"I'm Ready to Eat and Grab Whatever I Can Get": Determinants and Patterns of African American Men's Eating Practices

Derek M. Griffith, PhD[1]
Alana M. Wooley, SM[1]
Julie Ober Allen, MPH[1]

This article examines determinants and patterns of African American men's dietary practices. Thematic content analysis was used to analyze data from nine exploratory focus groups conducted with 83 urban, middle-aged and older African American men from southeast Michigan. The men distinguished between healthy and unhealthy foods and "meals" versus other instances of eating. Eating patterns and content differed depending on the meal, work and family schedules, food availability, and whether it was a weekday or weekend. When eating alone or outside the home, men prioritized convenience and preferences for tasty, unhealthy foods. Men often reported skipping breakfast or lunch and grabbing snacks or fast food during the day. They emphasized sharing dinner with their spouses and families—usually a home-cooked, "healthy" meal. On weekends, spouses often cooked less and men snacked and dined out more frequently. Sunday dinners involving favorite, unhealthy comfort foods were the highlight of men's eating practices. African American men tended not to follow healthy eating recommendations because of their busy lives, reliance on spouses to prepare food, and preferences for unhealthy foods. These findings suggest that healthy eating interventions must consider how the contexts of African American men's lives shape their eating practices.

Keywords: *African American; men; men's health; nutrition*

African American men have higher rates of developing and dying from chronic diseases associated with unhealthy eating practices than White men, White women, and African American women (Warner & Hayward, 2006). Despite this, few healthy eating interventions have engaged significant numbers of men, particularly African American men (Kumanyika et al., 2008). Gender-specific differences in eating behavior and dietary health are well documented and highlight the importance of gender as a determinant of health behavior (Millen et al., 2005), yet research identifying gendered barriers to healthy eating and eating patterns for men is scant, particularly for African American men.

Men tend to have patterns of consumption that are framed as masculine, such as consuming large, calorie-dense meals that include more red meat, eggs, and foods high in sugar than women (Courtenay, 2000; Mróz, Chapman, Oliffe, & Bottorff, 2011; Roos, 1998). Compared with women, men also have been described as eating more for sustenance and focusing more on eating for pleasure (Kiefer, Rathmanner, & Kunze, 2005; Mróz et al., 2011). Men's eating also has been described as being more heavily influenced by convenience than women's, especially outside the family context (Moss, Moss, Kilbride, & Rubinstein, 2007; Mróz et al., 2011; Sellaeg & Chapman, 2008).

Although African American men are more likely to perform household food-related activities than White men, food shopping and preparation is still largely performed by and considered within the domain of women

Health Promotion Practice
March 2013 Vol. 14, No. 2 181–188
DOI: 10.1177/1524839912437789

[1]*University of Michigan School of Public Health, Ann Arbor, MI, USA*

in African American households (Haynes, 2000). Shopping for and preparing food may be avoided by men because these activities are traditionally framed as feminine (Sobal, 2005; Vartanian, Herman, & Polivy, 2007). In fact, some research suggests that African American men's eating practices, particularly at home, largely depend on their spouses, whose influence can be both positive and negative (Allen, Griffith, & Gaines, in press).

Although spouses are often considered responsible for the overall and nutritional health of men in their homes (James, 2004; Lyons & Willott, 1999), men do differentiate between healthy and unhealthy foods and are concerned about their health (Gough & Conner, 2006; Sellaeg & Chapman, 2008). In a qualitative study by James (2004, 2009), African American men were found to consider healthy foods to be bland and less filling than unhealthy foods. Other studies also have shown that men, regardless of race or ethnicity, often characterize eating healthy as requiring self-denial (Gough & Conner, 2006). James (2009) argues that many African American men prioritize meat intake and do not consider nutrition when they evaluate the quality of their diets. Instead, they often evaluate their diet based on whether they have enough to eat, have a variety of foods, and do not have to fill up frequently on starchy foods. Samples of men, including African American men, have also been found to consider health-promoting dietary modifications as unnecessary until the onset of health problems (Gough & Conner, 2006; James, 2004). James (2004) found that African American men who had health problems were concerned about their health, but they equated getting healthy with exercising and staying fit and not with improving their diets. Even after serious medical diagnoses, men involved in dietary interventions are unlikely to adopt and maintain healthy dietary modifications (Mróz et al., 2011).

