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Gender, Health Behavior, and Intimate Relationships: Lesbian, Gay, and Straight Contexts

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Abstract

Many studies focus on health behavior within the context of intimate ties. However, this literature is limited by reliance on gender socialization theory and a focus on straight (i.e., heterosexual) marriage. We extend this work with an analysis of relationship dynamics around health behavior in 20 long-term straight marriages as well as 15 gay and 15 lesbian long-term cohabiting partnerships in the United States (N=100 individual in-depth interviews). We develop the concept of "health behavior work" to align activities done to promote health behavior with theories on unpaid work in the home. Respondents in all couple types describe *specialized health behavior work*, wherein one partner works to shape the other partner's health behavior. In straight couples, women perform the bulk of specialized health behavior work. Most gay and lesbian respondents—but few straight respondents—also describe *cooperative health behavior work*, wherein partners mutually influence one another's health behaviors. Findings suggest that the gendered relational context of an intimate partnership shapes the dynamics of and explanations for health behavior work.

Keywords

US; health behavior; gender; gay and lesbian; intimate relationships; marriage; sexuality

Marriage is associated with more health-enhancing behaviors and fewer risky health behaviors (Umberson, 1987, Waite & Gallagher, 2000), and the influence of spouses on one another's behavior is one of the primary explanations for how marriage benefits health. Because the link between health behavior and overall health is well-established (McGinnis et al., 2002), the influence of marriage on health behavior is increasingly viewed as important for population health (Umberson & Montez 2010). In fact, U.S. and British public health initiatives, such as *Healthy People 2010* (U.S. DHHS 2000), *Change4Life*, and *Healthy Lives, Healthy People* (British DH, 2010), emphasize the importance of marital relationships in influencing health behaviors.

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Research consistently shows that attempts to influence a spouse's health are not equally enacted by men and women. Women do more to promote their spouse's health behavior, and this gender gap is identified as a primary reason that men's health benefits more from marriage (Umberson, 1992; Waite & Gallagher, 2000). In order to explain this persistent and well-documented gender gap, previous research has relied primarily on gender socialization theory to suggest that girls are socialized from a young age to care about others' health, while boys are not. Yet, the gender socialization approach has been criticized for placing men and women into "two fixed, static and mutually exclusive role containers" that do not vary by context or change over the life course (Kimmel, 1986, p. 521). In response, a range of cognate contemporary gender theories have been developed as a critique of gender socialization theory; these perspectives suggest that a gendered self is emergent in interactions that occur between and among men and women within broader stratified structural contexts (Connell, in press; Martin, 2004; Ferree, 2010). Such theories have been used to examine other activities that women disproportionally do in marriage—most predominantly unpaid work (Ferree, 2010)—but have not been applied to an examination of health behavior in intimate relationships.

Moreover, the focus on health promotion in the context of straight marriage raises questions about whether similar health promotion dynamics occur in gay and lesbian relationships. Extending the focus to gay and lesbian partnerships is important for at least two reasons. First, ongoing debates about the value of marriage for gays and lesbians have only articulated the health benefits of marriage for straight couples, neglecting to include empirical data on gays and lesbians (Wienke & Hill, 2009). Second, an exclusive focus on straight marriages precludes analysis of how the relationship dynamics between two women or two men shape health behavior.

We extend research on gender and health behavior in intimate ties with an analysis of 100 individuals in 20 long-term straight marriages as well as 15 gay and 15 lesbian couples in long-term cohabiting partnerships in the U.S. We analyze these interviews to ask: How do men and women describe relationship dynamics around health behavior in intimate relationships? We use contemporary gender theories to frame our analysis of health behavior dynamics within these partnerships.

Gender, Health Behavior, and Intimate Ties

Scholars have long attempted to understand the mechanisms through which intimate ties shape health, and social control of health behavior has been identified as one pivotal pathway (Umberson et al., 2010). Health behavior refers to a range of personal actions that influence health, disability, and mortality, and includes "risky" behavior (e.g., heavy substance use) and "health enhancing" behavior (e.g., regular exercise, eating healthy). Social control refers to direct and indirect efforts to influence the health behavior of significant others. Social control processes shape health behavior indirectly through the internalization of "appropriate" norms. For example, marriage introduces new health-related norms such as increased sense of responsibility to stay healthy and care for others. Social control also operates directly when a spouse attempts to curtail, regulate, or sanction their partner's unhealthy behaviors (Umberson, 1987); for example, when spouses "tell or remind an individual to engage in healthy behavior or avoid taking risks" (Umberson, 1987; p. 310).

Most studies emphasize that women do more to promote a spouse's health behavior because of gender socialization (Umberson, 1992). Gender socialization or "role" theory suggests that a gendered self is formed via socialization in childhood and reinforced throughout life so that "one's gender role script becomes so natural as to be seen as an integral part of oneself" (Fox & Murray 2000, p. 1163); thus, the gender gap in health behavior promotion

exists because women are socialized to care for others' health, while men are socialized to take health risks. This approach has been criticized for placing men and women into discrete roles that are largely unchanging over time (Butler, 1990; West & Zimmerman, 1987). Further, this approach has limited theoretical power to explain relationship processes in gay and lesbian couples. A gender socialization approach suggests that lesbian women would attempt to promote one another's health behavior while gay men would not; yet, recent gender theory suggests that such dynamics are more complex (Courtenay, 2000; Hash, 2006).

