to the future, which motivated them to become better providers for their families. Khalaf, Wah, Ghorbani, and Khoei (2013) found similar results in their study of unmarried men who portrayed the future position of being a family man as an understood role of masculinity.

Some men in the present study told of experiences when they overexerted themselves physically and continued to compete in sporting events while being severely injured so as to maintain the perception that they were masculine. These hegemonic behaviors of denying weakness or vulnerability and trying to appear strong and robust were concordant with Courtenay's (2000b) findings. In addition to trying to be seen as physically strong, participants tried to appear masculine by eating more and drinking more in public than they would if they were in private. Our finding is also in line with Gough and Conner (2006), who found men typically think being preoccupied with food



choices as a feminine activity or un-masculine. This is also consistent with de Visser and McDonnell (2013) in that when men are in traditionally masculine or macho settings, they are more likely to behave in traditionally masculine ways. The men in the present study also reported that the context in which men were present seemed to change how men displayed masculinity, which was in line with Messerschmidt (1993): “Although men attempt to express hegemonic masculinity through speech, dress, physical appearance, activity and relations with others, these social signs of masculinity are associated with the specific context of one’s actions and are self-regulated within that context” (p. 83).

In addition to men trying to appear masculine in front of their peers, men in the current study told of events when they tried to appear masculine to impress a woman they were dating. Our findings were consistent with findings from Khalaf and colleagues (2013) that correlated a man’s body shape to the meaning of masculinity. “His body shape was a means through which they were able to attract women with the intention of forming heterosexual relationships” (p. 5).

Participants reported several factors that influenced their health care use, all of which had strong links to masculinity: upbringing, family history, and finances. These findings are consistent with reports from the World Health Organization (2014), which reports the determinants of health include the social and economic environment, the physical environment, and the person’s individual characteristics and behaviors.

Men told of incidents when they were injured and how they believe toughing it out was the best course of action. They also told of how their fathers did the same thing. This socialization and modeling appeared to make men feel that they should not seek

health care because it was either not necessary because it was not an extreme situation, or because they saw their father as toughing it out and so they too felt the need to do the same. This perspective coincides with the concept of masculinity as men may feel reluctant to seek medical attention because if they do go to the doctor, they see themselves as un-masculine, weak, and vulnerable (Courtenay, 2000b; Sloan et al., 2009).

Men overall agreed they would seek medical attention if they had a family history of an illness or disease. Gast and Peak (2011) found similar results in their study in that men had fears linked to having a family history of a specific disease, which prompted them to seek medical attention. Markey and colleagues (2005) also found that men are more likely to seek medical attention if they view themselves having a perceived susceptibility to a disease or disability.

The cost of medical care was mentioned as a major deterrent when seeking medical treatment. Moller-Leimkuhler (2002) stated that men's lack of help-seeking can be reinforced by societal factors. She points out that one such societal factor in the USA is that health care costs, to a great extent, have to be covered by the individual. The concern some men had surrounding their loss of earning potential due to missing work was highlighted by Moller-Leimkuhler, who found men have difficulties setting time aside from work to seek medical attention. Other research has found that the more vulnerable position a man is in in the labor market, the more likely he is to conceal health concerns and potentially delay accessing healthcare (Dolan, 2011). Other research found that men in non-professional roles (i.e., blue collar workers) are not able to take time off to seek medical care due to their need to make ends meet financially (Farrimond, 2012).

These past findings are all consistent with comments made from our focus study group participants.

As mentioned in the concept of family relationships above, the role of provider influenced men's reluctance to seek medical care. Dolan (2011) found that regardless of the potential impact men's work could have on their health, work ethic was an important aspect of masculinity. Finances and maintaining their role as provider seemed to coexist in men's views of why they did not seek health care. Because of the financial pressures men felt, most men in our study did not seek medical attention because they felt that when they did, they were taking away needed finances from their families. This perspective also coincided with the concept of masculinity as men believed it was more masculine to avoid health care and to not admit they needed help, and providing for the family was more important for men than taking care of themselves.

As mentioned above, there are many factors that appeared to influence men's help-seeking behaviors. Tudiver and Talbot (1999) found men had personal and systematic barriers that prevented them from using the medical system. Those systematic barriers included lack of time/and or access, having to state the reason for the visit, and not having a male physician. The men in our study did not mention any of Tudiver and Talbot's systematic barriers as factors in preventing them from seeking medical care. Some could argue that the vulnerable workers mentioned above, who were worried about their lost earning potential while missing work to seek medical care, were referring to the fact that they did not have time to seek medical attention, although none of our participants specifically mentioned they did not have time to seek medical attention.

Tudiver and Talbot (1999) also identified personal barriers men have in regards to why they did not seek medical attention. They associated these personal barriers with traditional social roles men face. Our study participants identified three of Tudiver and Talbot's personal barriers: feeling a sense of immunity and immortality, difficulty relinquishing control, and a belief that seeking help was not an acceptable behavior for men.

An aim of the present study was to see how men reacted to being ill. Participants overwhelmingly reported that they do not get sick very often, and several men proudly stated they had not been to see a doctor in years. Courtenay (2000b) stated that when a man brags that he has not been to the doctor in a long time he is situating himself in a masculine arena and is demonstrating a dominant norm for masculinity when he refuses to take sick leave from work.

In line with the above statements is the belief that real men do not go to the doctor; they tough it out. As Dolan (2011) found, the norms and values associated with the working class masculinity, such as being tougher, could mean men delaying medical assistance. These characteristics are in line with the dominant form of hegemonic masculinity: self-reliant, not prone to disease or illness, and unconcerned with pain or minor health problems as described by Connell (1995), Farrimond (2012), and Levant (1996).

As other research has shown, men will seek medical attention if their illness or disability is severe, or if it is an extreme situation (Peak et al., 2010), or, as Seymour-Smith et al. (2002) stated, a health problem fits the "serious category." Men in our study reported similar ideas. For example, one man stated that his wife could take him to the

doctor only when he had passed out. This rejection to seek help is an endorsement of hegemonic ideals in which men feel that if they did seek medical help they would be seen as a wimp or a sissy and would therefore be seen as feminine (Courtenay, 2000b). An interview of general practitioners and their nursing colleagues' accounts of men's health care use found men to be serious users of health care when compared to women, who are seen as seeking health care for routine or standard problems (Seymour-Smith et al., 2002). They also found that men seek health care for two reasons (a) their wife ordered them to come, or (b) they are seriously ill. Physicians' interviews in the study noted that men's attendance for a medical appointment was usually a signal of something more major (Seymour-Smith et al., 2002). Both of the perspectives highlighted in the above study were found to be consistent with findings in the present study. In line with Seymour-Smith et al. labeling men as "serious users" of health care, Noon and Stephens (2008) labeled men as "legitimate users" of health care. They suggested that when men did seek medical care, they were at a point in their illness that there was no way to recover from their illness on their own, and medical attention was necessary. This view was similar to how our study participants viewed health care. As noted above, our study participants did not seek medical attention for minor issues as they saw their wives frequently doing. Men believed they should see a doctor only in extreme cases.

As mentioned earlier, participants in the current study reported feeling pressure to provide for their families. Participants noted that if they do get sick or injured and it impedes their ability to work and provide for their family's needs, they will seek medical attention so they can quickly regain their status as provider. This finding was similar to O'Brien and colleagues (2005) in that firefighters sought medical attention to allow them

to maintain their health and thus retain their jobs. This is an excellent example of how masculine capital can encourage healthy practices in men. Gough (2013) spoke of how masculine capital can reframe traditionally non-masculine behaviors, such as help-seeking, to be seen as brave and therefore in line with valued masculine traits rather than be seen as a weakness or feminine. Masculine capital will be discussed in the following section.

The concept of gender scripts was examined in the current study. The study sought a better understanding of how these gender scripts are maintained or inhibited. Participants noted that overall, masculine gender scripts are maintained by engaging in hegemonic activities and avoiding feminine activities. They also noted that men can lose their man card, or tarnish their masculinity, by not abiding by ‘universal man card expectations.’ These expectations are unwritten rules of conduct that all men should abide by. These unwritten rules of conduct are consistent with past research stating that men should possess stereotypical masculine traits such as being assertive, dominant, in control, strong, invulnerable and having emotional restraint (Sloan et al., 2009), conform to certain socially sanctioned masculine behaviors, and avoid certain proscribed behaviors (Levant & Richmond, 2007; Levant et al., 2009).

### **Masculine Capital**

The component of masculine capital and how it related to masculinity, health behaviors, and spousal social control were examined in this study. Socially prescribed norms of masculinity, or gender scripts, were reported by Burns and Mahalik (2007) to influence how men feel, act, and think. The present study found support for Burns and

Mahalik's hypothesis. Participants in the current study reported that they were more concerned about appearing masculine when they were single than they are now as married men. They also stated they are now more concerned about having a happy family relationship than appearing masculine. The concept of masculine capital and how it relates to men's masculine gender scripts and men's role as provider was also examined in the current study.

As noted in Chapter IV, participants in the present study reported a shift in focus from wanting to be seen as a physically strong masculine male to wanting to be seen as a male that can provide for his family. This shift was discussed and several participants contemplated whether men felt this shift was due to the fact that they no longer had to impress or be physically impressive to the opposite gender now that they had a partner. This shift in focus is consistent with de Visser and McDonnell's (2013) findings that men accrue masculine capital when they are in a heterosexual relationship and when the perceived pressure to be seen as competent in the domain of predatory heterosexuality is no longer present.

The reported shift men experienced following marriage of being more concerned about having a happy family relationship than appearing masculine is congruent with findings from Evans and colleagues (2011). Evans and colleagues found that how masculinity is displayed changes over time and that men define and redefine masculinity in response to location, life events, age, and the social context of their experiences throughout their life. It is important to note that while men felt less compelled to follow strict masculine gender scripts, they still did so in other possibly less obvious ways, such as avoiding health care and providing for their families financially.

The research aim of masculine gender scripts, and how they may be lost or maintained, was examined in the current study. As mentioned in Chapter IV, men agreed that masculine gender scripts can be shown by engaging in hegemonic, non-feminine behaviors such as being competitive, aggressive, emotionally contained, self-reliant, and heterosexual. These characteristics were in line with several other researchers' views of masculinity (Connell, 1995; Courtenay, 2000b; Farrimond, 2012; Levant, 1996). Although participants reported these hegemonic behaviors as an important way in which to maintain their masculinity, they also reported engaging in non-masculine behaviors, but justified those occasional non-masculine behaviors by still being competent in other masculine domains. These justifications are prime examples of masculine capital as described by de Visser et al. (2009).