Ravenell et al. (2006) found that African American men may define health broadly and in relation to aspects of their lives that are not directly linked to their individual health or health behaviors. African American men have conceptualized being "healthy" as being able to fulfill key social roles that are fundamental aspects of their identities such as provider, husband, father, employee, and community member (Bowman, 1989; Hammond & Mattis, 2005; Ravenell et al., 2006). Particularly during their middle-adult years, approximately ages 34 to 60 (Erickson, 1980; Newman & Newman, 2009), African American men tend to treat fulfilling these roles as more important than their own physical health and health-promoting behaviors (Griffith, Gunter, & Allen, 2011). *Role strain* is a theoretical framework that describes how African American men balance fulfilling important social and cultural roles with coping strategies to manage and mitigate social inequities (Bowman, 1989, 2006). Bowman's (1989) conceptualization of role strain characterizes masculinity not simply as a universal and abstract notion, but as a stressor that becomes more or less salient in different phases of men's lives, social and economic conditions, and in relationship to different behaviors. This theory connecting male gender role strain with African American men's eating behavior has not been tested.

African American men's patterns of eating behavior and disproportionate rates of chronic diseases suggest that there is a need to examine the cognitive, social, and contextual factors that influence African American men's dietary practices. Food choice, preferences, portion size, and patterns are important, gender-typed behaviors. In this study, we examine how middle-aged and older, urban African American men describe factors that influence their dietary patterns and practices, particularly how African American men conceptualize and prioritize healthy eating in the context of other social priorities and demands.

METHOD

Setting

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

Study Design

We conducted exploratory focus groups with middle-aged and older African American men and important women in their lives to examine the social, cultural, and environmental barriers and facilitators to African American men's healthy eating and physical activity as part of the preliminary research for a larger intervention study called *Men 4 Health* (Griffith, Gunter, & Allen, in

press). This article is based on data derived from a subset of the focus groups conducted with men and exploring their eating behaviors and attitudes.

The focus groups were designed to have a relaxed atmosphere to facilitate open dialogue and mutually beneficial interactions among participants and between participants and facilitators. The groups lasted 2 hours and included a meal, written informed consent, a demographic survey, and an audiotaped, in-depth discussion. The guided, semistructured focus group discussion centered on the following questions: What influences what African American men age 35 and older eat? What influences what you eat? Extensive probing was used to gather greater detail. The University of Michigan Institutional Review Board reviewed the focus group study, protocols, and materials. An African American male facilitator led the focus groups and was assisted by an African American male cofacilitator who took notes to document group dynamics and track individual speakers' comments. Each participant was assigned a unique identifier for anonymity.

Recruitment

Participants were recruited by snowball sampling via word of mouth, flyers, and the social networks of the *Men 4 Health* outreach staff and partner organizations. The project's outreach staff was composed of African American men who lived in the cities of interest and had experience and reputations of being actively involved in addressing men's health in their communities. Participants received a meal and $20 in incentives.

Study Participants

Between July 2008 and February 2010, 83 African American men aged 35 years and older participated in nine focus groups on eating behavior: two groups with a total of 26 men from Detroit; five groups with 32 men from Flint; and two groups with 25 men from Ypsilanti (see Table 1 for participant characteristics).

