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**Gender Relations and Couple Negotiations of British Men's Food Practice  
Changes after Prostate Cancer**

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## Abstract

Nutrition plays an important role in the health of men diagnosed with prostate cancer and dietary interventions can therefore be a significant part of prostate cancer survivorship supportive care. Family food provision, however, involves complex social interactions, which shape how men engage with their diets and dietary interventions. The role that gender plays in shaping prostate cancer couples' food practices and men's diets after a prostate cancer diagnosis is thought to be important but is little understood.

This study explored couples' accounts of nutrition information seeking and diet change to gain a better understanding of how gender relations shaped men's food practices after prostate cancer diagnosis. Qualitative health interviews with men and their partners were conducted and analysed using interpretive descriptive methods.

Findings demonstrated how couples navigated food change journeys that involved seeking information, deciding what changes were warranted and implementing and regulating diet changes. Two overarching themes that illustrated couples' food negotiations were called '**Seeking information and deciding on food changes**' and '**Monitoring food changes**'. Additional sub-themes described who led food changes, women's filtering of information, and moderation or 'treats'. Throughout these food change journeys interactions between men and women were at play, demonstrating how gender relations and dynamics acted to shape couples food negotiations and men's food practices.

Findings reveal that attention to gender relations and the men's family food dynamics should inform diet interventions for men with prostate cancer in order to improve uptake.

Keywords: Nutrition; food choice; diet change; prostate cancer; men's health; gender relations

## **Introduction**

Nutrition plays an important role in health outcomes for men diagnosed with prostate cancer and dietary change interventions can be an important part of prostate cancer survivorship supportive care programs (Davies, Batehup, & Thomas, 2011). Epidemiological research suggests that obesity and diets high in meat and saturated fats and low in fruits and vegetables are associated with increased risk of death from prostate cancer (Gathirua-Mwangi & Zhang, 2013; Hori & Butler, 2011; Leitzmann & Rohrmann, 2012).

Diet has also been linked to prostate cancer progression and recurrence and clinical studies indicate that adopting a plant-based diet can reduce the rate of increase in prostate specific antigen (PSA) in men diagnosed with low-grade prostate cancer (Arab et al., 2013; Nguyen et al., 2006; Ornish et al., 2005; Van Patten, de Boer, & Tomlinson Guns, 2008). Because PSA can be used as a proxy marker of prostate cancer progression, these findings suggest that diet changes can potentially slow or stop prostate cancer growth and thus delay the need for treatments and decrease the substantial burden of treatment side-effects men with prostate cancer face (Berkow, Barnard, Saxe, & Ankerberg-Nobis, 2007).

As the number of prostate cancer survivors increases, there is growing interest in diet amongst this group of men and their partners and carers. Although some research suggests that UK men are interested in diet improvements as part of prostate cancer supportive care, (Avery et al., 2014) there is currently little research or services available to address this need for nutrition education and interventions. Consequently, little is known about what features of diet interventions would best contribute to changing men's diets favourably after a prostate cancer diagnosis (Demark-Wahnefried, 2009; Avery 2013; Carmody 2012).

Food choice behaviour research shows that men's diets are shaped by multiple factors including their partners and families (Baranowski, Cullen, & Baranowski, 1999; Bisogni, Connors, Devine, & Sobal, 2002; Wardle et al., 2004). However, the role that gender plays in shaping men's food practices after a prostate cancer diagnosis is little understood.

Masculinities and food practice research has demonstrated gendered differences in attitudes and practices around food and healthy eating (Newcombe, McCarthy, Cronin, & McCarthy, 2012). For example, eating red meat and large meals is often associated with masculinity and eating vegetables and being concerned about healthy eating is seen as feminine (Sobal, 2005). Such gendered food and eating stereotypes then position men's dietary preferences and practices as being in opposition to healthy eating guidelines which instruct men to eat in what can be

framed as 'feminised' ways (Gal & Wilkie, 2010). Masculine food and food practice ideals can shape the diets of prostate cancer survivors and might prevent them from healthier eating (Mróz, Chapman, Oliffe, & Bottorff, 2010, 2011b).

