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Together through thick and thin

Cohabiting partners' reciprocal influence during men's attempts to change their dietary practices and physical activity to lose weight and maintain weight loss

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**Submitted in fulfilment of the requirements for the
Degree of Doctor of Philosophy**

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2019

Abstract

Background: Overweight and obesity are major health problems globally, particularly in men. Some group-based interventions for men, such as Football Fans in Training (FFIT), a gender-sensitised weight management and healthy living programme for overweight or obese men, have proven successful in helping men initiate and achieve weight loss. However, there is still a need to understand how men's attempts to make changes to health practices are influenced by their social context. This study explored how men's attempts to change their dietary practices and physical activity to lose weight and maintain weight loss were influenced by, and influenced, their cohabiting female partners within the context of FFIT. **Method:** Separate interviews were conducted with 20 men and their cohabiting female partners 3-12 months after men had completed FFIT. Their experiences around men's participation in FFIT and subsequent attempts to change dietary practices and physical activity were explored. Data were thematically analysed, guided by Self-Determination, Social Support, Interdependence, and Gender theories. **Results:** All partners in this study were supportive of men's autonomous decisions to join FFIT. Each partner displayed varied levels of involvement in the process of men's attempts to make changes to dietary practices and physical activity. Men's success or failure in making and maintaining changes, and/or achieving weight loss, was described as resulting from their resoluteness for the changes, responsiveness to FFIT and reliance on/receptiveness to the partner's involvement and support. Men's participation in FFIT also positively influenced the partners' dietary practices and physical activity, as well as couples' relationships despite some tensions and conflicts arising during this process. **Conclusion:** Cohabiting couples' close relationships provide a supportive context for overweight or obese men to initiate the pursuit of weight loss, and maintain healthy dietary practices and physical activity. This study also highlights the mechanisms by which partners influence men's changes to dietary practices and physical activity following a weight loss intervention, and how they too are influenced in this process. It thus helps explain how varying behaviour change outcomes can occur within an intervention. This study highlights the importance, and the bidirectional nature, of health behaviour change in the cohabiting couples' context.

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Acknowledgements

This PhD has been an amazing journey of discovery for me and I could not have done it without the support of so many remarkable people.

My supervisors, Dr Helen Sweeting, Dr Stephanie Chambers and Dr Alice MacLean, have supported me with their expertise, constant encouragement, productive feedback and insightful comments. I am immensely grateful for your time and support - it has been privilege learning from you. Stephanie - your constant guidance, mentorship and support even before this PhD is the reason I am here today and I am eternally grateful to you.

I want to thank the 20 couples who graciously and openly shared their stories with me. This study would not have been possible without them. I would also like to thank the SPFL Trust and all the FFIT coaches for their support.

I want to thank the UK Medical Research Council for funding my PhD project.

I would like to thank Dr Katie Buston for taking the time to read my thesis and providing constructive comments, and Professor Kate Hunt for her support and advice throughout my PhD research. Many thanks to all the students at the MRC/CSO SPSHU, and especially Craig, Karen, and my mentor Gillian, for friendship as well as interesting conversations, advice, laughs, and encouragement. Thanks also to all the support staff, especially Carol, Patricia, Avril and Brenda for IT and administrative support.

To my husband Gopal Sapkota, thank you for your wholehearted support, inspiration, engagement, positivity and care. I could not have done this without you. Very especial thanks to Maya and Shreya for grounding me with your beautiful smiles at my times of stress.

This thesis is dedicated to my mother Mina Devi Tripathee and my father Bishnu Niwas Tripathee, who raised me to value education, and taught me to dream beyond my horizons.

Author's declaration

I declare that, except where explicit reference is made to the contribution of others, this dissertation is the result of my own work and has not been submitted for any other degree at the University of Glasgow or any other institution.

Sheela Tripathee

A handwritten signature in black ink, appearing to read 'Sheela Tripathee', with a large initial 'S' and a long horizontal stroke extending to the right.

Chapter 1 Background

1.1 Overweight/obesity and health

The worldwide prevalence of overweight and obesity in adults increased by 27.5% between 1980 and 2013 (Marie et al., 2014). In 2016, 39% of adults over the age of 18 worldwide were overweight and 13% were obese (WHO, 2016). Overweight and obesity contribute to poor health and quality of life. Overweight and obesity are major risk factors for various chronic diseases including diabetes, cardiovascular diseases and cancer (Di Angelantonio et al., 2016; Jousilahti et al., 1996; Ley et al., 2004; WCRF, 2018; WHO, 2003). At least 2.8 million adults die each year as a result of being overweight or obese (WHO, 2016). Treatment of overweight, obesity and related co-morbidities are major financial burdens globally (Kelly et al., 2008). Obesity directly accounts for an estimated cost of £175 million per year to the Scottish health services (Scotland, 2013).

An unhealthy diet and lack of physical activity are recognised as crucial factors in causing overweight and obesity (WHO, 2016). Weight loss is best achieved and maintained through a combination of reducing calorie intake and increasing physical activity (Anderson et al., 2001; Santos et al., 2017; WHO, 2003). Maintenance of weight loss is crucial to sustain health benefits (Penn et al., 2013). Therefore, understanding how best to support people in sustaining weight loss is essential for controlling the consequences of obesity. However, studies in this area tend to mostly focus on initial weight loss (Jeffery et al., 2000; Kwasnicka et al., 2016).

1.2 Men's overweight, obesity and weight management

Of particular concern is the increase in overweight and obesity in men globally (Stevens et al., 2012). More men than women are overweight or obese in the UK, and this difference is expected to continue (Cancer Research UK, 2018). In Scotland in 2016, 68% men were overweight or obese compared to 61% women (SHeS, 2015). In Western societies, men's diets differ from women's and are

often less healthy (Arganini et al., 2012; Jensen & Holm, 1999; Wardle et al., 2004). For example, men consume more meat-based foods, higher amounts of alcohol and less fruits and vegetables than women (Wardle et al., 2004). Some men have also reported facing additional barriers in their attempts to adopt healthy practices compared to women (Caperchione et al., 2012), such as lack of control in household dietary practices. In spite of this, men are under-represented in weight-loss intervention programmes (Robertson et al., 2014). Although the literature on men's weight loss, and participation in weight loss interventions, has proliferated in recent years, the mechanisms behind men's success or lack of success in making weight related behavioural changes, after participating in weight loss intervention are not well understood.

1.3 Men's diet and physical activity changes and weight loss within cohabiting contexts

Studies focusing on men's diet and/or physical activity have demonstrated that their health and health behaviours are inextricably tied to their family or household context (Berge et al., 2012; Caperchione et al., 2012), relationship status, such as being married or cohabitating (Aarseth & Olsen, 2008; Berge et al., 2012; Kemmer et al., 1998), and family members' participation and support (Golan et al., 2010; Gorin et al., 2008; Matsuo et al., 2010; Schierberl Scherr et al., 2013). Kemmer et al. (1998), in a qualitative study undertaken in Scotland that interviewed members of 22 heterosexual couples before and after their cohabitation, found that food shopping and eating patterns were more regular and planned in cohabiting couples compared to when they lived separately. Shared meals, routines, and home environments provide many opportunities for cohabiting partners to observe and engage in their partners' weight-related habits. Hanna and Collins (2015), in a review investigating the difference in food and nutrient intake between adults living alone and cohabiting, reported that men living alone were at greater risk of eating unhealthy foods compared to women living alone or men who cohabit.

Couple members are found to mirror both weight gain and weight loss in their partners. Studies have found that having an obese partner increases the

possibility of becoming obese (Christakis & Fowler, 2007). ‘Cobesity’ is a term introduced by Wilson (2017) to indicate the concordance of obesity in cohabiting partners. Wilson (2017) argues that as families play a role in causing obesity, they also play an important role in dealing with its consequences. Studies indicate that the impact of the cohabitation context on an individual’s health is complex, with evidence of both positive and negative impact of cohabitation in relation to different aspects of health practices such as diet (Mötteli et al., 2017).

The evidence that is available with regard to the influence of partner involvement on men’s weight loss or health behaviour change goal pursuit is both limited and inconsistent. Some studies indicate that involving family members, such as partners, as a part of a weight loss intervention can positively influence men’s weight loss and weight loss maintenance (Golan et al., 2010). Others have found that men lose more weight when treated alone compared to treated together with the partner (Wing et al., 1991). Some studies have suggested no differences in respect of weight loss maintenance between those treated alone and with partners (Dombrowski et al., 2014; Robertson et al., 2014). A small number of studies that have focused on the influence of untreated partners suggests that partner support in couples is closely linked to goal implementation in daily life (Feeney & Collins, 2015), including increased physical activity (Berli, Stadler, et al., 2018) and dietary changes (De Souza & Ciclitira, 2005).

Within couples, taking a joint approach to overcome a challenge, referred to as dyadic coping or dyadic planning, is linked positively to health practices and having a better relationship (Bodenmann, 2005). Berli, Bolger, et al. (2018) found that participants who received daily partner support adhered to higher physical activity levels compared to those who did not. Their study emphasises the importance of mutual attempts in helping primary participants achieve set behaviour change goals, and calls for future studies to examine whether joint engagement is also associated with higher intimacy or relationship outcomes in addition to better goal implementation. It has also been suggested that

providing support could be beneficial for the providers themselves (Lewis et al., 2006; Patrick et al., 2007).

The importance of the relationship context for the effectiveness of behaviour change interventions has also been emphasised in respect of other behaviours, such as drug rehabilitation (Joolaei et al., 2014; Riehm et al., 2003) and smoking cessation (Foulstone et al., 2017; Manchón Walsh et al., 2007; Oliffe et al., 2010; Scholz et al., 2016; Westmaas et al., 2010; Westmaas et al., 2002). Men are found to be more likely to engage with smoking cessation treatment (Richardson et al., 2013), and quit or reduce their smoking after a quit date, with partner support (Scholz et al., 2016; Westmaas et al., 2002). Although the specific mechanisms through which the couples' relationship context determines the outcomes of smoking cessation interventions are not well-understood (Hubbard et al., 2016), the positive influence of partner support in men's smoking cessation attempts has been attributed to their partner's engagement in stereotypically feminine behaviours such as caregiving and nurturing (Bottorff et al., 2010).

1.4 The FFIT programme: foundation for this PhD project

The Football Fans In Training (FFIT) programme provides an opportunity to explore the ways in which men changing their dietary practices and physical activity are influenced by their female partners. The influences of these changes on their female partners' dietary practices and physical activities can also be explored.

FFIT is a 'gender-sensitised' weight management, physical activity and healthy living programme for overweight men aged 35-65, and was designed by researchers from University of Glasgow, including some from the MRC/CSO Social and Public Health Sciences Unit (SPHSU). This programme aims to help men lose weight and maintain healthy lifestyles. Men attend 12 weekly 90-minute sessions held at Scottish Premier League football club training grounds, where they receive personalised advice and targets for changing their diet (portion control and healthy eating) to suit individual circumstances. They also participate in

structured exercise training sessions, which are tailored to individual fitness levels and ability. Outside the weekly sessions, men are given an incremental walking programme. Men are encouraged to supplement walking with more vigorous physical activity if they are able, and are expected to achieve at least 45 minutes of moderate physical activity most days. They are also encouraged to avoid behaviours that would undermine weight loss. Men keep a weekly log of their weight loss and compare their personalised weight loss goals at the end of 12 weeks. Men are also given tips on how to maintain the changes that they have made (Hunt, Wyke, et al., 2014).

This men-only programme is designed to attract participants by incorporating notions of masculinity both in terms of the programme setting as well as style and delivery of the content. FFIT is delivered at traditionally male environments of the professional football clubs by the club community coaches. Club-based incentives and branding, such as club T-shirts, are incorporated into FFIT to extend its appeal to male football fans. Information in relation to the science of weight management is provided in simplified form. The sessions are informal and coaches encourage participative learning, and ‘banter’ in discussion of sensitive topics (Hunt, Gray, et al., 2014).

Evidence shows that men and women prefer different types of weight management programmes and they respond to these programmes differently (Robertson et al., 2014). For men, tailoring interventions, and the settings in which they are delivered, has been found to enhance programme effectiveness (Hunt, Wyke, et al., 2014). FFIT has been successful in attracting overweight and obese men from varying socio-economic backgrounds, and in helping many men achieve and maintain clinically significant weight loss (Gray et al., 2018; Hunt, Wyke, et al., 2014). However, further research is needed to better understand: the mechanism of men’s behavioural changes following their participation in FFIT; the influence of men’s family or relationship contexts on their attempts to change their dietary practices and physical activity; and the impact of this process on couple relationships.

FFIT participants are encouraged to utilise support from their social networks outside of the programme in making changes to their dietary practices and physical activity. However, exploration of the influence of family and relationship contexts on FFIT participants' dietary practices and physical activity has been limited. MacLean et al.'s (2014) men-only focus group study, is the only FFIT-related research that has explored the ways in which men's efforts to change their eating practices (during and after completion of the FFIT programme) were influenced by their female family members, including partners. Consistent with prior studies (Allen et al., 2013; Mallyon et al., 2010; Mróz et al., 2011), MacLean et al. (2014) found that men described their attempts to change their dietary practices as requiring negotiations with their female family members. However, existing gender roles in their relationship did not change to a great extent as a result of these negotiations. Men reported that female family members responded in a range of ways to the changes they wanted to make, representing different levels of positive and negative influences. These influences are investigated further from the perspectives of both partners in this PhD project.

In the study by MacLean et al. (2014), men suggested that their female partners did not directly control their dietary practices or position themselves as more skilled in these matters than men. However, according to the men, their female family members' prominence in family food was sometimes in conflict with their own attempts to change their diet. For example, when offered (unhealthy) food by their female family members, men felt compelled to accept it to keep harmony in their relationships.

MacLean et al. (2014) provide a foundation for further investigation into how men's efforts to lose weight are situated within their cohabiting contexts, particularly in relation to the influence of their female partners and existing gender roles. However, MacLean et al. (2014) did not investigate men's negotiations with, and the influence of, female family members with regard to physical activity changes. Similarly, the study did not investigate the reciprocal effect of men's attempts to lose weight on female family member's dietary

practices and physical activity. Further, and importantly, the study was based on *men's* reports only.

MacLean et al. (2014) suggest that exploring men's dietary changes from the female partner's perspective might improve the understanding of whether men changing their dietary practices represents a challenge to, or a disruption of, feminine influence in those dietary practices within the cohabiting context. Exploring the female partner's perception could also provide insights into whether the women presented themselves as welcoming or not of the changes, and whether negotiations around the changes had any impact on them.

1.5 Research aims and research questions

The **central aim** of this qualitative PhD project is to investigate how men's attempts to change their dietary practices and physical activity to lose weight and maintain weight loss, within the context of the FFIT programme, are influenced by and influence their cohabiting female partners.

The novelty of this study is that it explores the mutual influence of healthy men and their cohabiting partners on both dietary practices and physical activity from the perspectives of both partners. The findings from this project will help deepen our understanding of the mechanisms by which social support influences men's attempts to change diet and physical activity after their participation in a weight-loss intervention. This will also help broaden insights into the social nature of weight loss and weight loss maintenance and inform the development of strategies to promote weight loss and weight loss maintenance in the cohabiting couples' context.

The following **research questions** were developed to address the aims of this study:

- 1) How do cohabiting female partners influence men's attempts to change and maintain their diet and physical activity with the aim of losing weight and maintaining weight loss?

- 2) How do men's attempts to change and maintain their dietary practices and physical activity influence their cohabiting female partners' dietary practices and physical activity?
- 3) How do the processes of men's attempts to change their dietary practices and physical activity with the aim of losing weight and maintaining weight loss positively or negatively impact couple relationships?

Cross-cutting these three process questions are four further issues:

- a) How do couple context factors (e.g. couple members' weight-related concerns, couples' caring relationship and interdependence, and expectations of positive outcomes from FFIT) impact on these processes?
- b) How do gender roles and gender-related expectations impact on these processes?
- c) Do processes in respect of dietary practices differ from those in respect of physical activity?
- d) How do these processes relate to men's weight loss?

1.6 Thesis structure

Chapter 2 presents an overview of relevant literature. It begins by summarising theories that relate to health behaviour change in social contexts. This is followed by a review of empirical studies, which provides a synthesis of literature focused specifically on men's weight loss and weight loss maintenance in the cohabiting context and the influence of female partners on men's attempts to change their dietary practices and physical activity.

Chapter 3 describes the methods used in developing, conducting and analysing the study. This chapter also includes my reflections on my interactions with the participants in my role as the researcher.

Chapters 4 to 7 report the findings of the study:

Chapter 4 presents an overview of the cohabiting context and the circumstances in which men were attempting to make and maintain changes.

Chapter 5 first presents a typology based on participants' descriptions of *women's involvement* in men's attempts to make the various changes, and *men's reliance* on their partners. This is followed by a detailed exploration of participants' perspectives on the influence of cohabiting partners on men's attempts to make changes to their dietary practices and physical activity.

Chapter 6 describes the ways in which men's attempts to make changes to their dietary practices and physical activities influenced their cohabiting partner's dietary practices and physical activities.

Chapter 7 focuses on the cohabiting couples' relationships. Specifically, it details the positive influence of the process of behavioural change on a couple's relationship, and how partners dealt with the tensions and conflicts that arose during this process.

Chapter 8 offers a discussion of key findings in relation to the relevant literature and theoretical perspectives. This is followed by a description of the strengths and limitations of the study. The thesis concludes by discussing issues to consider for future research and suggests some implications for weight loss related behaviour change interventions for men and cohabiting couples.

1.7 Terms and definitions

For the purpose of this thesis, hereafter:

'Men' or 'male partners' are used in this thesis to refer to the men who participated in FFIT, including cohabiting husbands, boyfriends, male fiancés or male partners of women.

Men's cohabiting wives or female partners, such as girlfriends and fiancées, are referred to as **'women' or 'partners'** in this thesis.

The terms **'participants'** or **'couple'** are used to refer to both men and women. Although all the partners were interviewed separately, **'couple/s'** is used in this thesis to indicate both partners.

The term **'primary participant'** is used in some studies to refer to the person who is the focus of a behaviour change intervention; this term is used in the literature review to replace the various terms, such as index member/partner and changer, that are used in various studies.

The term **'treated'** is used in the literature review to refer to either men or women who took part in a dietary, physical activity and/or weight loss intervention and is used accordingly while discussing those studies.

The term **'untreated'** is used in the literature review to refer to men or women who did not take part in a dietary, physical activity and/or weight loss intervention, and is used accordingly while discussing those studies.

The term **'healthy men'** is used to refer to men who at the time of an intervention had not been diagnosed with chronic diseases as a part of inclusion criteria for intervention (although some men did have some health problems).

'Cohabitation' refers to couples living in the same accommodation regardless of whether they live with other family members such as parents and children or not. The terms **'Cohabiting context'** or **'Cohabiting couples' context'** are used to refer to this setting of cohabitation.

In health research and studies relating to overweight and obesity, **'weight loss'** refers to the reduction of excessive weight through diet and/or physical activities (Sainsbury et al., 2017). The term is used accordingly in this thesis.

Sustaining a stable body weight by keeping a balance between consumed energy (or calories) and expended energy is considered **'weight maintenance'** (Elfhag & Rossner, 2005). In relation to weight related health interventions, not gaining any weight for at least six months (Elfhag & Rossner, 2005), or 12 months (Wing

& Hill, 2001) after meeting certain weight loss goals, is referred to as weight maintenance and the term is used accordingly in this thesis.

Keeping a healthy weight, defined by having a Body Mass Index (BMI) within a healthy range, is referred as **'weight control'** (Wardle, 2001) and the term is used accordingly in this thesis.

'Cobesity' refers to concordance in a couple's obese weight status (Wilson, 2017). The term is used accordingly in this thesis.

'Coactive' is a term coined in this study which refers to the practice of a couple purposefully being physically active together (for example, by participating in activities together or doing separate activities but having planned them together) with the intention of losing weight, feeling fitter or being healthy.

'Codietsing' is a term coined in this study which refers to the practice of a couple purposefully changing their dietary practices to eat healthily (by following the same dietary practices or purposefully eating healthily during the same period as each other) with the intention of losing weight, feeling fitter or being healthy.

'Co-weight loss' is a term coined in this study which refers to concordance within a couple of purposeful weight loss.

'Partner support' is defined as help provided by the partners within a couple to each other in their attempts to make and maintain changes. It includes both practical support in aspects of the changes and emotional help, such as providing encouragement.

'Partner influence' is referred to as the impact of one partner's involvement or lack thereof on the other's pursuit of changes, or behaviour change outcomes, either positively or negatively.

Chapter 2 Literature review

2.1 Overview

The role of behavioural and social factors in the development of disease and disorders has been evident for many decades, resulting in an extensive body of both theoretical and empirical interdisciplinary research literature. This review of the literature begins with an overview of some of the broad theoretical perspectives, and some of the more recent theoretical concepts, which underpin the research around health behaviour change in the social context (Section 2.2 and 2.3). This is followed by a structured review of empirical literature focused on studies examining weight loss and changes in dietary and physical activity practices only in relation to cohabiting couples, that informed the development of the current study (Section 2.4).

2.2 Theoretical perspectives around health behaviour change

A wide range of physical, psychological, sociological and environmental factors influence the adoption and maintenance of weight loss and associated health behaviours (Michie et al., 2008). Adopting and maintaining health promoting behaviour, or altering health-compromising behaviour, is a complex process. The literature in this area is diverse and brings together a number of theoretical perspectives (Kwasnicka. et al., 2016).

Traditionally, theories or models based on social cognition have been predominantly employed to study weight-management, dietary changes and physical activity. Although these theories have been successful in predicting behavioural intentions, they have had limited success in predicting actual behaviour (Armitage & Conner, 2001; Webb & Sheeran, 2006). With the intention-behaviour gaps evident in these early cognition-based theories, more comprehensive theories have been developed by incorporating post-intentional processes involving environmental cues and facilitators that transform intention into action.

In psychology-based models, individual intentions and subjective interests are studied. In contrast, sociological perspectives on behaviours are conceptualised as individual's and groups' performances of social practices (Spurling et al., 2013) in relation to a social context. Some social theories such as the Social Ecological models (Bronfenbrenner, 1992; McLeroy et al., 1988) position individual practices as fundamentally linked to their wider social context, and emphasise that people's behaviour patterns form in relation to others, and as part of other related everyday activities (Delormier et al., 2009). Therefore, health practices, such as eating a healthy diet and being more physically active, need to be considered in relation to their social contexts (Robertson, 2007).

While most health psychology literature focuses on *self-regulation* of health behaviour, increasingly studies also consider social and dyadic processes. The concept of social context can be understood as “the local configuration of social relations, which comprises social structures such as ... individual behaviour and intersecting personal biographies” (Poland et al., 2006, p. 60). Family and cohabiting partners are considered important parts of the social context that influence individual behaviours (Moblely et al., 2009). Social influence occurs when one's opinions, emotional states and behaviours are affected by others. Social relations, such as those with cohabiting partners, can affect the effort needed to perform new behaviours and capacity to maintain behaviour (Berli, Stadler, et al., 2018; Dombrowski et al., 2014; Kwasnicka. et al., 2016).

Social networks in which two individuals are linked are called dyads. Research with dyads originated in psychology in relation to the study of couples and romantic relationships. Many researchers have adopted a dyadic approach to study individuals' behaviour change in couple contexts. The literature on health behaviour and behaviour change in couples consistently demonstrates that close and continuing relationships are important for health and well-being (Cohen et al., 2000). However, behaviour change interventions that have attempted to utilise partner support to decrease health risk and prevent health problems, such as losing weight by making changes in diet and physical activity, have only

achieved partial success (Black et al., 1990; McLean et al., 2003; Wing et al., 1991). In recent years, dyadic conceptualisations of originally individualistic health behaviour change models have been applied as alternative ways of introducing social components into health-behaviour change, for example by employing the Theory of Planned Behaviour to the dyadic context (Howland et al., 2016), and extending action planning as dyadic planning (Burkert et al., 2011). However, important theoretical concepts with regard to couples' health behaviour change are rooted in ideas around interdependence and have emerged through integration of concepts from the areas of relationship science and interpersonal interaction (Lange & Joireman, 2008; Lewis & Butterfield, 2007).

The following sections provide an overview of some of the predominant theoretical perspectives on behaviour change that are commonly used to explain how different factors related to the social relationship context can influence health practices, such as diet and/or physical activity. These include Self-Determination Theory and its sub-theories that are relevant to the thesis, theoretical concepts around Social Support and Social Control, Interdependence Theory and its implications for couples' reciprocal influence, and Theories of masculinity and femininity that are relevant to couple contexts in relation to diet and physical activity.

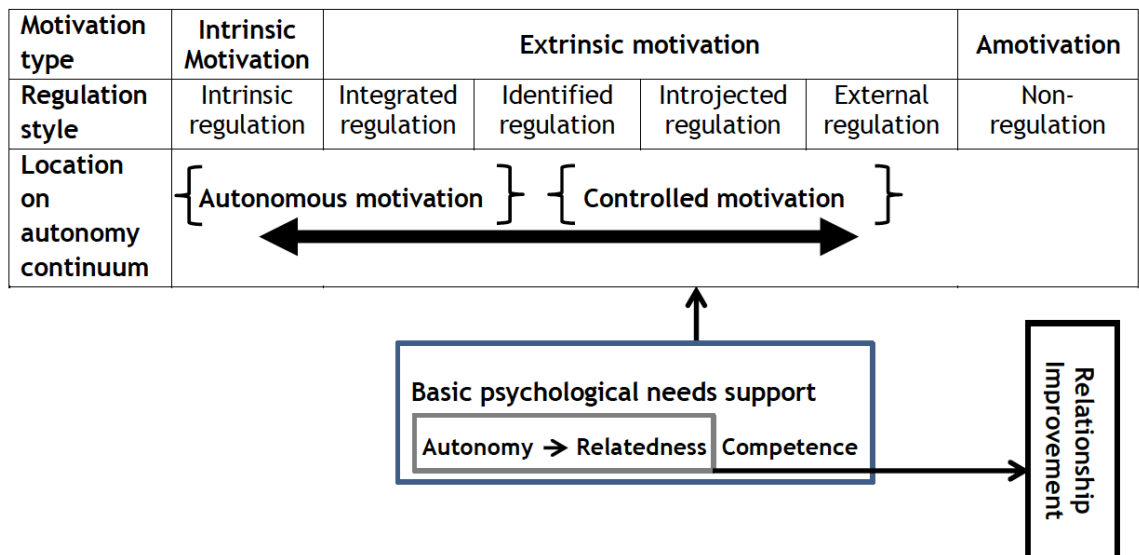
2.2.1 Self-Determination Theory

Self-Determination Theory is a social psychological theory that addresses the post-intentional phases of behaviour change. It has shown great utility in increasing understanding around initiation and maintenance of behaviour change. Originally proposed by Deci and Ryan (1985), this theory posits that people are naturally oriented towards growth, positive psychological wellbeing, and adaptive forms of motivation. This theory argues that these natural developmental tendencies require ongoing social supports to operate. The 'nutriments' (promotion of growth) for healthy development and functioning are described using the notion of basic psychological needs for **autonomy**, **relatedness** and **competence**. This theory argues that people develop and function effectively and experience wellness when these needs are satisfied

continually. Therefore, social/environmental factors can either foster or hinder individuals' natural propensity or motivation towards wellbeing by either supporting or thwarting their need for **autonomy, relatedness and competence**.

Self-Determination Theory incorporates six sub-theories that explore particular motivational phenomena and correspond directly to different aspects of motivation and psychological integration to explain human behaviour (Ryan & Deci, 2000b; Ryan & Deci, 2017). These are: **Cognitive Evaluation Theory; Organismic Integration Theory; Basic Psychological Need Theory; Causality Orientation Theory; Goal Content Theory; and Relationship Motivation Theory**. Due to their relevance to the current study, elements of only four of these sub-theories (Cognitive Evaluation, Organismic Integration, Basic Psychological Need, and Relationship Motivation) are described below. Figure 2.1 shows how these elements relate to each other.

Figure 2.1 The constructs of Self-Determination Theory, adapted from Deci and Ryan, (2000) and Ryan and Deci, (2017), that are relevant to the cohabiting couples' context



Cognitive Evaluation Theory is focused on understanding the impact of different contextual factors, environmental conditions and external events on motivation. Ryan and Deci (2000a) argue that regulations towards any behaviour can either be Intrinsically motivated, Extrinsically motivated or Amotivated. According to Self-Determination Theory, interest or pleasure in the activity itself results in **Intrinsic motivation**, therefore the greatest degree of autonomy is

evident in this form of motivation. However, many of the behaviours that people engage in everyday life are not in themselves innately interesting or pleasurable and thus are extrinsically motivated. **Extrinsic motivation** triggers behaviours driven towards achieving an outcome independent of the behaviour itself (e.g. increasing physical activity not for the enjoyment of it but to achieve desirable body image or weight). **Amotivation** is when the desired outcomes are not perceived to be dependent on one's behaviour, or the person lacks the willingness or ability to produce the behaviour (Ryan & Deci, 2000a).

Organismic Integration Theory addresses the quality of extrinsic motivation by describing different reasons or regulations that underpin a behaviour (Deci & Ryan, 1985). It consists of four regulations, namely integrated, identified, introjected and external, that contribute to the continuum of motivation (Figure 2.1). **Integrated regulation** refers to when the value served by a particular behaviour fits coherently with other values and goals of the self. **Identified regulation** refers to behaviour that serves a personally endorsed value or goal. Both integrated and identified regulations are the basis of self-determined behaviours, and are therefore characterised as autonomous motivation. **Introjected regulation** refers to behaviour that is regulated by internal pressures to maintain self-worth or to avoid guilt or anxiety. **External regulation** describes behaviours practiced to obtain external rewards or avoid punishments and is therefore stimulated by direct external contingencies. Both external and introjected regulations are control processes for behaviours, and are therefore characterised as controlled motivation.

Separation of the types of motivations along a continuum from **autonomous motivation** to **controlled motivation** (based on the degree to which extrinsically motivated behaviours are self-determined) has widened the focus of motivation orientation from the *initial* concepts of intrinsic versus extrinsic motivations. This theory distinguishes between autonomous motivation (characterised by feelings of choice and self-regulation) and controlled motivation (characterised by feeling of pressure, guilt, or obligation). Self-Determination Theory further suggests that motivation is dynamic, and therefore, a less autonomous form of motivation can become more autonomous through the process of internalisation.

Extrinsically motivated behaviour can be internalised as autonomous when individuals value it and develop a sense of ownership (identification) over it and integrate it into their sense of self (Ryan & Deci, 2000b).

Basic Psychological Needs Theory suggests that social and cultural factors that support basic psychological needs (autonomy, relatedness and competence) promote optimal personal growth, autonomous forms of motivation and greater psychological wellbeing (Ryan & Deci, 2000a; Ryan & Deci, 2017). **Autonomy** need involves the need to feel volitional, as the originator of one's actions. In contrast to the interchangeable use of the term 'autonomy' with 'independence' by some researchers, the term autonomy in this theory means that the behaviour and behaviour changes are carried out due to the individual's self-interest, willingness and freedom, even when they might be indirectly influenced by external sources. Ryan and Deci (2017) argue that people tend to exhibit more positive physical and psychological outcomes, and more adaptive forms of motivation, when they encounter situations which enable satisfaction of these three basic psychological needs (Ng et al., 2012; Ryan & Deci, 2017). **Relatedness** pertains to the need to feel close to, understood and supported by one's important others. Relatedness also refers to caring and being cared for by others and having a sense of belonging with one's community (Deci & Ryan, 2002). **Competence** need refers to the need to feel one's skills are effective within the domain where the particular behaviours are performed. Thus, perceived competence is feeling confident and capable rather than obtaining (further) skills or ability (Deci & Ryan, 2002).

This theory proposes that a needs supportive context gives rise to optimal motivation and internalisation (Ryan & Deci, 2000a, 2000b). Hence, people are more likely to internalise behaviour if they are encouraged by important others in their lives, helping them in the process to fulfil their basic psychological needs for autonomy, relatedness and competence. Therefore, the extent of one's ability to internalise a behaviour is dependent on important others, even though the type of relationship might influence the level of fulfilment for a particular need (e.g. a team member might support the relatedness need more and a romantic partner may support the autonomy need more).

Relationship motivation theory: Research in relationship science has mostly focussed on understanding a range of relationship processes, such as attachment, communality, intimacy, and interdependence. However, little attention has been paid to the motivational foundations of these processes. Relationship motivation theory, the most recent sub-theory within Self-Determination Theory describes the motivational dynamics of close relationships to address the entangled nature of autonomy and relatedness needs in responsive, mutually satisfying relationships (Ryan & Deci, 2017). Self-Determination Theory recognises that relatedness is a core psychological need that fuels internalisation of social practices and is also reciprocally facilitated or undermined in the process.

A central point of RMT [Relationship Motivation Theory] is therefore that there is much more to good, high-quality, relationships than merely warmth or tangible supports. Instead people have a deep need to experience relatedness, or the sense that they are valued and cared for. Relatedness however only results when another cares for and supports one's self. It is when we feel non-contingently valued, or loved for our own sake, and supported in our autonomy, that relatedness is most fulfilled (Ryan & Deci 2014, p. 69).

Self-Determination Theory assumes that a basic psychological need for relatedness mobilises people to pursue relationships, however not all relationships satisfy the need for relatedness. Even among strong relationships, only those in which both partners experience autonomy and provide autonomy support to the other are deeply satisfying of the relatedness need, which contributes to good relationships. In contrast, control not only thwarts the need for autonomy but also the relatedness need, resulting in poor quality relationships (Ryan & Deci 2014). Thus, provision (both providing and receiving) of needs support contributes to volitional reliance and greater individual wellness for the receiver, as well as better relationship functioning and outcomes for both (La Guardia & Patrick, 2008).

2.2.2 Social Support and Social Control

The term ‘social support’ is frequently used by health researchers in a broad sense, referring to any process through which social relationships might promote health and well-being (Ozbay et al., 2007). In theorising social support in relation to health behaviour change, the concept has been described as support “accessible to an individual through social ties to other individuals, groups, and the larger community” (Lin et al., 1979, p. 109) or “as the resources provided by significant others that are intended to facilitate an individual’s achievement of a goal or outcome” (Berli, Bolger, et al., 2018, p.333). Historically, the social support literature identified three main support functions comprising of emotional (e.g. comforting/appraisal/praise/reinforcement), instrumental/tangible (e.g. practical assistance), or informational (e.g. advice) (Weiss, 1974).

Rodriguez and Cohen (1998) elaborated on social support further by identifying different processes of social support through which relationships can influence health. The processes are categorised into two groups - the first involves the provision or exchange of instrumental, emotional or informational resources, while the second focuses on the health benefits that result from participation within the social group. This conceptualisation of social support argues that *others* can influence cognitions, emotions and behaviours through direct provision of support, as well as through those interactions that are not explicitly and purposefully performed with the aim of providing help or support.

Studies emphasising the effectiveness of social support, particularly during times of high stress, suggest that social support helps ease the stress of behaviour change attempts and strengthens coping abilities for those changing behaviour (Scholz et al., 2016; Westmaas et al., 2010). Researchers in recent years have also emphasised the need for understanding social support in non-adverse life contexts such as pursuing a goal in daily life, or the opportunities to thrive (Berli, Bolger, et al., 2018; Feeney & Collins, 2015).

Social support and social control are considered distinct interpersonal constructs that are related to each other (Novak & Webster, 2011). Social control is an individual's attempt to regulate and sway someone else's behaviour even if he/she is unwilling to change that behaviour (Lewis & Rook, 1999). Although social control has not been researched extensively in health behaviour change studies, it appears to be an important interpersonal process related to health behaviour change, especially among cohabiting couples (Luscher et al., 2014; Rook, 1990). Health-related social control is referred to as "the way that people in relationships attempt to influence and regulate each other's health behaviour" (Novak & Webster, 2011, p.224). Thus, in the couples' context, partners are considered as potential sources of social control (Novak & Webster, 2011; Rook, 1990).

For health behaviour change, researchers have identified specific social control tactics (Butterfield & Lewis, 2002; Lewis & Butterfield, 2005). Drawing from the areas of interpersonal communication, persuasion, and social psychology, Lewis and Butterfield (2005) propose three sets of social control tactics: *positive* and *negative*, *direct* and *indirect*, *bilateral* and *unilateral*.

Positive social control, such as persuasion or expression of positive emotions, is conceptually linked to social support, as it involves being indirectly supportive through rewarding desired behaviour. *Negative* social control, which is conveyed through actions such as nagging or withdrawing affection, is linked to pressuring the partner into a desired behaviour change. *Direct* social control tactics refer to open discussion of the topic or problem, whereas *indirect* tactics represent indirect attempts to persuade such as by dropping hints. *Bilateral* tactics refer to give and take or negotiations between the partners (Knoll et al., 2012; Lewis & Butterfield, 2007; Rackow et al., 2017), whereas *unilateral* tactics are one-sided attempts to get someone to change. Studies have found that *positive*, *direct* and *bilateral* social control strategies positively predict healthy behaviours, while *negative*, *indirect* or *unilateral* social control tactics have been found to be counterproductive or ineffective for initiating behaviour change or health enhancing behavioural reaction in the primary participant

(Helgeson et al., 2004; Lewis & Butterfield, 2007; Lewis & Rook, 1999; Tucker & Anders, 2001; Tucker et al., 2006).

2.2.2.1 Dual effects of social support/control and invisible support

Social support and social control have also been found to have two different effects at the same time (Lewis & Rook, 1999). This 'dual-effects' perspective proposes that while social support or positive social control may lead to *better* health practices, they may also lead to *increased* psychological distress (Bolger et al., 2000; Helgeson et al., 2004; Novak & Webster, 2011).

Bolger et al. (2000) argue that the reason that support does not always appear to be beneficial to the receiver is that it carries two opposing effects, "the benefits people experience when support is provided to them and the costs they experience when they perceive - accurately or inaccurately - that support has been provided" (Bolger et al., 2000, p. 954). Bolger et al. (2000), in a study investigating the supportive acts that providers perceive as support but recipients do not, concluded that the most effective support is that which is invisible or unnoticed by the receiver. Bolger and Amarel (2007) propose several mechanisms for the negative emotional effects of social support even when the actual performance of the health behaviour might be unaffected. For example, due to the need to depend on others, the recipient might feel less competent; the help of others may draw more attention to the problem than the recipient wants and so make them feel uncomfortable; the provision of support might disrupt the recipients' sense of autonomy; and support provided by others might make the recipient feel obliged to the provider.

Luscher et al. (2014) proposed that it is the *awareness* of receiving support that entails an *emotional cost* to the recipient. In a study of 85 couples, Howland and Simpson (2010) found that individuals whose partners provided more invisible practical and emotional support, but who reported receiving less support, experienced the largest declines in negative emotions. This study suggests that the benefits of invisible support stem from a combination of the recipient's lack of awareness that support is being provided, as well as the provider's skilful contribution. Another interesting but less researched type of invisible support

occurs when neither provider nor recipient is aware of, and does not consider as support (Lieberman, 1986) and the support is taken for granted as a routine practice by both. Researchers advise that understanding invisible support is particularly important in the context of close relationships (Bolger et al., 2000), where subtle and latent aspects of day to day life have the potential to contribute towards the behaviour change of couples (Lüscher et al., 2017).

Social support is as important for behaviour change maintenance as it is for changing behaviour. Studies indicate that successful weight loss maintenance is linked to social support (Elfhag & Rossner, 2005). Changed practices are likely to be maintained if they become the dominant response across settings. A supportive environment, fostered by positive social influences (e.g. encouragement or help), can facilitate the maintenance of behaviour change by affecting the effort required to perform the new behaviours over time and in varying contexts, and by increasing the individual capacity to maintain behaviour (Kwasnicka. et al., 2016). As individuals are more likely to respond to the support provided to them by people they feel connected to, developing a sense of relatedness (Ryan & Deci, 2000a, 2000b) to their partner for changing practices can be particularly important to maintain the changed practices.

It is noteworthy that both social support and social control have been theorised as one directional processes, where one provides and the other receives support in a given situation. However, the reciprocal nature of support provision or mutuality in dyads has not been adequately considered.

2.2.3 Interdependence Theory

The impact of being married or in a committed relationship on individual health outcomes and wellbeing has been well researched (Berge et al., 2016; Schoenborn, 2004; Wood et al., 2007). Although some dyadic studies in recent years have attempted to also investigate the impacts of the couples' *relationship* on health behaviour and behaviour changes (Helgeson, 2017; Patrick et al., 2007), the mechanisms remain poorly understood.

While partners in a relationship attempt to influence each other, they also in turn jointly and independently shape behaviour and relationship outcomes. In carrying out day to day tasks together, couples invest in both convergent and divergent interests. As not all practices are preferred or enjoyed by each couple member, the activities they take part in together or provide support toward, may or may not be valued equally by both. Thus each partner experiences costs and rewards associated with carrying out certain behaviours together (Thibaut & Kelley, 1959). One theory that addresses the multifaceted nature and outcomes of individual behaviours in the cohabiting partners' context is Interdependence Theory (Kelley & Thibaut., 1978). The concept of interdependence was originally proposed by Thibaut and Kelley in their 1959 book *The Social Psychology of Groups*, and later introduced as a theory of interdependence in their 1978 book *Interpersonal relations: A theory of interdependence*. This theory is concerned with how people make decisions in interdependent settings when an individual's outcome is based on the decisions of others, as well as their own decisions, and addresses the reciprocal nature of partners' influences on each other.

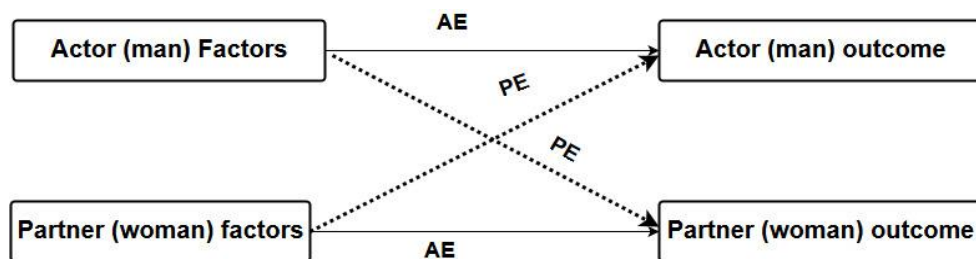
Describing the concept of power on a micro-level in the couples' context, Thibaut and Kelley (1959) initially explained two types of power with which partners can influence each other's behaviour. They used the terms 'fate control' and 'behaviour control'. **Fate control** is one partner's ability to affect another's behaviour outcome. A couple member demonstrates fate control if he/she, by changing their own behaviour, can affect their partner's behavioural *outcome*, regardless of what the partner does. **Behaviour control** is the power to cause another's *behaviour* to change by changing one's own behaviour. A couple member demonstrates *behaviour control* if he/she, by changing their own behaviour, makes it desirable for the partner to change his/her behaviour too (Thibaut & Kelley, 1959).

Interdependence Theory has since been extended into a comprehensive theory of social interaction (Kelley, 2003; Lange & Balliet, 2015). This theory has been used in many dyadic contexts and has been successfully elaborated, tested, and applied to a range of important social phenomena, such as social dilemmas,

uptake of health services, and health behaviour change (Lange & Joireman, 2008; Lewis et al., 2006; Manne et al., 2012; Virtue et al., 2015).

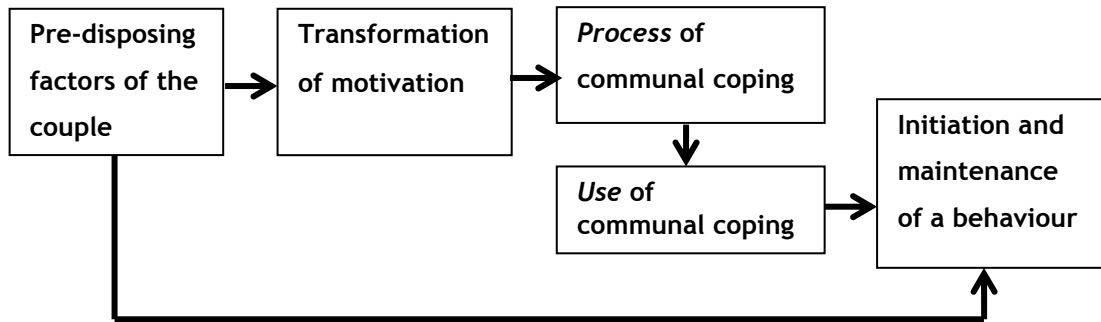
Many quantitative studies employing Interdependence Theory have used the Actor Partner Interdependence Model (Figure 2.2) with several possible paths of influence from and on each couple member in a given situation (Kashy & Kenny, 2000; Kenny & Ledermann, 2010; Patrick et al., 2007). Within this model, bidirectional influences are emphasised as something inherent in most close relationships (Cook & Kenny, 2005; Kenny & Ledermann, 2010). Studies using this model have highlighted that behaviour change outcomes are impacted by both Actor and Partner factors, and the combined effect of both factors termed as *joint effects*. The *joint effect* defines those behaviours that are influenced by *both* participants, and is considered to be stronger than either the actor or the partner factor (Lewis et al., 2006). Figure 2.2 illustrates the Actor Partner Interdependence Model adapted to show how it relates to the participants in the current study. The solid lines represent actor effects (AE); the dotted lines represent partner effects (PE); AE+PE for either partner = a mutual effect for *either* partner; AE+PE for *both* partners = a mutual joint effect.

Figure 2.2 Actor partner interdependence model



Lewis et al. (2006) argue that **actor**, **partner**, and **joint effects** may be more useful in *initiating* behaviour change and that the *mutual joint effect* may be more effective in sustaining health behaviour change in close relationships. Lewis et al. (2006) further elaborate on this and propose a conceptual model that illustrates the *process* of behaviour change in couples' contexts that produces outcomes for the actor, the partner or both. Figure 2.3 illustrates the 'Interdependence model of couple communal coping and behaviour change' adapted from Lewis et al. (2006) that is relevant to this study.

Figure 2.3 'Interdependence model of couple communal coping and behaviour change' adapted from Lewis et al., (2006).



This 'Interdependence model of couple communal coping and behaviour change' incorporates different constructs that play vital roles in the process of behaviour change, namely **pre-disposing factors of the couple**, **transformation of motivation**, **processes of communal coping**, **use of communal coping**, and **initiation and maintenance of behaviour change**.

Each partner's perception of a health threat; their preferred outcome; the couple's communication style and relationship functioning; and the gender of the supporting partner are considered as **pre-disposing factors of the couple** (termed as 'pre-disposing couple factors' hereafter) in this model.

Transformation of motivation is a key construct within Interdependence Theory that "accounts for changes in couple member's behaviour from a primarily self-centred orientation or motivation to one that is more pro-relationship" (Lewis et al., 2006, p. 1373). Through this process, couple members come to interpret practices or outcomes as being meaningful to the relationship or the partner, rather than simply for themselves as individuals. **Process of communal coping** refers to a dyadic process that involves appraising a problem as 'our' problem rather than 'yours' or 'mine'. **Use of communal coping** refers to applying joint efforts for behaviour change, such as making joint decisions and planning, and/or engaging with behaviour change practices together. 'Communal coping' is an expansion of the concept of coping (Rippeto & Rogers, 1987; Rogers, 1975) in the dyadic context and has often been used in studies related to chronic illnesses (Helgeson, 2017), or distress following special events, such as natural disasters (Afifi et al., 2012) and less in health behaviour change studies.

Lewis et al. (2006) suggest that couples may have one or more pre-disposing couple factors that influence whether they experience a transformation of motivation. According to this model, relationship-centred motivation activates communal coping, where couple members share an understanding about a problem that they are facing and the course of action required to solve it, and recognise the effectiveness of a joint response and act accordingly. Lewis et al. (2006) also recognise that joint engagement in supporting a close other's goal pursuit could bring benefits for the provider too.

Lewis et al. (2006) propose that in couple contexts, the joint and interactive nature of the interdependent relationship, and the partner's motivations, preferences, and behaviours affect an individual's health practices and outcomes. This model (Figure 2.3) explains the *processes* of influence and the degree to which couples cooperate or work together to accomplish a goal. Interdependence is a key principle in this model, which refers to the ways in which interacting partners mutually influence each other's behaviours. Therefore, the ability to rely on each other for support impacts the likelihood of adopting and maintaining health-enhancing behaviours (Rogers et al., 2016).

The use of this approach in empirical studies related to weight loss has been limited. However, those using the theory to understand partners' influence, for example in respect of dietary and physical activity changes after diagnosis of a disease (Virtue et al., 2015), in areas of HIV screening (Montgomery et al., 2012) or colorectal cancer screening (Manne et al., 2012), report its usefulness in understanding behaviour change in couples. Montgomery et al. (2012), in a qualitative study regarding HIV tests among African women (or couples), reported that a couple's transformation of motivation and communal coping was stronger in a dyadic intervention and contributed to strong spousal support for adherence and retention. Virtue et al. (2015), in quantitative study among prostate cancer survivors and their spouses, reported that co-dieting and co-activity were related to relationship satisfaction, partner support and each partner's diet and exercise behaviours.

2.2.4 Theories of masculinity and men's weight loss

It has been well documented that, depending on the social context, there are multiple masculinities, which encourage men to be independent, tough, strong, and assertive on one hand, and caring, responsible and sensible on the other hand (Connell, 1995; Courtenay, 2000; Whitehead, 2002). The theoretical perspectives around masculinity remain strongest when centred on a view of gender as a set of relations, which take shape within particular social contexts and according to dominant forms of knowledge.

'Hegemonic masculinity' refers to a culturally normative ideal of male behaviour and the ways that men think about and "do" manliness, and specifically as a construct that is the opposite of femininity (Connell, 1995). The term is commonly used to define successful ways of 'being a man' in particular places at specific times (Connell, 1995). According to this concept, men are expected to aspire to, or be aware of, a conventional code of masculine standards such as autonomy, control, rationality, self-reliance, competitiveness, physical strength and risk-taking behaviour. Hegemonic masculinity refers to the traditional, patriarchal view of men and men's behaviour as the most influential and culturally accepted notion of manliness (Smith et al., 2007). However, it is not a categorical character type that is always the same, but rather is a gender position in a certain context (Connell & Messerschmidt, 2005; Idris et al., 2017) that places this form of masculinity above femininity, and alternative masculinities as 'subordinate', 'marginalised' and 'complicit' (Connell, 1995).

According to Social Constructionist theories of gender, dominant gender ideals (of both masculinity and femininity) serve as guidelines for appropriate behaviour for both men and women (Courtenay, 2000). West and Zimmerman (1987) refer to this process as 'doing gender' and they argue that gender should be considered as a process of social doings produced through individuals' interactions with others, rather than as a set of traits or roles (West and Zimmerman, 1987). By 'doing' gender in daily interactions (West & Zimmerman, 1987) through various acts and behaviours, gender is constantly constructed and reconstructed. Connell and Messerschmidt (2005) argue that men maintain a

hegemonic form of dominance in this process of constructing and reconstructing masculinity.

One of the central aspects of male identity, however, relates to how men conform to and negotiate the standards of hegemonic masculinity in their day to day lives (Whitehead, 2002). In varying social contexts, a variety of hegemonic representations of men are praised, however adaptations of other forms of masculinities, or femininity by men are ridiculed. This can affect some men's social practices, such as eating healthy diets and being physically active, as they conform to ideologies that are considered appropriately masculine or reject those considered feminine (Courtenay, 2000).

Health related practices, such as eating and physical activity, are important examples of the means through which some men may reinforce certain performances of masculinity, such as being tough and independent (Courtenay, 2000). Therefore, dominant cultural constructions of masculinity may determine men's decisions about health-related practices (Robertson, 2003).

Certain unhealthy foods, drinks and eating habits tend to be associated with hegemonic masculinity. For example, eating meat (Rothgerber, 2013), drinking excessive amounts of alcohol, and eating large portions are practices often associated with masculinity in Western societies. These perceptions mean that men generally eat more unhealthy foods than women (Rothgerber, 2013) and tend to consciously avoid dieting. Gough and Conner (2006), A UK study, found that men from a range of social backgrounds considered healthy foods as not sufficiently satisfying, and not enough to provide the energy demands required for manual labour compared to traditional masculine foods, such as meat (Gough and Conner, 2006). These perceptions are further reinforced by wider social institutions, such as the media. An analysis of 44 UK newspaper articles that focused on men and dieting found that media presentations of men's involvement in cooking or food preparation activities tend to construct men as rational, forward-thinking, goal-oriented and taking control of cooking (Gough, 2007). For example, an article compared men preparing Christmas dinner with

“the most successful military campaigns—a product of planning, equipment, recruitment, tactics and strategy” (Gough, 2007, p. 332).

Due to cultural conventions about ‘appropriate’ masculine performances and health, men are said to be faced with a dilemma between needing to display that they ‘don’t care’ about health, but at the same time acknowledging that they ‘should care’ (Robertson, 2003). This may be why some men who embrace healthy dietary practices themselves have been found also to criticise dieting and consider the behaviour to be feminine. In response, they re-define the process to make it reflect masculine ideals. This may include defining food as fuel and dieting as gaining knowledge and control over their diet (Bennett and Gough, 2013), talking about their health promoting behaviours in terms of sporting targets (Gough & Conner, 2006), and as a means of being autonomous (Sloan et al., 2010), which is considered masculine, rather than relating these behaviours to health consciousness (Bennett & Gough, 2013; De Souza & Ciclitira, 2005; Gough, 2007; Mallyon et al., 2010; Mróz et al., 2011).

Another important aspect of men’s weight management and masculinity is the masculine ideology of physical toughness (MacLean et al., 2014; Mahalik et al., 2007). Men have traditionally been expected to enjoy physical activities and sports, which may be health promoting if carried out appropriately. This may be why studies have found that men prefer physical activity to changing their diet in order to lose weight (Gough & Conner, 2006). Sloan et al. (2010) argue that because conventional masculinities are associated with ‘unhealthy’ practices (Courtenay, 2000), some men who adopt ‘healthier’ practices and reject certain practices that are considered masculine such as drinking alcohol, may attempt to preserve their masculine status by emphasising other aspects of hegemonic masculinity, such as rationality, functionality and autonomy. Sloan et al. (2010), in a study of men undertaking regular exercise and limiting their alcohol intake, found that participants reconstructed their masculine identity by critiquing the practices of most/other men and positioning themselves as the ones making sensible decisions and remaining independent. De Visser et al. (2009) describe this practice of having (or emphasising) enough of one masculine capital to compensate for the lack of another as ‘trading masculine capital’.

2.2.5 Feminine influence on men's health behaviour change

Femininity refers to the socially constructed attributes associated with being a girl or a woman. Therefore, men may attempt to refrain from practices that are associated with femininity in their attempts to conform to conventional ideologies of masculinity. However, men cohabiting with female partners may be subjected to feminine influences, which may in turn impact on their health behaviours and their attempts to change them.

The gendered division of labour in the household context is one of the important ways by which men's weight and weight loss could be impacted by feminine influences. In Western societies, cooking family meals is traditionally considered a woman's responsibility and is tied to femininity. Over 30 years ago, Murcott (1982) and Charles and Kerr (1988) argued that for women, cooking dinner for their husbands, and being obliged to prepare meals according to their food preferences, was a fulfilment of the wife's role, emphasising the symbolic importance of women's role as food preparers.

However, more recent studies suggest that both the domestic division of food related work and its relevance have changed in the last few decades (Kemmer et al., 1998; Lupton, 2000). Lupton (2000) suggests that the gendering of food preparation within the domestic context has changed due to social, economic and cultural changes which have impacted on family and household structures and gender roles, as well as food preparation and choice. In households where both partners work full-time, men's increased involvement in family food-related tasks makes food preparation a family activity rather than a woman's responsibility (Aarseth & Olsen, 2008). Aarseth and Olsen (2008), however, argue that while this slight change in family food dynamics provides the foundation for changing the gendered division of labour, it does not replace traditional gender relationships. Gender is still a significant factor in structuring couples' division of labour and the majority of food related tasks are still carried out by female members of the family (Allen et al., 2013; Lupton, 2000).

Gendered social norms and practices surrounding the division of food responsibilities suggest that female partners may have considerable influence on men's eating practices, particularly in a cohabiting context. Studies have consistently shown that female partners affect their male partners' diet both in general (Lupton, 2000) and when they attempt to make changes to their diet and eating practices (Mróz et al., 2011). However, it is important to note that women's prominence in respect to food within the family context is not as simple as women determining the family diet, and involves gender and power dynamics within the couples' relationship (Brown & Wenrich, 2012; Gregory, 2005; Mróz et al., 2011). For example, while the female partner might be primarily involved in preparation of meals, the role expectation of serving according to 'powerful' family members' preferences might determine *what* is prepared (Brown & Wenrich, 2012).

2.3 Synthesis of the theoretical perspectives

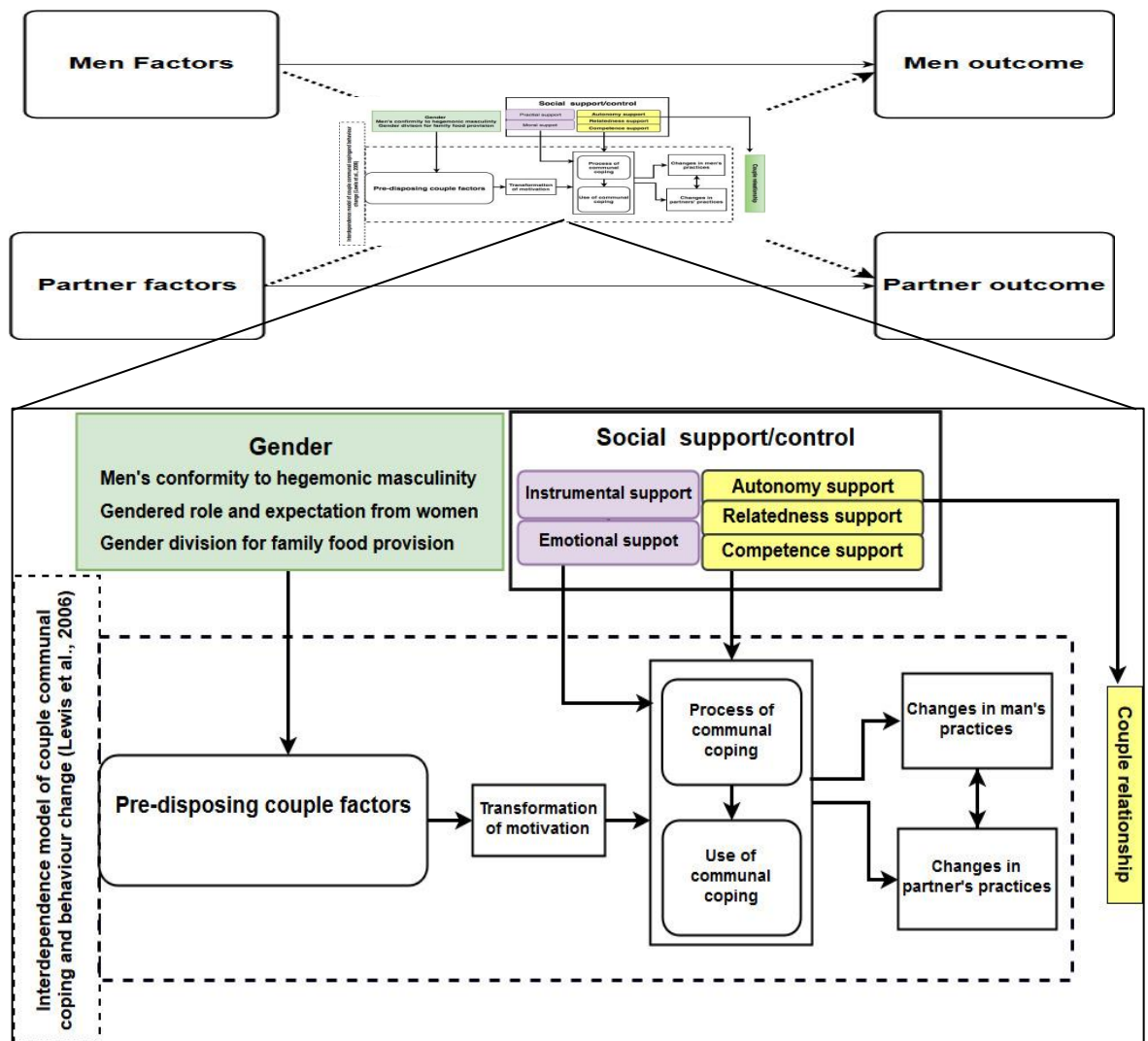
The sections above outlined in detail the theoretical perspectives from Self-Determination Theory, theories of Social Support/Control, Interdependence Theory and Gender Theory that are relevant to the current study. Each of these theories is independently valuable, and provides significant insights into many aspects of health behaviour change and provision of support in the social context. However, only the *relevant* aspects of each of these theories that are pertinent to the cohabiting partners' context and could assist in analysing the findings have been synthesised here. A brief summary of the relevant theoretical perspectives discussed earlier, and how these concepts can be aggregated within a model of Interdependence Theory proposed by Lewis et al. (2006) is presented below.