TABLE 1
Selected Characteristics of Participants

Characteristic	*Participants n = 83*
Demographics	
African American men	100%
Average age (years)	56.7, range 32-82
Married	62.5%
Have a girlfriend, not married	18.8%
Very or somewhat difficult to pay bills	52.5%
College graduates	22.9%
Health	
Self as primary grocery shopper	33.3%
Wife/girlfriend as primary grocery shopper	45.3%
Eat 5+ servings of fruit/ vegetables daily	15.2%
Obese (body mass index ≥30)	29.6%
One or more chronic health conditions	74.7%

Data Analysis

Our data organization process was similar to the methods used by Griffith, Allen, and colleagues (Allen, Alaimo, Elam, & Perry, 2008; Griffith, Allen, et al., 2011; Griffith, Gunter, & Allen, in press). The focus group interviews were audiotaped, transcribed verbatim, and entered into the qualitative data software package, ATLAS.ti. We used a systematic data analysis process involving six steps: (1) Each focus group transcript was separated into segments of text that represented distinct meaning units—segments of text that conveyed their original meanings apart from the complete transcript. (2) A random selection of segments of transcripts was reviewed to inductively ascertain recurring patterns that emerged from the transcripts. (3) A deductive approach, drawing on the relevant literature, was combined with inductive strategies to capture the breadth of perspectives articulated by the focus group participants. This process yielded a codebook of concepts or codes chosen to enhance the ease and reliability of the assignment of codes to the text segments. (4) A team of trained, university-based researchers assigned codes to the segments of text in the focus group transcripts. (5) To determine how African American men conceptualize meals and healthy eating and to understand determinants and patterns of their eating practices, we examined six codes from the codebook: food quality; habit; health behaviors; choices/motivations/priorities; individual-level quantity; and routine (see Table 2). The research team combined the coded text segments across discussion groups, participants, and the six codes to form one consolidated document. Finally, (6) we reviewed the consolidated document to identify themes that were included in the Results section.

TABLE 2
Thematic Codes Analyzed

Code Name	*Description*	*Excludes*
Food quality	Mention of food quality; issues or concerns related to food quality including but not limited to mention of organic foods, genetically modified foods, use of pesticides; food preparation (the actual state of the food and how it's prepared—fried, baked, no salt —but not the behavior of "cooking"). Includes references to "eating healthier," with "healthier" referencing the quality of the food. Also includes references to unhealthy foods.	
Habit	Unconscious choices and decision making about any habits or behaviors. Habits or daily routines that may promote or be obstacles to health (e.g., time you wake up, tardiness, lack of planning, watching TV). The speaker doesn't have to perceive them as a habit.	Mental health, motive, stress
Health behaviors	General references to physical activity, eating, or other behaviors related to health. Does not include specific mention of health in general. Includes references to "eating healthier" with "eating" referencing habit/behavior. Includes references to cooking (as a behavior), and eating habits. Could be unhealthy behaviors.	Physical activity type, food type, stress
Choices/motivations/ priorities	Conscious decision making, choices regarding health, comparisons of things must/want to do and what gets done and what gets neglected, goal setting. Reported reasons why individuals do or do not engage in any health behavior; e.g., "I want to get up but I don't". Reasons given are not exclusively personal.	Habit
Individual-level quantity	Any mention of quantity in relation to an individual health behavior or health outcome: portions, amount, discussions about quantity; frequency, sustainability over time, regularity, mention of amount of time (e.g., minutes, hours); mention of "more," "less," "a lot," "a little"	
Routine	Timing in day, how busy people are; generic references to "routine" "schedule"	

RESULTS

Healthy and Unhealthy Foods and Practices

The men who participated in our focus groups tended to clearly distinguish between healthy and unhealthy foods. They described healthy meals as ones that included green vegetables, organic ingredients, poultry, salt substitutes, and whole-wheat ingredients. Generally, healthy meals were described as home-cooked and prepared by their spouses. The men considered "light" meals to be healthy, although they often found them unappealing and inadequate. Unhealthy meals were described as fried and containing salt, salty seasonings, fatty red meat, pork, or organ meat. Eating practices such as skipping meals and snacking were not noted as either healthy or unhealthy. In addition, men viewed weekends as opportunities to cheat or deviate from healthier diets followed during the week. One participant justified, "We are all gonna cheat every once in a while. You can eat healthy five days. We can say, okay, Sunday or Saturday is going to be my cheating day . . . Sometimes we get an extra little cheating in."

