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"She Looks out for the Meals, Period": African American Men's Perceptions of How Their Wives Influence Their Eating Behavior and Dietary Health

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Objective: Women play a critical role in men's dietary health, but how men think about the nature and mechanisms of their wives' influence on their eating behavior is not well understood. This study examined how African American men described the roles their wives played in shaping their eating behavior. ***Methods:*** Thematic content analysis was used to analyze data from nine exploratory focus groups conducted with a convenience sample of 83 African American men who were middle aged or older and lived in southeast Michigan. ***Results:*** Men perceived having more freedom to choose what they ate while eating out, even when accompanied by their wives, compared with at home. The men indicated their wives influenced what they ate at home more than their own preferences. They described traditional gendered food roles at home and were satisfied that their wives played a dominant role in household food preparation and decision making. Men had mixed feelings about wives' efforts to prepare healthier meals. While they appreciated that their wives cared about their health, the men felt they were rarely consulted on how meals could be healthier and often disliked the healthy changes their wives made. The men prioritized keeping their wives happy, preserving spousal division of roles, and maintaining marital harmony over participating in food decision making or expressing their personal food preferences. ***Conclusions:*** Interventions to improve married African American men's eating behaviors need to explicitly consider that men may prioritize marital harmony and the preservation of spousal food roles over their tastes, preferences, and desired food decision making roles.

Keywords: African American men, gender roles, spouses, men's health, nutrition

Gender-specific differences in eating behavior and dietary health[1] are well documented and highlight the importance of gender as a determinant of health behavior (Millen et al., 2005). Both men and women have been complicit with traditional gendered food roles in which men are less involved in food purchasing and preparation and less focused on dietary health than the women in their lives, particularly their wives (DeVault, 1994). Compared with women, men are generally less interested and knowledgeable about nutrition and less concerned with the negative health implications of unhealthy eating (Kiefer, Rathmanner, & Kunze, 2005; Mróz, Chapman, Oliffe, & Bottorff, 2011). Men tend to have a more pleasure-oriented approach to eating, and they have been described as often eating for convenience, especially outside of the home (Kiefer et al., 2005; Mróz et al., 2011). Men tend to have patterns of consumption that are framed as masculine, such as consuming large, calorie-dense meals that include more red meat, eggs, alcohol, and foods high in sucrose than women (Mróz et al., 2011; O'Doherty Jensen & Holm, 1999; Roos, 1998). These practices have contributed to increasing rates of morbidity and mortality for chronic diseases associated with unhealthy eating among men, and especially among African American men (Ervin, 2008; Warner & Hayward, 2006).

Marriage and Men's Health

Numerous studies have documented associations between marital status and health and health behaviors such as healthy eating (Kiecolt & Glaser, 2001). Several, but not all, researchers (Davis, Murphy, Neuhaus, Gee, & Szkupinski Quiroga, 2000; Kremmer, Anderson, & Marshall, 1998) have found that married men had healthier diets than unmarried men. Homish and Leonard (2008) conducted a study with married dyads, a third of which were African American, and found that wives influenced their hus-

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[1] Dietary health refers to nutrient intake and eating practices that reduce the risk and severity of many chronic diseases and increase quality of life and longevity.

bands' diets positively or negatively depending on how healthy the wives' own eating practices were.

Wives often assume responsibility for their husbands' health, including promoting healthy eating (Markey, Gomel, & Markey, 2008; Umberson, 1992). Women's active engagement in addressing their husbands' health is often heightened when men are diagnosed with chronic health issues (Berg & Upchurch, 2007). Wives' efforts to protect and improve their husbands' health have been described as expressions of nurturing and caring (Charles & Kerr, 1988; DeVault, 1994). Men often appreciate and expect their wives' involvement in managing their health (Rook, August, Stephens, & Franks, 2011).

Wives attempt to influence their husbands' health behaviors in a myriad of ways with varied levels of success (Helgeson, Novak, Lepore, & Eton, 2004; Kelsey, Earp, & Kirkley, 1997; Lewis, Butterfield, Darbes, & Johnston-Brooks, 2004; Umberson, 1992). In exploratory research by Lewis and colleagues (2004), focus group participants described more than 30 distinct strategies they used to improve their spouses' health behaviors, ranging from providing social support and education to reasoning, nagging, modeling, and changing the home environment. A follow-up study (Lewis et al., 2004) exploring these strategies found that husbands' perceptions of their wives' efforts to influence their health behaviors were not associated with men's behavior change, though wives' reports of their efforts to influence their husbands' health behaviors were. Thus, each partners' perceptions of wives' efforts and effectiveness at influencing men's health behaviors greatly differed.