In contrast, women typically associate food provision as part of their role as a 'good wife' or partner and in health care provision for their partners and families (Furst, 1997). In many heterosexual households, women continue to play primary roles in family food provision whilst also being careful to defer to their male partner's food preferences and expectations (Charles & Kerr, 1988; Cronin, McCarthy, Newcombe, & McCarthy, 2014; DeVault, 1991; McPhail, 2012). Consequently, family food provision is thought to involve complex couple interactions, which shape how women and men engage with their diets and diet change.

Couple dynamics have long been explored and recognised as important in prostate cancer to the extent that the disease has been referred to as a 'couples disease' (Riechers, 2004; Soloway, Soloway, Kim, & Kava, 2005). Women play important roles in the overall health of partners diagnosed with prostate cancer and there remain societal and personal expectations for them to play an equally important role in men's nutritional health (Forbat, Place, Hubbard, Leung, & Kelly, 2014; Harden et al., 2002; Wootten et al., 2014). Likewise, women are also expected to play important roles in shaping how men engage in nutrition interventions and diet change after a prostate cancer diagnosis, however, there is little known about how heterosexual couples decide about and make food practice changes in this context.

Understanding couple diet change requires an examination of men and women's gendered food practices and how gender dynamics are implicated in couples' diets. Doing so means exploring the intricacies of interactions between expressions of masculinities and femininities from men and women and how they influence men's health (Lyons, 2009) and relies on a lens that exposes how gender relations are at play (Bottorff, Oliffe, Kelly, & Chambers, 2011).

One study showed that within some Canadian heterosexual couples men and women worked together to maintain hetero-normative food roles after the man was diagnosed with prostate cancer. This finding demonstrated the importance of understanding the gendered dynamics of couple food interactions and how they navigate nutrition and diet change (Mróz, Chapman, Oliffe, & Bottorff, 2011a). Consequently, the current study further explored couple's accounts of food and diet change negotiations to gain a better understanding of how gender relations and couple dynamics shaped their diets after prostate cancer diagnosis.

## Methods

Qualitative interviews with men diagnosed with prostate cancer and their partners were conducted and analysed using interpretive descriptive methods (Thorne, 1997). As part of this analytic approach, the phenomenon of diet change for men with prostate cancer was explored using a gender-relations conceptual framework to help organise and interpret the findings. Interactional patterns between the men and their partners were explored by seeking the perspectives of both partners, helping to expose gender-relations at play in shaping food negotiations and subsequent diet changes (Bottorff, Oliffe, Robinson, & Carey, 2011).

Institutional research ethics approval was obtained and ethics procedures were followed. Participants were recruited within the UK using a study brochure and advertisements on the national charity Prostate Cancer UK (PCUK) website and through the 'Prostate Matters' newsletter. Upon contact by email or telephone, potential participants were asked for details about their prostate cancer diagnosis and men who self-reported that they had been diagnosed with early to mid-stage prostate cancer at least 6 months before and within the last 5 years, and their co-habiting partners were invited to be interviewed for the study. Informed, signed consent was obtained from each participant.

Upon entry to the study, men were asked to complete a personal week-long food journal which was then used to customize questions for semi-structured, in-depth interviews lasting between 40 minutes to 120 minutes. Interviews with the men and their partners were conducted by the first author in-person in the participants' homes, by telephone or in an office at Leeds Metropolitan University.

Thirty-one participants in total were recruited and data from 28 participants (14 heterosexual couples) are presented in the current article. Each man was given the option for the couple to be interviewed separately as individuals or jointly as a pair. Exceptions were couples that were interviewed by telephone rather than in-person, in which case for convenience only individual interviews were offered and for one couple where the man was interviewed by telephone but the woman preferred to answer questions by email. For nine of the couples, the man and his partner were interviewed separately but five of the couples were interviewed as pairs- i.e. with the man and his partner interviewed together as a 'dyad' - yielding a total of 23 interviews. Although some participants resided throughout the UK including Scotland, Wales and North Yorkshire, they were mostly from the South, white, in their 60's, well-educated and middle-class (see table 1, Participant Characteristics).