As mentioned earlier, men in the present study reported avoiding or ceasing to participate in risky physical activities to avoid injury that could impede their ability to provide for their family. This finding is consistent with past studies crediting masculine capital as a way to encourage healthy behaviors. According to de Visser and McDonnell (2013), masculine capital helps us understand why practices are adopted by individuals. This study allowed a better understanding of how men utilized masculine capital as a way to maintain their masculinity. From the current study we now have a better understanding of why men may not have engaged in risky behaviors once they got married, as well as why men may seek medical attention. We believe it may be because these men feel it is unwise to risk injury or delay medical treatment if an injury could impair their ability to provide for their family. Also, those men who stated they did not care about appearing masculine anymore believed it was more important to have a happy relationship with



their wife than to impress other males. This could also be a form of masculine capital in which men place their role as husband and keeping their wife happy as a form of masculine behavior. And as part of the model shows, family relationships trump all other relationships.

### **Health Behaviors**

As past research has shown, marriage can encourage healthy and unhealthy behaviors. Spousal social control and support can impact men's eating habits, physical activity, and mental health status. The current study also found that men reported their wife's example and knowledge base as influencing their health behaviors.

Participants reported their wives impacting their dietary habits mainly through their cooking styles, by their eating example, by their encouragement to eat healthy, and their wife's knowledge. Participants in the current study noted how easy it was to join their wives in eating unhealthy food or snacks. This finding was consistent with Wilson (2002) who proposed some evidence that the BMI of the wife correlated with the husband's health and the obesity of the wife may predict her husband's health if it reflects characteristics of the husband's diet, such as high intake of saturated fats. Markey, Markey, and Birch (2001) also found data of a positive correlation between husbands' and wives' BMIs.

As participants mentioned, their wife's education and knowledge in the area of health played a large role in their diet. Much research has been done to examine how wives' educational attainment influences their spouse's health. Jafee and colleagues (2006) found that a wife's educational achievement was a greater predictor of her husband's risk of dying than his own education level; the higher the wife's education the

healthier her husband. In fact, Skalicka and Kunst (2008) found a wife's education was not only the strongest predictor of her husband's mortality, but the only predictor of mortality across all causes of death examined, except stroke.

Results of wives' influence in their husband's physical activity were mixed for the present study. Only a few men reported their wives encouraging them to exercise, while numerous men stated that they wished their wives would encourage them to exercise or join them in exercising. Past research examining spousal concordance in physical activity has conflicting results. Falba and Sindelar (2008) examined spousal concordance in health behavior change over time. In regards to physical activity, they found that one spouse's exercising habits effect on the other's exercise activity was positive, and continual exercise by one spouse was found to be equally associated with a positive behavioral change as a new upsurge in exercise by the other spouse. Pettee et al. (2006) also found spousal concordance in physical activity levels. They found that highly active men were almost three times as likely to have a similarly active spouse when compared to men who were not active, and that married men reported higher levels of exercise participation when compared to single men. They further emphasized that a wife's exercise status was an important determinant of her husband's exercise status (Pettee et al., 2006). In fact, Homish and Leonard (2008) found a significant prospective association between wives who were regular exercisers prior to marriage and their husband's exercise habits through the first four years of marriage. Wallace, Raglin, and Jastremski (1995) found monthly attendance in an exercise program was significantly higher among married pairs who joined together, as opposed to married singles whose spouse did not join the exercise program. They also found the married pairs' dropout rate

from the exercise program was significantly lower than for married singles (Wallace et al., 1995).

However, other research has found no link to spousal concordance in physical activity. Schierberl Scherr, McClure Brenchley, and Gorin (2013) assessed whether spousal diet and activity changes impacted each other's weight loss. Schierberl Scherr and colleagues tested two groups: one in which partners attended an active weight loss program together and one where only the primary participant attended treatment alone. They found no reciprocal effects found with physical activity changes. A second study by Barnett, Guell, and Ogilvie (2013) examined physical activity concordance among recently retired couples. They found shared participation in physical activity was rare and regular exercise was an individual and independent habit, but spouses were nonetheless an important source of social support.

Men in the current study reported that once they entered into marriage, they felt their physical activity levels declined. Some attributed this decline to lack of personal alone time, lack of motivation to look physically fit because they had already found a wife, and lack of time due to having children. Baxter, Hewitt, and Haynes (2008) supported our findings by proposing that the social and domestic pressures that come with marriage may decrease the available time adults have for physical activity, although this finding was found to be more common for women than for men. A study of African American men, by Griffith, Gunter, and Allen (2011), revealed interrelated barriers to physical activity, several of which were consistent to findings in the present study. These barriers found in Griffith and colleagues' study and the present study included the fact that men prioritized family responsibilities and family time over physical activity, and

also that the effort men exerted in seeking to fulfill the provider role limited their energy to engage in physical activity.

Past research examining how marriage influences physical activity levels has been found to be inconsistent. King, Kiernan, Ahn, and Wilcox (1998) found marriage increased physical activity levels. Other researchers found marriage decreases physical activity (Brown & Trost, 2003; Eng et al., 2005), while yet others propose marriage does not change physical activity levels in adults (Bell & Lee, 2006; Hull et al., 2010). One finding that has been consistent in studies examining marriage is that the transition into marriage is associated with weight gain (Dinour, Leung, Tripicchio, Khan, & Yeh, 2012) and a higher BMI (Averett, Argys, & Sorkin, 2013; Sobal, Rauschenbach, & Frongillo, 2003).

As mentioned above, participants in this study claimed their physical activity levels may have declined because they were less concerned about staying physically fit as they had already found a wife. Klos and Sobal (2013) found similar findings in their study. They reported that never-married men were more likely to be working towards weight prevention than their married/cohabitating and widowed men. Klos and Sobal attributed this to the fact that these never married men were working on maintaining or improving their weight to better their position in the marriage market.

Multiple fathers in the current study reported having less time to exercise, especially when their children were young. Hull and colleagues (2010) also found physical activity levels significantly declined after individuals had children, compared with individuals who stayed childless. When examining physical activity changes specifically in men after the birth of their first child, Hull and colleagues found males'

physical activity levels significantly decreased when compared with males who did not have a child. However, when examining physical activity levels after the birth of a second child, the researchers found no significant difference in their physical activity change.

Past research has found that married men are happier than single men (Stack & Eshleman, 1998), and married individuals report higher levels of well-being than their single peers (Dush & Amato, 2005; Horwitz, White, & Howell-White, 1996). When focus group participants were asked if marriage had helped or hindered their health, participants' beliefs varied as to whether marriage helped or hindered their mental status. Some newly married men believed the added stress of learning to understand their wife and her emotions, and the responsibility that comes with marriage, hindered their mental health. One such participant explained that he felt he was in a consistent state of caution with his new wife for fear of upsetting her. These findings were consistent with Duncombe and Marsden (1993) who shared how men in their study responded to their wife's emotions with incomprehension, anger, and puzzlement, just as our study participants did.

Other participants reported that having a consistent companion from marriage enhanced their mental well-being and emotional status. Our findings were consistent with past research showing married men reporting high levels of subjective well-being (Dush & Amato, 2005; Horwitz et al., 1996). Our study found that men freely spoke about their emotional stability and mental status. This finding was unusual as past research has found that men do not want to talk about personal and emotional issues (Sloan et al., 2009).

### **Physical Health/Mortality**

The final component of Umberson's (1987) model is physical health or mortality. Although several men in our study highlighted the negative impact marriage had on their eating patterns and physical activity levels, overall they believed they were better off being married and that the pros of marriage outweighed the cons. The present study also found social control and spousal support from wives lead to men having a healthier lifestyle. Past research has also found social support improves health behaviors (Franks et al., 2006) as well as social control (Stephens et al., 2010; Umberson, 1987; Westmaas et al., 2002), whereas some past research has found spousal control inhibits healthy behaviors (Franks et al., 2006; Stephens et al., 2010).

A consistent finding throughout all groups was that marriage improved men's spiritual well-being. This study also found that the responsibility that comes with marriage encouraged men to engage in health protective behaviors and encouraged men to quit engaging in unhealthy habits. These positive behaviors should lead to a longer mortality.

### **Limitations**

The qualitative data obtained from study participants brought invaluable information, although this study does have several limitations. First, these results may not be generalizable to other married males outside of the state of Utah. However, the purpose in conducting focus group data is not to generalize but to explore a specific topic in more depth. Additional limitations of our study included the similar demographic background of participants. Participants in this study were predominately white (91%,  $n =$

40); most had received at least some college education (45%,  $n = 20$ ), or were current university students enrolled in college full-time (52%,  $n = 23$ ). The majority of our study participants were young (57%,  $n = 25$  under the age of 30); and over half of participants had been married less than five years (59%,  $n = 26$ ), and were predominately of the same religion: The Church of Jesus Christ of Latter-day Saints (84 %,  $n = 37$ ). Since the majority of participants affiliated themselves with a religion that emphasizes traditional gender roles, it is not surprising to the researchers that participants' views sided with traditional male gender scripts; it should, however, be noted that this is a limitation of the study and may not be found in other geographic locations outside the state of Utah. Since focus group participants also volunteered, they may have strong feelings of how marriage had influenced their health. As with focus group discussion, the chance of a participant being influenced by a dominant or opinionated member of the same group is also a limitation of this study. An additional limitation of this study was that, due to the personal subject matter discussed during the focus groups, participants may not have portrayed themselves as they truthfully were (Krueger & Casey, 2009).

The focus group discussion method used in this study may have caused several additional limitations. Several researchers suggest that focus group discussions involving men may cause men to portray more exaggerated masculine views (Gough, 1998; Pietila, 2008). This brings to light an additional limitation of this study, considering that one of the main areas of the study was examining masculinity and that the study was conducted in the form of a focus group discussion. While the study was conducted in a focus group setting, we may have received a better view as to "what is common to the individuals concerned as group members, whereas individual differences and subjective, personal

feelings will often be filtered out” (Alasuutari, 1995, p. 92). As opposed to individual interviews, which tend to elicit people to describe the group or groups they belong to and its culture. Whereas in a group interview, that culture is present during the discussion and the researcher is able to see, hear, and analyze aspects that do not surface in individual interviews (Alasuutari, 1995). While participants in this study did occasionally publicly challenge each other’s views and opinions, it may have been possible to receive more opposition if this study was conducted through individual interviews as they more commonly evoke comments about the individual’s personal thoughts and how their ideas may differ from others around them (Alasuutari, 1995).

An additional limitation that should be noted was that women were present during each discussion group. The women managed the PowerPoint, managed the recording equipment, and took notes during the study. Prior to beginning the first focus group, the researchers contemplated whether it would be detrimental to have women in the room during the focus group discussions. The research team decided they would ask participants at the conclusion of the first focus group if having women in the room during the discussion impacted their answers. Participants were asked to anonymously write down their opinions. Five participants reported that the women did not impact their answers, while two other participants wrote that having women in the room made them more hesitant to discuss health behaviors related to sexual intimacy. The research team reviewed the men’s comments and decided having women in the room did not severely impact participants responses and as a result, women were present in all focus group discussions. Because of this, a possible limitation of the current study may be that



participants were not as forthcoming in their responses to the discussion questions, especially if their responses related to sexual intimacy.