Interdependence Theory (Kelley & Thibaut, 1978; Lewis, DeVellis, & Sleath, 2002; Rusbult & Van Lange, 2003) highlights how dyadic relationships, such as marriage, can affect behaviors and outcomes. It proposes that individuals' health behaviors and outcomes are affected by a combination of three factors: their own characteristics; their partners' motivations, preferences, behaviors, and health outcomes; and the joint and interactive nature of their interdependent relationship. Individuals' decisions about health behaviors, whether well thought out or involving little conscious reflection, are influenced by their consideration of how their choices may affect their partners and their relationships (Lewis, McBride, Pollak, Puleo, Butterfield, & Emmons, 2006). Sometimes prorelationship objectives, such as maintaining marital harmony, supersede personal preferences, which is referred to as a transformation of motivation (Lewis et al., 2006). This theoretical model is particularly relevant for examining how wives influence their husbands' eating behaviors because of the interdependent nature of their lives; gendered social norms surrounding food provision and men's health, and wives' roles in these domains; and the close, personal nature of marital relationships (Kelley et al., 1983). Research applying this model to understand how wives influence men's health behaviors, particularly eating behaviors, is limited and lacks attention to how men, particularly African American men, perceive the influence of their wives on their eating practices.

Although African American men are more likely to engage in cooking and other household tasks than White men (Bove & Sobal, 2006; Haynes, 2000; Sobal, 2005), "foodwork" is still largely performed by and considered within the domain of women in African American households (Haynes, 2000). Food preparation, selection, and consumption can reflect and illuminate broader social, cultural, and economic influences, as well as how these dynamics play out within a family (Semmes, 1996). In African American families, a home-cooked meal made by a wife and consumed by her husband has been described as a symbolic expression of love and caring, and acts as confirmation of both their gender identities (James, 2004). These shared eating experiences provide opportunities to reaffirm gender dynamics and couples' interdependence (Kelley & Thibaut, 1978; Rusbult & Van Lange, 2003). In African American households, this gendered division of roles has been associated with greater marital satisfaction and stability (Haynes, 2000; Tucker & Mitchell-Kernan, 1995).

Current Study

Gendered social norms and practices surrounding marital division of food responsibilities suggest that wives may have considerable influence on their husbands' eating behaviors, particularly at home. Researchers have consistently shown that wives affect their husbands' eating behavior, but few studies have examined the nature and mechanisms of wives' influence on men's eating behaviors, particularly from men's perspectives. According to Interdependence Theory, married men must negotiate between prorelationship objectives and their potentially conflicting personal tastes, food preferences, and desired decision making roles in eating behavior. In this exploratory study, we examined how middle-aged and older African American men described the roles their wives played in shaping their eating practices and dietary health.

Method

Setting

This study took place in three U.S. cities: Detroit, Flint, and Ypsilanti, which are the first, fourth, and fifth largest metropolitan statistical areas in Michigan, respectively (U.S. Census Bureau, 2009). All three cities have a high percentage of African American residents, whereas the surrounding areas are predominantly white (U. S. Census Bureau, 2009). They rank below the state and the country on most socioeconomic indicators (U.S. Census Bureau, 2009; U.S. Department of Labor, 2011). African American men in these cities experience elevated rates of health problems associated with poor diet such as heart disease, stroke, diabetes mellitus, and certain cancers, when compared with women and men of other ethnic groups living in the same counties, and when compared with state and national averages (Hoyert, Arias, Smith, Murphy, & Kochanek, 2001; Michigan Department of Community Health, 2008, 2010).

Participants

African American men, ages 35 and older, living in the Flint, Ypsilanti, and Detroit metropolitan areas of southeast Michigan were recruited to participate in this study. They were recruited by snowball sampling via word-of-mouth, fliers, and the social networks of outreach staff and partner organizations of a university-based research center on men's health. The outreach staff is composed of African American men who live in the cities of

interest; they have experience and reputations of being activity involved in addressing men's health in their communities. The outreach staff strategically attended events and contacted organizations, groups, and informal social networks serving the population of interest to raise awareness about the study and recruit a diverse sample of men that met our eligibility criteria to participate in the study. Participants received a meal and $20 in incentives for participating in a focus group.