Table 1 Participant Characteristics

<b>Participant Code</b>	<b>Age</b>	<b>Profession</b>	<b>Treatments*</b>
PC2M	68	Office manager	RP; RT
PC2P	64	Secretary	
PC6M	69	Prison guard/Chaplain	RT; ADT
PC6P	63	Nurse	
PC8M	62	Telecom technician	AS
PC8P	61	Office worker	
PC9M	58	IT Manager	RP
PC9P	57	Speech Therapist	
PC11M	70	Engineer	AS
PC11P	66	Teacher	
PC12M	62	Office Manager	RP; RT
PC12P	57	Office worker	
PC14M	64	Telecom technician	RP
PC14P	57	Nurse/Dietitian	
PC15M	53	Salesperson	RP
PC15P	52	Accountant	
PC16M	68	Civil servant	RP
PC16P	52	Civil servant	

\*Treatments: RP=Radical Prostatectomy; RT=Radiation Therapy; ADT=Androgen Deprivation Therapy; AS=Active Surveillance

Interviews were digitally audio-recorded and transcribed verbatim, accuracy checked and imported into NVivo™ software program and coded by the first author. The second author re-checked the codes against the data and descriptive themes were developed and organised by both authors, separately initially then agreed upon and integrated using a gender-relations framework. Themes were used to illustrate how couples' food negotiations shaped their diet change journeys and illuminate how gender relations were implicated in shaping the men's diets.

## Findings

Most participants described seeking information on various aspects of prostate cancer self-care, including nutrition. How couples sought, negotiated and incorporated diet information into their food practices varied. Upon finding nutrition information, the man, his partner or both decided on what, if any, changes to his/their diets were warranted and determined how these changes would be made and sustained. The 'food change journey' from seeking, finding, deciding

about and incorporating nutrition knowledge, whilst unique for each couple, highlighted how these elements were negotiated and the gender dynamics at play.

Findings are organised and presented under two overarching themes: **Seeking information and deciding on food changes;** and **Monitoring food changes.** Additional sub-themes described who led food changes, women's filtering of information, and moderation and diet exceptions or 'treats'. Illustrative quotes are labelled to identify the couple and distinguish between the man (e.g. PC1M = couple #1 man) and his partner (e.g. PC1P = couple #1 partner).

### **Seeking information and deciding on food changes**

Although most couples sought diet information, who searched and who made food change decisions varied among couples and seemingly within couples over time. Whilst couples could and did move between seeking and deciding styles, they nevertheless tended to present certain configurations of food practices that were more consistent than others. Headings below are therefore used for these styles as a heuristic device to help organise and present emerging food negotiations rather than as fixed typologies.

#### **Men leading food changes: *"Educating the wife, it's not easy."***

Several men in the study described seeking diet information, and deciding on what diet changes to make, presenting it as the 'masculine', logical and practical response to having cancer. However, their partners were often expected to incorporate these findings and decisions, into food provision practices. One couple [PC15] described his extensive nutrition research yet also highlighted the difficulties involved in then negotiating their joint food changes:

"I kept bothering her and showing her the videos. [Laughs]. Initially she struggled, you know, there's something about food in people, it's like religion. You know, if you tell someone that they can't eat something that they've been for the last 20 or 30 years they get quite defensive. Trying to get the wife on board, educating the wife, it's not easy, to be honest" [PC15M]

As indicated by her "defensive" reaction, his new involvement in family food created tension because it disrupted their traditional gender food roles, especially their tacit acceptance of her responsibility for their diet. He described how he thought she was threatened by his interest in healthy eating and his requests for food changes:



“I think partly because I’m saying, well my diet is partly to blame for why I have prostate cancer, she felt as though I was criticizing what she had been feeding me for the last 30 years.” [PC15M]

She in turn recognised it wasn’t easy to adapt to his decisions, but stated, “I slowly came round” [PC15P] to his requests. Notable here is a shift in domestic food dynamics from where she controlled food decision-making and provision to where she relinquished some power and he began to influence dietary decision-making.