A key aim of this study is to understand how cohabiting partners influence each other as men attempt health behaviour changes. Aspects of all the theories discussed above can be seen as relevant in trying to understand different elements of the links between relationships and behaviour change in social and/or couple contexts. However, no single theory adequately captures the nuances around the provision and receipt of partner support. On a fundamental

level, the principle of interdependence theory, that behaviour change in a dyadic context is bidirectional and factors associated with each partner have the potential to impact the outcome for self and the partner, provides the foundation for this study. However, aspects of other theories, such as considerations relating to gender roles, gender-related expectations and power relationships from gender theories, components of Self-Determination Theory, including relationship motivation and psychological needs, and the concepts of social support and control, are also key to understanding the provision and receipt of support between cohabiting couples in relation to changing dietary practices and physical activity. Therefore, it was important to synthesise aspects of these theoretical perspectives in ways that complement each other, rather than being constrained by using a single theory.

Figure 2.4 presents a synthesis of how various elements of the theories discussed above can be integrated with the *Interdependence model of couple communal coping and behaviour change* to explain the behaviour change process in the cohabiting couples' context, which is central to this thesis.

Figure 2.4 Synthesis of theoretical elements of Gender, Social Support and Self-Determination Theory and Interdependence theory



*Green box = theoretical concepts derived from Gender theory,
 Purple box = theoretical concepts derived from Social support/control theory,
 Yellow boxes = theoretical concepts derived from Self-determination theory,
 White boxes within dotted lines = theoretical concepts derived from the Interdependence model of couple communal coping and behaviour change.*

Self-Determination Theory highlights the importance of the provision of support for behaviour change, especially in relation to behaviours triggered by extrinsic motivation. This theory also emphasises the importance of relationships not just as a source of needs support but also as a motivation for successful goal pursuit. Self-Determination Theory offers a perspective on the mechanisms, particularly needs support for *autonomy*, *relatedness* and *competency*, through which successful adoption of health-enhancing practices might be associated with positive relational processes, thereby contributing to improved relationships.

However, this theory has limitations when addressing some of the factors specific to the cohabiting couples' context that might indirectly impact one's motivation or behaviour. While provision of emotional appraisal and informational support are acknowledged, the instrumental support that one partner provides to the other, and how each partner's *own personal* choices made in a *mutual space* can contribute to one's behavioural motivation, are not adequately considered by this theory.

The **Social Support/Control** literature provides insights into the types of support that can produce positive or negative outcomes in a particular context. It has mainly focussed on understanding and developing effective pathways of social support that can produce positive outcomes for the receiver. Similar to most traditional theories of behaviour change or goal pursuit around individual motivation and self-regulation, social support and control have also been studied at an actor level, or as an individual's attempts being supported by a member or members of their social network. While provision of support and the support provider are at the forefront of discussions around Social Support/Control Theory, the mutuality in the process of making behaviour changes, and the reciprocal nature of support provision, are not adequately addressed.

Gender Theories have assessed how and to what extent constructions of masculinity or masculinities influence men's health behaviour and behaviour change attempts. Studies in recent years have looked at how men's conformation to hegemonic masculinity may influence their dietary changes, physical activity and/or engagement in weight loss interventions. A small number of dyadic studies have also reported how performance of conventional gender roles in the family context presents significant barriers, increasing complexity in relation to men's dietary practices and/or weight loss attempts and explained how performance of hegemonic masculinity may result in men being vulnerable to unhealthy practices, both through their own participation in such practices and as a result of the gendered practices of their partner. While Gender Theories address how certain *practices* carried out by a *man* or a *woman* might be influenced by masculine or feminine ideologies they conform to, they do not adequately address the reciprocal impact of health behaviour changes in

cohabiting couples. This is of particular importance as studies suggest that gender relations and roles play an important part in determining the impact of social support for health behaviour changes. For example, social support or control provided by a partner for the same behaviour change may result in different outcomes for a man compared to a woman.

Interdependence Theory provides a useful framework for analysing social interactions in a way that acknowledges each couple member may be involved in, and negotiate, the intended behaviour change. Models based on Interdependence Theory expand on the idea of Social Support further by addressing the mutuality involved in both pursuing behaviour change goals and supporting them in the couples' context, and provide mechanisms to the process. Models such as the Actor-Partner Interdependence Model provide a foundation for the reciprocal nature of social support and potential outcomes in a dyadic context. Additionally, the *Interdependence model of couple communal coping and behaviour change* provides further insights into the mechanisms by which partners influence each other in the process of providing and receiving support for health behaviour change. This model also acknowledges the role of gender as a pre-disposing couple factor that may influence the provision of support from one couple member to the other.

2.4 Weight loss, dietary practices and physical activity in the cohabiting context: a structured literature review

During January - May 2015, I reviewed a range of literature related to men's weight, diet and physical activity. The topics of the articles reviewed included: prevalence of overweight and obesity and its impact on health; men's health and masculinity; and men's health and health related practices in relation to their family members. These studies provided a grounding in the literature within this field and helped me to develop comprehensive search strategies for a structured literature review.

The purpose of this structured review was to gain an insight into the scope of existing literature on weight loss and weight loss maintenance in the cohabiting

context. Both the influence of female partners on men's attempts to change health practices related to weight loss, and the impact of these processes on their cohabiting partner were investigated. The following sections present the literature search, including inclusion/exclusion criteria, discussion of the findings and gaps in current literature.

2.4.1 Structured literature search

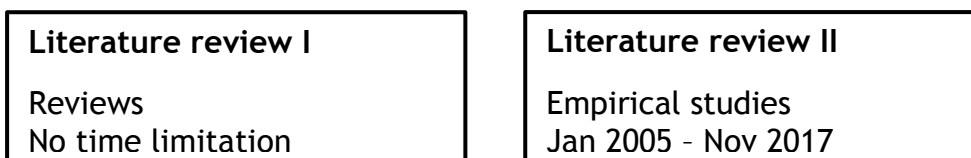
In consultation with an information scientist at the Social and Public Health Sciences unit and my supervisors, MEDLINE, Psycinfo, Socindex (with full text) and EMBASE were used for literature search. The PICO tool was used to guide a comprehensive list of search terms. The PICO tool focuses on Population, Interest, and Context and is considered particularly useful for qualitative reviews "seeking to analyse human experience and social phenomena" (Stern et al., 2014). Although the current review included both qualitative and quantitative studies, this tool was suitable due to the focus of this review on participants' experiences. This search therefore covered: population (men living with a female in a long-term relationship), interest (weight loss attempts through diet and exercise) and context (household/spousal relationship). Multiple search terms and combinations were tested before the final search. The list of terms used in the final search is included in Table 2.1.

Table 2.1 Search terms used for structured literature review

<p>Population: Men or Man or Husband or Masculin* or Spouse* or Boyfriend or Women or Woman or Girl* or Wife or Wives or Spouse* or Partner</p> <p>And</p> <p>Interest: Diet* or Food or Meal* or Eat* or Snack* or Takeaway* or Fried* or Fat* Carbohydrate* or Sugar or Beverage* or Obesity or Obese or Dinner or Lunch or Breakfast or Fruit or Vegetables or Meat or Sausages or Burgers or Sport or Exercise or Gym or Training or Fit* or "Weight loss" or activit*</p> <p>And</p> <p>Context: Home or House* or Cohabit* or Co-habit or Married or "Living together" or Family* or Families or "Long term relationship" or Couple</p>
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Because the potential relevant studies were disparate, deciding the precise search terms was difficult and the result was a large number of returns (82,392 titles). Therefore, it was decided that, as a first stage, identifying relevant reviews might be useful to gain an insight into the scope of the existing literature.

Accordingly, in May 2015, *Literature review I* was restricted to only reviews identified by these search terms, with no time limitation. For *Literature review II*, all identified empirical studies spanning 10 years (from 2005 to May 31st 2015) were searched. The search was updated in November 2017 to include recent literature (both reviews and empirical studies) spanning the period from June 2015 to Nov 2017.



Only studies relevant to men’s or partner’s weight, weight management, diet and/or physical activity in the cohabiting context were included. As cohabitation is an important topic to understand for this research, studies related to cohabitation and partners’ influence in weight loss or relevant health practices were included even when they were not related to *men’s* weight loss. Table 2.2 shows the inclusion and exclusion criteria that were employed.

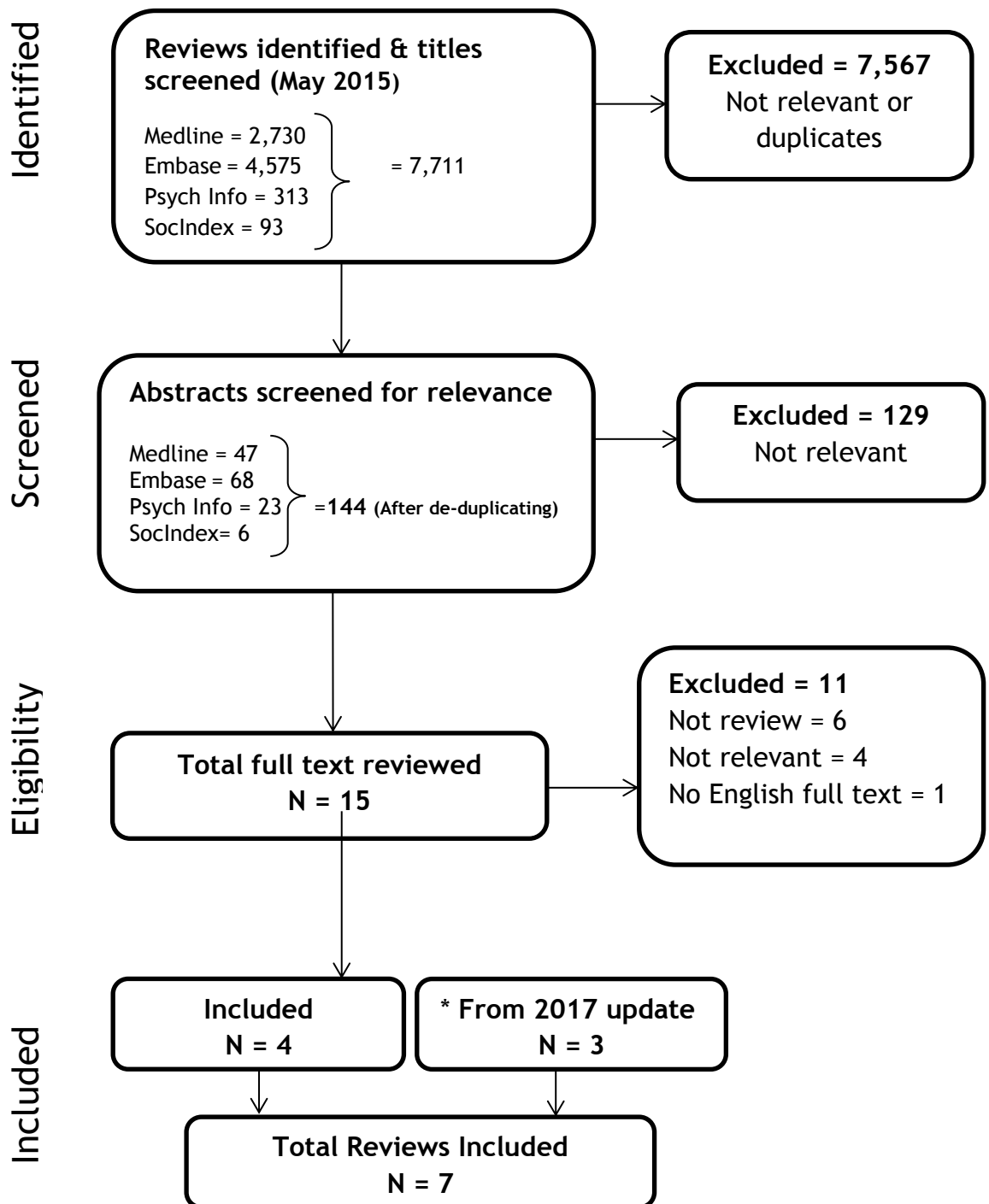
Table 2.2 Inclusion and exclusion criteria

Inclusion	Exclusion
Men’s and/or their partner’s weight, weight loss, weight loss maintenance, diet and physical activity in the cohabiting context	<p>Studies only focusing on the female partner without examining the male partner’s role</p> <p>Studies focused on children</p> <p>Studies only focusing on men’s physical activities and diet but not focusing on factors related to their partner</p> <p>Studies exploring general family diet without the context of men’s dieting, physical activities or weight</p>

2.4.2 Literature review I: A review of reviews relevant to weight loss in the cohabiting context

Literature review I focused on *reviews of the literature* relevant to weight loss and weight loss maintenance in the context of cohabiting partners. Seven (four in the initial search and three in the 2017 updated search) *partially* relevant reviews were identified (Barbarin and Tirado, 1984; Sobal, 1984; McLean et al., 2003; Robertson et al., 2014; Archibald et al., 2015, Robertson 2016; Manfredini et al., 2017). A four-phase flow diagram (Liberati, 2009) of the number of potentially relevant, subsequently included and excluded reviews is presented in Figure 2.5. Appendix One details the characteristics of the included reviews.

Figure 2.5 Literature review I, selection and elimination process for the identified reviews



* For the literature review I update, conducted in 2017 (for relevant reviews published between 2015 and 2017) the number of reviews identified, screened or excluded was not documented separately, as this search included both reviews and empirical studies together.

Publication dates of the seven reviews ranged from 1984 - 2017 and included studies published between 1944 and 2016. Sobal (1984) and Manfredini et al. (2017) reviewed literature on the relationship between marriage or cohabitation and body-weight or health practices. Barbarin and Tirado (1984) and McLean et al. (2003) investigated the literature on family involvement in weight control and maintenance. Robertson et al. (2014) reviewed literature on men-specific weight management interventions and briefly discussed five studies in relation to partner's involvement in men's weight loss attempts. Archibald et al. (2015) presented a synthesis of qualitative data and discussed only one study in relation to partners' influence on men's attempts to lose weight and (briefly) two studies regarding the influence on men's partners. Robertson et al. (2016) briefly discussed the data from three randomised control trials in relation to partner involvement in weight loss interventions for men. Details of the included reviews are presented in Appendix One.

The reviews in *Literature review I* in the most part discussed the context of women's weight loss in relation to the partner's support, the involvement of both partners in weight loss interventions, or aspects of men's weight loss not related to the cohabitation context or partners. Barbarin and Tirado, (1984); McLean et al. (2003); and Sobal, (1984) suggested a positive influence of cohabiting partners in reference to *women's* weight loss. However, the implications with regard to men's support of their female partners' weight loss attempts are not necessarily applicable to female partner's support on *men's* weight loss. Manfredini et al. (2017) suggested that being married was beneficial for men's health and some health practices but did not investigate the *partner* influence in relation to men's purposeful weight loss attempts.

Only three reviews (Robertson et al., 2014, Archibald et al., 2015 and Robertson 2016) covered studies that specifically focussed on men's weight loss or weight loss maintenance. Only a few of the empirical studies included in these three reviews focused on the cohabitating context. The reviews did not discuss the impact of cohabitation or cohabiting partners in detail and mostly focused on the potential impact of the partner's *involvement* in the intervention. In reviews

by Robertson et al. (2014 and 2016), discussion of the influence from and to men's cohabiting partners in relation to men's weight loss was very brief and considered together with influences from/to other social networks, such as friends and other family members. Both of these reviews reported that the evidence with regard to whether the partner's involvement in the intervention has a positive or negative impact on men's attempts to lose weight was inconsistent. Archibald et al. (2015) presented one study in relation to the partner's involvement in men's dietary practices and weight loss, and suggested that partners' influence on men's attempts to make changes to dietary practices could be impacted by men's conformity to hegemonic masculinity where their *female partners* took responsibility for changing the man's dietary practices. This review concluded that partners play a crucial role in successful weight loss attempts, especially by providing support for those choosing practices that are against the expected social norms of masculinity (i.e. eating a healthy diet). At the same time, the influence of family members who responded in a negative way tended to have detrimental effects on men's efforts to lose weight. Archibald et al. (2015) also presented a very brief discussion of two studies that suggested men's engagement in weight loss programmes could have a positive impact on their partner's health practices and wellbeing.

Literature review I highlighted the importance of cohabitation and the couples' context in weight and weight loss attempts, and also indicated the potential reciprocal influence of partners in this process. However, none of the reviews focussed specifically on the reciprocal influence of cohabiting partners in relation to men's attempts at weight loss and maintenance. Therefore, a comprehensive review of empirical studies was warranted in order to uncover and evaluate the existing evidence base regarding the influence from and to cohabiting partners in relation to men's weight loss attempts. **Literature review II** presents a narrative review of relevant empirical studies.

2.4.3 Literature review II: Changes in men's diet and physical activity in relation to their partners (empirical studies)

This section presents the narrative review of empirical studies identified through the search described earlier in this chapter. The included articles focused on: men's weight loss, diet and physical activities and cohabiting couples' weight loss and weight loss maintenance. A four-phase flow diagram (Liberati et al., 2009) of the number of potentially relevant, subsequently included and excluded studies is presented in Figure 2.6. Table 2.3 shows a brief overview of the included studies; Appendix Two details the characteristics of the included studies.

Because the same search terms were used for both **Literature reviews I and II**, it was expected that some of the studies that were covered by the reviews in **Literature review I** would also be found in **Literature review II**. Three of the reviews included in Literature review I were conducted before 2005. Of the four conducted after 2005, Manfredini et al. (2017) did not review any of the studies included in Literature review II. However, seven of empirical studies included in **Literature review II**, De Souza and Ciclitira, (2005), Gorin et al. (2008), Gray et al. (2009), Golan et al. (2010), Mallyon et al. (2010), Morgan et al. (2011) and Gorin et al. (2013), were included in Literature review I (in Robertson et al., 2014, 2016 and/or Archibald et al., 2015); none of these three reviews focused on the influence of partners.

Figure 2.6 Literature review II: selection and elimination process for articles identified (in 2015 search and 2017 update search)

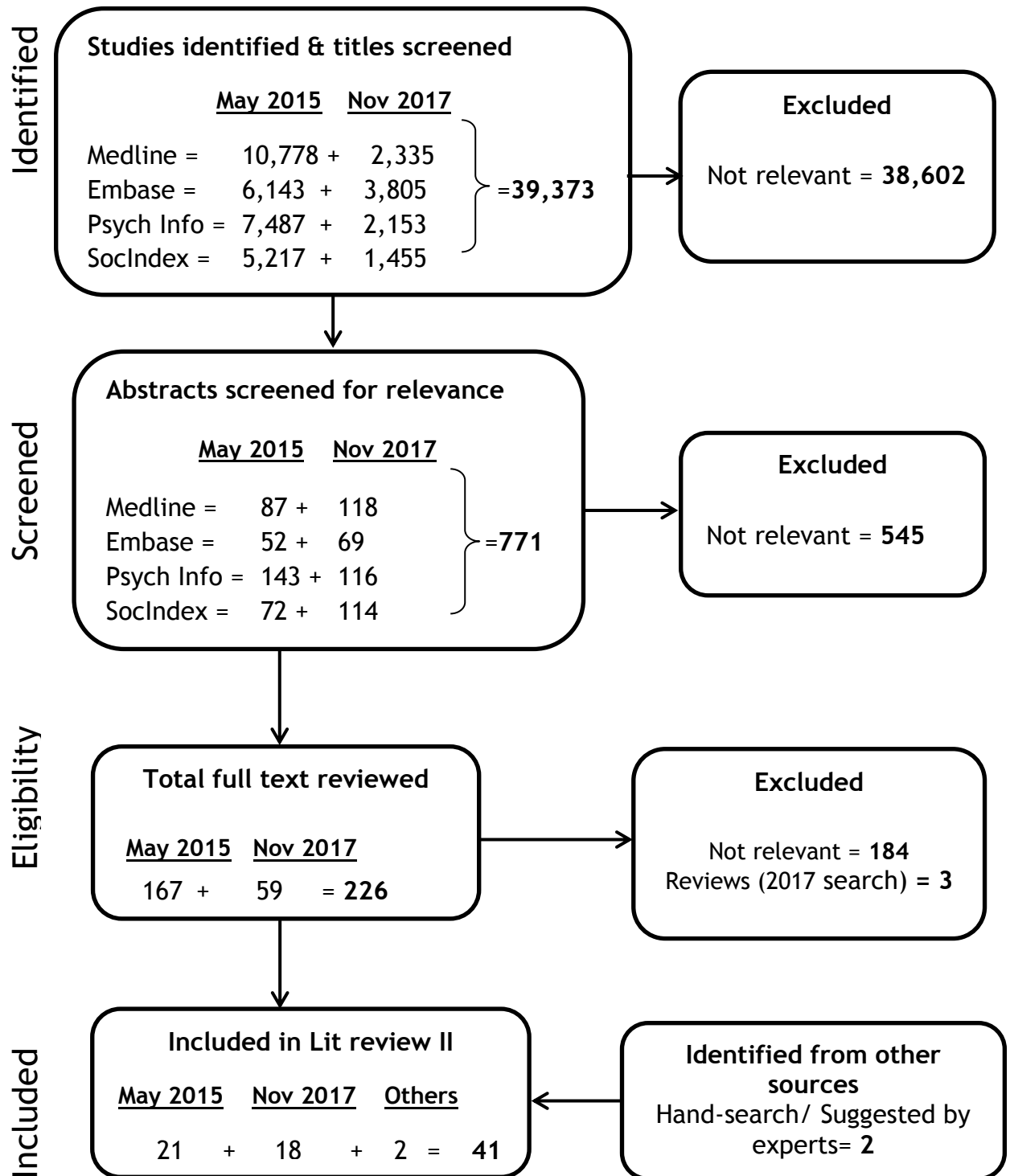


Table 2.3 Overview of the included studies

Studies	N = 41
Method	
Qualitative	19
Quantitative	22
Country	
USA	19
UK	9
Australia	2
Canada	2
Germany	4
Israel, Japan, Switzerland & Norway	1 (each)
Multinational	1
Primary focus of the studies	
Diet only	10
Physical activity only	5
Diet, weight and physical activity	7
Diet and weight loss/maintenance	7
Diet and physical activity	9
Physical activity and weight	2
Weight and marriage	1
Sample	
Men only	7
Women only	2
Couple	22
Non-couple men and women	10
Theories/models used/referred	
Gender	9
Interdependence theory	7
Social support or social control	5
Dyadic planning	3
Grounded theory	3
Social cognitive theory	2
Family systems theory	1
Relationship turbulence model	1
Confirmation theory	1
The dyadic growth curve model	1
No theories used or referred to	8

2.4.3.1 Characteristics of the included studies

In all, Literature review II included 41 empirical studies (Figure 2.6). The studies differed in their focus, method, location and sampling. Most studies were conducted either in the USA or UK. Of the identified studies, seven were men-only studies, 22 included cohabiting couples, two were women-only (including

women whose partners were participating in a weight loss intervention) and 10 included both men and women, but not dyads. Twenty two studies were quantitative and 19 were qualitative (mostly interviews). The topic of the studies ranged from only focusing on either dietary or physical activity changes, to focussing on a combination of diet, physical activity, weight loss and cohabitation. A majority of the studies either used or were guided by one or more theoretical perspectives, informing the design, hypotheses and/or analysis. Such theories included gender theories, interdependence theory, social support or social control, dyadic planning, grounded theory, social cognitive theory, family systems theory, the relationship turbulence model, confirmation theory and the dyadic growth curve model. Eight studies did not use any theories. All studies were conducted amongst adults.

The following sections discuss the main findings from the included studies grouped by the following themes: couple concordance in health practices and weight; the influence of female partners on men's pursuit of weight loss or changes in diet and physical activity; and the influence of men's attempts to make changes to the diets and physical activity of untreated partners. The influence of *gender* in these contexts is discussed throughout. Limitations and gaps in the existing literature are also presented.

2.4.4 Couple concordance in health practices and weight

The included studies demonstrated that couples are highly concordant for weight measures and many health practices in general, and have been found to make similar health behaviour changes (Schierberl Scherr et al., 2013). One partner's positive health related attitudes are associated with those of the other (Berge et al., 2012). The frequency of health-specific communication between cohabiting partners is also directly associated with, and has positive impacts on their health attitudes and health behaviours (Baiocchi-Wagner & Talley, 2013). Beverly et al. (2008) argue that aspects of spousal relationship, such as control over food, commitment to support, and spousal communication, translate into positive behaviour changes, such as adherence to a healthy diet.

Cobesity has been on the rise in recent decades. Researchers have argued that the influence of behaviour modelling (where people observe and adopt the behaviours of those around them) might be the reason for greater prevalence of obesity (Perry et al., 2016). Perry et al. (2016) suggest that within couples there is greater opportunity to observe someone's behaviour. This proximity provides more opportunity for assessment of either the short-term or long-term consequences of the partner's behaviour, which should encourage the other to adopt exercise and dietary practices and modifications, through mutual reinforcement of healthy behaviour. However, the partners might also be prone to imitate each other's unhealthy practices. In a study investigating social influences on women's dietary practices, Mötteli et al. (2017) suggest that the shared understanding of what constitutes normal behaviour could be the reason why partners imitate each other's practices.

The studies included in this review suggested mixed findings with regard to the influence of cohabitation, or of partners, on *men*. For example, some studies suggested that cohabitation or the female partner can have a *positive impact* on men's *dietary practices* (Mata et al., 2015; Matsuo et al., 2010; Mróz et al., 2011). However, studies have reported *positive* (Gorin et al., 2008; Jackson et al., 2015), and *negative* or *no* (Mata et al., 2015; Matsuo et al., 2010) impact on *physical activity*, and both *positive* (Matsuo et al., 2010; Gorin et al., 2008; Jackson et al., 2015) and *negative* (Mata et al., 2015) impact on *weight* or *weight loss*. These studies either did not report on or reported no impact on *weight loss maintenance*.

As various aspects of diet, such as meal choice, preparation and consumption, take place within the cohabiting context, this context is important in determining people's dietary practices (Mróz et al., 2011). Specifically for men, having a cohabiting partner or being married has been found to positively influence their dietary practices and weight in general, although it may negatively impact their physical activity (Caperchione et al., 2012). Mata et al. (2015), in a multinational qualitative study among 4555 participants from nine European countries, highlighted the complex relationships between cohabitation and weight-related outcomes for men. This study showed that the impact of

marriage varied according to individual health practices. Married men were found to adopt healthier dietary practices but exercise less compared to single or widowed men. The findings reported by Mata et al. (2015) that married men had higher rates of overweight or obesity than never-married, divorced or widowed men, despite their improved dietary practices, also emphasises the importance of physical activity along with healthy diet for healthy weight.

When a partner improves her health practices, the man is likely to be influenced (Gorin et al., 2008; Jackson et al., 2015; Matsuo et al., 2010; Schierberl Scherr et al., 2013). For example, Matsuo et al. (2010) investigated the effects of 'indirect lifestyle intervention' on weight loss and metabolic syndrome of overweight or obese Japanese couples. This study, which included dietary modifications within/beyond a physical activity programme, found that untreated obese men whose female partners participated in the lifestyle intervention were more successful in losing weight than men whose female partners did not participate. Women's changes in dietary practices had a strong positive impact on the dietary practices of their untreated male partners. The authors suggest that this did not result from the direct assistance of a weight loss programme but only through their female partners' support. However, Matsuo et al. (2010) suggested that there was no influence of partners' physical activity changes on those of the men.

Similarly, Schierberl Scherr et al. (2013), in a US study involving an 18-month randomised control trial of a dietary intervention and increased physical activity amongst 132 couples (71% female primary participants), found that at six months, untreated men's weight loss was positively influenced by the dietary changes made by their partners participating in a weight loss intervention. However, partners' changes in physical activity were not associated with men's weight loss. The authors argue that men may have benefitted because the female participants made weight loss promoting changes to the shared home food environment such as greater availability of lower calorie drinks, fewer food choices, and smaller meals, which have been found to impact weight loss, as opposed to women's changes in physical activity where the cues for physical activity are not as direct. Interestingly, this study also reported that the

participant-partner associations for dietary changes and weight loss were more robust when men were not involved in the intervention compared to those groups where *both partners* were given assistance to make changes together. The authors speculate that men who did not receive any active intervention may have been more reliant on their partner's dietary changes because those were the only changes to which they were exposed, compared with men who may have been more influenced by changes made to their home environments as well as information they received at the intervention.

2.4.5 The influence of female partners on men's pursuit of weight loss or changes in diet and physical activity

Studies of cohabiting female partners' influence on men's weight loss and weight maintenance have been conducted mostly among men diagnosed with a medical condition and only a few among healthy (overweight or obese) men. The findings from both types of studies are discussed below.

Cohabiting contexts, and support from partners, are recognised as important factors in men's purposeful attempts to lose weight and manage weight loss maintenance (Cornelius, 2017; De Souza & Ciclitira, 2005). Cohabiting contexts can also influence weight loss and weight loss maintenance *interventions*. A qualitative US study by Theiss et al. (2016), including both males and females, examined the ways in which partners facilitate or interfere with each other's weight loss *goals* and identified several facilitators, such as the partner enabling healthy dietary practices, motivation and encouragement, emotional support and positive reinforcement, co dieting, the partner enabling exercise, coactivity, and positive relationship. They also identified a number of inhibitors, such as a partner's inability to plan for healthy meals, attempts to control the food environment and preventing or discouraging exercise. This study however did not report the result of partners' influence on men's weight loss *attempts* or *outcomes*.

Studies in this review investigating partners' influence on men's weight loss and/or related health practices have focused on three main aspects: partners' partial involvement in an intervention targeted at men (Golan et al., 2010;

Jackson et al., 2015), the influence from partners who are not part of the intervention but were involved in their male partner's dietary changes (Mallyon et al., 2010; Allen et al., 2013; MacLean et al., 2014), and modifications in the home environment (Cornelius, Gettens, et al., 2016; Gorin et al., 2013). These studies also vary in terms of their focus on reported outcome (weight loss), and health practices (e.g. diet, physical activity or both). The following sections outline these studies based on their areas of focus

2.4.5.1 Partners' influence on men's attempts to lose weight

Golan et al. (2010) investigated whether partners' partial involvement (invited to attend 90-minute support group meetings) in an intervention that focused on men was more beneficial for men than partners' lack of involvement. This study reported that at the end of the trial, men whose partners had attended support meetings lost significantly more weight than men whose partners had not.

Jackson et al. (2015) argue that involving partners in behaviour change interventions can help improve weight loss for the primary participant. This study examined the influence of the partner's behaviour on the likelihood of positive health behaviour change over time among 3722 married and cohabiting couples in the UK participating in the English Longitudinal Study of Ageing. This study found that men were more likely to make a positive health behaviour change and succeed in achieving weight loss if their partner also participated. This influence was even stronger if the partner had newly adopted healthy practices compared to those who had been consistently healthy in those practices.

Two US studies (Cornelius, Gettens, et al., 2016; Gorin et al., 2013) investigated whether modifying the home environment (e.g. by modifying the type and amount of food consumed and the availability of exercise equipment at home where participants cohabited with a partner) had additional benefits on men (treated), and their (untreated) cohabiting partners. Gorin et al. (2013) examined the long-term impact of this and found that adding a home element to the intervention significantly improved initial weight loss in men but these men had not maintained the weight loss at 18-month follow-up. In contrast to this, Cornelius, Gettens, et al. (2016) examined weight loss between the groups of

men with or without modification in their home environment (in addition to a weight loss programme for men), and found that *men* who did not have home environment modifications benefited *more* from the weight loss programme in relation to their own weight loss, although home environment improvement had some positive impact, such as adoption of healthier dietary practices, on both men and their partners.

2.4.5.2 Partners' influence on men's attempts to change dietary practices

Studies have found that men perceive the influence of their partner in their diet as significant, especially at home (Allen et al., 2013; MacLean et al., 2014). Some studies investigating the influence of women (partners) in men's attempts to lose weight and change dietary practices following diagnosis of chronic diseases have also found that their role in the family food environment is influential (Gough and Conner, 2006; Mroz et al., 2011). In a study among prostate cancer patients, Mroz et al. (2011) found that although men's involvement in their diet and food practices increased after the diagnosis, female partners still took the leadership in changing the man's diet according to his changed needs.

Changing dietary practices is an important aspect of most weight loss programmes including those designed for men. As women are traditionally more involved in food preparation at home than men, involvement and support from female partners can have a significant positive influence on men's diet when men attempt to make changes to their dietary practices in order to lose weight (De Souza & Ciclitira, 2005). With regard to men's participation in weight loss interventions, Bennett and Gough (2013) found that men presented themselves as in control of their diet and eating practices. In this study, investigating how men talked about their weight loss/dieting experiences in a male oriented online forum, men rarely mentioned the support of their female partner in their attempt to lose weight. However, other studies have consistently shown that men are more likely to participate in dieting programmes (De Souza & Ciclitira, 2005) and have positive weight loss outcomes (Golan et al., 2010) when they are supported by their female partners.

Studies of men's dietary changes after they were diagnosed with a medical condition have found that the special circumstances created by major life events, such as chronic illnesses, can encourage men to be more involved in practices that are traditionally considered feminine, such as cooking, eating a healthy diet and adhering to healthy practices (Mróz et al., 2011). However, the female partner's role in dietary practices still persists, and changes to the diets of men in these circumstances are usually accommodated by their female partners (Gough & Conner, 2006; Gregory, 2005; Mroz et al., 2011; O'Hara et al., 2013). In a qualitative study among men and their partners, exploring how gender relations shaped men's food practices after prostate cancer diagnosis, Mroz et al. (2015) analysed couples' accounts of food negotiations and dietary changes. The study showed that food negotiation interactions between couples revolved around seeking information, deciding on and monitoring food changes, where the female partners were very involved. The study by Virtue et al. (2015) suggested that couple-based interventions may be effective to stimulate healthy behaviours among prostate cancer survivors (men) and their partners. Recent studies by Anderson et al. (2016) and Trief et al. (2016) also highlight the importance of partners in helping type 2 diabetes patients (both male and female) adopt and maintain healthy dietary practices.

A few studies have specifically explored the influence of female partners (and other female relations) with regard to diets of *healthy* men as they attempt to lose weight (Allen et al., 2013; MacLean et al., 2014; Mallyon et al., 2010).

In an Australian study, Mallyon et al. (2010) found that half of the men participating in a dieting intervention were dependent on their female family members (partners) to cook for them. The study showed that men who conform to a hegemonic masculinity and followed more traditional gender roles within their relationships were happy to receive help with their diet from their female family members, which helped them adhere to their weight management programme. This study also indicated that hegemonically masculine men who attempted to distance themselves from dieting emphasised the female partner's role in providing foods for them. However, those who were less inclined to

conform to hegemonic masculinity were more likely to take control of their dietary practices.

Allen et al. (2013), in a study of overweight or obese married African American men from different US cities, found that men perceived their female partners to have strong control over their diet. Men thought the influence of their female partners was greater than that of their own food preferences. Men in this study appreciated their female partners' nurturing behaviour and recognised the care for their health; however, they felt that they were not asked or expected to be involved in decision making for food choices or asked about how the meals could be healthier. Allen et al. (2013) argued that men avoided expressing dissatisfaction with food that their female partners provided them, in order to maintain marital harmony, describing how "men prioritised 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" (Allen et al., 2013, p. 447).

Similarly, a recent UK study (MacLean et al., 2014) (also see chapter one), investigated how men perceived the influence of female family members (including partners) in their attempts to lose weight through an organised weight loss programme tailored for men (Football Fans in Training-FFIT) that included advice on physical activities and dietary practices (Hunt, Wyke, et al., 2014). This study used focus groups to explore how men perceived the influence of significant female family members, such as their wife, mother, or mother-in-law, on their dietary practices, and how men negotiated changes to their diet and to food practices in the family. The study found that men considered their female family members to have a strong influence on their diet and eating practices. Different levels of both positive and negative influences from female family members were identified. Based only on men's perceptions, MacLean et al. (2014) categorised these female family members as: facilitative; detached; undermining of changes; resistant to changes; or threatened by men's dietary changes to lose weight. Consistent with previous studies (deVault, 1991; Mallyon et al., 2010), the female family members were described as mostly conforming to a stereotypical gender role, looking after men's diet and fulfilling feminine

ideals, such as being caring and nurturing. At the same time, men also presented themselves as keen to work with their female partners in their weight loss attempts.

Allen et al. (2013), MacLean et al. (2014) and Mallyon et al. (2010) also provide examples of how men's (engagement with) hegemonic masculinity and/or men's concerns for harmony in their relationship with their partners could make their adherence to healthy eating plans more vulnerable to social sabotage, which in turn could be detrimental to their weight loss. For example, some men in these studies reported finding it difficult to refuse their female family members' food offerings even when it included unhealthy food, which some men in these studies blamed for their overweight or obesity. While the above studies (Allen et al., 2013; MacLean et al., 2014; Mallyon et al., 2010) provide a better understanding of the influence of gender relations and the cohabiting context in healthy men's attempts to change their diets in order to lose weight, it is important to consider that the findings are based only on *men's* (treated participants) perceptions.

Paisley et al. (2008) argue that understanding dietary change from the perspective of significant others (family members) can help in the development of strategies to promote dietary modifications as a shared activity. This qualitative study among 21 Canadian cohabiting adult pairs (17 couples, and four pairs of other relationships) investigated the perceptions of the significant others of people engaged in dietary change and how that change had impacted their shared eating experiences. The significant others in this study described a range of emotional responses to the dietary changes of the 'changers' (Paisley's term), including cooperation, encouragement, scepticism, and anger. Significant others' descriptions of the roles that they played in the dietary change were mostly positive. However, the impact that their support had on the experiences of the 'changers' varied, based on the type of support that the 'changers' received. For example, the impact of indirect support, such as significant others not complaining about dietary changes, was less helpful to 'changers' than the direct support offered through positive reinforcement and encouragement. Some 'changers' perceived that their significant others hindered their ability to

change their diets, while the significant others did not report the same perception regarding their behaviours.

2.4.5.3 Partners' influence on men's attempts to increase their physical activity

Although physical activity is an important aspect of most weight loss programmes, this literature review found that studies with a specific focus on female partners' influence on men's physical activity changes are limited. This search only found two studies (Berli et al., 2016; Jackson et al., 2015) investigating the influence of female partners on men's attempts to make changes in their physical activity and four studies (Deci & Ryan, 2000; Feeney & Collins, 2015; Kashy & Kenny, 2000; Novak & Webster, 2011) discussing the impact of couples' dyadic attempts to make changes to physical activity.

Jackson et al. (2015) and Berli et al. (2016) reported specifically on the influence of untreated partners on men's physical activity changes. Jackson et al. (2015) showed that men are more likely to be influenced by their partner's physical activity and are even more likely to make changes if the partner is also changing her physical activity. In an intervention among overweight and obese couples, including men intending to increase their physical activity, Berli et al. (2016) reported that text messages from a partner prompting the other to adhere to their physical activity goals seemed to be an effective tool for increasing physical activity in everyday life. However, it is noteworthy that while this study demonstrates that involving a partner could have beneficial effects on physical activity changes, the text messages from the partners were not any more effective than the automated ones sent by the study team. Berli et al. (2016) suggest that the perceived caring and support represented by the gesture of sending a message could have been effective, rather than who the messages came from.

Studies have also reported on the impact of female partners in cases where they have not been part of a formal intervention but used dyadic planning for physical activities by making plans jointly and/or being coactive (Cornelius, Gettens, et al., 2016; Keller et al., 2017; Knoll et al., 2017; Lüscher et al.,

2017). Keller et al. (2017) found that dyadic planning of physical activity positively affects the enactment or implementation of those plans for both partners compared to couples who planned the changes individually. However, the relationship between dyadic planning and enactment appears to be more complex and is determined by partners' relationship quality (Knoll et al., 2017) and specific context (Lüscher et al., 2017). Lüscher et al. (2017), in a dyadic daily-diary study among 61 overweight couples, found that dyadic attempts to change health practices were inconsistent across varying health practices. This study found that one partner's disengagement with their dyadic goal had a negative effect on another's attempts when the goal was to increase physical activity but not when the goal was to quit smoking.

Similarly, Cornelius, Desrosiers, et al. (2016), in a study among 157 American new-parent couples, suggested variation in partners' influence across practices. This study also found variation by gender. In these couples, only female to male influence was evident for dietary changes and there was no influence either way for physical activity. The authors argue that this gender difference might have resulted from female prominence in food provision for the family. They also argue that the variation in partners' influence in different practices could have been affected by the circumstances of being a new parent, where *codieting* was possible even with the baby present but coactivity was difficult.

Thus, while these studies mostly reported either no impact or negative impact of partners' participation in men's weight loss *intervention* on men's physical activity, the findings from studies investigating the influence from *untreated* partners on men's physical activity suggest a mostly positive impact.

2.4.6 Influence on untreated partners' dietary practices and physical activity

A change in an individual's health practices can also influence other individuals who are part of their social context. For example, behavioural weight loss treatment for one partner can have an impact on their untreated partner (Archibald et al., 2015; Golan et al., 2010; Gorin et al., 2008; Matsuo et al., 2010; Schierberl Scherr et al., 2013). While evidence for the effectiveness of

involving female partners in formal weight loss interventions for men is inconsistent (as discussed in the previous section), evidence for the indirect impact of *men's* participation in weight loss interventions *on the female partner's* dietary practices and/or weight loss is consistently positive (Gray et al., 2009; Morgan et al., 2011; Gorin et al., 2008; Golan et al., 2010).

In a focus group study with partners of Scottish men participating in a men-only weight loss programme, Gray et al. (2009) reported that partners' dietary practices were positively influenced by men's engagement with the programme. Consistent with this, Morgan et al. (2011) reported that a majority of the Australian men participating in a men-only programme said that their participation had an instant positive impact on their partner's eating practices and physical activities. Gorin et al. (2008) refer to this impact from intervention participants (*treated*) to their *untreated* partners as a 'Ripple effect'. Gorin et al. (2008) examined whether a weight loss programme delivered to one partner had beneficial effects on the untreated partner and the home environment. This US-based 12-month randomised controlled trial among overweight males and females with type 2 diabetes incorporated both dietary changes and physical activities in the intervention. The findings showed associations between weight loss in the treated participants and that of their partner. Regardless of their gender, untreated partners lost nearly 3% of their body weight and decreased their intake of high-fat foods at home. This study also compared two groups of participants in which the partners were not formally involved. In one group, men were given advice on ways to enhance social support (e.g. ways of communicating assertively with family members about desired dietary changes or effectively involving family members in their physical activity), while the control group did not receive this advice. The study found that after a year, the partners of men who had been given advice around social support lost more weight than the partners of those in the control group.

Gorin et al. (2013) reported that home modifications (i.e. exercise equipment, portion plates) made in relation to men's attempts to make changes also resulted in women's weight loss and weight loss maintenance, interestingly even when the men (who were the primary participants) had not maintained their

own weight loss. This study compared two groups of participants described as 'standard' and 'modified'. Only primary participants received treatment (exercise advice and behavioural therapy) in the standard programme, while both primary participants and their partners received treatment and home environment modifications in the modified programme. This study found that at 18 months, women (both as primary participants and partners) lost more weight in the modified programme than in the standard programme. These findings suggest that women could benefit from their partners' involvement, both through co-weight loss attempts and through a ripple effect.

Similarly, a US study involving an 18-month randomised control trial of a dietary intervention and increased physical activity among couples found that the (male and female) participants' dietary changes impacted positively on their partner's weight loss (Schierberl Scherr et al., 2013). This study also compared whether partners' diet and physical activity changes impacted each other's weight loss when couples attended an active weight loss programme together or when only one partner participated. Dyadic data analyses showed that, while participating women's weight loss was not predicted by their untreated partners' behaviour changes, untreated women's weight loss could be predicted by the dietary changes but not by physical activity changes of their male partner, who was participating in the intervention.

These findings are consistent with another study by Golan et al. (2010), a randomised control trial on 74 cohabiting couples in Israel, which described a 'halo' effect of men's participation in a weight loss programme on their partners. This study found that men's participation in a health intervention programme positively influenced their female partners' nutrition, weight loss and weight loss maintenance. In this study, men received a dietary intervention and some female partners attended one 90-minute dietary consultation session every two months. A two-year follow-up survey showed that the female partners lost weight and improved their nutritional patterns *regardless* of their husbands' weight loss outcomes. However, since *some* female partners were involved in the intervention through support group consultation, this study cannot answer

questions relating to the specific indirect impact of an intervention only conducted with men.

The studies above suggest that changes in an individual's dietary practices are linked to changes in their partner's dietary practices and/or weight loss. This implies a 'ripple effect' from the treated participants to their untreated partners, indicating that a weight loss intervention with one partner could be utilised to promote weight loss in the other. It is important, however, to consider this ripple effect from a gender perspective because women may be uniquely placed to benefit from an intervention that involves their partners' dietary modification at home. As women in many societies are expected to serve what their male partners like (or need), this expectation can be a strong determinant of their own diet (Brown and Wenrich (2012). Gorin et al. (2013) speculate that if women are primarily involved in dietary practices, such as preparing meals, having another adult in their household who is following a healthy dietary plan may motivate them to follow the same dietary patterns rather than preparing separate meals for themselves. Researchers also suggest that perceiving high levels of both acceptance and challenges to weight management and dietary practice goals from their partners is associated with the accomplishment of those goals in women (Dailey et al., 2016).

2.4.6.1 Limited evidence around influences on untreated female partner's physical activity

There is very limited literature investigating the indirect impact of men's weight loss interventions on untreated female partners' physical activity outcomes. Interventions including *both* dietary changes and physical activities have, as noted above, consistently found that one partner's participation in the intervention has a positive impact on the untreated partner's dietary practices and weight outcomes. However, they have found no impact on physical activities (Gorin et al., 2008; Matsuo et al., 2010; Schierberl Scherr et al., 2013). It should be noted that the focus of some of these interventions was primarily on diet and less on physical activities.

Studies have suggested that male partners can positively influence women's attempts to make changes to physical activity in healthy populations (Jackson et al., 2015; Ranby & Aiken, 2016) as well as when men are diagnosed with chronic illnesses (Winters-Stone et al., 2016).

The evidence that changes to physical activity by one member of a cohabiting couple can impact on those of their partner is important, especially for the partners of those who attempt to make positive changes too (Jackson et al., 2015). Jackson et al. (2015), in a quantitative study, analysed data from couples aged over 50 years. They compared the effects on partners of participants newly adopting physical activity as opposed to those who were already physically active. This study reported that if men make changes to their physical activity, their partners are also likely to make those changes, even more than the partners of those men who already undertook healthy physical activity practices (Jackson et al., 2015).

Although a few studies (mentioned above) focusing on physical activity have found that men's attempt to change physical activity can have a positive impact on their partner's practices, these studies do not provide evidence for the mechanisms through which the female partners are influenced to make these changes. The lack of robust evidence in the existing literature with regard to the influences on female partners when men change their physical activities is notable. However, this should not be considered as evidence of no influence and should therefore be explored further.

2.5 Conclusion of the empirical literature review

The purpose of this review was to summarise the existing research relevant to the current study.

Literature review 1, which was an appraisal of (seven) reviews, suggested that cohabiting partners can impact each other's health-related practices, such as (changes in) diet and physical activities and weight loss or weight loss maintenance.

Literature review II, which was a review of empirical studies, further explored and shed light on the complex reciprocal influences between cohabiting couples with regard to weight management, where levels and directions of influence can vary according to gender, targeted practices (diet and physical activity) and expected outcomes (weight loss and weight loss maintenance).

The literature has highlighted the importance of gender roles and relations within the cohabiting context that can impact on men's diet, eating practices and, potentially, physical activity. The important roles that gender norms (e.g. men's conformity to hegemonic masculinity and around food practices) might play have been identified. These are particularly important in relation to diet and physical activity for men, and when they attempt to change these practices within a cohabiting context. Studies reporting on health behaviour in the couples' relationship context also suggest that individuals are aware of the need to balance their desire for their partners to be physically healthy with their desire to maintain their relationship, which might also determine how each partner navigates the process of helping their partner to adopt healthier practices.

These studies highlight the influence of couples' contexts on weight and weight loss attempts and further clarify the necessity of interventions targeting dyadic and interpersonal factors for health behaviour change. Although the level of influence from a partner may vary based on practices (for example, diet vs physical activity), and for weight loss vs weight loss maintenance, it is evident that the couples' context can play a role in either facilitating or hindering the adoption of healthy practices. These findings are also suggestive of the need for practice-specific consideration to understand mechanisms of the weight loss process.

2.6 Gaps in the literature

2.6.1 Influence of untreated female partners

Although a growing number of male-targeted weight management programmes have been delivered in recent years, a key limitation of the existing body of literature is the lack of investigation into the influence of female partners on *healthy* men's attempts at weight loss and weight loss maintenance.

Studies investigating the influence of men's untreated partners have focused on dietary practices but only a very few studies have focused on physical activities. Given that physical activity is a crucial aspect of weight loss and weight loss maintenance, especially for men, it is important to understand the female partner's role in helping or hindering men's attempts to make changes to their physical activities as well as diet.

Some studies have looked at weight loss or nutrition intake outcomes as a measure of the influence from treated to untreated partners and *vice versa*. However, the specific nature of how, and the mechanisms by which, female partners can enable or inhibit healthy men's attempts to lose weight through changes in their diet and exercise and sustain those changes is not well understood, particularly from the female perspective. Furthermore, attributes of female partner support such as emotional (caring, empathy) and instrumental support (providing tangible assistance or materials) have not been analysed in samples of healthy men and their partners.

The limited studies that have investigated female partners' role in men's weight loss/maintenance, from both partners' perspectives, have mostly focused on men diagnosed with chronic diseases. A few of these studies have reported poor weight loss maintenance among men. However, partners' influence on weight loss maintenance has not been adequately addressed.

2.6.2 Influence *on* untreated female partners

Another key gap in the existing body of literature is that the few studies that have investigated the influence from treated to untreated partners were all (except Jackson et al., 2015) conducted outside of the UK.

In addition, most studies investigating the influence from a treated man to an untreated female partner have included *both* partners as intervention participants, at least in some aspects of the intervention programme. Therefore, investigating these influences in a sample with men participating in an intervention in which their female partners have no formal involvement is needed to clearly identify the indirect impact of an intervention for men on their untreated female partners' health practices.

Studies investigating the impact of a treated (male or female) partner's attempt to lose weight on an untreated partner have primarily focused on the untreated partner's weight loss outcome or nutrition intake. Only a very small number of studies have reported impacts from treated to untreated partners' physical activities, all suggesting no impact. However, these studies have focused on physical activities combined with diet and have not analysed the influence of men and women on these practices separately. Therefore, an understanding of if, and how, female partners' physical activity is affected by men's weight loss and maintenance attempts is missing.

2.6.3 Role of gender in health practices in cohabiting couples' context

The existing literature (both theoretical and empirical) shows that gender clearly has an influence on men's weight loss in the cohabiting couples' context. Female prominence in food provision, some masculine ideologies encouraging unhealthy dietary habits in men, and stereotypical understandings of weight loss as feminine, are important gendered issues that can impact on men's weight loss and weight loss maintenance in the cohabiting couples' context. However, performances of masculinity and femininity in relation to healthy men making dietary and physical activity changes within the cohabiting context, and the role

they may play in men's attempts to lose weight and maintain weight loss have not been thoroughly explored from both partners' perspectives.

An understanding of how control and power associated with gender-based practices, such as dieting and physical activity, play a role (and/or shift) when men and women negotiate changes in these practices, may help inform the design of effective weight loss and weight loss maintenance programmes for men and women.

Chapter 3 Methods

3.1 Introduction and overview of chapter

This study aims to explore how men's attempts to change their dietary practices and physical activity to lose weight and maintain weight loss are influenced by and influence their cohabiting female partner, within the context of the Football Fans In Training (FFIT) weight management, physical activity and healthy living programme. This chapter outlines the issues central to planning, developing, and conducting this study. It presents epistemological considerations and practical issues concerning: the underpinning approaches and the decisions made in planning the project; specific topics and issues of concern due to the nature and subject matter of this particular study; and the methods and techniques used in data collection, management and analysis. The chapter ends with a reflective account of practical, theoretical and ethical issues encountered during the course of this study.

3.2 Paradigms of research: Disciplinary and epistemological considerations

Ontological and epistemological considerations can guide the adoption of methodology in research (Guba & Lincoln, 1994). Ontology refers to what we view as truth or knowledge. The researcher's ontological views frame their interaction with what is being researched, and their belief about the validity of that research. For example, researchers who consider knowledge to be fixed and governed by the laws of nature believe that this view of the world is objective, whereas researchers who see knowledge as something interpreted by individuals believe that the world can only be subjectively experienced.

Epistemology is the study of knowledge. The debate about whether the social world can, and should, be studied following the same procedures, principals and ethos used to study the natural world has led to consideration of alternative epistemological approaches. Research is guided by two fundamental epistemological understandings - positivist, and post-positivist. There are a range of approaches established in the post-positivist tradition. These

epistemological approaches imply different ways of gaining knowledge and different explanations of the status of that knowledge (Green & Thorogood, 2013; Hesse-Biber & Leavy, 2006). Based on their ontological and epistemological stance and the nature of the study, a range of quantitative and qualitative research methods can be selected by researchers (Green & Thorogood, 2013; Guba & Lincoln, 1994).

3.2.1 Positivist, post-positivist and realist approaches

Positivist approaches posit that there is a single truth or reality waiting to be discovered, and that reality can be understood by experimental and statistical methods. Positivists believe that reality stays the same regardless of whether or how it is understood. Some of the fundamental implications of positivist philosophy are *empiricism* (studying only what can be observed), *unity of method* (that the same method of examination should be suitable for all studies), and *value-free inquiry* (that knowledge derived from scientific inquiry is categorical 'truth' and is not loaded with subjective, emotional or political perceptions).

A fundamental criticism of positivist approaches in respect of studies of people and behaviour is that an understanding of the context is essential. Because humans, unlike most *matters* in the natural sciences, are responsive to the researchers, complex, and unpredictable, the reality can be different for each individual based on their unique understanding of the world and their experience of it. Therefore, a context-free experimental design following positivist approaches is insufficient (Berger & Luckmann, 1996) when studying people and their social world.

Post-positivists believe that research with people and social phenomena should be focused on understanding complexities associated with context and peoples' understandings. Post-positivist scholars have identified and described competing paradigms of inquiry (Guba & Lincoln, 1994) such as *interpretivism*, *phenomenology*, and *social constructionism*. While all these approaches contrast themselves with those of positivists, and with each other, they are similar in

their definition of what should be considered as knowledge. One of these approaches, namely interpretivism, is discussed below due to its relevance to the current study. The realist approach, which attempts to bridge the gap between positivist and post-positivist approaches, is also discussed due to its relevance to the current study which is situated within post-intervention circumstances.

3.2.1.1 Interpretivism

The foundation of interpretivist philosophy comes from a core belief that social reality cannot be known in absolute terms but can only be subjectively interpreted through exploration of people's understanding of their world. The focus is therefore on understanding the social world through an examination of the interpretation of that world by its participants. For example, a smile may be happy/wry/sarcastic and can be interpreted in different ways and will have different meanings depending on the context. Thus, in order to gain knowledge, interpretivists prioritise individual perceptions and seek to identify patterns within these subjective experiences.

3.2.1.2 Realist approach

The realist approach is an epistemological position that attempts to bridge positivism (advocating knowledge as a categorical truth) and post-positivism (understanding of truth or knowledge as flexible and as constructed by people and context). According to those adopting a 'realist approach' there are aspects of any reality that are hidden from what can be observed. Realist approaches emphasise the need for researchers to understand the observable (empirical) reality as well as uncover the underlying causal mechanisms that produce the observable outcomes (Hibberd, 2010). *Context*, *mechanisms* and *outcome* are the three central elements of this approach, and each of these elements influences the other to bring about a cycle of change. The realist approach addresses the fluidity of the social context and suggests that based on the nature of the intervention, what is contextually significant relates to the systems of interpersonal and social relationships. Mechanisms refer to the aspects of interventions that bring about changes. It is believed that it is not just the

mechanisms of an intervention that produce an outcome but the context itself changes during the process, thereby producing multiple outcomes from the same intervention (Hawe et al., 2009; Pawson & Tilley, 1997). Thus, the realist approach employs contextual thinking to address the issues of ‘for whom’ and ‘in what circumstances’ a particular intervention might work (Pawson & Tilley, 2004). Understanding of what works for whom lets researchers interrogate why an intervention might be effective only for some. The focus on transparency, pragmatism and conceptualisation of an outcome (for example, expecting an unexpected outcome) makes this approach particularly relevant for social science and health research (Bhaskar, 2008; Sayer, 2000).

3.2.2 Epistemological framework for the current study

Interpretivist beliefs that social reality can only be subjectively interpreted through exploration of people’s understandings of their world appear to be the most suitable epistemological approach for this study. Additionally, a focus on understanding the social world through the interpretations of its participants can help understand social practices, such as diet and physical activity (and the practices of changing them), as they are established through what people say and do in everyday life. By exploring perceptions relating to changes in men’s dietary practices and physical activities through qualitative research, insights can be generated around these social practices beyond established (biomedical and psychological) presumptions.

This study is focused on men, following their participation in the FFIT programme, and their cohabiting partners. Given this, consideration will also be given to the principles of the Realist approach by paying close attention to the participants’ relationship context and the mechanisms contributing to men’s dietary and physical activity changes. Timmermans (2013) argues that focusing on the experienced effect of an intervention uncovers “unintended consequences, spill over effects and collateral damage” (Timmermans, 2013, p. 4), and using qualitative methods allows researchers to tap into the lived experience of the participants. One of the seven uses or ‘warrants’ (Timmerman’s term) of qualitative research that Timmermans (2013) outlines is

to identify ‘unfulfilled promises’, or the inconsistency between the intentions of health interventions and the complexity of people’s experience of them. When there are interventions or trials, there is a promise of cure or improvement; however, these promises are not always fulfilled. Qualitative methods allow for further exploration to not only find out what other elements influence an outcome or lack thereof, but also possibly understand why (Milburn, 1995).

3.2.3 Methodology

Although not always mutually exclusive, epistemology and methodology differ in the sense that while the former is about what is believed to be knowledge, and the source of that knowledge, the latter is about how researchers practically go about obtaining knowledge. Methodology therefore refers to the strategic approaches that a researcher employs to carry out research and obtain knowledge by using suitable techniques (Gray, 2013). How researchers view knowledge, relate to it and the methodological strategies they use to discover it frame their overall research (Guba & Lincoln, 1994). Both quantitative and qualitative methods are used in social and behavioural research.

Quantitative methods will not be discussed in detail due to their lack of relevance for the current study. Qualitative research generally attempts to answer questions relating to the what, how or why of certain phenomena rather than how much or how many. Qualitative methods are recognised as valuable tools to gain an in-depth understanding of processes. They also provide a useful way to explore any changes taking place within a cohabiting context by providing an opportunity to investigate complexities, processes and dynamics (Milburn, 1995). Qualitative approaches have been used extensively in previous studies exploring behavioural changes in family settings, household food environments and dietary changes in the cohabiting context (Golan et al., 2010; Gorin et al., 2008; MacLean et al., 2014).

Qualitative approaches in general focus on two main types of data; naturally occurring data, and gathered data. Naturally occurring data come from participants’ natural enactment of social behaviours in their own settings, and

gathered data come from participants' recounting of social behaviours for the purposes of a research study (Ritchie, 2003). Examples of the approaches frequently used to obtain naturally occurring data are observation and ethnographic approaches. Frequently used techniques to obtain gathered data are interviews and focus groups.

Due to this study's interpretivist orientation, a qualitative method was chosen. In line with the objectives outlined in Chapter Two, and informed by existing literature, it was decided that a dyadic approach including a separate interview with each couple member would be most suitable.

3.3 Additional methodological considerations important for research with couples

Cohabiting partners, due to their close relationship and proximity to each other, have a profound influence on each other's lives. The cohabiting couples' context provides an opportunity to understand how people change their daily practices in relation to another member of their close social network. One of the contentious issues in the field of family research is that researchers are often restricted by relying on one family member's perception (usually the female 'head' of the family) for the shared experience of that family (Valentine, 1999). In doing so, the conclusions derived from such studies do not represent the perspectives of others in the family (Warin et al., 2007).