Contemporary gender theory includes a variety of related approaches; most commonly, "a gender relations" approach—which views gender as a system of stratification that simultaneously signifies power and structures interactions between and among men and women (Connell, 1987)—and a "doing gender" approach—which emphasizes that a gendered self is emergent in interaction with others (West & Zimmerman, 1987). Research on intimate ties and health behavior has not consistently incorporated these contemporary gender theories. However, these gender theories have significantly advanced our understanding of *other* aspects of intimate relationships—most notably, the dynamics around unpaid work in gay, lesbian, and straight couples (Ferree, 2010).

Gender, Unpaid Work, and Health Behavior

Gender theory—most notably "doing gender" (West & Zimmerman, 1987)—has been consistently utilized in research on unpaid work and provides a useful framework for understanding relationship dynamics around health promoting activities. According to a doing gender perspective, the traditional breadwinner ideal in marriage—wherein men earn wages outside the home but do little unpaid work in the home—is a central feature of masculinity, whereas the performance of unpaid work is a central feature of femininity (Ferree, 2010). Consequently, the division of unpaid work occurs because men and women enact gendered norms that are structured by the institution of marriage and the paid labor force (Ferree, 2010). In relation to health behavior, a doing gender perspective suggests that a married straight man would strive to enact hegemonic ideals of masculinity by failing to pay attention to his wife's health behavior (Courtney, 2000; Gough et al,, 2006). In contrast, enacting cultural ideals of femininity would involve promoting the health behavior of family members (DeVault, 1991). While not typically utilized in the literature on unpaid work or health behavior, a "gender relations" approach enhances a doing gender approach by suggesting that notions of masculinity and femininity exist within "structures of practice" that produce and reproduce gender inequalities (e.g., unequal household labor, unequal management of health behavior) (Connell, 1987, 1995, in press). Interwoven institutional (e.g., marriage, workplace) and ideological (e.g., men and women are "opposites") forces constrain gendered expectations and behaviors (Ferree, 2010; Martin, 2004). A gender relations approach adds that men's inattentiveness, in relation to women's attentiveness, towards health is not merely a function of individual performances of gender. Rather, these gendered performances persist as social practices that are constitutive of—and constitute—a gender order (Connell, 1987; Schofield 2010).

Doing gender and gender relations approaches can provide insight into the dynamics of unpaid work in gay and lesbian couples. According to doing gender theory, gay men and lesbian women have very different relational (man-man, woman-woman) and sexual identity (gay, lesbian) contexts in which unpaid work takes place (Butler, 1990). Due to non-normative sexual identities and a non-heterosexual context, gays and lesbians may perform gender in alternative ways, creating new more egalitarian configurations of unpaid work (Courtney, 2000; Kurdek, 2006; Sullivan, 2004). A gender relations approach extends a doing gender approach by suggesting that broader social and institutional structures promote

inequality for gays and lesbians—such as an inability to participate in legal marriage and a pervasive culture of homophobia (Connell, 1987; Meyer, 1996). Because of these structural contexts, health behavior patterns of gay men and lesbian women may not align with their straight counterparts (Conron et al., 2010; Courtenay, 2000; Schofield et al., 2000). Taken together, these theories suggest that gay men may enact alternative masculinities through attention to their partner's health behavior in ways that straight men—who may be compelled to enact more strictly hegemonic ideals—do not (Courtney, 2000). Lesbian women may enact alternative notions of femininity through risky behaviors and inattention to their partner's health behavior (Yancey et al., 2003). Alternatively, some scholars suggest that "participating in a 'family' results in scripts of actions that, more often than not, carry established gendered meanings" (Moore, 2008, p. 352). Early research suggests that while some gay and lesbian relationships may be egalitarian, in other contexts partners may align themselves with notions of "husband" or "wife" in ways that promote an unequal division of unpaid work (Carrington, 1999; Moore, 2008). Actions specific to health behavior may produce similar dynamics wherein partners unequally promote one another's health.

Health Behavior Promotion as Unpaid Work

Research on unpaid work that draws on contemporary gender theory provides a useful frame for the study of health behavior in straight, gay, and lesbian couples. Additionally, theory on unpaid work provides an opportunity to reposition activities that promote health behavior as part of unpaid work in the home. As public policies encourage family members to promote health, activities done to promote health behavior have been transformed into a high-stakes resource understood as critical for well-being (Carr, 2009, Glass & McAtee, 2006). The shift toward holding individuals responsible for producing family health is akin to other actions that are commonly understood as family responsibility—most notably the unpaid work of providing shelter, food, clothing, and care for children and adults in the home (Coltrane, 2000). According to family theorists, unpaid work is any activity that is unpaid and produces goods, services, or resources to others in the home (Coltrane, 2000). Given this definition, the activities done to promote family members' health behavior are unpaid actions thought to produce the resource of health.