### **Implications for Health Education**

Through the use of the researcher's alterations to Umberson's (1987) conceptual model of social control, it was found that most men welcomed their wife's social control and social support efforts. The present study also found that participants overwhelmingly agreed as to how men could and should comply with traditional masculine gender scripts. And finally, several men did share how they took advantage of masculine capital to compensate for their non-masculine behaviors. These findings should be carefully considered and researched when conducting community needs assessments and planning any intervention designed to impact men's health behaviors.

Findings in the current study indicated that men were open and willing to discuss not just their physical health, but also their spiritual and mental/emotional well-being. Men were also open to discussing their mental instability that seemed to be more apparent among newly married men. Men being open to talking about their physical health is common in past research, but the fact that men brought up the concept of the mental well-being is unusual, as past research has found that men do not want to talk about personal and emotional issues (Sloan et al., 2009). Future interventions aimed at examining men's health behaviors may find participants willing to discuss their mental health in addition to other health behaviors.

Although men in this study, and past studies, have reported their spouses to be their greatest, or sole, source of support, future health programs should be warned that

having a spouse as men's sole source of support could be detrimental to the spouse (Addis, 2011). Future interventions may focus on teaching men how to seek support from other trusted sources beside their wives to decrease the stress placed on these men's wives.

As this study found, as well as many past researchers, men underutilized health care. Past research has shown that men not only seek medical care less than women, but the health care services men receive are inferior to those women often receive (Courtenay, 2011). Courtenay summarized some reasons that may assist in men's underutilization of health care services: physicians spend less time in their visits with men than with women; men generally receive less services than women; men are provided with fewer and briefer explanations in medical encounters; and men receive less advice from physicians about changing risk factors for disease than women do. In Courtney's book, *Dying to Be Men*, he proposes six strategies or guidelines to use when working with men. Courtney utilizes the acronym HEALTH to present his guidelines. He believes men can be reached best if society would *Humanize* health care so when men do feel pain or need help, communicating that need for help becomes a normal human experience. His second proposed strategy is to increase men's inadequate knowledge base, or *Educate* men about their specific health risks, how to conduct self-examinations, and educate men that following good health habits can be manly and lifesaving. The *A* in the acronym *HEALTH* stands for *Assume the Worst*. Courtney states that because men minimize their symptoms, health care providers need to compensate for the tendency among both men and clinicians to overlook health risks and illness in men. As Addis emphasized above, men often have limited social support. We need to help men *Locate*

*Supports* and suggest ways for men to use them. *Tailor a Plan* is encouraged to help men develop a realistic health maintenance plan that includes specifics concerning their illness. Courtney's final suggestion is *Harness Men's Strengths*. Courtney suggests this may be done by changing the format of promotional material to capitalize on men's attitudes and behaviors. He suggests various promotional strategies such as appealing to men's intellect, autonomy, and control; he also suggests using a problem-solving approach or a teamwork approach. Courtney's acronym is accompanied by a list of ways to educate or inform men of health care service. He suggests bringing services and education to men in places men typically congregate (church, gyms, barber shops, senior centers); providing free men's health care kits with promotional items; establishing an e-mail based education campaign; providing internet survey tools and games; offering competitive contests; providing a sports and fitness expo; using high-profile spokesmen to promote health; providing incentives; making wellness workshops for men fun; hiring male staff; creating worksite programs; and working with public health agencies to deliver health care during nontraditional hours for working men. The researchers believe by implementing both Addis's and Courtney's suggestions, men would more likely utilize health care, and their mental health would be better served.

In addition to these suggestions, the researchers believe that the wives' impact on their husband's eating habits and physical activity should be considered. Overall, men in the present study reported the desire to become healthier and desired for their wives to make healthy changes along with them as they believed it would provide motivation and support for their goal. As men in this study reported, wives seemed to have a strong influence in dissuading their husbands from engaging in physical activity. It is important

for wives to be aware of the impact they have on their husband's behaviors and to support and allow their husbands the chance to engage in physical activity and healthier behaviors overall.

Lastly, combining results from Beverly and colleagues' (2008) findings and our own study's findings, we conclude that men should not rely solely on their wives to cook healthy food, but men could encourage their wives to cook healthy food, and men could learn how to cook healthy food themselves so that both they and their wives could both contribute to making health meals. Work- and community-based cooking classes catered for male participants could help in this area. As participants mentioned, it may also be helpful for wives to provide positive reinforcement to their husbands when the men make healthy changes. This will increase husbands' self-efficacy around healthy eating behaviors. And as Social Cognitive Theory proposes, self-efficacy is a strong influence in the power an individual has to face challenges, and it strongly predicts the choices an individual is likely to make (Bandura, 2001).

### **Implications for Further Research**

While this study provided support for Umberson's (1987) conceptual model of social control, findings from this research study indicate areas for other research. More qualitative research is needed to determine attitudes and perceptions of men from other demographic areas and ethnic backgrounds related to how men view their wife's social control as well as how masculinity and masculine capital influence these men's health behaviors. In addition, focus groups with older men and men that have been married for a longer amount of time should be considered. It is also suggested to conduct research with

wives to see how they perceive their social support and social control strategies affecting their husband's health behaviors. Much of the past research has been related to wives' influence on men's diet. More research is needed to determine inconsistencies found in our research on how wives' use of social control influences their husband's physical activity, mental health, and spirituality. As multiple participants reported their spirituality increasing since becoming married, more research could be conducted to support this finding as well as how men's attitudes about their wives working relates to religious norms. Future researchers may also wish to examine how men view the idea of using their wife as an excuse to seek medical attention, or whether using the excuse 'my wife made me come' encourages more prompt or frequent medical care.

Future researchers examining the concept of masculinity may also want to avoid focus groups as a method of data collection and opt for individual interviews alone or in addition to focus groups. Gough and Edwards (1998) suggest that individual interviews may allow men greater freedom to endorse non-hegemonic masculinities, and that individual interviews are necessary to examine properly how masculinity is embodied (de Visser et al., 2009). Other research suggests focus group discussions involving men can cause men to portray more exaggerated masculine views (Gough, 1998; Pietila, 2008). However, de Visser and colleagues state that group interviews and individual interviews could complement each other. It would also be suggested that future research examine the concept of universal man card exceptions and allow men to provide a more detailed review of the concept.

## Summary

Men in this study shared their views, concerns, insights, and strategies related to their wife's social control strategies. Participants also expressed their views concerning the concept of masculinity and how it impacted their health behaviors. Focus group participants stated that they believed their wives could be key factors in aiding a healthy lifestyle through example and by providing motivation. This study also examined the concept of masculinity and how it shapes men's health behaviors. Overall, participants agreed that the importance of being perceived as masculine diminishes after entering marriage. These findings are useful and there has been very little, or no, qualitative research done to examine how wives' use of social control and the impact of masculinity and masculine capital interrelate to affect men's health behaviors. Qualitative research, such as what was conducted in the present study, provides in-depth data that can create a better understanding of the concerns and needs of a specific population. Conducting qualitative research can subsequently provide more efficient and appropriate interventions and health education programs.

## REFERENCES

- Addis, M. E. (2011). *Invisible men: Men's inner lives and the consequences of silence*. New York, NY: Henry Holt and Company.
- Addis, M. E., & Mahalik, J. R. (2003). Men, masculinity, and the contexts of help seeking. *American Psychologist*, *58*(1), 5-14.
- Alasuutari, P. (1995). *Researching culture: Qualitative method and cultural studies*. London: SAGE.
- American Community Survey. (2012). Median Age at First Marriage. U.S. Census Bureau. Retrieved from <http://factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t#>
- AmeriStat. (2003). Analysis of data from the 2002 current population survey (March Supplement). U.S. Census Bureau: Marital Status and Living Arrangement. Retrieved from <http://www.prb.org/Articles/2003/TraditionalFamiliesAccountforOnly7PercentoUSHouseholds.aspx>
- August, K. J., & Sorkin, D. H. (2010). Marital status and gender differences in managing a chronic illness: The function of health-related social control. *Social Science and Medicine*, *71*(10), 1831-1838.
- Averett, S. L., Argys, L. M., & Sorkin, J. (2013). In sickness and in health: An examination of relationship status and health using data from the Canadian National Public Health Survey. *Reviews of Economics of the Household*, *11*(4), 599-633.
- Bandura, A. (2001). Social cognitive theory: An agentic perspective. *Annual Review of Psychology*, *52*, 1-26.
- Barnett, I., Guell, C., & Ogilvie, D. (2013). How do couples influence each other's physical activity behaviours in retirement? An exploratory qualitative study. *BMC Public Health*, *13*, 1197.
- Baxter, J., Hewitt, B., & Haynes, M. (2008). Life course transitions and housework: Marriage, parenthood, and time on housework. *Journal of Marriage and Family*, *70*(2), 259-272.
- Bell, S., & Lee, C. (2006). Does timing and sequencing of transitions to adulthood make a difference? Stress, smoking, and physical activity among young Australian women. *International Journal of Behavioral Medicine*, *13*(3), 265-274.

- Beverly, E. A., Miller, C. K., & Wray, L. A. (2008). Spousal support and food-related behavior change in middle-aged and older adults living with type 2 diabetes. *Health Education and Behavior, 35*, 707-720. doi:10.1177/1090198107299787
- Bovbjerg, V. E., McCann, B. S., Brief, D. J., Follette, W. C., Retzlaff, B. M., Dowdy, A., . . . Knopp, R. H. (1995). Spouse support and long-term adherence to lipid lowering diets. *American Journal of Epidemiology, 141*(5), 451-460.
- Brown, W. J., & Trost, S. G. (2003). Life transitions and changing physical activity patterns in young women. *American Journal of Preventative Medicine, 25*(2), 140-143.
- Burke, W., Beeker, C., Kraft, J. M., & Pinsky, L. (2000). Engaging women's interest in colorectal cancer screening: A public health strategy. *Journal of Women's Health and Gender-Based Medicine, 9*(4), 363-371. doi:10.1089/15246090050020673
- Burns, S., & Mahalik, J. (2007). Understanding how masculine gender scripts may contribute to men's adjustment following treatment for prostate cancer. *American Journal of Men's Health, 1*, 250-261.
- Calasanti, T. (2004). Feminist gerontology and old men. *The Journals of Gerontology. Series B, Psychological Sciences and Social Sciences, 59*(6), S305-14.
- Calasanti, T., Pietila, I., Ojala, H., & King, N. (2013). Men, bodily control, and health behaviors: The importance of age. *Health Psychology, 32*(1), 15-23.
- Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. (2004). Youth risk behavior surveillance – United States, 2003. *Morbidity and Mortality Weekly Report, 53*, 1-96.
- Church of Jesus Christ of Latter-day Saints, The. (1995, November). The Family: A Proclamation to the World. *Ensign, 102*.
- Church of Jesus Christ of Latter-day Saints, The. (2008, January 17). Utah membership. Retrieved from <http://www.mormonnewsroom.org/article/utah-membership>
- Connell, R. W. (1987). *Gender and power: Society, the person and sexual politics*. Stanford, CA: Stanford University Press.
- Connell, R. W. (1995). *Masculinities*. Berkeley, CA: University of California Press.
- Connell, R. W. (2005). *Masculinities* (2<sup>nd</sup> ed.). Berkeley and Los Angeles, CA: University of California Press.
- Corney, R. H. (1990). Sex differences in general practice attendance and help seeking for minor illness. *Journal of Psychosomatic Research, 34*, 525-534.