Interest in the study of close relationships in relation to health behaviour has highlighted the importance of methodological advances including the collection of data that represent the practices and perceptions of both participants in a relationship. It is suggested that using the dyad as the unit of analysis helps by allowing a thorough exploration of multiple perspectives compared to relying on one partner's report of mutual experiences and processes within the relationship (Valentine, 1999).

Thus, conducting research with couples provides an opportunity to gain a holistic picture of the issues that impact both partners. However, the tendency of

couples to present themselves as a single united entity (for example, by referring to practices in terms of 'our' and 'us') rather than as individuals may sometimes blur the lines between what is one member's individual perception and what each or both of them consider true of themselves as a couple. This means that in designing qualitative research with, and analysing qualitative data from, couples, the interview context, and a focus on everyday lives, and power dynamics are important areas to consider (Braybrook et al., 2016; Charmaz, 2006).

More generally, as discussed in section 3.9, the importance of reflexivity in research has been highlighted in many qualitative studies (Denzin & Lincoln, 2005). How researchers' own subjectivity shapes their engagement with the topic and the respondents, and how respondents perceive the researcher and their responses can shape the data. Therefore, in addition to specific logistical considerations (such as the settings and order of the interviews) required during data generation, how partners present themselves during the interview; the researcher's position within the research process; and how power is balanced between partners, and between the participants and the researcher, need to be considered while conducting interview-based research among couples (Britten, 1995).

3.3.1 How the participants present themselves

Family researchers emphasise that family is not just a social structure consisting of its members, but rather a flexible entity where members' understanding of 'family' may change over time. Morgan (1996) argues that family members' behaviours and practices are ways of 'doing family', where daily mundane activities, conversation and care among family members work to constitute them as a family. Therefore, the changing of these practices by one family member, need to be understood in relation to other members, or the family as a context. Finch (2007) further suggests that there is a need to think of 'displaying family' as well as 'doing family'. By the use of term 'displaying', Finch (2007) emphasises the profoundly social nature of family practices where:

“the meaning of one’s actions has to be both conveyed to and understood by relevant others if those actions are to be effective as constituting ‘family’ practices...display is the process by which individuals, and groups of individuals, convey to each other and to relevant audiences that certain of their actions do constitute ‘doing family things’ and thereby confirm that these relationships are family relationships. (Finch, 2007, p. 66).

The concept of displaying family was important in two respects for this research with cohabiting couples. As a researcher, I needed to be aware that participants’ ‘portrayal’ and narration of their daily family routine and changes in practices might be influenced by how they wanted to be seen, both individually and as a couple (for example, a healthy eating and supportive couple). Therefore, this was considered during data collection as well as the interpretation of (both convergent and divergent) data drawn individually from each partner. Perlesz and Lindsay (2003) suggest that while dissonant data collected from couples may pose challenges, researchers can engage in multifaceted and meaningful analysis by considering the context and process of the research when interpreting data.

In couples’ research, the researcher should not only attempt to represent each partner’s individual stories and perceptions, but also present a dyadic interpretation of shared family stories revealed through participants’ perspectives and presentations of self (Gabb, 2010). The researcher has to make sense of different versions of some common stories when differences may only become evident after the data collection is complete. Thus the interpretation of triangulated data collected from partners may pose challenges as to whose story is being told (Perlesz & Lindsay, 2003).

3.3.2 The researcher’s position within the research process

In order to tell a coherent story within interview-based research with couples, the researcher must also address the elements of mutual positioning that occur during the interaction between the researcher and both participants. This issue is especially relevant to research that involves partners in intimate relationships (Valentine, 1999).

Forbat and Henderson (2003), reflecting on their experiences of two separate research projects involving interviews with both partners, discuss the ethical and practical complexities involved in conducting research with two people in an intimate relationship. In attempting to understand both sides of the stories, the researcher can be stuck between the differing perspectives of the two interviewees during the interviews as well as while interpreting the data. Forbat and Henderson (2003) suggest that getting stuck between respondents in intimate relationships can be risky. There are a number of ethical and procedural concerns, such as conflicts of interests between participants and the researcher, the imbalance of the researcher's alliances with either partner, intrusion in the participants' relationship and the influence of the first interview on the second.

Being 'stuck-in-the-middle' may lead the researcher to consciously or subconsciously prioritise one participant's perspective over the other. This may raise a further concern regarding whether equal emphasis is being given to both accounts, or whether the researcher is purposively choosing to prioritise one version over another. Therefore, there is a need for the researcher to recognise, and respond to, the possibility of unequal representation of the participants' accounts throughout the research process and while reporting the results.

3.3.3 Power balance between partners, and between participants and researcher

Qualitative research by its nature is grounded in the perceptions, experiences and expressions of participants. Thus, qualitative research, and more specifically in-depth or semi-structured interviews, potentially allows participants to have greater control within the research process. However, it is important to create an equal balance of perception of power between the individual participants as well as between them and the researcher (Braybrook et al., 2016). This is of particular importance for the current study as the mutual positioning of power and the relationship between the researcher and each participant could influence the data (Britten, 1995). In the current study, the exploration of each partners' personal and shared experiences was equally important. However, the

interview topics revolved around men's attempts to change daily practices at home following participation in a weight management programme familiar to the researcher. Therefore, it was important to carefully balance each partner's perception of power so that each felt that their role in the research was important and independent. For example, it was important that a female partner did not perceive me as being more aligned with the man, as I was likely to have more knowledge of the man's weight loss intervention or the FFIT programme. At the same time, it was important to ensure that the man did not feel as though he was being assessed by me and/or his female partner.

3.4 Methods used for this study

The following sections in this chapter begin by outlining the methods and techniques used in the current study. This is followed by a section which details the planning and experience of the data gathering and analysis processes, and their implications for the current study. The lessons learned from the pilot with regard to each method and technique and how they were used to modify the methods in the main study are also discussed.

3.5 Sampling and recruitment

3.5.1 Sampling

For this study, a purposive sampling strategy was developed (Bowling, 1997). The key inclusion criteria were that men had completed the FFIT programme three to 12 months prior to recruitment and had a cohabiting partner. Researchers have different benchmarks for what is the minimum duration since weight loss for it to be considered weight maintenance, with some suggestions ranging from six months (Anderson et al., 2001) or 12 months to three years (Dombrowski et al., 2014). Although weight loss maintenance outcomes can only be evaluated at least six months after initial weight loss (Anderson et al., 2001; Wing & Hill, 2001), the practices that contribute to sustained weight loss may emerge much sooner (Baugh et al., 2014). After consultation with the researchers involved in FFIT design, delivery and evaluation, a time frame of between three to 12 months after FFIT completion (six to 15 months after the

start of the 12 week programme) was deemed appropriate to investigate participants' perceptions of the changes they attempted to make and sustain. It was anticipated that this would be a long enough period to investigate the continuation of any changes after completing FFIT, while not too long for the participants to have forgotten the programme period. Quota sampling (based on a predetermined number of participant subgroups) was applied to ensure the recruitment of equal samples of men who:

1. Had lost at least 5% of their weight during FFIT;
2. Had not lost at least 5% of their weight during FFIT.

Sampling on the basis of socio-economic status was considered, but this would have required the men to report details such as occupation or qualification on the initial 'permission to contact' form. It was decided this would be inappropriate and likely to have a negative impact on recruitment. It was hoped that because FFIT attracts men from various socio-economic backgrounds (Hunt, Gray, et al., 2014), the sample would broadly represent that diversity.

3.5.2 Sample size

Researchers have different perspectives on what is an appropriate sample size for a qualitative study (Bertaux, 1981; Charmaz, 2006). It has been argued that qualitative samples should not be so large that data becomes repetitive and, eventually, unnecessary, but at the same time they need to be large enough to cover most or all of the perspectives that might be important to the investigation (Bertaux, 1981; Mason, 2010). In qualitative studies, the size of the sample is partially determined by the quality of data. Two criteria are generally used to evaluate sampling: adequacy and appropriateness (Morse, 1994). The data are considered adequate if the volume is sufficient to support the insights developing from it. The data are considered appropriate if they can provide the descriptive and interpretive depth needed to clearly describe theoretical underpinnings. Following these principles, data saturation occurs when no new information emerges from subsequent participants (Beverly & Wray, 2010).

Due to the focused research questions and potential for richness of data from interviews with each participant, it was decided that a sample size of 20 couples would be adequate for a thorough examination of the topic. The strict timeline of the PhD project was also taken into consideration when determining this sample size.

Most couples that agreed to participate early in the recruitment process included men who had lost at least 5% weight during the FFIT programme. Therefore, after interviewing the 11th couple, the remaining participants were purposively selected from those men who had consented and who had not lost 5% weight at the end of the FFIT programme. This process was followed in order to maximise the potential for diverse perspectives.

3.6 Recruitment

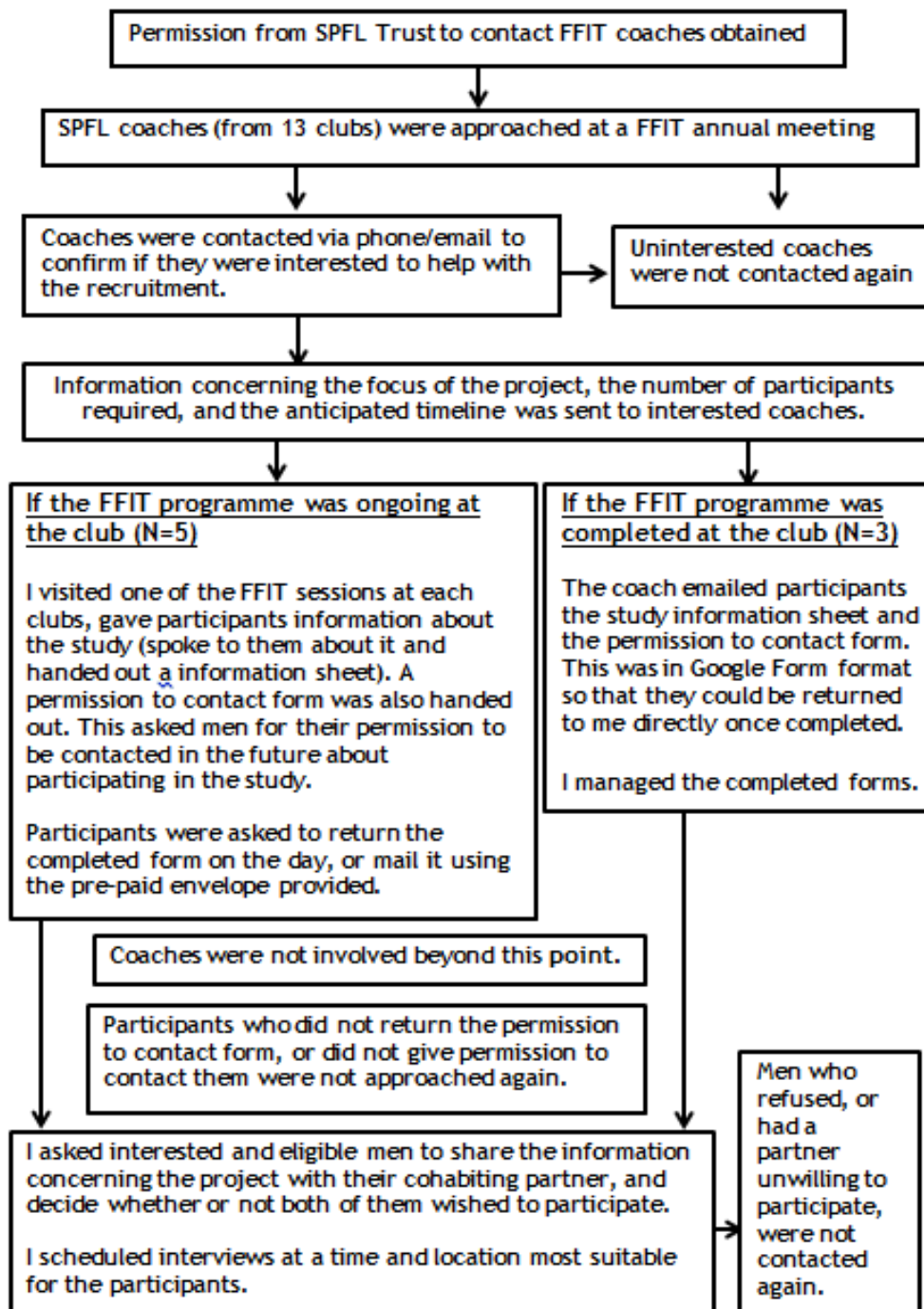
Participants were recruited through the Football Fans in Training (FFIT) programme at eight Scottish football clubs. FFIT has been running at most major Scottish professional football clubs since 2011 (it was running at 32 clubs when the study took place in 2016), and was an efficient route to approach and recruit targeted participants. The recruitment process is presented in detail below.

3.6.1 Recruiting couples through clubs delivering FFIT

FFIT in Scotland is organised and coordinated centrally by the Scottish Premier Football League (SPFL) Trust. Therefore, in order to recruit FFIT men from SPFL clubs, permission was obtained from the SPFL Trust. Following receipt of University of Glasgow ethical permission (Appendix Three), SPFL Trust officials were contacted and provided with details of the proposed study and the study was discussed with them. Any concerns raised during these discussions were addressed and necessary changes were made. For example, the information sheet was changed from “female partner” to “cohabiting partner” as the SPFL Trust advised that any information sent to the participants should not suggest the study was restricted to *female* partners.

After receiving permission from the SPFL Trust to recruit men through FFIT, SPFL club coaches were approached at an annual FFIT meeting and were provided with the information regarding this study. FFIT coaches or coordinators at eight clubs who were willing to support the process were subsequently contacted to approach FFIT participants, and to ask if the coaches would be interested in helping to recruit the participants. Contacting the FFIT coaches and coordinators required multiple attempts, but they were helpful and welcoming once contact was established.

Figure 3.1 The recruitment process flow chart



I visited one FFIT session at each of the five SPFL clubs where the programme was ongoing (see figure 3.1) and spoke to men about taking part in the study. All men present at these sessions were happy to fill out the ‘permission to contact form’ and complete it before the session started. This form (Appendix Four) asked the FFIT participants: 1) consent to be contacted three months after they had completed FFIT; 2) whether or not they were living with a partner; 3) their contact details (mail, email or phone); and 4) the method/s of contact they would prefer. In three clubs where FFIT sessions were not ongoing at the time of

recruitment, the coaches emailed an electronic ‘permission to contact form’ to men who had completed the programme. These coaches were asked to send the PhD ‘study information sheets’ and the ‘permission to contact form’ to all of the FFIT participants who had completed the programme at their club three to 12 months prior to the point of contact. It has to be assumed that the coaches did so; it is not known how many participants each coach sent the information to.

Table 3.1 shows that the overall recruitment process resulted in 165 ‘permission to contact form’ returns (61 from stadium visits and 104 from emails sent by the club coaches). Of these, five returned the form saying they did not want to be contacted, and 22 were ineligible because they were not cohabiting with a partner. All 138 eligible men (cohabiting with a partner) who consented to be contacted were sent an information sheet about the study via email (Appendix Five). They were asked to share the information with their cohabiting partner, and confirm if both of them were interested in participating. All 138 men were contacted via email or phone (based on what they had indicated they preferred) after at least seven days to confirm if both partners were interested and able to participate. If no responses were received, they were contacted up to three times. Recruitment stopped after 20 couples were recruited, and the rest of the eligible men were contacted to inform them that they were not needed and were thanked for their interest. Consenting couples were then interviewed at their home or in another mutually agreed location at a time that was most convenient for each of them.

Table 3.1 Participant recruitment: returned permission to contact form

Clubs	Total contacted (completed the ‘permission to contact form’)	Did not give permission (returned the form saying they did not want to be	Not cohabiting	Further information sent to	Included in the final sample

		contacted)			
Club 1	20	0	2	18	2
Club 2	6	0	2	4	1
Club 3	15	2	1	12	3
Club 4	8		1	7	1
Club 5	12	2	2	8	1
Total responses	61	4	8	49	
Couples recruited from stadium visits					8
Clubs 6, 7 and 8: Responses to coaches' emails (Google form)*					
Total responses	104	1	14	89	12
Couples recruited via coaches					12
Total couples recruited					20

**Note: It is not known how many FFIT participants the coaches emailed*

3.7 Data generation

Interviews are useful to explore or investigate topics that may be personal to participants, and need to be discussed in detail (Kvale & Brinkmann, 2009). Compared with focus groups, interviews allow privacy, time, and ensure that the researcher can give personal attention to participants. In the current study, data were collected through separate individual semi-structured interviews, including a significant retrospective element with each partner.

3.7.1 Semi-structured face to face interviews

Interviews are considered as one of the best methods to employ when obtaining in-depth personal perspectives on a particular issue (Ritchie, 2003). Interviews can be used to gather a thorough and detailed understanding of the topics being investigated as they benefit from the rich and detailed information from people's responses (Britten, 1995; Inglis et al., 2005).

Three common interview techniques employed in social research are: structured, semi-structured and unstructured. Unlike the unstructured interview (in which questions are not prearranged), semi-structured interviews allow the researcher to use an interview schedule to guide the interview, and help keep the conversation relevant to the topic. Since this research involved multiple sets

of topics and dynamics, (as illustrated by research questions in Chapter One), it was important to provide some level of structure to the interviews. At the same time, unlike the structured interview which uses a fixed questionnaire, semi-structured interviews allow for further exploration of any new relevant topics arising during the interviews. Although semi-structured interviews can be more time-consuming and labour-intensive than structured interviews, they enable detailed conversations, as respondents are encouraged to freely express their opinions and bring forward issues that are relevant and important to them.

Conducting interviews face-to-face allows the researcher to observe body language, facial expressions and the context in which the interview takes place, which can provide further insights into latent issues not covered by participants' answers (Hesse-Biber & Leavy, 2006).

'Emic' and 'Etic' refer to two different approaches to qualitative research. An emic approach is focused on the perspectives and words of research participants as the foundation of the analysis. In this approach the researcher looks for themes, patterns, and concepts to emerge from participants' words, without considering prior theories and assumptions. An etic approach uses theoretical viewpoints and hypotheses as a starting point for the research. Thus within an etic approach, prior theories, assumptions or conceptual frameworks are used to see if they apply to a new situation or population (Lett, 1990). A completely etic approach may prevent a researcher from finding potentially new and innovative concepts. However, as all researchers approach their work with certain ideas and perspectives, it may be impossible to follow a strictly emic approach (Headland et al., 1990). Both emic and etic approaches to questioning were employed in my study, depending on the topic being discussed. For example, questions about day to day dietary practices and physical activity were more open, such as asking participants to describe their typical meal preparation or eating rituals, and what they meant for them. Other questions, such as whether men think it is manly for them to diet, or normal for women to prepare meals for their partner, were direct, and guided by existing assumptions and theories on gender roles.

3.7.2 Interview topics

Separate interview topic guides (Appendix Six) were developed for men and their cohabiting partners on the basis of relevant theoretical and empirical literature (and gaps in that literature), and with the aim of answering the project's research questions. Previous studies with FFIT men (MacLean et al., 2014), and the coaches' guide for the FFIT programme delivery assisted with question wording and prompts. The content of the topic guides was discussed during supervision meetings and reviewed by all three supervisors. The appropriateness of these topic guides in regard to the length of the interviews was tested in the pilot.

The topic guides included questions in relation to men's decision to join FFIT, their initial impressions and expectations, practical and emotional experiences relating to the man's attempt to make changes and maintain each change, as well as their experience of the whole process. They included open-ended questions on each partner's expectations from, and experiences of men attending FFIT, what it was like for each of them when the man initiated the changes, and how they found maintaining the changes since completing FFIT. Additionally, men were asked about how they personally felt about their partner's reaction to each of the changes they attempted, and if and how that impacted them. They were asked whether there was variation in the partner's engagement or their own required efforts for making changes to dietary practices and physical activity. Partners were also asked about their engagement with, and their views about, the man's attempts. The topic guides also focused on pre-existing daily routines and how they were impacted by the man's attendance at FFIT, if there was any tension or conflict between the couple members, and how their relationship might have been impacted in this process. The participants were also encouraged to talk about any important issues not covered by the topic guide.

3.7.3 Separate one-to-one interviews

As discussed earlier, studies of family topics are frequently based on interviews with women, as the household and family have been regarded as women's

domains. However, the literature indicates that in the family context, when one member speaks for the whole family, that member's account may not reflect the perceptions of the other members that they speak for (MacLean & Harden, 2014; Sweeting, 2001; Valentine, 1999). Therefore, it is important to explore each partner's perception in couples' research, as in the current study.

Techniques used in dyadic studies may involve either interviewing partners together or drawing dyadic interpretations from data collected with each family member separately (Morris, 2001; Sakellariou et al., 2013). There are advantages and disadvantages to each of these methods. Joint interviews might provide a level of depth and detail similar to individual interviews, while also providing opportunity for interaction as in focus groups (Arksey, 1996; Morgan et al., 2013). Joint interviews are commonly used in the context of inquiries involving married or cohabiting couples (Backett-Milburn et al., 2010; Brown & Wenrich, 2012; Lupton, 2000; Seymour et al., 1995). They can also facilitate the conversation as each participant can elaborate on the other's comments, help the other to divulge information concerning both, and help provide a complete picture of an event or issue through individual perspectives.

However, the joint interview method can be labour-intensive and difficult to organise, and can also present ethical and practical challenges (Seymour et al., 1995). One participant may dominate, police or influence the other (Bjornholt & Farstad, 2012), and one or both participants may withhold their opinions in the presence of the other, which can undermine the validity of the data as less information is collected. Moreover, when researching sensitive topics, there is the potential for conflicts surfacing during the interviews that might have a negative impact on the couple's subsequent relationship.

For the current study, a *separate interview* format was considered suitable. The interviews were focused partly on couples' common household experiences. However, many of the topics to be discussed were personal perceptions or experiences in connection with the other partner, some of which were potentially negative, that might not have been brought up in the other's presence. Therefore, allowing the partners a separate and private space, where

they knew they could raise issues that might upset their partner, helped to reduce potential risks of unpleasantness or friction associated with joint interviews. The individual interviews were also useful for discussing potential conflicts between partners. The data collected in these interviews included personal reflections on their experience of the changes that participants may not have felt comfortable sharing if it was a couple interview or focus groups.

It was anticipated that recruiting and organising separate interviews could be challenging due to the time commitment and potential difficulty in each partner arranging time to be alone (e.g. due to caring responsibility, space for individual interviews at home or take time away from the partner to another location). However, for this study, maintaining a flexible schedule in respect of time to conduct the interviews meant it was not challenging to schedule them. Most couples did not have any caring commitments. Most participants preferred to be interviewed one immediately after another at their homes. Interviewing one partner immediately after another helped to minimise some of the drawbacks of separate interviews such as one partner discussing his/her interview with the other, and therefore potentially influencing the second partner's responses, and also made the process time and resource efficient.

3.7.4 Order of interviews

As discussed earlier, there has been considerable debate on appropriate methods for collecting qualitative data while conducting research with couples. Joint interviews and separate interviews have each been used, and, sometimes, combinations of both. The benefits and shortcomings of each design have also been discussed by many researchers as already described (section 3.7.3) (Bjornholt and Farstad 2012; Brown and Wenrich, 2012).

Less consideration, however, has been given to whether the order of interviews (which member of the couple is interviewed first) may influence interviewees' power perceptions, and the data obtained. Boeije (2004) and Seymour et al. (1995) suggest that partners should be interviewed separately and simultaneously. Although this is not always practical as it requires two

interviewers, and can be difficult to find a time when both partners are simultaneously free, they argue that this method can reduce the risk of a partner (who is interviewed second) being influenced by the experience of the partner who has been interviewed first. This method can also reduce the risk of the second interview being guided by discussions within the first interview. For example, the partner being interviewed first may introduce an area of interest to the research question that is unique to the couple, but whether the researcher can explore that topic with the second partner, while ensuring that information from the first partner is not revealed, is an issue to be considered in dyadic studies with couples (Finch, 2007). This was an important area to be mindful of in the current study, as there was the potential for participants to divulge negative experiences, instances of conflict and other sensitive topics.

Participants were given the choice to decide which one of them preferred to be interviewed first. After comparing both (male first and female first) during the pilot, it appeared that the order of the interviews did not affect the data gathered. With regard to the sensitivity of personal data, in some cases I had to be mindful of not raising certain issues discussed by the first interviewee with the second, but it did not impact the ease or the flow in the following interview. The semi-structured method and use of topic guides helped to focus each interview, regardless of who was interviewed first. Eighteen couples were interviewed one partner immediately followed by the other. The other two couples were interviewed on separate days as they were unable to find a mutual date that would suit them both. The method of interviewing one partner after another in the same visit had all the benefits of simultaneous interviews without requiring additional resources or a second researcher.

3.7.5 Retrospective interviews

Retrospective interviews (collecting data about past events) were conducted in this study. Retrospective interviews help participants to recollect and reflect clearly on past experiences as they occur after the potential confusion and burden of the event when it was happening (Atkinson, 2002). Studies investigating behavioural practices have successfully used retrospective

interviews to investigate the pattern of changes in physical activities (MacDonald et al., 2009), and cohabiting partners' shared and individual experiences, including dietary practices (Bjornholt & Farstad, 2012). Although the accuracy of retrospective narration has often been debated, studies have found reasonable correspondence between information recalled in retrospective interview contexts compared with official records of the same information (Blane, 1996).

During the interviews, except for some women who were unsure of some of the specific aspects of the changes the man had initially made, all participants were able to recall their experiences and perspectives regarding the man's attendance at FFIT and the changes made as a result.

Since one of the key foci of this study was to investigate any changes that took place in dietary practices and physical activity during and after men's 12-week FFIT intervention delivery, the interviews were planned 3-12 months after men completed FFIT. This allowed an opportunity to compare any differences in participants' experiences based on the duration since men completed FFIT. For comparison, during analysis the participants were split into groups based on whether men completed FFIT 3-7 months or 8-12 months prior to the interview.

3.7.6 Interview setting

The interview setting is also an important factor that can influence the data because it has the potential to empower the researcher or participants (Britten, 1995). Letting participants choose the interview location can help create a comfortable research environment, thereby helping the interview process, by making participants feel empowered and in control in a setting that they are comfortable with. However, the researcher needs to be aware of, and prepared for, the consequences of any interview setting. For example, a participant may prefer to be interviewed at their home and may feel at ease in their own space. However, conducting interviews in the participant's home means that outside interruptions (e.g. telephone calls) and distractions (e.g. other family members' presence or the television) may present unavoidable pitfalls (Field & Morse, 1985). Boeije (2004) describes this process in respect of a study with 20 couples,

and suggests that the researcher should be prepared for ethical and practical difficulties when other family members spontaneously participate in the interviews. She advises that depending on the sensitivity of the interview topic, the researcher should consider scheduling the interview when there is likely to be no third person present. She argues that the presence of a third-person during the interview can result in less information being collected and undermine the validity of the data. This becomes even more complicated while interviewing cohabiting couples in their homes because the partner is more likely to be in the house at the time of the interview.

In the current study, participants were asked to choose the location they preferred. During the pilot (see section 3.8), it was noted that interviewing in a public venue could be unsuitable if it is noisy. Therefore, after the pilot, participants were given the choice of being interviewed at their home or at the MRC/CSO Social and Public Health Sciences Unit at the University of Glasgow. The remaining interviews were conducted at one of these venues according to each participant's preference.

While scheduling the interview dates, participants were told that, if possible and they were comfortable, it would be better to have a private space where they were less likely to be interrupted. Thirty-three of the 40 interviews were conducted at participants' homes. This setting offered further background insights into the participants' lives and circumstances. I was able to observe where they lived, the type of accommodation, and if there were other members of the family cohabiting with them. However, I felt like a guest in their home and was trying to not come across as too demanding, for example, while deciding on where to sit down for the interview, closing the doors in the room used for the interview, or regarding having their pets around during the interview.

3.8 Piloting and project timeline

3.8.1 Piloting the methods

This project consisted of a pilot and main study. The pilot informed the development of the main study, by identifying the practical challenges of recruitment, data collection and analysis. The pilot also informed the utility of the proposed methods in answering the research questions.

Having decided to conduct separate semi-structured interviews with each partner, I drafted the interview topic guides (described earlier), and piloted them on the first three couples recruited. The aims were to: 1) test the proposed method of data collection; 2) explore whether it made a difference to interview the man or the woman first and; 3) refine the interview topic guide (topics of interest, potentially sensitive questions related to weight and/or the couple relationship). While these objectives are common across various types of qualitative pilot work (Sampson, 2004), some of the issues around the interview settings were of particular importance for the current study due to the close relationship between cohabiting partners and the potential sensitivity of the topic of research. It was hoped that the pilot and associated preliminary analysis would help to confirm the utility of themes covered in the topic guides and suggest themes for further investigation in the main study. The lessons learned from the pilot, and the amendments made to the subsequent data gathering, are described below.

As information about men's weight loss outcomes during the FFIT programme was of interest to this study, the participant information sheet clearly stated that I was interested in speaking to men with a variety of weight loss experiences. I then asked them to self-report their weight loss when they confirmed a willingness to participate. How men reacted to being asked to reveal their weight before and after FFIT, and how partners reacted to being asked about their weight loss since the man joined FFIT, were tested during the pilot. All three men and their partners interviewed for the pilot study appeared to be comfortable with reporting their current weight. Therefore, for the main

study, men were asked to reveal their weight before/after FFIT, and the partners were asked if they had lost any weight during the man's participation in FFIT or since then.

In the pilot phase, the participants were asked for various demographic details (e.g. age, employment status/occupation, duration of cohabitation) during the interview. After familiarising myself with the pilot transcripts, it appeared that this information was crucial. However, there was a chance of information not being gathered uniformly from every participant if it was part of the interview. Therefore, it was decided that using a pre-interview questionnaire to gather this information would be more efficient and ensure uniformity across the sample. For the main study, both partners responded to a questionnaire that asked about this socio-demographic information prior to the interviews (Appendix Seven). This included information on: duration of cohabitation; number/age and living arrangements of children; nature of each partner's current/last job; current weight; weight loss at the end of FFIT (most men referred to the booklet they received at FFIT that had their weight loss record in reporting their weight loss); if they had purposely attempted to lose weight before (partners were asked if they had lost weight and most reported this information, and the amount of weight loss); and when (i.e. date) the man had completed FFIT. I also took notes about the interview venue, order of interview (whether male or female partner was interviewed first) and the privacy of the interview setting, and added this information to the completed questionnaire.

The pilot stage helped to make the subsequent interviews more efficient and gather routine data in an organised way. In addition, this process also helped with more practical issues such as deciding to avoid public venues for interviews because two interviews conducted at a restaurant were difficult to transcribe due to background noise.

However, there were no major differences between the pilot and the main study. In terms of the feasibility of the proposed methods, the pilot showed that both semi-structured interviews and conducting interviews separately worked well to generate rich data. As the characteristics of participants from both the

pilot and main study were the same, data gathered from the pilot study were included in the analysis with those from the main study. The description hereafter includes both the pilot phase and the main study.

3.8.2 Project timeline

Recruitment for the pilot study started in March 2016. After analysis of the pilot study, minor amendments were made (as described earlier) to the methods. Data collection for the main study was partly determined by the FFIT programme timeline at different football clubs, and occurred between May and October 2016.

3.9 Data management and analysis

3.9.1 Recording interviews and taking notes

With participants' written consent, the interviews were audio recorded using a small digital Dictaphone. Recording enabled me to thoroughly focus on the conversation during the interview, and review and analyse the discussions by listening to them again. Brief notes were taken during the interviews and were expanded on afterwards. Note taking during fieldwork can provide additional richness to the interview data while helping with the data management and analysis processes (Wolfinger, 2002). In the current study the notes taken during the interviews and afterwards helped me reflect on my experiences of the research and the context of the interview, as well as serving as a reference guide while familiarising myself with the data.

3.9.2 Transcription and data management

The interview recordings were transcribed verbatim. I transcribed all six interviews from the pilot stage. The remaining 34 interviews were transcribed by a company vetted by University of Glasgow and returned via secure internet link. Although self-transcribing could have further ensured the accuracy of the transcription, the length of time it would have taken would have been inefficient. However, I checked the accuracy of all the transcripts by listening to

the recording and reading the transcripts simultaneously. This process helped not only to correct the small number of grammatical errors present and ensure the accuracy of the transcripts, but also allowed me to add notes on the non-verbal aspects of communication (tone of voice) that would not have been obvious just by reading the transcripts. Because I conducted all the interviews I was aware of the impression the participants gave during the interview, however those could have been forgotten at a later stage of analysis if not recorded. This process also helped me to become familiar with the data. Each of the interview transcripts was saved in Microsoft Word and later imported to NVivo. Hard copies of the transcripts were stored in a locked cabinet in the MRC/CSO Social and Public Health Sciences Unit at the University of Glasgow.

Following the idea of memo writing throughout the data analysis (Braun and Clarke, 2006), I wrote a summary (paragraph) of each participant's account and the participant profile for each couple based on the transcripts and the field notes. The memos were extremely useful during analysis. As some topics emerged as more important than anticipated, the memos aided the recall of my initial impressions of the participants, as well as helping with the identification of patterns across the data. At a later stage of analysis, these memos also helped to clarify some of the implied remarks that participants made ensuring accurate interpretation.

3.9.3 Thematic analysis using a framework approach

Qualitative interviewing methods are often used with the aim of developing meaningful interpretations of data based on the spoken word. Analysis of qualitative data from in-depth interviews involves identifying themes, patterns and meanings that emerge from the "thick description" recounted by participants (Hesse-Biber & Leavy, 2006). Qualitative studies in the social sciences frequently use grounded theory, discourse analysis or thematic analysis approaches (Bowling, 1997). In grounded theory, patterns and structures are identified and conceptualised through the process of constant comparison of data, without being guided by any pre-existing theories (Charmaz, 2000). Discourse analysis focuses on the ways in which language is used to construct

participants' accounts, and language use as a socio-cultural practice (Parker, 2004).

As this study focused on some specific practices, and was guided by prior research findings and theories, a thematic content analysis approach was deemed most suitable. In thematic content analysis approaches, commonalities, differences and relationships are drawn from descriptive data (Gibson & Brown, 2009).

A 'Framework' approach was used to manage the data and to facilitate analysis (Ritchie and Spencer 1994). A framework approach is a content analysis approach which involves summarising and classifying data within a thematic framework. The framework approach compliments the thematic analysis as it starts deductively from the objectives and research questions of the study, while the overall findings are grounded in the original accounts of the participants (Pope et al., 2000).

This approach helped me to develop descriptive accounts by synthesising key categories and presenting them in matrices and also allowed me to move beyond descriptive accounts to provide explanations based on interpretations grounded in the data (Ritchie & Lewis, 2003; Smith & Firth, 2011; Srivastava & Thomson, 2009). Different stages of the data analysis process are detailed below.

3.9.3.1 Familiarisation

Following the five stages for data management and analysis in a framework approach (Ritchie and Spencer, 1994), I first *familiarised* myself with the data by listening to the audio-recordings and reading the transcripts multiple times. Several transcripts (all transcripts from the pilot stage and some from the main study) were also read independently by my supervisors, who between them have extensive experience of conducting qualitative research in diverse settings and with a range of populations. We discussed the themes each of us noted in detail.

3.9.3.2 Construction of a thematic framework

Based on the themes discussed, the second stage involved identifying key themes from each transcript. These themes included partners' pre-existing family routines, various changes to dietary practices and physical activity, perceived threat of overweight and obesity, partner's support, couple conflict and negotiation, and impact on daily routine. By incorporating the principles of 'theoretical thematic analysis' (Boyatzis, 1998; Braun & Clarke, 2006), the generation of themes in this study was guided by the topics of interest and also topics emerging inductively from the data. Each of these main themes consisted of several sub-themes and a number of codes associated with each sub-theme. Any new themes emerging from the transcripts were noted and previous transcripts were revised in light of the additional themes. In accordance with a structured thematic approach, I developed an initial coding frame (Figure 3.2) which was refined through discussions with my supervisors. At the end of this process, some of the initial themes were also integrated as sub themes.

Figure 3.2 Coding frame

<p>Coding Frame: First Reading</p> <p>Diet: Any reference to eating, drinking, food related activities such as cooking, shopping meals</p> <ul style="list-style-type: none">• During the FFIT Programme• After the FFIT Programme• Maintained/Unmaintained changes• Barriers to eating/drinking well• Facilitators for eating/drinking well• Motivations for continuing/stopping change <p>Physical Activity: Any reference to physical activity, exercise, or activity requiring physical movement</p> <ul style="list-style-type: none">• During the FFIT Programme• After the FFIT Programme• Maintained/Unmaintained changes• Barriers to being active• Facilitators for being active• Motivations for continuing/stopping change <p>Making and maintaining changes: Any reference to making or maintaining (lack of) changes in eating practice and physical activities. <u>(Most of the codes in this category overlap either with diet or physical activities.)</u></p> <p>Men's influence on partners: Any explicit or implicit reference to any changes or lack of changes that influenced partners' diet, physical activities, perception, motivation as a result of men participating in FFIT or aftermath of it. (Both men's and partners' expressions are included in the same code.)</p> <p>Reference to partners' support or influence: Any reference that men make regarding practical or moral support, influence (or lack of it) from partners with regard to men making or maintaining changes</p> <p>Women's reference to supporting or influencing: Any reference that partners make regarding practical or moral support, influence (or lack of it) for men with regard to men making or maintaining changes</p> <p>Conflicts, inconvenience, challenges, disagreement: Any reference to challenges to participating in FFIT, making or maintaining changes. Conflicts or disagreements (between partners) caused by anything related to FFIT or making or maintaining changes to diet or physical activities. (Explicitly expressed lack of conflicts, or disagreements are also included in this code, which may overlap with the codes related to support.)</p> <p>Gender: Any explicit or implicit reference to gender, gender role that is relevant to diet, physical activity, weight or living as a couple</p> <p>Weight: Any reference to weight and weight management. Their own or partner's weight, weight loss or weight loss goal, mention of losing/gaining/re-losing/re-gaining weight, and emotion around it</p> <ul style="list-style-type: none">• During the FFIT Programme• After the FFIT Programme• Maintained/Unmaintained changes• Barriers to weight-loss/maintenance• Facilitators for weight-loss/maintenance• Motivations for continuing/stopping changes

3.9.3.3 Indexing and charting

The third and fourth stages in framework approaches are iterative processes. The third stage is coding/indexing, where sections of the data are linked or

associated with a particular code. Coding creates categories that are used to describe general features of the data. A code (termed as *nodes* in NVivo) can reflect a range of data examples and helps to show commonalities within a dataset. Codes created for this study were both ‘empirical’, through examination of the data (such as conflicts/tension) and ‘apriori’, identified from existing literature were used (such as influence of gender) based on the iterative process of reading and identifying themes (discussed above) (Gibson & Brown, 2009).

The aim of the coding process was to classify *all* of the data to allow for the comparisons of themes across the dataset. At this stage, the transcripts were imported into NVivo qualitative data analysis software (QSR International Ltd. Version 11, 2016), which facilitated the management and coding of data. This allowed each theme and sub-themes to be coded together while also allowing for the original data to be accessed easily. All transcripts in this study were coded into 14 *Nodes* (Figure 3.3). Due to the interconnected nature of the themes some of the data were double or triple coded. This process also allowed for irrelevant data to be stored separately (one of the *Nodes*) where it could be easily accessed if needed and in order to account for all of the data collected.

Figure 3.3 NVivo coding framework

Name	Sources	References	Created On	Created By
Weight or Weight loss	38	331	13/09/2016 15:13	ST
Men making and maintaining changes	40	975	13/09/2016 14:50	ST
Physical Activity	40	422	13/09/2016 13:11	ST
Partners' reference to supporting or influencing husband (or lack of it)	20	366	15/09/2016 16:43	ST
Men's reference to partner support or influence (or lack of)	20	355	15/09/2016 11:50	ST
Dietary Practices	40	940	13/09/2016 13:12	ST
Less relevant Prior FFIT or current reference (Daily routine etc)	40	231	15/09/2016 11:13	ST
Influence on Partner	39	483	15/09/2016 17:43	ST
Physical activity	36	300	13/09/2016 15:11	ST
Dietary practices	39	280	15/09/2016 15:04	ST
Conflicts, inconveniences, challenges, disagreements, tensions	40	244	15/09/2016 14:36	ST
Gender	35	112	13/09/2016 13:05	ST
Doing FFIT	40	410	13/09/2016 12:29	ST
Relationship	33	115	21/09/2016 14:23	ST

Charting is the fourth stage, where individually coded data were arranged in charts of the themes. At this stage, the coded materials were reread and the summarised text was transferred from the original context (transcript) and organised in a chart with headings and sub-headings. For this study, theme and case-based charts were used for organising the dataset. Charts were developed with the participants in rows and codes in columns in Microsoft excel. For example, frameworks were developed for each overarching themes with all participants in rows and a number of themes under the codes such as *participation in FFIT, dietary changes, physical activity changes, weight loss/maintenance, reference to relationship, and gender references* in columns. I also revised each case additionally with attention given to both couple members for each theme by considering each couple as a unit of participants (Appendix Eight). This helped to better understand both each couple member's accounts in relation to each other's perspectives and their mutual experience. Throughout this process I worked closely between the transcripts and frameworks to ensure that rigour was maintained and the data were not misinterpreted.

3.9.3.4 Mapping and interpretation

At the final stage, analyses were conducted through mapping and interpretation of the codes (Figure 3.4). This involved a matrix output, where cases (rows), codes (columns) and 'cells' of summarised or synthesised data (from relevant frameworks described earlier) ensured a rigorous methodical approach to the management and analysis of data. Guided by the principles of a thematic content analysis approach (Gibson & Brown, 2009), patterns and exceptions were identified based on the analysis of the characteristics presented on the chart (Ritchie & Spencer, 1994). I was able to visually cross-examine data across each of the frameworks as well as relating back to the original transcripts. Thus, I was able to identify patterns and irregularities across each code, and interpret and relate the findings to wider theoretical explanations in order to address the research questions.

Figure 3.4 An example of Framework Matrix

Partners' influence on men								
Name	Club	WL	Weight	Diet	Physical activity	Relationship	Gender	
1 Jeremy	Club 1	YM	Partner found out about FFIT and encouraged him to join. She expected him to do well.	Says that his wife thinks he is obsessed with weight lose and worried that he might just keep losing. Says wife is happy for him but is 'a bit jealous' of his weight loss achievement because he is doing better than her. Says he his wife thinks diet control is important for	They eat same meal but if she is snacking unhealthly, he would not do the same. Says his diet is driven by what his wife is eating. Afeter FFIT he followed what she was eating as a part of her weight watchers. Diet is something they talk about a lot	They go to the gym together but do different activities, they go for walks and play badminton together Says his wife joining him helped him to maintain his PA changes.	Positive impact on their relationship. But she is envious of his weight gain. She is supportign him a lot and thinks as a result she is not able to do as much.	She is in control of
2 Shawn	Club 2	YN	Found out about the programme on the radio and joined himself. Told partner about his decision and she was supportive. Told her what he did at the club after he came home from FFIT sessions.	Sife noticed the weight loss and talked aabout it. She is trying to lose wight herself so he thinks its good for both of them	Supportive of him eating healthier meals but they have different tastes so they tend ot eat different meals.	They go out for walks together. She is a bit concerned that he is doing too much (exercise). He got her a fitbit and she is doing it for herself as well.	Communicate with each other more. 'she thinks it's been great for me and I've changed not just physically, I mean, I'm a lot more outgoing now.	Cofortable with die household practice gendered.
3 Kenneth	Club 2	YM	Discussed joining FFIT before he joined. Thought about the arrangemetns needed to make for other family commitments. She was very supportive of him going to FFIT I " I don't think there is anything that she doesn't, she might say different but she certainly does not tell me "	He has a weight loss goal and she is supportive of that. He also thinks she probably feels about herself because his weight loss because she wants to lose weight but is not able to do so because of health issues preventing her from exercising	They both are involved in food shopping and cooking. Her diet was not bad in general so there is no conflict between to as to what to eat. she discouraged him when he wanted to eat unhealthy snacks. She buys fruits for him to snack on.	She cant join him in many exercises casue of her health problem but she is supportive of all the changes he is making. And talks care of other commitments so that he can go. She supports him in doing charity runs and other physical activities he does.	Both think it has helped their relationship as he is not as grumpy as he was before and happier in general. "I don't think there is anything that she doesn't"	Household practice gendered. But she responsibility to care
4 Anthony	Club 2	YM	Told her about joining the programme, she did not make much of it in the beginning but she is keen	Partner comments positively on his weight loss. He knows that She is encouraged by his presistance and	Wife has changed he diet as well. He does not berate her but she is encouraged to eat healthly by seeing	She encourages him to continue with the physical activities. She has joined the gym herself and they go together	Food practices are not gendered in the house.	I don't like vacuum that basically, 'cau don't like the noise,

This stage also included development of typologies based on similarities and differences across responses from specific groups of participants. Typology of men based on their level of *reliance* on their partner, and of women based on their *involvement* in their partner's behaviour change attempts were developed (see Chapter Five).

The systematic nature of this method allowed for commonalities, differences and relationships to be drawn both within and across cases. For example, comparison across topics within a specific category (e.g. an individual participant/couple/category of men) could be drawn from rows, and comparison across cases within specific topics (e.g. dietary change) could be drawn from columns. This made any subsequent analysis very efficient. For example, I was able identify patterns based on participants' demographic characteristics or men's weight loss outcomes from the frameworks as all the cases were charted together.

Overall, the framework approach and use of NVivo helped with the organisation of large volumes of qualitative data in different interconnected stages and guided the data coding process, resulting in codes that described and helped interpret participants' views in a methodical way. It was particularly suited for analysing descriptive data as it allowed for various themes to be captured and analysed under a limited number of codes. Although the framework approach and simultaneous management of data in NVivo was time consuming, it enhanced the reliability of the study, as this method is comprehensive and transparent, where full original transcripts are reviewed and can be easily retrieved to ascertain how the conclusions are drawn (Braun & Clarke, 2006). Throughout the course of the analysis I discussed the analytical process with my supervisors in considerable detail as mentioned above, which added rigour to the processes.

Clearly defined stages of the framework approach are supposed to provide structure and routines for the otherwise potentially overwhelming task of organising qualitative data. However, for this study, it was necessary to go back and forth between different iterative stages, as new insights emerged during the analysis process. For this study in particular, due to its dyadic nature, the framework matrices had to be prepared for individuals as well as couples as a unit as described below.

3.9.4 Analysing dyadic interviews with couples

In couples' research with data collected separately, dyadic analysis of individual interviews can be challenging. There has been considerable debate with regard to the most appropriate way of interpreting studies with multiple family members (Harden et al., 2010; Jamieson et al., 2011). While some scholars advise researchers to construct overall and conclusive representations of accounts from all interviewees (Hesse-Biber and Leavy, 2006), others suggest that contradictions emerging from qualitative research should be left the way they are, as the truth is subjective, and reality is socially constructed by and between the persons who experience it (Gergen, 1999). Warin et al. (2007) argue that the research outcome:

“must succeed in containing the complexity and inconsistencies of respondents’ accounts, the difference between their accounts and most significantly, it must contain, as far as possible, an account of ‘our’ own influences with the making of the story” (Warin et al., 2007, p. 132).

In accordance with Eisikovits and Koren (2010), an approach of combining individual interviews for dyadic analysis was practised. Each interview was coded separately, but at different stages of analysis the couples were also treated as a unit. In each theme and code, both partners’ accounts were considered. For example, during the development of the typologies, men and their partners were grouped separately but both couple member’s accounts were considered in assigning each participant within a certain category and were analysed in relation to each other. Analysing individual data with dyadic considerations facilitated the exploration of each partner’s individual perceptions, whilst taking into account the context of their shared life to understand the basis of their experience and perceptions. I was aware that the multifaceted nature of the couples’ context and the focus on personal subject matter were likely to produce dissonant data (where partners have contradictory perceptions of mutual experiences) (Perlesz & Lindsay, 2003). Throughout the analysis, careful attention was given to both complimentary and contradictory accounts from each partner.

In terms of methodology, this study emphasises the utility and effectiveness of dyadic methods for conducting research with couples consistent with Paisley et al. (2008). In this study, couple members generally agreed in descriptions of mutual experiences but there were some inconsistencies in participants’ descriptions of their own experiences. Such apparent inconsistencies in their remarks did not seem to represent their inability to recall their habits or experiences but actually highlighted the lack of rigidity and changing circumstances present in people’s day to day lives, where they are consciously or unconsciously driven to behave in different ways due to the changing context. Obtaining accounts from both partners helped to understand this context better.

In line with Timmermans's (2013) argument on the benefits of conducting a qualitative study by focusing on the experienced effect of an intervention, this method helped to uncover both intended and unintended outcomes, 'unfulfilled promises', and the inconsistencies between the intentions of health interventions and the complexity of people's experience of them.

3.9.5 Reporting qualitative findings

The use of sample numbers in reporting findings from qualitative research is controversial. Some researchers argue that it can lead to misinterpretation of the data and detract from the more valuable, detailed and nuanced qualitative data, whereas others suggest that the use of numbers is a legitimate and valuable strategy for qualitative researchers when it is used to complement an overall process orientation to the research (Maxwell, 2010).

In the current study, the development and integration of two typologies (based on men's *reliance* and women's *involvement* as described in chapter 5.3) has resulted in participants being assigned in different categories, and some categories consisting of small numbers of cases. Some important perspectives related to even a small number of cases are discussed within their respective categories rather than as deviant case studies. Therefore, on several occasions while reporting key findings, the numbers of cases are reported for clarity and rigour as well as to not overemphasise any issue. The use of numbers is therefore intended to describe sample characteristics such as number of participants in a certain category and key demographic data rather than to emphasise the value of a given response or emergent theme based on frequency. As the findings in the current study report subtle differences within the samples, this semi-quantification exercise is useful to give precision to participants' remarks and identify emerging patterns.

3.10 Ethical Considerations

Ethical issues related to this study, and potential risks for participants and myself, were considered in consultation with my PhD supervisors, who all have previous experience of conducting qualitative work in the family context. I was

aware that due to the nature of the topics being discussed, interviews could potentially cause friction between couples and impact negatively on their relationship. I consulted with members of the University of Glasgow College of Social Sciences Ethics Committee and was advised of protocols for addressing these potential risks. Participants were also told before starting the interview that they did not have to answer any question that they did not wish to and were free to stop the interview at any point they wanted.

Ethical approval for the pilot and main study was obtained from University of Glasgow College of Social Sciences Research Ethics Committee in January 2016 (ref: 400150077) (Appendix Three). Before deciding to take part, potential participants were provided with a copy of the information sheet (Appendix Five) and were given the opportunity to ask questions to clarify anything they were unsure of. They were informed that participation was voluntary and that they did not have to discuss any issues that they did not feel comfortable with, and could leave the study at any time without explanation. The participants were informed that the discussions would be recorded with their permission and assured that everything they said would be confidential and anonymised in any publications. Consent forms were provided and completed before the interview (Appendix Nine).

All data were treated confidentially by de-identifying the sample and data. All identifiable data were kept securely in a locked cabinet and in a password-protected computer within the Social and Public Health Sciences Unit.

All participants were given pseudonyms to preserve their anonymity. Identifiable details (for example names of clubs, towns or parks) were also changed in reporting of findings. As this study included both couple members there was a potential of an individual being able identify their partner through their own details. However, the rigorous anonymisation adopted in this thesis means that they would have to read through the thesis and remember their own quotes from the interview in order to identify themselves and their partners, which is highly unlikely. As participants' accounts were mostly convergent, and not highly sensitive in nature, I am confident that the information contained in this thesis

will not cause any detrimental effect to any participant in the unlikely event that they can identify themselves or their partner.

3.11 Reflexivity in research

The importance of reflexivity in research has been discussed in many ethnographic and qualitative studies (Denzin & Lincoln, 2005; Gill & Maclean, 2002). How researchers' own subjectivity shapes their engagement with the topic and the respondents, and how respondents perceive the researcher and their response can shape the data. Warin et al. (2007) emphasise the need for researchers to incorporate themselves within their narrative in order to present a well-balanced story from everyone relevant to the research topic.

The researcher's identity, such as gender, class and age, and how the participants perceive it, can be either strengths or challenges for any study. I was aware that my identity as a married female might influence my understandings and perceptions of the research topic, and my interpretation of the data. At the same time, this 'insider identity' (Cohen & Hoshino-Browne, 2005) could lead to identification with married female research participants. This may have resulted in participants not sharing certain information they assumed common knowledge, or withholding information due to my perceived identification with women. On the other hand, my being (and looking) South Asian could be a useful 'outsider identity' perhaps resulting in participants explaining their daily routine and behaviour in more detail due to the expected cultural differences that we potentially had. However, researchers argue that each of the positions, 'insider' or 'outsider', has its strengths and weaknesses (Finlay & Gough, 2008). Furthermore, being a researcher can be an outsider identity to the non-academic general public regardless of gender, class and ethnicity (Thomson & Gunter, 2011). With regard to my subjectivity, I have considered my position reflexively throughout the research process, and have documented the impact of this within this thesis.

During the interviews all participants were welcoming, and appeared happy to be interviewed. Regardless of their experiences of the programme and of weight

loss and weight maintenance, most participants appreciated the FFIT programme itself. I recognised that my affiliation with the research unit that designed FFIT or my position as a researcher could have presented me as an expert in the field, therefore I thought introducing myself as a PhD student helped participants to be open about the different aspects of the programme and especially men explaining the principles of the programme and what they thought of it. I think me being overweight myself might have helped both me and them to be at ease, especially while asking about lack of success in weight loss and the issues around overweight and obesity.

Studies suggest that the data generated in interviews can be influenced by how the researcher is perceived by the participants. A researcher's professional role, such as being a medical doctor or researcher, and/or their gender might influence the participants' accounts. Thus, Richards and Emslie (2000), comparing their experiences as female researchers conducting interviews, found that participants spontaneously raised different topics when interviewed by a researcher who introduced herself as a general practitioner as compared to when interviewed by a researcher who introduced herself as a university researcher without using her academic 'Doctor' title. For example, participants mentioned health problems and asked medical questions to the general practitioner, and talked about non-health issues, and what would happen to the interview material to the university researcher. These authors also suggest that, in the absence of a professional identity, the researcher's gender may become a particularly important identifying factor for participants. In relation to this, Brown (2001), comparing men's responses to being asked about their health by *the same* female interviewer in two different studies, found they talked less and in less detail when interviewed about their health and health needs in general, but more when asked to 'tell the story' of a specific illness (a heart attack). Potential reasons suggested by Brown, included the fact that health is not a normal part of men's discourse but may become so when health needs are 'thrust upon them' (p193) when vulnerability and openness in relation to health may also become more acceptable. Some men in the second (heart attack) study also appeared to assume she had medical training, perhaps because of slightly different recruitment processes. Brown (2001) concludes that while gender is an

important factor in the research process, these results highlight the importance of subject matter, power and professionalism in determining participant responses.

In relation to the interviews I conducted, I think my being a female might have made it easier for the female participants to relate to me. This was reflected in them saying things like 'you know what I mean' or 'us' while referring to women in general. Men did not explicitly make any stereotypical remarks about me as a female researcher along the lines of 'as a women yourself I expect (do not expect) you to understand'. However, none of the men appeared to be uncomfortable talking about any issues. It is possible that my status as an academic who was 'interested in their stories and experiences', along with the presence of formal processes within the interview (e.g. completion of consent form and use of recording device) may have helped them to view me as a professional, in turn diminishing any potential gender power imbalance between us.

While all the interviews were pleasant in nature, there were two cases (two couples) that I think were out of the ordinary. In the first case, both partners voiced negative opinions of one another. I got the impression that they wanted to use their interview to express their dissatisfaction about how each of them was negatively impacting the other's attempts to lose weight. Usually home interviews were conducted in a room with doors closed if the other partner was present at home, but in this case both of them kept the door open. Although I was uncomfortable during the interviews, they remained on topic, and at the end of the interview both couple members were pleasant. In the second case, the couple had recently lost a family member. I only became aware of this once I met the couple. I offered to cancel the interview or stop if they felt uncomfortable at any point. At the beginning of the interview I was uncomfortable asking questions that might make them recall the period of the death, however they seemed comfortable talking about it. Both partners said that doing the interview was their way of going back to normality. I did not have significant concerns about the impact of the interview on them as they seemed

comfortable until the end, but this experience, I think is an example of how qualitative research can present the researcher with unexpected circumstances.

3.12 Summary

This chapter presented a discussion of the research methods and procedures that I employed throughout this PhD project. It outlined my decisions regarding an appropriate epistemological position and subsequent methods used, and described how these enabled me to explore men's and their partner's experiences by generating substantive data to address my research aims. This chapter described my choice of a qualitative approach and separate semi-structured interviews with each couple member, with particular attention to methodological considerations important for research with couples. It also illustrated how the study was conducted, including my choice of sample of men with varying weight-loss outcomes following their attendance at the FFIT programme, and the recruitment process in coordination with the SPFL Trust. I discussed the methods and process of managing and analysing the data, highlighting the benefits of thematic analysis using the framework approach. Finally, I described the ethical considerations related to this study, and reflected on my influence in shaping the data.

In the following four chapters I will present the analysis of the data that resulted from this process. These chapters relate to the following three research questions and four further issues that cross-cut the three research questions, as outlined in Chapter One.

1. How do cohabiting female partners influence men's attempts to change and maintain their diet and physical activity with the aim of losing weight and maintaining weight loss?
2. How do men's attempts to change and maintain their dietary practices and physical activity influence their cohabiting female partners' dietary practices and physical activity?

3. How do the processes of men's attempts to change their dietary practices and physical activity with the aim of losing weight positively or negatively impact the couple relationships?

Cross-cutting these research questions, which focus on processes, are four further issues:

- a) How do couple context factors (e.g. couple members' weight-related concerns, couples' caring relationship and interdependence, and expectations of positive outcomes from FFIT) impact on these processes?
- b) How do gender roles and gender-related expectations impact these processes?
- c) Do processes in respect of dietary practices differ from those in respect of physical activity?
- d) How do these processes relate to men's weight loss?

Chapter 4 presents an overview of the cohabitating context and the pre-disposing couple factors against which men joined FFIT and were attempting to make and maintain changes. This chapter specifically focuses on the couple context factors, such as participants' concerns relating to weight, caring relationship and expectations of positive outcomes from FFIT.

Chapter 5 focuses on participants' perspectives on the influence of partners on men's attempts to make changes to their dietary practices and physical activity.

Chapter 6 describes the ways in which men's attempts to make changes to their dietary practices and physical activities influenced their partners' dietary practices and physical activities.

Chapter 7 presents how the behavioural change process positively influenced couples' relationships, as well as how partners dealt with any tension and conflicts arising from this process.

In order to address the cross-cutting issues, examples of participants' performances or presentations of gender, differences in participants' remarks in relation to dietary practices and physical activity, and the accounts of those who

achieved their 5% weight-loss target during FFIT and those who did not are highlighted throughout the findings chapters where appropriate.

Chapter 4 Cohabiting context in which men joined FFIT and attempted to make behavioural changes

4.1 Overview of chapter

In order to understand fully how female partners influenced men's attempts to make changes to dietary practices and physical activity after joining FFIT, and how men's attempts to make these changes influenced their partner's dietary practices and physical activities, it is important to understand the context within which men were attempting to make changes. The following sections describe men's personal motivations to participate in FFIT, and the "pre-disposing couple factors" (see section 2.2.3) and the context within which men in this study attempted to make changes.

This section begins by describing the sample. This is followed by a discussion of how men and women described: men's reasons for joining FFIT; the partner's reactions to, and expectations from, the man's participation in FFIT; the partner's involvement in the man's initial attendance at FFIT; and why partners were supportive of the men's decision to join FFIT.

4.2 Description of the sample

All 40 participants in this study were of white Caucasian descent from different socio-economic positions and locations within Scotland. The duration of the couple's cohabitation ranged from 4 to 50 years. Fifteen couples had been living together for more than 10 years. Nine couples were over the age of 60. Twelve men had completed FFIT 3-7 months prior to the interview date, while eight had completed it around 12 months prior to the interview date. Seven men had attempted to lose weight in the past prior to joining FFIT, but only two of them had followed formal weight loss plans (Table 4.1). Seventeen women considered themselves overweight and were actively attempting to lose weight. Eleven of them had followed a formal dieting and/or exercise plan prior to men's participation in FFIT. All women, including those who described themselves as being happy with their current weight, expressed a desire to maintain healthy practices. Seven men and one woman reported being retired, and three women

described never working outside of their homes. The participants reported having had, or being engaged in, a range of occupations, such as company management, administration and warehouse work, which were indicative of both sample diversity in respect of socio-economic position and a range of physical activity requirements as a part of their job.