Another couple [PC2] demonstrated how implicit gendered narratives provided discursive support to changing dynamics. His partner agreed to his suggested diet changes and changed her food provision and her own eating practices to match his to reduce tension and “make life easier”. She invoked traditional gender roles as justification when she described his masculine academic leadership skills and her feminine more practical cooking skills:

“I leave it to him because that’s what he does [laughs] ... he’s got that sort of brain, he’s an academic so, you know, I’m more practical! ... I mean I’m such a hands-on give me the food and I’ll cook it, just point me in the direction.” [PC2P]

There is an interesting, implicit, invoking of a Cartesian Dualist mind (male)/body (female) split here. In situations of urgency, such as following a prostate cancer diagnosis with rising biomedical markers of disease progression, it becomes acceptable, if not morally imperative, for a man to become interested in the previously feminine area of dietary decision-making. Further, traditional masculine notions of rationality are drawn upon to support this involvement in order to discursively legitimate it.

This mind/body split was also often linked to suggestions of hierarchy with the decision-making male clearly now taking the leadership role in family food; a cultural field that previously was the realm of the female partner for this couple:

“He decides the meals. I prepare.... I’m the sous chef.... He tends to lead the way really.” [PC8P]

In both the above accounts [PC2 & PC8] the man claimed the important (rational, intelligent) work of making dietary decisions, as it became no longer a mundane aspect of everyday life but a potentially vital part of survival. However, the pragmatic, practical, work-based daily task of food preparation remained the responsibility of the female partner.

The dynamics at play here then allow these men to become involved in the 'feminised' field of family food whilst still engaging in dominant masculine practices that draw particularly on rationality. Simultaneously, the female partners were not totally usurped from this domestic field but retained roles that facilitated their continued engagement in typically feminine practices described as caring and domestic ability (Charles & Kerr, 1988; Cronin et al., 2014; DeVault, 1991; Furst, 1997; McPhail, 2012).

Similar to this, were situations where both partners shared in the information and decision making elements but there was still a stereotypical gendered division of labour when it came to actual food preparation. For one such couple [PC11], she described how: "he would buy a book off the computer, read it and hand it to me and say "read that!" She then researched appropriate cooking information and recipes. Based on his research they jointly decided to become vegetarians, but he noted his autonomy when he stated: "I was driving it (food changes)." [PC11M].

Once she knew how he wanted to eat, she then made the practical food provision decisions and reaffirmed her dominant role as family cook when she described how she decided what meals they would have without input from him: "Oh no, he wouldn't get asked, he just gets it put in front of him!" [PC11P]. They jointly displayed a dynamic where there was a careful balancing of his need/desire to be involved in global dietary decision-making with her need for control over practical aspects of daily food provision.

### **Women leading food changes: "*Acquiescing to a wife*"**

In many couples, the women were long-time leaders in household food provision, which led to them taking a more active role in seeking nutrition information, regardless of how much interest in food their partners had. This is not surprising given the well-documented links between femininity and women's traditional roles in food provision (Beagan, Chapman, D'Sylva, & Bassett, 2008; Charles & Kerr, 1988; DeVault, 1991; Furst, 1997; Meah, 2013). This is shown in couple PC14 where the man justified her leadership in his food changes as 'natural' despite his dramatic increased interest in food, when he said:

"It's because she's interested in diet and dietary needs and things like that, more than I am really [...] She is more of an expert on this than I am really."  
[PC14M]

Calling her interest and knowledge of food and cooking “expert” offers insight into how food provision can be tacitly expressed as ‘women’s work’ without necessarily invoking sexist stereotypes (McPhail, 2012). Regardless, she downplayed her leadership role describing how they were jointly involved in decision-making, positioning her ‘place’ to lead food provision but to also defer to her partner’s wishes and needs:

“Well I think we share it. He’d probably say that I was the leader type of thing, but only from the fact that, you know, it’s the wife’s place to prepare food etc.” [PC14P]

A balance was observed here between her leadership in family food provision and his involvement in ‘helping out’. His increased interest in his diet satisfied male ideals of ‘taking control’ or autonomy in decision-making but he maintained a safe distance from feminine ideals about being too concerned about healthy eating.