Although home-cooked meals were overwhelmingly categorized as healthy, many of the men also provided

examples of specific dishes and meals (e.g., soul foods, sweets, Sunday dinner) at home that they considered to be unhealthy. Dining out, particularly at fast-food restaurants, offered an expedient and convenient meal option, but one which men recognized was not healthy. One man described,

> Eating a lot of fast food, when people are on the go, something that's quick and easy to eat. You eat a lot of that stuff that's high in salt . . . high in fat because you can hold it in one hand and drive the car with the other.

Several men indicated that some restaurants had healthier options but they did not select them. When dining out, it was common for men to report eating an unhealthy meal and larger portions than they typically ate at home. One man explained,

> I noticed that when I go out to a restaurant, I go down the menu and see things that I feel is good for me is not [tasty]. I'm spending my money, [so] I'm going to make sure I get something that tastes good.

What Is a Meal?

A central theme in the data was men's differentiation between meals and other instances of consuming food such as snacking. A major component of men's descriptions of meals was protein sources, usually meat. This was generally the first type of food mentioned. Side dishes, consisting mainly of vegetables and starches, and dessert were mentioned as critical, albeit less valued, components of a full meal. Meals were described as quality time that a family spends together, sometimes just shared by a man and his wife and sometimes including children, extended family, and friends. Dinner was the primary meal that men discussed; breakfast, lunch, and snacks were more frequently characterized as food eaten for sustenance, alone, and with food choices driven by convenience and taste.

Characteristics of Different Meals

This section reviews how men thought and talked about different mealtimes. We focus on what was considered part of the meal, who prepared it, how it was prepared, and the context in which it was consumed.

Breakfast. Although men recognized that breakfast was important, they often reported skipping it because of limited time in the morning. An important determinant of whether and what men ate for breakfast was if they were at home, at work, or elsewhere. Men distinguished a light breakfast (e.g., cereal, yogurt, oatmeal, boiled eggs, or a donut and coffee) from a filling one (e.g., multiple meats and starches). Few descriptions of breakfast mentioned fruits or vegetables. Most men reported eating breakfast alone or with their spouses, especially during the week. Some men described preparing themselves a light breakfast on a weekday (e.g., toast, cereal), although they noted that their wives typically prepared more elaborate breakfasts (e.g., eggs and bacon). Some men reported having a later breakfast or brunch on the weekends after sleeping late, attending church services, or in between errands and family and community activities. They explained that they were more likely to eat a light breakfast on weekdays and a heavier breakfast on the weekend.

Lunch. Lunch was mentioned infrequently in the focus groups. Many men reported skipping lunch on weekdays because they did not want to interrupt their schedule or take time away from work. Others ate what was easily available, usually a burger or sandwich from a fast-food restaurant or something from a vending machine. As one focus group participant described, "When it come[s] down to lunch, I'm usually rolling then and I'm ready to eat and grab whatever I can get." During the week, the majority of the men who ate lunch appeared to eat alone. On the weekends, the men continued to skip lunch frequently. Others described eating a lot of fast food and having a "lunch that's handy, not necessarily healthy" during leisure time activities; sporting, community or family events; or while watching television or sports at home.

Dinner. Dinner was the meal mentioned most frequently; it was described as the heaviest meal of the day and identified as the one that men almost never skipped. Weekday dinners were generally home cooked, prepared by their spouses, consumed in the evening, and eaten in the company of their spouse or other family members. When their spouses did not prepare dinner and leftovers were not available, men would report eating at fast-food restaurants or taking their wives to a sit-down restaurant. Some of the men's wives prepared elaborate, multidish dinners most days of the week, whereas other men described their weekday dinners as consisting of a simple main meat dish (e.g., baked or fried chicken, red meat, pork, or turkey substitutes for red meat) and at least one type of vegetable. Although the men generally thought of the dinners their wives prepared as healthy, their descriptions of the contents and cooking methods suggest that they were often high in fat, salt, and sugar and lacked fruit and whole grains.