Table 4.1 Characteristics of the sample

Men	Age	Partners	Age	Interview order	Cohabitation (years)	Time since FFIT (Months)	Men's weight change after FFIT (kg)		Women achieved weight loss since their partner joined FFIT
							At 12-weeks after joining FFIT	At Interview (3-12 months since completing FFIT)	
Ryan	31	Amanda**	34	F/M	8	5	0	+6	Yes
Jason	35	Nicole**	30	M/F	4	11	-3	-2	Yes
Kenneth	36	Kelly**	34	F/M	18	5	-15	-5	No
Kevin	40	Michelle**	45	F/M	8	5	0	0	No
Matt*	44	Sarah	43	F/M	21	12	-7	+2	No
Jeremy	47	Lisa**	51	M/F	10	12	-26	-18	Yes
Mark**	53	Dawn**	42	M/F	9	4	0	0	Yes
Shawn	56	Tracey	53	F/M	30	4	-8	+1	Yes
Eric*	57	Heather*	53	M/F	37	5	0	0	No
Jeffrey**	57	Laura*	51	F/M	5	4	-6	-4	Yes
Mathew*	58	Kimberly**	57	M/F	36	12	0	+24	Yes
George	62	Barbara	60	F/M	34	6	-10	+3	Yes
William	63	Sandra*	61	M/F	44	12	-5	-4	No
Anthony	63	Andrea	61	M/F	45	12	-14	-4	Yes
Scot	63	Judith**	61	M/F	33	6	-22	-16	Yes
Paul*	64	Lorna**	64	F/M	44	3	-4	-2	No
Luke	65	Mary**	67	M/F	50	12	-6	-1	No
Richard*	67	Hillary**	67	M/F	42	12	-16	+3	Yes
Peter	69	Angela	65	M/F	40	7	-6	-1	No
Joseph	70	Tricia	67	M/F	40	3	-3	-2	Yes

*: had attempted to lose weight on their own prior to FFIT

** : had participated in weight loss programme prior to FFIT

0 denotes no weight change; - denotes weight loss; + denotes weight gain

Whilst the table above provides a basic snapshot of the sample, the following expanded case studies provide a deeper understanding of the differing couples' contexts within the sample:

Jeremy and Lisa

Jeremy is 47 years old and Lisa is 51. They are a married couple who have been cohabiting for ten years. Both Jeremy and Lisa have non-manual occupations. They do not have any caring commitments.

FFIT participation: *Jeremy had never participated in any weight loss programme prior to FFIT. He joined FFIT because Lisa encouraged him to do so. He had lost 44 kg since he joined FFIT 15 months ago. Both were very appreciative of the FFIT programme. He described being content with the dietary practices and physical activity he had changed and maintained. He and Lisa were codieting and coactive. They did most of their activities together. Lisa was in charge of making changes to dietary practices for both. Lisa considered herself overweight and described trying to lose weight for years.*

Interview: *Jeremy was interviewed first followed by Lisa in their home. They were keen to take part in this study. Lisa seemed comfortable to talk about her experience, and expressed both positive and negative feelings, in relation to his participation in FFIT and subsequent changes.*

Scot and Judith

Scot is 63 years old and Judith is 61. They have been cohabiting for 33 years. Scot's job requires manual labour. He described having temporarily left the job due to his alcohol problem and weight-related discomfort, but had gone back to work since starting FFIT. Judith is unemployed. They have a teenager son living with them.

FFIT participation: *Scot joined FFIT on his own initiative. Both he and Judith were appreciative of the FFIT programme. He had never participated in any weight loss programme before. He had lost 38 kg since he joined FFIT 9 months prior to the interview. He seemed optimistic about maintaining the changes. They were neither coactive nor codieting, and he was in charge of all the dietary changes.*

Interview: *Scot was interviewed first followed by Judith at their home. Judith disclosed about, and appeared to have, morbid obesity. She was not able to walk without her walking frame and seemed uncomfortable to undertake even basic movement (i.e. bending down to sign the consent form or reach for her bottle of coke to drink during the interview). She spoke at length about her health problems related to her obesity, and her weight loss plan essential for her medical procedures.*

Matt and Sarah

Matt is 44 years old and Sarah is 43. They have been cohabiting for 21 years. Both Matt and Sarah have non-manual occupations. They have two daughters aged 12 and 8 who live with them.

***FFIT participation:** Matt joined FFIT on his own initiative and was similar to most men in describing the affiliation with his football club as one of the important motivating factors for joining. He had never participated in any weight loss programme before but had unsuccessfully tried to lose weight through exercise multiple times in the past. He and Sarah were both appreciative of the FFIT programme. He had lost 7 kg upon completion of FFIT 12 months ago, but had gained 2 kg since. He described having maintained the changes despite gaining some of the weight he had lost at the end of the FFIT. Sarah expressed her desire to stay fit but did not describe herself as overweight. They were not coactive but Sarah had also changed some of her dietary practices since Matt joined FFIT. He was more involved in food shopping and planning, but Sarah was responsible for food preparation and cooking.*

***Interview:** Sarah was interviewed first followed by Matt at their home. Their daughters were at home during the interviews. Sarah spoke about being proud of his pursuit for weight loss but recounted reasons, particularly related to children, that prevented her from being coactive or changing the family food practices significantly.*

Ryan and Amanda

Ryan is 31 years old and Amanda is 34. They have been cohabiting for 8 years. Ryan's job requires manual labour and Sarah is in a non-manual occupation. They do not have any caring commitments.

***FFIT participation:** Ryan joined FFIT on his own initiative. He had never participated in any weight loss programme before. He had not lost any weight upon completion of FFIT 5 months ago, and had gained 6 kg since. He described starting very few dietary changes but gave them up soon after. Amanda describes herself as overweight and expressed her desire to stay fit and lose more weight for their upcoming wedding. They were not coactive but Amanda was physically active. They described both of them being equally involved in food preparation at home and also influencing each other to eat unhealthy foods.*

***Interview:** Amanda was interviewed first followed by Ryan at their home. Amanda spoke about being frustrated with Ryan's lack of interest in changing his dietary practices and physical activity.*

4.3 Men's motivation for joining FFIT

Men's accounts about their reasons for joining FFIT suggested that various factors, such as health concerns, a desire to look and feel fit both for themselves and their partner, and social interactions with other FFIT participants, motivated them.

Most participants presented the men's attempts to lose weight as something they needed to do to reduce their health risks and feel fitter. These men described either being confident or hopeful about losing weight when they decided to join FFIT. None of them reported being pessimistic about their ability to lose weight. They also appear to have taken personal responsibility for being overweight, and illustrated their awareness that being overweight was a consequence of their own unhealthy dietary practices and lack of physical activity.

I was putting weight on so I had to try and lose a bit of weight. And that's why when I saw this [information about FFIT programme], I phoned them up and applied for it. (Joseph 70, cohabitation with Tricia 40 years.)

Almost half of the men's accounts also illustrated how their desire to look and feel good motivated their weight loss attempt. For some, this was linked to their relationship with their partner. These men described being fitter and weighing less when they first met their partner or before they got married. Although none of the men and women suggested that they felt insecure in their relationship due to their weight, some men, including those who had been with their partner for long periods of time, reported wanting to lose weight 'to look good' for her. In his interview, Matt articulated how, for him, attempting to lose weight demonstrated that he was putting an effort into his relationship.

A lot of the stuff I do, I want to look good for being wae her [...] So there's an incentive, there [...] I wouldn't want me to keep putting on weight [...] to the point where she's saying "you've let yourself go and you're not putting any effort in," so you have to put in effort for your family. (Matt 44, cohabitation with Sarah 21 years.)

In addition to their expectations of the benefits that their weight loss could have on their relationship with their partner, some men also alluded to their expectation that their partner might benefit from their changed practices.

When I discussed it wi' Mary and told her what we're looking at trying to achieve, we just agreed that both of us could probably benefit from it [him participating in FFIT]. (Luke 65, cohabitation with Mary 50 years.)

Some participants, mostly retired men, talked about social aspects of the programme as being the primary reason for joining FFIT. These participants emphasised that participating in FFIT was good not just for their physical health but also because they were among a group of other men. Richard and his partner Hillary in their interviews talked about how Richard had turned into a 'house person' after he retired and FFIT gave him an opportunity to socialise.

It's good for me to go back out and meet people again. (Richard 67, cohabitation with Hillary 42 years.)

I think he misses the outlet of company, since he stopped work. And I says "Well, for that alone", because I still go out with friends, but Richard's quite a house person. (Hillary 67, cohabitation with Richard 42 years.)

Of the eleven men whose partners were following healthy lifestyles to lose weight prior to the man's involvement in FFIT, a few appeared to have been influenced to do the same after seeing their partner benefit from her changed practices. Nicole's account below illustrates that even when women were not directly involved in encouraging men to lose weight, some might have indirectly motivated their male partner to join FFIT.

Jason wasn't really bothered about his weight and it was when I lost so much weight [...] then I think Jason started to realise maybe he could lose some weight and that's when [FFIT] kind of advertised which was perfect timing. (Nicole 30, cohabitation with Jason 4 years.)

4.4 Women's reactions to, and expectations from, their partner's participation in FFIT

All men in this study informed their partners of their decision to join FFIT prior to the programme starting. However, most participants reported that joining

was the man's own decision. Only two men reported joining FFIT because their partner urged them to or initiated the process of joining. In almost all cases, women appeared to be pleased about their partner's decision to join. The term 'supportive' was used almost universally by both men and women in describing the partner's reaction to the man joining FFIT. Even women who were either unaware of the programme content, or doubtful of the man's ability to make changes and lose weight after attending FFIT, reported being supportive of his decision. This was presented as a taken-for-granted aspect of the woman's role in supporting men by both men and women. No man described expecting his partner to be unsupportive.

I told her that I'd be going to doing some walking [...] she was fairly amenable to that. (William 63, cohabitation with Sandra 44 years.)

She was happy because [...] I done it off my own back kind of thing and I think she was happy that I'd done that. (Ryan 31, cohabitation with Amanda 8 years.)

A majority of men and women suggested that there was no negotiation between partners about the man joining FFIT and that the decision to join did not require extended discussions around the need for compromises between them and their partner. Most men appear to have not expected any input from their partners in the decision making and suggested that the conversation regarding their participation in FFIT was more to provide information than to seek the partner's permission, highlighting their autonomy in making the decision to join.

No, [didn't discuss with wife before joining] I just said I was... I was going to the [name of the football club], try and get, you know, fitter, lose a bit of weight. (Peter 69, cohabitation with Angela 40 years.)

He didn't say "Do you think I should do it?" He just wanted to do it, so, he did. So, I thought 'Well, that's good' Yeah. (Angela 65, cohabitation with Peter 40 years.)

In most cases, the woman's agreement with the man's autonomous decision to join FFIT was not considered a major issue by either partner. However, a few participants reported having discussed certain practical arrangements in order to allow the man to attend the sessions. For example, all (three) couples with young children talked about having discussed the challenges of and

inconvenience caused by the man attending FFIT, mostly due to their work schedule and childcare commitments.

Because it [FFIT] was a Friday night and [...] because the girls have got a lot of clubs on a Friday and we had to decide that I was going to do them all. (Sarah 43, cohabitation with Matt 21 years.)

For men who had talked with their partners about their weight in the past and had been encouraged by them to participate in activities independently, FFIT was an opportunity to do just that. For example, Matt below described how attending FFIT was his way of following his wife's suggestion that he should do something for himself. His wife Sarah also said that she was pleased about Matt getting an opportunity to have some time for himself despite the additional household responsibilities that this would give her.

Sarah has always said, as well, subtly, "maybe one night a week, you should maybe do a class or do something," so I just came back and said "well, that's my one night for twelve weeks". (Matt 44, cohabitation with Sarah 21 years.)

Similar to almost all men who said that the FFIT programme's association with their football clubs was as an important pulling factor for them to join FFIT, women who recounted being 'surprised' by their partner's decision to join a weight-loss programme recognised that FFIT's association with the football club was a strong motivation for him to participate.

He is motivated by football. You know, it's his club and he is interested in [...] it kept a nice link for him. (Kelly 34, cohabitation with Kenneth 18 years.)

[Name of the football club] are massively important to him [...] I think what made the difference for him was the connection with the football club which he feels really strongly about. (Tracey 53, cohabitation with Shawn 30 years.)

It is notable that a few women, usually partners of older men, were described as being concerned that these men might sustain injury during the FFIT sessions. These women described encouraging their partners to be cautious when exercising rather than discouraging him from participating.

I was slightly concerned because of his age and because of the activities that they might be doing [...] although he seems to be fit, you just never know. (Angela 65, cohabitation with Peter 40 years.)

Joseph and Peter described how they needed to assure their concerned partners that the exercise was safe and suitable for them, for example, by explaining how the coaches tailored the exercises according to men's abilities.

I'd come back and she'd ask. The first thing she'd say is, "Are you okay?" (Joseph 70, cohabitation with Tricia 40 years.)

She said "Is it not too much for you? She always says, "Don't overdo it." [...] I've never been fit [...] I wasn't very fast. So, I never strained myself. So, I just did what I could. (Peter 69, cohabitation with Angela 40 years.)

Although almost all women described having welcomed their partner's decision to join FFIT, their expectations around his participation varied for many reasons, including the man's personality and his previous attempts to change behaviours. Thus, women who were optimistic about their partner's abilities to either make the required changes or lose weight often described his personal characteristics as 'determined', 'strong-willed' or 'committed'. These women suggested that they believed their partner would be able to succeed at the FFIT programme because of these personal attributes, even before they had fully understood what his participation would entail.

I knew he'd stick to the programme for the weeks that he was going because when he commits to something he does commit to it. (Nicole 30, cohabitation with Jason 4 years.)

In contrast, a few women who suggested that they were sceptical about their partner's ability to achieve weight loss through FFIT or said they were uninterested in his attempts, alluded to his prior failed attempts to either lose weight or change other behaviours. About one third of the men in this study were reported to have followed a weight loss plan in the past prior to joining FFIT. Most had followed a plan that their female partners had followed or initiated and these men and their partners described the man either not being able to lose weight or maintain weight loss subsequently. The partners of some of these men referred to the man's past unsuccessful attempts in describing reservations about men's ability to commit to the FFIT programme.

I knew it was, it would be really hard for him, because he has always found it hard to lose weight.

ST: When you say he had always- like had he tried in the past?

He's, oh he's tried, yeah. Yeah. But I mean, he has lost weight but then something happens and then it just goes back on again [...] it seems he can put it on really easy. (Heather 53, cohabitation with Eric 37 years.)

However, these women reported not expressing their doubts directly to their partner in order to be supportive, despite their reservations about the man's ability to make changes or lose weight. Kimberly described her partner's participation in FFIT as one of the 'silly things that he always does,' while adding that she did not say anything to him directly as she did not wish to discourage him.

He does daft things occasionally....I never actually gave it much thought to be honest. (Kimberly 57, cohabitation with Mathew 36 years.)

Interview data from men also indicated that most were unaware of their partner's doubts regarding their ability to comply with the FFIT programme. Anthony was one of the few men who described being aware of his partner's doubts about him being able to maintain the changes that he would be making.

I told her I was going to apply. I don't think she said anything [...] I think she thought, 'This is one of his strange ideas that he's probably got in his head'. (Anthony 63, cohabitation with Andrea 45 years.)

4.5 Partner involvement in men's attendance in the FFIT programme

This section outlines participants' experiences of the partner's involvement in men's initial attendance at FFIT. It is kept brief because a more thorough analysis focused around how cohabiting partners influenced each other following the man's attendance in FFIT is presented in Chapters Five, Six and Seven.

Most participants talked about having a conversation with their partner about the content of the FFIT programme once the man had attended the first session.

Interviews with both men and women illustrated that most men shared their experiences and perceptions of the programme with their partners, informed them of the changes they were encouraged to make by FFIT coaches, and talked about how they felt about participating in FFIT. A few women reported not having any assumptions about the programme content until their partner explained what it entailed. While most women described being informed of the details of what FFIT would entail from what the man had shared, some partners' enthusiasm about the process was reflected in their description of how they had thoroughly read the FFIT information booklet that was given to men when they started FFIT.

I thought it was more football based, 'til he went and came back, and then started to tell me what it actually involved. (Mary 67, cohabitation with Luke 50 years.)

I wasn't really sure [before]. I knew they'd be doing something like physical exercise wise, but I didn't actually realise they would have been educating Jason on foods [...] and alcohol, I didn't realise they were going to do an educational part of it. So it was very good. (Nicole 30, cohabitation with Jason 4 years.)

Most men said that their partner was interested in finding out what he did at the programme and the kind of changes he was planning to make. In most cases, both men and women talked about the women being 'supportive'. However, being supportive meant different things to different participants. For some, support meant removing the barriers that could have prevented men from taking part in FFIT, such as driving them to the sessions or looking after children, whereas for others the woman's support meant showing approval of the man's decision to attend FFIT and providing encouragement. The way women expressed their support appeared to have been guided by what they felt would be appropriate, based on their perception of the partner's personality or 'the type of person' he was and the way they supported each other as a couple within their lives more generally. For example, some thought they were supporting their partner by showing interest in different aspects of the changes that he was making or activities at the FFIT programme. The two interview extracts below reflect some of the ways these issues were expressed by both men and women.

She would ask questions when I would come back, I'd usually tell her to be honest [...] I think she was quite interested in some of the stuff. (Jason 35, cohabitation with Nicole 4 years.)

[...] he'd tell me about what was happening [at FFIT sessions]. And I think if I had not listened or not responded or not given my input to it, he would have not talked to me about it, and then he would have felt a lot more isolated on the whole thing. Cause he's the type of person, you know, if he's telling me something and I don't take an interest in it, he'll just be like, "Oh right, forget it then." And what I didn't want was him forgetting it. (Nicole 30, cohabitation with Jason 4 years.)

In contrast, other women suggested that allowing their partner space to be able to do things independently was their way of supporting him. Thus, the level of pre-existing interdependence between couple members seemed to determine the degree of both the men's expectations for women's support and how engaged the women were in the changes that men planned initially.

Although we're a couple, do you know, we're quite independent as well, and quite strong-willed. So, if he wants to do something, he'll do it, and if I want to do something, I'll kinda do it too [...] I would [just] manage it for him [arranging house work so that he goes to exercise] because he does that for me, we would both do that for each other. (Sarah 43, cohabitation with Matt 21 years.)

It never happened as a conversation [...] it's unspoken ... I always support her to say "look, I'll do that so that you can go". So just, it was sort of reciprocated so that both of us have got our exercise time. (Matt 44, cohabitation with Sarah 21 years.)

Matt's remark above regarding him knowing that his partner would be supportive even without them having to discuss it was representative of many other participants' accounts suggesting that the woman's support was taken for granted by both men and women. In cases of supportive women, the woman assuming the supportive role was described as something normal for them as a couple and not the product of the man's attempts to make changes. Many men and women described the support that their partners provided for them generally, reflecting the kind of supportive context evident in their relationship.

We've always been very supportive of each other. Like, if he wants to do something or if I want to do something, we've always been the type of

couple that would push that person to do it. (Nicole 30, cohabitation with Jason 4 years.)

I think she was definitely supportive [...], I think it would have definitely made it harder [if she was not supportive]. (George 62, cohabitation Barbara 34 years.)

Don't think there is anything that she doesn't [support with], she might say different but she certainly does not tell me. Anything I want to do, she is supportive of it. (Kenneth 36, cohabitation with Kelly 18 years.)

Most men said their partners were happy about them taking the time to attend FFIT and participate in other physical activities. None of the men described their partner being unsupportive of their attendance at FFIT or creating any practical barriers that might have caused him to stop or miss FFIT sessions. However, in a few cases, women described being unhappy about the additional responsibilities they inherited because of the man's time away from home for FFIT but said that they did not complain to him. None of the men seemed to be aware of their partner being unhappy about their participation.

4.6 Women's motivation for supporting men's decision to join, or their attendance at, FFIT

Although not all women thought it was their responsibility to help their partner make specific changes, most suggested that in their relationship, being supportive of their partner was embedded. As Tricia (67, cohabitation with Joseph 40 years) described, *"that's what happens when you're in a relationship"*.

Many women emphasised that their moral support was crucial in helping their partner make changes. This meant most women being supportive and/or appearing to be supportive even when they were not. The following excerpt from Tracey represented the views of many women who were aware of the effect that their encouragement could have on their partner. They wanted their partner to know that they were supporting his decision in order to encourage him regardless of whether they were optimistic or not about his ability to make behavioural changes or lose weight.

I think in a partnership it really helps if the other partner is at least seen to be supportive of it. If for instance I didn't value it, either verbally didn't say it or my body language reflected that, I think that would be harder for him to maintain and indeed if I were to moreover diminish it by making fun of it, I think he'd have stopped. (Tracey 53, cohabitation with Shawn 30 years.)

Consistent with the men's own accounts of the various reasons for joining FFIT, interviews with women also highlighted multiple factors that motivated them to be supportive of their partner's decision to join FFIT. These included women's concerns around the man's weight and related health risks, their expectation of how their partner could benefit from FFIT, the fact that FFIT provided an opportunity to address sensitive issues around weight and related behaviour, and their wish to support their partner's personal growth and independence. Partners' accounts around these reasons were also suggestive of their expectation that men's pursuit of weight loss would be beneficial for the man as well as them as a couple.

4.6.1 Women's concerns for their partner's health

Many women in this study identified their partner's attempts to lose weight as something he needed to do for health-related reasons because, like the men, they associated overweight and obesity with health risks. Although almost all men were reported by both themselves and their partners as having been overweight for a long time, for 13 of these men FFIT was their first attempt to actively lose weight. Partners of these men and a few of those who had attempted weight loss in the past, were mostly optimistic about their ability to make changes and lose weight and subsequently reduce their weight related health risks. Therefore, most of these women appeared to be pleased and supportive of their partner joining FFIT due to their anticipation that he would lose weight and improve his health as a result.

Although he says he's going up and down in weight - he never actually did anything about it. So, when [...] he said he was going to go for it, it was a wee bit of a shock. But it was a good shock. (Barbara 60, cohabitation with George 34 years.)

Most women were also happy about the fact that he had decided to do ‘something’ about his weight, regardless of their expectations of outcomes from their partner’s participation in FFIT. Although many men had not participated in any formal weight loss programmes prior to joining FFIT, some women said they were not surprised when their male partner joined a formal weight loss plan, as he had been overweight for a long time and had mentioned wanting to do something about it.

Extremely happy that he was gonnae at last do something [...] he came to the point where he knew he had to do something and that really interested him, so I was pleased. (Heather 53, cohabitation with Eric 37 years.)

I think it’s the best thing that he’s ever done, is when he admitted himself that he had a weight problem [...] and doing something about it. (Hillary 67, cohabitation with Richard 42 years.)

4.6.2 An opportunity to deal with the sensitive issue of weight/weight loss

One issue that was central to most participants’ accounts regarding men’s weight was sensitivity around weight/weight-loss, and how it added to the complexity for cohabiting partners in providing support for weight related behaviour changes. Most women suggested that their partner joining FFIT made it more comfortable for them to discuss his weight-related issues and also provided them with an opportunity to support him without having to worry about hurting his feelings.

Throughout the interviews, many women highlighted their uneasiness regarding their conversations about their partner’s weight prior to his participation in FFIT. They described the negative experiences they previously had when encouraging him in relation to health behaviours related to weight loss, with many suggesting that their previous encouragement had been perceived by their partners in a negative way. The terms ‘nag’ or ‘moan’ were used by many when discussing their attempts to advise their partners to eat healthy meals or lose weight. These women reflected on how their advice or concern at times had an adverse effect, resulting in him becoming frustrated or even reacting by

adopting unhealthier practices, such as eating more unhealthy foods. Many women also provided a range of examples to highlight the ways in which they were consciously being considerate of their partner while attempting to encourage him to lose weight or adopt healthy practices.

Maybe a few hints now and again but he - if you moaned, it would get worse. He would go and have another biscuit and a cup of coffee or something [...] I think you've got to speak about it, but you can't- you can't be negative about his weight. (Barbara 60, cohabitation with George 34 years.)

He thought I was nagging when I suggested him [doing] something. (Amanda 34, cohabitation with Ryan 8 years.)

Some of these women reported either not having previously talked about the man's weight or that the man had not liked being asked by her to adopt a healthy diet and increase physical activities to lose weight. For women who described wanting their partners to lose weight, the man initiating the weight loss attempt by joining FFIT appeared to make it easier to address their concerns openly and so directly support the man. The extract below from Barbara echoed many women who thought their partner initiating attempts to lose weight meant that both partners could be comfortable around this issue, and also that he would benefit from his self-motivation.

You would feel guilty about saying something [about his weight in the past]. But it was his choice to do it, and it was his idea [...] it was nobody telling him 'Look at this' [...] he did it, so, it's his thing. And I think that's probably why it was a success. (Barbara 60, cohabitation with George 34 years.)

Six women who had unsuccessfully tried to get their partner to follow one of their own healthy diet plans in the past, described feeling vindicated once he received information on diet and physical activities from FFIT. Amanda and Dawn's accounts below resonated with those of other women who were pleased that their partners were convinced about the importance of healthy practices as a result of joining FFIT.

I was annoyed that he did not listen to me [in the past] but I understand and at least he knows I'm not talking rubbish. (Dawn 42, cohabitation with Mark 9 years.)

He sees my caring as nagging and so if I tell him to do something he's not as likely to do it as if someone else tells him to do something [...] It was nice for him to get this information from someone new and validate the stuff that I'd said before. (Amanda 34, cohabitation with Ryan 8 years.)

4.6.3 Men's personal growth and independence

In addition to the perceived benefit of weight loss, one issue which was common in most women's accounts of men's attempts to change their behaviours, as a result of their participation in FFIT, was men's personal growth, for example, thriving as an individual beyond physical health. This was reflected in women's accounts around wanting their partner to get out of the house so that he could have some time to himself to do something on his own.

The man taking the initiative and independent motivation to pursue better health by joining FFIT was valued by many partners. These women recognised their partner's need for autonomy in both taking ownership of the commitment they were making and physically taking the time away from their family commitments. Although most partners described dependence on each other for moral and practical support, many women also emphasised the importance of individual space and motivation in their discussions about the man's behaviour changes. In this regard, most women highlighted the need and importance of, firstly, their partner's individual motivation, and secondly, their own ability to allow him personal space to make the changes himself.

He's always kind of been interested in keeping fit and exercise but his job or family life came in the way all the time, so it [joining FFIT] provided a nice wee block of time dedicated for that. (Kelly 34, cohabitation with Kenneth 18 years.)

I was delighted, surprised, 'cause he'd done it, he'd found the programme all on his own and just applied [...] 'cause he was taking ownership it was really good [...] he'd done it off his own back meant that he was far more likely to take it on of course [...] Allowing him to do it on his own in his own space and his own time's far better for him. (Laura 51, cohabitation with Jeffrey 5 years.)

Because if he was not doing that [exercising] he would be in the house and it was better for him doing that than sitting in the house. (Sandra 61, cohabitation with William 44 years.)

In describing the importance of having an independent space within the relationship, a majority of participants, both men and their partners, emphasised the virtues of the men-only aspect of the FFIT programme, which allowed men space to connect with other men and engage in conversations on certain issues away from their partners.

[...] you don't get the same conversation wi' your wife as you do wi' the boys. (Eric 57, cohabitation with Heather 37 years.)

The majority of men said that it could have been counterproductive towards their own attempts to lose weight had their partners also been allowed to join FFIT, despite acknowledging that the partner might like to join and may benefit from doing so. Some of these remarks were focused on men's own sense of comfort in participating alone, and achieving weight loss goals, whereas others seemed deeply rooted in their sense of autonomy and responsibility. Eric, like many other men, talked about how he would not have liked to have his partner in the programme, even if it had been possible for her to join, and thought it could have been counter-productive.

I think just... maybe find that if there was couples that you probably wouldnae talk to the guys as much [...] And then you'd be kind o' hanging back an' helping your partner an' maybe no' pushing yourself quite as much as you should, because your partner's there, sort o'. I don't know. I just think I ... no, I'd just rather do it on my own. (Eric 57, cohabitation with Heather 37 years.)

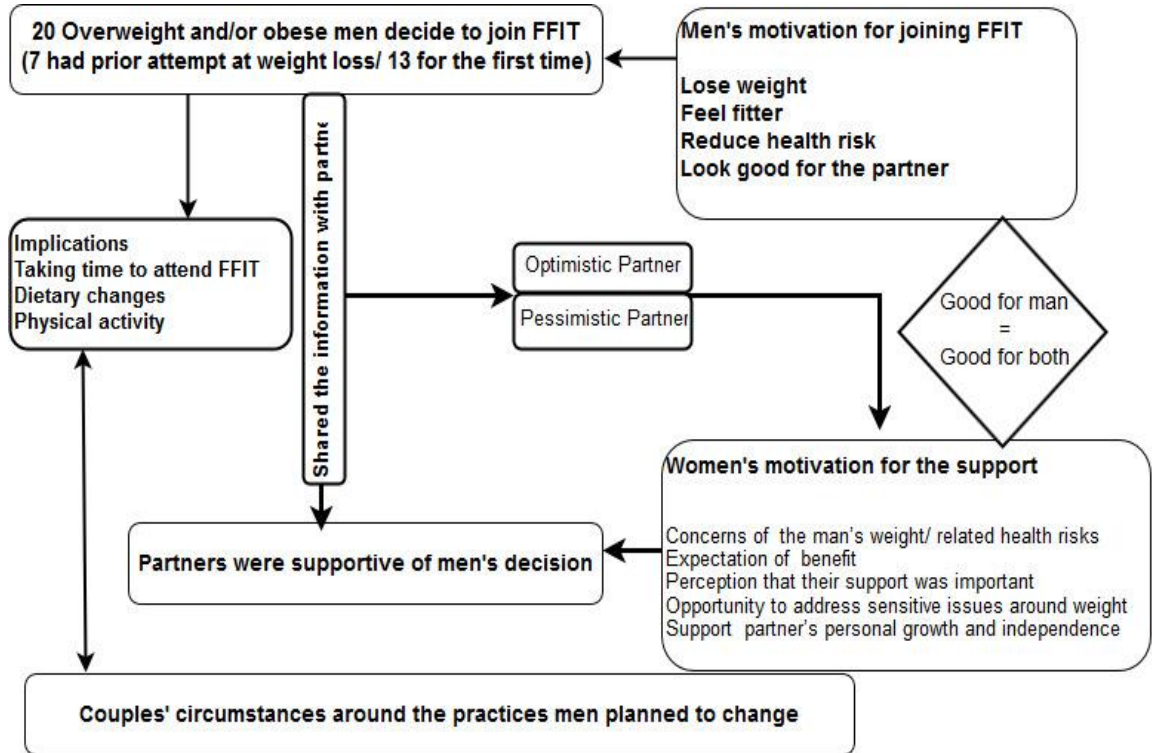
When asked whether they would have preferred to participate in FFIT as a couple, some women suggested that either joint participation in the programme or being part of the programme could facilitate their attempts to support the man. However, many others suggested not wanting to participate in the FFIT programme together, emphasising instead men's autonomy in their pursuit of weight loss. In both cases, the partners seemed to be putting men's needs first.

4.7 Chapter four summary

The findings outlined in this chapter focused on men's personal motivations to participate in FFIT and the couples' context in which they attempted to make behavioural changes. All men were in committed and caring relationships with their cohabiting partners. Consequently, most couples displayed a mutual motivation for the man's attempts to lose weight and mutuality in many practices to this end. While the anticipated weight loss outcome was identified as a major reason for men's motivation for joining FFIT, and for partners' support of the process, the participants' accounts identified several other reasons. Most men identified a desire to feel fitter, in line with FFIT's stated aims, to enhance their relationship, and to promote their personal wellbeing as additional reasons for joining FFIT.

Figure 4.1 outlines the 'pre-disposing couple factors' around men's participation in FFIT. The findings highlight women's supportiveness towards men's attempts to lose weight and their sense of care, obligation and commitment towards men. They also illustrate how women's expectations that making changes would benefit them and their relationship, as well as men's health and personal development, enthused women in supporting men's attempts to make changes. Most participants considered the changes that the men were making not only as means for losing weight but also as means to thrive as individuals.

Figure 4.1 Circumstances around men's participation in FFIT



In some cases, women's expectations about their partner's weight loss outcome were guided by their experiences of his past behaviour change attempts and/or self-motivation in general, rather than the content of the FFIT programme and the specific changes that the men would be encouraged to make. This is of particular importance because the men in this study had varying experiences of weight loss attempts prior to FFIT. Some had never tried to lose weight before while others had made unsuccessful attempts to make changes or lose weight. Although some women talked about being doubtful about their partner's ability to make changes, none said they had discouraged or prevented him from attending FFIT. Most women described their appreciation of their partner's personal space in his weight loss attempt and reflected on how they respected the man's autonomy within the relationship despite their commitment to support him.

The findings reveal that despite awareness of the health consequences of overweight and obesity, and their desire to encourage the man to lose weight, for many women, discussions about weight loss and healthy practices were still sensitive topics. These findings suggest that individuals in a relationship might

consciously hold back from initiating health behaviour changes or provide direct support and encouragement for such changes despite their desire to do so.

It was apparent that most women were not involved in their partner's decision to join FFIT but they welcomed it. However, the decision making was not always autonomous when it came to changing behaviour in practice, where some changes were made by men or partners individually and some collectively as a couple. Together, these findings emphasise the performance of gender roles in men making independent decisions and taking ownership of their practices, and women being supportive and caring allies.

Overall, the findings discussed in this chapter indicate that several crucial pre-existing factors, in addition to the primary participants' desire to improve health, could influence their motivation for, and the successful adoption of, new health practices within couples' contexts. These findings are discussed in relation to Interdependence Theory, sociological understandings of gendered norms around family food practices and theoretical perspectives of Self-Determination Theory in Chapter Eight.

The following chapter describes the findings related to the ways in which men's attempts to make and/or maintain changes to their dietary practices and physical activity are influenced by their partners.

Chapter 5 The influence of female partners on men's attempts to change their diet and physical activity and to maintain those changes

5.1 Overview of chapter

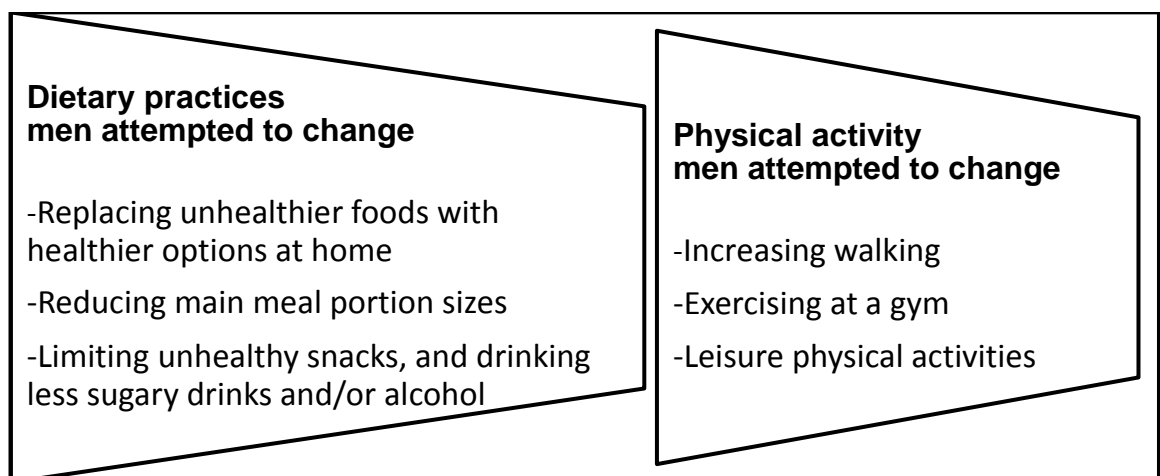
The previous chapter outlined cohabiting partners' motivations for, as well as reactions to and expectations of, men's decisions to participate in FFIT. By taking into account both partners' perspectives, this chapter examines the mechanisms by which men's attempts to change dietary practices and physical activity following participation in FFIT were influenced by their cohabiting partner. Because participants' accounts of partner involvement and men's reliance on partner support showed clear differences between dietary practices and physical activity, the findings relating to partner influence are presented separately for each practice.

The chapter begins by outlining the range of dietary practices and physical activities that men attempted to change as well as the circumstances around those practices in general. Next, typologies are developed to encapsulate how men and women described, firstly, women's varying levels of support towards men's attempts to make changes, and secondly men's varying levels of dependence on the support provided by their partner. This is followed by sections focusing on couples' dynamics based on how *reliant* men were on their partner's support in order to make changes, and the level of their partners' *involvement* in men's attempts to make and/or maintain changes to, firstly dietary practices, and secondly physical activities. Examples of the participants' performances or presentations of gender in their remarks will be highlighted throughout this chapter. The subsequent sections focus on participants' accounts specifically in relation to whether or not the men had maintained dietary practices and physical activity changes, and achieved 5% weight loss target during FFIT. The chapter concludes with a summary of these findings.

5.2 Practices that men attempted to change and the couples' circumstances around those practices

Every participant in this study said that healthy eating practices and physical activity were important in order to lose weight and be healthy. Their accounts suggested that most men had attempted to make changes to some aspects of these practices after they joined FFIT. However, there was variation in the types and degree of changes that the men had attempted to make. This section outlines these practices and the circumstances around each of these practices. Most participants discussed altered dietary practices, including replacing some unhealthier foods with healthier options at home, reducing main meal portion sizes, limiting unhealthy snacks, and drinking less alcohol and/or sugary drinks. Changed physical activities included setting and achieving walking step count goals, exercising at a gym and leisure-based physical activities (Figure 5.1).

Figure 5.1 Practices that men attempted to change once they attended FFIT



5.2.1 Dietary practices that men attempted to change

Making changes to dietary practices is an important component of the FFIT programme. Men are encouraged to replace fatty and sugary foods with healthier foods including fruit and vegetables, and gradually reduce their meal portion sizes and alcohol intake. They are taught about food labels and encouraged to be more involved in practical aspects of their food preparation

and consumption. They are also encouraged to take responsibility for their diet and to avoid blaming their partners or other family members (Gray et al., 2013).

Across the interviews, conversations about men's attempts to make changes to dietary practices were often linked to their food practices in general, prior to joining FFIT. About half of the participants said that they used to eat the same meals as a couple prior to FFIT.

Michelle would eat what I was eating and, I would eat what she was eating. (Kevin 40, cohabitation with Michelle 8 years.)

Most participants discussed making changes to the **main meals** in their homes after the man joined FFIT. The extent of those changes varied considerably. However, many described some aspects of food content or preparation style that they made changes to.

I did make some changes but not a lot, because I was eating fairly healthily. But [...] there's always things you can improve on [...] They [the FFIT coaches] gave us a lot of good pointers [...] although I knew these things [...] they reinforced what I had been thinking, quite forcefully. (William 63, cohabitation with Sandra 44 years.)

The majority (15 out of 20) of the couples said that either the woman alone or both partners were responsible for preparing meals for both partners prior to the man joining FFIT. In nine of those couples, it was the woman alone. In a few of these nine couples, men reported explicitly telling their partner about the kind of changes they wanted to make and how she could help, while other women started making meal changes once they were aware of what was required and without the man asking.

Most participants suggested that a previously uninvolved man's involvement in food-related tasks did not change markedly as a result of attending FFIT. However, a few talked about the man becoming more involved. Unlike cooking, most men increased their involvement in food shopping, by going to the shops with their partners or on their own, or discussing what to buy with their partner after joining FFIT. Joseph, who said he did not cook at all, talked about how he started joining his wife for food shopping after joining FFIT.

I walk with the trolley [in the supermarket] now and again, she'll say "Would you like that? Would you like this?" And I say "Yes, get soup". (Joseph 70, cohabitation with Tricia 40 years.)

Many women appeared happy with the man being more involved in discussing what meals they should eat, food shopping and preparation. However, in five (all over the age of 60) of the nine couples where men were not involved in cooking at all, neither partner wanted the man to be more involved in cooking. These participants had various reasons, often linked with why the woman was responsible for food related provision in general. These included her being more skilled or interested in food-related tasks, and her upbringing encouraging gendered division of household work where women are more involved in family food provisions and serving their partner.

I think she likes looking after me, really. (Peter 69, cohabitation with Angela 40 years.)

When he did do it [cook], there was so much cleaning up to do, you know what I mean [...] that would drive me mad, you know, if I came through and it was like a bomb site [but] one job he gets, is cutting, you know you've got to cut all the peppers up. I hate all that, so he does all that prep. (Lorna 64, cohabitation with Paul 44 years.)

Within the five couples in which men were reported as being primarily responsible for preparing meals for the family *prior* to FFIT, the men appeared to have either changed their dietary practices on their own, or after having discussed the changes to be made with their partner once they joined FFIT. Their partners also said that they were happy to follow the changes for the main meals in the house.

The most commonly mentioned practice for changing the man's diet was reducing **portion sizes**. Men who prepared meals themselves said it was easy to reduce their meal portion sizes. However, in cases where partners prepared meals for the man, a few older women described finding it difficult in the beginning, as they were used to serving him large portions. Although these women seemed to be aware of the negative impact of this practice on men's attempts to eat healthier meals, they described doing so as a matter of habit. They often associated this with either their personality as a 'feeder' or habits

stemming from their family food background, where serving bigger portions to male members of the family was a common practice. In her interview, Mary also justified not cutting down the portion sizes of her husband's main meals too much as a strategy to prevent him eating unhealthy snacks later.

I find it quite hard to give him smaller portions because I am a bit of a feederI still cook a lot but freeze the leftovers now. So I need to get my head round doing smaller, smaller amounts [but] I feel if I cut him down too much it just causes him to snack later on. (Mary 67, cohabitation with Luke 50 years.)

Unlike meals which were illustrated as shared practices, discussions about **snacking** indicated that it was seen mostly as an individual eating habit. Many participants said that snacking was a significant factor in the man's unhealthy diet prior to joining FFIT. Although men and women often talked about their own or their partner's snacking habits separately, rather than something "we" eat, most indicated that they were aware of their partner's snacking habits in the house. Most men and some women described strategies to reduce the accessibility of unhealthy snacks in the house, such as buying healthy snacks in order to change the man's or both of their unhealthy snacking habits. Many women also described their initial scepticism about the man's ability to stop unhealthy snacking.

He said he was going to cut down on unhealthy foods (biscuits) and I thought 'Well, let's see if he can keep it up.'.... I thought 'He'll never keep this up. (Angela 65, cohabitation with Peter 40 years.)

Most participants described the man not finding it hard to reduce his **alcohol** intake and a few men described not having planned to change their occasional drinking. However, two men who described finding it particularly challenging to reduce their alcohol intake described drinking as something they would do either discretely on their own or with friends, but not with their partner, both before and after FFIT.

Tracey doesn't drink at all. It's just me [...] I tend to drink in private and secret and try to avoid her knowing. She knows but (smiles). (Shawn 56, cohabitation with Tracey 30 years.)

Some participants appeared to consider **occasional unhealthy eating practices**, which occurred during holidays, while eating with other family members, or eating out of the house as inhibiting their weight-loss attempts. However, eating out occasionally or while on holiday were often discussed as a treat, and as times when they would not be as strict about their diet as they would be at home. Unlike snacking practices these were almost always described as something the partners did together.

when we were away for that weekend there then, you know, that was crazy [...] An' you felt so guilty an' you felt so full an' it was just silly, but then it's just what happens when you [are on holiday]. (Mathew 58, cohabitation with Kimberly 36 years.)

5.2.2 Physical activity changes that men attempted to make

The physical activity component of the FFIT programme includes a pedometer-based incremental walking programme and fitness, strength and physical training (Gray et al., 2013). Most men in this study had attempted to make changes to their physical activity after joining FFIT. These included increasing walking, exercising at the gym and participating in more physical recreational activities. Most participants described the man as not having been active prior to FFIT.

Although a few couple members described **walking** together as a part of their daily life prior to the man joining FFIT, none described being purposefully *coactive* with the aim of the man losing weight before joining FFIT. One of the major changes talked about by most participants was the man's attempts to walk more in order to reach a certain number of steps each day. Many described men achieving their step-count goals on a regular basis and many men reported finding it easy to start and maintain, right up to the time of the interview.

The steps [target] thing, he became very involved with that, like, tracking it on the trackers and then on his phone and that type of thing. (Nicole 30, cohabitation with Jason 4 years.)

Some men reported doing additional **exercises at a gym** after joining FFIT. These men had either joined a gym for the first time or had re-joined after a long period of time. Although a few women described going to the gym on their own before their partner joined FFIT, none were going to the gym together when

the man joined. About half of the men in this study reported having increased their physical activity as part of their leisure activities, such as through playing football, bike rides or charity runs. However, only a few women appeared to participate in these regular activities. These couples often reported the partner's inability or unwillingness as the main reason for not being *coactive*.

If he was walking [I would join him], but I'm not gonnae go running. No, that's not something I would do. (Mary 67, cohabitation with Luke 50 years.)

Very few men and women reported having made a joint decision to purposely start engaging in **leisure-based physical activities** that both of them could manage after he joined FFIT. For example, Kenneth and his partner described starting cycling together because she was slower than him at running or walking.

Thus, for most men their physical activity was something new they were starting and something they had not mutually practised together with their partner in the past. Unlike *codieting*, where many couples changed some or all of the practices together, most couples did not plan to be *coactive*.

5.3 Typologies: Women's involvement and men's reliance

Two sets of typologies have been developed based on participants' accounts regarding the levels of women's support towards men, and men's dependence on them. They are characterised firstly, by women's levels of involvement, and secondly, by men's levels of reliance on the support provided. Throughout the development of the typologies, responses from both men and women were systematically compared (Appendix Ten). In addition to the participants' own explicit remarks in reference to the overall process, the analysis investigated various practices across the sample in relation to which of the couple member(s) were responsible for and/or if the partner provided support towards. These included: meal planning, food shopping, food preparation, meals in the house, outside meals, snacks, codieting and the partner's moral support for dietary practices; and walking, gym, leisure activity, time management, coactivity, and the partner's moral support for physical activity practices. Although the participants are discussed in relation to their 'types' later in this chapter, a

brief description of each type is presented below. It is important to note that some participants belonged in different categories for dietary practices and for physical activity.

5.3.1 Typology: Women's levels of involvement

Based on men's and women's accounts of women's levels of involvement in providing instrumental and emotional support to men's attempts to make changes, women were classified as *Very Involved*, *Partially Involved* or *Not Involved*.

Very Involved: Across the interviews, several men and women reported that the woman was providing extensive practical and moral support to her partner to help him make changes. *Very Involved* women were practically facilitating every aspect of their partner's changes, for example by setting positive contingencies or avoiding unhelpful practices. Many of these women also considered helping the man make changes as their responsibility.

Partially Involved: *Partially Involved* women were involved in only some aspects of their partner's changes. Although the involvement of these women could include both practical and/or moral support, they did not consider their partner's changes as their responsibility. The accounts of both men and women suggested that partial involvement from women was not a sign of disinterest in their partner's attempts to make changes. They discussed various reasons for their lack of greater involvement, such as practical challenges, the woman's appreciation of the man's independence in making changes, and the man's desire to make some of the changes independently.

Not Involved: Although participants' accounts suggested that most women were involved in men's attempts to make changes, a small number of men and their partners talked about the woman's lack of involvement in the man's attempts to make dietary and/or physical activity changes. These women are categorised as *Not Involved*. Often discussions about this lack of involvement were linked with circumstances that prevented greater input.

5.3.2 Typology: Men's levels of reliance

Participants' accounts also highlighted varying levels of men's reliance on their partner for practical or moral support to make and/or maintain changes. Consequently, men have been categorised into three groups based on their need for, and utilisation of, their partner's support in order to make changes and maintain them - **Resolute**, **Reliant/Receptive** and **Non-Responsive**. It is important to note that these categories are *not* based on men's success or failure in achieving their weight-loss goals.

Resolute men: Men who suggested that they were able to make changes to their practices themselves without any support from their partner are categorised as **Resolute**. Although these men did not depend on their partners, they utilised the help they received from them for the *dietary* changes they made. However, they preferred *not to* have her *practical* involvement in their attempts to change their physical activity.

Reliant/Receptive men: Men who were dependent on their partner for making changes to their dietary practices are categorised as **Reliant**. Therefore, the partner's Involvement (whether very or partial), and these men being responsive to the support provided by the partner was a key factor in these men being categorised as **Reliant**. While **Reliant** men did not necessarily make fewer dietary changes than **Resolute** men, they appeared less determined and motivated than **Resolute** men to overcome the challenges to make those changes without support from their partner. Many **Reliant** men, including those who had not discussed their decision to join FFIT prior to joining, reported either having explicitly asked their partner to help with making dietary changes or expecting her to help with specific aspects of changes they were making to their dietary practices. No men were **Reliant** on their partner for making physical activity changes. However, some were amenable to her involvement in their attempts to make physical activity changes even though they were able to make changes without any support from her. These men are categorised as **Receptive**.

Non-Responsive men: Men who were not making the changes themselves, and did not utilise (or benefit from) the practical or moral support provided by their partners, are categorised as **Non-Responsive**. Even when their partner attempted to provide support, they were still **Non-Responsive**. Although some of these men had intended to make changes to their practices initially, having joined FFIT, they either did not make the changes that were suggested, or discontinued with the changes they initiated before the FFIT programme finished.

The tables below present participants in relation to their levels of involvement and reliance with regard to men’s attempts to make changes to dietary practices (Table 5.1) and physical activity (Table 5.2).

Table 5.1 Participants in relation to their levels of involvement and reliance with regard to men’s attempts to make changes to dietary practices

Dietary changes		Women		
		Very Involved (N=8)	Partially Involved (N=9)	Not Involved (N=3)
Men	Resolute (N=9)	Kenneth/Kelly Anthony/Andrea	<u>Jeffrey/Laura</u> George/Barbara William/Sandra <u>Eric/Heather</u> Shawn/Tracey Jason/Nicole	Scot/Judith
	Reliant (N=7)	Luke/Mary <u>Paul/Lorna</u> Jeremy/Lisa Joseph/Tricia	Peter/Angela <u>Matt/Sarah</u> <u>Richard/Hillary</u>	
	Non-Responsive (N=4)	<u>Mark/ Dawn</u> Ryan/Amanda		<u>Mathew/Kimberly</u> Kevin/Michelle

Underlined: men had tried to lose weight in the past

Table 5.2 Participants in relation to their level of involvement and reliance with regard to men's attempts to make changes to their physical activity

Physical activity changes		Women		
		Very Involved (N=6)	Partially Involved (N=10)	Not Involved (N=4)
Men	Resolute (N=6)		Peter/Angela Jason/Nicole Eric/Heather Richard/Hillary	Paul/Lorna William/Sandra
	Receptive (N=10)	Shawn/Tracey Anthony/Andrea Jeremy/Lisa	<u>Jeffrey/Laura</u> <u>Matt/Sarah</u> Luke/Mary Kenneth/Kelly George/Barbara Joseph/Tricia	Scot/Judith
	Non-Responsive (N=4)	Ryan/Amanda <u>Mark/ Dawn</u> <u>Mathew/Kimberly</u>		Kevin/Michelle

Underlined: men had tried to lose weight in the past

Some overarching conclusions can be drawn from the tables above (5.1 and 5.2).

Firstly, the vast majority of women were *Very* or *Partially Involved* for dietary practices and physical activity. However, while some women were *Very Involved* for both practices and some *Partially Involved* for both, others were *Very Involved* for one, and *Partially Involved* for the other. Only a few were *Not Involved* for one practice, and only two were *Not Involved* for both.

Secondly, the vast majority of men were *Resolute* or *Reliant/Receptive*. Only a few were *Non-Responsive* and this group were *Non-Responsive* to *both* dietary practices and physical activity.

Thirdly, there was a difference in the way involvement and reliance categories were patterned: By definition, no man who was *Reliant* for changes to dietary practice had a *Not Involved* partner. No man who was *Resolute* for physical activity changes had a *Very Involved* partner. Of the few *Non-Responsive* men, all but one had partners who were either consistently *Very Involved* or consistently *Not Involved*. No *Non-Responsive* men had *Partially Involved* partners.

Fourthly, men who had tried to lose weight in the past are scattered across the different categories, suggesting that their past experience may not have impacted on either the partner’s involvement or the men’s reliance.

5.4 The influence of partners on men’s attempts to make and maintain changes to their dietary practices

The following sections present how men and women described the partner’s influence on men’s attempts to make and maintain changes to their dietary practices in relation to the men’s level of reliance. More women than men were reported as being responsible for food related activities in the household. However, this was not always reflected in their level of involvement in the dietary changes that men were making. Various factors related to both the men and their partners were identified as associated with women’s level of involvement and men’s level of reliance. Working hours for men and women, gendered division of labour in their household, or men’s own skills in preparing food were frequently highlighted when discussing men’s reliance on their partner for their dietary changes.

5.4.1 The influence of partners on *Resolute* men’s dietary changes

Dietary changes	Partner		
	Very Involved	Partially Involved	Not Involved
Resolute men	Kenneth/Kelly Anthony/ Andrea	Jeffrey/Laura George/Barbara William /Sandra Eric/Heather Shawn/Tracey Jason/Nicole	Scot/ Judith

All nine *Resolute* men and their partners reported that the man took charge of making and maintaining the changes himself and was determined to overcome any resulting difficulties and discomforts. Most *Resolute* men were either fully or partially involved in food-related activities in the household even before joining FFIT and described being practically competent in making all the planned changes. The accounts of these men and their partners suggested that most men

did not consider food provisioning and preparation practices to be only the responsibility of women. For these men, adopting healthier meals meant making changes to practices that they were familiar with rather than starting something new.

He's always been quite good at cooking and does a lot of it but it's directed [...] whereas I think now he's probably becoming more independent 'cause he is more aware of calorie intake, fat contents. (Kelly 34, cohabitation with Kenneth 18 years.)

Resolute men's confidence and sense of ownership was also reflected in the way they described the process of making changes. Unlike *Reliant* men, and most women who used the word 'We' while describing the changes, *Resolute* men often used the word 'I' while describing their changed dietary practices.

I would say it's usually me. I mean, she's so busy. I went shopping yesterday [...] I'll look at the labels now [...] which I never did before. And if I see there's a red one, red [food label] I really don't buy it. (Jeffrey 57, cohabitation with Laura 5 years.)

Only two *Resolute* men (**Kenneth and Anthony**) had *Very Involved* partners for dietary practices. Although both were capable of making, and taking ownership of, the changes, their partners facilitated their attempts by providing emotional and instrumental support where possible, and making the same changes to their own dietary practices as well. For example, Kelly, who was primarily responsible for preparing meals for Kenneth, prior to his participation in FFIT, talked about how he started being more involved and responsible for changing his diet and food-related household activities after attending FFIT. At the same time, Kenneth recognised the ways in which she facilitated his attempts to adopt healthier practices such as reducing unhealthy snacking.

He's taken more ownership of it [...] he is more involved in suggesting ideas [...] I think Kenneth was more in control of portion sizes and alternatives to what we were eating. (Kelly 34, cohabitation with Kenneth 18 years.)

When I was doing the FFIT, I was telling her to make sure that I don't snack 'cause it was always at night when you are sitting watching telly you want to eat something so. She would moan if I was gonna get

something or if she's been to the shop during the day she'd get more sort of fruits for me to eat. (Kenneth 36, cohabitation with Kelly 18 years.)

The majority (six of the nine) of *Resolute* men in this study had *Partially Involved* partners for dietary practices. These couples (Jeffrey/Laura, George/Barbara, William/Sandra, Eric/ Heather, Shawn /Tracey and Jason/ Nicole) indicated that the women were involved in only some aspects of their partner's attempts to change his dietary practices. Although these *Resolute* men did not ask their partner for specific support, they did accept emotional and practical support such as help with cooking if she provided it.

I think I had to, you know, try and do it myself [...] it definitely helped that she was eating healthier as well [...] It would have been a bit disconcerting if she'd been going for takeaways and I was eating healthily. (George 62, cohabitation with Barbara 34 years.)

Resolute men whose partners were *Partially Involved* described taking responsibility for aspects of changes that she was not involved in. For example, William, whose partner did the majority of cooking for both of them, discussed how he had changed food shopping and breakfast habits himself.

I was looking more at the food shopping with regards to my own healthy eating [...] But just really basically doing it on my own 'cause she wasn't really involved that much. (William 63, cohabitation with Sandra 44 years.)

I do a lot of cooking but William goes shopping, and I prepare what he brings. (Sandra 61, cohabitation with William 44 years.)

Like some other *Resolute* men, William further talked about how his partner's help was something she liked or chose to do rather than something he needed help with.

A lot of women like doing things themselves. They think somebody else is no' capable o' doing it. Or not capable of doing it as well as they'd be. (William 63, cohabitation Sandra 44 years.)

Although the *Resolute* men's involvement in family food practices was suggestive of a lack of conformity to the gendered division of food-related household labour, participants' accounts suggested that women's involvement in dietary

practices was still assumed. In the cases where women were *Partially* (rather than *Very*) *Involved*, a justification was generally provided. Thus, some *Partially Involved* partners of *Resolute* men described circumstances, such as work schedules, as reasons for their inability to practically support their partner despite wishing to do so. Some also suggested that they were intentionally less involved because they thought that if the man made the changes independently, they would be more successful or sustainable. Some used traditionally disparaging female descriptors such as ‘nag’ or ‘moan’, suggesting that their advice or encouragement might be perceived negatively by their partner.

Because I was working full-time, he would do the cooking [...] I’ve stopped buying biscuits in [...] we did cut down portion sizes [But] you can’t moan at somebody to do something, they’ve got to want to do it. (Barbara 60, cohabitation with George 34 years.)

I’ll say, “well you’ve got to do it for yourself”, like, I’m not going to get on at him and nag him about it because, like, he’s got to do it you know. He’s got to want to do it [...] I stopped buying crisps and snacks, because that was his downfall [...] I would still have my cake or a biscuit if I wanted one. (Heather 53, cohabitation with Eric 37 years.)

I do try and say that, “You’ve been eating well,” you know, kind of, “Well done.” But sometimes I think he thinks I’m patronising, so. (laughs) So I probably have said it the first time but never again. (Nicole 30, cohabitation with Jason 4 years.)

Tracey, who was *Partially Involved*, described being aware of her *Resolute* partner as not expecting much involvement from her and further explained how she tried to help him as much as she could, but also recognised her inability to ‘control’ every aspect of his dietary changes.

He didn’t expect me to get involved but he was sounding me out about some of the things that was mentioned and what did I think about them [...] the healthy eating options and some of the advice that were given about the combination of foods [...] I’ve tried to put more healthy options in the house but experience tells me it does not make a whole lot of difference [...] He is his own man [...] If I could nag him or bully him in eating the way I wanted ...he’d not be my husband, you know? He is who he is and so I can’t change him fully, but I like the way that he is changing himself and I support him in that. (Tracey 53, cohabitation with Shawn 30 years.)

Tracey's partner, Shawn's account suggested he was aware that she tended to eat different meals but that he was unaware of the fact that she was intentionally trying to be less involved in providing verbal encouragement to him. Shawn echoed other *Resolute* men with a *Partially Involved* partner who only discussed her lack of involvement in respect of practical aspects of the changes and seemed unaware of her conscious decision to be less involved, especially in providing moral support.

I thought she might join in but then we both have different tastes to what we eat. At tea time we eat two different things. She'll eat something and I'll eat something totally different. So I didn't expect [for her] to join in though. (Shawn 56, cohabitation with Tracey 30 years.)

Only one *Resolute* man (Scot) had a partner who was *Not Involved* in his attempt to change his dietary practices. Scot described her as being less supportive than he would have liked and suggested that she was continuing to eat unhealthy foods, and that meals were less healthy when she was cooking, with which her account agreed.

I didnae feel I got a lot o' support [...] I had issues over what she was cooking. Maybe the fact there was no veg at all [...] I'd like her to be more involved in choosing what [healthy] food we're gonnae have. (Scot 63, cohabitation with Judith 33 years.)

I did support him (laugh). But Scot...he wanted to do a lot of the cooking his self, and it was different to what we used to eat [...] I was just like getting a breast of chicken and I would [cook it] I wouldn't weigh it, I would just say, "That's mine." Scot would weigh it and cut the bit off that he wasnae allowed. (Judith 61, cohabitation with Scot 33 years.)

Scot's partner, Judith, disclosed during her interview that she was obese and suggested that her lack of practical involvement in her husband's changes resulted from her poor physical health (e.g. pain in her knees prevented her from food shopping or cooking), and that she was not indifferent to his attempts to make changes. Her account suggested that despite not providing any practical or moral support to her partner, she paid attention to, and was aware of, the changes he was (or was not) making and maintaining.

We went to the Indian [restaurant] and I thought, 'Scot will no' go' cause it's one of these buffet [...] he did go up a couple of times to the

[buffet], which I don't think he would've at the beginning of this [FFIT]. (Judith 61, cohabitation with Scot 33 years.)