The lead role played in information seeking and subsequent changes in food practices was not always straight-forward. For one couple [PC16], whilst she had always taken full responsibility for food decisions and preparation, their shifts in food practices following his diagnosis and her nutrition research took some getting used to. Like several other study couples, one of the most challenging food changes they made was a reduction in meat consumption coupled with an increase in vegetable consumption. Their accounts of these changes revealed the complexity of their food negotiations and how meat consumption can be seen as a form of gender expression and/or control.

His language demonstrated his resistance to eating less meat, something that he consented to despite his preferences:

“We made an agreement that I would cut back on... I mean I love red meat, I’m a real meat eater, and years ago I would eat steak, beef lamb, pork and all that sort of stuff. With no qualms, I mean I was a real carnivore. But having been diagnosed and having her read up on all this we agreed that I would cut back on red meats.” [PC16M]

By detailing his love of meat he could preserve a masculine attachment to eating it, as “a real meat eater” – a real man - despite the practical and rational decision to give it up. Likewise, he defended his adoption of eating vegetables and salads on medical grounds whilst asserting that this was nonetheless ‘unnatural’ for him. He goes further in stating explicitly that ‘acquiescing’ to his wife in terms of

food decisions could be crucial to his survival and therefore justifiable and on his terms:

“I don’t want to die of cancer. And if there’s any way that they can get around that, and it means acquiescing to a wife or whatever... I’m very happy to go along with it. I don’t think “oh God she’s telling me I shouldn’t do this or shouldn’t do that”. [PC16M]

Despite his struggle to maintain control of his decisions, she was blunt about how much she controlled his diet when she commented to the interviewer privately: “I could’ve made him into a vegan no problem at all!” [PC16P]

For some couples, this female leadership role was ascribed to a combination of the male partners lack of knowledge about how/where to look and a lack of interest in food, again in line with stereotypes of food being a female domain:

“All I’ve got to say to him is, “I think we need to add this into what you’re eating” and he’ll just say “okay that’s fine” he just accepts it, he knows that I researched it as best I can... He won’t read about it, no, he leaves it all for me. He wouldn’t have looked for it because he wouldn’t have known to look for it.” [PC6P]

Yet this was often more complex than the male partners lack of interest, skill or knowledge, it could also be about coping mechanisms in prostate cancer survivorship. Some female partners who were the main seekers of information were careful how they shared their findings with their partners. In practice, this often meant assimilating the information, thinking through the implications and explaining as much as was necessary to ensure changes could be implemented with minimum disruption to current food practice dynamics.

**Filtering information: “I’d like to talk to him a lot more”**

In the context of life-threatening illness there is often good reason why people struggle to cope with information seeking and implementing changes. For one couple [PC12], her ‘filtering’ of information was essential for helping him manage the stress of having prostate cancer. Although she wanted to talk more about what she had learned about diet, he would become upset if he worried too much about his cancer so she carefully chose what information to discuss with him and when:

“I would read something and tell him some latest research and he will say to me “please don’t bring this up to me at night”. Because he then can’t sleep. It’s difficult to talk to him about it because, he really doesn’t want to think

about his prostate cancer. So the communication now, is hmmm... I'd like to talk to him a lot more about the things I read but he's really like, "okay, I don't really want to", he kind of wants to sweep it under the carpet the whole time and just live. So I have to respect that." [PC12P]

Embedded here is her tacit responsibility for family food work, extended to restricting how to convey information to him. Likewise, for another man, having his partner filter information helped him to avoid worrying about having prostate cancer. Again traditional gender roles are invoked when he suggested that as a man he would probably not seek information on his own:

"Well she's the one that gets on the Internet, checks it out and reads it all. And hmmm, really, without her, I would probably try but... she's the one that really goes into it. ... it's a bit of a male thing probably. I would probably not want to obsess with it. In that sense, left to my own self, I would probably... I would try not to be thinking of prostate cancer all the time. I want to just get on with my life and enjoy life." [PC6M]

Shown here is recognition of need for 'balance' in implementing and sustaining dietary changes, which is often portrayed as the woman's responsibility for monitoring men's diets and allowing for exceptions or treats to healthy eating.

