MARITAL UNIONS AND RISK BEHAVIOR: MOTIVATIONS, PERCEPTIONS AND REGULATORY AGENTS

On-going study

ABSTRACT

In Brazil, where "true masculinity" is inherently unhealthy, celibacy may reinforce gender stereotypes, making men more prone to risk behavior to affirm their dominant position. Most studies, however, show a relationship between marital unions and the acquisition of health benefits as result of protective factors, especially for men. This study aims at analyzing the incidence of selected risk behaviors by marital status among Brazilian men and the personal motivation for these behaviors. Logistic regressions were performed using Brazilian National Health Survey (2013) data with a subsample of men over 18 years. Preliminary results show a smaller probability of men in formal unions to adopt risk behaviors, such as binge drinking and tobacco consumption compared to unmarried individuals. In-depth interviews are currently being conducted and will elucidate the mechanisms in which marital unions promote the abandonment of risk behaviors and the role of health regulation and support agents for men.

INTRODUCTION

Family structure is recognized by the literature as one of the main determinants for the well-being and health of individuals (Carr and Springer, 2010; Zella, 2017). Most studies show a relationship between marital unions and health benefits as result of protective factors and the maximization of economic resources (Duncan, 2006; Musick and Bumpass 2012, Davis, 2016, Zella, 2017). In the Western context, marriage has been identified as an even more protective institution for men's health compared to women's (Lillard & Waite, 1995; Williams & Umberson, 2004).Other authors, on the other hand, explain the the married individual's advantage in relation to the singles as a selection effect. In this perspective, healthy people are more attractive and, consequently, more likely to enter an union (Goldman, 1993).

In a lifestyle context, risk behaviors - with emphasis on the use of licit and illicit drugs and dangerous driving - are associated with greater exposure to chronic conditions and the occurrence of accidents and, consequently, to higher mortality (Verbrugge, 1979, WHO, 2002, WHO, 2014).

Most of the empirical studies on the subject address the differences in individual well-being and mortality attributed to marriage rather than the identification of determinants associated with differences, such as behavior, socioeconomic status, and the existence of support networks. Besides, Brazil offers a unique opportunity to study the relationship of marriage and health because gender stereotypes of masculinity include engaging in risky behavior (Gomes, 2008). Deaths from external causes, for example, account for 58.3% of all deaths in people aged 15 to 39 years in 2016, with men representing about 90% of the victims (Brazil, 2016).

Aiming at the analysis of the behavioral determinant, the objectives of the study are: To analyze the incidence of selected risk behaviors (excessive alcohol consumption, smoking and bad driving habits) by marital status among Brazilian men; To analyze the personal motivation and perception of men from 25 to 39 years old of different marital status, parental status (had a child) and levels of education about these behaviors; To

identify the mechanisms that promote the abandonment of the risk behaviors cited above; To identify the role of health regulation and support agents for men aged 25 to 39.

LITERATURE REVIEW

The reasons for health differentials between individuals of different marital status are explained from two main models, the marital resource model and the crisis model (Williams, 2003; Williams & Umberson, 2004). The first one, the model of marital resources, suggests that health differentials associated with marital status stem from better economic resources, social support, and behavioral regulation of married individuals. The crisis model, in turn, understands that a significant part of the differentials would be explained by deleterious effects of transitions in marital status in health, especially widowhood and divorce.

Williams (2003) points out that the distinction between the two models requires the identification of the effects of engaging in union and the impact of the transition into union. Duncan et al. (2006), reinforcing this perspective, presents the possibility of the temporary action of the effects after a short period of change of habits as a result of the transitions.

Following the perspective of marital resources, the literature points to the performance of four main mechanisms of union protection: institutionalization, social roles, social support and interpersonal commitment (Waite, 1995; Musick & Bumpass, 2012). The institutionalization emphasizes the influence of the legal structure under a normative behavior. The social function approach, in turn, highlights the role of marriage from the standpoint of the expected behavior of men and women. Social support focuses on the provision of regulation, daily interaction between the spouses and associated contact networks. Finally, interpersonal commitment foresees a facilitation of long-term investments resulting from the public nature of marriage and the consequent involvement of family members, friends, and religious quests.

In contrast to these models, Goldman (1993) argues that the advantage of married individuals in terms of mortality would be attributed mostly to selection. According to Goldman, the selection of partners for hereditary or psychological diseases, behaviors such as alcohol and tobacco consumption and age differentials between married and single (correlated with different mortality regimes) would be responsible for a spurious causal relationship between marriage and health.