Among the *Resolute* men whose partners were *Partially* or *Not Involved*, divergent opinions emerged with regard to whether they were influenced by their partners' unaccommodating behaviours in relation to dietary practices. Some, such as Jason, talked about how he made the effort on his own without any influence or expectation of influence via compliments or verbal encouragements from his *Partially Involved* partner.

No, no, not [wanted any appreciation or any praise] personally anyway. I mean I know a lot of the guys there might have wanted that, but nothing, no' for myself..... I mean she did say along the lines that she was proud that I was going to that thing [FFIT] and trying to do something about weight and stuff like that. (Jason 35, cohabitation with Nicole 4 years.)

However, a small number of *Resolute* men with *Partially* or *Not Involved* partners talked about the inconvenience caused by her lack of involvement or support. They suggested that *codieting* could have been helpful for them, but did not try to enforce all the changes on their partners. For example, in his interview, Scot implied that his *Not Involved* partner's unhealthy eating habits did not inhibit him from eating healthier meals but he indicated a feeling of discomfort caused by her lack of support.

I found it quite easy. Cutting out the bad stuff [...] With her [partner] and my son, it was like they would have takeaways [...] two or three times a week. And I thought 'Just get out there and cook something'

ST: That's a temptation?

Not a temptation, no, it's annoying for me [...] that's how they [wife and son] want to do. I can't change the way they're eating. (Scot 63, cohabitation with Judith 33 years.)

In describing the challenges caused by lack of partner support in respect of changes to dietary practices, most *Resolute* men constructed themselves in line with masculine traits, such as independence and as responsible people who could overcome problems. Many reinforced this by suggesting that they had strategies to overcome difficulties and the use of terms such as 'disciplined,'

and ‘in control of’ when referring to their practices and describing how they overcame challenges created by their partners’ lack of support.

She is still buying crisps and chocolate when I was going through which was a bit of a...I just had to be stronger myself, a bit disciplined. (Shawn 56, cohabitation with Tracey 30 years.)

Although *Resolute* men appeared to have accepted, and benefited from, the support that was provided by *Very* or *Partially Involved* partners, they and their partners indicated that the men were in control of the dietary changes and able to make the changes even in the absence of partner support. Therefore, while the partner’s involvement was expected and mostly described as facilitative to the man’s dietary changes, the level of partner involvement did not appear to determine *Resolute* men’s ability in making or maintaining their dietary changes.

5.4.2 The influence of partners on *Reliant* men’s dietary changes

Dietary changes	Partner		
	Very Involved	Partially Involved	Not Involved
Reliant men	Luke/ Mary Paul/ Lorna Jeremy/Lisa Joseph/ Tricia	Peter/Angela Matt/ Sarah Richard/ Hillary	

Seven men were reported as *relying* on their partner to make changes to their dietary practices. None of these *Reliant* men were described as completely taking charge of any aspect of the dietary changes they were making or maintaining. These men were not only dependent on their partners for healthy meals, but were also encouraged by the moral support provided to them through indirect acts, such as the partner changing her own eating habits and/or discouraging them to eat unhealthy foods. These men and their partners constructed the partner’s involvement as highly influential in their discussion of men’s attempts to change dietary practices.

Five of the seven *Reliant* men were from couples aged 60 years or older. They appeared to recognise their own inability to make changes without the support from their partners and some also seemed to take their partner’s practical support for granted. *Reliant* men and their partners suggested that the man’s

dependency on the partner was due to his lack of involvement in household food-related practices before joining FFIT, or his lack of meal preparation skills.

No. No [he does not cook], he's a typical Scotsman. I think he's made two meals in the forty-six years we've been married. And that's not a joke. That's real [...] He still doesn't prepare anything. (Mary 67, cohabitation with Luke 50 years.)

Four *Reliant men* had *Very Involved* partners for dietary practices. All four couples (Luke/ Mary, Paul/ Lorna, Jeremy/ Lisa and Joseph/ Tricia) suggested that the woman was in control of the changes. The excerpts below represent how they talked about the woman's level of control over, and responsibility towards, the man's diet.

I've always taken responsibility for the shopping and the cooking, [...] the diet, that's something that I've kinda controlled [...] Jeremy will tell you that. He has... he has little or no input to what goes on the food table. (Lisa 51, cohabitation with Jeremy 10 years.)

It's like the meal situation [...] he'll maybe say, "could we have something different", or I'll say, "well that's not as healthy as this, do you not think we should have this", and he goes, "yeah, okay then" [...] And I'm doing it for the right reasons, yeah, I think he knows that. (Lorna 64, cohabitation with Paul 44 years.)

These men's lack of instigation of dietary changes was not an indication of their lack of interest or motivation but more their expectation that their partner would and/or should do it for them.

I'm no' much of a cook (laugh)[...] That's forty-four years, and she's always done it [...] And she's always on at me to look at the labels and check what's sugar and fat and that, content, [...] I would say, "What are we gonna have tonight?" and that, and I would suggest something, she would suggest something, and she would decide. (Paul 64, cohabitation with Lorna 44 years.)

Reliant men and their *Very Involved* partners justified this expectation by providing either a practical rationale for women's prominence, or suggesting barriers around men's lack of involvement. Examples of this included the woman's habit of cooking for both, her being more skilled or her more suitable work schedule. Similar to older women in other categories, three women aged

over 60 years in this group explicitly described their sense of responsibility and remit in relation to their partner's dietary changes and their gender roles.

Well, that's the way we were brought up. You get the meals on the table for them coming in fae work and all that. (Tricia 67, cohabitation with Joseph 40 years.)

Because when we got married, that was what you did. You were brought up to be like the home maker, and the men didn't do that [...] I was at home all day and I thought 'well, if he's out working and I'm at home, it's my job.' (Lorna 64, cohabitation with Paul 44 years.)

Remarks from these women's partners indicating that they had not even contemplated being involved in family food provision were also suggestive of ingrained gender norms around division of household labour in these couples.

My wife, she does it [cooking or food related work in the house] just she's always done it. That's 44 years, and she's always done it [...] it's just, it's just what's always happened [...] my mother always done the cooking [when growing up] I'd never do it [cook]. (Paul 64, cohabitation with Lorna 44 years.)

In couples where *Very Involved* partners of *Reliant* men had been adopting healthy eating practices for themselves by following a formal diet plan prior to the man joining FFIT, both partners suggested that the man's attempts to eat healthily made preparing family meals easier, as they could now eat the same meal. For example, Jeremy described following his partner's diet plan rather than what was suggested during FFIT.

I think largely what we do in terms of diet was probably driven by what she did with Weight Watchers and what she, you know, she does herself [...], I've completely left that to her. (Jeremy 47, cohabitation with Lisa 10 years.)

On the other hand, Tricia, who was also *Very Involved*, but not already trying to eat healthy meals herself, changed her food-related practices specifically to help her partner. Tricia talked about how she prepared separate meals for her partner, also cooked for him for times she would be away from home and consciously encouraged him to eat healthily.

I think I do [make sure that his meals are healthy], because I take all the fat off. I put things in the oven to cook instead o' frying [...] So, I kinda watch what I'm doing as best I can [...] I was away at [an American city] last year and he was home [...] I'd left him something easy to cook, so, he did. (Tricia 67, cohabitation with Joseph 40 years.)

These women, like several other *Very Involved* women (regardless of the level of their partner's reliance), also suggested that attempts to help their partners were not only focused on the healthiness of the food content but also on making it easier for them to adjust to healthier eating practices. For example, Lorna described what strategies she proactively adopted to facilitate her husband, Paul's healthy eating both at home and away. In doing so, she illustrated the support and control she employed, which was more than just cooking and serving healthier meals.

If we're doing this together there's no point in me saying well, you're having the smaller portion and I'm having this,' you know, so we tend to just have the same now [...] Actually I bought smaller plates as well [...] I always try to make [less food] now so there's not any leftover [...] he'll say, "what's for dessert"? And I'll say "well you might get a little treat" [...] but that's a smaller portion of that as well [...] if I buy anything that's really, really not good for you, I keep it in the garage [...] if it's not in the house you don't even think about it [...]when you're [we are] out somewhere [a reception or a buffet] this is what he'll say, "will you get mine" [...] And then I put on what I think is healthy. (Lorna 64, cohabitation with Paul 44 years.)

Paul also talked about Lorna's extensive involvement in helping him make changes to his diet through both practical support (e.g. meal planning, shopping and cooking) and moral support (e.g. by discouraging him from eating bigger portions of meals or unhealthy snacks). Paul's perception of his partner's involvement was consistent with many other men's accounts suggesting that their partner was both directly and indirectly involved in making it possible for them to continue their healthy eating practices.

My wife gets on at me when I buy it [unhealthy snacks] She more buys like [...] the nuts and that things, more, Yeah, than the chocolate biscuits and that[...] If they're here, they're here, they'll get eaten. Yeah.....It's like crisps and nuts and stuff like that. (Paul 64, cohabitation with Lorna 44 years.)

Three *Reliant* men had *Partially Involved* partners for dietary practices (**Peter/Angela, Matt/ Sarah and Richard /Hillary**). These couples suggested that both partners were involved in making changes to their dietary practices. However, although the men were involved in some aspects of dietary practices, such as food shopping, planning and preparation, their diet was mostly driven by what the women decided to make or not make changes to.

He'll go out for shopping now and again [...] but not for the meal, unless I write down what he's to get. (Angela 65, cohabitation with Peter 40 years.)

She eats the same food as I get. Well, I'm eating the same as she makes. (Peter 69, cohabitation with Angela 40 years.)

Sarah might do it and pick up stuff during the week [but] nine Saturdays out of 10, I'll do the shopping. (Matt 44, cohabitation with Sarah 21 years.)

He goes food shopping but I tell him what to buy. (Sarah 43, cohabitation With Matt 21 years.)

These *Partially Involved* women talked about being supportive, and taking complete responsibility for meal preparation for their *Reliant* partner mostly out of compulsion as the partner 'never' cooked. However, unlike *Very Involved* women, they were generally not involved in encouraging their partner to eat healthy snacks or choose healthier options outside of the house, and none of the women in this group appeared to have changed their own dietary practices significantly. For example, Sarah talked about how she and her partner had replaced a lot of unhealthy food items with healthier options that he suggested after joining FFIT, but they did not change the snacks that were bought.

There probably is more snacks in the house than there should be but it's for the kids as well, which is a terrible thing to say but, you know, sometimes they'll just look at the healthy stuff and go "I don't want that", you know? (Sarah 43, cohabitation with Matt 21 years.)

Interviews across the sample suggested that *Reliant* men depended on their cohabiting partner (and not any other family member) for their dietary practices even before FFIT. Therefore, no *Reliant* man had a *Not-Involved* partner for dietary practices.

Almost all *Reliant* men expressed their appreciation for their partners' support and suggested that this determined the extent to which they had adopted and maintained healthy eating practices.

She certainly drives what we eat [...] I know I've been very, very fortunate. You know. I think if Lisa hadn't been doing that [...] then I would have been a lot less successful than I am now. I probably would have done the thirteen weeks, jacked it in, and gone back to where I was before. You know. So she gets a lot of credit for that. (Jeremy 47, cohabitation 10 years.)

These findings illustrate that a combination of factors enabled the *Reliant* men to make and maintain dietary changes. In addition to benefiting from their partner's practical support, most *Reliant* men also seemed to be encouraged by the commendations that they received from their partners during the FFIT programme and when trying to maintain the changes. This is in contrast to a few *Resolute* and most *Non-Responsive* men, who suggested that the moral support they were receiving from their partner had no impact on their attempts to make changes.

Greater manifestation of conventional gender relations and roles was reflected more in the accounts of *Reliant* men and their partners compared to *Resolute* men and their partners. Some men appeared to describe family food provision as in line with gendered expectations for women, and female prominence in family food was apparent across the sample, particularly in older participants. Most *Reliant* men and their partners not only constructed women as performing the nurturing or caring roles by assuming the responsibility for practical aspects of dietary changes and providing moral support while the man received care but also implied the man's entitlement of support from the partner in order to make the dietary changes.

5.4.3 The influence of partners on *Non-Responsive* men's dietary changes

Dietary changes	Partner		
	Very Involved	Partially Involved	Not Involved
Non-Responsive men	Mark/Dawn Ryan/ Amanda		Mathew/Kimberly Kevin/Michelle

Four men and their partners in this study described the man as not making any dietary changes. Two of these men had *Very Involved* partners who initially provided practical support and encouraged them to make dietary changes. These couples (Mark/ Dawn and Ryan/ Amanda) described having initially discussed as a couple the dietary changes that the man wanted to make, but that he became uninterested in making, or continuing with, the changes soon after the FFIT programme started. Amanda and Dawn both described difficulty in convincing their partners to eat the healthier options that they were eating. They explained how their extensive involvement did not always result in their partner changing his diet due to his apparent lack of motivation to make and/or maintain the changes.

I will, like, make smoothies, I will make breakfast, I will do this for him to have, but then it's his decision whether he has it or not and he doesn't always. So despite giving him the tools... not always. (Amanda 34, cohabitation with Ryan 8.)

Amanda's partner Ryan who recognised that she tried to support him as '*best as she can*' appeared to take responsibility for having discontinued the changes, and reported that she had also discontinued the healthy practices after a period of him initiating the changes.

She was helping me, it was a case of, she would tell me "this is what you need to do". She read, she looked at my book [FFIT booklet] and we started doing it, we were doing okay. The first six weeks we were doing the food bit, but then we stopped [...] Amanda would make smoothies, and we'd have that, and it would help, and you'd feel healthier [...] It was perfect for a wee while I just don't know what happened and then it just went back to square one. (Ryan 31, cohabitation with Amanda 8 years.)

Contrary to most couples' accounts that were generally convergent about the woman's positive or negative influence on the man's attempts to make changes, Mark (*Non-Responsive*) and his partner Dawn (*Very Involved*) had conflicting perceptions regarding the influence she had on his food intake. Dawn reported that she was doing the Weight-Watchers programme and had tried to make both of them eat according to her meal plan at one point, however this still resulted in him eating too much food or unhealthy options. Mark, in his interview, contradicted what Dawn said, saying that she gave him too much food. He

reported that it was Dawn who was encouraging him to eat unhealthy options. In the remarks below, he described how she was encouraging him to eat more than he would have liked.

I do all the shopping and cooking, I try to make the meals healthy [...] you put him down tea, a salad, and he'll, "What's that?" "Well, eating healthy." And, he'll eat everything around the plate, and leave the lettuce and tomato 'til last. Does it all the time [...] I am cooking different meals for the two of us cause I am eating healthy and he would not eat that [...] I have tried telling him maybe he should eat similar to me but that does not go down well. (Dawn 42, cohabitation with Mark 9 years.)

I says, "Know, what, just gi' me spicy chicken strip things you get out of Pizza Hut." And then she ordered the pizza and then next minute she gave me my box wi' that five pieces of chicken and half a pizza and I wasn't even in the mood because I had the rolls earlier on. (Mark 53, cohabitation with Dawn 9 years.)

Only two *Non-Responsive* men had *Not Involved* partners. In these couples (**Matthew/Kimberley** and **Kevin/Michelle**), there appeared to be different reasons for the partner's lack of involvement. Mathew described how he had initiated some of the dietary changes once he joined FFIT, but did not complete the programme and discontinued the changes. His partner Kimberly described having made a conscious decision to completely ignore the changes he was making as she did not want to be involved. She talked about how Mathew had previously tried to follow various plans to make his diet healthy but had failed to maintain changes. Her account suggested that might have been the reason why she had ignored his attempts to change his diet after joining FFIT. She and Mathew both reported that he did most of the cooking for the family and they each ate different meals. She added that although her own diet was healthy, she had given up on convincing him to do the same.

I just tend to eat what I eat and, like, I don't have the crazy diets that he has [...] If he wants to do it [adopt healthy dietary habits], I'll encourage him to do it. But I don't think you can force somebody to do something they don't want to do. Because that way, they'll end up disliking it even more and it's not worth it. (Kimberly 57, cohabitation with Mathew 36 years.)

Mathew suggested that his attending FFIT for only a short period of time (five weeks) prevented him from convincing Kimberly to be involved in the changes he

was attempting to make. Although Mathew did not explicitly say that her lack of involvement in his changes inhibited his attempts to make those changes or participate in FFIT, he suggested he would have been more successful if she had been involved in his attempts to make changes.

The help o' your family [is important] because if they're doing it, you know, you feel you have tae do [...] if we're all doing it together I think it is easier [but] I could eat any amounts of vegetables. But my wife struggled because since, you know, we've been married [...] she's never eaten vegetables. (Mathew 58, cohabitation with Kimberly 36 years.)

The other couple with a *Non-Responsive* man and *Not Involved* partner, Kevin and Michelle both, during their interviews, described eating the same meals and both being equally involved in what was eaten in the house. They shopped together and discussed meals they wanted to eat. During their interviews, they suggested that they influenced each other to undertake less healthy dietary practices and that neither of them changed their diet after Kevin joined FFIT despite being aware that their diet was unhealthy in general and contributed to them both being overweight.

We'll go shopping together. But, if she's wanting macaroni tonight then she's obviously influenced me for tonight. But, then if I want Kiev tomorrow then I've influenced [her]. (Kevin 40, cohabitation with Michelle 8 years.)

It [him joining FFIT] didn't make any difference because he eats what I eat [...] We know what we should eat, we know what we shouldn't eat, but [...] We tried a smaller portion and a lot more veg. Later on at night when we were both really hungry, we'd go and sit and eat something else. (Michelle 45, cohabitation with Kevin 8 years.)

Although Michelle stated that Kevin did not expect her to help him and that “he listens [to her encouragement]... it goes in one ear and out the other”, she reflected on how her lack of support at the time and modelling unhealthy practices might have hindered his ability to make the changes and suggested that she felt responsible for his inability to make and maintain the changes.

[I] probably didnae help him, he must have just thought ‘Oh, well, she’s doing that’ [...] maybe in hindsight, like, I could have done a lot more

*with the cooking [...] I could have probably cooked a lot healthier.
(Michelle 45, cohabitation with Kevin 8 years.)*

While Michelle seemed to feel guilty about not supporting and encouraging her partner to embrace healthy eating practices, Kevin, unlike Mark and Ryan, did not suggest that her lack of involvement contributed to him not making any changes to his dietary practices after joining FFIT.

Thus, the accounts of *Non-Responsive* men and their partners, two of whom were *Very Involved* and two who were *Not Involved*, suggested that the men were unresponsive to making changes to dietary practices, regardless of the level of partners' support.

5.5 The influence of partners on men's attempts to make and maintain changes to their physical activity

The following sections present an analysis of partners' influences on men's attempts to change their physical activity in relation to men's levels of receptiveness. Central to both men's and women's accounts in relation to men changing their physical activity were the issues of men's own ability and preference, as well as their receptiveness to their partner's involvement. The participants indicated that the variation in men's level of receptiveness also contributed to the variation in levels of partner involvement, which included coactivity, and providing practical and moral support. Despite the range of women's involvement levels, all three 'types' of women in this study reported being aware of the kind of physical activities that their partner was increasing, and whether or not these were maintained.

5.5.1 The influence of partners on *Resolute* men's physical activity changes

Physical activity changes	Partner		
	Very Involved	Partially Involved	Not Involved
Resolute men		Peter/Angela Jason/Nicole Eric/Heather Richard/Hillary	Paul/Lorna William/Sandra

Six men appeared to want to make changes to their physical activities on their own, hence none of these *Resolute* men had a *Very Involved* partner. These men often linked their lack of desire for *coactivity* to the partner's inability to do as much exercise as them. Aligned with dominant cultural ideals of masculinity that include physical prowess, self-reliance and independence, these men described how their partner joining them would 'curtail' the amount of exercise they wanted to do and described it as an inconvenience, unnecessary, or disadvantageous.

I don't think it [partner exercising together] would have helped me more, it would have helped her more. But [...] It wouldnae gave me any more encouragement because I was already, I was totally into doing what I was doing. (Richard 67, cohabitation with Hillary 42 years.)

The accounts of most *Resolute* men and their partners illustrated the emphasis the partners also placed on the importance of the man's independent commitments towards making changes to their physical activities, and constructed the man's ownership of the changes as essential for ensuring he made those changes.

I don't think I needed to be any more supportive. It's like he was quite happy to go and do it himself, you know [...] it's one of those things that I just don't push him to do it. I'm not going to keep saying to him, "look you've got to do it" [...] he's got to do it for himself. (Heather 53, cohabitation with Eric 37 years.)

Four *Resolute* men had *Partially Involved* partners for physical activity. Although these couples (**Peter/Angela, Eric/Heather, Jason/Nicole and Richard/Hillary**) were *coactive* for some practices, men preferred to avoid their partner joining them, and wanted to take charge of the changes being made. Although these men accepted their partner's participation in a few physical activities together, they were described as exercising longer or doing more intense exercises than the partners.

I took her [to the gym] once and then I was glad she wasn't in it because... because she was telling me what I'm doing wrong, and "You're

doing this and that.” I said “No. I’ll just do what I want. No.” I’m glad she didn’t come. (Peter 69, cohabitation with Angela 40 years.)

Well we always walk together anyway [...] there was a wee bit [competition] maybe at the beginning. Although we’d never actually said that to each other (laughing) [...] But he always seemed to do more than me [...] and I was always quite impressed when he told me how many [steps] he had done. (Heather 53, cohabitation with Eric 37 years.)

The interviews with *Resolute* men and their partners also highlighted that the men’s desire to exercise alone could have resulted from both their own and their partners’ beliefs that they were capable of making the changes without any support from the partner. *Partially Involved* partners of *Resolute* men often described the man achieving his physical activity goals without her support and expressed their admiration for it.

I was quite impressed when he first started going [to FFIT] ‘cause he would get the bus down. And then he started to walk down, so he was actually walking from here to [the football club]. And I did used to say to him, “oh well that’s great that you’re doing that” [...] he was determined his steps was going to be higher again. (Heather 53, cohabitation with Eric 37 years.)

He has joined the gym and he is going to classes every second day [...] He would tell me how many reps he had done of certain things [...] he’s more active now than he was before he started it [FFIT]. (Nicole 30, cohabitation with Jason 4 years.)

Two *Resolute* men (**Paul and William**), who had *Not Involved* partners for physical activity, described not wanting any involvement from their partner as they liked the solitude of exercising on their own regardless of whether the partner wanted to be involved or not.

Oh, I liked it [going for walks alone]. I liked it. I mean, I always - I’ve got an iPod and I listen to music all the time ever, whenever I’m out- I’ve always download programs and whatever. (William 63, cohabitation with Sandra 44 years.)

No [would not like his wife to join him when he goes for walks] she’s a bit slow (laugh). (Paul 64, cohabitation with Lorna 44 years.)

There were many similarities between how the *Partially Involved* and *Not Involved* partners of *Resolute* men, described their lack of involvement. These women often emphasised that as a couple they did not want to be together all

the time and implied that each partner needed their own personal space. However, this perception did not seem to mean that these women were unsupportive, or were indifferent, as they paid attention to whether the man was making and maintaining the changes, and provided indirect support to accommodate his physical activity changes. Thus, even in the absence of providing tangible support, these women presented their lack of involvement as fostering the partner's independence in line with feminine norms of care and nurturing.

He did not do much exercise [before FFIT] now he walks everywhere. He likes to go on his own because he likes listening to his music. I have been occasionally... I am gonna join the gym, we may do [go to gym together], but we don't want to be together all the time [...] you got to have a time of your own. (Sandra 61, cohabitation with William 44 years.)

He seemed to feel better when he came back from [walking], you know. If he goes for a walk and he'll come back and he'll say, "oh that was good, I really enjoyed that". (Lorna 64, cohabitation with Paul 44 years.)

5.5.2 The influence of partners on *Receptive* men's physical activity changes

Physical activity changes	Partner		
	Very Involved	Partially Involved	Not Involved
Receptive men	Shawn/Tracey Anthony/Andrea Jeremy/Lisa	Jeffrey/Laura Matt/Sarah George/Barbara Joseph/Tricia Luke/Mary Kenneth/Kelly	Scot/Judith

While none of the men in this study described *relying* on their partners for making changes to their physical activity, 10 men and their partners reported the man as being amenable to coactivity. Most of these *Receptive* men described benefiting from being *coactive*, the partner making practical arrangements to allow them to exercise, and receiving verbal encouragement from their partner to maintain their additional physical activities.

Three *Receptive* men had *Very Involved* partners for physical activity. In these couples (**Shawn/Tracey, Anthony/Andrea and Jeremy/Lisa**), the partner joined

the man in most activities. Similar to the *Resolute* men, a few (two) *Receptive* men perceived that involving the partner could prevent them from achieving their physical activity goals. However, these *Receptive* men described feeling obliged to include their partner, and framed their responsiveness as them being a responsible partner in wanting to help her to be healthier. These men sought to strike a balance, for example, by changing their own physical activities to accommodate her. As a result, the partners of a *Receptive* man could be involved in the changes if they wished to do so, and were *Very Involved* in these cases.

I prefer to walk by myself because I walk faster pace than she does, but if it is just going out for an afternoon walk that's fine. (Shawn 56, cohabitation with Tracey 30 years.)

I run round the park. Andrea can't run round the park. So I would have to curtail my activity [...] if she was coming out wi' me in the morning, I would just walk. (Anthony 63, cohabitation with Andrea 45 years.)

These three couples described how the female partner's practical and emotional involvement encouraged and enabled the man's attempts to increase certain physical activities.

Certainly when we started the walking and things like that, it was things we could do together. And we played badminton as well [...] that's just something we do together.

ST: And do you think that helped you to keep up with your changed routine as well?

I guess so [...] It's either both of us or neither of us [...] I think if we hadn't been doing it together then it woulda been almost impossible to do it [...], the fact that we were both overweight, we both wanted to do it, helped a lot. (Jeremy 47, cohabitation with Lisa 10 years.)

The great awareness and appreciation that Jeremy's *Very Involved* partner Lisa described in her remark below was representative of most partners of *Receptive* men reflecting her involvement in his changes.

He has a focus where [...] he'll go to the gym and he'll do his hour and a half [together with her]. And then he'll play badminton, or extras. So his is probably pretty much static [duration wise]. But what he's done is increase the intensity. (Lisa 51, cohabitation with Jeremy 10 years.)

Although most of the *Very or Partially Involved* women in this study were themselves trying to be active, some appeared to be *coactive* in order to encourage the man. For example, in the quote below, Tracey, who was *coactive*, suggested that it was her partners' step-count goal that she worked towards rather than hers.

Now we go regularly for countryside walks, which we used to enjoy as a stroll you know just a Sunday afternoon stroll, but now there is more purpose beside it. [...] And if he needs to make up his steps then we'd go out together later on until he reaches his steps count. (Tracey 53, cohabitation with Shawn 30 years.)

The majority (six of the ten) of *Receptive* men had *Partially Involved* partners for physical activity (Jeffrey/Laura, Matt/Sarah, George/ Barbara, Joseph/Tricia, Luke/Mary, Kenneth/Kelly). These women, who described being *coactive* for some of the physical activities, were mainly involved in providing moral support, and seemed to be aware of the level of physical activity changes the man was making and maintaining. Therefore, unlike the men with *Very Involved* partners who were *coactive* for every exercise, these men were undertaking some activities on their own as well. However, unlike the *Resolute* men and their partners, these participants suggested that the man benefited from being *coactive*, for example, by being more likely to go out for walks, or walking longer distances, when being accompanied by her.

I walk further if she's with me [...] Aye, 'cause she's fitter than what I am. I set myself a goal, it's exactly a mile to one o' the farms down there, so, if I walk a mile there and a mile back, that's another two miles I've walked. (Jeffrey 57, cohabitation with Laura 5 years.)

She's the walker, she loves to go walks, she loves to say to me "Joseph, we'll get up tomorrow morning, we'll go to [town centre], and if she's saying that to me, keep her happy, 'fine'.

ST: If she's not doing it you would still be doing it on your own?

No.

ST: No, you would not?

No, no. (Joseph 70, cohabitation with Tricia 40 years.)

A few *Partially Involved* partners of *Receptive* men attributed their inability to be *coactive* to commitments such as work schedules and childcare arrangements,

or their physical limitations. In these cases, both men and their partners described the circumstances as missed opportunities for *coactivity* rather than describing the woman's absence as a favourable condition for the man's changes.

If she'd more time, she would go out and do more walking, but it's just getting the time. (Jeffrey 57, cohabitation with Laura 5 years.)

When I was on the programme, you know, I was walking during the day, so, she wasnae really participating at that time [because she was at work]. (George 62, cohabitation with Barbara 34 years.)

I think it's hard wae the kids, [otherwise] I'd love to do more exercise with Sarah. (Matt 44, cohabitation with Sarah 21 years.)

The participants' accounts suggested that these *Partially Involved* women, including those who were not coactive, provided moral support to the man to help him change his physical activities. Examples of this included the women verbally encouraging men to go out for exercise, praising their commitment to increasing their physical activities, and making it easier for them to take up additional activities. Some also described just showing an interest in what their partner was doing, as a way of encouraging him to maintain the changes they made during the FFIT programme.

Every day he would tell me how many steps he'd done or whatever.

ST: How would you react to that?

Oh, yeah. I was good. I would give him praise or whatever [...] Yeah, he liked telling you [me]. (Barbara 60, cohabitation with George 34 years.)

I'd like to hope that I verbally encourage him [by] recognizing when he's losing weight and kinda having those discussions. You know, listening when he came home from the football and talking about what he's been doing. (Kelly 34, cohabitation with Kenneth 18 years.)

Three of these *Partially Involved* women framed even their lack of practical involvement and/or verbal encouragement as a way to provide support, and not a sign of their indifference toward the changes the man was making. Similar to the partners of *Resolute* men, these women often emphasised the man's ability and desire to exercise independently and his personality, and highlighted the value of the personal time away from each other for them both.

He's quite strong-willed. He's very strong-willed so he would have done it on his own if I didn't want to do it.

ST: *Do you think you not going out for a walk, how do you think he takes it? Does it have an impact on how he would do?*

No. No. No, it doesn't. (Sarah 43, cohabitation with Matt 21 years.)

So it is quite nice to see him going off [...] doing his run himself [...] because it does give you [me] a wee bit more space [...] we do get on pretty well and we are good pals, so it's not really a big problem, being together. But it's nice just to get your own little bit of space too. (Mary 67, cohabitation with Luke 50 years.)

We have always done quite a lot together and made choices together and it's nice that he's got more independence [...] it's not that we control each other, it's just the way we've fallen in to the patterns over the years. (Kelly 34, cohabitation with Kenneth 18 years.)

Scot was the only *Receptive* man who had a *Not Involved* partner for physical activity. Unlike three other *Not Involved* women in this study who chose not to be involved, Scot's partner Judith described her physical limitations as the reason behind her lack of involvement. Although she expressed her sense of guilt for being unable to be *coactive* during her interview, she and Scot both suggested that she did not offer him any moral support or verbal encouragement either.

I feel bad that he's having to go and do it (go for run) all his own [...] I feel like we're not doing anything together [...] my legs have been bad for about a year and a half and we just kinda did nothing [together] I feel bad for him that I cannae help him or cannae go wi' him [...] I don't mind him going away, you know? But it would be nice if he had company. (Judith 61, cohabitation with Scot 33 years.)

Similar to a few other *Receptive* men whose partners were unable to join them in physical activities, Scot talked about how "it'd be nice if she could join". However, aligned with most men in this study who suggested that their motivation and/or ability to increase physical activities were not inhibited by their partner's lack of involvement, Scot recounted that his partner's lack of involvement did not affect his ability to make physical activity changes.

5.5.3 The influence of partners on *Non-Responsive* men's physical activity changes

Physical activity changes	Partner		
	Very Involved	Partially Involved	Not Involved
Non-Responsive men	Ryan/Amanda Mark/ Dawn Mathew/Kimberly		Kevin/Michelle

There were four men who neither made any physical activity changes themselves nor responded to their partner's attempts to encourage them to do so. Although three of these men attended all of their FFIT sessions and took part in the physical activity there, they described not making changes outside of the FFIT sessions. One of the men in this group (Mathew) did not complete the FFIT programme.

Three of these *Non-Responsive* men had a *Very Involved* partner for physical activity (Ryan/Amanda, Mark/Dawn and Mathew/Kimberly). These couples suggested that the man did not increase his physical activity even when his partner encouraged him to do so. Dawn and Amanda both expressed their frustrations about not being able to convince their partner to increase his physical activities. Amanda implied that her partner may have used a lack of time as an excuse not to exercise.

I ask him why don't we go for a walk together? He doesn't want to do that [...] I encourage him to go on the bike, even threaten to sell the bike but he does not [...] I'll go for a walk [...] Trying to get Mark to come with us is a different story. (Dawn 42, cohabitation with Mark 9 years.)

I do encourage him but he doesn't really listen. It's a bit of a sticking point, if I'm honest. An' I'm always trying to persuade him to do stuff with me and it never happens [...] I think he thinks he doesn't have time and that's why, but he doesn't realise that you have to make time. (Amanda 34, cohabitation with Ryan 8 years.)

Although these couples had different perceptions about whether or how the man should increase his physical activity, all three couples' accounts of the man's lack of physical activity were convergent. Men still acknowledged the partner's efforts in encouraging them.

She was trying to make me do that [go for a walk together], but I was stubborn. She goes out walking some... once a week, twice a week, and I'm just sort of, go on then.

ST: Do you not want to go with her, like are you not tempted?

Sometimes. But it's not my kind of fun [...] Sometimes she was doing exercise and I was just like, 'I should be doing that but I'm not' [...] It's because I had it in me mind I was going to do exercise at night time, but she wasn't doing exercise at night time. So, I could have been doing the same thing as her, but I chose not to. (Ryan 31, cohabitation with Amanda 8 years.)

I do my thing and Dawn does her thing. We don't go for walks together. Dawn's always suggested, "Aye, we'll get bikes and we'll do this and we'll do that." And it's never happened. (Mark 53, cohabitation with Dawn 9 years.)

However, men's lack of response to their partner's efforts did not appear to reflect indifference to what their partner thought of them. The excerpt below from Ryan, explaining how he would mislead his partner about achieving his step goals, suggests that he cared about her judgements and positive perception towards him but was still unable to follow what she would have liked him to do.

Some [step count] goals I made, some goals I didn't, so. I didn't tell her when I failed the goals. (Ryan 31, cohabitation with Amanda 8 years.)

Of these three partners, Dawn and Amanda at the time to the interview (four and five months after their partner had completed FFIT respectively) suggested having given up on their attempts to encourage their partner. However, Kimberly, whose *Non-Responsive* partner Mathew did not complete FFIT (about 12 months prior to interview), talked about how her constant attempts to be *coactive* encouraged her partner to some extent, and seemed optimistic about her efforts having some impact on his uptake of additional physical activity.

I hate exercise, but I'll do that [walking]. And that's about it. But - and I also feel if I go, Mathew'll go [...] Getting him going as well. (Kimberly 57, cohabitation with Mathew 36 years.)

Kevin was the only *Non-Responsive* man who had a *Not Involved* partner for physical activity. He described participating in physical activity at the FFIT sessions but not making any changes himself outside of that setting. His partner Michelle, who described participating in some organised physical activities

herself, reflected on her lack of involvement and suggested that being *coactive* could have encouraged him to be more active.

Probably [her lack of exercise] did hinder, actually. Yeah. 'Cause I wasn't doing [exercising with him] whereas if I did, he would have followed on a lot more[...] and maybe even saying, like, "Come on, let's go out for a walk". (Michelle 45, cohabitation with Kevin 8 years.)

5.6 Maintenance of men's dietary practices and physical activity changes

When talking about specific changes that men initiated after FFIT, many participants described men's changed dietary practices and physical activity becoming habit and them not having to purposefully think about choosing healthy food options or conscious planning about being physically active. A few men even described aversions towards the unhealthy foods they previously ate and described enjoying their new diet.

However, the participants' descriptions of maintaining the changed practices showed that some considered this to be more challenging than initiating the changes. In particular, the participants who had attempted to lose weight through a formal weight loss programme, or make changes prior to the men joining FFIT, were more vocal about the challenges around maintenance of the health practices and weight loss in general.

Our biggest problem is maintaining it. And that's what we talk about all the time, trying to maintain it. Likes of going on holiday and things like that. Trying to watch what you're eating, but you're on holiday, so you've got to relax a wee bit. (Richard 67, cohabitation with Hillary 42 years.)

A comparison of participant descriptions of maintenance based on time since completing FFIT, (i.e. seven or less months versus eight or more months prior to the interview) did not show any clear differences in patterns or reported difficulty of maintaining the changes. Interestingly, it showed that most partners' levels of involvement and men's level of reliance on their partners did not appear to change over time, except for a few *Non-Responsive* men. Thus,

two *Non-Responsive* men and their partners described initiating a few dietary changes, such as healthy breakfasts, once the man joined FFIT, but suggested that these practices discontinued due to the lack of the man's interest after only a few weeks.

Although most men who made changes to their diet reported that they were able to reduce unhealthy snacks during FFIT, most also talked about finding it difficult to maintain this. Some of these men were described as being less strict about their occasional eating, and drinking after the FFIT programme had finished. A few participants, who described the man drinking on his own and often discretely, reported the man's attempts to reduce alcohol intake as a major challenge, and described man finding it more difficult to change or maintain than changes in other dietary practices.

I think we're still eating fairly healthy [...] I think it's just the snacking thing again that's sorta crept in a bit, so, I'll have to try and restrain myself from that again. (George 62, cohabitation with Barbara 34 years.)

I see him now maybe snacking at night and I think 'You wouldn't have done that maybe six weeks ago'. (Sarah 43, cohabitation with Matt 21 years.)

I drink too much and that has not changed at all. It's one thing I've to change [...] Yeah, that's definitely difficult [...] I tried during FFIT. And since FFIT I've tried really really hard various times during the years as well. (Shawn 56, cohabitation with Tracey 30 years.)

Unlike the changes in main meals that both partners maintained as a couple, many *Partially Involved* and *Not Involved* women reported continuing to buy unhealthy snacks for themselves. While some described feeling guilty about doing so, a few women who continued to eat unhealthy snacks themselves openly described doing so despite the awareness that it could make it harder for their partner to maintain his healthy snacking practices.

The participants' accounts suggested that their levels of physical activity (vigorous activities such as football with other FFIT participants, training for 10k runs) had reduced by the time of the interview. However, men appeared to maintain their step count goals and some of the other activities they had

initiated. Many described this becoming a part of the daily routine and being maintained.

He walks from here to the city centre which is about 5 miles, I think he does 25 length at the [pool]. He started last year and now it just comes naturally. (Sandra 61, cohabitation with William 44 years.)

While some described the positive influence of coactivity (as discussed in earlier sections), none of the men described any aspect of their partners' involvement or lack thereof that had impacted on the reduced maintenance of their physical activity. Most *Receptive* men suggested that they were encouraged by their partner's support and reinforcement, regardless of whether or not they were *coactive*. These men described their appreciation of the encouragement that their partners provided not only for a specific activity but also for how the partners helped them persevere when their motivation declined while attempting to maintain the changes they made.

If there was any nights when it was pouring wi' rain or it was the snow in March, and she said "No, just go." You know? And I'd say "Yeah, you're right." [...] it was just somebody...Yeah, need a nudge. A wee nudge at times. (Jeffrey 57, cohabitation with Laura 5 years.)

As much as she's no' involved in what I'm doing, she encourages me to keep it [maintain physical activity]. (Luke 65, cohabitation with Mary 50 years.)

5.7 Variation in participants' accounts between cases where men did and did not lose weight and maintain weight loss

Weight loss as an outcome was central to most participants' conversations about making or maintaining the behavioural changes. Many associated changes in their dietary practices and physical activity with weight loss. Table 5.3 indicates (by colour codes) the differences in participants' weight loss outcomes, with the data presented according to the involvement-reliance typologies for dietary practices and physical activity described above.

Table 5.3 Men's weight loss outcomes (indicated with colour keys) according to the level of partner involvement, and men's reliance/receptiveness for changes to dietary practices and physical activity

Dietary changes		Women		
		Very Involved	Partially Involved	Not Involved
Men	Resolute	Kenneth/Kelly Anthony/Andrea	William/Sandra Jeffrey/Laura Jason/Nicole George/Barbara Shawn/Tracey Eric/Heather	Scot/Judith
	Reliant	Luke/Mary Jeremy/Lisa Paul/Lorna Joseph/Tricia	Peter/Angela Matt/Sarah Richard/Hillary	
	Non-Responsive	Mark/ Dawn Ryan/Amanda		Mathew/Kimberly Kevin/Michelle

Physical activity changes		Women		
		Very Involved	Partially Involved	Not Involved
	Resolute		Peter/Angela Jason/Nicole Richard/Hillary Eric/Heather	William/Sandra Paul/Lorna
Men	Receptive	Anthony/Andrea Jeremy/Lisa Shawn/Tracey	Jeffrey/Laura Joseph/Tricia Luke/Mary Kenneth/Kelly George/Barbara Matt/Sarah	Scot/Judith
	Non-Responsive	Ryan/Amanda Mark/ Dawn Mathew/Kimberly		Kevin/Michelle

*The colour keys: Green: Men lost and maintained weight loss; Amber: Men lost weight but did not maintain weight loss; Blue: Men did not meet weight loss goals during FFIT but lost and maintained since; Red: Men did not lose weight
Underlined: Men who had attempted to lose weight prior to joining FFIT.*

As presented in Table 5.3 above, eleven (out of 20) men in this study lost 5% or more of their weight during the FFIT programme, and seven of them had maintained this at the time of the interview. Four (out of 20) men did not lose weight during FFIT but started to do so after completing the programme. Of these 15 men who lost weight, 14 partners were either **Very** or **Partially Involved** for dietary practices and 12 for physical activity. Of the four men who had not maintained their weight loss, all had a **Partially Involved** partner for dietary practices, and three had **Partially Involved** partners for physical activity changes.

Five (out of 20) men did not lose 5% or more of their weight during or after the FFIT programme. Of these, two (Eric and Mathew) did not complete the programme (Eric due to a family bereavement; Mathew did not provide a clear reason). All five men who had not lost 5% or more of their weight described either not making the changes or not maintaining the changes they had initiated at the beginning of FFIT. Eric said he had started some of the suggested initial changes at the time of the interview and was **Resolute** for both. Of these five men, two had **Not Involved** partners for dietary practices and one had **Not Involved** partner for physical activity.

Of the seven men who had attempted unsuccessfully to lose weight in the past (Table 5.3), five were **Resolute** or **Reliant** and all of them (except Eric, who had not completed the programme) reported losing weight either at the end of the FFIT programme, or since they completed it. All of these men had a **Very** or **Partially Involved** partner for both dietary changes and physical activity, except one whose partner was **Not Involved** for physical activity. Citing past unsuccessful attempts, a few of these women expressed scepticism about the man's commitment to the FFIT programme initially. This data suggests that the man's past unsuccessful attempts at weight loss and maintenance did not affect most partners' level of involvement and the man's motivation to join, and achieve the target weight loss at, FFIT.

When men's weight loss and/or weight loss maintenance was compared against their reliance categories, as summarised in Table 5.3, there were clear patterns. All **Resolute** men for *either* dietary practices and/or physical activity except one (Eric) reported losing weight either at the end of FFIT or since the end of FFIT. Similarly, all **Reliant/Receptive** men also reported losing weight. All couples, in which men achieved their weight loss goals during or after FFIT, described explicitly that either the man's **Resoluteness** and/or the partner's **Involvement** was instrumental in determining the weight loss outcome. These men and their partners were also more likely to report continuing with most of the changes that the man had initiated, and appeared to be optimistic about the partner's continuous involvement. These men acknowledged the positive influence of moral support they received from their partner.

She'll say that to me, "You're getting smaller." I'll say "Well, I'm happy to hear that." Aye, I'm delighted. Yes. She notices. (Joseph 70, cohabitation with Tricia 40 years.)

I think she can see that I've lost the weight and she comments on it...which is probably the best thing [...] she was always supportive and she always would be supportive in terms of me not putting on a lot of weight. (Matt 44, cohabitation with Sarah 21 years.)

Four **Non-Responsive** men for both dietary practices and physical activity (regardless of their partner's level of involvement) described not achieving the weight loss goals during or after FFIT. These men described their lack of resoluteness to adopting behaviour changes. Two of these men talked about lack of partner support for changes to dietary practices. Although they recognised that their own unwillingness caused them to not make or maintain changes, they were also explicitly or implicitly critical of their partners for not facilitating their attempts.

Because Dawn bakes [...] she went to college to do patisserie, so she's into baking, eh? Which was a problem [...] Cause you dinnae want that in your house, eh? Know what I mean? [...] I would have a cup of tea wi' a ginger nut [but whenever she bakes she offers] which were delicious, But, they're no' healthy. (Mark 53, cohabitation with Dawn 9 years.)

5.8 Chapter five summary

This chapter presented the accounts of men and their partners about the influence of female partners on men's attempts to change their diet and physical activity and to maintain those changes. The findings illustrate how despite all men participating in the same intervention (FFIT), the mechanisms by which the changes they made differed due to the varying couple contexts contributed by the man's resoluteness/receptiveness, and the partner's involvement.

Circumstances around some dietary practices were greatly determined by couples' daily routines as well as, for some couples, a long-established gendered division of household labour, where the woman took the lead in food practices

that the man needed to change. This meant that men either needed to change the normal practices themselves or required their partner's support in order to make the dietary changes. In contrast, changes to physical activity were mostly described as activities that men decided to uptake or increase.

Many participants suggested that the couple's relationship, not just as cohabiting partners, but also as considerate and caring allies, had a positive influence on men making the changes. However, men's desire for independence in making changes for themselves in respect of certain practices, and the level of dependency they had on their partners for others, resulted in men showing different levels of *reliance* on their partners. Thus, there was a range of interdependence between partners within and across health practices.

The couple clusters presented in this chapter (Table 5.1 and 5.2) with differences for both dietary practices and physical activity within couples, and for individual practices across the sample, highlight that men's needs and desires partially determined the extent to which the women's involvement was required. Most participants suggested that men's reliance on the partner for food provision did not greatly change as a result of men joining FFIT, and they continued to receive moral and practical support. The findings show that the *Very Involved* and *Partially Involved* partners provided both instrumental and emotional support and were *codieting*. They facilitated the man's attempts to increase his physical activity by allowing him time to exercise alone, encouraging him, and/or by being *coactive*. The *Partially Involved* women, however, were not involved in every aspect of the changes that men made for various practical or attitudinal reasons. The small group of *Not Involved* women were uninvolved in *any* aspect of the changes that the men attempted to make due to their inability or indifference to the partner's attempts to make changes, or because their partner either took charge of the changes or did not make any changes. Only two *Non-Responsive* men appeared to suggest their partner's lack of support as inhibiting their dietary practice changes during or after FFIT.

Most men described the *maintenance* of changes in terms of the *practices* that were changed rather than the *support*, or lack thereof, provided by their

partner. However, the differences men described in relation to partner involvement for maintaining changes were more pronounced with regard to the maintenance of some dietary practices than physical activity.

Men's success or failure in achieving weight loss was described as resulting from both their resoluteness for the changes and responsiveness to the programme, and the partner's involvement and support. For *Resolute* men, their resoluteness appeared to help them lose weight during FFIT, and even after the programme was complete, regardless of the partner's involvement. For *Reliant* and *Receptive* men, their partner's involvement was crucial in helping them make the crucial changes that led to their success in losing weight and maintaining it.

Overall, this study identified variety in terms of both partner support strategies and levels, and their receipt by men. The findings highlight changes to health practices as mutual efforts between partners in a cohabiting context.

Chapter 6 The influence of men’s participation in FFIT on their female partners’ dietary practices and physical activity

6.1 Overview of chapter

Chapter Five outlined the range of ways in which men and women described how female partners influenced men’s attempts to make changes to dietary practices and physical activity following the men’s attendance at FFIT. The aim of this chapter is to detail how this process influenced the female partners’ dietary practices and physical activities, and the mechanisms by which this influence occurred.

It outlines how men and women described the types of improvements women made in their dietary practices and physical activities, and the factors that facilitated or prohibited this process. It is, however, important to note that because the practices being changed happened in a shared context of cohabiting couples, the direction of influence is sometimes blurred. For example, it is sometimes hard to distinguish between a woman being involved in order to support the man from a woman making changes for herself after being influenced by the process.

6.2 Changes in women’s dietary practices: What, why and why not?

Sixteen (of the 20) women in this study were reported to have had made at least some changes to their dietary practices as a result of their partner’s participation in FFIT. Fifteen of these women had either a *Resolute* or *Reliant* partner, and 14 of these women were *Very* or *Partially* involved. Ten women described having improved their already healthy dietary practices, whereas six described having made significant changes to their prior unhealthy dietary practices. Of the four women who were reported as not having made any changes to their dietary practices, two described not needing to change their

diet as it was already healthy and reported continuing with their healthy practices, and the other two expressed a lack of desire to make changes.

Seventeen women in this study described themselves as overweight or needing to lose weight. As the women’s height measurement was not obtained during the interview, it is not possible to report their BMIs. However, 12 of the 17 women reported having lost at least 5% of their weight since their male partner’s participation in FFIT. Table 6.1 shows the variations in women making changes based on their perceived healthiness of their pre-existing dietary practices, their own levels of involvement in their partner’s dietary changes and men’s reliance on the partner (as defined in Section 5.2).

Table 6.1 Variation in women’s changes to dietary practices

Dietary practice		Women			
		Changed after men joined FFIT (N=16)		Did not change after men joined FFIT (N=4)	
		Already eating healthily (N=10)	Started eating healthily once men joined FFIT (N=6)	Already eating healthily (N=3)	Considered diet to be unhealthy (N=1)
Men	Resolute (N=9)	<u>Laura</u> /Jeffrey <u>Sandra</u> /William <u>Andrea</u> /Anthony <u>Tracey</u> /Shawn <u>Nicole</u> /Jason	<u>Heather</u> /Eric <u>Judith</u> /Scot <u>Kelly</u> /Kenneth <u>Barbara</u> /George		
	Reliant (N=7)	<u>Tricia</u> /Joseph <u>Angela</u> /Peter <u>Hillary</u> /Richard <u>Lorna</u> /Paul	<u>Sarah</u> /Matt <u>Mary</u> /Luke	<u>Lisa</u> /Jeremy	
	Non-Responsive (N=4)	<u>Amanda</u> /Ryan		<u>Dawn</u> /Mark <u>Kimberly</u> /Mathew	<u>Michelle</u> /Kevin

Colour key: Green: Very Involved, Amber: Partially Involved, Red: Not Involved
Underlined: described being overweight or needing to lose weight
Italics: women who had attempted to lose weight in the past

6.2.1 Types of dietary practices that women changed

Most participants talked about a range of dietary practices that women changed but some practices were changed by more women than others. Participants’

accounts suggested that the majority of these women reduced meal portion sizes, replaced unhealthy meals with healthier options, limited unhealthy foods in the house and read food labels. The changes they described were similar to those that their male partner reported as making and maintaining.

What we would do [in the past], probably, is have a sandwich and half a packet [of crisps] between us on the side [...] we've kinda stopped doing that. And I've stopped, kinda, buying them as well. [...] I have paused and thought I should, and then I think 'No, I'm not gonnae bother, I won't do it'. Aye, so it has made me think twice about that [eating unhealthy snacks]. (Mary 67, cohabitation with Luke 50 years.)

A few participants suggested they had adapted to the dietary changes, and not 'necessarily notice[d] them all because it's happened over a period of time' (Kelly 34, cohabitation with Kenneth 18 years). However, most appeared to be certain about the changes that were made. Their accounts suggested that even in cases where the woman considered her pre-existing diet to be healthy, she had made changes to some aspects of dietary practices, with the level of changes varying throughout the sample. Some seemed to make minor changes to only a few practices such as eating additional fruits and vegetables, while others suggested they had made substantial changes in their overall dietary practices similar to those their partner was making.

There was diversity in how participants conceptualised changes in women's dietary practices. Some considered reducing meal portion size as a major change. However, a few participants, especially women who were already adopting a formal dieting programme (but had not reduced portion sizes), explicitly said there was no change in their dietary practices, although the reduction in the portion sizes of their main meals were similar to the ones described by some as a 'major' change. Laura, who changed some of her dietary practices including portion sizes, and Heather, who started eating healthier evening meals that her husband prepared, initially said that they had not made changes to their diet.

There weren't massive changes to our diet really. It's just less. Portion size was the main thing. Yeah, I think it was more portion size [...] I was kinda doing it [eating healthily] anyway a little bit 'cause through my job

[medical profession] anyway, so I'm kind of a little bit more aware hopefully. (Laura 51, cohabitation with Jeffrey 5 years.)

It [her diet] didn't change because I didn't feel like I was really needing to change that much anyway. (Heather 53, cohabitation with Eric 37 years.)

Most of the women who had changed their dietary practices described the changes as now part of their daily routine and as having become normal for them, regardless of the level of their practical involvement in their partner's dietary changes, and their own participation in any formal weight loss programme. However, their descriptions of how consciously they needed to plan and think before making decisions about buying, preparing and eating healthy foods varied. Most women said that it was not challenging for them to maintain most of the dietary changes they had made after their partner joined FFIT, and anticipated being able to maintain them in future, although several women described finding it hard to change and/or maintain snacking habits. The fact that there seemed to be no difference in women's descriptions of ease or difficulty in making changes according to the time since men's participation in FFIT suggested that the duration since they initiated the changes did not appear to influence their optimism about maintaining the changes. For example, Tracey, Kelly and Andrea, whose *Resolute* partners completed FFIT four, five and 12 months prior to the interview, respectively, made similar remarks about the ease in maintaining their dietary changes.

I'm feeling cautiously optimistic because we have lasted this long and its becoming habitual every day so after a while we won't think about it and we will just be automatic. (Tracey 53, cohabitation with Shawn 30 years.)

There is a lot of things [related to healthy eating practices] that we do without thinking. They [the changes that were made] have definitely become more of a routine. Which looking back it's quite a big change to our family routine. (Kelly 34, cohabitation with Kenneth 18 years.)

We're determined to keep going at it [...] I don't miss puddings at all. I don't think my husband does either. No we're good. (Andrea 61, cohabitation with Anthony 45 years.)

Interestingly, some participants appeared to have not recognised some of the indirect and subtle ways that the man's participation in FFIT might have

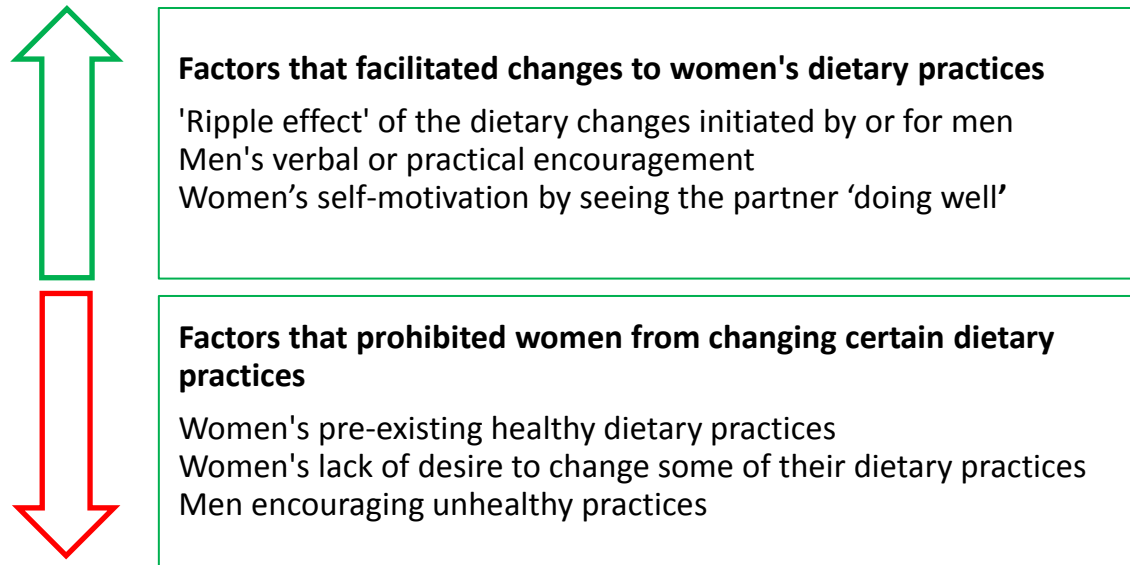
influenced the woman's dietary practices. This was mostly reflected in accounts from three couples (**Richard/Hillary, Peter/Angela and Matt/Sarah**), where the man was *Reliant* and the woman was *Partially Involved*, and neither partner was solely leading the changes. In these cases, there were contradictions in what was said regarding the changes in women's dietary practices described by women themselves at different points during the interview, as well as divergent accounts given by each couple member. For example, Richard and Hillary both said that Hillary's dietary practices did not change as a result of Richard joining FFIT but both made references to the influences being made.

Just lots and lots of wee things [suggested in FFIT programme], that was similar to what we were doing, but, basically, overall, it was what we were doing. But we just weren't doing it in the right order [...] I wouldnae say anything changed much, you know? [...] I think she's more concerned about me eating healthy than herself, although she does eat healthy all the time. (Richard 67, cohabitation with Hillary 42 years.)

Sometimes he'll say to me, or I'll say to him, "Do you want a cup of coffee and do you want anything in with it?" And you just go "No, thanks." So, if one says no then the other one just sort of follows on. (Hillary 67, cohabitation with Richard 42 years).

Participants described several ways in which men's attempts to make changes to their dietary practices influenced those of their partner, and why some women did not make any or some of the changes to their dietary practices. These direct and indirect factors are described in the following sections. Figure 6.1 lists factors that facilitated or inhibited the changes to women's dietary practices following the man's participation in FFIT.

Figure 6.1 Facilitators and inhibitors of women's dietary changes



6.2.2 Factors that facilitated changes to women's dietary practices

As already described, most participants suggested that they discussed the changes the man wanted to make to his dietary practices once he began attending FFIT. Most women appeared interested in the changes that men planned. Therefore, they were aware of the healthy dietary practices suggested by FFIT, regardless of the level of their practical and/or emotional involvement in helping their partner make changes. Many men and women described the information that men received through FFIT as useful for both of them, even in cases where the man did not directly encourage his partner to make the changes to her own dietary practices. Many participants described some pre-existing healthy practices around women's eating behaviours, suggesting that changes that were not triggered by their male partner's attempts to make changes to his own diet were also facilitated in this process. Women's own participation in a weight loss programme, and/or both partners eating similar meals for convenience before or after men started FFIT were raised by most.

6.2.2.1 Ripple effect of the dietary changes initiated by or for men

A variety of *indirect* factors resulted in dietary changes for most women, even in cases where they were not actively attempting to make such changes. This impact from men to their partners without their active attempt to make a

change has been described as a ‘Ripple effect’ (Gorin et al. 2008). In the current study the ripple effect of men’s attempts to make dietary changes on the women’s practices appeared to be evident in most cases except for the partners of *Non-Responsive* men. Both men and women reported that the ripple effect resulted from the couples’ habits of eating similar meals together before FFIT, limited access to unhealthy food options in the house as a show of encouragement for men, and women following men’s changes for convenience.

It was just little things like changing to semi-skimmed milk and changed to whole-wheat bread and things. So he did learn bits and pieces and it’s tips that we still use now [...] I had already cut down on bread before Jason went on this ‘cause of Slimming World. But I am now a whole-wheat bread person because of Jason (laughs) [...] It’s just something that we buy now. (Nicole 30, cohabitation with Jason 4 years.)

Although men and women seemed to be aware of the benefit that women might have had from the changes, for these women the changes were not something methodically planned but rather something they felt was natural to adopt.

He made changes to his diet. Well it’s something that he would do himself, [for both] [...] because it’s much easier just cooking the same thing [...] so we have cut a lot of the stuff out, like fat, and we don’t eat as much meat. (Heather 53, cohabitation with Eric 37 years.)

Practical involvement in helping their *Reliant* partner make changes also appeared to have prompted many *Very* or *Partially Involved* women to make changes themselves and this benefited their own health. Many women who were primarily involved in preparing meals for their male partner talked about being motivated to make changes to their own practices as they found this more convenient than preparing two separate meals. Besides eating healthier meals, most *Very Involved* women also described limiting their unhealthy snacking habits as a show of support for men’s efforts and to reduce men’s temptations for unhealthy foods, and as a result significantly improving their own diet.

I actually moved away from those things [unhealthy foods] as an acknowledgement to what he was saying because I figured if I didn’t support him on that there is less chance that he’d continue [...] I was aware of that [reading food labels] before but I wasn’t always following it through. And it has been quite shocking at times to discover what the

content is in some food. So that has been an influence on me. (Tracey 53, cohabitation with Shawn 30 years.)