Between July 2008 and February 2010, 83 African American men participated in nine focus groups on healthy eating: two groups with a total of 26 men from Detroit; five groups with 32 men from Flint; and two groups with 25 men from Ypsilanti (see Table 1 for participant characteristics). Though the participants ranged in age from 32 to 82, three quarters (75.6%) were in their 50s and 60s.

Study Design

We conducted exploratory focus groups with middle-aged and older African American men and important women in their lives to examine the social, cultural, and environmental barriers and facilitators to African American men's healthy eating and physical activity as part of the development of a *Men 4 Health* (*M4H*) intervention (Griffith, Gunter, & Allen, 2011b). This study is based on data derived from a subset of the focus groups that were conducted with men and explored eating behaviors and attitudes.

The focus groups were designed to have a relaxed, casual atmosphere to facilitate open discourse and mutually beneficial interactions among the participants and between participants and the facilitators. The groups lasted two hours and included a meal, written informed consent, a demographic survey, and an audio taped, in-depth discussion. The guided, semistructured focus group discussion included four broad questions: Why do you think African American men do not eat more fresh fruits and vegetables? What influences what African American men age 35 and older eat? What influences what you eat? How does stress affect eating for African American men in your age group? Extensive probing was used to gather more information on eating patterns; barriers and facilitators of healthy eating; food decision making; the influences of gender and ethnicity on eating behavior; and perceptions and attitudes influencing eating practices. Facilitation was designed to keep the discussion on topic while allowing the participants to pursue avenues they found particularly salient. The focus group study, protocols, and forms were reviewed by the University of Michigan Institutional Review Board. An African American male focus group facilitator led the groups and was assisted by an African American male cofacilitator who took field notes to document group dynamics and track comments of individual speakers. We asked participants to keep everything discussed during the focus group confidential, while acknowledging that this could not be guaranteed. Each participant was assigned a unique identifier to ensure anonymity.

Table 1
Selected Characteristics of Participants

Characteristic	Participants (n = 83)
Demographics	
African American men	100%
Average age (years)	56.7
Married	62.5%
Have a girlfriend, not married	18.8%
Children 18 years old and under in the home	29.9%
Very or somewhat difficult to pay bills	52.5%
College graduates	22.9%
Discussed wives/girlfriends during focus group (n = 51)	61.4%
Health	
Self as primary grocery shopper	33.3%
Wife/girlfriend as primary grocery shopper	45.3%
Eat 5+ servings of fruit/vegetables daily	15.2%
Obese (BMI $\geq$ 30)	29.6%
Have a chronic health condition with dietary implications (cardiovascular/heart disease, cancer, diabetes, high cholesterol, hypertension)	56.9%

Data Analysis

The systematic data organization and analysis processes we used were similar to the methods used by Allen and colleagues (2008) and Griffith and colleagues (Griffith et al., 2007; 2008; Griffith, Allen, & Gunter, 2011; Griffith, Ellis, & Allen, 2012; Griffith, Gunter, & Allen, 2011a). The focus group interviews were audio-taped, transcribed verbatim, and entered into the qualitative data software package, ATLAS.ti. Each focus group transcript was chunked into segments of text that represented distinct concepts that conveyed their original meanings apart from the complete transcript. Each segment of text was linked to the unique identifier of the speaker, the geographic location and date of the focus group, the interview guide question, and any other stimuli (prompts, comments of other participants) that appeared to influence the individual's statement. Several research assistants and the authors reviewed a random selection of approximately half the transcripts to inductively ascertain recurring patterns and topics that emerged from the transcripts and collectively identified an initial set of codes. Phenomenological, rather than thematic, codes were chosen to enhance the ease and reliability of the assignment of codes to the text segments. During the process of testing the utility of the codes and training the coding team, some codes were collapsed or divided for clarity and a few concepts that had not previously been identified were added. This process yielded a codebook of 54 codes, which was used by a team of six student research assistants to code the text segments in the focus group transcripts.

During the iterative process of reviewing the data coded with the Spouse code, which was one of the most frequently assigned codes, compelling themes emerged related to how the men described the ways their wives and girlfriends influenced how and what they ate. Spouse was a broad code used to identify and capture all mention of spouses and girlfriends in the focus groups, regardless of content. Because of the breadth and comprehensiveness of text segments captured with this code, examining text assigned this code was appropriate and adequate for a thorough analysis of how men discussed issues associated with their spouses and girlfriends. Throughout the remainder of this article, we use the term "wives" to refer to spouses and girlfriends for simplicity. Four fifths (81.3%) of the men were married or had a girlfriend (see Table 1), and nearly half (45.5%) of those with a girlfriend lived with their partner.