- Courtenay, W. (2011). *Dying to be men. Psychosocial, environmental, and biobehavioral directions in promoting the health of men and boys*. New York, NY: Routledge.
- Courtenay, W. H. (1998). Better to die than cry? A longitudinal and constructionist study of masculinity and the health risk behavior of young American men. Dissertation Abstracts International, 59 (08A), Publication No. 9902042.
- Courtenay, W. H. (2000a). Behavioral factors associated with disease, injury, and death among men: Evidence and implications for prevention. *The Journal of Men's Studies*, 9(1), 81-142.
- Courtenay, W. H. (2000b). Constructions of masculinity and their influence on men's well-being: A theory of gender and health. *Social Science and Medicine*, 50(10), 1385-1401.
- Courtenay, W. H., McCreary, D. R., & Merighi, J. R. (2002). Gender and ethnic differences in health beliefs and behaviors. *Journal of Health Psychology*, 7, 219-231.
- Cranshaw, P. (2007). Governing the healthy male citizen: Men, masculinity and popular health in *Men's Health* magazine. *Social Science and Medicine*, 65(8), 1606-1618.
- Creighton, G., & Oliffe, J. L. (2010). Theorising masculinities and men's health: A brief history with a view to practice. *Health Sociology Review*, 19(4), 409-418.
- Cubbins, L. A., & Szaflarski, M. (2001). Family effects on self-reported health among Russian wives and husbands. *Social Science & Medicine*, 53(12), 1653-1666.
- Davidson, K. (2013). Older men: The health and caring paradox. In A. Kampf, B. L. Marshall, & A. Petersen (Eds.), *Aging men, masculinities and modern medicine* (pp. 175-188). New York, NY: Routledge.
- Day, J. C., & Newberger, E. C. (2002). The big payoff: Educational attainment and synthetic estimates of work-life earnings. (Current Population Reports, Special Studies, P23-210). Washington, DC: Commerce Dept., Economics and Statistics Administration, Census Bureau.
- de Visser, R. O., & McDonnell, E. J. (2013). "Man points": Masculine capital and young men's health. *Health Psychology*, 32(1), 59-14.
- de Visser, R. O., Smith, J. A., & McDonnell, E. J. (2009). 'That's not masculine': Masculine capital and health-related behavior. *Journal of Health Psychology*, 14(7), 1047-1057. doi:10.1177/1359105309342299

- Denzin, N. K., & Lincoln, Y. S. (2005). The discipline and practice of qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *The SAGE handbook of qualitative research* (3<sup>rd</sup> ed.) (pp.1-42). Thousand Oaks, CA: Sage.
- Diet. (2012). In *Merriam-Webster online*. Retrieved from <http://www.merriam-webster.com/dictionary/diet?show=0&t=1340130777>
- DiETING. (2012). In *Merriam-Webster online*. Retrieved from <http://www.merriam-webster.com/dictionary/dieting>
- Dinour, L., Leung, M. M., Tripicchio, G., Khan, S., & Yeh, M. C. (2012). The association between marital transitions, body mass index, and weight: A review of the literature. *Journal Of Obesity*, 2012, 1-16. doi:10.1155/2012/
- Dolan, A. (2011). ‘You can’t ask for a Dubonnet and lemonade!’: Working class masculinity and men’s health practices. *Sociology of Health & Illness*, 33(4), 586-601. doi:10.1111/j.1467-9566.2010.01300.x
- Duncan, G. J., Wilkerson, B., & England, P. (2006). Cleaning up their act: The effects of marriage and cohabitation on licit and illicit drug use. *Demography*, 43(4), 691-710.
- Duncombe, J., & Marsden, D. (1993). Love and intimacy: The gender division of emotion and ‘emotion work’: A neglected aspect of sociological discussion of heterosexual relationships. *Sociology*, 27(2), 221-241. doi:10.1177/0038038593027002003
- Dush, C. M. K., & Amato, P. R. (2005). Consequences of relationship status and quality for subjective well-being. *Journal of Social and Personal Relationships*, 22(5), 607-627. doi:10.1177/0265407505056438
- Eng, P. M., Kawachi, I., Fitzmaurice, G., & Rimm, E. B. (2005). Effects of marital transitions on changes in dietary and other health behaviours in US male health professions. *Journal of Epidemiology and Community Health*, 59, 56-62. doi:10.1136/jech.2004.020073
- Evans, J., Frank, B., Oliffe, J. L., & Gregory, D. (2011). Health, illness, men and masculinities (HIMM): A theoretical framework for understanding men and their health. *Journal of Men’s Health*, 8(1), 7-15.
- Exercise. (2012). In *Merriam-Webster online*. Retrieved from <http://www.merriam-webster.com/dictionary/exercise>
- Falba, T. A., & Sindelar, J. L., (2008). Spousal concordance in health behavior change. *Health Research and Educational Trust*, 43(1), 96-116. doi: 10.1111/j.1475-6773.2007.00754.x

- Farrimond, H. (2012). Beyond the caveman: Rethinking masculinity in relation to men's help-seeking. *Health, 16*(2), 208-225. doi:10.1177/1363459311403943
- Fekete, E. M., Stephens, M. A. P., Druley, J. A., & Greene, K. (2006). Effects of spousal control and support on older adults' recovery from knee surgery. *Journal of Family Psychology, 20*(2), 302-310.
- Franks, M. M., Stephens, M. A. P., Rook, K. S., Franklin, B. A., Keteyian, S. J., & Artinian, N. T. (2006). Spouses' provision of health-related support and control to patients participating in cardiac rehabilitation. *Journal of Family Psychology, 20*(2), 311-318.
- Fryar, C. D., Carroll, M. D., & Ogden, C. L. (2012). Prevalence of overweight, obesity, and extreme obesity among adults: United States, trends 1960-1962 through 2009-2010. National Center for Health Statistics. Available from: [http://www.cdc.gov/nchs/data/hestat/obesity\\_adult\\_09\\_10/obesity\\_adult\\_09\\_10.htm#table1](http://www.cdc.gov/nchs/data/hestat/obesity_adult_09_10/obesity_adult_09_10.htm#table1)
- Galdas, P.M. (2009). Men, masculinity and help-seeking. In A. Broom & P. Tovey (Eds.), *Men's health: Body, identity and social context* (pp. 63-82). London, UK: Willey.
- Gast, J., & Peak, T. (2011). "It used to be that if it weren't broken and bleeding profusely, I would never go to the doctor": Men, masculinity, and health. *American Journal of Men's Health, 5*(4), 318-331. doi:10.1177/1557988310377926
- Getrich, C. M., Sussman, A. L., Helitzer, D. L., Hoffman, R. M., Warner, T. D., Sanchez, V., Solares, A., & Rhyne, R. L. (2012). Expressions of machismo in colorectal cancer screening among New Mexico Hispanic subpopulations. *Qualitative Health Research, 22*(4), 546-559. doi:10.1177/1049732311424509
- Gierveld, J. d. J., Groenou, M. B. v., Hoogendoorn, A. W., & Smit, J. H. (2009). Quality of marriages in later life and emotional and social loneliness. *Journal of Gerontology: Social Sciences, 64B*, 497-506.
- Good, G. E., Dell, D. M., & Mintz, L. B. (1989). Male role and gender role conflict: Relations to help seeking in men. *Journal of Counseling Psychology, 36*, 295-300.
- Goodman, C. R., & Shippy, R. A. (2002). Is it contagious? Affect similarity among spouses. *Aging and Mental Health, 6*(3), 266-274.
- Gough, B. (1998). Men and the discursive reproduction of sexism: Repertoires of difference and equality. *Feminism and Psychology, 8*(1), 25-49.

- Gough, B. (2013). The psychology of men's health: Maximizing masculine capital. *Health Psychology, 32*(1), 1-4. doi: 10.1037/a0030424.
- Gough, B., & Conner, M.T. (2006). Barriers to healthy eating among men: A qualitative analysis. *Social Science and Medicine, 62*(1), 387-395.
- Gough, B., & Edwards, G. (1998). The beer talking: Four lads, a carry out and the reproduction of masculinities. *Sociological Review, 40*(3), 409-435.
- Griffith, D. M., Gunter, K., & Allen, J. O. (2011). Male gender role strain as a barrier to African American men's physical activity. *Health Education & Behavior, 38*(5), 482-491. doi:10.1177/1090198110383660
- Health. (2012). In *Merriam-Webster online*. Retrieved from <http://www.merriam-webster.com/dictionary/health>
- Heffner, K. L., Kiecolt-Glaser, J. K., Loving, T. J., Glaser, R., & Malarkey, W. B. (2004). Spousal support satisfaction as a modifier of physiological responses to marital conflict in younger and older couples. *Journal of Behavioral Medicine, 27*(3), 233-254.
- Helgeson, V. S. (1990). The role of masculinity in a prognostic predictor of heart attack severity. *Sex Roles, 22*(11), 755-774.
- Helgeson, V. S. (1994). Relation of agency and communion to well-being: Evidence and potential explanations. *Psychological Bulletin, 116*(3), 412-428.
- Helgeson, V. S., Novak, S. A., Lepore, S. J., & Eton, D. T. (2004). Spouse social control efforts: Relations to health behavior and well-being among men with prostate cancer. *Journal of Social and Personal Relationships, 21*, 53-68.
- Hinojosa, R. (2010). Doing hegemony: Military, men, and constructing a hegemonic masculinity. *The Journal of Men's Studies, 18*(2), 179-194.
- Holland, D. J., Bradley, W., & Khoury, J. M. (2005). Sending men the message about preventive care: An evaluation of communication strategies. *International Journal of Men's Health, 4*(2), 97-114.
- Homish, G. G., & Leonard, K. E. (2008). Spousal influence on general health behaviors in a community sample. *American Journal of Health Behavior, 32*(6), 754-763.
- Horwitz, A. V., McLaughlin, J., & White, H. R. (1998). How the negative and positive aspects of partner relationships affect the mental health of young married people. *Journal of Health and Social Behavior, 39*(2), 124-136.