Several men mentioned that their spouses did not cook on Saturdays, so men would often take their spouses out to eat, sometimes for multiple meals. Sunday dinners were major events and often described as the meal men looked forward to all week. One participant distinguished weekday dinners from Sunday dinners: "You just cook, just to get through the week. But . . . I still try to cook all the main dishes on Sundays. . . . On Sundays, we have a big meal." Sunday dinners also were described as "a full-scale landslide of food," including several meat dishes and multiple side dishes of vegetables and seasoned greens. Sunday dinners were typically prepared by their spouses and often eaten with larger groups of extended family and friends.

Snacks. When asked about snacks, the men's statements suggested that they did not consider snacking as part of their conceptualizations of eating or meals. Men described snacking often, but their patterns and content varied depending on the context. Some men reported snacking throughout the day on things that were convenient (e.g., cookies, fruit), often to compensate for their skipped meals. One focus group participant described having a soda and candy to provide an energy boost when working late. Several participants also described snacking on chips, ice cream, nuts, soda, or popcorn to satisfy late night cravings while relaxing at home or watching television before bed. Some men explained that they slept better after snacking, though they recognized it was unhealthy to eat so late. On the weekends, men reported snacking more often and generally consuming greater quantities of snack foods.

DISCUSSION

This article discusses focus group findings describing determinants and patterns of middle-aged and older urban African American men's eating practices. We found that African American men distinguished between healthy and unhealthy foods but often chose foods they viewed as convenient, tasty, and filling. These findings are consistent with other studies that suggest men do not prioritize dietary health (Moss et al., 2007; Mróz et al., 2011). Men from our study described fulfilling work, family, and community commitments as more important than their dietary health, which is consistent with research on role strain as a barrier to other health behaviors for African American men (Griffith, Gunter, & Allen, in press). Throughout the workweek and on weekends, men indicated that skipping meals was common and that time constraints, spouse's food preparation, schedules, and availability of food shaped if, what, and how much they ate.

Meals, chiefly dinner, were described in greater detail and with greater frequency, suggesting that meals were more meaningful and important to men than other, sustenance-focused instances of eating. Their spouses typically prepared and shared dinner with the men during weekdays but the healthiness of these meals varied. Men described having more control over food eaten alone or outside the home, and they usually chose unhealthy but tasty foods. Although men from our study frequently described snacking on or grabbing unhealthy fast food, junk food, high-fat food, and sweets for breakfast, lunch, and occasionally dinner, they did not consider these instances of eating as "meals."

Men grabbed foods that were fast and convenient throughout the day and on both weekdays and on weekends because of busy schedules, family priorities, and personal preferences. On the weekends, men ate more for pleasure, and Sunday dinners involving favorite, unhealthy comfort foods shared with family and friends were depicted as the highlight of men's eating over the course of the week. Although deviating from healthier diets during the weekend could be interpreted as an "unhealthy" behavior, men's weekend dietary practices may serve as an important mechanism for accessing social support, relieving tension, experiencing love, and coping with chronic social and economic stressors (Geronimus, 2000; Semmes, 1996).

Limitations and Strengths

Qualitative research methods and data analysis techniques often elicit concerns about the validity and reliability of the data. Our data analysis strategy involved a systematic process of coding scheme development, refinement, and quote attribution. Although our procedures captured the strongest and most prevalent themes, they may have eliminated unique perspectives voiced by a minority of respondents. Despite these limitations, our qualitative methods tap into different voices and perspectives in participants' own words and help identify patterns, subjective interpretations, and perceptions of causality (Banyard & Miller, 1998).