We reviewed all the Spouse text segments to identify themes within each segment, using a combination of short restatements of the data and direct quotes. Comparison analysis was used to ensure consistent interpretation of the statements. We then documented potential questions, underlying themes, and possible implications of the data for further analysis. We also documented the frequency of focus groups and men who discussed each topic to ensure broad representation. We then developed an outline of the prominent themes within the data and organized the text segments into a comprehensive document according to this outline.

For the purpose of this article, we focused on the men's narratives about their wives' influence on their eating practices, which represented 88% of the text segments assigned the Spouse code. We excluded from this analysis the small number of text segments that were unrelated to food or eating, focused on the wives' eating practices, or were too vague to interpret. Although wives were discussed in all of the focus groups, fewer Detroit focus group participants talked about their wives compared to the Flint and Ypsilanti participants, which is consistent with the smaller proportion of Detroit participants reporting being married or in a heterosexual relationship (68.0% compared with 90.0% and 82.6% of the Flint and Ypsilanti participants, respectively). The themes within the Spouse data were consistent across the three cities, so we did not include geographic comparisons. In total, 61.4% of the men (n = 51) discussed Spouses. Only four text segments were gathered from single men related to wives' influences on men's eating behaviors, and these included descriptions of how men's former wives influenced them during their marriages and one man's observations of food norms and behaviors among his male friends and their wives. Quotes presented were selected to reflect the diversity of perspectives and opinions that emerged from the data as well as examples to the contrary where applicable.

We conducted two member checking groups (Creswell, 1998) with men from our population of interest to ensure that the research team's interpretations of the data were congruent with the experiences and perceptions of members of our sample population. These groups helped to refine our interpretation of the data and confirmed the congruence of our analysis with men from our population of interest.

Results

The narratives from the men in our study showed that the relationships between men, their wives, and the men's eating behavior and dietary health were complex and multifaceted. The men primarily discussed dinner; other meals and snacks were discussed infrequently (Griffith, Wooley, & Allen, in press). Four major themes emerged from our analysis of how men discussed the role of their wives in their eating behaviors and dietary health: (1) men's gendered notions about household food preparation and decision making shaped their eating behaviors; (2) wives had considerable influence on what men ate at home, especially healthy foods; (3) the men avoided expressing dissatisfaction with food their wives provided to maintain marital harmony; and (4) men were more likely to participate in food decision making that was short-term, made for the benefit of others, or that occurred outside of the home. Table 2 indicates the number of men who discussed each theme.

Table 2
Number of Men Discussing Each Subtheme (n = 51)

Theme and subtheme	Frequency[a]
Marital food roles	
Food preparation and decision making within wives' domain	17
Satisfied with wives' dominant role in food provision	10
Men could cook, but did not often	5
Some men cooked, but differently than women	10
Wives influenced what men ate even when wives did not cook	15
Wives influence men's eating and dietary health	
Wives a major influence on what men ate at home, often more than men's preferences	24
Wives managed men's diets	13
Healthy food as wives' caretaking	6
Wives improved healthiness of household food environment	11
Men prioritize the marital relationship over food satisfaction	
Mixed feelings about wives' efforts to improve their diet	6
Wives made healthy changes to men's diet, usually without men's input	7
Men did not express dissatisfaction, did not want to disrupt marital harmony	6
Men engage in some food decisions	
Men made decisions about meals	3
Occasional food requests to fulfill cravings	4
Openly discussed food decisions between husband and wife	2
Freedom to choose preferred foods outside the home, even when with wife	2

[a] Columns do not total as many men discussed several themes.

Marital Food Roles

According to the men in our study, food preparation and decision making, particularly for evening meals, were primarily within their wives' domain. The men were careful to respect and maintain this division of roles. The men talked about cooking as a household task generally fulfilled by, and the responsibility of, women in their lives—their mothers during childhood and their wives in their adult lives. One man succinctly stated that his wife "looks out for the meals, period." The men's wives did most of the household's cooking, and most prepared home-cooked dinners several nights a week. In a number of cases, wives were employed outside the home yet continued to prepare dinner for the couple or family.