An exploration of men's and women's accounts of their dietary changes in relation to men's level of reliance showed that all partners of *Resolute* men made changes to their dietary practices, regardless of their level of involvement in men's changes and participation in any other weight loss programme. Four partners of *Resolute* men described their diet as not being healthy prior to their partner participating in FFIT and suggested that the changes they made were substantial. They not only stated the extent of, and their commitment to the dietary changes, and the weight loss they achieved, but also described the effect the changes had on them feeling healthier and fitter.

Most participants reported having eaten the same or similar meals to their partners before FFIT. This meant that when the men attempted to make changes to their diet, the women also changed their diets. In these cases, many *Resolute* men who were primarily responsible for preparing meals described preparing healthier meals after they joined FFIT. This resulted in their partners improving at least the main meals they ate together.

Most of the time I'm doing the cooking [...] So actually we eat a lot more home-made meals [...] that's probably impacted [her diet] because I'm making the food. (Jason 35, cohabitation with Nicole 4 years.)

I joined for my benefit, you know? But obviously [...] it has an effect on Barbara as well [...] I would say a huge influence on Barbara now. Well, obviously, she was eating what I was eating. (George 62, cohabitation with Barbara 34 years.)

Therefore, the influence of men's changes on women's practices was not restricted to only the *Very Involved* women who seemed to make consciously planned changes to their diet. Some *Partially* or *Not Involved* women also benefited from their partner's dietary changes without intending to make changes. The excerpts below reflect how Judith, who was *Not Involved*, and Angela who was *Partially Involved*, described the way in which their meals were impacted.

He doesn't use cooking oil. He doesn't like me frying anything—occasionally, like burgers, I like to fry... But now we do them in the oven

now. So it is helping me as well as Scot. (Judith 61, cohabitation with Scot 33 years.)

Her's [diet] has always been good. But wi' me stopping buying... If I was getting apple pies then she'd have it. So, it was me saying "No, don't buy things like that" because you saw how fat they were. So, she's quite happy not to have it. (Peter 69, cohabitation with Angela 40 years.)

As discussed in the last chapter, a small number of *Resolute* men attempted to increase their involvement in family food practices. Although several women (mostly the partners of older *Reliant* men) talked about how they preferred to take the lead in food preparation for the family, a few women described men's increased involvement in family food activities as helpful for them in adopting healthier dietary practices.

I think it was probably helpful because sometimes when we are both working late and it's easy to get a takeaway ...not to do that as often which is easier because I am quite easily led. I will go, what will you have for dinner? And if Kenneth says I will have a takeaway then I'll be woo yeah let's just do that so [...] we seem to have this daily conversation, I am sure that goes on in every household across the country, what will we have for dinner tonight? And it was always me that would say well shall we have [certain food]. Yeah [...] he is more involved in suggesting ideas [after FFIT]. (Kelly 34, cohabitation with Kenneth 18 years.)

It appeared that most partners of *Reliant* or *Resolute* men, who were primarily responsible for preparing food for both, altered their dietary practices without consciously planning for them. This highlights the ripple effect which men's attempts to make changes had on their partner's dietary practices as well as how the changes these participants made were maintained and became habits. This was reflected in Kelly's and many other participants' accounts describing making healthier dietary choices, such as buying healthier food options and increasing cooking meals rather than ordering takeaways, without consciously thinking about them.

As a family we've all adapted to the changes [to dietary practices] and [...] they have definitely become more of a routine. Which looking back it's quite a big change to our family routine [...] There is a lot of things [related to healthier dietary practices] that we do without thinking [now]. (Kelly 34, cohabitation with Kenneth 18 years.)

6.2.2.2 Men verbally or practically encouraging women to adopt healthy dietary practices

More than half the men described trying to encourage their partner to adopt healthy dietary practices that they were initiating for themselves, regardless of whether she was trying to change her diet or not. All *Resolute* men and their partners also discussed men practically providing their partner with healthier food options. Many men and women recognised that the conversations that men had about healthy eating habits with their partners helped motivate women to adopt such dietary practices. They described the ways men either verbally encouraged their partner to adopt healthier dietary practices or discouraged unhealthy dietary practices. Sarah described a number of ways her own diet improved after she and her *Reliant* husband discussed the changes and started *codieting*.

I think him coming home and telling me that there was, for instance, twenty spoonfuls of sugar in the such-and-such drink, which I thought was maybe particularly quite healthy. I thought 'Jeez. Right, let's stop buying that'. (Sarah 43, cohabitation with Matt 21 years.)

Similarly, several partners of both *Resolute* and *Reliant* men recognised that their partner discouraging unhealthy dietary practices also made them more aware of the unhealthy foods they were eating on their own, and encouraged them to change their snacks as well as the meals they used to eat together. Their remarks also provide insights into how couple members' proximity to each other provided the opportunity for partners to have surveillance of the other's practices and encouraged partners to attempt to keep up appearances with each other.

I think that's [unhealthy snacks] my downfall, that's when I snack. And then Paul'll say to me, in the morning he'll say [...] "I've found a chocolate wrapper in the bin [...] "you shouldn't have been having that", I didn't need it. And then you feel guilty you've done it. (Lorna 64, cohabitation with Paul 44 years.)

If he catches me—eating [unhealthy snacks], he nags at me, eh? [...] In a way and I... nag back (mumble). But I know in the back of my head that he's right. (Judith 61, cohabitation with Scot 33 years.)

Interviews with both men and women made it apparent that in most of the cases where men were *Resolute* and partners were either *Very* or *Partially Involved*, making changes to their diet was a mutual practice, where both jointly planned healthy eating strategies and/or prepared, and ate together. Many talked about both of them paying increased attention to the nutritional value of the foods they were buying, discussing the changes they made and being considerate of each other's preferences, and as a result mutually deciding to replace some previously purchased food items with healthier options. These couples included both women who were attending a slimming club and had previously eaten healthier meals than the man and those where the woman was not trying to lose weight and the man was or was not involved in cooking.

We've both spoke about it 'cause we are both overweight, so we said we'll cut down a lot, as I say, crisps, biscuits, all that stuff [...] anything we did have we just stopped buying all that [...] I was never a big, big eater so I don't think it's been hard for me because I'm trying to do the same as Anthony [...] So I'm just trying to do the same as what he's doing. (Andrea 61, cohabitation with Anthony 45 years.)

We came back from full fat milk to semi-skimmed milk and now she is on red thing [red cap milk] totally fat free [...] It kind of just happened naturally, But we spoke about it and she was quite happy that I got the semi-skimmed, which I think she wanted to do for a while because she didn't see the point in buying two different kind of milk just for herself. (Shawn 56, cohabitation with Tracey 30 years.)

Several *Resolute* men who were preparing joint meals described being considerate about creating a balance between encouraging healthy dietary practices for their partner and not making changes that were only preferable for themselves. These men, regardless of their partner's interests in changing her diet, attempted to encourage her to adopt healthier dietary practices and were mostly able to influence changes in a range of dietary practices. Some were not only aware of whether their female partner made changes to her dietary practices but also considerate about how she felt about the changes. The excerpt below exemplifies how men performed the balancing act.

I had to concentrate on what I was doing for myself. But I wanted to introduce the healthy eating with Judith as well. It all depends what we're having, you know? What we're having with it. I think she'll eat - she would eat it if I dished it up, but... Even if she wasn't too keen on it, you know? But sometimes I'll do a different thing for her [...] mainly I try

to cook meals that we're gonnae eat anyway. I wouldn't - I don't wanna just pick things that she doesn't like. (Scot 63, cohabitation with Judith 33 years.)

Scot, however, highlighted that, although his partner's diet changed to a certain extent due to his efforts, he was unsuccessful in encouraging her to adopt healthier options in many aspects of her diet.

She still has - I think she has larger portions, like, if she's having cereal in the morning, she'll have a lot more in her bowl. You know. No, we hardly eat any meals together. (Scot 63, cohabitation with Judith 33 years.)

Most of the women who described themselves as overweight or actively trying to lose weight by following certain healthy eating plans emphasised that their diet was 'not too bad' or was 'healthy' and so they did not need to make many changes. However, they suggested that it became easier for them to maintain their healthy dietary practices once the couple's motivation, and perceptions of healthy dietary practices were aligned. These women suggested that the man had become more understanding and encouraging after he joined FFIT.

Because he wasn't just seeing me going off and trying to be healthy but he was also doing it as well so he didn't see it as just a ridiculous fad type thing. He's now actively trying to eat healthily which is good. [before FFIT] If it was things like pizza [he ate], did make it harder because you're trying to be good and you're trying to lose weight and there's somebody eating a takeaway in front of you. (Nicole 30, cohabitation with Jason 4 years.)

Additionally, for women whose *Resolute* partner started preparing meals for both following her existing healthy dietary habits rather than changing their diets according to the advice from FFIT, codieting became the norm even though the content of women's diet did not change.

I kind o' have it ready tae dish up for her coming in [from work] I'll have it dished up for her when she's ready [...] I probably went down tae what Heather was eating. (Eric 57, cohabitation with Heather 37 years.)

A few men with a *Partially* or *Not Involved* partner talked about how they did not want to impose their own new healthy dietary practices on her. They were generally aware of their female partner's unhealthy eating habits and some suggested that she could benefit from making changes. Although most of these

men did not directly imply that their encouragement was aimed toward the partner's weight loss, some described being aware of their partner's desire or attempt to lose weight. Unlike those who were comfortable encouraging their partner to change her dietary practices, these men highlighted negative experiences related to suggesting such changes. Below, Matt described being considerate of how his partner might receive the FFIT advice, and acting with caution not to make her feel uncomfortable.

What I didn't want to do was impose anything on Sarah, even quite a few times, I'd come back and I'd pass comment on something she was eating and she would say "you're getting sanctimonious. See since you've been on that course?" and she would pass comment to say "oh aye, so we've all to change our diets 'cause you're going to some course?" and I'm saying "no, I'm just saying that's probably healthier than that, or why don't you try that?" So I didn't want to, so I just hope that through seeing what's happened to me, she might change. (Matt 44, cohabitation with Sarah 21 years.)

6.2.2.3 Women's self-motivation by seeing the partner 'doing well'

As described above, in most of the cases where women made dietary changes, both couple members indicated that these started when the man initiated his own changes, and described the man as therefore modelling healthier *practices* that the partner followed. However, five women appeared to have been motivated to make changes to their diet *after* they noticed their partner maintaining the changes and/or losing weight. Some of these (*Very Involved*) women followed all the changes that their partner was making, and often referred to the process of making changes as something 'we are doing' rather than 'he is' or 'I am' doing. Lorna and Sarah provide examples of how some women described being inspired by how determined and/or successful their partner had been in making changes or losing weight, and how most of these women talked about *codieting*.

I'm thinking about mine [healthy diet], but I was, I'm more thinking about, because he's done so well with the whole programme, I sort of feel I've got to keep this going, so, you know what I mean. So it benefits me too. (Lorna 64, cohabitation with Paul 44 years.)

He probably influenced me more into buying [healthy food options] but I didn't really put up a huge fight 'cause' [...] I could see him losing weight so I knew he was right. (Sarah 43, cohabitation with Matt 21 years.)

6.2.3 Factors that prohibited women from changing dietary practices

The data suggested that most female partners changed their diet as a result of the man's participation in FFIT. However, some women described not changing *some* of their dietary practices and four (**Lisa, Dawn, Kimberly and Michelle**) described not making *any* changes to their dietary practices as a result of their partner's participation in FFIT. Three of the four had a *Non-Responsive* partner. The reasons reported for lack of changes included women thinking their diet was already healthy and not requiring any alternation, or, in one case, being uninterested in changing her diet even though she appeared to think it was unhealthy.

6.2.3.1 Women who reported already having healthy dietary practices

Across the overall sample, some of the *Very* and *Partially Involved* women with *Reliant* partners for dietary changes appeared to continue with their own eating habits, making the man follow those practices rather than changing to what he had suggested. Although many of these women discussed *following some aspects* of the changes men learned from FFIT, most talked about how they were responsible for and in control of the diet for both of them.

Three couples talked about the woman's diet being healthier than that of the man before he joined FFIT. These men and women said that the women's diet did not change remarkably as a result of the man wanting to adopt healthier eating practices.

Of the four women who did not make any changes to their dietary practices, three discussed having followed a formal dietary plan, such as Slimming World or Weight Watchers, either at some point in the past, or at the same time as the man's participation in FFIT. Lisa was the only partner of a *Reliant* man who did not make *any* changes to her dietary practices. Although she talked about how

she appreciated that her partner's participation in FFIT helped her continue with her already healthy dietary practices, she indicated that she preferred not to have his involvement in food-related practices in the household.

So thinking back to the information that came from the football club, I can't really remember much about the diet side because we weren't go - I wasn't gonna be following that[...] It was there but I can't remember much about it[...] I probably do see it as my responsibility. I feel more in control. But [...] because he's following a healthy eating plan that I'm putting in place [...] I'm following a healthy eating plan but my healthy eating plan is a plan that has to be monitored. You know, it's got values to it. So if Jeremy cooks the meal, I don't know the values. So it knocks my plan off. So it's a bit of a control thing. (Lisa 51, cohabitation with Jeremy 10 years.)

Dawn, Kimberly and Michelle, all had a *Non-Responsive* partner. Kimberly and Michelle, who were *Not Involved* in their partner's dietary changes, also described being uninfluenced by his participation in FFIT. Dawn, who was *Very Involved* and primarily responsible for food provision for the family described unsuccessfully and consistently attempting to get her partner to follow her healthy dietary practices. However, she described how her practices remained uninfluenced by his participation in FFIT because the information he shared following his participation in FFIT was only reinforcing what she was already practising.

6.2.3.2 Women's lack of desire to change

Michelle and Kimberly who were *Not Involved* in any aspects of dietary changes made remarks suggestive of their unwillingness to make any changes. While their remarks around lack of interest were similar to the ways several other women described their lack of interest in *certain* aspects of dietary practices, Michelle and Kimberly explicitly expressed their lack of interest in *any* change the man might have been encouraged to make during at FFIT. Although both were participating in a weight loss programme themselves, both made references to their diet being healthier than it should be. Kimberly suggested that her partner unsuccessfully followed various dietary plans and she was uninterested in his attempts after FFIT, whereas Michelle suggested that neither herself, nor her partner were interested in making changes.

I never actually gave it [his attempts to change his diet] much thought to be honest...I never really gave it much thought. (Kimberly 57, cohabitation with Mathew 36 years.)

It [his participation in FFIT] hasn't really impacted us at all. We're just really - we're so laid-back, it's quite scary. It's not until when you're asked these questions and you're sitting thinking 'Right, okay, I never thought about that'. (Michelle 45, cohabitation with Kevin 8 years.)

The interview data from Michelle's and Kimberly's *Non-Responsive* partners were also suggestive of these men's awareness of their partner's unwillingness to make any changes, as well as their own indifference towards helping her change her dietary practices.

Additionally, several women (most of the *Partially Involved* women), who reported having changed their dietary practices, still described unchanged unhealthy snacking and drinking habits, mostly due to their own lack of interest, despite the man nudging them to change.

We still ate the same things [as each other], so I suppose it did change a bit. But you know I like my wee cup of tea, I like a biscuit you know [...] So no I didn't change that way, I would still have my cake or a biscuit if I wanted one, you know, whereas he wouldn't have anything. (Heather 53, cohabitation with Eric 37 years.)

If I maybe sit at night and we're watching TV and have a packet of crisps and maybe, I don't know, I quite, I quite like a bottle of beer, an' he'll say "I thought you were trying to lose weight?" You know? "You'll never lose weight that way."

ST: How do you react to that?

Ach, I just go 'Ach, well, I'm just having a wee treat.' You know? (Angela 65, cohabitation with Peter 40 years.)

6.2.3.3 Men encouraging unhealthy practices

Unlike the couples who encouraged each other to undertake healthier practices, or those who influenced each other in respect of occasional unhealthy eating practices such as drinking or snacking, two couples (Michelle/Kevin and Amanda/Ryan) described being encouraged by each other to engage in unhealthy dietary practices in general. They also described eating unhealthy foods when they were with their partner rather than alone. Michelle, a *Not Involved* partner

of a *Non-Responsive* man, described both encouraging each other to eat unhealthy foods in general, and not having changed that even after he joined FFIT. Amanda, a *Very Involved* partner of a *Non-Responsive* man, described being encouraged to make changes once he initiated them, but also suggested that she stopped when he was not motivated to continue the changes. Amanda's partner Ryan, who talked about both initially encouraging each other to eat healthier meals, also described times they encouraged each other to eat less healthy food in a way that was counterproductive to any attempts to make positive changes. Ryan's and Amanda's accounts below demonstrate the complexities within the cohabiting couple's context, where due to the intimacy and care present in the relationship, partners respond to each other's needs in a way they feel is important for the other person, which could inhibit the partner's pursuit of healthy practices directly and indirectly.

Days we want to be healthy and other days, we're just like "oof, don't want to do this" [...] There was positive to start with, then it was a case of we both enjoyed the new challenges that we got. But then, as I say, it just deteriorated [...] we'll get to the stage where [one partner] we'll crave something else. It's like the other night, the Great British Bake-Off was on, [...] and she was like, "I need food to eat with it". So, I'm across to the shop getting her munchies. I shouldn't encourage it, but I do [because] it makes her happy. (Ryan 31, cohabitation with Amanda 8 years.)

He wanted to do it [make dietary changes] together and for us to help each other with it [...] we kept that up for a while [...] we're both as stubborn as each other and I'm just like 'Well, if you're not gonna make the effort, I'm not gonna make the effort.' It's really silly but it's just the way we are. (Amanda 34, cohabitation with Ryan 8 years.)

6.3 Changes in women's physical activity: What, why and why not?

All women described being aware of the changes or lack of changes that their partner had made to his physical activities after joining FFIT. As discussed in the previous chapter, women's involvement and men's responsiveness towards women's involvement varied throughout the sample. Nonetheless, both men and

women appeared to agree that physical activity was important for losing weight and to be fit.

Table 6.2 below shows the variation in women making changes to their physical activity in relation to their pre-existing level of activeness (self-reported), their involvement in men’s attempts to make changes, and men’s responsiveness to their involvement.

Table 6.2 Variation in women’s changes to their physical activity

Physical activity changes		Women			
		Made changes (N=8)		No (major) changes (N=12)	
		Previously active (N=2)	Previously inactive (N=6)	Previously active (N=8)	Previously inactive (N=4)
Men	Resolute (N=6)		<u>Angela</u> /Peter	<u>Nicole</u> / Jason <u>Heather</u> / Eric <u>Hillary</u> /Richard	<u>Lorna</u> /Paul <u>Sandra</u> /William
	Receptive (N=10)	<u>Laura</u> / Jeffrey <u>Sarah</u> /Matt	<u>Mary</u> / Luke <u>Kelly</u> / Kenneth <u>Tracey</u> / Shawn <u>Andrea</u> / Anthony <u>Barbara</u> / George	<u>Lisa</u> / Jeremy <u>Tricia</u> / Joseph	<u>Judith</u> / Scot
	Non-Responsive (N= 4)			<u>Amanda</u> / Ryan <u>Dawn</u> / Mark <u>Michelle</u> / Kevin	<u>Kimberly</u> / Mathew

Colour key: **Green:** Very Involved, **Amber:** Partially Involved, **Red:** Not Involved
Underlined: described being overweight or needing to lose weight
Italics: those who had attempted to lose weight in the past

Eight women described changing at least some aspects of their physical activities after their partner started making changes. Seven of these women had a *Receptive* partner, and one had a *Resolute* partner. Six of the eight women were *Partially Involved* and two were *Very Involved* in the man’s physical activity changes. None of the women who had a *Non-Responsive* partner made any changes to their physical activity.

Of the 12 women who reported not making any changes to their physical activity as a result of the man’s participation in FFIT, four reported not doing so despite describing themselves as inactive, and eight described themselves as already

active. Two of these 12 women described not needing to lose any weight. Women are scattered across the different categories in relation to the level of their Involvement and the man's responsiveness. Although fewer women appeared to make changes to physical activity compared to dietary practices, of those who changed, increased walking habits were described by most. Mostly *Very Involved* and some *Partially Involved* partners of *Receptive* men described taking up additional exercises, such as by joining a gym or cycling.

6.3.1 Types of physical activity women changed

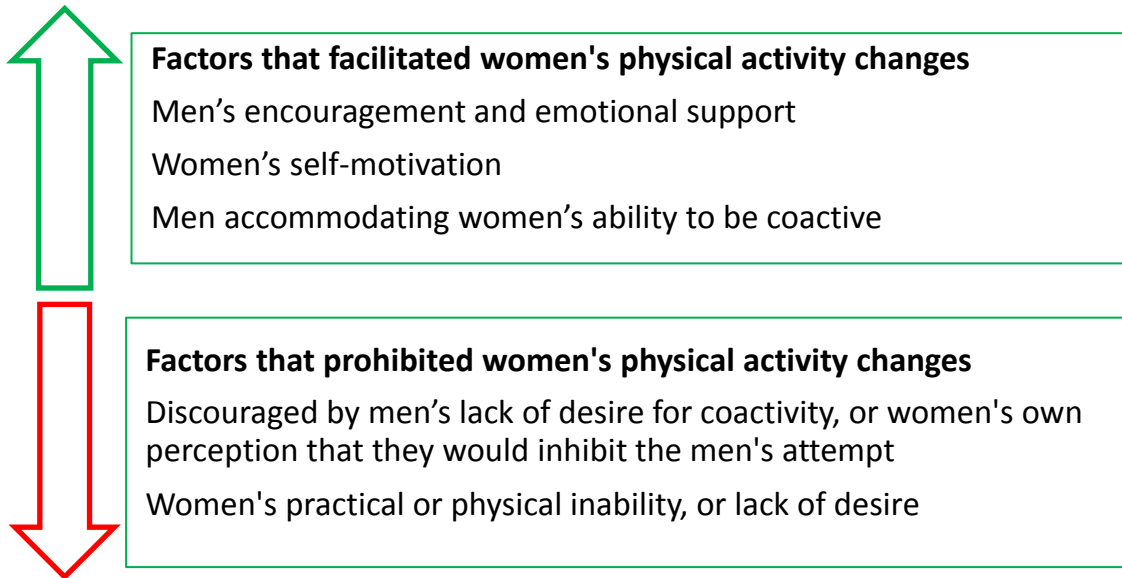
Joining their male partner for walks, awareness of step count goals, and increasing their walking in general, were discussed by most women. Some of them also reported being *coactive* for other activities, for example, going to the gym, cycling and swimming, which resulted in changes in the women's physical activity.

The 10,000 steps, I think that's a major one [...] We go for longer walks on purpose. (Tracey 53, cohabitation with Shawn 30 years.)

I'm actually going back to the gym [since he joined FFIT] now to try, and swimming, to try and lose some weight myself [...] [even when on holiday] we went to the gym every morning. (Andrea 61, cohabitation with Anthony 45 years.)

The following sections outline whether women made changes to their physical activities, and the reasons why some women did/did not change their physical activities as a result of their partner attending FFIT.

Figure 6.2 Facilitators and inhibitors of women's physical activity changes



6.3.2 Factors that facilitated changes to women's physical activities or maintenance of pre-existing physical activities

Participants' accounts of how men's attempts to make changes to their physical activities influenced their partner's activities indicated the importance of several factors. These included the man's encouragement and emotional support for his partner, and his desire to include her in the activities he was undertaking, the woman's self-motivation and her ability to be *coactive*.

In describing their role in facilitating the woman's physical activity changes, almost all men and many partners emphasised the man's performance of a masculine role. This was conveyed by presenting the man as 'determined' and in 'control of' his own changes, so encouraging the women, as a 'responsible' man who was helping his partner who needed support.

6.3.2.1 Men's encouragement and emotional support for partner

Of the women who described their physical activities as being positively influenced as a result of their partner's attempts to increase his physical activity, a few reported having started physical activities entirely due to the man's participation in them. These were usually *Very Involved* women whose partner was *Receptive*. In the excerpts below, Andrea, who indicated being

inactive before her husband joined FFIT, mentioned she began physical activity after seeing Anthony commit to his changes.

We started taking walking. [...] [At the gym] I do the treadmill, I do the bike [...] I think it [him changing his physical activity] spurred me on to do something [...]. He keeps pushing me. At the gym the other day he was pushing me. "Do another one, do another one". (Andrea 61, cohabitation with Anthony 45 years.)

She wasn't overly enthusiastic [in the beginning], she probably thought, 'This is one of his strange ideas, he'll maybe grow out of this, or forget about it,' or whatever. But I've stuck with it. In fact, as I say, Andrea, she'll tell you this, but Andrea's joined the gym as well. (Anthony 63, cohabitation with Andrea 45 years.)

Anthony described his strategies to encourage his wife to be more active and how he was careful about her feelings while encouraging her to do so. He highlighted the sensitive nature of weight-related issues and physical activity in relation to losing weight, that could make it an uncomfortable area to discuss with a partner.

At the beginning I was very careful not to be saying, "You should go to the gym. You should be doing this." I says, "Maybe we should both get, try a wee bit exercise and get fitter." [...] Andrea would get up in the morning and come with me. But without me pushing or whatever. I knew that I didn't want to be pushing her because she would maybe be, take the contrary view. "No, I'm not doing this. I'm not doing this." So she's got, I think I've encouraged her by not... berating her, or, or pushing her or anything at her own pace. (Anthony 63, cohabitation with Andrea 45 years.)

Men's vested interests in helping their partner increase her physical activity were also manifested in the way they described their awareness of her fitness levels. Some men also provided examples of the indirect and subtle way of encouraging coactivity, for example, by buying them an activity tracker and being thoughtful in this process.

We do a lot of walking together. We go out a lot.. I bought Tracey a Fit-bit [...] When I first got mine, I'd walk around the house to get my steps and I'd go out of the house 11 o' clock at night and now she is doing the same thing [...] I try to involve her in everything [...] we do walk a lot. (Shawn 56, cohabitation with Tracey 30 years.)

The excerpt above from Shawn reflects the nature of direct and indirect support and encouragement that some *Receptive* men provided initially to enable their partner to increase her physical activity. This was also enforced by the statement below from his wife, Tracey.

The fact that he bought me the Fit-bit is a definite change, I'd not have thought to do that myself. Whereas now, at least I'm doing 10,000 steps a day that's something of value, which I can build on. I couldn't tell that before so that's a direct result of his influence and FFIT. (Tracey 53, cohabitation with Shawn 30 years.)

Some women, who described themselves as already 'active', appeared not to have changed their physical activities as a result of their partner making changes to his. However, some of these women talked about how their partner's attempts to change his activities had been helpful for them in maintaining theirs, regardless of their involvement in his attempts to make changes. In the excerpts below, Laura and Lisa, who had been active before their husbands joined FFIT, described their experiences of physical activities after the men joined FFIT.

We probably do more walking and we attempt to walk further, or longer. It [him joining FFIT] brought it back, yeah, probably, 'cause Jeffrey was probably not as fit as I was when we started so I probably had curtailed what I do a little bit[...] we didn't start going out more, we didn't start particularly swimming or go back to swimming. No, mostly walking. It's changed in that we're more aware and we do walk further and longer. (Laura 51, cohabitation with Jeffrey 5 years.)

Men appeared to be aware of their *Very* or *Partially Involved* partner being influenced by their commitment to the changes or weight loss outcomes. Jeremy who was *Receptive* to his partner's involvement and was coactive, described his attempt to encourage his *Very Involved* partner by maintaining his own changes.

I need to do it [maintain the changes] to help her. 'Cause if I actually said "Okay, I've reached where I wanna be now", and stop [...] it would mean that she might do that same [...] so I don't wanna do that. (Jeremy 47, cohabitation with Lisa 10 years.)

Of the women who said they were also actively trying to get fitter, some talked about trying to lose weight themselves, even before the partner joined FFIT, whereas others had joined the gym with the man after he joined FFIT. Although

their accounts demonstrated that the practice of 'going to the gym' or exercising was different for men and women, these couples described joining a gym or going there together as coactivity.

We're usually at the gym more or less at the same time but we're not necessarily exercising together [...] She'll either go to Aqua Fit or she goes to classes. Occasionally she'll go the gym itself. But I tend to be pretty strict and do the same thing all the time. (Jeremy 47, cohabitation with Lisa 10 years.)

We've got a new gym membership since August which Jason has joined as well and I go to two classes there as well, so I go to the gym maybe three times a week [...] I prefer classes, he prefers actually going to the gym. I don't have the commitment for the gym. (Nicole 30, cohabitation with Jason 4 years.)

Similarly, Lisa, who reported participating in a formal weight loss programme even before her husband joined FFIT, also described being encouraged to maintain her practices by her husband after he joined.

He would say "Let's go for a walk", or something like that. So, yeah, he influences extra... extra, you know, extra physical activity. You know, playing maybe badminton, starting to play badminton, probably was maybe more him than me. (Lisa 51, cohabitation with Jeremy 10 years.)

Some already active women suggested that a sense of competition with men when exercising together contributed positively towards their attempts to increase their physical activity.

Because I wear... he bought me a Fitbit for Christmas so we had like a little competition of how many we were, who could walk the most steps in a day. (laughs) And we still do that now even and come home, after a particularly good day, I'll come home, like, "Oh I'm on 18,000 steps," and he'd be like, "Oh I'm on..." (laughs) So it is, it's nice, like, it's a little competitive thing but it's active. (Nicole 30, cohabitation with Jason 4 years.)

In addition to the sense of competition, Nicole talked about how the conversation and exchange of information she had with her husband regarding their activity levels due to him undertaking new exercises was beneficial for her even though they were not participating in physical activities together.

6.3.2.2 Woman's self-motivation

Besides being involved in the activities with their male partner, a few *Partially Involved* women discussed starting to be more active independently. These women were mostly the ones who recognised that their partner was supportive of their attempts to increase their physical activities but also aware of their own inability to undertake the same level of exercise as him. They thought that by joining, they might inhibit his ability to exercise as much as he wanted to, and therefore refrained from coactivities. However, they were motivated to increase their physical activity and did so independently.

I've started doing it [walking certain number of steps] at work, informally at work, through step-count challenge [...] We'll walk into town but he walks much faster than I do, so, it's hard sometimes keeping up. But he's - no, he's very supportive of what I do.

ST: And do you think your motivation to do that had anything to do with George being-

Yeah, I probably saw him doing it and I've started it. (Barbara 60, cohabitation with George 34 years.)

6.3.2.3 Men accommodating women's ability to be coactive

A few couples, mostly *Partially* or *Very Involved* partners of *Receptive* men attempted to undertake activities that both could do together. This was despite some of these men and/or the partner's perceptions that coactivity could make the man's attempt to achieve his physical activity goals difficult. Tracey, who was coactive with her *Receptive* partner, and Kenneth, whose wife was unable to participate in all the physical activities he was undertaking, explained choosing activities to accommodate the woman's ability or pace.

That [exercising together] was a challenge for us because his pace is much faster than mine, so we struggle to find something that was similar that we could do [...] we decided to do that [cycling] together because we could manage the pace more easily. (Tracey 53, cohabitation with Shawn 30 years.)

We talk about it [exercising together] and we managed to get her to come to the gym a couple of weeks ago. She can't do much but it's just a way to get active [...] cause she likes to do more. She does try her best to do may be things she would not have done. Get out for a wee walk or out

on the bike [...] We go out on the bikes together as well. I probably say I encourage her cause, I'm saying to her do you want to come to gym with me. (Kenneth 36, cohabitation with Kelly 18 years.)

6.3.3 Factors that prohibited women from changing physical activities

More than half the participants discussed why it would not be possible for them to exercise together as a couple. The woman's inability to do a similar level of exercise as the man, such as walking, was implied or explicitly expressed by many of these participants. In most of these cases, the woman did not join her partner in his physical activities.

Twelve women in this study did not change their physical activities as a result of their partner attending FFIT. Several women who described not changing their physical activities had been exercising prior to their partner joining FFIT and continued with what they were doing. However, a small number, who described themselves as physically inactive, remained so even after their partner started changing his physical activities. Some of these women appeared to be uninterested in making any changes even when their partner encouraged them to do so, while others were unable to make the changes. The factors that participants described as inhibiting the woman's physical activity changes included the man's lack of desire for coactivity and the woman's own perception that she would inhibit the man's attempt by being *coactive*, the woman's practical or physical inability, and her lack of desire to increase physical activity.

Most participants' descriptions of the issues that prohibited women from increasing their physical activity in general, and coactivity in particular, were suggestive of being guided by their gendered perceptions and expectations. Some examples include, the women putting the man's needs first, and only doing what would benefit him, and men expecting that women would provide them the autonomy they required. Additionally, for many of these men and women, their lack of desire for coactivity also appeared to be rooted in the gendered perception that the women would be physically weaker than men.

6.3.3.1 Discouraged by men's unwillingness to involve them, or due to the perception that they would inhibit men's attempts

Although not specifically raised by participants as a reason for why some women did not increase their physical activity, a number of *Resolute* men and their partners talked about how the man preferred to exercise alone and did not want the partner to join him. Most suggested that the partner being slow might hinder both the man's attempts to achieve certain levels of physical activity goals, and discourage the woman. Lorna, who did not increase her physical activities after her husband joined FFIT, described how she was considerate of the differences in their abilities to walk at the same pace and therefore did not join him.

Every day, "have you been for a walk?" When he comes back from his class [...] I don't walk enough to be honest [but would join him for walks] I think if he got me persuaded to go, but he'd have to go back to the, not walking so fast [...] So he's kind of not in that zone any more, he's like, "oh no, I'll have to hurry, away from you". (Lorna 64, cohabitation with Paul 44 years.)

A few of these couples were purposely not *coactive*. This was not only because it might have a detrimental impact on the man's ability to be physically active but also because the personal space which he got while exercising on his own was important.

I like if he goes out [for exercise] on his own, he's got to have his own life. (Sandra 61, cohabitation with William 44 years.)

Although the partners did not always agree about how they felt about each other's need for independence, these men and women talked about how exercising provided the personal space for men that they needed.

Because I do my thing and Dawn does her thing [...] As I say, because we're individuals in this relationship it's just, it was all about me losing the weight. (Mark 53, cohabitation with Dawn 9 years.)

The above excerpt from Mark, who was *Non-Responsive* to the support that his *Very Involved* partner provided for physical activity changes, represents a deviant case with regard to a *man* emphasising the detachment from each other's attempts. However, many other men and women who were responsive

and/or involved in each other's attempts to make changes also suggested the preference for personal space gained by exercising separately. In most of these cases, they described it being good for the man, despite their accounts suggesting that the lack of coactivity could have had a negative impact on women's motivation to increase physical activity after the man joined FFIT.

6.3.3.2 Women's inability, or lack of desire, to make physical activity changes

Some participants described factors other than the man's lack of interest in coactivity that prevented female partners who were described as wanting to increase their physical activities from being able to do so. This group included Kelly, Judith and Sarah, whose health conditions prevented them from increasing their physical activities.

ST: The frequency of you going cycling...did that change after FFIT?

To begin with, it probably changed that I'd go more but my health problem [doctor had advised] that I need to cut back to what I was doing which then impacted what I'd do. (Kelly 34, cohabitation with Kenneth 18 years.)

Scot is very active and I'm not [...] But I could barely walk right fae here out tae the bucket [place at other side of the room], it hurts my knees, eh? But I just have to live wi' that. (Judith 61, cohabitation with Scot 33 years.)

For a few couples, issues such as childcare arrangements or long working hours prevented them from increasing their physical activities together as much as they would have liked to.

She'd come walking wi' the dog every night if she could but not always finished [her job]. It's just her job, it's very tiring. (Jeffrey 57, cohabitation with Laura 5 years.)

The reason I was not doing it I was working morning to evening, by the time I got home I was too tired. (Sandra 61, cohabitation with William 44 years.)

The only woman who appeared uninterested in changing physical activities despite the man's encouragement was Hillary. While she did not give reasons other than her lack of interest, her partner, who was *Resolute* and did not want

to be coactive together, described her lack of interest despite his attempts to encourage her to be active on her own.

I'm no good gym-wise, I don't go to the gym wi' him [...] he come up and he said to me "There's a ladies night as well if you want it." I said "You know me wi' the gym." Because years ago I took out a gym membership and I think I used it about three times [...] when Richard worked [some years ago], I used to bring out my Wii Fit and use that. (Hillary 67, cohabitation with Richard 42 years.)

I'd have wished she'd have maybe taken up some of the activities. And she'll no' do it, she just won't do it. [...] Oh I've asked her many a times. I've asked her manys a time, and she just won't do it.

ST: How does she react to you when you asked her?

"You do your thing and I'll dae mine." It's as simple as that. That's it, that's the reaction you get. (Richard 67, cohabitation with Hillary 42 years.)

6.4 Chapter six summary

This chapter presented accounts of men and their partners about how the female partners' dietary practices and physical activities were influenced by the men's participation in FFIT, and the mechanisms which influenced how this occurred.

Similar to the practice-based differences in partner influence discussed in the last chapter, the findings in this chapter also highlight differences in influences on women's changes in respect to dietary practices and physical activity. Changes to dietary practices mostly represented an improvement on pre-existing practices that a lot of men and women were already doing together. Therefore, changes made by or for the man automatically impacted both, regardless of who was making the changes. In contrast, physical activity in general, and coactivity in particular, for most couples was something they were newly adopting after the man had joined FFIT.

The findings show that regardless of a woman's level of involvement, and a man's level of reliance on her for making changes to dietary practices, for most women, at least some aspects of their dietary practices were positively

influenced after the man joined FFIT. This included changes to main meals for most women, and snacking and drinking habits for some. These findings suggest that the mutual nature of food practices amongst cohabiting couples meant that one partner's attempts to change could make an unhealthy partner become healthier through active involvement or a ripple effect.

The *Resolute* men, who were practically involved in family food practices and encouraged their partner to adopt the healthy dietary practices that they were following, appeared to influence changes in their partners' dietary practices regardless of the women's level of involvement. The partners of *Reliant* men who practically supported men by adopting healthier dietary practices changed their own dietary practices in the process, sometimes with the intention of being healthier or losing weight, and other times due to the ease of preparing the same meals for both. These women were also more likely to endorse strategies recommended in FFIT for men. The *Not Involved* women whose partner was either *Non-Responsive* or not primarily involved in the food provision for the family did not appear to have changed dietary practices.

While the partners of *Resolute* men changed some aspects of dietary practices, whether it was intended or not, no such changes were apparent for physical activity. Indeed, most *Resolute* men did not encourage their partners' involvement for physical activity changes, and in turn, they not only inhibited women from being practically involved in men's physical activity changes, but possibly also reduced the opportunity for women to increase their physical activities. However, the *Very* or *partially involved* partners' of receptive men increased their physical activity due to the men's encouragement for coactivity and emotional support, and women's own self-motivation and ability to be *coactive*.

Chapter 7 The influence of men's attempts to change their dietary practices and physical activity on the couples' relationships

7.1 Overview of chapter

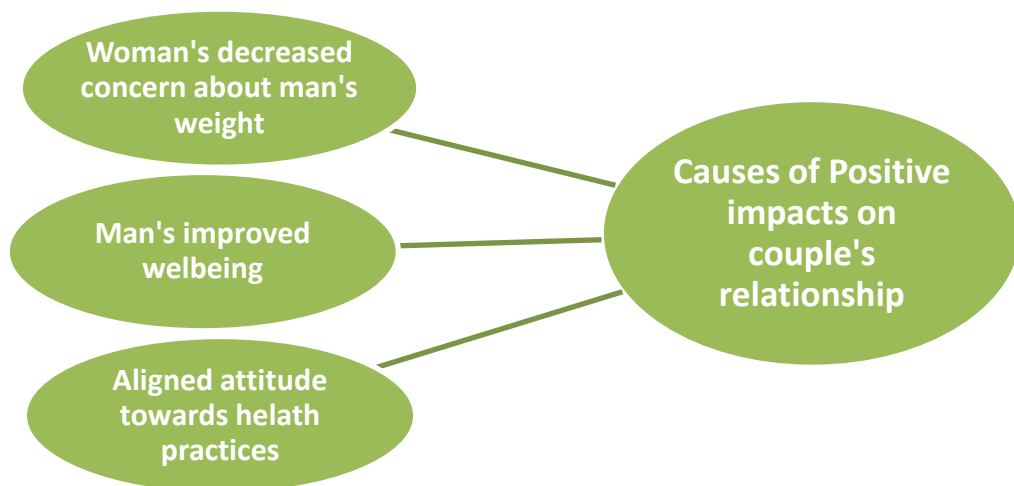
The previous findings chapters presented analyses of how men's attempts to make changes to their diet and physical activities were influenced by their female partners, and how the partners' dietary practices and physical activity were influenced in this process. In addition to the specific influences on these practices, also recurrent throughout the interviews were participants' descriptions of how the process of the man joining FFIT and making changes had influenced other aspects of their lives and relationships. These included positive feelings towards each other, sense of togetherness and care, as well as expressions of frustration or envy. Only a few participants reported noticing no impact on the relationship, and none specifically described a negative impact, despite some tensions and conflict arising from the process.

This chapter illustrates both positive and negative effects of men's participation in FFIT or associated behavioural changes on the couples' relationships. It does so by exploring how the cohabiting couples' context, where partners live in close proximity, with vested interests in each other's wellbeing, evoked sensitivities and tension during the process. It begins with a discussion of both explicit accounts and their implications regarding positive influences on couple relationships when partners attempted to change their dietary practices and physical activity. This is followed by the findings relating to conflicts and tension triggered by men's attempts to make changes and experiences of any weight loss, and how participants navigated a way to minimise the potentially negative impact of those tensions. The chapter ends by presenting a summary of these findings.

7.2 Positive impacts of men's attempts to change their dietary practices and physical activity on the couples' relationship

As discussed in previous chapters, in most couples both members generally demonstrated some involvement in the process of each other making behavioural changes. Men's participation in FFIT and making changes was reported to have had positive impacts on many couple's relationships. Positive impacts on relationships were mostly described by the men and their partner in cases where the man was responsive to the FFIT programme and/or had lost weight. Participants' discussions in this regard were related to the man or both partners being less concerned about the issue of the man's weight, the man's improved wellbeing, and aligned attitudes towards health between couples (Figure 7.1). These were reported to have contributed to the couple's relationship being more pleasant than before and decreased conflicts and arguments about healthy practices in daily life.

Figure 7.1 Causes of positive impacts on couples' relationship



7.2.1 Woman's decreased concern about man's weight

Many women whose partners were successfully adopting healthy lifestyle choices in response to FFIT suggested feeling happier about the man becoming fitter or healthier. While none of the women suggested that their own attempt to be

healthier was aimed at changing their partner's perception of them or to improve their relationship, some said that making changes brought them closer as a couple.

Some men, who talked about their partner's prior concerns regarding the man's weight and health, described the positive influence that his changes had made to their relationship and on her concerns. Many of these men and their partners described being more comfortable about men's weight-related issues, and suggested talking about it had contributed to them being more relaxed around, and happier with, each other.

She is happy that I've lost weight. And she knows I'm not drinking. She was worried about that, (Scot 63, cohabitation with Judith 33 years.)

He used to have [...] sleep apnoea because he'd choke in his sleep [...] that used to worry me. He is not doing that anymore so I think that's because [...] he has been losing weight. (Tracey 53, cohabitation with Shawn 30 years.)

I'm [was] worried about his weight so it was good [...], I could actually see that I didn't have to do anything to get him to continue with it [changes]. He did it all himself. So it made me a bit more relaxed around it [...] I think we're a lot more comfortable with each..., happier with each other. [...] it's made us closer and more, I'm not nagging him about his weight and what he's eating [...] I think on the whole we're a lot... he's happier and that makes me happier as well. (Laura 51, cohabitation with Jeffrey 5 years.)

Other couples described how the process of making changes provided them with an opportunity for sharing and planning, so increasing their communication with each other and helping to make their relationship more pleasant.

She says that when I came in at night I was more communicative; talking about it [exercise], things like that [...] she says "You were more up for talking about things". (Richard 67, cohabitation with Hillary 42 years.)

I think socially [social confidence] has been Richard's greatest benefit out of [FFIT]. Richards's no' a great talker, but he'll always come in and talk [...] he's got something to talk about [...] because he'll come in and he'll talk about what's went on [at FFIT] So it's a great boost in his morale as well [...] if it's good for him then it must be good for us. (Hillary 67, cohabitation with Richard 42 years.)

Many couples who were *codieting* or *coactive*, and so experienced the women's practical involvement, talked about how the process of doing something together, which for most was new, made them feel closer to each other. These participants often described how the man's attempts to make changes had broken the routine they had fallen into over the years.

I think it [his attempts to make changes] has brought us together. We're doing things together now an' we're encouraging one another to do it [...] It maybe sounds silly but I think it has [helped us be closer with each other] 'cause we're doing things more together now. (Andrea 61, cohabitation with Anthony 45 years.)

Some women who did not expect their partner to commit to the programme also talked about being pleasantly surprised by his commitment to making and maintaining the changes. This seemed to have evoked strong emotions in them, which were reflected in the use of terms such as 'proud' and 'amazed'. These women expressed appreciation of their partner's efforts and indicated that this was not just in respect of the behavioural change outcome but also for his commitment to personal growth.

I was quite proud of him, you know, that he was actually sticking to it and he wanted to see it through [...] he did lose quite a lot of weight on it and it's probably the first time in twenty-one years that he's ever actually lost weight. (Sarah 43, cohabitation with Matt 21 years.)

I was delighted, surprised, 'cause he'd done it, he'd found the programme all on his own and just applied for it [...] I was pleased that he was doing it [...] wasn't sure how he would commit to it. But he certainly did commit completely, yeah, he was really good. (Laura 51, cohabitation with Jeffrey 5 years.)

7.2.2 Improved wellbeing in men

Most couples where men made behavioural changes discussed benefits other than weight loss that had resulted. In addition to feeling fitter and more active, many men talked about improved mental and emotional wellbeing. These positive reactions were associated with men's weight loss. In addition, the pursuit of change and the actual activities were described as something pleasant

and the sense of achievement in carrying out the changes was described as bringing positivity to most men.

Just literally a state of mind. It's a positive attitude as opposed to a negative attitude [...] Because it hurts to run 5K at the time. I feel great afterwards 'cause I know it's done. (Luke 65, cohabitation with Mary 50 years.)

He was a lot happier. He was just a lot more relaxed [...] Just being Kevin, I suppose, just being a lot more happier and doing different things [...] And it was just like his eyes lit up. (Michelle 45, cohabitation with Kevin 8 years.)

Many other participants similarly talked about the various ways in which the process of the man making changes had directly or indirectly helped their relationship. This included improvement in intimacy between each other, the man's temperament, and their positive attitude towards their weight and health practices.

He feels fitter, he's losing weight, which is a bonus, and it's continuing to come off. No, he's more relaxed about it [...] he's happier and that makes me happier as well. (Laura 51, cohabitation with Jeffrey 5 years.)

Yes, happier with each other [...] think it's made us better together...we're very open wi' one another... Oh, well, the sex life's improved... I think we're both calmer wi' one another as well. (Jeffrey 57, cohabitation with Laura 5 years.)

Many men also appeared to be self-aware of how the process of making changes had helped them in other aspects of their lives, and the ways in which their partners had directly and indirectly supported their personal growth.

I think she looks forward to me getting out of the house more rather than sitting on computer and not actually doing something [...] I'm a lot more outgoing now (laughs). (Shawn 56, cohabitation with Tracey 30 years.)

As well as getting a result [weight-loss], it's a hobby. It's something for me to do on my own. (Luke 65, cohabitation with Mary 50 years.)

I don't think it [participating in extra physical activities] really bothers her. I think she probably finds I have got a bit more life to myself rather than just going to work, coming home and sitting down watching telly. (Kenneth 36, cohabitation with Kelly 18 years.)

They also described how the man's positive mental health and improved state of mind had directly helped them in their relationship.

I was quite grumpy and the job I was in, I was going through a hard time due to things that had happened so [...] losing the weight, internally helped me feel better about myself and kindaa helped with the stress and pressure that was going on [...] I'm not as grumpy. (Kenneth 36, cohabitation with Kelly 18 years.)

His mood [has improved], because when you eat healthily you are in a better mood [...] the improvement in his mood is good because you know I have a less grumpy husband (laughs) and more happy husband. (Kelly 34, cohabitation with Kenneth 18 years.)

7.2.3 Aligned attitudes towards health practices

Most participants (except some *Non-Responsive* men and their partners) talked about men's changed understanding of healthy lifestyle choices following their participation in FFIT. Many described how this had impacted positively by reducing conflicts between them. As well as the relief women felt from their lessened worry about their partner's potential weight-related health problems, their statements also reflect their positive views around the couple's increased alignment in their ways of thinking about healthy lifestyle choices and their weight.

Often, participants linked discussions about the processes of men changing their diet with either their prior attempts to make behavioural changes or descriptions of their prior eating practices. Many women suggested feeling vindicated once the partner expressed appreciation of her past advice regarding healthy choices.

Definitely positive, because, I think rather than fight against what I was trying to do he agrees with me now. (Lorna 64, cohabitation with Paul 44 years.)

Some women, mostly those who were participating in a formal weight loss programme themselves, spoke about how their partner joining FFIT validated the healthy practices that they had (unsuccessfully) advised him to follow in the past. They described feeling happy about their partner adopting healthy practices. Some also talked about how the process made it easier for them to

make and maintain healthy lifestyle choices as well as improving their relationship, even when the man was *Non-Responsive* and did not change his own practices.

When I started tae diet first it was like, he wasnae congratulating us at all. Kind of put us off. So, I was just going like, excuse my French, I would go “Fuck it, I’m daeing it.”[...] But, then when he went to the [FFIT] programme [...] I saw, like a different side of him. A better person. He wasn’t so narky, like, wi’ me going to my classes [...] he was just no’ thinking about his-self, he was thinking about me at the same time [...] it made us better people. (Dawn 42, cohabitation with Mark 9 years.)

Like Dawn, many women reported that they perceived the man’s personal thriving as reflected in his improved demeanour.

He probably sticks to things more now. He knew he could do that [FFIT] and he’d probably go and do something else if something came up. (Barbara 60, cohabitation with George 34 years.)

He feels stronger, fitter, lost weight. I think it was good for him, to have a healthier lifestyle and its better for him because he feels better about himself [...] He is quite proud of himself. (Sandra 61, cohabitation with William 44 years.)

Jason and his wife Nicole talked about how both of them trying to adopt healthy eating practices had reduced arguments by making them want similar meals. Their accounts were suggestive of how eating similar meals did not just mean mutuality in a practical sense but also good understanding of and respect towards each other’s choices.

It [codieting] means we’re no’ fighting against each other to see who wants to buy a take-away (laughs) Most of our arguments were about, “I want a take-away tonight”, and “no I want to cook something”. (Jason 35, cohabitation with Nicole 4 years.)

[FFIT] it was just kind of reinforcing what I was trying to do, which was nice ‘cause he, now he was kind of trying it as well. Not Slimming World but he was trying to eat a little bit healthier [after joining FFIT]. So probably lessened little snippy arguments [...] about what we were eating. (Nicole 30, cohabitation with Jason 4 years.)

Nicole during her interview also suggested that, although on one hand her husband’s participation in FFIT increased the complexity around arrangements

for her own exercise, on the other it made it easier for her to carry on due to his increased understanding of her efforts.

Because it's always looking for someone to look after [son] so, like, if there was a class on that I wanted to go to and Jason was away with work for example, I just couldn't go. So now he's into the gym it's a lot easier 'cause he understands 'cause he wants to go and I want to go. So we just have to take it in turns. (Nicole 30, cohabitation with Jason 4 years.)

Some couples in which the partner was following a different dietary plan also talked about working together to establish dietary practices that would be suitable for both, when ideas for healthy eating practice in the slimming plans that the woman was following contradicted with those of FFIT.

Some of the stuff did maybe conflict wi' what Slimming World does as well. But actually there wasnae a huge debate on it, it was more, this is what I've been told and this is what you're doing, so we'll figure out a way in the middle somewhere. (Barbara 60, cohabitation with George 34 years.)

Some of the men whose partners were involved in helping them make the changes suggested that the partner fulfilling his expectation of her support avoided the friction that could have been created between them if she had not. Joseph, who was *Reliant* on, and appreciative of, his *Very Involved* partner, described how the process of change did not evoke any conflicts in his relationship. However, he recognised that this might not have been the case had circumstances been different.

If she's not happy doing it [making changes to his diet], I wouldn't be happy she's not doing it. So, it could cause friction, but it doesn't. When I explained to her what I wanted, what to eat, what to try and cut down, she's fine with that. (Joseph 70, cohabitation with Tricia 40 years.)

7.3 How couples navigated ways to minimise the impact of potential conflicts and tensions provoked by men's attempts to make changes

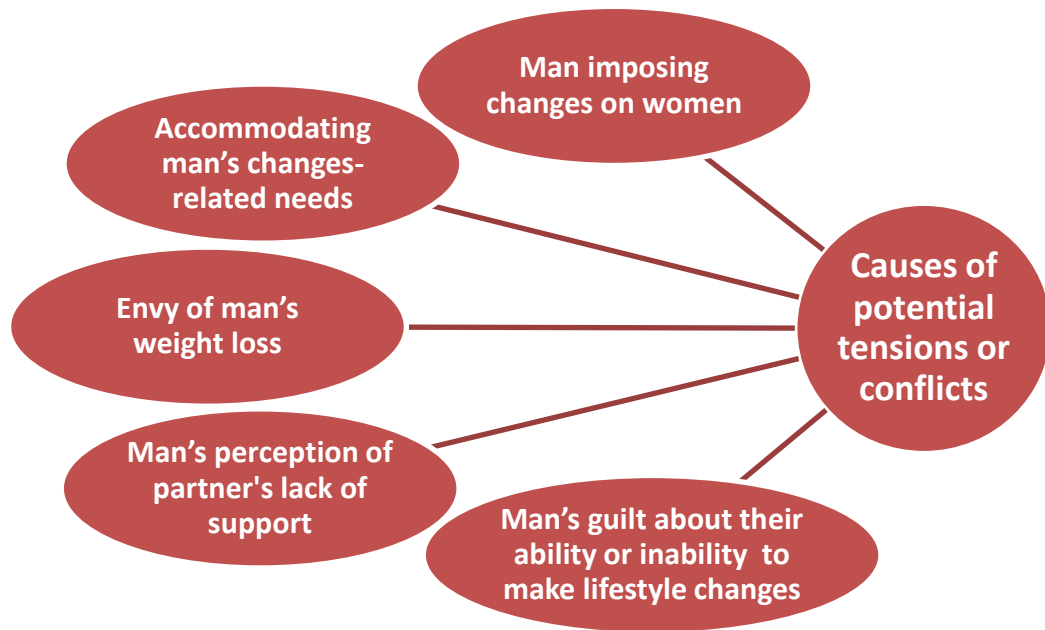
As previously noted, the interviews highlighted that some health-related practices, especially eating practices, are often ingrained in subtle aspects of the day to day life of cohabiting partners. For example, buying certain foods out

of habit, always eating snacks while watching television, a certain couple member taking responsibility for certain tasks, could be a normal part of their daily routine. Several participants in this study described the man's attempts to make changes to dietary practices and physical activity, as disruptions to some of their established routines.

Most participants in this study described the process of men's attempts to make changes as having had either a positive or no impact on their relationship. None said that the FFIT process had a detrimental impact on their relationship. However, a few talked about how some elements of the process had resulted in some conflicts and tensions between the man and his partner. Although conflicts and tensions were mostly discussed by couples where the men did not achieve their weight-loss goals, a few participants brought these issues up even where the man had lost weight. These tensions were related to men imposing changes on their partner, the inconveniences caused in the process of accommodating men's change-related needs, the partners' envy of the men's weight loss, the men's perception of partners' lack of support, and/or men's feelings of guilt about their ability or inability to make lifestyle changes (Figure 7.2).

Importantly, most participants who discussed the tension also described a number of ways through which they prevented any potential negative impacts on their relationship or the attempted changes. Mostly, these efforts arose from their consideration for each other and the fact that they were working towards a goal that could benefit both of them. This section provides an overview of the factors that led to tensions between partners and also the negotiations they made to make sure the changes would work for them as a couple.

Figure 7.2 Causes of potential conflicts or tensions on couples' relationship



7.3.1 Men imposing changes on women

Almost one third of the men and their partners in this study described how the partner was unhappy when there were clashes of ideas about healthy lifestyle choices and the man had tried to impose changes suggested by the FFIT programme. These conflicts were recounted mostly in relation to dietary changes, and reflected a gender role reversal and clashing of gender expectations. Both men's and women's remarks in relation to this suggested that men's additional involvement in making dietary changes could have been seen by women as a reversal of gender roles in family food provision, where women were the custodian of the practice in general. For example, men described how their partners used the terms such as 'lecturing' or 'nagging' that are often used to describe women's behaviours, and to emphasise that these were not always welcomed by them.

In the following extract, Matt suggests that his partner was unhappy when he asked her to adopt the changes he wanted to make with regard to dietary practices. Matt talked about how his partner did not change her unhealthy snacking habits and further described how, although he was not happy about still having to buy unhealthy snacks for her and their children, he did not want to

impose the changes that he was making on her and thought she needed to change herself.

Not argument, as such, but just maybe tension where I've maybe passed a comment and "you should try that or try that" and then Sarah would say "gonnae stop lecturing us, just 'cause you go to this class" [...] I always just felt as if I was trying tae help and just change the eating habits of the family [...] Sarah might bring something in and I'll say "have you actually read this [label]?" And she'll say "right," in a nice way, saying, "look, stop lecturing me" [...] I still bring in stuff that's specifically for Sarah and the kids [...] Sarah's going "there's no chocolate biscuits in the shopping, what's happened?" [...] Cause she's quite strong-willed and I wouldn't, as I said, I'd like it to happen subtly, rather than she feels as if she's being lectured. (Matt 44, cohabitation with Sarah 21 years.)

Similarly, Scot talked about how he attempted to encourage his partner to adopt the changes that he had made. While his efforts to change her practices reflected his care towards her, he also hinted at his frustration about not being able to influence her, and how that had increased arguments and tension between them.

I wish she would be able to do more and lose weight. [...] I know how good I feel now. And I just wish she could take some of that and feel a bit better in herself, but [...] It's hard to give encouragement, right, when you get accused o' - it's like I get accused o' nagging [...] we were talking about something the other week and she says "There's nothing I can do about it" [...] I went "So it's never gonnae change then? It's always gonnae get worse? 'Cause it's not gonnae get better, 'cause you think there's nothing you can do about it?". You know? (Scot 63, cohabitation with Judith 33 years.)

During her interview, Matt's wife Sarah talked about continuing to buy unhealthy snacks and recognised that her partner's attempts to encourage her to adopt healthy practices were positive. However, a few other women expressed frustrations over not being listened to for many years when they had asked their partners to eat more healthily, and the man was now trying to educate them about healthy practices. These women's remarks were also suggestive of how they were not happy about this role reversal, where the man instead of them was upholding the family health issues.

He was telling me everything. And, I'm going like that, "Shut up. I already know that. Shut up." [...] he would go on about something and,

“Oh, look at that, read that.” And, I’m going, “I know that.” “No, you don’t know that. Look.” (Dawn 42, cohabitation with Mark 9 years.)

7.3.2 Accommodating men’s change-related needs

Some men suggested that they thought their partner was unhappy about them taking the time away from home to exercise. When asked if the changes that he made brought about any arguments, conflict or tension between him and his partner, Kenneth described how he recognised possible tension with his partner and how he tried to deal with it.

Probably to start with [there was tension] because I was out, there was times that I’d maybe be [out every evening for work, FFIT or other physical activities] she would not see me any night of the week and she was moaning because I was never there [home] after a while I knew myself I was probably doing too much, I’d just say do you mind if I play football tonight and she would be yeah on you go, ‘cause I’d then at least given her the option to say no. (Kenneth 36, cohabitation with Kelly 18 years.)

A few women described the difficulties for themselves created by the man’s additional exercising commitment, for example, additional childcare responsibilities or other commitments in the household. Kelly highlighted how she would always try to appear supportive of her partner by hiding any resentment towards his additional time away from home. Throughout her interview, she suggested that her partner’s perception of her being supportive was as important as the practical support she would provide.

Trying not to moan that he is off out again (laughs) for exercise I think, you know, “oh I have so much to do in the house”, and yeah just being accepting of him having that other aspect of his life [...] I am really trying not to do that [moan about him taking time away] so much, and you know, in my head, ‘Oh really! Do you, do you need to go for the fourth night out or something’, and that’s just the selfish side of me talking. [...] Outwardly I try to encourage him so, I am not sure that he is always aware that I am feeling that. (Kelly 34, cohabitation with Kenneth 18 years.)