- Horwitz, A. V., White, H. R., & Howell-White, S. (1996). Becoming married and mental health: A longitudinal study of a cohort of young adults. *Journal of Marriage and the Family*, 58(4), 895-907.
- Hughes, M. E., & Waite, L. J. (2009). Marital biography and health at mid-life. *Journal of Health and Social Behavior*, 50(3), 344-358.
- Hull, E. E., Rofey, D. L., Robertson, R. J., Nagle, E. F., Otto, A. D., & Aaron, D. J. (2010). Influence of marriage and parenthood on physical activity: A 2-year prospective analysis. *Journal of Physical Activity & Health*, 7(5), 577-583.
- Jafee, D. H., Eisenbach, Z., Neumark, Y. D., & Manor, O. (2006). Effects of husbands' and wives' education on each other's mortality. *Social Science and Medicine*, 62(8), 2014-2023. doi: 10.1016/j.socscimed.2005.030.
- Joiner, T. E., & Katz, J. (1999). Contagion of depressive symptoms and mood: Meta-analytic review and explanation from cognitive, behavioral, and interpersonal viewpoints. *Clinical Psychology: Science and Practice*, 6, 149-164.
- Kandrack, M. A., Grant, K. R., & Segall, A. (1991). Gender difference in health related behavior: Some unanswered questions. *Social Science and Medicine*, 32(5), 579-590.
- Kaplan, R. M., & Kronick, R. G. (2006). Marital status and longevity in the United States population. *Journal of Epidemiology and Community Health*, 60, 760-765.
- Khalaf, Z. F., Wah, Y. L., Ghorbani, B., & Khoei, E. M. (2013). Perception of masculinity amongst young Malaysian men: A qualitative study of university students. *BMC Public Health*, 13(1), 1-16. doi:10.1186/1471-2458-13-1062
- Kirk, J., & Miller, M. L. (1986). *Reliability and Validity in Qualitative Research*. London, UK: Sage.
- King, A. C., Kiernan, M., Ahn, D. K., & Wilcox, S. (1998). The effects of marital transitions on changes in physical activity: Results from a 10-year community study. *Annals of Behavioral Medicine*, 20(2):64-69.
- Klos, L.A., & Sobal, J. (2013). Marital status and body weight, weight perception, and weight management among U.S. adults. *Eating Behaviors*, 14(4), 500-507.
- Koball, H. L., Moiduddin, E., Henderson, J., Goesling, B., & Besculides, M., (2010). What do we know about the link between marriage and health? *Journal of Family Issues*, 31(8), 1019-1040. doi:10.1177/0192513x10365834.

- Kristofferzon, M. L., Löfmark, R., & Carlsson, M. (2003). Myocardial infarction: Gender differences in coping and social support. *Journal of Advanced Nursing*, *44*(4), 360-374.
- Krueger, R. A., & Casey, M. A. (2000). *Focus groups: A practical guide for applied research* (3rd ed.). Thousand Oaks, CA: Sage.
- Krueger, R. A., & Casey, M. A. (2009). *Focus groups: A practical guide for applied research* (4th ed.). Thousand Oaks, CA: Sage.
- Levant, R. F. (1995). Toward the reconstruction of masculinity. In R. Levant & W. S. Pollack (Eds.), *A new psychology of men* (pp. 229-251). New York, NY: Basic Books.
- Levant, R. F. (1996). The new psychology of men. *Professional Psychology: Research and Practice*, *27*(3), 259-265.
- Levant, R. F., & Richmond, K. (2007). A review of research on masculinity ideologies using the male role norms inventory. *The Journal of Men's Studies*, *15*(2), 130-146. doi:10.3149/jms.1502/130
- Levant, R. F., Wimer, D. J., Williams, C. M., Smalley K. B., & Noronha, D. (2009). The relationships between masculinity variables, health risk behaviors and attitudes toward seeking psychological help. *International Journal of Men's Health*, *8*(1), 3-21. doi:10.3149/jmh.0801.3
- Lewis, M. A., McBride, C. M., Pollak, K. I., Puleo, E., Butterfield, R. M., & Emmons, K. M. (2006). Promoting preventive health behavior change among couples: An interdependence and communal coping approach. *Social Science and Medicine*, *62*(6), 1369-1380.
- Lewis, M. A., & Rook, K. S. (1999). Social control in personal relationships: Impact on health behaviors and psychological distress. *Health Psychology*, *18*(1), 63-71.
- Liamputtong, P., & Ezzy, D. (2005). *Qualitative research methods* (2nd ed.). Melbourne, Victoria, Australia: Oxford University Press.
- Lillard, L. A., & Panis, C. W. A. (1996). Marital status and mortality: The role of health. *Demography*, *33*(3), 313-327.
- Liu, H., & Umberson, D. (2008). The times they are a changin': Marital status and health differentials from 1972-2003. *Journal of Health and Social Behavior*, *49*(3), 239-253.
- Lynch, S. M. (2003). Cohort and life-course patterns in the relationship between education and health: A hierarchical approach. *Demography*, *40*(2), 309-331.

- Mahalik, J. R., Burns, S. M., & Syzdek, M. (2007). Masculinity and perceived normative health behaviors as predictors of men's health behaviors. *Social Science and Medicine*, *64*(1), 2201–2209.
- Mahalik, J. R., Lagan, H. D., & Morrison, J. A. (2006). Health behaviors and masculinity in Kenyan and U.S. male college students. *Psychology of Men and Masculinity*, *7*(4), 191–202.
- Mahalik, J. R., Locke, B. D., Ludlow, L. H., Diemer, M. A., Scott, R. P. J., Gottfried, M., & Freitas, G. (2003). Development of the conformity to masculine norms inventory. *Psychology of Men and Masculinity*, *4*, 3-25.
- Marcell, A. V., Ford, C. A., Pleck, J. H., & Sonenstein, F. L. (2007). Masculine beliefs, parental communication, and male adolescents' health care use. *Pediatrics*, *119*(4), e966–975.
- Marcell, A. V., Howard, T. L., Plowden, K., & Watson, C., (2010). Exploring women's perceptions about their role in supporting partners' and son's reproductive health care. *American Journal of Men's Health*, *4*(4), 297-304.  
doi:10.1177/1557988309335822.
- Markey, C. N., Markey, P. M., & Birch, L. L. (2001). Interpersonal predictors of dieting practices among married couples. *Journal of Family Psychology*, *15*(3), 464-475.  
doi:10.1037//0893-3200.15.3.464.
- Markey, C. N., Markey, P. M., & Gray, H. F. (2007). Romantic relationships and health: An examination of individuals' perceptions of their romantic partners' influences on their health. *Sex Roles: A Journal of Research*, *57*, 435–445.
- Markey, C. N., Markey, P. M., Schneider, C., & Brownlee, S. (2005). Marital status and health beliefs: Different relations for men and women. *Sex Roles*, *53*(5/6), 443-451. doi:10.1007/s11199-005-6767-y
- Maselko, J., Bates, L., Avendano, M., & Glymour, M. M. (2009). The intersection of sex and marital status in shaping stroke incidence: Differential prevalence and consequences of stroke risk factors. *Journal of the American Geriatrics Society*, *57*(12), 2293-2299.
- Matsuo, T., Kim, M. K., Murotake, Y., Numao, S., Kim, M. J., Ohkubo, H., & Tanaka, K. (2010). Indirection lifestyle intervention through wives improves metabolic syndrome components in men. *International Journal of Obesity*, *34*(1). 136-145.  
doi:10.1038/ijo.2009.226
- Men's Health Network. (2013). Retrieved from [www.menshealthnetwork.org](http://www.menshealthnetwork.org)

- Messerschmidt, J. W. (1993). *Masculinities and crime: Critique and reconceptualization of theory*. Lanham, MD: Rowman and Littlefield Publishers.
- Messner, M. A. (1998). The limits of "The Male Sex Role: An analysis of the men's liberation and men's rights movements' discourse. *Gender & Society, 12*(3), 255-276. doi:10.1177/0891243298012003002
- Meyler, D., Stimpson, J. P., & Peek, M. K. (2007). Health concordance within couples: A systematic review. *Social Science and Medicine, 64*(11), 2297-2310. doi:10.1016/j.socscimed.2007.02.007
- Mirowsky, J., & Ross, C. E. (2003). *Education, social status and health*. Hawthorne, NY: Aldine de Gruyter.
- Moisander, J., & Valtonen, A. (2006). *Qualitative marketing research: A cultural approach*. London, England: Sage.
- Moller-Leimkuhler, A. M. (2002). Barriers to help-seeking by men: A review of sociocultural and clinical literature with particular reference to depression. *Journal of Affective Disorders, 71*, 1-9.
- Monden, C. W., van Lenthe, F., de Graff, N. D., & Kraaykamp, G. (2003). Partner's and own education: Does who you live with matter for self-assessed health, smoking and excessive alcohol consumption? *Social Science and Medicine, 57*(10), 1901-1912.
- Morse, J. M. (2010). How different is qualitative health research from qualitative research? Do we have a subdiscipline? *Qualitative Health Research, 20*(11), 1459-1464. doi: 10.1177/1049732310379116.
- Muhajarine, N., & Janzen, B. (2006). The heart of employed women and men: Work, family, and community correlates. *Journal of Community and Applied Social Psychology, 16*(3), 233-241. doi:10.1002/casp.857
- Murray, J. E. (2000). Marital protection and marital selection: Evidence from a historical prospective sample of American men. *Demography, 37*(4), 511-521.
- National Center for Health Statistics. (2014). *Health, United States, 2013: With special feature on prescription drugs*. Hyattsville, MD: USDHHS.
- Noon, J. H., & Stephens, C. (2008). Men, masculine identities, and health care utilization. *Sociology of Health and Illness, 30*(5), 711-725. doi:10.1111/j.14679566.2008.01095.x