Several of the men described themselves as lucky and happy that their wives cooked; they were content that their wives were responsible for food preparation. Some men added that their wives were excellent cooks, and they looked forward to the meals their wives prepared. Many of the men expressed relief that they did not have to cook. Some of the men described themselves as too lazy to cook. More explained they were busy with work demands. One man stated, "Most of us men, we don't sit down and have time to cook. We're working."

Several of the men stated that they, and other middle-aged and older African American men they knew, *could* cook, but they reported that men did not cook often. One man explained that he did not want to interfere with his wife's dinner plans, "She [my wife] goes out and works now . . .. I don't want to mess with it

[dinner] because she might do it a different way. Because when I do something, she's going to say, 'Well, why did you do that? That ain't what I wanted to do.'" Focus group participants described social norms dictating that men should only engage in regular food preparation in specific circumstances: when they had children in the home or were employed part time or unemployed. None of the men, however, acknowledged that they had ever cooked for either of these reasons or provided examples of men they knew who cooked for these reasons.

A small number of the men indicated that they cooked regularly in their households; several explained this was a new activity they had recently adopted, often since retiring. When men cooked, what they cooked was characterized differently than what women cooked. It was more normative for men to prepare breakfast, rather than dinner. Men also were described as cooking "whatever they want," rather than catering to the needs and preferences of their entire family. Men focused on meat and typically did not describe preparing a "complete meal" including side dishes.

Even when wives did not cook, they indirectly played a large role in determining what (or whether) men ate. In the majority of instances when focus group men described going out to eat with their spouses, they said that their wives were the ones who suggested it. A lot of the men explained that when their wives did not cook, they typically grabbed something fast and quick, went to eat at a restaurant or fast food place, or skipped meals altogether. Few described assuming cooking responsibilities themselves—even those who were unhappy with the alternatives. One man amused the members of his focus group as he conveyed how dependent his eating practices were on his wife:

> I don't cook. So when me and the wife have a falling out, my whole eating changes. (laughter). Because I'm reduced to figuring out what am I going to eat. I'm very stressed at that moment. I go to what I know—snacks and everything else—whatever I don't have to cook. (laughter). I'm on my way out, going to anything outside. (laughter). And I'm just filling myself up. I go into a buffet because I can sit there and just eat myself away. (laughter). Because I know I'm going home, and there ain't nothing at home. So, I'm just gonna go stuff myself.

Wives Influence Men's Eating and Dietary Health

The focus group men described wives as the most important influence on what they and other middle-aged and older African American men ate. With few exceptions, the men described their wives as dominating what they ate at home even more than their own preferences and desires. A commonly expressed sentiment was that the men had limited or no influence over what they ate. A 36-year-old indicated, "All my life, I've been influenced by either my mother or my wife as far as food choices. I really didn't have any choice other than what she put in front of me at the table." Another man explained that his wife decided to change how both of them ate 40 years ago: "When we first got married at 21 and 20, my wife decided that we weren't going to eat like our parents. She made that decision for me. I didn't think about it . . .. She made the decision that we're not going to do this, and I didn't argue with her." Many of the men provided examples of how their diets had changed because of their wives' influence, including both healthy and unhealthy changes.

A prominent theme in the focus groups was the role of wives in managing their husbands' diets to maintain or improve the men's health. Wives were identified as more health- and nutrition-conscious than their husbands. One man explained, "The main person I think who influences me is my wife. She really is involved in everything healthy." Later he added, "I think that's one of my major problems—not really focusing on what you need to do for your body, what you need to eat, and how you need to eat it. My wife has a big understanding of it . . .. I ain't thinking about the healthy side of it." Several of the men described their wives as interested in healthy eating and actively seeking ways to adjust their recipes and cooking techniques to be healthier.

Some men characterized their wives' efforts to prepare healthy food as a form of caretaking and explained that this was one way in which their wives "helped" and "looked after" them. A 65-year-old man discussed the important role wives played in promoting their husbands' health, "Those of us, especially those over 50, our spouses or significant others are normally those who keep us in line in regards to our diet." Several of the men noticed that their wives seemed to have increased their focus on nutrition and healthy eating within the past few years and often after the men had been diagnosed with a medical problem. One man with several chronic health problems with dietary implications said, "My wife has really been a big influence on my eating habits since we have been married. Because of my health problems, she tries to cook the right meals and things like that."