Finally, the literature establishes a relationship between risk behaviors and socioeconomic variables (Hardarson et al, 2001), family background (Litman, 1967), community context (Robert ,1998), peer effect (Cohen, 2006), risk perception (Becker, 1974), gender relations (Laurenti e Gotlieb, 2005) and the timing and order of the transitions in the life cycle (Elder;1985).

DATA AND METHODS

In order to contemplate the first proposed objective, Brazilian men aged 18 years and over will be analyzed, using a secondary data source, the Brazilian National Health Survey of 2013. The National Health Survey is a household sample survey at the national level, (sampling probability is based on information from the 2010 census).

After selecting the households, an adult of 18 years or older were sampled from the household.

Descriptive and logistic analyzes were conducted for the responses given to the following questions: In the last 30 days, did you consume 5 or more servings of alcoholic beverages on a single occasion? (Yes or no); Do you currently smoke any tobacco products? (Yes, daily - Yes, less than daily - Do not smoke currently); How often do you wear a seat belt when driving or riding a car, van, or taxi? (Never stays in the front seat - Always wears a belt - Usually wears a belt, Sometimes wears a belt - Rarely wears a belt - Never wears a belt); How often do you wear a seat belt when riding a car / car, van, or taxi? (Never stays in the front seat - Always wears a belt - Usually wears a belt - Sometimes wears a belt - Rarely wears a belt, Never wears a belt); How often do you wear a helmet when riding a motorcycle? (Never walks in the front seat, Always wears a belt, Usually wears a belt, Sometimes wears a belt, Rarely wears a belt, Never wears a belt); On any of the days that you drank alcohol, did you drive after drinking? (Yes or no); In the past 12 months, have you ever been involved in any traffic accident in which you have sustained personal injury? (Yes or no).

To answer the other objectives, in-depth interviews are currently being conducted with 40 male individuals aged 25 to 39 in a consensual union for at least one year and men who have never been with a partner, of low and high education level, with and without children. We chose to study these age group in detriment of older individuals to minimize memory failures related to the period prior to the phenomena of interest, the union, and to reduce effects that do not refer directly to the transition from marital status, correlated with non-constant variables throughout the life cycle, such as income and occupation. In addition, the age group prevents recruitment of people who have been in unions for many years, while also minimizing the identification of behavioral changes resulting from the possible deterioration of the quality of the relationship over time. Thus, the study will capture the effects of the transition of marital status on the health of individuals and their permanence for at least a year after the marriage. Unfortunately, longitudinal data is not available on the topic, so this study in unable to answer whether selection effects might be occurring. With the in-depth interviews, we intend to identify mechanisms that involve the possible transformations in the health behavior of men after unions, minimizing the bias of the selection effect.

Likewise, given the important mortality differentials between young male and female in Brazil, it is possible that individuals with high probability of engaging in risk behavior might be already dead. Nonetheless, in-depth interviews will also be able to capture the experience of friends and acquaintances of these men.

PRELIMINARY RESULTS

The analytical sample from PNS (2013) is composed of individuals in formal unions (46.6%), consensual unions (19.2%), separated /divorced (3.4%), widowed (2.2%) and single/never married (28.6%). Regarding risk behavior, 21.6% of men consumed alcohol abusively in the last month, 16.2% consumed any tobacco products daily and 4.5% were involved in accidents with serious injuries. Regarding the use of belt and helmet in vehicles and motorcycle, respectively, 46.5% and 21.4% of individuals declared do not use the accessories occasionally, either as passenger or driver.

The results of the logistic regressions presented in Table 1 below shows a lower probability of men in formal unions engaging in the following behaviors when compared to their single counterparts: abusive alcohol consumption in the last month

(28% lower) and daily tobacco consumption (28% and 32% lower, respectively). Men in formal unions also have more probability to use seat belt (39%). Differences between single men and individuals in consensual unions, however, are not significant in any of the analyzed variables.

Marital status	Odds ratio	P>t
Alcohol abuse		
Single	REF	
Formal union	0.72	0.000
Consensual union	0.99	0.949
Daily consumption of tobacco		
Single	REF	
Formal union	0.68	0.000
Consensual union	1.10	0.319
Involvement in accidents with serious injuries		
Single	REF	
Formal union	0.80	0.121
Consensual union	0.93	0.634
Use of seat belt		
Single	REF	
Formal union	1.33	0.000
Consensual union	1.07	0.331
Use of helmet		
Single	REF	
Formal union	1.03	0.697
Cohabitation	0.88	0.172

* Controlled by age, education, race, residence status (urban and rural) and attendance at religious services

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