- Norcross, W. A., Ramirez, C., & Palinkas, L. A. (1996). The influence of women on the health care-seeking behaviour of men. *Journal of Family Practice, 43*(5), 475 - 480.
- Nostrand, R. L. (1992). *The Hispano homeland*. Norman, OK: University of Oklahoma Press.
- Oboler, S. (1999). *Ethnic labels, Latino lives: Identity and the politics of (re)presentation in the United States*. Minneapolis, MN: University of Minnesota Press.
- O'Brien, R., Hunt, K., & Hart, G. (2005). 'It's caveman stuff, but that is to a certain extent how guys still operate': Men's accounts of masculinity and help seeking. *Social Science and Medicine, 61*(3), 503-516.
- O'Brien, R., Hunt, K., & Hart, G. (2009). 'The average Scottish man has a cigarette hanging out of his mouth, lying there with a portion of chips': Prospects for change in Scottish men's construction of masculinity and their health-related beliefs and behaviors. *Critical Public Health, 19*(3-4), 363-381.  
doi:10.1080/09581590902939774
- Organisation for Economic Co-operation and Development. (1999). *OECD Historical Statistics 1960-1997*, Paris, France: OECD Publishing.
- Organisation for Economic Co-operation and Development. (2011). *Doing better for families*, Paris, France: OECD Publishing. doi:10.1787/9789264098732-en
- Orina, M. M., Wood, W., & Simpson, J. A. (2002). Strategies of influence in close relationships. *Journal of Experimental Social Psychology, 38*(5), 459-472.  
doi:10.1016/S0022-1031(02)00015-X
- Padula, C. A. (1996). Older couples' decision making on health issues. *Western Journal of Nursing Research, 18*(6), 675-687. doi: 10.1177/019394599601800600605
- Padula, C. A., & Sullivan, M. (2006). Long-term married couples' health promotion behaviors: Identifying factors that impact decision-making. *Journal of Gerontological Nursing, 32*(10), 37-47.
- Pai, C. W., Godboldo-Brooks, A., & Edington, D. W. (2010). Spousal concordance for overall health risk status and preventive service compliance. *Annals of Epidemiology, 20*(7), 539-546.
- Pampel, F. C., Krueger, P. M., & Denney, J. T. (2010). Socioeconomic disparities in health behaviors. *Annual Review of Sociology, 36*, 349-370.
- Patulny, R. (2009). The golden years? Social isolation among retired men and women in Australia. *Family Matters, 83*, 39-47.

- Peak, T., Gast, J., & Ahlstrom, D. (2010). A needs assessment of Latino men's health concerns. *American Journal of Men's Health*, 4(1), 22-32.  
doi:10.1177/157988308327051
- Pettee, K.K., Brach, J.S., Kriska, A.M., Boudreau, R., Richardson, C. R., Colbert, L.H., . . . Newman, A. B. (2006). Influence of marital status on physical activity levels among older adults. *Medicine and Science in Sports and Exercise*, 38(3), 541-546.  
doi:10.1249/01.mss.0000191346.95244.f7
- Physical Activity. (2012). World Health Organization. Retrieved from [http://www.who.int/topics/physical\\_activity/en/](http://www.who.int/topics/physical_activity/en/)
- Pierce, L. S., Hong, T. B., Franks, M. M., & Ketterer, M. W. (2002). Health-related interactions and the self in marriage. *Journal of Women and Aging*, 14(3/4), 149-164. doi:10.1300/J074v14n03\_10
- Pietila, I. (2008). *Between rocks and hard places: Ideological dilemmas in men's talk about health and gender*. (Doctoral dissertation, University of Tampere, Tampere, Finland). Retrieved from <http://uta17kk.lib.helsinki.fi/bitstream/handle/10024/67877/978-951-44-73999.pdf?sequence=1>
- Pinkhasov, R. M., Wong, J., Kashanian, J., Lee, M., Samadi, D. B, Pinkhasov, M. M., & Shabsigh, R. (2010). Are men shortchanged on health? Perspective on health care utilization and health risk behavior in men and women in the United States. *The International Journal of Clinical Practice*, 64(4), 475-487.  
doi:10.1111/j.1742-1241.2009.02290.x
- Pleck, J. H., Sonenstein, F. L., & Ku, L. C. (1994). Problem behaviors and masculinity ideology in adolescent males. In R. D. Ketterlinus & M. E. Lamb (Eds.), *Adolescent problem behaviors: Issues and research* (pp. 165-186). Hillsdale, NJ: Lawrence Erlbaum.
- Rehkopf, D., Berkman, L., Coull, B., & Krieger, N. (2008). The non-linear risk of mortality by income level in a healthy population: US national health and nutrition examination survey mortality follow-up cohort, 1988-2001. *BMC Public Health*, 8, 383. doi:10.1186/1471-2458-8-383
- Robertson, S. (2003). Men managing health. *Men's Health Journal*, 2(4), 111-113.
- Rook, K. (1990). Stressful aspects of older adults' social relationships: Current theory and research. In M. A. P. Stephens, J. H. Crowther, S. E. Hobfoll, & D. L. Tennenbaum (Eds.), *Stress and coping in later-life families* (pp. 173-192). New York, NY: Hemisphere.

- Rook, K. S., August, K. J., Stephens, M. A. P., & Franks, M. M. (2011). When does spousal social control provoke negative reactions in the context of chronic illness? The pivotal role of patients' expectations. *Journal of Social and Personal Relationships, 28*(6), 772-789. doi:10.1177/0265407510391335
- Ross, C. E., & Mirowsky, J. (2010). Gender and the health benefits of education. *The Sociological Quarterly, 51*(1), 1-19. doi:10.1111/j.1533-8525.2009.01164.x
- Sandman, D., Simantov, E., & An, C. (2000). Out of touch: American men and the health care system. Commonwealth fund men's and women's health survey findings. Retrieved from [http://www.usrf.org/breakingnews/Men\\_out\\_of\\_touch.pdf](http://www.usrf.org/breakingnews/Men_out_of_touch.pdf)
- Satcher, D. (2003). Overlooked and underserved: Improving the health of men of color. *American Journal of Public Health, 93*(5), 707-709.
- Sayer, G. P., & Britt, H. (1996). Sex differences in morbidity: Case study of discrimination in general practice. *Social Science and Medicine, 42*(2), 257-264.
- Schierberl Scheer, A. E., McClure Brenchley, K. J., & Gorin, A. A. (2013). Examining a ripple effect: Do spouses' behavior changes predict each other's weight loss? *Journal of Obesity, 2013*, 1-8. doi:10.1155/2013/297268
- Schnittker, J. (2004). Education and the changing shape of the income gradient in health. *Journal of Health and Social Behavior, 45*(3), 286-305. doi:10.1177/002214650404500304
- Schoenborn, C. A. (2004). Marital status and health: United States, 1999-2002. *Advance Data from Vital and Health Statistics* (Research Report No. 351). Hyattsville, MD: National Center for Health Statistics.
- Seale, C. (1999). *The quality of qualitative research*. London, UK: Sage.
- Seymour-Smith, S., Wetherall, M., & Phoenix, A. (2002). My wife ordered me to come! A discursive analysis of doctors' and nurses' accounts of men's use of general practitioners. *Journal of Health Psychology, 7*(3), 253-267.
- Silverman, D. (2006). *Interpreting qualitative data* (3rd ed.). London, UK: Sage.
- Singh-Manoux, A., Ferrie, J. E., Chandola, T., & Marmot, M. (2004). Socioeconomic trajectories across the life course and health outcomes in midlife: Evidence for the accumulation hypothesis? *International Journal of Epidemiology, 33*(5), 1072-1079.
- Skalicka, V., & Kunst, A. E. (2008). Effects of spouses' socioeconomic characteristics on mortality among men and women in a Norwegian longitudinal study. *Social Science and Medicine, 66*(9), 2035-2047.

- Sloan, C., Gough, B., & Conner, M. (2009). Health masculinities? How ostensibly healthy men talk about lifestyle, health and gender. *Psychology and Health, 25*(7), 783-803.
- Smith, K. R., & Zick, C. D. (1994). Linked lives, dependent demise? Survival analysis of husbands and wives. *Demography, 31*, 81-93.
- Sobal, J., Rauschenbach, B., & Frongillo, E. A. (2003). Marital status changes and body weight changes: A US longitudinal analysis. *Social Science and Medicine, 56*(7), 1543-1555.
- Sobral, M. (2006a). Community-based strategies to improve the health of Mexican American men. *International Journal of Men's Health, 5*(2), 153-171.
- Sobral, M. (2006b). Health care seeking among Mexican American men. *Journal of Transcultural Nursing, 17*(2), 129-138. doi:10.1177/1043659606286767
- Springer, K. W. (2010). Do wives' work hours hurt husbands' health? Reassessing the care work deficit thesis. *Social Science Research, 39*(5), 801-813. doi:10.1016/j.ssresearch.2010.04.008
- Springer, K. W., & Mouzon, D. M. (2011). "Macho men" and preventive health care: Implications for older men in different social classes. *Journal of Health and Social Behavior, 52*(2), 212-227. doi:10.1177/0022146510393972
- Stack, S., & Eshleman, J. R. (1998). Marital status and happiness: A 17-nation study. *Journal of Marriage and Family, 60*(2), 527-536.
- Stephens, M. A. P., Rook, K. S., Franks, M. M., Khan, C., & Iida, M. (2010). Spouses use of social control to improve diabetic patients' dietary adherence. *Families, Systems and Health, 28*(3), 199-208. doi:10.1037/a0020513
- Stewart, D. W., & Shamdasani, P. N. (1990). *Focus groups: Theory and practice*. Newbury Park, CA: Sage.
- Stimpson, J. P., Masel, M. C., Rudkin, L., & Peek, M. K. (2006). Shared health behaviors among older Mexican American spouses. *American Journal of Health Behavior, 30*(5), 495-502.
- Stimpson, J. P., & Peek, M. K. (2005). Concordance of chronic conditions in older Mexican American couples. *Preventing Chronic Disease, 2*(3), A07.
- Stolzenberg, R. M., & Williams, K. (2008). Gendered reciprocity: Work discontent and the household production of health. *Social Science Research, 37*(1), 180-201. doi:10.1016/j.ssresearch.2007.01.004

- Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, *19*(6), 349-357. doi:10.1093/intqhc/mzm042
- Torssander, J., & Erikson, R. (2009). Marital partner and mortality: The effects of the social positions of both spouses. *Journal of Epidemiology and Community Health*, *63*(12), 992-998. doi:10.1136/jech.2009.089623
- Tower, R. B., & Kasl, S. V. (1995). Depressive symptoms across older spouses and the moderating effect of marital closeness. *Psychology and Aging*, *10*(4), 625-638.
- Tower, R. B., Kasl, S. V., & Darefsky, A. S. (2002). Types of marital closeness and mortality risk in older couples. *Psychosomatic Medicine*, *64*(4), 644-659.
- Tudiver, F., & Talbot, Y. (1999). Why don't men seek help? Family physicians' perspectives on help-seeking behavior in men. *The Journal of Family Practice*, *48*(1), 47-52.
- Umberson, D. (1987). Family status and health behaviors: Social control as a dimension of social integration. *Journal of Health and Social Behavior*, *28*(2), 306-319.
- Umberson, D. (1992). Gender, marital status and the social control of health behavior. *Social Science and Medicine*, *34*(8), 907-917.
- Umberson, D., Chen, M. D., House, J. S., Hopkins, K., & Slaten, E. (1996). The effect of social relationships on psychological well-being: Are men and women really so different? *American Sociological Review*, *61*(5), 837-857.
- Umberson, D., & Montez, J. K. (2010). Social relationships and health: A flashpoint for health policy. *Journal of Health and Social Behavior*, *51*(Suppl), S54-S66. doi:10.1177/0022146510383501
- Van Daalen, G., Willemsen, T. M., & Sanders, K. (2006). Reducing work-family conflict through different sources of social support. *Journal of Vocational Behavior*, *69*(3), 462-476.
- Van Jaarsveld, C. H. M., Miles, A., Edwards, R., & Wardle, J. (2006). Marriage and cancer prevention: Does marital status and inviting both spouses together influence colorectal cancer screening participation? *Journal of Medical Screening*, *13*(4), 172-176.
- W. K. Kellogg Foundation. (1998). *Community voices*. Retrieved from <http://www.communityvoices.org>

- Waite, L. J., & Gallagher, M. (2000). *The case for marriage: Why married people are happier, healthier, and better off financially*. New York, NY: Doubleday.
- Walker, R. B., & Luszcz, M. A. (2009). The health and relationship dynamics of late-life couples: A systematic review of the literature. *Ageing and Society, 29*(3), 455-480.
- Wallace, J. P., Raglin, J. S., & Jastremski, C. A. (1995). Twelve month adherence of adults who joined a fitness program with a spouse vs without a spouse. *The Journal of Sports Medicine and Physical Fitness, 35*(3), 206-213.
- Westmaas, J. L., Wild, T. C., & Ferrence, R. (2002). Effects of gender in social control of smoking cessation. *Health Psychology, 21*(4), 368-376.
- Williams, K., & Umberson, D. (2004). Marital status, marital transitions, and health: A gendered life course perspective. *Journal of Health and Social Behavior, 45*(1), 81-98. doi:10.1177/002214650404500106
- Wilson, S. E. (2002). The health capital of families; an investigation of the inter-spousal correlation in health status. *Social Science and Medicine, 55*(7), 1157-1172.
- Wood, R. G., Goesling, B., & Avellar, S. (2007). The effects of marriage on health: A synthesis of recent research evidence (Research Report). Princeton, NJ: Mathematica Policy Research.
- World Health Organization. (2000). What about boys? A literature review on the health and development of adolescent boys. Geneva, Switzerland: WHO.
- World Health Organization. (2013). Life expectancy at birth. Retrieved online on June 28, 2014. Retrieved from <http://apps.who.int/gho/data/view.main.680?lang=en>
- World Health Organization. (2014). Health Impact Assessment. The determinant of health. Retrieved online on February 8, 2014. Retrieved from <http://www.who.int/hia/evidence/doh/en/index.html>
- Zhang, Z., & Hayward, M. D. (2006). Gender, the marital life course, and cardiovascular disease in late midlife. *Journal of Marriage and Family, 68*(3), 639-657. doi:10.1111/j.1741-3737.2006.00280.x

APPENDICES

APPENDIX A  
Discussion Guide



## DISCUSSION GUIDE

- I. Opening Agenda:
  - Welcome Participants
  - Introduction of the Moderator, Note Taker & Assistant
  - Brief Overview of Study and What Participants Can Expect
  - Revisit Requirements for Participation
  - Housekeeping
  - Distribute Letter of Explanation/ Informed Consent
  - Distribute Demographic Questionnaire
  - Reminder that Discussion Will Be Recorded
  
- II. Introductory Question:
  - To allow us to get to know each other a little better, please briefly introduce yourself to the group by telling us your **first** name (again this will not be included in the report), how long have you been married, and what you like most about being married?
    - I will start. My name is \_\_\_\_\_.
  
- III. Transition Question:
  - How do you think you and your wife perceive health differently?
  - How do you think you and your wife react to being ill differently?
  
- IV. Key Questions:
  - Can you give an example of a time when your wife tried to change your health behavior?
  - What strategies does your wife use to get you to change a health behavior? What works best? Can you give an example?
  - If your wife makes unwelcomed suggestions about your health, how do you deal with it?
  - Let's talk about the idea of your Man Card and maintaining your masculinity. A Man Card can be defined as what men do to maintain their masculinity.
  - Show video clip: <http://www.youtube.com/watch?v=KcQmBCM3JMs>
  - How did this man maintain his man card despite his wife's influence on his health?

- Given that many of you today have mentioned your wife tries to influence your health behaviors, how do you then maintain your man card?
- Describe a time when a desire to appear masculine shaped your health behavior, either in a good or bad way.
- Describe a time when a desire not to appear feminine shaped your health behavior, either in a good or bad way.
- Some people say that men avoid going to the doctors or reporting their illness. Is this true for you? Why or why not?
- How does having a family or spouse impact your health behaviors?

V. Ending Questions:

- What could your spouse do differently, if anything, to help you improve your health?
- Summary question: Is there anything else anyone would like to add? Or is there anything you would like to add that may have been missed?

VI. Brief overview:

- Have note taker summarize what has been discussed.
- Allow the men to clarify the summary or to add to it.
- Ask participants to write down anything else they would like to add to our study that was not covered in our discussion.

VII. Conclusion

- Thank the participants for their time and tell them this is the end of the study.
- Pass out Notice of Cash Received form and distribute cash and parking validations.

APPENDIX B  
Informed Consent



Page 1 of 3  
 USU IRB Approved: Aug. 09, 2013  
 Approval Terminates: 08/08/2014  
 Protocol Number: 5266  
 IRB Password Protected Per IRB Administrator

Department of Health, Physical Education & Recreation  
 7000 Old Main Hill  
 Logan UT 84322-7000  
 Telephone: (435) 797-1495

## **INFORMED CONSENT**

### **The Role of Masculinity, Masculine Capital, and Spousal Social Control on Men's Health Behaviors**

**Purpose:** Dr. Julie Gast, Associate Professor, and Melinda Arnell, graduate student in the Department of Health, Physical Education and Recreation at Utah State University are conducting a research study to find out more about marriage and men's health. You have been asked to take part because you are a male who is currently married. There will be approximately 5 to 10 participants in this group. There will be approximately 20 to 40 total participants in this research study.

**Procedures:** If you agree to participate in this research study, you will be asked to attend a group interview that will last approximately two hours. During the interview, you will be asked to comment about different things that have impacted your health. The interview session will be video and audio taped. These tapes will be destroyed two years after data analysis is complete.

**Risks:** Participation in this research study may involve some added risks or discomforts. There are minimal risks to being involved in this study. These risks may include embarrassment concerning sharing information about health behaviors and self-disclosure concerning health habits in a group format. Be aware that we will not identify you in any interview transcripts, research presentations or reports and aliases will be used for all data analyses, presentations, and final reports.

**Benefits:** There may or may not be any direct benefit to you from these procedures. The investigators, however, may gain a greater understanding of marriage and men's health. By gaining a greater understanding of marriage and men's health, more effective programming can be provided to improve men's health.

**Explanation and Offer to Answer Questions:** Eric Nielson has explained this research study to you and answered your questions. If you have other questions or research-related problems, please contact Dr. Gast at (435) 797-1490 or [julie.gast@usu.edu](mailto:julie.gast@usu.edu).



Page 2 of 3  
 USU IRB Approved: Aug. 09, 2013  
 Approval Terminates: 08/08/2014  
 Protocol Number: 5266  
 IRB Password Protected Per IRB Administrator

Department of Health, Physical Education & Recreation  
 7000 Old Main Hill  
 Logan UT 84322-7000  
 Telephone: (435) 797-1495

## INFORMED CONSENT

### The Role of Masculinity, Masculine Capital, and Spousal Social Control on Men's Health Behaviors

**Compensation:** If you choose to participate, you will receive \$20 cash for participation in this study. (*\*Note: The Internal Revenue Service (IRS) has determined that if the amount you get from this study, plus any prior amounts you have received from participating in research studies at USU since January of this year, total \$600 or more, USU must report this income to the federal government. If you are a USU employee, any payment you receive from this study will be included in your regular payroll).*

**Voluntary nature of participation and right to withdrawal without consequences:**

Participation in this research is entirely voluntary. You may refuse to participate or withdraw at any time; however you will forfeit the \$20 cash incentive. You may be withdrawn from this study without your consent by the investigator. If you do not meet the criteria for being included in this study, your participation will be terminated. The researchers will notify you by phone, email, or in person if you are not eligible to participate in the study.

**Confidentiality:** Research records will be kept confidential, consistent with federal and state regulations. The interviews will be video and audio tape recorded in order to observe body language and group dynamics. These data will assist the researchers in writing the final thesis.

The audio and video tapes will be kept for three years on a password-protected computer and/or in a locked cabinet in a locked office to maintain confidentiality. After this time period, they will be destroyed. A list of participant names will also be securely stored during the study to allow for interview scheduling. When all interviews are completed, the list of participant names will be destroyed. To protect your privacy, as well as the privacy of your spouse, your name will not be associated with any other study documents or digital files and will not be included in any study report. Only Dr. Gast, Melinda Arnell, and Eric Nielson will have access to the data.



Page 3 of 3  
 USU IRB Approved: Aug. 09, 2013  
 Approval Terminates: 08/08/2014  
 Protocol Number: 5266  
 IRB Password Protected Per IRB Administrator

Department of Health, Physical Education & Recreation  
 7000 Old Main Hill  
 Logan UT 84322-7000  
 Telephone: (435) 797-1495

**INFORMED CONSENT**  
**The Role of Masculinity, Masculine Capital, and Spousal Social Control  
 on Men's Health Behaviors**

**IRB approval statement:** The Institutional Review Board for the protection of human participants at Utah State University has approved this research study. If you have any questions or concerns about your rights or a research-related injury and would like to contact someone other than the research team, you may contact the IRB Administrator at (435) 797-0567 or email [irb@usu.edu](mailto:irb@usu.edu) to obtain information or to offer input.

**Copy of consent:** You have been given two copies of this Informed Consent. Please sign both copies and keep one copy for your files.

**Investigator statement:** "I certify that the research study has been explained to the individual, by me or my research staff, and that the individual understands the nature and purpose, the possible risks and benefits associated with taking part in this research study. Any questions that have been raised have been answered."