Implications for Practice

Interventions to improve African American men's dietary health should recognize the challenges African American men face in fitting eating into their busy schedules and the reality that eating healthy is often not a high priority. Instead of focusing on home food preparation, choice, and portions, interventions should help men make healthy choices at fast-food restaurants, convenience stores, and in other easily accessible settings. Skipping meals likely contributed heavily to the

focus group participants' high consumption of fast food and unhealthy snacks. Interventions, therefore, may suggest that men carry healthy snacks and foods or work with them to increase their motivation and knowledge for selecting healthier foods at fast-food restaurants and in other community settings.

Interventions to improve middle-aged African American men's eating practices also must find a way to engage their spouses in preparing healthier foods at home. Although men described meals eaten at home as healthy, particularly when prepared by their spouses (with the exception of Sunday dinner), the content and preparation of these meals were not always healthy, though perhaps healthier than foods they would consume outside the home. It is critical to determine how best to engage men's spouses in these efforts without negatively affecting their relationships. It may be necessary to educate and intervene with the couple to effectively address men's eating at home.

REFERENCES

Allen, J. O., Alaimo, K., Elam, D., & Perry, E. (2008). Growing vegetables and values: Benefits of two neighborhood-based community gardens for youth development and nutrition. *Journal of Hunger & Environmental Nutrition, 3*, 418-439.

Allen, J. O., Griffith, D. M., & Gaines, H. C. (in press). "She looks out for the meals, period": African American men's perceptions of how their wives influence their eating behavior and dietary health. *Health Psychology.*

Banyard, V. L., & Miller, K. E. (1998). The powerful potential of qualitative research for community psychology. *American Journal of Community Psychology, 26*, 485-505.

Bowman, P. J. (1989). Research perspectives on Black men: Role strain and adaptation across the adult life cycle. In R. L. Jones (Ed.), *Black adult development and aging* (pp. 117-150). Berkeley, CA: Cobb & Henry.

Bowman, P. J. (2006). Role strain and adaptation issues in the strength-based model: diversity, multilevel, and life-span considerations. *The Counseling Psychologist, 34*, 118-133.

Courtenay, W. H. (2000). Constructions of masculinity and their influence on men's well-being: A theory of gender and health. *Social Science & Medicine, 50*, 1385-1401.

Erickson, E. H. (1980). *Identity and the life cycle*. New York, NY: Norton.

Geronimus, A. T. (2000). To mitigate, resist, or undo: Addressing structural influences on the health of urban populations. *American Journal of Public Health, 90*, 867-872.

Gough, B., & Conner, M. T. (2006). Barriers to healthy eating amongst men: A qualitative analysis. *Social Science & Medicine, 62*, 387-395.

Griffith, D. M., Allen, J. O., & Gunter, K. (2011). Social and cultural factors that influence African American men's medical help-seeking. *Research on Social Work Practice, 21*, 337-347.

Griffith, D. M., Gunter, K., & Allen, J. O. (2011). Male gender role strain as a barrier to African American men's physical activity. *Health Education & Behavior, 38*, 482-491.

Griffith, D. M., Gunter, K., & Allen, J. O. (in press). A systematic approach to developing contextual, culturally, and gender sensitive interventions for African American men: The example of Men 4 Health. In R. Elk & H. Landrine (Eds.), *Cancer disparities: Causes and evidence-based solutions*. New York, NY: Springer.

Hammond, W. P., & Mattis, J. S. (2005). Being a man about it: Manhood meaning among African American men. *Psychology of Men and Masculinities, 6*, 114-126.

Haynes, F. E. (2000). Gender and family ideals. *Journal of Family Issues, 21*, 811-837.

James, D. C. S. (2004). Factors influencing food choices, dietary intake, and nutrition-related attitudes among African Americans: Application of a culturally sensitive model. *Ethnicity & Health, 9*, 349-367.

James, D. C. S. (2009). Cluster analysis defines distinct dietary patterns for African American men and women. *Journal of the American Dietetic Association, 109*, 255-262.