Scholars have long identified activities that promote the recovery of illness and injury as "care work" or "health work" done in the home (Graham, 1991; DeVault, 1991; Stacey, 1988). We extend this by developing the term "health behavior work" to draw attention to the work done to specifically promote family members' *health behavior*. We define "health behavior work" as any activity or dialogue concerned with enhancing others' health behavior. We examine the gendered relationship dynamics around health behavior work with data collected from long-term gay, lesbian, and straight couples.

METHOD

We analyzed 100 in-depth interviews with respondents in 50 long-term relationships. Because one of the strengths of qualitative research is that it can best "advance insight or understanding into the meanings of gender differences and the ways they are created and maintained" (Williams, 1991, p. 225), this method is ideal for investigating understandings of gendered health behavior work in intimate relationships. Interviews took place in a midsized southwestern city in the U.S. With Institutional Review Board approval, the research team composed of the authors and two graduate students interviewed 40 individuals in 20 straight married couples, 30 individuals in 15 gay cohabiting couples, and 30 individuals in 15 lesbian cohabiting couples who have been together between 8 and 52 years (see Appendix). We use the terms "gay" and "lesbian" because individuals in our study self-identified as "gay" and "lesbian." We use "straight" for consistency with "gay" and

"lesbian." We restricted our sample to couples of seven years or longer because the median duration of marriage for divorcing U.S. couples is 7 years (NCHS, N.d.) and our goal was to capture the dynamics of long-term relationships. Because gay and lesbian marriage was not legal where the study took place, we chose to include long-term gay and lesbian couples who saw themselves as having a life-long commitment; all but one respondent in this sample of gay and lesbian couples *would* legally marry if they could, and all respondents viewed themselves as "married-like"; therefore, they are the closest comparison group to straight married couples.

Interviews

Each partner was interviewed separately. Interviews lasted an average one and a half hours and were conducted in the respondent's home or at University offices. Respondents were recruited through a variety of methods (e.g., newspaper story, flyers in diverse areas). Respondents were chosen with attention to racial and socioeconomic diversity. Interviews, conducted from 2003–2007, were recorded and transcribed. The main purpose of the semi-structured interviews was to obtain narratives that focused on how relationship dynamics change over the life course. In the present study, we focus on responses to a series of open-ended questions investigating the ways in which partners influenced one another's health behavior.

Sample

Racial composition of the sample is as follows: Straight respondents included 32 (80%) whites, six (15%) African Americans (15%), one Asian American, and one Latina; gay and lesbian respondents included 19 (63%) whites, eight (27%) Hispanics, Latinos, or Latinas, one African American, one Native American/Hispanic, and one South American. Household income ranged from $40,000 to $120,000 with an average of $60,000. Average age was 45 years for straight respondents, and 49 and 43 years for gay and lesbian respondents respectively. The average relationship duration for straight couples was 17 years, 21 years for gay couples, and 14 years for the lesbian couples. This difference in relationship duration is consistent with other research suggesting that lesbian relationships are of shorter average duration than gay and straight relationships (Andersson et al., 2006).

Analysis

Interviews were analyzed and coded using NVivo software and qualitative procedures developed by Charmaz (2006). Charmaz's methods build on a grounded theory approach to emphasize the construction of codes for the purpose of developing analytical and theoretical interpretation of data. Qualitative coding allows for the emergence of categories and subcategories to come from numerous readings of transcripts, rather than predetermined categories. We used inductive reasoning to guide the analysis, identifying patterns and conceptual categories as they emerged from readings of the transcripts. We conducted line-by-line categorization in order to summarize each piece of data. Next, we used "focused" coding, to develop categories by connecting initial line-by-line codes together for conceptual purposes and developing themes around partners' influence on one another's health behavior. In the final stage of analysis, we examined how the categories and subcategories related to one another on a conceptual level.

FINDINGS

We analyzed interviews with gay, lesbian, and straight respondents in order to understand how men and women describe health behavior work. Respondents described two general forms of health behavior work in their relationships. First, the majority of gay, lesbian, and straight respondents emphasized how *one* partner in the relationship performed health work

around a particular health behavior—a dynamic we refer to as "specialized health behavior work." Second, a majority of gay and lesbian respondents also described a dynamic in which *both* partners performed health work in mutually reinforcing ways—a process we refer to as "cooperative health behavior work." The majority of gay and lesbian respondents described dynamics of both cooperative and specialized health behavior work; very few straight respondents described cooperative work. Respondents further identified *why* they believed health behavior work took place in their relationship. We explore these explanations in detail below.

Specialized Health Behavior Work

Respondents described a *specialized health behavior work* dynamic wherein one partner performed work to enhance their partner's health behavior throughout the course of a relationship. Findings revealed that at least one partner in 80 percent of gay couples (12 of 15), 73 percent of lesbian couples (11 of 15), and 85 percent of straight marriages (17 of 20) describes or is described by their partner as doing specialized work. Partners were in high agreement regarding who did specialized health behavior work and why, and deployed two discourses of *difference* to explain why one partner does specialized health behavior work. Respondents emphasized that one partner has inherently unhealthy behavior—necessitating health behavior work—or that one partner is a "health expert," holding more expertise to perform this type of work.