\_\_\_\_\_  
 Julie Gast, Principal Investigator  
 (435) 797-1490  
[julie.gast@usu.edu](mailto:julie.gast@usu.edu)

\_\_\_\_\_  
 Melinda Arnell, Student Researcher  
 (801) 663-3429  
[melinda.hunt@aggiemail.usu.edu](mailto:melinda.hunt@aggiemail.usu.edu)

\_\_\_\_\_  
 Eric Nielson, Graduate Research Assistant  
 (435)890-2977  
[nielson981@gmail.com](mailto:nielson981@gmail.com)

**Signature of Participant** By signing below, I agree to participate.

\_\_\_\_\_  
 Participant's signature

\_\_\_\_\_  
 Date

APPENDIX C

Demographic Questionnaire

Demographic Questionnaire

- 1) Age: \_\_\_\_\_
  
- 2) Occupation: \_\_\_\_\_
  
- 3) Employment Status: (Circle all that apply)
  - a. Currently employed part-time
  - b. Currently employed full-time
  - c. Unemployed
  - d. Retired
  - e. Other: \_\_\_\_\_
  
- 4) Student Status:
  - a. Enrolled in school part-time
  - b. Enrolled in school full-time
  - c. Not enrolled in school
  - d. Other: \_\_\_\_\_
  
- 5) What is the highest level of education you have completed?
  - a. Some high school or less
  - b. High school graduate
  - c. Some college (Associates Degree, Vocational Degree, etc.)
  - d. College graduate (Bachelors Degree)
  - e. Post-college graduate (Masters Degree, PhD)
  
- 6) Race:
  - a. American Indian/Alaska Native
  - b. Asian
  - c. Black or African American
  - d. Native Hawaiian or Other Pacific Islander
  - e. White
  - f. Other: \_\_\_\_\_
  
- 7) Ethnicity:
  - a. Hispanic/Latino
  - b. Not Hispanic/Latino

Continued on back side →



- 8) What religion do you affiliate with?
  - a. Baptist
  - b. Catholic
  - c. Episcopal
  - d. The Church of Jesus Christ of Latter-day Saints (LDS)
  - e. Presbyterian
  - f. Jewish
  - g. Other: \_\_\_\_\_
  - h. No religious affiliation.
  
- 9) Have you been married previously?
  - a. Yes
  - b. No
  
- 10) How many times have you been married? \_\_\_\_\_
  
- 11) Does your current wife work for an income either inside or outside the home?
  - a. Yes
  - b. No
  - c. Not Applicable
  
- 12) What is the highest level of education your current wife has completed?
  - a. Some high school or less
  - b. High school graduate
  - c. Some college (Associates Degree, Vocational Degree, etc)
  - d. College graduate (Bachelors Degree)
  - e. Post-college graduate (Masters Degree, PhD)
  - f. Not Applicable

APPENDIX D

Notice of Cash Received



Department of Health, Physical Education & Recreation  
 7000 Old Main Hill  
 Logan UT 84322-7000  
 Telephone: (435) 797-1495

**The Role of Masculinity, Masculine Capital, and Spousal Social Control  
 on Men's Health Behaviors**

\_\_\_\_\_ I have received \$20 cash as an incentive for participating in the research study,  
 Initial The Role of Masculinity, Masculine Capital, and Spousal Social Control on  
 Men's Health Behaviors.

\_\_\_\_\_ I have received \_\_\_\_\_ parking token(s) for participating in the research study, The  
 Initial Role of Masculinity, Masculine Capital, and Spousal Social Control on Men's  
 Health Behaviors.

\_\_\_\_\_  
 Print Name

\_\_\_\_\_  
 Sign Name

\_\_\_\_\_  
 Date

APPENDIX E  
Opening Statement

## OPENING STATEMENT

Thank you for coming today to aid us in our study on marriage and men's health. Today we are going to be discussing a topic that concerns you all; health, and how it is influenced by marriage. Because of the topic, only those who are currently married may participate in this study. If you are not currently married, I will now invite you to leave.

This discussion will be video and tape recorded to allow for the discussions to be referred back to when writing the report. If anyone is uncomfortable with this, of course you are free to leave. To maintain confidentiality, the report will not mention any of your names. To assist in maintaining each other's confidentiality, please do not share the information provided by others outside of this focus group.

Before we begin our discussion, I have a few requests. Please turn off all cell phones to help limit distractions. During our discussion, please try to speak clearly and loud enough so that you can be heard. Please be considerate of each other and let one person speak at a time. I will try to make sure that everyone gets a turn to speak. Finally, please say exactly what you think. Don't worry about what I think or what your neighbor thinks, but only share what you are comfortable sharing. We are here to exchange thoughts and opinions and have an enjoyable time doing it. Negative comments are as helpful as positive ones.

I hope that the discussion that takes place will be beneficial to all of you. Relax and enjoy yourselves.

APPENDIX F

Table of Research Theme Summaries

## Table of Research Theme Summaries

<p><u>Theme 1: Wives' use of social control to influence their husband's health behaviors</u></p> <ul style="list-style-type: none"> <li>- How wife has changed or has tried to change husband's health behaviors <ul style="list-style-type: none"> <li>a. Diet</li> <li>b. Physical activity</li> </ul> </li> <li>- Social control strategies wives use to change husband's health behaviors <ul style="list-style-type: none"> <li>a. Spousal support <ul style="list-style-type: none"> <li>- Encouragement</li> <li>- Team effort</li> </ul> </li> <li>a. Spousal control <ul style="list-style-type: none"> <li>- Guilt</li> <li>- Repetition/persistence</li> <li>- Coercion</li> </ul> </li> </ul> </li> <li>- Husband's want encouragement and support to make healthy changes</li> <li>- How wives react when husband is ill <ul style="list-style-type: none"> <li>a. Wife as nurturing and encouraging husband to seek medical attention</li> </ul> </li> </ul>
<p><u>Theme 2: How men combat their wives social control strategies</u></p> <ul style="list-style-type: none"> <li>- Procrastination</li> <li>- Encouraging wife to make changes with them</li> <li>- Sincerely trying to implement wives' suggestions</li> </ul>
<p><u>Theme 3: Men's perception of 'Man Card'</u></p> <ul style="list-style-type: none"> <li>- Trading your man card in for an adult card</li> <li>- I don't care about my man card <ul style="list-style-type: none"> <li>a. Now that I'm married, I don't have to worry about appearing feminine</li> <li>b. Happy wife, happy life</li> <li>c. I don't care what other people think</li> </ul> </li> <li>- How to lose your man card <ul style="list-style-type: none"> <li>a. Engaging in non-masculine behaviors <ul style="list-style-type: none"> <li>- Food choices</li> <li>- Exercise routine</li> <li>- Employment</li> </ul> </li> <li>b. Showing weakness</li> <li>c. Not being able to provide for family</li> <li>d. Peer pressure</li> </ul> </li> <li>- Maintain masculinity to be perceived as sexually attractive</li> <li>- Universal man card expectations</li> </ul>
<p><u>Theme 4: Masculine Capital</u></p> <ul style="list-style-type: none"> <li>- Men justify their healthy behaviors because they ultimately help them provide for their families</li> <li>- Men utilize masculine capital to compensate for engaging in non-masculine behavior</li> </ul>

<p><u>Theme 5: How men react to being ill</u></p> <ul style="list-style-type: none"> <li>- I don't get sick</li> <li>- Real men tough it out</li> <li>- When I do get sick, sleep is the best remedy</li> <li>- I don't see doctors</li> <li>- You can take me to the doctor when I pass out</li> </ul>
<p><u>Theme 6: Factors that influence men's health care use</u></p> <ul style="list-style-type: none"> <li>- Upbringing and Family History</li> <li>- Finances</li> </ul>
<p><u>Theme 7: How men's feelings of responsibility to their family impact their health behaviors</u></p> <ul style="list-style-type: none"> <li>- Healthier behaviors to be able to provide for family</li> <li>- Risk aversion</li> <li>- Change in perspective</li> <li>- Seeking medical attention/illness <ul style="list-style-type: none"> <li>a. Finances</li> </ul> </li> </ul>
<p><u>Theme 8: How marriage encourages men to engage in positive health behaviors</u></p> <ul style="list-style-type: none"> <li>- Selflessness</li> <li>- Increased Spirituality</li> <li>- Mental/emotional well-being</li> <li>- Diet</li> </ul>
<p><u>Theme 9: How marriage discourages men to engage positive health behaviors</u></p> <ul style="list-style-type: none"> <li>- Loss of routine/time</li> <li>- Physical Activity</li> <li>- Diet</li> <li>- Mental/emotional well-being</li> </ul>



APPENDIX G

Table of Research Model Summaries

Table of Research Model Summaries

<p><u>Family Relationships</u></p> <ul style="list-style-type: none"> <li>- Risk averse</li> <li>- Selfless lifestyle</li> <li>- Motivation to become healthier</li> <li>- Motivation/strain to become a better provider</li> </ul>
<p><u>Spousal Social Control</u></p> <ul style="list-style-type: none"> <li>- Wives influence their husband's health behaviors <ul style="list-style-type: none"> <li>a. Wife as motivator to seek medical attention</li> <li>b. Wife as influencer of diet</li> <li>c. Wife as contributor of mental stability/support</li> </ul> </li> <li>- Spousal social control and support strategies <ul style="list-style-type: none"> <li>a. Spousal control</li> <li>b. Spousal support</li> </ul> </li> <li>- How husbands perceive social control strategies influencing them <ul style="list-style-type: none"> <li>a. Husbands wish for wives to make concordant healthy changes</li> </ul> </li> </ul>
<p><u>Masculinity</u></p> <ul style="list-style-type: none"> <li>- Peer pressure</li> <li>- Impressing women</li> <li>- Factors that influence men's health care use <ul style="list-style-type: none"> <li>a. Tough it out</li> <li>b. Family history</li> <li>c. Finances</li> <li>d. Role of provider</li> <li>e. Barriers to seeking medical care</li> </ul> </li> <li>- How men react to being ill <ul style="list-style-type: none"> <li>a. Tough it out</li> <li>b. If it's severe, I'll go</li> <li>c. I'll go if it impedes my ability to provide</li> </ul> </li> </ul>
<p><u>Masculine Capital</u></p> <ul style="list-style-type: none"> <li>- Now that I'm married I don't care about appearing masculine</li> <li>- I'm more concerned about having a happy family relationship than being masculine</li> <li>- Masculine gender scripts</li> </ul>
<p><u>Health Behaviors</u></p> <ul style="list-style-type: none"> <li>- Eating Habits</li> <li>- Physical Activity</li> <li>- Mental Health</li> </ul>

Physical Health/Mortality

- Marriage may enhance diet and lead to greater physical health and longer mortality
- Marriage may inhibit a healthy diet and hinder physical health and mortality
- Marriage and parenthood may limit physical activity and inhibit physical health and mortality
- Social control and support may enhance health behaviors and lead to greater physical health and longer mortality
- Marriage may improve men's spiritual well-being and improve men's physical health and mortality