### **Monitoring food changes: "*She controls my diet brilliantly!*"**

Exploring couples' food negotiations revealed important insights into implementation of diet changes. The question asked of "How are decisions made about which foods/meals are bought, prepared or served in your home?" often revealed multifaceted replies. Additional issues surrounding maintenance of these changes were also revealed, especially around monitoring changes and ideas about moderation or 'balance'. Although men instigated or agreed upon diet changes this did not guarantee straightforwardness in maintaining them and the responsibility of doing so often fell on partners. It became clear that maintenance depended, at least rhetorically, on the partner's on-going monitoring or 'control' of these new food practices, ensuring men kept to the diet changes they had agreed upon. This is revealed by this man who had previously stated that he 'drove' their diet changes but then commented that despite this, the responsibility for his diet remained hers:

"We make a decision and she took it on board and she controls my diet brilliantly! And she knows that with a few exceptions that I back her entirely." [PC11M]

Such narratives link to work showing how discursive positioning of ‘men as children’ and ‘women as mothers’ serve to help bring about or legitimise health changes for men in ways that sustain the presentation of gender stereotypes (Lyons & Willott, 1999; Mróz et al., 2011a; Robertson, 2007). The difference here is that while Lyons & Willott (1999) show how female partners often use indirect and ‘sneaky’ means in executing this role, an ill-health context provides opportunity for making these practices more overt and direct.

Yet, as implied above, the dynamics here were often not simply of men’s acquiescence. One couple [PC16] described how he was happy for her to monitor his diet and to rely on her advice to make appropriate changes. She described careful monitoring of his diet to ensure that diet changes were manageable. However, despite this mutual agreement there was conflict in relation to this ‘mother/child’ gender dynamic where she felt the burden of responsibility:

“We would be out shopping, he would say, especially leading up to Christmas, he said “this time last year I would’ve bought three of those cakes.” And I said to him “don’t make me have to keep saying no”. I don’t want to be the one that is like mom, and saying “No, you can’t have that. No, you can’t have that. You’ve got to think about if you want it then okay.” And so it was like asking him to join me and take ownership himself, as well as me you know?”  
[PC16P]

For couple PC6 he described how crucial her role was in monitoring what they ate and at first invoked her traditional female gender food role when he described her as ‘policing’ him. However, he then immediately clarified that he did not need or want policing, perhaps to reassert his autonomy to the interviewer:

“She’s the one who researched it and came out with the books to read, and polices it. I’m quite happy with that.” [PC6M]

“So policing means?” [Interviewer]

“I don’t need any sort of... I don’t need someone to sit and tell me “you’re not having that!”” [PC6M]

Clearly then, whilst providing an opportunity for legitimising changes in men’s dietary practices there is often a cost involved in terms of the emotional labour required from female partners to carry through this monitoring responsibility.

### **Moderation and treats: “He doesn’t always listen”**

Much of the tension in couple dynamics outlined above links to the wider issue of 'balance' and 'moderation' in health practices; a common theme in lay perspectives on health, including lay men's perspectives (see for example Robertson, 2007). It was common for couples to describe the importance of relaxing diet 'rules' and having occasional 'treats' to preserve enjoyable aspects of their life including holidays, special events and meals out. Men especially described this need to "live and enjoy yourself as well!" [PC12M] or "don't obsess" about diet because "I think you've got to be sensible." [PC2M]

Embedded in these passages, and as mentioned in health promotion literature (Crawford, 2006), going against recommended healthy lifestyle advice, having a 'little bit of what you fancy', was itself postulated as health enhancing as the activities involved are seen as an important aspect of enjoyment, of living life, of 'wellbeing' (see also Robertson, 2007: 45ff). This becomes even more salient for men considering how there are tacit understandings that healthy foods are typically discursively positioned as 'bland' and 'unfulfilling' for men (Gough & Conner, 2006).