Kiefer, I., Rathmanner, T., & Kunze, M. (2005). Eating and dieting differences in men and women. *Journal of Men's Health & Gender, 2*, 194-201.

Kumanyika, S. K., Obarzanek, E., Stettler, N., Bell, R., Field, A. E., Fortmann, S. P., . . . American Heart Association Council on Epidemiology and Prevention, Interdisciplinary Committee for Prevention. (2008). Population-based prevention of obesity: The need for comprehensive promotion of healthful eating, physical activity, and energy balance: A scientific statement from American Heart Association Council on Epidemiology and Prevention, Interdisciplinary Committee for Prevention (Formerly the Expert Panel on Population and Prevention Science). *Circulation, 118*, 428-464.

Lyons, A. C., & Willott, S. (1999). From suet pudding to superhero: Representations of men's health for women. *Health, 3*, 283-302.

Michigan Department of Community Health. (2008). *2008 Michigan Resident Death File*. Vital Records and Health Statistics Section. Lansing, MI: Author.

Michigan Department of Community Health. (2010). Michigan resident cancer incident file: Three-year age-adjusted cancer incidence rates by race, sex and county, Michigan residents, 2005-2007. Vital Records and Health Statistics Section. Lansing, MI: Author.

Millen, B., Quatromoni, P., Pencina, M., Kimokoti, R., Nam, B., Cobain, S., . . . D'Agostino, R. B. (2005). Unique dietary patterns and chronic disease risk profiles of adult men: The Framingham nutrition studies. *Journal of the American Dietetic Association, 105*, 1723.

Moss, S. Z., Moss, M. S., Kilbride, J. E., & Rubinstein, R. L. (2007). Frail men's perspectives on food and eating. *Journal of Aging Studies, 21*, 314-324.

Mróz, L. W., Chapman, G. E., Oliffe, J. L., & Bottorff, J. L. (2011). Men, food, and prostate cancer: Gender influences on men's diets. *American Journal of Men's Health, 5*, 177-187.

National Center for Health Statistics. (2001). *National vital statistics report* (Vol. 49, No. 8). Hyattsville, MD: U.S. Department of Health and Human Services.

Newman, B. M., & Newman, P. R. (2009). Middle adulthood. In B. M. Newman & P. R. Newman (Eds.), *Development through life: A psychosocial approach* (9th ed., pp. 452-491). Belmont, CA: Wadsworth Centgage.

Ravenell, J. E., Johnson, W. E., Jr., & Whitaker, E. E. (2006). African-American men's perceptions of health: A focus group study. *Journal of the National Medical Association, 98*, 544-550.

Roos, E. (1998). Gender, socioeconomic status and family status as determinants of food behaviour. *Social Science & Medicine, 46*, 1519.

Sellaeg, K., & Chapman, G. (2008). Masculinity and food ideals of men who live alone. *Appetite, 51*, 120.

Semmes, C. E. (1996). Emancipation and the roots of health. In C. E. Semmes (Ed.), *Racism, health, and post-industrialism* (pp. 1-16). Westport, CT: Praeger.

Sobal, J. (2005). Men, meat, and marriage: Models of masculinity. *Food and Foodways, 13*, 135-158.

U.S. Census Bureau. (2009). *Annual estimates of population of metropolitan and micropolitan statistical areas: April 1, 2000 to July 1, 2008*. 2008 Population Estimates. Suitland, MD: U.S. Census Bureau, Population Division.

U.S. Department of Labor. (2011). *Local area unemployment statistics.* Washington, DC: U.S. Department of Labor, Bureau of Labor Statistics. Retrieved from www.bls.gov

Vartanian, L., Herman, C., & Polivy, J. (2007). Consumption stereotypes and impression management: How you are what you eat. *Appetite, 48*, 265-277.

Warner, D. F., & Hayward, M. D. (2006). Early-life origins of the race gap in men's mortality. *Journal of Health and Social Behavior, 47*, 209-226.