Unhealthy Behavior—In explaining why one partner performed specialized health behavior work while the other did not, men and women in gay, lesbian, and straight relationships framed one partner as having inherently unhealthy behavior in need of intervention. Nearly half the respondents who described specialized health behavior work used this frame. In straight couples, men were typically framed as having unhealthy behavior in need of health work. Maria illustrated this pattern:

> He doesn't take care of himself physically, his food, his diet—and it drives me crazy. I try so hard to make good meals for him and to have fruits and vegetables available to him and whole grains because that is my background in science. He will not take care of himself. I try to balance things out, I fill the house with the best things I can.

Maria, like other straight women, believed her husband was unable to make healthy choices, necessitating her health behavior work. Maria's husband reiterated this theme in his own interview. He discussed Maria's efforts to make healthy choices for both of them, then said, "Me on the other hand, when I go to the grocery store, she hates it. Because I always bring home crap that she doesn't…that's not healthy."

Jake is a musician and recounted how in the past he abused alcohol and drugs. Recently, his wife Louise performed health behavior work to stop his heavy drinking and cocaine use. Jake recounts these interactions: "So we had a problem in that she thought you know, 'you are doing too much of this' and we have had discussions about that, and there have been concerns." When asked if Louise's concern stopped his substance use, Jake responds, "Yeah, it probably reined me in at some point. I mean, I am totally an animal as far as that goes. I could have been much more involved in it without her trying to put a control on it." Jake's account of an animalistic character emphasizes "natural" difference between him and his wife, justifying Louise's health behavior work.

In nearly all straight couples, women were described as performing health behavior work because of their husband's unhealthy behavior. In contrast, only three straight men were

framed as doing health behavior work. Wei discussed how her husband Bruce works to get her to exercise:

> He encourages me to exercise more and I encourage him to eat more healthy. He used to eat a lot of fatty and greasy food; a lot more meat. And I'm doing a lot of vegetarian dishes and he is learning to like them. I'm basically a couch potato and he really just, "Go. Get out. Let's take a walk. Let's go play badminton."

Like Bruce, only a few straight men are described—and described themselves—as doing health behavior work, and only did so in response to women's exercise behaviors.

Gay and lesbian respondents tended to describe one partner as having unhealthy behavior in need of health work in similar ways as straight respondents. Rex discussed how he is more conscious of healthy eating than his partner Tucker, and therefore does health behavior work:

> I'll sort of guide. Then we have to go to supermarket and get this and this and this —we need yogurt we need eggs we need lettuce and no we don't need that. But he's more likely—I'll pass the donuts and, boy, he would get… [I say] "No you can't have that."

Similar to many straight respondents' accounts of men's unhealthy behavior necessitating health work, Rex explained that Tucker would make bad choices at the supermarket if not for Rex's attention. Similarly, Clarissa framed herself as having unhealthy behavior in need of her partner's specialized work: "I could sit in front of the television every day. Megan is always encouraging me and saying, 'Let's go. Let's go do stuff. Let's get out and play.'" Megan also illustrated this in her interview: "I am somewhat athletic—very active. She is not athletically inclined at all." Both partners point to Clarissa's unhealthy behavior—attributed to Clarissa's lack of natural athleticism—to explain the work done by Megan to promote Clarissa's health.

In sum, gay, lesbian, and straight respondents explained why one partner did health behavior work by emphasizing difference between partners—framing one partner as having what they consider unhealthy behavior resulting from inherent characteristics in need of health behavior work. In straight couples, this pattern was systematically gendered in that men were overwhelmingly understood as being unable to make healthy choices, and consequently women were overwhelmingly understood as the partner in charge of health promotion.

The Health Expert—Respondents also explained why one partner performed specialized health behavior work by framing that individual as having a natural ability, knowledge, or interest in health. Over half of the respondents who described specialized health behavior work used this frame, and there was a high level of agreement between partners as to who was the "health expert." While only one partner was typically identified as the health expert in all couple types, straight men and women almost exclusively identified straight women as the health expert. Moreover, straight respondents used a qualitatively different language when describing the health expert in their relationships; both straight men and straight women used terms such as "health nut," "health person," "health protector" to describe why straight women were health workers.

Richard's description of Jane's health work illustrates this theme: "My wife is kind of a health nut. She put me on skim milk immediately. And I said I would never drink skim milk. She took me to 2% milk and then skim milk." Richard's depiction suggests that he framed his wife as having superior health knowledge in order to justify her health behavior work. Jane used a similar discourse to describe why she does health work for Richard, saying, "I

am what you call a health nut." In a similar vein, Phil said of Christine: "She is the health person and I am not. She takes care of herself, but she is always on me about trying to be healthier." While Phil drew on the view that his wife is a health "person," Christine explained her health work in terms of Phil's unhealthy behavior: "His health habits are pathetic. He doesn't eat fruits and vegetables or salads or anything healthy. He eats all junk." As Christine and Phil illustrate, in some couples both partners agreed that specialized health behavior work was done by the same person, yet deployed varying discourses of difference to explain why one partner did this work.