Many wives were described as making changes to the household food environment to improve the quality of their husbands' diets. These changes included altering what foods were available at home, the amount of produce included in meals, and the ingredients or cooking techniques used for familiar dishes. Men described how their wives purchased mostly healthy foods from the market and avoided having unhealthy snacks in the house. Men stated that they ate certain healthy foods only because their spouses included them in meals they prepared. Others commented that they probably would not eat nearly as much fruit, vegetables, and lean proteins if it was not for their wives. According to one man, "I eat a lot of fruits and vegetables, and the only reason is my wife buys them and cooks them. If I'm cooking for myself or shopping for myself . . . I won't do the right thing." The men seemed particularly engaged in discussions about how their wives were substituting ingredients in dishes they prepared (e.g., turkey instead of beef), preparing food in different ways (no more deep frying), and reducing salt use to make their husbands' diets healthier.

Men Prioritize the Marital Relationship Over Food Satisfaction

Most of the men acknowledged that eating healthier was beneficial and something they should do. The majority of the accounts, however, illustrated that the men disliked the changes that eating healthier entailed. The men also had mixed feelings about their wives' role in facilitating their consumption of healthier foods. A man with several chronic health issues shared:

> My wife, she's a great influence on me eating healthier because she's always on my case about something . . . you know, I'm eating wrong . . .. But she's probably the best influence, living with me, and she buys the kind of foods that I'm supposed to eat. I don't like it, but I try to compromise as much as I can.

Nearly all the men whose wives had begun cooking healthier foods at home described these changes as ones their wives initiated

without consulting them or gaining their input or buy-in. In fact, only a few men reported that their wives actively tried to work with them on improving the health of their diet and eating behaviors. A number of men described being nagged by their wives. An equal if not larger number reported that they and their wives had never openly communicated about the changes their wives were making to the foods they provided to their husbands.

Rather than engaging in open dialogue with their wives about conflicting food values and preferences, the men rarely voiced their dissatisfaction. They explained that they did not want to upset the harmony or division of roles and responsibilities in their relationship. The men did not want to cause conflict, displease their wives, or indicate a lack of appreciation for their wives' cooking. One man explained that he did not enjoy the healthier way his wife was preparing food, but "I'm not going to fuss at her about it. I might not want the taste, but I'm a person that will eat it and not say anything." Another man indicated, "I wanted to do what's right and satisfy her." Overwhelmingly, the men described themselves as eating the food their wives provided, whether they liked it or not and whether it was healthy for them or not. Most of the comments in which men reported remaining silent about their dissatisfaction with their wives' food were about healthy foods. There were also a few instances in which men explained that they ate what their wives made even though the food was unhealthy, went against their dietary prescriptions, or could exacerbate their health problems.

Men Engage in Some Food Decisions

A small number of men in our focus groups talked about independently making decisions about what they ate at home that affected their interactions with their wives. One man saw a TV show that convinced him he should stop eating beef. He said to his wife, "honey, I'm *thinking* to stop eating that [italics added]." Only one man reported getting into arguments with his spouse about what he ought to be eating. This man continued to eat unhealthy and in excess, even though he had health issues caused and exacerbated by poor diet and knew it upset his wife.

More common were examples in which men occasionally expressed their food preferences to their wives to fulfill cravings rather than to advocate for long-term changes. Periodically, the men asked their wives to prepare a meal with a particular, usually unhealthy, ingredient or cooking technique. One 55-year-old man provided the following account, "Every once in a while, I have to tell [my wife], 'look, you got to put some ground chuck in this spaghetti this time, because we had enough with this turkey business.' It tastes good, but sometimes you just have to go back to that type of cooking."

The men only provided two examples in which they made openly discussed, collaborative decisions with their wives about dietary changes. Neither decision was motivated by the men's health or food preferences. For both couples, the desire to model healthy eating practices for children and grandchildren in the home prompted them to talk about their current eating habits and what changes they wanted to make to be better examples for the children.

Although wives were often described as the ones who decided when the couple would eat outside the home, the men's narratives indicated that they perceived themselves to have more input on what they ate when they were out. This was often true even when the men were eating out with their wives. In contrast to the care with which the men avoided impinging upon their wives' decisions about food at home, similar negotiations and tension were not voiced in discussions about eating outside the home. Several men characterized eating at restaurants, especially buffets, as a splurge or treat. These venues were viewed as places where they could eat different foods and quantities than when at home.