Many women supported a 'balanced' approach to diet change and recognised the man's desire (and right) to have a life that was not overwhelmed by a strict dietary and cancer focus. Here again were signs of women's implicit responsibility for men's diets and to 'allow' for treats:

"I don't want to make his life misery. You know what's the point of living to 100 if you haven't enjoyed the last 20 years?" [PC16P]

Again, this was not always without tension in relation to the expected (feminine) caring monitoring role that required more leadership on her part and resistance on his as demonstrated by this partner who commented: "And he doesn't always listen, even now." [PC12P]

Couple PC9 exhibited considerable tension in their differing views on moderation and her role in directing his diet. Fundamentally, she was critical of his food choices and, in turn, he was critical of her 'obsessive' approach to eating healthily. The following exchange (one of many similar exchanges through the joint interview) demonstrated this as they argued about her desire to purchase low-salt food products:

"I've got more strict with myself really, haven't I? It can take hours to do the shopping because I'm looking at the back of the packages now for the salt in it." [PC9P]

"Well you can't live like that." [PC9M]

“No? Well you can!” [PC9P]

“You can to a certain degree, but you could become obsessed with it can’t you?” [PC9M]

“Well I’m not obsessed, I just know...” [PC9P]

“Well you can become obsessed, that’s what I’m saying. I mean it can take you four hours to go around the supermarket. Because you’re checking absolutely everything. Reading about all the salt in everything, it can consume you!” [PC9M]

“Well I don’t see that as the same.” [PC9P]

“Well it is the same!” [PC9M]

Apparently then, the processes of monitoring dietary changes and of finding an appropriate balance between new dietary regimens and living an enjoyable life also often required major and on-going negotiation which was easier for some couples than others.

## **Discussion**

Negotiations around gathering information about what constitutes a ‘healthy diet’, making decisions based on that information about what foods to eat and then providing that food often disrupted couples’ established food gender dynamics. Furthermore, these shifting dynamics extended to monitoring the implementation of negotiated dietary changes, how strictly these should be enforced (and by whom) and when they could be ‘relaxed’; that is, when moderation was called for and ‘treats’ allowed.

Men’s decisions to become more engaged with their diets required complex and sometime contentious couple negotiations that potentially disrupted or reinforced traditional food roles. Canadian couples revealed how they adapted to prostate cancer and diet changes by maintaining hetero-normative food roles within their relationships (Mróz et al., 2011a). The current study examined couples’ food roles in more depth by exploring how gender relations shaped food negotiations in similar UK couple diet change journeys.

Previous research also highlights how men have often prioritised marital harmony over involvement and participation in food decision-making (Allen, Griffith, & Gaines, 2013). Whilst some men in the current study seemed satisfied to let their partner continue to make dietary decisions, it seems the identity disruption caused by a prostate cancer diagnosis prompted many of the men to become more



actively interested in this area of domestic life. In turn, previously established gender dynamics around domestic food arrangements often needed to be re-negotiated with most couples managing this through incorporating his increased involvement in decision making whilst she retained control in the role of food production.

Whilst some couples found this negotiation process easy, for others it was an on-going process with no easy resolution. Doubtless, the ease or not of these negotiations and changing involvement in food decision making and food production is linked to the pre-diagnosis nature of the couples relationships in terms of gender role expectations and whether, in Brown and Miller's (2002) (Brown & Miller, 2002) terms, couples hold 'traditional', 'transitional' or 'egalitarian' views of gender relations in respect of domestic food arrangements.

Linked to this, the ease of such negotiations is also likely to be affected by how similar the couples are in terms of 'readiness' or 'willingness' to change. A large part of food choice is dependent on long-term food habits developed over many years and gendered or not, these practices are hard to change once embedded in daily life (van't Riet, Sijtsema, Dagevos, & De Bruijn, 2011). As Franks et al (2012) have shown, dietary changes are far more likely to be sustained when both members of a couple are at a similar high level of readiness to change.