Respondents in gay and lesbian couples, as in straight couples, identified one partner as having expert knowledge. Yet, in contrast to straight men and women, gay men and lesbian women did not typically use an explicit label (e.g., "health expert") but instead used more subtle notions of expertise to explain one partner's health work. Tim explained why he is the expert in charge of his partner Donald's health behavior:

> I have a broader base of medical knowledge than he does. I try to make him eat better. I choose better quality food. I think that I have some positive effect on that because he has made comments. For example, "I am going to eat whatever because you think it is healthy."

Similar to the emphasis on straight women's health knowledge, Tim emphasized that his specialized work was a result of his "broader base of medical knowledge." Olivia described how her partner Karla's inherent knowledge about exercise facilitates Karla's health behavior work: "She's kind of like a jock. So encouraging me to run, swim, bike, that's been a positive effect." Karla discussed this in her own interview: "I'm a jock… I buy all her fitness stuff for her. And because I love it so much, she gets into it too." Both partners point to Karla's expert status as "jock" in order to explain why she does specialized health behavior work in their relationship.

In sum, men and women from gay, straight, and lesbian couples typically described one partner as the health expert based on personal style or ability, or as a reflection of intrinsic tendencies, interests, and knowledge. Straight women, lesbian women, and gay men were framed as health experts.

Cooperative Health Behavior Work

In addition to specialized health behavior work, respondents emphasized times when they and their partner worked together in mutually reinforcing ways to promote one another's—and their own—health behavior. We call this dynamic *cooperative health behavior work*. Cooperative health behavior work was described by at least one partner—and usually by both partners—in 80 percent of gay couples (12 of 15) and 86 percent of lesbian couples (13 of 15) couples, yet emerged in only 10 percent of straight couples (2 of 20). A majority of respondents who described cooperative health behavior work also described specialized health behavior work processes in relation to a different health behavior or at different point in their relationship. Respondents deployed three general discourses of *similarity* to explain cooperative health work dynamics: (1) both partners have *always* been on the same page about health behavior work, (2) both are on the same page about health behavior work *as needed*, or (3) partners *take turns* initiating cooperative health behavior work.

On the Same Page Since Day One—Of those respondents who described cooperative health behavior work, about half described being "on the same page" with their partners about health behavior work since the start of their relationship. Karen described the work that she and Paige do together to stay healthy: "We are always on a diet. We are always trying to exercise. We both initiate diets. Just to be healthy or participate in some kind of

exercise." Paige reiterated this in her own interview: "When we're good, we're so good. Diets are followed…she's right there with me." Bobby and Terry also described cooperative health behavior work around exercise since the beginning of their relationship. Bobby said:

> From day one. Both of us were runners when we met each other. In fact, we began running with each other the first two or three weeks that we met. And we still go running as often as possible. We are lucky that we keep each other healthy like that.

Terry emphasized the importance of cooperative health behavior work in his own interview: "The best times we ever have is when we go running together… I think it has helped keep our illnesses down." Both partners mention that their cooperative health behavior has kept them healthy since the start of their relationship. This suggests that they view their health behavior work as both a mutually reinforcing aspect of their relationship and vital to each partner's health. Several gay and lesbian respondents drew on beliefs about their mutual desire for good health, as well as recreation, in order to explain cooperative health behavior work processes. Only one straight respondent described this dynamic.

On the Same Page As Needed—One-third of those respondents who described cooperative health behavior work described an *intermittent* cooperative dynamic. Amanda and Julie discussed how they failed to pay attention to their health in the past, but are now working together to be healthier in preparation for having a child. Amanda said: "We are right now getting healthier. We are starting to eat better. More fruits and vegetables. No cokes, no frappuccinos," while Julie said: "I think that we definitely have decided to be much more healthy on the food approaches and are trying to make healthier food choices." Both partners focus on "we work" to collectively become healthier because of their plans for parenthood. This is in stark contrast to specialized health work dynamics wherein one partner works to keep the other healthy.

Similarly, Spencer and Elliot independently emphasized how they work together to be healthy when needed. Spencer said:

> We talk about our [alcohol] intake. To try to keep each other in balance sometimes, so it's not something that we're overdoing. We have a Sunday dinner group and sometimes, we just get flowing. And we're like," Okay, well let's have a water this time."

In turn, Elliot described how he now has nerve damage and is unable to exercise rigorously. Because of this, he said, "[Spencer will] adapt his workout schedule to accommodate my less active needs. So he is more likely to go for longer walks with me rather than go to the gym or go bike riding for an hour because I can't do either of those things." Elliot and Spencer both point to instances where, when needed, they work together to do cooperative health behavior work with the mutual aim to keep one another—and themselves—healthy.

Angie was one of the two straight respondents who described cooperative health behavior work processes. Angie talked at length about how it has been her responsibility to do health behavior work for her husband throughout the relationship. However, she recently came to believe that health behavior work should be a cooperative effort:

> Up until very recently, it's always been me trying to figure out how to help him become healthy and fit. Whereas now…we're in the same boat and we need to figure out how we're going to do this together so that we'll be healthy and live a long healthy life. Because we—I guess when you're in your twenties, you feel like you're immortal and you can worry about all of that later. So he and I are both right now, together, trying to find a way to become healthy together.