Discussion

This study presents middle-aged and older, urban African American men's perceptions of how their relationships with their wives influenced their eating behavior. According to the men in our study, wives played a dominant role in household food provision and decision making, and the men were satisfied with their wives' assumption of these responsibilities. The men overwhelmingly agreed that their wives influenced what they ate more than their own preferences. Wives were generally described as a healthy influence, altering foods available in the home, recipes, and cooking techniques to improve the health of their husbands' eating behaviors. Wives, however, rarely consulted their husbands or involved them in decisions on how to provide them with healthier foods. Though they often disliked the changes eating healthier entailed, men avoided expressing their dissatisfaction to maintain harmony in their marital relationships and roles. When the men did express themselves, it was to occasionally satisfy cravings for unhealthy foods, rather than to make sustained dietary changes. Outside the home and when wives elected not to cook, men assumed more control over what they ate and typically chose less healthy foods because they were focused on convenience and pleasure rather than health. The few dietary changes openly discussed between men and their wives were motivated by the couples' concerns about the wellbeing of others and not the men's health or food preferences.

Our findings on the prominent roles of wives in managing household food provision and men's health are consistent with previous research on gendered roles and expectations that are common among African American couples (Haynes, 2000; Tucker & Mitchell-Kernan, 1995). Avoiding involvement in household foodwork and attending to one's own health may be ways in which men simultaneously sought to fulfill norms and expectations of masculinity while reinforcing the interdependent, gendered division of roles and responsibilities within their marriages (Courtenay, 2000). Although many men reported eating healthy foods at home, few were on board with the healthier changes their wives were making, and most selected unhealthy options when their wives did not cook. A sizable portion of our focus group men had been diagnosed with chronic diseases associated with poor diet, yet few expressed much support for how their wives' sought to improve the health of their eating behaviors. Samples of men, including African American men, have been found to consider healthy eating unnecessary until the onset of health problems, if at all (Gough & Conner, 2006; James, 2004). James (2004) found that African American men with health problems were concerned about their health but equated getting healthy with exercising, and not with improving their diets. Even after receiving serious medical diagnoses, men involved in dietary interventions are unlikely

to adopt and maintain healthy dietary modifications (Mróz et al., 2011).

Wives fulfilled the dual roles of family caretaking and preparing most household meals, which inevitably shaped what their husbands' ate because of the interdependence of their lives on multiple levels (Kelley & Thibaut, 1978; Kelley et al., 1983). The men in this study appeared to be more influenced by a desire to keep their wives happy and their relationships in harmony, rather than to assert their individual food preferences or protect their own health. This illustration of prorelationship motivation shows the utility of Interdependence Theory for understanding how interpersonal relationships, such as marriage, can affect health behaviors (Kelley & Thibaut, 1978; Kelley et al., 1983; Lewis et al., 2006). Our findings indicate that eating at home, particularly given the deep-seated gendered norms around foodwork and marital division of roles, is clearly a domain in which the men in our study considered the broader ramifications of their decisions about eating behavior on the quality and functioning of their marital relationships. When wives were not responsible for food provision, such as outside the home, men did not express this same level of apprehension about upsetting their wives and relationship and ate what they liked. The men's concern that expressing dissatisfaction with food their wives provided could lead to conflict is not unwarranted. The men in this study may have been keenly aware that disrupting the division of responsibilities and asserting their own food preferences could challenge gender identities, upset marital harmony, and deter their wives from continuing to cook for them. Marital conflict and imbalance also may yield stress (Kiecolt-Glaser & Newton, 2001), so the men may have also been protecting their own social, emotional, and physical well being in choosing to nurture their relationships with their wives.

Our finding that men perceived themselves to have little influence on the content of meals at home may appear to contradict previous research suggesting that husbands often have the largest influence on family meals (Charles & Kerr, 1988; DeVault, 1994; Mróz et al., 2011). More careful consideration of our data, however, indicates that this incongruence may simply represent the differing perspectives of husbands and wives. The men in our study reported they had little control over what they ate at home, yet previous research notes that wives tend to prepare foods that they know their husbands will eat and like (Charles & Kerr, 1988; DeVault, 1994). The men also described how their wives' concerns about their husbands' health led them to adopt healthier cooking practices, showing that they, or at least their health issues, influenced the contents of meals as wives considered their husbands' health needs when making decisions about food provision. Future research is needed to gain wives' perspectives on how women make decisions regarding food preparation for their spouses and families. Further research is also needed to examine wives' perspectives on how men influence family meals, particularly to determine how men affect what "healthy" meals look like in their households. Wives may have been balancing a variety of needs and desires that could be difficult to integrate, such as helping their spouses eat healthier, preparing foods that the men would actually eat, and cooking something their husbands would enjoy.