In a similar way, the current study shows how an 'ill-health' context can both challenge and sustain previous empirical findings that men have a 'less worried' stance toward food and are more likely to 'just eat what they like' (Beardsworth et al., 2002). The situation for many men in the current study is that they do, understandably, begin to show more interest in food following prostate cancer diagnosis yet often not to the extent that they would allow it to become too central in their lives or to interfere with the enjoyment of particular life activities; that is, most still view moderation and 'treats' in dietary choices as an important part of 'balance' in their lives.

This reflects men's wider narratives about the importance of 'balance', 'moderation' and 'having fun' in discussions about healthy lifestyles and adhering to health promotion advice (Robertson, 2007). This study revealed how these tensions created by the compensatory nature of food with the rational notions of eating and moderation played out within couples along gendered lines. Men relied on their partners to help them balance food enjoyment with healthy eating, thereby reinforcing both men's masculine food and health ideals and women's feminine nurturing roles.

When changes to stereotypically gendered food practices were pursued, the men needed ways to legitimise these. Men in this study, often supported by their partners, legitimised new healthy eating patterns mainly by recourse to masculine rationality in the face of a serious diagnosis and by the men continuing to present a (rhetorical) preference for 'male foods', mainly meat but also alcohol (Mróz et al., 2010; Nath, 2011; Sobal, 2005) even when their actual eating habits had altered.

Given that responsibility for family food decisions and preparation is still highly feminised in contemporary society (Bava, Jaeger, & Park, 2008; Bellows, Alcaraz V, & Hallman, 2010; Blake, Bisogni, Sobal, Jastran, & Devine, 2008; De Backer, 2011; Lupton, 2000), it is not surprising that women played important roles in couple food leadership. Likewise because men's leadership in food provision is not typically framed as masculine (McPhail, Chapman, & Beagan, 2011; Newcombe, McCarthy, Cronin, & McCarthy, 2012) it is not surprising that the men in this study needed to find such ways to legitimise their increased food involvement. Similarly, having partner support, tacitly or explicitly, featured prominently in men's accounts of diet change decisions and food negotiations.

The small and relatively homogeneous study sample here limits how these findings can be transferred or generalised to diverse populations and are not intended to represent broader accounts of food negotiations and gender relations across the UK. However, the in-depth exploration of these accounts as found in qualitative studies such as this provide rich detail and offer an in-depth understanding of how food negotiations can be constructed within heterosexual couples and in the context of prostate cancer.

Complex issues surrounding 'patient' and carer roles and related responsibilities and expectations are also expected to be at play and shaped by gender. These issues were beyond the scope of the current study and were not explored further because the participants were diagnosed with early stage disease, however, further explorations of these roles could be warranted, especially in advanced prostate cancer. Likewise, further research into couples from different social groups and ethnicities are warranted as well as same-sex couples to better understand the complexities of couple food dynamics after a prostate cancer diagnosis.

## **Conclusion**

Data presented show that the gender dynamics of domestic food arrangements are brought into stark relief in the context of a prostate cancer diagnosis where diet may possibly have played a part in the development of the condition but can also play a role in prostate cancer survivorship. Yet much current

research on gender and domestic food arrangements has not incorporated work on the ways in which stereotypical gender dynamics and food negotiations might shift within men's ill-health contexts. These shifts warrant further attention as there is growing interest in providing nutrition information and interventions designed for men with prostate cancer.

As prostate cancer supportive care needs are met, understanding couple's gendered food dynamics will be important considerations in the design and delivery of nutrition interventions where recognising that men's increased interest in nutrition or involvement in food decision-making might not extend to greater involvement, or interest, in daily food preparation. Likewise, the role that female partners play in nutrition information seeking, diet change implementation and monitoring and/or regulating men's diet changes means that diet interventions must provide for women's interests and expectations regarding food provision after her partner is diagnosed with prostate cancer and the ways that couples navigate and negotiate food change journeys.

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