Angie has viewed herself as the primary health worker, yet, she recently sees the importance of working toward being healthy cooperatively because of her growing awareness of aging. Angie's husband did not discuss cooperative health work in his interview. The shift from specialized to cooperative work was not described among gay and lesbian couples in this sample. Instead, gay and lesbian respondents described cooperative health work that took place when both partners agreed that their health behavior was in need of work.

Taking Turns: Shifts in Cooperative Health Work—Of those respondents who described cooperative health work processes, several (about 15 percent) described how partners took turns facilitating cooperative work over the course of their relationship. These couples point to a mutual view that they should work together to stay healthy. Janet and Courtney independently described their cooperative health work around exercise. Janet said: "I did persuade both of us to get bicycles last year. I said, 'Let's go get some bikes and bike.' So we bought some bikes and we have been biking. So we both… now we are at the stage where we are kind of helping each other kind of move along." Courtney also emphasized their cooperative health work: "We bought bikes last summer, so I pulled her out. Get on the bike. Let's go. That was one of the big ways we got together." Janet and Courtney's recounting who initiated exercise illustrates the way "we work" dissolves the static role of a knowledgeable "expert" into work that both partners view as something they individually instigate, but do collaboratively.

Rex described above how he does specialized work around Tucker's unhealthy eating behavior by managing what he purchases at the store. However, both partners also discussed the ways each of them initiated cooperative health work at other points throughout their relationship. Rex said:

> I actually lost 20 pounds. And we did that through diet. He's lost weight too. And yeah, he's the one that got this diet started and got it going and kept it going, and kept me honest about it. Now it's the tables turned and I have to do the same thing for him.

Tucker also talked about how the couple's health behavior work has shifted hands over time, describing how he "used to cook all the time" and tried to keep Rex healthy, but now they are purchasing pre-made meals to help with weight loss. This suggests that while Rex performed specialized health behavior work when the couple goes to the supermarket, both partners performed cooperative health behavior work to keep one another eating healthy. Rex and Tucker, along with the other couples in this section, illustrate how cooperative health behavior work is a process that is initiated by both partners at different times over the course of the relationship.

DISCUSSION

We extend work on gender, intimate relationships, and health behavior with an analysis of the gendered dynamics of "health behavior work" in gay, lesbian, and straight long-term relationships. Our findings suggest that the gendered relational and institutional contexts of an intimate tie shape the dynamics of and explanations for health behavior work in three central ways. First, this study provides new insight into the gendered dynamics of health behavior promotion in straight relationships (Umberson, 1992). Straight respondents primarily described *specialized health behavior work*, whereby women perform most of the health behavior work over the course of a relationship. In order to explain why women performed this work, straight respondents tended to emphasize stark differences between themselves and their spouses by framing women as health experts and men as having unhealthy behavior. Straight respondents describe these differences as a reflection of individual attributes with no mention of gender. However, these socially patterned

discourses are linked to longstanding gendered institutional forces (Connell, 1995; Lorber, 1995) that situate women as health workers and men as inattentive to their own health behavior (Courtenay, 2000). According to a doing gender perspective, justifying straight women's health work via notions of women's "natural" health expertise and men's "naturally" unhealthy behavior facilitates "the accomplishment of work *and* the affirmation of the essential natures of women and men" (Fenstermaker, West, & Zimmerman, 1991, p. 201; authors' emphasis). Thus, women and men may perform gender *difference* by doing—or not doing—health behavior work. A gender relations approach further suggests that women's work—and men's lack of work—is a social practice though which the gender order is both constituted and reinforced (Schofield et al., 2000). In this view, interpersonal performances have important implications for producing and reproducing gender inequality beyond couple dyads. For example, beliefs about a spouse's inherent characteristics and abilities around health may be a strategy used to justify and reinforce women's work in the context of broader inequalities in the division of household and workforce labor (Hochschild, 1989; Pfeffer, 2010). Straight respondents may deploy terms like "health nut" as a way to suggest women do specialized health behavior work because of their personality—evading the notion that women do this work because of gender inequity in both their intimate relationships and the larger gender order. Moreover, straight men's work around exercise suggests they do health behavior work only when they are able to demonstrate their expertise in traditionally masculine activities (Courteney, 2000). A gender relations approach further suggests that in using these discourses men derive a health dividend—in relation to—and at the expense of straight women's health behavior work, producing and reproducing gender inequalities (Connell, 1995).