Many researchers have used Social Control as a framework for examining how individuals and social norms influence health behavior (Helgeson et al., 2004; Franks et al., 2006; Lewis et al., 2004; Lewis & Rook, 1999; Umberson, 1992; Westmaas, Wild, & Ferrence, 2002). Informal social control has traditionally been conceptualized as the exercise or perception of power and control in informal relationships (such as with friends or family, vs. formal relationships with health care providers) to regulate others' behavior (Lewis, DeVellis, & Sleath, 2002). In research linking social influence and health behavior, social control has often measured as overt, explicit attempts by one person to change another's behavior (Lewis et al., 2004). Research findings on the effectiveness of informal social control at changing health behaviors, however, are inconsistent (Helgeson et al., 2004; Markey et al., 2008). Wives' nagging was the most evident form of social control discussed in our focus groups. Similar to Lewis' and colleagues' (2004) findings, our study participants primarily described more subtle ways in which their wives tried to increase the healthiness of the men's eating behavior, many involving no direct communication whatsoever. Our findings suggest these less overt forms of influence are not only important, but in some cases may be more prominent than the more explicit forms of social control that have been the subject of more health behavior research. In addition, the emphasis on power inherent in the concept of social control seems an ill-fitting and distorted characterization of the perspectives and experiences of the men in our focus groups. Although the men perceived themselves to have little control over what they ate at home and did not enjoy the healthier foods they were provided, they appreciated the care and concern for their health that drove their wives to alter the foods they provided. The men also indicated they chose not to interfere with their wives' food decision making because of their prioritization of their marital relationship over fulfilling their own food preferences. Social control is typically assessed using quantitative methods, which do not lend themselves toward discerning the emotional and relational underpinnings of the types of influence attempts that played such a prominent role in these men's narratives.

The men in our research are embedded within complex webs of gendered social and cultural contexts and influences. They appear to be highly motivated to consider the relationship implications of interfering with their wives' roles in food preparation and decision making, and of expressing their dissatisfaction with foods their spouses prepared for them at home. Given our findings, interventions to increase healthy eating at home among African American men need to explicitly consider the role of wives and the interdependent nature of married couples' lives to be successful with this group.

Limitations

Although the men involved in this study provided some unique insight, several limitations of this study should be noted. While our procedures captured the strongest and most prevalent themes, topics that were not probed in greater depth during the focus groups and perspectives voiced by a minority of respondents are not always included in this article. Aspects of our findings may have been more salient to some men in our study (e.g., those with chronic diseases; men who were married or had a girlfriend, especially those who lived with their partner) than others; however, this study was designed to identify key trends and not to compare men with different characteristics. The large proportion of men in our study with chronic diseases may, in part, account for

the prominence of discussions about wives' efforts to improve their husbands' diets, as men who have not been diagnosed with a chronic disease are less likely to be experiencing this. Exploring how different groups of men perceive the issues raised in this study would be a valuable topic for future research. In addition, although we asked the men about their eating practices throughout the day, the participants in all the groups focused on dinner, limiting conclusions we can draw about the influence of wives on other meals and snacks. Our interview guide also did not include questions or probes specifically about the influence of wives on men's eating, so all our data resulted from the salience of wives to our more general queries and the spontaneous unfolding of the focus group discussions. In addition, because of the group data collection format, some men may have opted not to share sensitive information related to this topic. The member checking groups (Creswell, 1998) we conducted with men from our population of interest, however, increased our confidence that we identified key aspects of the roles of wives in influencing African American men's eating behaviors.

Our findings are generalizable to the limited literature that describes how gendered social norms and marital relationships influence men's health behaviors, particularly eating behaviors. We found Interdependence Theory to provide a useful framework for examining and understanding the multitude of mechanisms and pathways through which marital relationships affect men's eating behaviors. Our findings show that men's prioritization of maintaining harmony and gendered roles within their marital relationship, rather than interfering with foodwork in the home, is a critical factor in African American men's eating behavior and dietary health.

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