Lisa, who said she felt pleased about her partner’s weight loss and happy about taking responsibility for making changes for them both, also expressed awareness of the extent of her contribution and frustration of the strain it had on her personally and not her partner. Both she and her partner noted tension

with regard to whether her support for him had any detrimental impact on her own desired outcome from *codieting* and *coactivity*. She emphasised how it was easier for her partner to exercise and achieve the weight loss goal because she was helping him. She suggested that the support she was providing for him made it challenging for her to achieve her desired weight loss.

He's gone to FFIT Fans and he's kept up his exercise and his diet [...] he's seven stone lighter now than he was when he joined FFIT Fans. In order for him to do that all he's had to do is go to his work and go to the gym. Everything else has been done for him. So it's not been a challenge for him apart from getting body into the gym. He's had the luxury of having somebody that's done it all for him [...] For me it's a challenge because I have a full-time job, I have to juggle that wi' then practically shopping every day because the amount of fruit that I have to buy to keep up with the amount he eats. I ha' to shop every day. I'm coming home, I'm having to cook fae scratch [...] it's been more of a challenge for me than him. (Lisa 51, cohabitation with Jeremy 10 years.)

In his interview, Lisa's partner Jeremy suggested that he could not understand why she was less successful because she was doing the same things and implied disagreement with Lisa's argument that her having to help him made it difficult for her to lose her own weight since they were doing the same amount of exercise.

She kinda feels that she's not as successful at it [losing weight], for some reason, because of the support she gives me. Which I can't quite understand 'cause she spends the same amount of time doing it [exercise]. (Jeremy 47, cohabitation with Lisa 10 years.)

All (three) young couples with childcare commitments in this study also indicated facing some practical difficulties with daily routines due to the male partner's participation in FFIT. They discussed how the partner would happily deal with the inconvenience to allow the man the time and space he needed, but these partners also emphasised the extra effort needed to accommodate it.

He was playing football every Tuesday and [my] Slimming World class is on a Tuesday. So I used to just have to take [son] with me and it was fine [although] it was annoying (laughs). (Nicole 30, cohabitation with Jason 4 years.)

7.3.3 Envy of men's weight loss

Some men and a few partners discussed the woman's envy and frustration as a negative effect of men's attempts to make changes. This was mostly discussed by participants where both partners were trying to make behavioural changes and lose weight. These participants spoke about how the man was able to lose weight more effectively than the woman. Those women who were *coactive* also perceived that their partner was able to benefit more from the same exercise and expressed their frustration. For example, Lisa described how she felt envious of her husband's success in losing weight while doing similar kind of exercises as her.

We don't tend to argue [...] Frustration's probably the word when he's losing and I'm not but we're doing the same sort of thing [...] He'll tell me that I'm not losing weight every week because I didn't come out the gym sweating and my clothes are soaked [...] I perceive that it's easier for a man to lose weight because - for whatever reason, they seem to be able to do more physical activity than women. (Lisa 51, cohabitation with Jeremy 10 years.)

No' a competition, but we always do, you know, comment [...] We eat the same meals and he could maybe lose a stone in a month or so, and I would maybe lose a pound. (Hillary 67, cohabitation with Richard 42 years.)

I probably felt guilty as I wasn't losing weight as quickly as him, or jealous. (Barbara 60, cohabitation with George 34 years.)

Men also seemed to be aware of the sense of frustration and jealousy from their partner who was also trying to lose weight but was not able to achieve as much weight loss. During his interview, Barbara's husband George stated that although his wife '*was quite happy [that he] was losing weight*', he mentioned that she might be jealous of the amount of exercise he was able to do because of his retirement while she was still working. Similarly, Shawn and Kenneth also described their awareness of the partner feeling bad or jealous of their weight loss.

She's been a bit jealous about it [my weight loss] she also wants to do it. (Shawn 56, cohabitation with Tracey 30 years.)

She moans about herself and her weight but there is not much she can do about it so when I'm losing weight obviously she's feeling bad in herself. (Kenneth 36, cohabitation with Kelly 18 years.)

7.3.4 Men's perception of partners' lack of support

A few men in this study talked about a lack of support from their partners, mainly in respect of practical aspects of the dietary changes they wanted to make, such as women bringing unhealthy snacks into the house and continuing to cook unhealthy foods. This was reflected in the way these men described various incidents or ways the partner was not following the changes as the man would have preferred. For example, Scot, who was the main cook in the household, talked about how he was not happy about his partner not cooking healthy options he had bought when she was preparing family meals.

She wouldn't cook, like, two different types of veg [...] we have a lot of problems at evening meals. You know, it might not be ready, it might not be cooked at all, or "I didn't know what you want" [...] I thought 'Well, everything you can cook is... you can cook fae frozen, you can do that. (Scot 63, cohabitation with Judith 33 years.)

These kinds of descriptions of frustration over the lack of support from their partner were suggestive of tensions created due to the unmet gender expectations of woman's role as a supportive partner, that was perhaps taken for granted.

In cases where the woman was *Partially* or *Not Involved*, some participants' accounts suggested that while she was neither intentionally nor consistently unsupportive, some of the actions of these women did not support certain aspects of the dietary changes that their partner was attempting to make. For example, Judith had a different perception to that of Scot around her not preparing healthy meals for him.

He likes all this different foods now and I don't. [son] doesnae like what we're having, so it's like making three meals and it's annoying [...] Scot makes a meal and if nobody likes it, that's tough [...] I do try to cook, but I'm a basic cook [...] And he'll say, "Oh, could you no' put a bit of something in that." I said, "You could do that once it's cooked, that's the thing..." [...] he does moan sometimes about my cooking. (Judith 61, cohabitation with Scot 33 years.)

A few *Reliant* men whose partner was primarily involved in preparing food for the family complained that she continued to serve more food than they wanted to eat, and suggested they were unable to refuse foods served to them even though they knew it was not healthy. However, the partners of some of these men shared conflicting accounts suggesting that the man would complain about not getting enough to eat when he was served smaller portions. Dawn, Laura and Lorna said that if they were to serve smaller portions, their partner would not be happy even though he had suggested cutting down the portion sizes. Thus, these couple members had conflicting perceptions around the support provided by the woman.

She'll make me say two Lorne rolls and two black pudding. So I'll have that breakfast [...] But, I've said to her, "That's too much." [...] I've been brought up where you never left the table 'til you emptied the plate..... Aye, you force yourself at times to finish [...] I've says on many occasion, "That's too much" I honestly dinnae [understand why she gives bigger portions]. (Mark 53, cohabitation with Dawn 9 years.)

For a while I was cutting out, like, the chips [...] And, he went, "I'm fed up eating tatties and whatnot." And, then, I bought one o' they air fryers and, God, he went, "Your chips arenae cooked properly. (Dawn 42, cohabitation with Mark 9 years.)

I'll you know dish up the dinner at night and he comes and he'll go, "is that it then"? And I go, "yeah" [...] he goes away and then he comes back and I'll, he'll say "is there any left"? "No". (Lorna 64, cohabitation with Paul 44 years.)

7.3.5 Men's guilt about their ability or inability to make lifestyle changes

While most participants described how aspects of their relationship had a positive influence on behavioural change attempts, a small number reported some relationship factors, such as consideration for partner's feelings, and their own feeling of guilt could negatively influence their attempts to make healthy lifestyle changes. These men talked about how their partner's inability to exercise impacted them when attempting to increase their own exercises. These men did not explicitly express that these concerns inhibited their ability to make changes, but described a sense of discomfort and guilt they felt while making

positive changes only for themselves or when not being able to make the expected changes. For example, Matt, whose wife Sarah had to limit her exercise due to health problems, described how he felt the need to be considerate towards her, in order to avert a potential tension, when he increased his physical activities.

I feel better about myself [but] because she's no' been able tae exercise as much [...] It's probably harder for her [...] she would love to be able tae do her aerobics and she feels that she's put on weight because she's not been able to do it and her back's been bad, now, for about a year and a half, so, but I don't think there's any fights, as such. And, as I said, I now go to the gym at half five in the morning and there's not a "I'm going out to exercise". (Matt 44, cohabitation with Sarah 21 years.)

In his interview, Matt talked further about how he tried to exercise discreetly so that his partner was not as aware of it. Similar to some other men whose partner was not able to exercise, he described how he needed to be considerate of his (supportive) partner's feelings about being unable to increase her own physical activity.

Participants often referred to the number of years they had been together to suggest that they had a good understanding of each other. Some talked about how they were considerate about trying to influence their partner in a way that would be most effective and would not cause any tension in their relationship. Anthony's statement below reflects the way many men and women talked about being sensitive towards their partner's independence and personality, whilst still being involved.

I mean we're forty-five years together now, I kind of know that I can't push that way or prod that way, or I've got to put something on the table and draw it back where she can say, "Right..." It's got to be her, she's got to want it, Me, I'll just go ahead and do it[...] maybe discussing wi' Andrea, but I'll just, "This is what I'm doing [...] I'm, I'm not berating her. I'm not whipping her. She'll make her own choice [...] Because I know her, she knows me. (Anthony 63, cohabitation with Andrea 45 years.)

Similarly, William described planning his physical activities by factoring in the time that his wife might want to do something together as a family to avoid any conflicts.

I always worked around it [other family activities], [...] she maybe wants to do [other] things together, so, I work it around whatever she wants to dae. (William 63, cohabitation with Sandra 44 years.)

Ryan recounted how consideration of one partner's feelings may sometimes lead to the other not being able to make changes or be open about self-perceived failures, as he repeatedly discussed his clandestine noncompliance with the changes that he let his partner believe that he was making. His remarks throughout his interview suggested his awareness of partner's desires for him to make changes, and his desire to keep her happy, despite being *Non-Responsive*.

To be honest I'll eat it [healthy food], but then when she goes for a bath I'll go and get something else[...] step goals, I would make, certain steps I would drive and I didn't take it [pedometer off], so it went up [...] Some goals I made, some goals I didn't, so. I didn't tell her when I failed the goals. (Ryan 31, cohabitation with Amanda 8 years.)

Additionally, similar to some other men who described their preference for participating in FFIT alone, he also described that his desire for an autonomous attempt to make changes was guided by his consideration, such as perceived pressure to meet expectations from the partner. In this regard, while on the surface it appeared that most men preferred to take on the weight loss attempts autonomously for their own benefit, Matt's remark below indicates how the value men placed on their ability to lose weight went beyond a health implication. In his remarks, Matt, who said his motivation for joining FFIT was his way of putting effort into his relationship, illustrates his consideration for his partner's perception of him as well as a strong emotion it could evoke for herself.

I would like to exercise more wae Sarah, but the problem is, I don't know, if you go together, then you don't want to be part of the other people's disappointments. So I can go, and if I've put on weight, the guy beside me would say 'och well' whereas I wouldnae want to feel as if I'd let her down and she might be the same, if you're not right into it. (Matt 44, cohabitation with Sarah 21 years.)

7.4 Chapter seven summary

The findings from this study illustrate how cohabiting couples make changes to dietary practices and physical activity in a mutual context with each partner being involved, either intentionally or not. Both members can be impacted by each partner's commitment towards the changes. This chapter explored how factors associated with making behavioural changes impacted couples' relationships.

The findings presented in this chapter highlight both positive and negative impacts of men's participation in FFIT, associated behavioural changes, and weight loss outcomes on the couples' relationships. The close and caring nature of couple's relationships meant that, on one hand there was a positive impact of the process on most couples (rather than just on men), which was important to them beyond the direct benefit of the FFIT programme. On the other hand, the process of making changes also gave rise to some tensions and conflicts, and the couple members had to work towards alleviating any potential negative impacts of these tensions.

Implicit references to partner's care and consideration for each other ran throughout most participants' descriptions of support and involvement. This was apparent in their discussions of both the positive impacts of the process on their relationship as well as their attempts to reduce conflicts with each other. Most partners talked about women being less concerned about men's weight and pleased about his attempt to address his overweight and obesity following his attendance at FFIT, men being happier about their own pursuit of changes as well as their ability to achieve their goals, and the couple having more similar attitudes and perceptions of healthy lifestyle choices. These factors contributed to an improved relationship in most couples, along with a sense of togetherness through coactivity and codieting for many.

Along with the positive impacts, some participants also highlighted potential sources of conflicts and tensions in this process. Some men's attempts to encourage their partner to adopt healthy practices, the partner's efforts to

accommodate the changes, some partners' sense of envy of men's greater weight-loss compared to their own, men's perception of the partner's lack of support, and their feeling of guilt and the need to consider their partner's feelings while making (or not making) the changes were described by some participants as sources of tensions in their relationship.

These findings highlight the complexities as well as opportunities inherent in making and maintaining health behaviour changes in a cohabiting context. These include negotiations and compromises required to minimise the impact of conflicts and tension, as well as the unintended positive impacts of the process on couples' relationships.

Chapter 8 Thesis discussion

8.1 Overview of the chapter

The aim of this study was to investigate how men's attempts to change their dietary practices and physical activity to lose weight and maintain weight loss are influenced by, and influence, their cohabiting female partners. The following research questions were developed in order to address the aim:

1. How do cohabiting female partners influence men's attempts to change and maintain their dietary practices and physical activity?
2. How do men's attempts to change and maintain their dietary practices and physical activity influence their cohabiting female partners' dietary practices and physical activity?
3. How do the processes of men's attempts to change their dietary practices and physical activity positively or negatively impact the couple relationships?

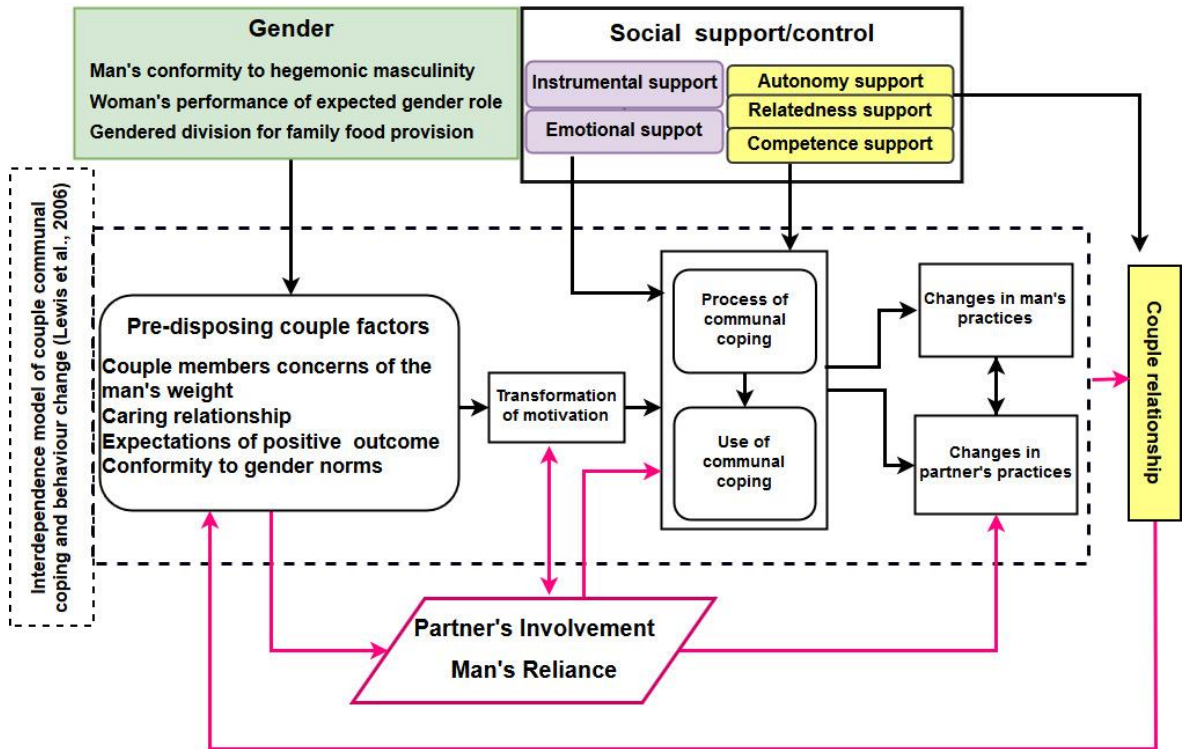
To answer these research questions, this study explored the perceptions and experiences of cohabiting couples as men attempted to make changes to dietary practices and physical activity following attendance at the men-only FFIT healthy lifestyle programme. The specific foci were on how cohabiting female partners influenced men in this process, and how the female partners' dietary practices and physical activities, as well as the couples' relationship, were influenced in this process.

By considering separate accounts from each partner in a sample of 20 couples, this study has identified a range of ways through which pre-disposing couple factors, and the female partners can impact the practices and processes of men's attempts to change health behaviours in a bid to lose weight and maintain weight loss (Chapters Four and Five). The study also explored how the processes of men's attempts at weight loss and weight loss maintenance influenced partners' dietary practices and physical activity (Chapter Six). How the process of making changes to health practices in the cohabiting context affected

individual partners, and the couples' relationship positively, and how the couples dealt with any conflict or tension arising during the process were also explored (Chapter Seven). This final chapter discusses some of the key findings of this study in relation to the overarching research questions as well as relevant existing theoretical and empirical literature. The strengths and limitations of the study are also considered in relation to both its empirical contribution and the research methods used. Finally, this chapter concludes by discussing the potential implications of this study for the development of weight loss and weight loss maintenance interventions for adults, and suggesting potential areas for future research.

Figure 8.1 outlines the integration of several theoretical perspectives, including theories related to Self-determination, Social Support/Control, Gender, and the Interdependence Model of couple communal coping and behaviour change (as presented in section 2.3), which are used to discuss the findings from this study. Additionally, the discussion will also consider how the concepts of *Involvement* and *Reliance* (developed in the current study) help explain the variations in, and the reciprocal nature of, partner influence on men's attempts to make behavioural changes, and each partner's behaviour change outcome in the cohabiting couples' context. The multi-dimensional role of, and impact on, the couple relationship in this process is also drawn out. Elements of this synthesis are discussed throughout this chapter as they relate to the findings from the current study.

Figure 8.1 Synthesis of the theoretical perspectives around gender, and social support integrated with Interdependence model of couple communal coping and behaviour change. Different colour boxes are used to indicate derivations from different theoretical concepts.



Green box = theoretical concepts derived from Gender theory,
 Purple box = theoretical concepts derived from Social support/control theory,
 Yellow boxes = theoretical concepts derived from Self-determination theory,
 White boxes within dotted lines = theoretical concepts derived from the Interdependence model of couple communal coping and behaviour change,
 Pink box and pink lines = how concepts developed in this study additionally contribute to the synthesis presented in section 2.3.

8.2 How do cohabiting partners influence men's attempts to change and maintain their diet and physical activity?

8.2.1 The impact of pre-disposing couple factors on partner's influence on men's attempts to initiate behavioural changes.

Chapter Four included participants' descriptions of pre-disposing factors related to themselves or the partner in relation to the man's attempts to lose weight by joining the FFIT programme. The similarities between couple members' descriptions of the circumstances and norms around diet and physical activity practices reflect the long-established routines, mutual understandings and

taken-for-granted everyday activities shared in the daily lives of cohabitating partners. The findings highlighted how despite men's autonomous decisions to join FFIT, they engaged with their partners immediately after their decision. Many men did not always verbalise their need for support, and the provision of partner support was often taken for granted by both couple members.

Concerns from both the man and his partner around the man's weight was a common reason for their positive perceptions of the man joining FFIT. In most couples, both partners recalled having expected that, and been optimistic about, the man losing weight as a result of his participation in FFIT. Men identified both self-centred and relationship-centred motivations for pursuing weight loss. These included the perceived health benefits, general well-being, and potential positive impact on the partner. The women's motivations for supporting men's attempts were driven by their care for their partners as well as the relationship. These findings reflect the *transformation of motivation* from the *man* joining FFIT to lose weight to him making changes that both partners valued and would benefit from. This often led to discussions between couple members on how best to approach the changes. Lewis et al. (2006) suggest that *pre-disposing couple factors*, such as shared perceptions of a health threat, preference for an outcome, relationship functioning, and gender, contribute to transformation of motivation. Transformation of motivation occurs when a partner considers certain threats, or behaviour to overcome those threats, as meaningful for their relationship or the spouse, rather than simply for themselves (Virtue et al., 2015).

Most couples in this study mutually navigated plans for changes in dietary practices and physical activity by sharing information, deciding on what changes were necessary and how the partner could support them. Lewis et al. (2006) describe the process of appraising a problem as 'our' problem rather than 'your' or 'mine' as *communal coping* and suggest that transformation of motivation activates communal coping. The process of communal coping, even before any behavioural changes were initiated, might have helped men in this study fulfil their competence need, which refers to the need to feel one's skills are effective for performing a particular behaviour or feeling confident and capable

(Deci & Ryan, 2000). Particularly for *Reliant* men in this study, optimism in respect of practical support from the partner in the face of their own perceived lack of skills (e.g. for food preparation), could have fulfilled their competence need around initiating their dietary changes.

Additionally, many partners perceived men's participation in FFIT as an opportunity to comfortably address and discuss the sensitive issues of overweight and obesity, and other health issues, that they had not previously been comfortable talking about with the man or providing support towards. This highlights how a health intervention within cohabiting couples, in addition to providing direct benefit to the recipient, can change the couple context by facilitating pre-existing intentions of social support from a partner that otherwise might not be realised.

In this study, some between-couple differences were identified with regard to both pre-disposing couple factors around the practices that men attempted to change, and in approaches to the required changes, such as which couple member was responsible for preparing food for the family prior to FFIT, and whether or not the couple co-dieted. However, there were many similarities across the sample around both issues of support and engagement from the partner, and mutual attempts to overcome the challenges of making changes. This highlights the care and sense of mutuality in close relationships within couples, which may not be evident in other relationships. This mutuality warrants a consideration beyond the individual level motivations in understanding health behaviour changes. Together these findings emphasise that pre-disposing *couple* factors might have a direct impact on the men's attempts to change health practices, and that although they can work in favour of making changes, they may also make them more difficult.

8.2.2 Women's involvement and men's reliance influence men's attempts to change and maintain their diet and physical activity

Couple concordance has been documented for several health behaviours, including diet and physical activity (Falba & Sindelar, 2008; Macken et al.,

2000). However, the evidence in relation to partner influence on *healthy* men's purposeful attempts to make changes to these practices is limited and disparate. Evaluation of the relationship between a partner's level of involvement and man's reliance on support for behaviour change in a cohabiting couple's context is a key gap in the current literature. Within the context of the FFIT programme, the current study presents this relationship with regard to both dietary practices and physical activity

8.2.2.1 Partner's influence on dietary practices

Most partners in this study positively influenced men's attempts to make changes to dietary practices through various support strategies, although to varying degrees. Findings of variations in the level of partner involvement are consistent with prior research also demonstrating varied levels of support from female family members more generally on men's attempts to make changes to their dietary practices (MacLean et al., 2014; Allen et al., 2013). In a study of men of similar age also sampled via FFIT, MacLean et al. (2014) found that on the basis of (only) men's reports, men perceived their partners to have had a range of influences on their attempts to make dietary changes. The findings from the current study are consistent with those reported by MacLean et al. (2014) in regard to how female family members were described as 'facilitative allies' (positive involvement) and 'detached allies' (lack of involvement). Similarly, only very few partners in the current study could be categorised as 'undermining changes' or 'resistant to changes through wanting to feed' as described by Maclean et al. (2014) in relation to a small number of female family members. Although men in the current study discussed being offered unhealthy foods by their partners, unlike the men in Maclean et al. (2014) study, their ability to refuse unhealthy foods when offered by their partner appeared to be influenced by their resoluteness in respect of dietary changes. However, these slight differences between Maclean et al. (2014) and the current study need to be considered together with differences in the nature of men's relationship with female family members, such as a mother or mother in law (included in Maclean et al. (2014) study) and cohabiting partners.

In contrast to the findings of Maclean et al. (2014) who described a small number of men perceiving their partners as ‘threatened’ by the changes and feeling insecure in their relationship, neither men nor their partners in this study described the partner feeling ‘threatened’ by the changes that men were making. Despite some tensions or conflicts (such as, partner’s envy over the man’s weight loss success, or disagreement over changes being imposed) that the couples navigated during the process of making changes, both men and their partners mostly described the changes as having a positive impact on both partners, and the relationship.

The important role and positive influence a partner can have on men’s dietary changes has been documented in many previous studies. However, many have focussed on partners’ influence in men’s dietary changes following men’s diagnosis with an illness (Gough & Conner, 2006; Mroz et al., 2011; Virtue et al., 2015; Winter-Stone et al., 2016; Paisley et al., 2008). Most studies among *healthy* men have only explored men’s perspectives on the partner influence (Allen et al., 2013; MacLean et al., 2014; Mallyon et al., 2010). The current study adds to the evidence by providing both partners’ perspectives on varying levels of (largely positive) influence of female partners on men’s attempts to make dietary changes.

8.2.2.2 Partner’s influence on physical activity

All partners in this study were aware of the health benefits of physical activity in regard to weight loss. The findings show that while partners of *Resolute* men were not *coactive*, partners of *Receptive* men appeared to positively influence men’s attempts to make changes by facilitating them to increase their physical activity by allowing them time to exercise alone, encouraging them, and/or being *coactive*.

Limited evidence from previous studies that have reported the influence of partners on men’s physical activity changes suggest that a partner changing her physical activity (Jackson et al., 2015), as well as providing direct support, such as sending text messages prompting the man to adhere to his physical activity goals (Berli et al., 2016), can be effective in helping men make changes. The

findings from the current study are consistent with this in relation to *Receptive* men. This was the case even when the support provided by partners in the current study was not methodically planned and varied in both level and strategy as in the study describe by Berli et al. (2016).

Not all men and/or partners in this study preferred to be *coactive*. However, those who jointly planned the man's or both partners' physical activity or were *coactive* suggested that these practices helped the man initiate and adhere to increased physical activity. The evidence on couples' dyadic planning for *coactivity* in the existing literature is inconsistent. While dyadic, rather than individual, planning of physical activity change has been found to be effective in the enactment or implementation of those plans for both partners (Keller et al., 2017), research findings also suggest that the couple relationship quality (Knoll et al., 2017) and level of adherence to the goal pursuit, may influence the impact of dyadic planning. Lüscher et al. (2017), in a dyadic daily-diary study among 61 overweight couples, found that one partner's disengagement with their dyadic goal to increase physical activity had a negative effect on the other's attempts.

Most evidence in regard to female partners' influence on men's physical activity changes has come from quantitative studies (Berli et al., 2016; Jackson et al., 2015; Keller et al., 2017; Lüscher et al., 2017). None of these studies provided explanations for *why* men did or did not make changes as a result of partner support. The findings from the current study provide useful insights. Firstly, they provide evidence of the positive impact of (both practical and emotional) partner support in the behaviour change attempts of men who are *Receptive* to their partner's involvement. Secondly, they show that partners' lack of involvement was determined not only by their inability or lack of interest in being *coactive*, but also by men's unwillingness to involve them.

This study also highlighted some exceptional cases in which the partner's involvement had *no impact* on men's attempts to make changes. These men were *Non-Responsive* for both dietary practices and physical activity, regardless of their partner's level of involvement. Self-Determination Theory refers to this

state of lack of motivation for behaviour change as *Amotivative*, and suggests that *Amotivative* people are less likely to respond to any outside support (Ryan and Deci, 2008). The social support literature defines social control as a person's attempt to regulate and influence another's health behaviour, even if the other is unwilling to change the behaviour (Lewis and Rook, 1999). The evidence on the positive or negative impact of social control is inconsistent but it is reported that a partner's support or control *strategies* generally *do* impact on an individual's behaviour change outcome (Lewis and Butterfield, 2005). In the current study, the partners of *Non-Responsive* men appeared to have used various social control *strategies*, but these did not result in the man making changes. These findings suggest that social control provided to an *Amotivative* person will be ineffective, even within close relationship contexts.

8.2.3 Mechanisms of partner influence: a theoretical discussion

As discussed in Chapter Two, the evidence on whether men benefit from partner involvement in their weight loss attempts, or in changing dietary practices and physical activity, is inconsistent. Studies have reported a mostly positive impact of partner involvement for dietary practices (De Souza & Ciclitira, 2005; Golan et al., 2010), and weight loss (Jackson et al., 2015; Gorin et al., 2013), but no impact (Gorin et al., 2013), or negative impact (Cornelius, Gettens, et al., 2016) for weight-loss maintenance. Similarly, both positive (Berli et al., 2016; Jackson et al., 2015) and negative (Lüscher et al., 2017) impacts of partner involvement for physical activity changes have been reported.

The current study shows that one of the explanations for these inconsistencies could be couples' context-based differences that are influenced by their pre-disposing couple factors.

The typology outlined in this study around the '*involvement*' of the female partner reflects the degree of her support. From the male recipient's point of view, the typology developed around '*reliance*' reflects the degree to which partners' involvement is crucial for the man's ability to make changes or whether the provided support is utilised by the man. The findings from this study

revealed that both pre-disposing couple factors, such as couple members' established gender roles and expectations (Lewis et al., 2006), and the nature of the practices being changed impacted on men's *reliance* on partner support. In turn, these resulted in the partner's *involvement* being more or less needed or crucial for the man's behaviour change attempt and outcome. This *involvement-reliance* dimension facilitated the description of how each partner's characteristics, as well as their mutual circumstances, contribute to their unique couples' context that is pertinent to the attempted change of behavioural practices, and the mechanisms that bring about variations in outcomes for individuals from the same or similar behaviour change interventions (Pawson & Tilley, 1997).

Interdependence Theory emphasises that bilateral influences between partners affect the behaviour outcomes for both (Kelley & Thibaut., 1978; Lewis et al., 2006; Rusbult & Van Lange, 2003). The findings from this study that most couples worked together to achieve a goal and mutually influenced each other's behaviours are consistent with previous studies that report mutuality and interdependence between partners in making behaviour changes, where the ability of partners to rely on each other for support impacts the likelihood of adopting and maintaining health-enhancing behaviours (Lewis et al., 2006; Manne et al., 2012; Montgomery et al., 2012; Rogers et al., 2016; Virtue et al., 2015). Pre-disposing couple factors are considered as important foundations for each couples' interdependence on each other. Variations in partner's levels of *involvement* and men's levels of *reliance* in the current study could be viewed as congruent with this, resulting from the pre-disposing couple factors of each couple in respect of each behavioural practice.

The basic tenets of Interdependence Theory and Social Support theory that highlight the impact of dyadic relationships on behaviours and outcomes (Kelley & Thibaut, 1978; Lewis et al., 2002) are also consistent with Self-Determination Theory on the provision of *psychological needs support*. Self-Determination Theory suggests that in aiming to change behaviour in order to achieve a weight loss goal, the focus solely on weight-loss outcome, although important, can overlook the inherent values of the behaviour change practices themselves.

These practices are enacted with extrinsic or less autonomous motivation (Gorin et al., 2014) and therefore might require more support for **autonomy**, **relatedness** and **competence needs**. A growing body of empirical research has provided evidence for the critical role of *needs support* from family members in facilitating health behaviour change, including dietary interventions and weight control (Gorin et al., 2014; Williams et al., 2006). Dyadic studies have suggested that greater autonomous self-regulation of behaviours and positive behaviour change outcomes can be achieved in supportive environments, where one's choice is supported and criticism and control are minimised (Gorin et al., 2017; Scholz et al., 2016). The findings from this study show that female partners provided *autonomy support* in men's attempts to make changes. Despite some men's *reliance* on the partner for making specific changes, the autonomy support was evident in women's positive responses towards the men's decision to join FFIT, understanding their lack of desire for *coactivity* and enabling them to take ownership of the process while also providing practical support.

Consistent with Self-Determination Theory, the partners' direct involvement via *codieting* or *coactivity*, in addition to the provision of moral support, in the current study could be interpreted as being supportive of the men's ongoing needs for *relatedness*. As most men's attempts to make changes to dietary practices or physical activity in this study were *extrinsically* motivated, arising from their weight loss goals and/or desire to feel fitter, the fulfilment of *relatedness* needs might have been instrumental in helping them adhere to the changes they initiated. Although most previous studies have focused on *relatedness* support in relation to group-based physical activity practices (Kinnafock et al., 2014), it is also possible that *codieting* or *coactivity* amongst couples in this study might have fulfilled the relatedness need for men after the FFIT programme in helping them maintain weight loss. Berli, Bolger, et al. (2018) in a study including both treated participants and their partners, found that *joint engagement* was one of the dyadic support behaviours that was related to goal pursuit.

While men in this study were both aware and appreciative of a partner's practical support, they seemed unaware of the purposeful lack of some partners'

involvement. This is consistent with past evidence which suggests that in couples, certain support and control attempts of a provider may go unrecognised by the receiver (Paisley et al., 2008). Previous studies suggest that this ‘invisibility’ of support could actually have helped men due to the lack of potential burden of knowledge that they were receiving such support (Bolger et al., 2000; Franks et al., 2006).

The existing literature has demonstrated the importance of receiving *needs support* from spouses or romantic partners for both dietary change and weight loss, and that needs support operates in distinct ways from other more direct forms of support (Gorin et al., 2014; Powers et al., 2008). These studies show that *autonomy support* from family and friends facilitates weight loss progress and weight loss outcomes even more than direct types of support (Gorin et al., 2013). These findings are supported by the current study, where *Resolute* men were able to make the changes they planned and achieve the goal they attempted regardless of their partner’s practical support. At the same time, many *Reliant* men were also able to make the changes they attempted while preserving their sense of autonomy due to the lack of negative control from partners who were providing instrumental support while being considerate of the man’s autonomy in the process.

In health psychology, most literature focuses on individual regulation of health behaviour, but increasingly it also considers social and dyadic processes. The notion of interdependence has been widely discussed in both psychological and sociological literature. However, there has been relatively little attention given to the Interdependence model in respect of health behaviour changes. Existing theoretical literature relating to *partner support* has mainly considered the perception or *provision* of support (Kwasnicka et al., 2016). Evidence on the benefits of the *receipt* of partner support for health behaviour change is both limited and mixed (Rafaeli & Gleason, 2009). The existing research on behaviour change in the couples’ context has mainly focussed, firstly on identifying and categorising *strategies* that couple members use to influence the other to undertake a health behaviour change, and secondly on investigating the impact of these *strategies* in relation to each other on the health behaviour change

(Bolger et al., 2000; Lüscher et al., 2015). Thus, the influence of close others has been extensively researched in terms of the types of support that can be provided, such as various needs support (in Self-Determination Theory), visible/invisible support, and emotional/instrumental support (Social Support theories). However, less consideration has been given to if and how support is utilised by the receiver. Indeed, how the receiver's *reliance* on the support provided determines its value is an underexplored area in health research. The findings from this study highlighting how men's *resoluteness* or *reliance* on the partner's support impacts their attempts at health behaviour change contribute to this important aspect of dyadic research in cohabiting couples.

The findings from this study could not be explained by using a single theory. The theoretical synthesis (Figure 8.1) is particularly useful for explaining partners' influence on men's dietary practices and physical activity because of the interdependent nature of their lives, gendered social norms surrounding food provision and men's health, and the partners' roles in these domains, and the close, personal nature of couple relationships (Kelley et al., 1983). Additionally, by addressing *actors'* levels of *resoluteness* and comparing two different practices, the current study also shows that one's *resoluteness* may help to overcome the difficulties created by pre-disposing couple factors and that the level of interdependence could vary according to the nature of health practices. Consistent with Allen et al. (2013), Lewis et al. (2006) and Manne et al. (2012), the current study also emphasises that a partner's role and the state of interdependence between couple members in health behaviour change needs to be identified. Due to the nature of cohabiting couple's relationship (long-term and interdependent), these findings are particularly important as current understandings of behaviour change suggest that individual behaviour change goal setting may facilitate the initiation of behaviour change, however it appears to be less useful for sustaining changes in the longer term (Dombrowski et al., 2014).

8.2.3.1 The role of gender in the influence of female partners on men's attempts to make health behaviour changes

Gender is considered an important pre-disposing couple factor in relation to health behaviour change (Lewis et al., 2006). The existing literature related to men's weight loss attempts has reported on how men's conformity to hegemonic masculinity could affect their own health practices (Rothgerber, 2013; Gough & Conner; 2006; Robertson, 2003), and how feminine influences, especially from female family members, may impact their attempts to make changes to dietary practices (Lupton, 2000; Brown & Wenrich, 2012; Maclean et al., 2014).

The current study explored if, and to what extent, gender played a part in female partners' influence on men's dietary and physical activity changes. The findings suggest that gendered roles, expectations and stereotypes have greater impact on partner influence on men's dietary changes than on men's physical activity.

The study found that most of the women were primarily or jointly involved in food provisions for the couple prior to joining FFIT. Many older women in this study considered it their responsibility to look after the man's dietary changes after he joined FFIT, and were *Very Involved* in men's dietary changes. The manifestation of these gender roles with regard to dietary practices is consistent with conventional gender theories and with studies that have reported both decreasing but still evident female prominence in family food provision (Lupton, 2000) and the influence of female partners on men's dietary changes (Brown & Wenrich, 2012).

The findings in relation to men's *resoluteness/reliance* for dietary practices suggested that these were guided by established norms (and in many cases by gender norms) around these practices within the relationship. Most of the older men were *Reliant* on their partner for making changes to dietary practices both prior to and after FFIT. Men who were either involved in cooking prior to FFIT or did not rely on their partners for cooking meals were mostly younger men. The *Reliant* men who appeared to have taken up any new responsibility in the

absence of partner support for dietary practices after FFIT were also mostly younger men. This is consistent with the notion of shifting gender norms and evidence of weakening gendered assumptions of the division of household labour in food provision (Kemmer et al., 1998; Lupton, 2000). This appeared to be particularly important in helping some men become more *resolute* in changing their dietary practices and less dependent on their partner. Although partner prominence in food practices was described as the reason for many men's *reliance* on their partner prior to FFIT, men and women (mostly older couples) who implied that the woman's prominence in food-related practices was guided by their gendered ideologies reported that men's involvement in these practices did not change after FFIT.

Some behaviour change studies in the context of men's illnesses have reported that couples re-negotiated their pre-existing gender roles around family food provisions when men's involvement in food practices increased following the man's diagnosis of a chronic disease, so that feminine prominence in family food practices continued in different forms (Mróz et al., 2011; Mróz & Robertson, 2015). The findings from the current study involving *healthy* men suggest that the rearrangement of family food practices was evident only among some younger men, and that in most couples, food-related gendered practices did not greatly change as a result of men's attempts to lose weight and maintain weight loss. These findings are consistent with previous studies that have found no greater input from men in food provision as a result of their behaviour change initiation for weight loss (Allan et al., 2013; Mallyon et al., 2010). In particular, the findings from the current study concerning *Reliant* men's dependency on their partner for dietary changes echo those of Mallyon et al. (2010), which reported that men conforming to hegemonic masculinity received support from female partners for dieting, which helped them to stick to the weight management programme. Mallyon et al. (2010) further suggested that this dependence, which is conceptually similar to *reliance* in this study, also meant that these men had less control of their own dieting practices, and that this lack of control could make them vulnerable to potential social sabotage from the partner. In contrast to this, *Reliant* men in the current study did not describe any threat of sabotage from their partner. Additionally, the conventionally

masculine idea of men taking control and being independent (Connell, 1995) was evident in the current study by the way many *Resolute* men (including those who received support from their partners for some aspects of dietary changes) described the changes they made in more autonomous ways.

The findings suggest that gender also contributed to the *variation* in partner influence between men's dietary changes and physical activity. Most men (except *Non-Responsive* men) made changes to several aspects of both dietary practices and physical activity. However, the findings reveal that both the level of partner involvement and support, and men's reliance on their support varied for dietary practices compared with physical activity. More partners were *Very Involved* in men's changes to dietary practices, which are associated with femininity and women's prominence, than in their physical activity, which is associated with masculinity. Additionally, even among women who were *Very Involved* for both practices, the degree of involvement and potential influence on men were more evident for men's dietary practices.

Many men were *Reliant* on their partners for making changes to dietary practices, and it was evident that the partner's involvement was essential to these men for making dietary changes. *None* were *Reliant* on their partners for making changes to physical activity. A lot of men described preferring to exercise alone and many women said they preferred not to be *coactive*. The gendered perception that men and women have different physical abilities could have influenced some men's desire to present themselves as resolute in relation to physical activity, and their lack of willingness to involve or engage their partners (Courtenay, 2000). Therefore, unlike the partners of men *Resolute* for dietary changes, who supported those changes by providing both moral and/or practical support, the partners of men *Resolute* for physical activity changes described being purposefully uninvolved, due to the man's and/or their own lack of interest in their involvement. This reflected the women 'doing gender' by being caring, nurturing, and putting their own needs last to help the man. These descriptions also reflected men's and women's performance of gender as they emphasised masculine traits that helped men while also alluding to how the women helped by allowing them to be autonomous.

There is a clear lack of evidence in the current literature when comparing partner support for, and how couple members perceive partner influence on, changes to dietary practices compared to physical activity changes. These differences highlight the importance of considering partner support in each practice separately, as well as the potential impact of gender in this variation.

Overall, the findings from this study could not be explained by using a single theory. The theoretical synthesis (Figure 8.1) is particularly useful for explaining partners' influence on men's dietary practices and physical activity because of the interdependent nature of their lives, gendered social norms surrounding food provision and men's health, and the partners' roles in these domains, and the close, personal nature of couple relationships (Kelley et al., 1983). Additionally, by addressing *actors'* levels of *resoluteness* and comparing two different practices, the current study also shows that one's *resoluteness* may help to overcome the difficulties created by pre-disposing couple factors and that the level of interdependence could vary according to the nature of health practices. Consistent with Allen et al. (2013), Lewis et al. (2006) and Manne et al. (2012), the current study also emphasises that a partner's role and the state of interdependence between couple members in health behaviour change needs to be identified. Due to the nature of cohabiting couple's relationship (long-term and interdependent), these findings are particularly important as current understandings of behaviour change suggest that individual behaviour change goal setting may facilitate the initiation of behaviour change, however it appears to be less useful for sustaining changes in the longer term (Dombrowski et al., 2014).

8.2.4 Differences in partners' influence based on men's weight loss outcomes.

An analysis was conducted to ascertain if there were any differences in partner *involvement* and/or men's *reliance* based on men's success in achieving and/or maintaining 5% or greater reduction in their body weight during or after the FFIT programme. Previous studies have reported both positive (Golan et al., 2010; Gorin et al., 2013) and negative (Wing et al., 1991; Cornelius, Gettens, et al.,

2016) impacts of partner involvement in men's weight loss attempts. The nature of the current study means that the direction of causality cannot be inferred. However, the findings were indicative of a relationship between men's level of *resoluteness* and *reliance* and their weight loss. All *Resolute* and *Reliant/Receptive* men reported losing weight either during FFIT or since the programme had finished. Unsurprisingly most (four out of five) men who had not lost weight during or after the FFIT programme were *Non-Responsive*.

There were differences in the accounts of men and their partners based on whether the men did or did not *achieve* and *maintain* weight loss. Most *Resolute* and *Reliant/Receptive* men were appreciative of their partner's practical and/or moral support and acknowledged that their partner's involvement had a crucial role in them being able to make and maintain the changes, especially to dietary practices. The partners of *Resolute* and *Reliant* men who achieved weight loss as a result of participating in the FFIT programme were more likely to describe the man being motivated, committed and having maintained the changes. These characterisations sometimes appeared to be confirmed by men who also associated their ability to commit by referring to previous successful behaviour change attempts, such as quitting smoking. However, as these interviews were after the fact, it is important to consider that both men who had maintained the changes and partners of these men might have formed their positive perceptions at least in part because of the man's ability to achieve their FFIT goals.

Most *Non-Responsive* men who had not lost weight spoke negatively of their partner's support or efforts. At the same time *Very Involved* partners of men that did not make changes and/or did not lose weight might have criticised the male partner more due to the frustration they felt from their unsuccessful attempt to support him. However, rather than lack of partner support impacting negatively on men's ability to make changes and/or achieve their weight loss goal, it could be that for these men, the lack of feelings of self-achievement and satisfaction resulted in negative perceptions of their partner's provision of support. Some of these men's blame towards their partner for their lack of success could also have arisen because the partner was primarily involved in food provisions for both, so men might have linked their inability to make or

maintain healthy practices with the partners' lack of support regardless of the partner's effort.

In a similar study, Paisley et al. (2008) found that some "changers" attempting to make dietary changes in the cohabiting context perceived that their partner played a negative role in their ability to change their diets. However, their partners did not report the same perception regarding their behaviours. Paisley et al. (2008) reported that partners were either unaware of, or unwilling to disclose, the negative impact they might have caused. In the current study, although there were some divergent accounts between partners, *Partial or Not Involved* women expressed their awareness of their own lack of involvement and how it might have impacted the man's weight loss attempts.

8.3 Ripple effect: The influence of men's attempts to make changes on their cohabiting female partners' dietary practices and physical activity

This study also focused on the influence of men's attempts to change their dietary practices and physical activity on their partner's dietary practices and physical activity. The findings in Chapter Six provide insights into the ways in which the partners' dietary and physical activity changes were initiated, facilitated or prohibited as a result of men's attempts to make changes, or the partner's own involvement in this process. The chapter also highlighted the mechanisms by which the potentially beneficial effects of men's participation in FFIT are exerted on their cohabiting partners. It is important to note that the FFIT programme is aimed at helping men lose weight and maintain healthy lifestyle. Therefore, any influence on the women's practices represents an unintended positive impact of the programme.

The dietary practices of most women changed to greater or less extent, and many reported increased physical activities but generally to a lesser degree. Participants' accounts indicated that these changes resulted from both women's active attempts and involvement in the changes that her partner was making, as well as via a ripple effect from the changes made by him. Therefore, regardless

of the woman's level of *involvement*, and the man's level of *reliance* on her for making changes, for most women at least some aspects of dietary practices were positively influenced. These findings are consistent with previous studies that have indicated a 'ripple effect' of one partner's weight loss attempt on the other's dietary practices (Golan et al., 2010; Gorin et al., 2008; Gray et al., 2013).

More importantly, the current study provides mechanisms for how this ripple effect occurred. *Resolute* men who were practically involved in family food practices provided healthy meals for the female partner even if she was not involved in making the changes. The partners of *Reliant* men who practically supported them by adopting healthier dietary practices changed their own dietary practices in the process, sometimes with the intention of being healthier or losing weight, and sometimes due to the ease of preparing the same meals for both. These findings suggest that the mutual nature of food practices amongst cohabiting couples means that one partner's attempts to change could make an unhealthy partner become healthier through a ripple effect. They also suggest why this effect could differ, based on the nature of the practice being changed.

Although only a few women appeared to make changes to physical activity, increased walking habits were described by most of those who made the changes. A few *Very Involved* and some *Partially Involved* partners of *Receptive* men described taking up additional activities, such as joining a gym or cycling. A recent quantitative study by Jackson et al. (2015) investigating UK couples over the age of 50 suggested that if men make changes to their physical activity, their partners are also likely to make those changes, even more than the partners of those men who already had healthy physical activity practices. The findings presented in this study only partially support these results. Only some women (*Very* or *Partially Involved* partners of *Receptive* men) increased their physical activities and made physical activity changes after men joined FFIT.

The current study also highlights the differences between men's influence on women's dietary changes and physical activity in relation to the level of men's *reliance*. Men's *resoluteness* for dietary changes resulted in women making at

least some changes to their diet, whether they intended to or not. In contrast, men's *resoluteness* for physical activity changes did not encourage their partners' *involvement* in physical activity changes but rather inhibited women from being practically involved in the changes, thereby reducing the possibility of them increasing their physical activity. In contrast to Jackson et al. (2015), and to the findings from the current study with regard to dietary practices, changes to physical activity (except for a few couples who already participated in some activities together prior to FFIT) were something entirely new that men were undertaking, and physical activity was mostly an individual practice to each partner. Therefore, motivation and active commitment were required from both men and their partners in order for the untreated partner to increase her physical activity.

These findings support some previous studies that indicate a difference in the ripple effect on the partner between dietary practices and physical activity (Gorin et al., 2008; Matsuo et al., 2010; Schierberl Scherr et al., 2013). The findings from this study further show that the changes in dietary practices were an *improvement over pre-existing practices* that a lot of men and women were already doing together, therefore, changes made automatically impacted both partners' dietary practices regardless of who was making them. In contrast, most men's own physical activity, or couples' *coactivity*, was something new *initiated* only after men joined FFIT. Furthermore, modelling of healthy eating practices by men in a mutual space was more noticeable to the partner than physical activity performed outside. Previous studies have not reported on these important distinctions between dietary practices and physical activity that could influence the subsequent changes and provide some explanation for practice-based differences in any ripple effect. The findings from this study help explain why shared, and/or cue-based health practices, such as eating, are more likely to be susceptible to a ripple effect compared to practice-based ones, such as physical activity (Jackson et al., 2015). It is however important to note that women who had changed their practices described maintaining those changes. They also described valuing the additional benefits from the changes, for example, a positive impact towards their weight loss goal and improved relationship with their partner.

Consistent with the concordance of couple obesity (*cobesity*) that has been highlighted in the literature (Wilson, 2017), most female partners in this study also described themselves as overweight or obese. Most participants' descriptions indicated that the couples' alignment in attitudes towards health practices after men joined FFIT had *facilitated* women's own attempts to adopt healthy practices. This could have fulfilled the *relatedness need* of women who were already attempting to adopt healthy practices prior to men's FFIT participation. Additionally, due to their *cobesity* and more aligned beliefs around weight loss after men joined FFIT, these women might have benefited more from the increased interdependence, while coping with the same problems together (Sullivan et al., 2010). This could be one of the explanations for why overweight partners of weight loss intervention participants lose more weight than those of normal weight as reported by Golan et al. (2010).

Lewis et al. (2006) propose that joint engagement in supporting a close other's goal pursuit could bring along benefits for the provider too. The findings from the current study in relation to a positive ripple effect on the partner's health practices support these perceptions. The current study shows that the process of the man making changes resulted in both partners reciprocating tangible support and autonomy and/or relatedness needs support for each other, probably due to the close nature of their relationship as well as the shared desires for, and expectations of, positive outcomes. As discussed in Chapter Two, Interdependence Theory posits that when a couple member attempts to make a behavioural change, the partner also receives a 'partner outcome' resulting from a combination of factors associated with themselves and the partner (mutual joint effect Figure 2.1). Existing weight loss interventions for men that have reported evidence of positive changes extending beyond treated individuals to their partners have focused on weight loss outcome as a measure of influence and have not paid attention to the behaviours being changed and the ways in which specific behaviours are influenced. Most studies have also not been inclusive of both partners or compared different health practices. The current study provides further insights into how factors associated with the partners,

men and the couples' mutual circumstances directly or indirectly influence each health practice for the partner.

8.4 The influence of the process of men's attempts to change and maintain their diet and physical activity on couples' relationships

Relationships between cohabiting partners exhibit unique dynamics of interdependence, with high potential for reciprocal, mutual exchange. The current study provides insights into how a cohabiting couple's relationship represents a context where partners have the potential to be highly influential, proximal and considerate of each other beyond the immediate behaviour change outcome.

This study sheds light into how a man's weight loss attempts can impact the couple's relationship *positively*. It found that most couple members were more relaxed around the issue of the man's weight and happier, both in general and with each other, once men joined FFIT and/or made changes to health practices. Many described their relationship being more pleasant than before and described decreased conflicts and arguments about health practices in daily life. Most men and their partners appeared to be proud of the initiative that men took to lose weight and even more so when they were successful. The partners' care for men was reflected in their descriptions of how they valued the man's attempts to change and the autonomy they needed in making these changes, and their consideration about the sensitivity of weight or weight loss related issues. Therefore, this process not only gave them an opportunity to live a healthier life but also to improve their relationship by fulfilling important psychological needs.

In a study examining mutuality of autonomy support in close friendships, Deci et al. (2006) found that greater *receipt* of autonomy support within friendships was related to greater emotional reliance, closeness, and satisfaction. At the same time, *giving* autonomy support was associated with more positive relational functioning as well as greater overall well-being, beyond the effect of support itself. Similarly, Patrick et al. (2007) in a quantitative study among 66 American

couples found that couples tended to perceive the least amount of conflict and were least defensive when both partners reported feeling a sense of belonging and strong connection (relatedness) with each other. The current study highlighted that giving support had its own unique effect on women beyond the benefit the men attained from receiving support, for example, a sense of togetherness and improved relationship described by women. These findings are consistent with previous studies reporting positive relationship outcomes from mutual attempts to make a health behaviour change, such as by *codieting* (Virtue et al., 2015), or both *giving* and *receiving* of support in general (Patrick et al., 2007).

Relationship Motivation Theory (discussed in section 2.2.1) proposes that those relationships in which both partners experience autonomy and provide autonomy support to the other are deeply satisfying of the relatedness need. On the other hand, control not only thwarts the need for autonomy but also the relatedness need, resulting in poor quality relationships (Ryan and Deci, 2017). Thus, needs support results in better relationship functioning as well as successful goal pursuits (La Guardia and Patrick, 2008).

Although Self-Determination Theory recognises romantic partners as different from other social connections in that “*romantic partners tend to be characterised by consent and mutuality, lacking in the element of authority differentials that are present in so many relationships in life*” (Deci & Ryan, 2014), a majority of the Self-Determination Theory literature on relationships has focussed on non-reciprocal partnerships (La Guardia & Patrick., 2008). Despite strong implications and a theoretical foundation for relationship context, there have been limited empirical studies using Relationship Motivation Theory (partially because it is a relatively new addition to Self-Determination Theory). The findings from the current study make important contributions to the development of this theory, firstly by confirming that men’s attempts to change health practices such as diet and physical activity are supported by relationship-centred aims, and secondly by providing insights into the relationship (as both a pre-disposing couple factor and an outcome of the

process); caring and interactive relationships contribute towards successful uptake and maintenance of health practices and improve the process of change.

This study found that making health behaviour changes in a cohabiting couples' context can also give rise to conflicts and tensions due to the mutuality of the practices and each partner's priorities and perceptions. The conflicts and tensions in this study were related to the inconveniences caused by the process of making changes, men's feeling of guilt when they attempted to thrive individually, men imposing changes on their partner, and/or partners being envious of men's weight loss.

A negative impact of an individual's weight loss attempt on a couple's relationship has been discussed in the context of weight loss surgery. Although studies have reported declines in couples' relationship quality after one partner's weight loss surgery (Ferriby et al., 2015), the current study showed that most partners worked together to minimise the impact of any tensions on their relationship, and that there was no detrimental impact of the process in their relationship. Therefore, it is important to note the differences in respect of varying weight loss *processes*, and the lack of mutuality in the way of achieving weight loss from a participant's surgery compared to the partners' mutual involvement for men's weight loss attempts in this study. This difference suggests that the negative impact on couple relationship from one couple member's weight loss after surgery may not be due to the loss of *weight* itself.

The participants in this study did not directly relate couples' conflicts to men's ability to make changes or achieve weight loss goals. The tensions and conflicts that arose also did not appear to be detrimental to the couples' relationship. However, as discussed above, all of the (few) couples with *Non-Responsive* men reported a degree of tension caused by the process. Given that almost all partners in this study were optimistic about and had positive expectations of men's participation in FFIT, it could be that, as previously discussed, when those expectations were not met the partners might have focused on the negative experiences more. In these cases, unmet expectations could have caused both men and their partners to shift the blame on to one another. Additionally, as

many women in this study were aware of their partner's expectations of support due to their pre-existing reliance, some might have provided support to maintain harmony in the relationship rather than to help the man achieve his weight loss goal. Some women's statements about 'appearing' to be supportive while continuing with some disadvantageous behaviour are manifestations of women not being fully supportive of the man while seeming to be involved.

8.5 Importance of the relationship context in health behaviour change interventions

The concept of context has been discussed previously in the Realist Evaluation literature where a context is defined as "systems of interpersonal and social relationships" (Pawson & Tilley, 2004 p.8). Researchers employing Realist Theory argue that social interventions are embedded in social systems. Therefore, a given intervention in different contexts (such as with different people or in different settings) will potentially produce different effects specific to each context. This perspective highlights the fluidity of context, and its relationship with the mechanisms of behaviour change that contribute to different outcomes from the same intervention (Pawson and Tilley, 1997, 2004). The current study lends support to these theoretical perspectives in relation to cohabiting couples' contexts by providing insights into how each practice and men's level of resoluteness or reliance on the partner determine the effectiveness of the support provided to them by their partners. This study highlights the need to consider individual couple contexts in research on cohabiting couples by showing different mechanisms through which changes to men's dietary practices and physical activity occurred even within the context of the same intervention (FFIT), and that these processes were also substantially influenced by the couple's relationship context.

The importance of the relationship context for the effectiveness of behaviour change interventions has been emphasised in settings such as drug rehabilitation (Joolae et al., 2014) and smoking cessation (Foulstone et al., 2017; Manchón Walsh et al., 2007; Westmaas et al., 2010; Westmaas et al., 2002). With regard to weight loss, some previous studies have explored similar health behaviour

interventions within couples' contexts but only after diagnosis of a disease of the male participants (Mroz et al., 2011; Robertson et al., 2014), or through men's perspectives only (Mallyon et al., 2010; MacLean et al., 2014). No research on a weight loss intervention for healthy men in cohabiting contexts involving perspectives of both partners exists. By highlighting how untreated cohabiting partners influenced FFIT participants' behaviour change attempts, the current study sheds light into the importance of the cohabiting context in understanding the effectiveness of a behaviour change intervention in *healthy* men.

The findings of clear beneficial ripple effects of men's FFIT participation on their untreated cohabiting partner in this study highlights a very important positive spill-over impact of the programme as well as the importance of cohabiting couples' context in designing behaviour change interventions.

Furthermore, the positive effect of the FFIT programme on the couples' relationship identified in this study provides important insights into how the programme positively impacts people beyond their physical health (Wyke et al., 2015). Although the FFIT programme primarily aims to help men lose weight and maintain a healthy lifestyle, these findings highlight the unintended benefits of the programme for both participants and their cohabiting partners. It is interesting that this positive influence arises from not just men's weight loss outcomes but also the process of making behavioural changes.

Collectively, the findings of this study highlight the importance of considering the cohabiting couples' context for designing effective interventions and understanding both intended and unintended effects beyond just primary participants, not only in relation to weight loss interventions but health behaviour change interventions in general.

8.6 Strengths and limitations of the current study

This study has a number of strengths. To my knowledge, it is the first qualitative study to explore *both partners' perspectives* on the untreated partners'

influence on *healthy* men's dietary practices *and* physical activity following men's participation in an organised weight loss programme.

The ability to explore each couple member's experience comprehensively was a major strength of this study. It has shed light on a previously under-researched area on *whether* and *how partner* support is linked with men's attempts to change dietary practices and physical activity, and how this process influences these practices in female partners. Therefore, this study provides a valuable contribution to the literature on health practices in cohabiting couples' contexts as well as on complexities associated with each health practice.

The dyadic approach taken was further strengthened by the study design, in which separate interviews were conducted with each partner. A particular strength of this method was the potential for greater openness in the discussions of experiences. In particular, the format of conducting the interviews with one couple member followed immediately by his/her partner ensured the benefits of separate interviews, while at the same time minimising many drawbacks of such approaches, for example, of one partner discussing his/her interview with the other, and therefore potentially influencing the second partner's responses and increasing the likelihood of convergent accounts (Eisikovits & Koren, 2010).

Another significant strength of this study was the investigation of two distinct health practices: dietary changes and physical activity. The data collected in this study provided an opportunity to explore similarities and differences in the reciprocal influences between partners in respect of the two practices. As the evidence in the literature regarding potential partner influence on individual practices is inconsistent, the comparison between the two practices in this study proved important.

The literature around social support and control in health research has mostly focussed on whether support is present and/or has translated into a specific outcome. The in-depth interviews with *both* partners in this study helped to get a thorough understanding of not only the mechanisms of how the support is provided and received but also the ripple effect or reciprocal impact of men's weight loss pursuits on the partners themselves from the perspectives of both parties involved. The analysis was supported by the use of wider theoretical

understandings drawn from Interdependence Theory, Social Support/Control theories, Self-Determination Theory, and theories around gender, and gender roles and health. This provided a unique and original perspective to look at men's attempts to make two distinct behaviour changes in a cohabiting context.

This study was able to draw upon qualitative methods to explore men's and their partner's experiences and reactions to men's participation in FFIT.

Retrospective interviews with a range of time periods since FFIT participation offered the chance to capture if and how experiences changed over time, even with the cross-sectional study design of collecting data at only one point in time.