Second, this study provides new insight into gender and health behavior dynamics in gay and lesbian relationships. A narrow focus on straight married couples would lead us to conclude that health behavior work is something that women typically perform and men do not. Including gay and lesbian couples in this study demonstrates how health behavior dynamics differ *among* men and *among* women (Connell, 1995; Schofield et al., 2000). Our analysis shows that gay men and lesbian women describe performing specialized health work in ways analogous to straight women. This suggests that health behavior work does not depend on whether an individual identifies as a man or a woman, but rather the *relational and institutional contexts* in which men and women enact gendered selves and sexual identities (Schofield et al., 2000). A doing gender approach suggests that gays and lesbians may perform gender in alternative ways due to their non-heterosexual identities and relational context. These alternative gendered norms emphasize the performances of "doing similarity"—rather than "doing difference"—between men and women, in turn promoting health behavior work by *both* men and women (Ferree, 2010; West & Zimmerman, 1987). A gender relations approach moves beyond performances of gender by highlighting the social and institutional conditions in which these interpersonal interactions take place (Connell, in press); conditions that constrain or enhance opportunities for health behavior work. Gays and lesbians exist in very different structural contexts (i.e., non-heterosexual, non-married) that promote the enactment of gender and sexuality in ways that blur what is commonly understood as the "natural" man/woman dichotomy (Connell, in press; Schofield et al., 2000). Consequently, the structural sites in which gays and lesbians exist may facilitate the dismantling of taken-for-granted gendered norms around health behavior work (Connell, in press), engendering the health behavior work of both men and women.

Importantly, however, gay, lesbian, and straight respondents alike emphasized differences between themselves and their partners—wherein one partner was an expert and the other had unhealthy habits. While these differences are not linked to the man/woman binary in gay and lesbian couples, other notions of difference may structure specialized health work. According to doing gender theory, partners may perform gender heteronormatively—

wherein one partner performs gender in a more normatively feminine way and the other in a more normatively masculine way (Lorber, 1995; Moore, 2006; Pfeffer, 2010). Differences in gender performance between partners may prompt the more feminine partner's specialized health behavior work in gay and lesbian couples, as found in straight couples. We are unable to address this possibility directly because we did not measure respondents' gender identity with a masculinity or femininity measure (Lorber, 1995) beyond self-identification as a "man" or "woman." However, we raise this as a possibility to be explored in future research. A gender relations approach further suggests that other features of social contexts, such as partners' relative income, education, labor force participation, occupation, parental status, and age might shape the division of unpaid health behavior work in gay and lesbian couples (Carrington, 1999; Moore, 2008; Sullivan, 2004). We conducted an exploratory analysis to examine whether these factors were associated with specialized health behavior work, yet no consistent theme emerged from this analysis. However, this may result from the homogeneity between partners on these characteristics in our sample.

Third, gay and lesbian respondents emphasized a distinct cooperative health work dynamic whereby both partners perform this work in mutually reinforcing ways. This finding is consistent with research suggesting that gay and lesbian couples perform other forms of unpaid work in more egalitarian ways than straight couples (Kurdek, 2006; Sullivan, 2004). A doing gender perspective suggests that couples who have a relational context of two men or women perform cooperative work because of the cultural emphasis on *similarities among* men and *among* women, in contrast to specialized dynamics structured around *differences between* men and women (Fenstermaker et al., 1991). For example, two lesbian women may do cooperative work as a result of both women's desire to stay thin in accordance with idealized women's bodies. Gays and lesbians may also perform masculinity and femininity in alternative ways, providing couples with more flexibility to negotiate cooperative health work (Kurdek, 2006). For example, two gay men may mutually draw upon alternative notions of masculinity that place emphasis on physical fitness and appearance (Conron et al., 2010) and perform cooperative health behavior work to achieve this common goal. Future work should examine the role that notions of masculinity and femininity have in these health behavior work dynamics even within same-sex couples. Further, a gender relations approach suggests that the social and institutional conditions within which gay and lesbian couples live—including a heteronormative and homophobic culture at large, and a non-institutionalized non-heterosexual union—structure a unique relational context for cooperative, more egalitarian health work processes to emerge (Schofield et al., 2000). The theme of cooperative health behavior work is illustrative of how gendered inequalities can be uniquely challenged in the context of gay and lesbian intimate ties.

While this study is designed to offer unique insights into gendered relationship dynamics around health behavior, several limitations must be considered. First, we compare legally married straight couples to long-term cohabiting gay and lesbian couples. Since gay and lesbian couples do not have access to national legal marriage, marital status is inconsistent across couples. However, with the exception of one respondent, all long-term gay and lesbian cohabiters viewed themselves as "married-like," and would legally marry if they could, making them the most appropriate comparison group available. Future research should examine cohabiting straight couples and married gay and lesbian couples to explore health behavior work in these contexts. Second, these findings are based on a non-representative U.S. sample of long-term intimate relationships. Additional insights could be obtained by examining health behavior work in non-U.S. contexts with different political economy, gender, and sexuality norms. Third, our data are drawn from accounts of individual *perceptions* rather than *observations* of health behavior. Given that perceptions of and actual amount of unpaid work done by partners are often inconsistent (Hochschild, 1989), future work should include both observational and interview data. Fourth, while

respondents describe attempts to make their spouse healthier, respondents may perform health behavior work with undisclosed or unrealized intentions—such as encouraging a spouse to align with popular appearance norms or with moralistic notions of "good" and "bad" behavior (Carr, 2009; Metzl & Kirkland, 2010). Additionally, some respondents describe cooperative health behavior work as integral to recreational activities. While health behavior work may be confounded with attempts to promote appearance, moralistic notions of good and bad behavior, and leisure activities, we suggest these actions constitute *work* because of respondents' explicit intention to promote one another's health. Fifth, we do not aim to determine whether health behavior work actually improves health behavior or health. Popular understandings of what is healthy or unhealthy behavior exist in the context of ever-changing governmental and privatized marketing campaigns (Carr, 2009; Metzel & Kirkland, 2010). In this shifting terrain, partners may have misinformation about what constitutes healthy behavior, sometimes promoting unhealthy behaviors despite intentions. Regardless, we believe the concept of health behavior work has the potential to inform health policy. Public health initiatives place responsibility for individual health onto family members (Carr, 2009; Metzel & Kirkland, 2010), and this study offers insight into how broader policies may be enacted in various relational contexts. Finally, as mentioned previously, we did not collect data on respondent's gender identity, limiting our gender analysis.

Despite these limitations, the present study advances understanding of the dynamics that shape health behavior in intimate relationships. Future research should view activities that promote health behavior as work, and utilize the concept of health behavior work in order to more fully situate these activities within the theoretical and material context of the home. Findings reveal important gender dynamics of health behavior work. While few straight men are described as performing health behavior work, in some contexts—namely intimate relationships between two men—men perform health behavior work in similar ways as straight and lesbian women. Additionally, cooperative health work occurred in most gay and lesbian relationships, but very few straight relationships. Taken together, this study suggests that the gendered relational context of an intimate partnership shapes the dynamics and explanations of health behavior work for gay, lesbian, and straight men and women in previously unexamined ways.

Research Highlights

Research on health behavior in intimate ties is limited by a reliance on gender socialization theory and a focus on straight marriage.

We analyze the relationship dynamics around health behavior in straight, gay, and lesbian long-term couples in the U.S. (N=100 individuals).

We develop the concept "health behavior work" to align activities done to promote health behavior with theories on unpaid work in the home.

Findings suggest that the gendered relational context of intimate ties shapes the dynamics of and explanations for health behavior work.

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Appendix

Description of Straight Respondents

Pseudonym A Gender/Age)	Pseudonym B (Gender/Age)	Relationship Duration (Years)
Richard (M/64)	Jane (W/63)	36
Robert (M/52)	Kinsey (W/44)	19
Harold (M/61)	Mary (W/60)	30
Jake (M/39)	Louise (W/35)	13
Joe (M/55)	Toni (W/53)	24
Keith (M/38)	Valerie (W/42)	12
Benjamin (M/31)	Susan (W/30)	9
Jason (M/31)	Maria (W/33)	8
Phil (M/49)	Christine (W/44)	23
Bret (M/34)	Angie (W/34)	10

Pseudonym A Gender/Age)	Pseudonym B (Gender/Age)	Relationship Duration (Years)
Joel (M/31)	Sasha (W/30)	11
Kyle (M/44)	Jenn (W/42)	20
Nathan (M/36)	Karen (W/35)	13
Bruce (M/41)	Wei (W/39)	12
Charles (M/54)	Emily (W/56)	31
Anthony (M/48)	Chantelle (W/40)	17
Rick (M/64)	Janna (W/54)	9
Aubrey (M/35)	Tonya (W/34)	9
Jim (M/55)	Sal (W/55)	32
Hal (M/50)	Gwen (W/52)	8

Description of Gay Respondents

Pseudonym A (Gender/Age)	Pseudonym B (Gender/Age)	Relationship Duration (Years)
Jeffrey (M/55)	Michael (M/48)	27
Kirk (M/53)	Brett (M/49)	23
Adam (M/50)	Paul (M/48)	23
Bobby (M/44)	Terry (M/48)	17
Edwin (M/49)	Kevin (M/55)	13
Gus (M/42)	Andrew (M/44)	23
Raymond (M/35)	Christopher (M/42)	14
Tim (M/58)	Donald (M/72)	23
Stanley (M/42)	David (M/41)	16
Albert (M/31)	Larry (M/51)	23
Aidan (M/49)	Max (M/50)	10
Elliot (M/49)	Spencer (M/47)	25
Stokes (M/43)	Noah (M/46)	23
Marcus (M/43)	Austen (M/62)	20
Rex (M/54)	Tucker (M/67)	34

Description of Lesbian Respondents

Pseudonym A (Gender/Age)	Pseudonym B (Gender/Age)	Relationship Duration (Years)
Sarah (W/48)	Jessica (W/56)	11
Carol (W/29)	Angela (W/34)	8
Marissa (W/45)	Janice (W/40)	10
Belinda (W/48)	Christina (W/47)	13

Pseudonym A (Gender/Age)	Pseudonym B (Gender/Age)	Relationship Duration (Years)
Amanda (W/29)	Julie (W/31)	13
Melissa (W/43)	Kristen (W/43)	10
Emilia (W/42)	Diana (W/43)	10
Gretchen (W/46)	Danielle (W/47)	8
Janet (W/40)	Courtney (W/50)	15
Megan (W/34)	Clarissa (W/34)	12
Jody (W/34)	Elaine (W/42)	12
Paige (W/44)	Karen (W/44)	25
Karla (W/41)	Olivia (W/47)	15
Ann (W/49)	Julian (W/39)	14
Darcy (W/50)	Carrie (W/60)	27