Research on men who had all taken part in the same healthy lifestyle programme, and received the same messages regarding changes to dietary practices and physical activity was another strength of this study. In part this was possible because the study was embedded within a broader and rigorous research context, a gender-sensitised men-only weight management programme which has been successful in helping men achieve clinically significant weight loss for up to 12 months (Hunt, Wyke, et al., 2014). Sampling via FFIT allowed me to gain access to men who were at high risk of future diseases but were 'healthy'. Therefore, the findings of this research provide insights into a population and context that needs to be better understood to tackle obesity effectively, both on an individual and/or family level. Additionally, recruiting participants from the same intervention also provided the opportunity to explore the effectiveness of the same programme among men with different characteristics and couple contexts.

Despite these substantial strengths, there are a number of important limitations of this study against which the findings need to be considered.

An important limitation of this study relates to the participant recruitment. All 20 men in this study opted in to participate. This 'self-selection' means that they may not represent FFIT participants who are less engaged with the programme. All 20 women in this study were in turn recruited through their male partners, who therefore acted as 'gatekeepers' to both information about, and

participation in the study. Additionally, women who were not happy with the partner's participation in FFIT, or were disengaged from his behaviour change attempts were unlikely to wish to participate. Similarly, couples who perceived FFIT as detrimental to their relationship may not have wished to participate in my study. Although the sample included men who were and were not successful in achieving their 5% weight loss target, and I identified varied levels of partner involvement, it is possible that men with unsupportive partners might not have been represented in this study. As such, the study may represent a sub-group of couples who are more engaged and/or positive about the programme or their experiences. This highlights the importance of understanding the perspectives and experiences of men whose partners did not agree to participate in the programme. For this reason, it is particularly important to pay attention to the cases where men and women voiced negative views, such as tension and conflict. Although they were a minority in this study, these views may to some extent represent the opinions of couples who chose not to participate, or men who were unable to participate due to lack of interest from their partner.

While the influence of the attempted changes on couple relationships was explored, partner relationship quality was not assessed. Assessing couples' pre-existing relationship functioning could have provided further insights into whether and how the quality of the relationship impacted on the level of both the man's and the partner's involvement. This comparison would have further strengthened the findings on the influence of the process on couple relationships.

While most men referred to their FFIT booklet to report their weight loss outcome and this is likely to be accurate, the findings with regard to weight loss maintenance, and weight loss of those who did not refer to the booklet, need to be understood with a consideration that it was self-reported and BMI was not objectively measured.

As with all qualitative research, the data are influenced by my understandings, in respect of both the ways they were generated and interpreted. The findings presented are based on *both* participants' narratives *and* how I interpreted them. It is also important to remember that participants' accounts are

representations they chose to present and so are potentially influenced by their choices over 'presentation of self' (Goffman, 1959) in general and to me as a researcher, which needs to be considered in understanding the findings of this study. Due to the personal and mutual nature of the topics of body weight and couple relationships, men and their partners might have presented their accounts in a particular way. Couples might also have consciously attempted to present a united front by discussing potential questions and answer prior to their interview.

Although every effort was made to ensure that the participants were comfortable and at ease during interviews, it is still likely that their judgement of me as an 'outsider' (Finlay and Gough, 2008) may have influenced the account they chose to present to me. Therefore, in interpreting the findings it is important to remember that they are based on my interpretations of the narratives that participants at the time chose to present to me. Furthermore, it is important to note that I may have been viewed by the men and partners as being affiliated with the FFIT programme in my position as a PhD research student. Therefore, it is possible that some may have been hesitant to provide negative opinions or thoughts about the outcome of the programme in general, despite being encouraged to express their views freely.

It is also possible that in some cases the participants held back on their negative views about the partner due to the partner's presence in the house and/or because their partner was also being interviewed.

Another limitation of this study is the lack of sample diversity. All of the 40 participants included were white European. While this is consistent with the demography of men who generally take part in FFIT (Wyke et al., 2015), there could be a number of groups to whom these findings are not relevant.

This study purposefully included men who had completed FFIT 3-12 months before the interviews. Despite my attempts to prompt participants to talk about their circumstances and experiences before, during and after FFIT, due to the range of time since FFIT, some participants were perhaps better able to recall aspects of their experience than others during the interviews.

8.7 Future research

This study raises a number of questions that warrant further research. First, further work is needed to understand if and how the influences described are maintained and impact over a longer time-period. As factors that reinforce maintenance of changed practices are likely to differ over time, a thorough understanding of how the changed practices become habitual practices is still needed.

The current study adds to our understanding of how untreated partners react to men participating in weight loss interventions and how their reactions are shaped by both the content of the programme and their pre-existing understandings of their partner. However, it would be useful to have a longitudinal qualitative study design with observations/interviews both prior to men's participation in the weight loss intervention and thereafter. Doing so would help identify if and in what ways partners' prior intentions are related to the provision of support.

This study has identified varying levels of both partner *involvement* and men's *reliance* on support. Future research using quantitative methods with larger samples, alongside further qualitative work to investigate these dimensions and their associations with behaviour change and subsequent maintenance, including not just weight loss/maintenance behaviours would be valuable.

In accordance with Mallyon et al. (2010), the findings of this study suggest that conformity with hegemonic masculinity may increase the likelihood of men relying on their partner in making dietary changes. However, this could be further investigated through quantitative measures of gender role orientation (i.e. behaviours) and gender role attitudes, and how they relate to dimensions of involvement and reliance.

It could also be useful to compare the findings of this study with future studies among women FFIT participants (Donnachie et al., 2018) investigating *the* influence of male partners and the ripple effect on them. This work would help

to better understand the role of gender in partner influence on individual attempts to make behavioural changes.

The findings from this study suggesting that men's attempts to make changes to their health practices impact the couple relationship indicate an interesting area for further research. This might be designed specifically to focus more narrowly on the benefits or tensions within the relationship resulting from men's attempts to make changes to health practices.

A further area of interest would be to research specifically with couples from minority groups (non-white population or same sex couples). The aim of such work would be to provide a comparative perspective on whether and how these varying couples' contexts and influences partner support or impact.

Exploration of the *causal* impact of partner's involvement on their own weight loss or maintenance *outcome* was beyond the scope of this current study and future research on this would be useful.

8.8 Implications for practice and future intervention development

This study explored the influence of female partners on men's attempts to initiate and maintain changes in their dietary practices and physical activity and the influence of the process on the female partners. The prevalence of *cobesity*, and evidence of a positive ripple effect of the weight loss intervention on the partner, highlight the importance of considering potential benefits for both partners when designing interventions. The results of this study suggest several recommendations for future interventions, especially for those wishing to engage partners in men's weight loss interventions.

This study suggests that men who join weight loss programmes are motivated enough to want to adopt healthier lifestyles. However, men's level of reliance on their partners' support for dietary practices was evident in *reliant* men successfully achieving changes and/or their weight loss targets. Acknowledging

varying levels of men reliance on potential partner support is thus recommended to enable men to fully utilise and benefit from partner support. *Resolute* men were successful in achieving changes regardless of partner involvement. Therefore, men might benefit from a provision of personalised strategies to increase their own resoluteness. Although men are more likely to attend and engage in programmes such as FFIT that are tailored for them and reinforce men's 'masculine capital' by providing access to valued spaces (Hunt et al., 2013), men in this study, including those who desired to be autonomous in making changes still engaged with their partners and valued their support. Therefore, combining health interventions, such as FFIT, that is tailored for men within 'male settings' with the provision of personalised advice on how best to solicit partner support, could provide an effective means of engaging men to adopt and maintain healthy practices. In the FFIT programme, men are encouraged to utilise the support from their social networks; however, in the cohabiting context, soliciting effective partner support could be specifically emphasised.

Consistent with theoretical understandings, this study suggested partners' involvement provided social support and might have fulfilled men's relatedness and competency need, which are crucial for successful behaviour change. However, the findings also reveal that partner involvement in physical activity was not appreciated by all men and indeed some perceived it to be negative and prohibitive to the attainment of their physical activity targets. Therefore, it is essential that emphasis on partner support as part of interventions is delivered in ways that are appealing to men, non-threatening to their sense of autonomy, and geared towards fulfilling their relatedness need in making the changes. Additionally, while ensuring men's desirability of partner support, weight loss interventions designed for men should also address the men's greater desire for, autonomy in adopting/increasing physical activity compared to changing dietary practices.

Making efforts not to alienate female partners in designing weight loss intervention for men would be equally important. Most partners in this study had positive views about men's participation in FFIT. Prompting the *partners* to

engage in supportive behaviours could be an effective approach in interventions targeting men. This could involve educating partners about the ways in which support can occur, including subtle or indirect forms of support that may not be perceived as such by the recipient. For most couples, both provision and receipt of support were linked with positive changes. Therefore, researchers may want to consider joint engagement in supporting each other's behaviour change or weight loss attempts.

This study highlighted transformation of motivation or motivational 'spill over' effects between partners (Lewis et al., 2006; Timmermans, 2013). Most female partners in this study were involved in men's attempts to make changes and most benefited from their involvement and/or through the ripple effect of men's changes. Reinforcing the relevance of an intervention to partners is likely to increase its impact for both. In addition to dietary practices, the findings of this study highlight the importance of partner's involvement for increasing (*Receptive*) men's physical activity and extend on previous research demonstrating that coactivity could be a form of social support between partners (Berli, Bolger, et al., 2018). Therefore, for a more comprehensive intervention impact, encouraging joint engagement in activities could involve other goals, such as relationship quality.

Participation in family-food provision could be viewed by some men as not fitting with their view of their masculine role, and female prominence in family food-related practices was apparent across the sample, particularly in older participants who described following more conventional gender roles. Alongside research suggesting that men are less likely to attend weight loss interventions compared to women (Robertson et al., 2014), the findings related to men's reliance on the partner for dietary practices, suggest that lack of partner support or unsupportive relationship contexts may prohibit men from enrolling in weight loss initiatives. Therefore, it is important to consider the practical skills and level of partner support required, particularly for older men, with regard to dietary practices. Similarly, although the gender-sensitised context and the content of the FFIT delivery has been found useful for men, encouraging men's greater involvement in family food provisions, and discussing the health

implications of their conformity to conventional masculine ideology could help men be more resolute, and less reliant on their partner for dietary changes. This is important, because in this study the gender roles in couples did not appear to change significantly as a result of men's attempts to make changes to their dietary practices and hence the female influence in dietary practices was pertinent.

It was apparent in some cases that partner involvement was not enough to help men initiate or adhere to the healthy practices. Therefore, it is important to identify personal characteristics of the participants and tailor intervention strategies to *Non-Responsive* men who, despite the motivation to join an intervention, may not make the required changes. Further research conducted with men to examine their level of commitment and resoluteness at the beginning would be beneficial, because *Non-Responsive* men are less likely to benefit from standard interventions despite partner support. Emphasising volitional strategies for *initiation* of behaviour change, and self-monitoring and self-reinforcement for maintaining those changes could be useful (Hardcastle et al., 2015).

Capitalising on partners' positive attitudes and reactions to men's attempts to make changes to their own practices might help maximise the health and relationship benefits of weight loss interventions for both partners.

These benefits could potentially apply to changes in practices other than diet and physical activity. Furthermore, given that obesity and overweight are still on the rise globally, and are high on the list of many governments' health priorities, the findings from the current study can potentially inform future policies targeted at reducing overweight and obesity at individual or social levels.

8.9 Thesis Conclusion

By exploring both partners' accounts, this study provides insights into the range of ways in which men's own characteristics and those of their partners can

facilitate or prohibit the process of making changes to their dietary practices and physical activity.

Despite health burdens associated with overweight and obesity, long-term weight loss intervention efforts have been largely unsuccessful (for some exceptions see (Gray et al., 2018; Hunt, Wyke, et al., 2014; Robertson et al., 2014)). The literature on men's weight loss and participation in weight loss interventions has proliferated in recent years. The findings from this study underscore the relevance of considering social support as an interpersonal process for positive goal outcomes and provide new insights into the cohabiting couples' context underlying men's health behaviour change. The current study is an important step towards elucidating how the cohabiting partners can be effectively incorporated into men's weight loss attempts.

This study provides a unique contribution to the literature by investigating both men's and their partners' experiences of men's attempts to make changes to dietary practices and physical activity within the context of a gender-sensitised weight management programme. The findings provide insights into the ways in which a female partner's involvement can support a man's autonomous motivation as well as provide relatedness support through *codieting* and *coactivity* which could be important for men's initiation and/or adherence of changed practices. However, they also indicate that aspects of pre-disposing factors such as men's skills and engagement in conventionally feminine practices around food preparation are integral in determining the resoluteness crucial for initiating and sustaining changes. Partner support that does not undermine feelings of competence, autonomy, and/or masculine identity is most likely to amplify the impact of organised weight loss intervention on men.

This study suggests that pursuit and attainment of behaviour change goals are influenced by a couple's interdependent relationship and highlights that having a shared goal of, or aligned perception towards, weight loss or particular health practices could change the nature and meaning of couple interactions around weight loss. It adds further insights into Interdependence Theory by suggesting that relationship functioning may not only be a pre-disposing couple factor

influencing partner support but also an outcome from providing and receiving support for changes to health practices.

This study also emphasises that weight loss interventions designed for men have a great potential to positively impact the health practices of cohabiting partners. In congruence with Relationship Motivation Theory and Interdependence Theory, these findings demonstrate the potential of social support from the partner benefiting men as well as themselves. Therefore, focusing on creating couples' contexts where partners provide relatedness support with consideration for men's needs for autonomy and competency may help to maximise the positive ripple effects of weight loss interventions designed for men on their partners.

The findings illustrate the value of a mutual and caring cohabiting couples' context, and how couples can enhance autonomous forms of motivation and leverage positive change toward health practice. They highlight how changing health practices in cohabiting contexts involves complex social interactions, which shape how men initiate and maintain changes to each practice. They confirm and extend previous research among FFIT men (Maclean et al. 2014) and demonstrate the ways in which factors associated with both men and their partners contribute to behaviour change outcomes for each partner (Lewis et al., 2006). Additionally, this study reports on relationship outcomes beyond the physical health benefits of the process, which reflect the positive 'spill over' or 'unintended' outcomes of the intervention (Timmermans, 2013).

By shedding light on these areas, it is hoped that this study contributes to developing a deeper and more nuanced understanding of the reciprocal impact of one couple member's pursuit of health behaviour changes on the other, and through this, to the development of appropriate interventions to maximise the impact of weight loss interventions for one couple member on the partner.

Appendix 1 – Overview of the included reviews (Literature review I) ordered chronologically

Author/Date	Principal focus of the reviews	Studies /Sample	Relevant findings
Barbarin & Tirado, 1984	Involvement of family members in weight loss programs.	Narrative review Mostly women	The effect of involving family members in the treatment of obesity appears strongest and most effective in cohesive and engaged families, and when the spouse is actively involved.
Sobal, 1984	Relationship between marriage, the socially sanctioned role relationship between husband and wife, and obesity.	Narrative review Married couples	Possible causes of similar degrees of obesity in marital partners such as selective mating and similar diet. Both marital problems and marital termination have been reported to be linked to weight change.
McLean et al., 2003	Family involvement in weight control, weight maintenance/weight-loss interventions.	Structured review of randomised trials Mostly women	Limited support for the involvement of spouses in weight loss intervention.
Robertson et al., 2014	Management strategies for treating obesity in men and investigate how to engage men in obesity services.	Quantitative, qualitative and health economic evidence base Focused on Men	The effect of family and friends on participants in weight-loss programmes was inconsistent. Tailoring interventions and settings for men may enhance effectiveness, though further research is needed to better understand the influence of context and content.

Archibald et al., 2015	Studies reporting research with obese men, or in contrast to obese women or lifestyle or drug weight management	Realist synthesis of qualitative studies Focused on men	Social support was identified as one of the facilitators for attendance/adherence. Lack of support for new food choices by friends/family was one of the barriers. Men's perspectives and preferences within the wider context of family should be sought.
Robertson et al., 2016	Long term weight management for obesity for men Whether programmes should be designed differently for men	Systematic review of RCTs Focused on men compared to women	Support from a partner and learning how to enhance social support from family members may also be particularly helpful for men, but having a spouse attend the same programme was not helpful for men. Individual support and tailoring was more helpful for men than women. Men and women responded differently to, and had different preferences for weight management programme.
Manfredni et al., 2017	Association between marital status and cardiovascular disease outcome and risk factors	Structured review Marital status, some about diet and PA	Most studies showed better cardiovascular risk and outcomes for married persons, and men who were single generally had the poorest results. Moreover, being married was associated with lower risk factors and better health status, even in the presence of many difficult effects.

Appendix 2 - Overview of the included studies (Literature review II) ordered chronologically

	Author, Year, Country	Study Design, Theoretical framework Linked to intervention?	Sample	Issues of interest	Main findings
1	De Souza & Ciclitira, 2005 UK	Qualitative Grounded theory Not intervention	N = 8 men (5 co-weight loss)	Diet Weight Gender	Men engaged in dieting and weight loss constructed themselves as different from women dieters. Seven of the eight men reported having tried 'crash diets', and their difficulties of maintaining weight loss.
2	Gregory, 2005 UK	Qualitative Gender theory Not intervention	N = 61 (Male 17 patients & 4 partners; Female 18 patients & 24 partners)	Diet Gender	Tasks and activities related to one partner's changed (new) diet became family practices. Female partners assumed the roles and responsibilities for caring for the other's dietary needs. Study concludes that constructions of the family relationship might be gendered but gender roles are not always constant.
3	Gough & Conner, 2006 UK	Qualitative Gender theory Not intervention	N = 24 Men	Diet Weight Gender	Men considered healthy foods not sufficiently satisfying, lacking in taste and not enough to provide the energy required for manual labour compared to traditional masculine food such as meat.
4	Gough et al., 2007 UK	Qualitative (Media research) Gender theory Not intervention	N = 44 newspaper articles	Diet Gender	Media presented men's involvement in cooking or food preparation activities according to masculine stereotypes. Men were presented as rational, forward-thinking, goal-oriented and taking control of cooking.
5	Aarseth & Olsen, 2008 Norway & Denmark	Qualitative Gender theory Linked to intervention	N = 19 Couples (2 studies, 9 Norwegian & 10 Danish)	Diet Gender	Masculine identification with food preparation as leisure activity did not represent a reproduction of the structural gender relationship, but rather a prerequisite for a more profound change in the gender division of labour.
6	Beverly et al., 2008 USA	Qualitative Social cognitive and social support theory Not intervention	N = 30 couples (One partner had type II diabetes)	Diet Gender	Spousal control over food preparation was relevant to the men diagnosed with diabetes. Aspects of the couple relationship such as partners control over food, dietary competence, commitment to support and communication contributed to adherence to healthy diet.

7	Gorin et al., 2008 USA	Quantitative Theory: NA Intervention (RCT Look AHEAD)	N = 357 couples (primary participants had type 2 diabetes)	Diet PA Weight Impact on partner	Partners of intensive 'lifestyle intervention' participants changed diet but not PA. Participant weight loss was linked to partner's weight loss. Untreated partner lost weight regardless of the spouses' gender or initial weight status, and had reduction in weight in 1 year follow up. Gender differences found for PA but not for Diet and weight. Significant others described their response as cooperative and supportive, but impact that their support may have had on changers' experiences varied.
8	Paisley et al., 2008 Canada	Qualitative Social support theory Linked to intervention	N = 42 pairs (19 partners, 18 cohabiting; Changers = 9 male, 12 female)	Diet Impact on partner	Men's participation in a men-only gender sensitised weight management programme positively influenced the partner's dietary practices.
9	Gray et al., 2009 UK (Scotland)	Qualitative Theory: NA Linked to intervention (Camelton model)	N = 24 female partners	Weight Impact on partner	Examined halo effect of dietary intervention on the untreated partner's weight and nutritional patterns. Husbands' diet change positively impacted wives weight loss at 6 months and 6 years. Wives had significant dietary improvement according to their husbands' diets. Wives attending support group impacted on husband weight loss at 6 months. Wife believing in husband's ability to succeed in his weight-loss project was a significant predictor for the men losing weight during the first 6 months of the intervention.
10	Golan et al., 2010 Israel	Quantitative Theory: NA Intervention (RCT)	N = 74 women (partners of men participating in a weight loss programme)	Diet Weight Reciprocal influence	Men assigned to 1 of 3 groups: no intervention, direct intervention or indirect intervention. Study found beneficial impact on untreated spouses. Influence of female participants to male untreated partner evident in weight loss but not in PA. No significant correlations found in physical activities between the spouses.
11	Matsuo et al., 2010 Japan	Quantitative Theory: NA Intervention (Control trial)	N = 124 men and 40 women, (40 couples, primary participants overweight men)	Diet PA Weight	Men assigned to 1 of 3 groups: no intervention, direct intervention or indirect intervention. Study found beneficial impact on untreated spouses. Influence of female participants to male untreated partner evident in weight loss but not in PA. No significant correlations found in physical activities between the spouses.

12	Mallyon et al., 2010 Australia	Qualitative Gender theory Linked to Intervention (Clinical trial)	N = 14 (8 men , 6 women)	Diet Weight Gender	Men understood and practiced their dieting in different ways from the women, but also from each other, depending on their conformity to masculinity. Some were eager to reframe their dieting in 'more manly' terms. The social support or sabotage received from friends and family could be significant to these experiences of dieting.
13	Morgan et al., 2011 Australia	Qualitative Theory: NA Linked to Intervention (RCT)	N = 18 men	Diet PA Weight	12-month follow-up results and process evaluation of the SHED-IT trial. Qualitative analysis by questionnaire and interview with men highlighted positive influence on partners as reported by treated men.
14	Mroz et al., 2011 Canada	Qualitative Gender theory Not intervention	N = 14 couples (men diagnosed with prostate cancer)	Diet Gender	Men's interest in their diets increased after a prostate cancer diagnosis. Women attempted to mitigate subordinate productions of masculinity by catering to, and monitoring the man's diets. Most couples mutually maintained traditional gender food 'roles' by positioning women as proficient leaders in domestic food provision and men as unskilled assistants.
15	Berge et al., 2012 USA	Quantitative Theory: NA Linked to Intervention	N = 1212 (519 men, 693 Women)	Diet PA Weight	Women whose partner had health promoting attitudes and behaviours were significantly less likely to be overweight or obese and were more likely to have healthier diet and physical activity, compared to partners of those who did not have health promoting behaviours/attitudes.
16	Brown & Wenrich, 2012 USA	Qualitative Family systems theory Intervention (RCT)	N = 20 couples (10 participants, 10 control)	Diet	No change in vegetable variety post-intervention. The role expectation of serving only what everyone liked and the honouring powerful family members' vegetable preferences was major barriers to women changing family diet.
17	Allen et al., 2013 USA	Qualitative Interdependence/gender theory Not intervention	N = 83 men	Diet Weight loss	Wives influenced what men ate at home more than men's own preferences. Traditional gendered food roles at home was prominent, and men suggested that their wives played a dominant role in household food preparation and decision making. Men described being rarely consulted on how meals could be healthier and often disliked the healthy changes their wives made. Men prioritised keeping their wives happy, preserving spousal division of roles, and maintaining marital

18	Baiocchi & Talley, 2013 USA	Quantitative Interdependence theory Not intervention	N = 433 Dyads (Primary participants: young adult and one family member)	Diet PA	harmony over participating in food decision making or expressing their personal food preferences. Frequency of health-specific communication, and Perceived confirmation from a family member during health-specific conversations directly influenced health attitudes; this partially accounted for the positive relationship. Family conversation orientation and health attitudes were directly associated with health behaviours.
19	Bennett & Gough, 2013 UK	Qualitative (media research) Gender theory Not Intervention	N = 7 threads (547 posts linked to men's magazine)	Diet(ing) Weight	Online discussions between men concerning bodily transformation were informed by particular notions of hegemonic masculinity. Men carefully constructed their conversation constrained by hegemonic masculinities founded on discipline, work-orientation, pragmatism and self-reliance, retaining control; fashioning a masculine body; manly support: heroism and pragmatism.
20	Gorin et al., 2013 USA	Quantitative Theory: NA Intervention (RCT)	N = 201 dyads (157 women, 44 men. Most pairs were partners)	Diet PA Weight Reciprocal influence	Participants in the home environment intervention had significantly greater weight loss than participants in standard behavioural weight loss treatment at 6 months, but not at 18 months. Women lost significantly more weight in the home environment intervention at 6 and 18 months. Both groups regained at similar rate. At 18 months, greater weight loss in women; however, men tended to lose more weight in the standard programme than in the home environment intervention at 18 months. Gender identified as a potential treatment moderator.
21	Schierberl Scherr et al., 2013 USA	Quantitative Interdependence theory Intervention (RCT)	N = 132 couples (94 female Primary participants)	Diet PA Weight Reciprocal influence	Participants' weight loss was not predicted by their partners' behavior changes. No reciprocal effects found with PA changes. Direct treatment had the greatest impact on primary participants and partners. Spouses' dietary changes positively influenced untreated partners' weight loss, suggesting a ripple effect for diet and weight, but not for PA. ALONE spouses' behaviour changes impacted the participants' weight loss, no reverse effect. Spouses weight loss was directly influenced by

					intervention effects, including the dietary changes in the home environment from participating in the intervention (TOGETHER) spouses or from the home environment changes made by (ALONE) spouse.
22	MacLean et al., 2014 UK (Scotland)	Qualitative Gender theory Linked to intervention (RCT)	N = 39 men (From 8 football clubs)	Diet Gender Partner influence	The level of female partner's influence varied. Relationship dynamics influenced the negotiation that men were making about changes on diet. Men considered their female family members to have strong influence on their diet and eating practices. Different levels of both positive and negative influences from female family members were identified. These female family members are categorised as facilitative, detached, undermining of changes, resistant to changes or threatened by men's dietary changes.
23	Jackson et al., 2015 UK	Quantitative Theory: NA Not Intervention	N = 3722 couples (Cohabiting couples)	PA Weight Reciprocal influence	When one partner changed to a healthier behaviour (newly healthy), the other partner was more likely to make a positive health behaviour change than if their partner remained unhealthy. Men and women are more likely to make a positive health behaviour change if their partner does too.
24	Mata et al., 2015 9 countries (Austria, France, Germany, Italy, the Netherlands, Poland, Russia, Spain, UK).	Qualitative Face-to-face interviews Theory: NA Not Intervention	N = 4555 (Men =2181 Women= 2374)	Diet PA Weight	Married people had better dietary practices, and eating-related cognitions. Married men had lower physical activity level compared to unmarried men. Married respondents had a higher BMI than never married respondents, but differences were small. The link between marital status and BMI was described as complex and not fully describable by one single explanation.
25	Mroz et al., 2015 UK	Qualitative Gender relations Not intervention	N = 14 couples (men had prostate cancer)	Diet Partner influence	Two overarching themes illustrated couples' food negotiations: 'Seeking information and deciding on food changes' and 'Monitoring food changes'. Additional sub-themes included who led food changes, women's filtering of information, and moderation or 'treats'.

26	Virtue et al., 2015 USA	Quantitative Interdependence theory Not intervention	N = 132 couples (men had prostate cancer)	Diet PA Reciprocal influence	Couples had similar fruit/vegetable consumption and physical activity. Greater <i>Codieting</i> was related to higher relationship satisfaction and greater patient and spouse-rated support. Greater coactivity was related to greater patient and spouse-rated support. Prostate cancer survivors and spouses influenced each other's diet and exercise behaviours.
27	Anderson et al., 2016 USA	Quantitative Stress exposure model Not intervention	N = 117 couples (Type 2 diabetes patients male 67, female 50)	Diet PA	Spouses played significant role in managing diabetes and informed specific targets for intervention programming. Patient and spouse diabetes stress and the number of patient comorbidities were related to patients' dietary and exercise adherence, through patient depression symptoms and both patient and spouse self-efficacy.
28	Berli et al., 2016 Germany	Quantitative Action control/social control theory Intervention	N = 121 couples (Overweight individuals & partners; control 60, information 61)	PA Weight Couple	Action control via text messages was an effective tool for increasing adherence to physical activity guidelines in daily life. Automated text messages were just as effective as personalised messages from the partner in the receiving partner's behaviour change.
29	Cornelius, Gettens, et al., 2016 USA	Quantitative Dyadic growth curve model Liked to intervention (RCT)	N = 201 pairs (125 spouses)	Diet PA Weight	Cobesity was evident at baseline. Integrating home elements was positive for both. Primary male participants benefitted more from standard treatment. Study concluded that intervening in home environment might have the potential to facilitate dyadic weight loss processes; restructuring an environment could positively impact weight loss within dyads.
30	Cornelius, Desros, et al., 2016 USA	Quantitative Interdependence theory Not intervention	N = 157 couple	Diet PA Partner influence	Partner influence on diet and PA was evident among newly parent and young adult couples because of the desire to maintain relationships. Results also varied by gender; only female-to-male influence was found for unhealthy eating.
31	Dailey et al., 2016 USA	Quantitative Confirmation theory Not intervention	N = 53 (10 men, 43 women)	Diet PA Weight	Combination of acceptance and challenge in daily reports of partner behaviours was helpful to those who were overweight and actively trying to lose weight. Different outcomes for diet and exercise goal attainment were found.

32	Perry et al., 2016 USA	Quantitative Social control theory Linked to intervention	N = 215 (40 men, 175 women)	Diet PA	Partner characteristics were associated with the obesity-related health behaviours of primary participant. Adoption of exercise or diet modifications by one partner was described as likely to spread to others, creating a social environment characterised by mutual reinforcement of healthy behaviour. Study concluded that obesity might operate through the modeling and adoption of health behaviours that contribute to weight control or obesity.
33	Ranby & Aiken, 2016 USA	Qualitative Social support/control Not intervention	N = 160 women	PA Partner influence	Husband support positively influenced wife's PA. Social control negatively influenced PA. Five social support components were identified along with social control injunctive norms, and descriptive norms as a broad assessment of husband social influence on physical activity.
34	Theiss et al., 2016 USA	Qualitative Relational turbulence model Not intervention	N = 122 (39 men and 83 women; did not interview the partner)	Diet PA Partner influence	Seven themes of partner facilitation for their weight loss attempts identified included partner enabling diet, motivation and encouragement, emotional support and positive reinforcement, coactivity, partner enabling exercise, dieting together, and relationship influence and priorities. Four themes of partner interference identified included inability to plan for healthy meals, inability to control the food environment, preventing or discouraging exercise, and emotional or relational discouragement.
35	Trief et al., 2016 USA	Quantitative: Interdependence theory Randomized trial	N = 280 couples (104 couples calls, 94 individual, 82 diabetes education)	Diet Weight	Couple intervention is more beneficial than individual for diabetes patient.
36	Winter-stone et al., 2016 USA	Quantitative Theory: NA Intervention (RCT)	N = 64 couple (Prostate cancer survivors/spouse coactive 32, usual care 32)	PA	Coactivity was feasible, and improved several health outcomes for both patients and their spouses. Study concluded that a couples-based approach should be considered in post-cancer programmes so that outcomes can mutually benefit both partners.

37	Cornelius, 2017 USA	Quantitative Theory: NA Linked to intervention	N = 43 Couples	Weight	The household environment and partner inputs significantly influenced weight-loss maintenance. Targeting environmental structure and social forces might improve interventions to support weight-loss maintenance in couples.
38	Keller et al., 2017 Germany	Quantitative Dyadic planning Linked to intervention	N = 225 couple (Individual planning 114 + Dyadic planning 111)	PA Dyadic planning	Dyadic planning was linked with higher enactment of PA plan than individual planning. However, mechanisms underlying this effect was not clear. Findings indicated that routines were positively related to plan enactment. Linking health behaviours to other behavioural routines was reported as beneficial for subsequent plan enactment.
39	Knoll et al., 2017 Germany	Quantitative Dyadic action planning model Intervention	N = 338 Couples	PA Dyadic planning	There were no beneficial direct effects of the intervention for DPC target persons. At lower relationship quality, 'dyadic planning condition' (DPC) target persons' activity decreased, whereas IPC target persons' vigorous activity increased. Positive effects of partners' on target persons' moderate activity in DPC and control, whereas for 'individual planning condition', negative effects of target persons' on partners' moderate activity emerged. Findings show the complexity of effects of dyadic planning on behaviour change.
40	Lüscher et al., 2017 Germany	Quantitative Interdependence theory Linked to intervention	N = 144 couples (Study 1- 61 increasing PA; Study 2- 83 couples quitting smoking)	PA	Investigation between health behaviours showed that goal disengagement is associated with better well-being, but lower goal achievement in everyday life. Partner influenced goal achievement for physical activity goal. Dyadic associations for health behaviour change might be more context-sensitive.
41	Mötteli et al., 2017 Switzerland	Quantitative Interdependence theory Not intervention	N = 841 (Study 1 579; Study 2= 262)	Diet Weight	Women shared their meals most frequently with spouses and family members. Women eating with healthy eaters reported better diet quality and a lower BMI. Dietary behaviour and body weight had similarities and interdependence between women's and their regular eating companions and similar perception of what constitutes a normal diet.

NA = Not applied
PA = Physical activity

Appendix 3 - Ethical approval



College of Social
Sciences

Administrative & Academic Review Feedback

Ethics Committee for Non-Clinical Research Involving Human Subjects

Staff Research Ethics Application

Postgraduate Student Research Ethics Application

Application Details

Application Number: 400150077

Applicant's Name: SheelaTripathee

Project Title: Men managing their weight through diet and physical activity: influences from and on their female partners

Application Status: Committee Review Complete - No Changes Required

Date of Administrative/Academic Review: 06/01/2016

NB: Only if the applicant has been given approval can they proceed with their data collection with effect from the date of approval.

Appendix 4 - Permission to contact form



FFIT men managing their weight through diet and physical activity: influences from and on their female partners

Permission to contact form

My name is Sheela Tripathee. I am a PhD student at the University of Glasgow, where researchers contributed to the development of the FFIT programme. I am recruiting for a study I hope to conduct with FFIT participants.

For this study, I would like to interview you, and your live-in female partner (wife/girlfriend/ fiancée) about the changes you are making in your diet and physical activity as a result of you participating in FFIT. These interviews would take place about three months after you complete the FFIT programme.

For now, I would like to know if you would give me permission to contact you about this study in the future. With your permission, I would send you further information about this research, such as what it aims to investigate and what it would involve for you and your female partner. You can then decide, along with your partner, whether or not you would both like to take part. Completing this form does not oblige you to take part in the study.

Please circle as appropriate

1. Do you live with a female partner (wife/girlfriend/ fiancée)?

Yes No

2. Do you give permission for me to contact you about this study in future, using the contact details that you provided to the football club when you joined the FFIT programme?

Yes No

If Yes, Please circle your preferred methods of contact. Please choose at least two.

Email Phone Mail

Your name: _____

Thank you for taking the time to complete this form.

Appendix 5 - Participants information sheet



Information Sheet

FFIT men managing their weight through diet and physical activity: influences from and on their partners

Who am I?

My name is Sheela Tripathee. I am a PhD student funded by the Medical Research Council (MRC). I am based at the University of Glasgow's MRC/CSO Social and Public Health Sciences Unit (SPHSU). Researchers at SPHSU were involved in the development of the FFIT programme. I would like to invite you and your partner to take part in a research study related to FFIT.

What is this study about?

The study is about men like you who have used diet and physical activity to manage their weight, and also about cohabiting partners. It aims to understand:

- how you might *influence* your partner's diet and physical activity; and
- how your diet and physical activity might be *influenced* by your partner.

What will you and your cohabiting partner have to do during the study?

I would like to interview you and your partner separately about any changes in diet and physical activity during and after your participation in FFIT. Interviews would last about 45 minutes and could be held at your home, at the SPHSU office in Glasgow City Centre, or at another agreed location. I will ask each of you to sign a consent form before starting the interview. If you agree, the interviews will be audio recorded so that I can review everything that we talk about.

After completing the interview, each of you would be given a £15 'Love2Shop' gift voucher in appreciation of the time you have given to participate.

What do you need to do next if you want to participate?

If you want to participate you should share this information with your partner and ask if your partner is also willing to take part. You can contact me using the contact details below to ask any further questions about the study and to let me know whether or not you would like to participate.

If I do not hear from you, I will contact you within the next seven days. If you are not interested, I will not contact you again. If you and your partner both agree to participate, we will arrange interviews at times most suitable for each of you.

I am interested in interviewing men with different experiences of managing their weight, including men who lost weight as a result of FFIT, those who didn't, and those who may have gained weight. Therefore, I will ask you whether or not you lost weight whilst in the FFIT programme, and if so, whether you have maintained this or not.

Do you have to take part?

No, taking part in this research is entirely voluntary. If you agree to take part you can still choose not to answer any questions that you do not want to. You can also withdraw from the study at any time.

Is this research confidential?

University of Glasgow requirements are that confidentiality will be maintained as far as possible, unless during our conversation I hear anything which makes me worried that someone might be in danger of harm. In this case, I might have to inform relevant agencies of this. No information that could identify you will be given out to anyone else.

What will happen to the information you provide?

Any information that you provide, including your name and identifiable details, will be kept strictly confidential. The interview recordings will be transcribed and the files will be stored on a password-protected computer. Any paper copies of the data, including your identifiable data will be stored in a locked cabinet. All personal data will be permanently deleted after completion of the study. The de-identified research data will be kept for ten

years after fieldwork has been completed, and then destroyed in accordance with MRC and University of Glasgow policy. It may be used by other researchers, with the MRC's approval, under strict rules protecting the confidentiality of your information.

What will happen to the results of this research?

The results of this research will be used in publications, presentations, and my PhD thesis about how men's attempts to lose weight and maintain weight loss influence, and are influenced by, their partners. However, your contributions will be anonymous (no one will be able to identify you in anything written about the project). I can send you a summary of the findings if you would like me to.

What is the benefit for you from this study?

You will not have any direct benefit from this study. However, the findings from this study will inform further research or interventions aimed at supporting men and women lose weight and maintain weight loss.

What if you have any more questions?

You can contact me, Sheela Tripathee, MRC/CSO Social and Public Health Sciences Unit (SPHSU), University of Glasgow, 200 Renfield Street Glasgow G2 3QB.

Email: s.tripathee@sphsu.mrc.ac.uk **Phone:** 0740 355 3045/07717 577 367

If you would like to speak to someone else not involved with this research or pursue any complaint, you can contact the College of Social Sciences Ethics Officer **Dr Muir Houston**, email: Muir.Houston@glasgow.ac.uk

This project has been approved by the Research Ethics Committee at College of Social Sciences, University of Glasgow.

Thanks for taking the time to read this. I would be delighted if you could take part!

Appendix 6 - Topic guides

Topic guide: Men

Before and during FFIT (initiating changes)

Thinking back before you started FFIT,

Can you tell me what made you join the programme?

What did you think about it at that time? What did you think it might be like before you attended the first session?

How do you think (partner's name) felt about you going to FFIT?

Was weight something the two of you had discussed before FFIT?

What was it about the FFIT programme that interested you in the first place compared to other programmes such as weight watchers, online management, going to Gym etc.? (Prompt: programmes, feminine, isolated, football club)

How did you feel at the first or second session when you were given the information about how to eat better and be more active? (FFIT programme and what you were expected to do at home)

What was it like for both of you when you went home and told your partner about what you had to do?

Did you want to make the changes on your own or did you suggest (Partner's name) joins in?

If so, how did you suggest that (partner's name) could support you or join you? How did you feel about this?

What changes did you discuss that could be made at home to help you manage your weight and feel fitter? (Prompt: buying different foods; smaller portion sizes; getting time to exercise more, changes to other household routines, active travel/who suggested the changes?)

Making changes

What kind of changes did you manage to make to the way (you) eat?

How do you feel about the changes that have taken place in relation to food and eating as a result of your being on the FFIT programme? (Probe: happy/unhappy about certain changes, frustrated, worried)

Have you got more involved in food related activities?

Why do you think you do not (cook, be involved in food preparation, shopping)?

If no: do you think she would have liked for you to take charge of your diet yourself?

Have there been any changes in your physical activity? What? (Prompts: Like going out for a run, walking to shops or to work, taking children to school (if applicable) or any recreational activities you do.

How do you feel about any changes that have taken place in relation to physical activity as a result of your being on the FFIT programme? (Probe: happy/unhappy about certain changes)

How about drinking alcohol?

At what point did you/she start noticing changes to how you look (weight/appearance/clothing, the way you were eating, being involved in food related activities; the way you were exercising).

What do you think helped or hindered you in making these change? (Prompts: elements of the FFIT programme, your support, work, children, other caring commitment).

Did you encounter any challenges?
How did you deal with these challenges?

Keeping in mind the changes you both may have made since you joined FFIT, can you tell me a bit about what day to day ? (Notes: changes in joint and separate activities) diet and PA (before and after FFIT)

Has (partner's name) shared with you how she feels about the changes you have made in your diet? (Prompts: pleased, fed up, frustrated, undermined?)

Maintenance (if not already covered)

Now that FFIT has finished, can you tell me about the ways in which you have kept with the changes that you made? (Prompt: changes made individually by each and joint activities or routines)

What were the easier changes related to eating /PA

What were changes relatively harder to maintain eating /PA

If changed/maintained:

How do you feel about the changed **eating habits and doing more exercise**, Do you think you consciously think about them or they are more or less habits and that's something you do)

How do you feel about the time you spend for physical activities? (how do you think she feels about it?)

How do you feel about your weight loss outcome now?

How do you think (partner's name) feels now about your weight loss now?

Are you involved in any activities with men you did FFIT programme with?

How have you noticed a change in how much you spend on food?

Influence on partner

How have the changes that you tried to make influenced what (partner's name) eats (or what is eaten in the household as a whole)? How did that happen? (Prompts: same meal or make separate meals, discuss what to eat)

How have the changes that you tried to make in relation to activity influenced the activities that (partner's name) does? How did that happen? Has it positively changed? (If yes: partner's weight loss outcome)

Did (partner's name) initiate or get interested or did you try to encourage her to make these changes? (Probes: for diet and for PA)

Do you think your partner making (not making) changes to his/her own dietary and exercise habits or influences you in any way?(Probes: staying motivated, wanting to give up, wanting take control of the changes etc)

Feminine influence

Other studies have found men's partners vary in how they react to men making changes to their diet, and physical activities. How did (partner's name) react? (Prompts: was she happy, wanted to help, thought you should be responsible for it got involved supportive. Any differences for Diet and PA)

Some people talk about how it is hard for men to make changes to what they eat because often women are more involved in food buying and preparation and men feel they need to accept what food is given to them to be polite- what do you think about it?

Whose responsibility is it for what your partner eats?

Do you feel it's up to (partner's name) to take responsibility for what you eat?

If yes to this: Does your partner ask you what you would like to eat before he/she decides what to cook?

What happens when you eat outside of the home (Prompt: does she influence what you eat?)

In what area do you feel (partner's name) supported you most?

If, and in what way it was it different for food related activities compared to physical activity?

Were there other areas where you would have liked for your partner to be more supportive? (prompts: limiting unhealthy food in house, preparing meals that were healthy for you, encourage you to keep going, joining you in physical activity , motivating you?)

What activities do you do together?

What activities to you do separately?

Masculinity

Have there been any changes in who buys the food, and what is bought, who does the cooking? If yes, how?

If his involvement has increased: Do you think of these changed routines as something special you are doing?

How do you feel about these changes as a man, because some men say they are not comfortable working in the kitchen?

Some people think making changes to what you eat to manage your weight is not for men, how do you feel about it?

Did you feel the same before FFIT or has it changed since?

Have there been differences in how easy it has been to make changes to your activity as compared to what you eat? If so, why might this be?

Some people think it is more masculine to exercise than to diet, what do you think about it?

Conflict

Has it impacted your relationship at all?

(Prompt: Some people talk about how they do more together and feel closer where and some people say because husband is away a lot they have less time together)

Times of change can have a bit impact on couples. Can you think of anyways that these changes have impacted you as a couple?

Are there any changes that have come about as a result of FFIT that have caused any tension or arguments between you at home? Negotiations

Closing

In what ways could your partner have been more or less involved in making these changes?

Have you experienced any other benefits from taking part in the programme? If yes, what? (Prompt: do more with family, do more with (new) friends)?

What was the most useful part of the programme for you? (Prompts diet, PA or plan goal setting)

Did you prefer any element over the other?

What do you say to friends or family about the changes you are making and attempting to lose weight?

If yes: Do you talk more in terms of losing weight, dieting, specific changes you are making in the household routine, How do they react?

Summary

At end of discussion, summarise what has been said and ask the participant if there is anything else he would like to add.

Are there any other issues or topics you want to raise?

Topic guide: Partner

Thank you for taking part
Consent form

Introduction

I am interested in what it is like to try and make diet and lifestyle changes when living as a couple. We want to find out what impact partners have when men are trying to make these changes or what it is like for partners when men start to change their diet and/or physical activity. In this interview we will talk about how you feel about the changes if there were any, and how they have impacted you on.

What you have to say is important to me, so please don't hesitate to speak your mind. If you would rather not answer any of the questions I ask you, or you want me to stop the conversation at any point, please feel free to let me know.

Are you OK with me audio recording the discussion? Everything you say will be in strictest confidence (and will not be shared with your partner or anyone else).

Do you have any questions?

Before we begin can you please ask you (Demographic information): Age, cohabitation duration (Marital status), Children, Weight loss/current weight, Nature of Job, Formal weight loss programme before)

Before and during FFIT (initiating changes)

Thinking back to when your partner decided to sign up for FFIT, how did you feel about him taking part in the programme?

Did it surprise you?

What did you discuss beforehand?

Was weight something the two of you had discussed before FFIT?

What did you think the programme might be like before (partner's name) attended the first session?

What was it like for both of you when (partner's name) was being given information about ...

how to eat more healthily?

physical activity? (Prompts: The information he had been given, Goals he was setting)

(prompt: Evening after the first session, can you remember what you talked about)

Did he seem to want to make the changes on his own or did (partner's name) suggest you join in?

If so, how did he suggest that you could support him or join him?

Why with this particular thing and not other areas?

How did you feel about this?

Other couples we have spoken to talk about the changes they discuss, ...What changes did you discuss that could be made at home to help him manage his weight and feel fitter? (Prompts: buying different foods; smaller portion sizes; getting time to exercise more, changes to other household routines, active travel/who suggested the changes?)

How did you feel about any changes he suggested at that point?
(Prompt: happy to go along with things? Fed up? Worried? Undermined? Emotional?)

Making changes

Can you tell me about any changes he manage to make to the way he eats?

Can you tell me about any changes you manage to make to the way you eat?

What kind of changes did he manage to make to his physical activities?

What kind of changes did you manage to make to your physical activities?

How about drinking?

Did you encounter any everyday challenges?

How did you deal with these challenges?

Keeping in mind the changes you both may have made since (partner's name) joined FFIT, can you tell me a bit about what you tend to do day to day now?

(Notes: changes in joint and separate activities) diet and activities

Have there been any changes in the daily life and who does what?

(prompts: who buys the food and what is bought; who does the cooking)

Have there been any changes in the daily life in terms of activities?

How involved is partner in food related activities (food shopping, cooking etc) since taking part in FFIT? How does this compare to before FFIT?

If more involved: How has it been for you when he got more involved in these tasks?

If not: would you have liked for him to take charge of his diet himself?

Why do you think he does not (shop, cook, be involved in food preparation)?

At what point did you start noticing changes to how he looks

(weight/appearance/clothing)? the way he was eating, being involved in food related activities; the way he was exercising

What do you think helped or hindered him in making these change?(Prompts: elements of the FFIT programme, your support, work, children, other caring commitment).

Maintenance (if not already covered)

Now that FFIT has finished, can you tell me about the ways in which he has kept with the changes that he made? (Prompt: changes made individually by each and joint activities or routines)

Can you tell me about the ways in which you have kept with the changes that you made?

What were the easier changes related to eating /PA for you and for him
What were changes relatively harder to maintain/PA for you and for him

Are there any old habits that have returned for either you or him? (Probe: what they are, why do you think you/he have gone back to)

If changed/maintained: How do you feel about the changes that are ongoing (eating healthy and doing more exercise) (probe: do you think you consciously think about them or they are more or less habits and that's something you now just do)

How do you feel about any changes? (Prompts: Happy/unhappy, frustrated, worried, and undermined about certain changes changes/lack of)

Has (partner's name) shared with you how he feels about the changes you are making (or about not making)?

How do you feel about the time he spends for physical activities?

Is he involved in anything with other guys he met during FFIT?

How have you noticed a change in how much you spend on food?

Influence on partner

Have the changes that (partner's name) has tried to make influenced what you eat (or what is eaten in the household as a whole)? What?

How did that happen? (prompt: he encouraged, you initiated)

If not already covered: Do you eat the same meals or make separate meals?

Have the changes that (partner's name) has tried to make in relation to activity influenced the activities that you do? What?

How did that happen? (Prompts: he directly/indirectly encouraged? you initiated?)

How do you think he feels about (diet change/PA/weight loss?

Has it affected you activity positively or negatively in any way?

(Prompt: preventing you from you doing something that you were doing before)

Have there been any changes in how and when you both exercise? (Prompts: going out for a run, walking to shops or to work, taking children to school (if applicable), or any recreational activities you do)

Do you do more on your own or are you both doing some of the activities together?

Partner influence

Whose responsibility is it for what your partner eats?
Why do you think you feel that way?
Some people talk about how it might be difficult for women who are preparing food when another family member decides to change diet as it may require extra time, how did you find it?

Do you ask him what he would like to eat before you decide what to cook?
(what would you ask him, how is this different from before FFIT)
What/who influences most what he is eating outside of the house?
Some people believe that it is woman's responsibility to feed their partner.
How do you feel about the idea that its up to you to take responsibility for what he eats?
Some people talk about how it is hard for men to make changes to what they eat because female family members are also involved in food buying and preparation and men feel they need to accept what food is given to them to be polite. What do you think?

Thinking about the changes he has made to both diet and PA do you feel you were able to support him more in one than the other?
If, and in what way was it different for you to support him in food related activities compared to physical activity?

Were there other areas where you would have liked to offer more support?
(prompts: limiting unhealthy food in house, preparing meals that were healthy for him, encourage him to keep going, joining him in his physical activity , motivating him)

Masculinity

What do you think it's easier for men to change- eating or activities or are they both equally easy?

What do you think about the idea that it is easier for men to change their physical activities than change what you eat?
Some people think or trying to lose weight is not very masculine or that it is only something that women do, how do you feel about it? Did you feel the same before FFIT or has it changed since?

Some people may think it is more masculine to exercise than to make changes to what they eat what do you think about it?

Negotiations

How do you feel about your weight loss outcome now? (do you tell him that?)

In what ways do you think you making (not making) changes to your own dietary and activity habits or what you do at home has influenced (partner's name)? (Prompts: staying motivated, wanting to give up, wanting take control of the changes) (NEGOTIATIONS)

Conflict

(Prompt: Some people talk about how they do more together and feel closer where and some people say because husband is away a lot they have less time together)

Times of change can have a bit impact on couples. Can you think of anyways that these changes have impacted you as a couple?
Has it impacted your relationship at all?

Are there any changes that have come about as a result of FFIT that have caused any tension or arguments between you at home? Negotiations

Closing

Would you have liked to be more or less involved in the changes (partner's name) was making (or more involved in any aspect of the FFIT training)?

Have you experienced any other benefits from (partner's name) taking part in the programme? If yes, what? (Prompt: do more with family, do more with (new) friends)?

Have you experienced any other challenges?

Appendix 7 - Demography table

	William	Sandra
Age	63	61
Living together (Marital status)	44 /48 (Married)	
Children	1 Daughter 41 (lives away)	
Weight before FFIT/ loss at the end of FFIT/current weight	80kg/75/71	7 stone 2 pounds (No weight loss)
Nature of Job	IT (retired, working part time)	Domestic assistant
Recommendation to lose weight by anyone	No	No
Formal weight loss programme before	No	No (now planning to join a Gym)
Completed FFIT (month/Year)	May 2015	
Venue	Their home (weekday afternoon)	
Order of interview	Male followed by female	
Length of interview:		
Notes:	Partner present at home but away from the room. Partner appeared anxious at the beginning but seemed more comfortable as the interview went on.	

Appendix 8 - Example of code specific couple framework



Partner influence on men's diet both perspectives	
Jeremy	<p>Diet before FFIT: Less healthy but was better when eating at home. Not involved at all. Partner did 'everything'. Changes after joining FFIT: Partner took the responsibility. He did not increase his involvement. Changing diet together: Yes but guided by her pre-existing dietary plan. Thinks it helped with his attempt. Alcohol: No difficult because 'was not much of a drinker' Maintenance of Diet changes: Happy with the maintenance, partner still helps. Coedting but she has not maintained hers as well as he does. Partner influence: They eat same meal <u>but if she is snacking unhealthy, he would not do the same</u>. Says his diet is driven by what his wife is eating. After FFIT he followed what she was eating as a part of her weight watchers. Diet is something they talk about a lot "When I am away I will ring... ref 14)</p>
Lisa	<p>Diet before FFIT: she has been in diet on and off for many years. He was not keen to follow her plans in the past and traveling for work meant that he was not eating healthy meals all the time. Changes after him joining FFIT: He followed her diet plan after joining FFIT. She cooks and does everything to prepare healthy meals and have healthy snacks. He influences healthy eating by refusing to go for unhealthy option such as takeaways or eating out. Changing diet together: Yes she 'controls' dietary plan. Maintenance of Diet changes: Thinks it helped with his attempt She thinks her having to help him might have impacted <u>her</u> weight loss attempt negatively. She finds it challenging time wise "I have to make time to follow the plan, do the extra cooking. It's not extra cooking, it's different cooking. And plan that and manage it, and then manage to go to the gym five or six times a week's had a bigger impact on me than him, definitely."</p>
Shawn	<p>Diet before FFIT: Changes after joining FFIT: Changing diet together: I thought she might join in but then we both have different test to what we eat. Out tea time we eat two different things. She'll eat something and I'll eat something totally different. So I didn't expect myself to join in though. Alcohol: He drinks along without the partner's knowledge. Considers reducing alcohol a challenge. Maintenance of Diet changes: Some practices maintained. Her involvement level is constant "she is still buying crisps and chocolate when I was going through which was a bit of a...I just had to be stronger myself, a bit disciplined". Partner influence: Supportive of him eating healthier meals but they have different tastes so they tend to eat different meals.</p>
Tracy	<p>Diet before FFIT: Tried to help him eat healthy for many years "he is his own man" would not... It's been easier for her to get him to eat healthy foods after FFIT Dietary changes after joining FFIT: They cook equally and goes food shopping together. "If I could nag him or bully him in eating the way I wanted I...he'd not be my husband, you know? He is who he is and so I can't change him fully, but I like the way that he is changing himself and I support him in that. "I've tried to put more healthy options in the house but experience tells me it does not make whole lot of difference. Because I can't control what he eats when he is not there he ever takes the biscuits (to work) which are a big step for him". Changing diet together: she says she would like to make their diet even healthier. She thinks her eating healthy influences him as well. I would like to still work on that (food shopping) so that we have more fresh fruit and vegetables and healthier diet. We are still way behind to where we want to be.</p>

Appendix 9 - Participants Consent Form



College of Social
Sciences

Men managing their weight through diet and physical activity: influences from and on their female partners

Consent Form

Please tick as appropriate:

1. I confirm that I have read and understand the information sheet for the 'Men managing their weight through diet and physical activity: influences from and on their female partners' study and have had the opportunity to think about the information and ask questions.
 2. I understand that participation in the study is entirely voluntary and that I am free to withdraw at any time, without having to give a reason.
 3. I agree to an audio recording of the interview and I understand that the information I give will be recorded and stored securely.
 4. I understand that extracts of what I say may be used by the researcher in future publications and/or presentations, but this will be done in ways that do not identify me.
 5. I understand that my name will not appear in any articles and/or presentations.
 6. I understand that interviews for this study might be held at my home or location that I mutually agree with the researcher in this study.
 7. I understand and agree that the information from my interview would be overseen by the researchers at the University of Glasgow in accordance with their strictest rules of confidentiality.
- I agree to take part in this study and agree that my participation has been fully explained to me.

Participant name Signature Date

Researcher name Signature Date

Appendix 10 - Typology development: comparison of participants to determine participants' involvement/reliance categories for diet or physical activity

Couples	Responsibility for making the man's dietary practice <i>healthier</i>									category
	Meal planning	Meals in the house	Food shopping	Food preparation	Outside meal	Healthy Snacks	In charge of changes	Partner's moral support	Codieting	
Anthony Andrea	Both	Self	Both	Self	Both	Both	Self	Yes	Yes	Resolute/ V Involved
Kenneth Kelly	Both	Both	Both	Both	Self	Self	Self	Yes	Yes	Resolute/ V Involved
Jeffrey Michelle	Self	Self	Self	Self	Both	Both	Self	Yes	Yes	Resolute/ P Involved
Jason Nicole	Both	Self	Both	Self	self	Self	Self	Yes	Yes	Resolute/ P Involved
George Barbara	Self	Self	Self	Self	Self	Self	Self	Yes	Partial	Resolute/ P Involved
William Sandra	Self	Both	Self	Both	Self	Self	Self	Yes	No	Resolute/ P Involved
Eric* Heather	Self	Self	Self	Both	self	Self	Self	Yes	Partial	Resolute/ P Involved
Scot Judith	Self	Self	Self	Self	Self	Self	Self	No	No	Resolute/ N Involved
Shawn Tracey	Both	Her	Both	Her	Both	Self	Self	Yes	Partial	Reliant/ P Involved
Luke Mary	Both	Her	her	Her	Both	Her	Her	Yes	Yes	Reliant/ V Involved
Paul Lorna	Her	Her	Her	Her	Self	Her	Her	Yes	Yes	Reliant/ V Involved
Jeremy Lisa	Her	Her	Her	Her	Self	Her	Her	Yes	Yes	Reliant/ V Involved
Joseph Tricia	Her	Her	Both	Her	Her	Her	Her	Yes	Partial	Reliant/ V Involved
Matt Sarah	Both	Her	Both	Her	self	Both	Both	Yes	Partial	Reliant/ P Involved
Peter Angela	Both	Her	Both	Her	Self	Self	Both	Yes	No	Reliant/ P Involved
Richard Hillary	Both	Her	Her	Her	Self	Self	Both	Yes	No	Reliant/ P Involved
Ryan Amanda	NR	NR	NR	NR	None	NR	Her	Yes	NR	Non-responsive/ V Involved
Kevin Michelle	None	None	None	None	None	None	None	No	No	Non-responsive/ N Involved
Mathew* Kimberly	None	None	None	None	None	None	None	No	No	None-responsive/ N Involved
Mark Dawn	NR	NR	NR	NR	NA	NR	Her	Yes	NR	Non-responsive/ V Involved

		Responsibility for increasing the man's physical activity						
	Couples	Walking	Gym	Leisure activity	Time arrangements	Partner's moral support	Coactive	Category
	Eric* Heather	Self	x	Self	x	Yes	Partial	Resolute/ P Involved
	Jason Nicole	Self	Self	self	Both	Yes	Partial	Resolute/ P Involved
	Peter Angela	Both	Self	Self	Self	Yes	Partial	Resolute/ P Involved
	Paul Lorna	Self	Self	Self	x	Yes	No	Resolute/ N Involved
	Richard Hillary	Self	Self	self	x	Yes	No	Resolute/ P Involved
	William Sandra	Self	self	Self	Self	Yes	No	Resolute/ N Involved
	Jeremy Lisa	Both	Both	Both	x	Yes	Yes	Receptive/ V Involved
	Shawn Tracey	Both	x	Both		Yes	Yes	Receptive/ V Involved
	Joseph Tricia	Both	x	Self	Her	Yes	Partial	Receptive/ P Involved
	Matt Sarah	Self	Self	Self	Her	Yes	No	Receptive/ P Involved
	George Barbara	Self	x	Self	x	Yes	Partial	Receptive/ P Involved
	Jeffrey Michelle	Both	Self	Both	Self	Yes	Partial	Receptive/ P Involved
	Kenneth Kelly	Self	Self	Both	Both	Yes	partial	Receptive/ p Involved
	Anthony Andrea	Both	Both	Both	NA	Yes	Yes	Receptive/ P Involved
	Luke Mary	Both	Self	Self	x	Yes	Partial	Receptive/ P Involved
	Scot Judith	Self	Self	Self	Self	No	No	Receptive/ N Involved
	Ryan Amanda	NR	NR	NR	NR	Yes	NR	Non-responsive/ V Involved
	Kevin Michelle	None	None	None	None	No	No	Non-responsive/ N Involved
	Mathew* Kimberly	Both	NR	NR	None	Yes	NR	None responsive/ V Involved
	Mark Dawn	NR	NR	NR	NR	Yes	NR	Non-responsive/ V Involved

Participants in Green denote Resolute men and their partners.

Participants in Amber denote Reliant/Receptive men and their partners.

Participants in Red denote Non-Responsive men and their partners.

** = Did not complete FFIT*

V Involved = Very Involved, P Involved = Partially Involved, N Involved = Not Involved

NR = Non - responsive, X = Not relevant

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