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The promotion of unhealthy habits in gay, lesbian, and straight intimate partnerships

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Abstract

Health habits are linked to nearly half of U.S. and British deaths annually. While a legacy of research suggests that marriage has important positive consequences for health habits, recent work emphasizes that intimate ties can also deter from healthy habits and promote *unhealthy* habits. However, few studies examine the mechanisms through which unhealthy habits are promoted in marriage. Moreover, little research explores how unhealthy habits are promoted in intimate ties other than marriage—such as in gay and lesbian cohabiting relationships. The present study analyzes the mechanisms through which gay, lesbian, and straight long-term partners ($N = 120$) contribute to one another's unhealthy habits. Three distinct mechanisms emerge. First, respondents identify a process of *unilateral health habit diffusion* wherein one partner's health habits directly influence the other partners' habits. Second, respondents describe *bilateral unhealthy habit diffusion*, wherein both partner's unhealthy habits are reinforced via mutual pleasure seeking or mutual failed motivation. Third, respondents describe a discourse of *personal responsibility*, wherein both partners purposefully fail to deter one another's unhealthy habits. Analysis further illustrates how these mechanisms operate differently for men and women in gay, lesbian, and straight relationships.

Keywords

USA; Health behavior; Gay and lesbian; Mechanisms; Marriage; Cohabitation

Introduction

Health behavior, also known as health habits, refers to personal actions that influence health including "risky" (e.g., substance use) and "health enhancing" (e.g., exercise) behavior. Health behavior is linked to nearly half of deaths in the U.S. and Britain annually (British DH, 2010; U.S. DHHS, 2010). Because of the importance of health behavior for overall health, a significant body of research attempts to uncover the social determinants of health behavior (McGinnis, 2002). The marital tie has been identified as one of the most important social influences on health behavior; a well-established line of research finds that marriage is associated with a reduction in risky habits and the promotion of health-enhancing habits, especially for men (Bachman et al., 2002; Reczek & Umberson, 2012; Umberson, 1992).

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While the positive effects of marriage on health behavior are clear, scholars have recently called attention to the ways marriage "may not necessarily promote good (or squelch bad) health behaviors" (Carr & Springer, 2010, p. 750). For example, the married weigh more and exercise less than the unmarried (Jeffery & Rick, 2002; Sobal, Rauschenbach, & Frongillo, 2003). Yet, little is known about the *mechanisms* through which unhealthy habits are facilitated, transmitted, or sustained within marriage (Carr & Springer, 2010; Pachucki, Jacquies, & Christakis, 2011). Moreover, research in this area has failed to examine how unhealthy habits are promoted within the context of other intimate ties such as gay and lesbian intimate partnerships. The present study extends previous research to examine the interpersonal mechanisms through which intimate partners promote one another's unhealthy habits. In-depth interview data with 120 individuals in 30 long-term straight marriages, 15 gay cohabiting couples, and 15 lesbian cohabiting couples in the U.S. are analyzed with the aim of understanding how men and women describe relationship dynamics around unhealthy behavior in their intimate ties. This analysis further explores how such processes operate differently for men and women in gay, lesbian, and straight relationships.

Promotion of unhealthy habits: theorizing mechanisms

Scholars have recently noted that the health benefits of marriage "are contingent on processes and interactions within that union," and thus, not all marriages are equal in their health promoting capacities (Carr & Springer, 2010, p. 748). To date, most research that examines how marriage deters from health focuses on the quality of the marital tie (Kiecolt-Glaser & Newton, 2001). An unhappy or conflict-ridden marriage contributes to higher levels of stress (Pearlin, Schieman, Fazio, & Meersman, 2005); stress, in turn, contributes to unhealthy health habits such as alcohol abuse and cigarette smoking (Kassel, Stroud, & Paronis, 2003). Little empirical work explores the likely possibility that unhealthy habits are promoted in marriage in ways not linked to marital quality (Meyler, Stimpson, & Peek, 2007). In contrast, there is long-standing research on how marriage promotes *healthy* behavior, predominantly via *social control* and *behavior diffusion*. Social control and behavior diffusion theories provide the backdrop for hypothesizing potential mechanisms through which *unhealthy* habits may be shaped in intimate ties.

Social control refers to indirect and direct efforts aimed at promoting the healthy behavior of others (Umberson, 1987,1992). Indirect social control operates through the internalization of "appropriate" norms that constrain and enable individual behavior (Durkheim, 1897/1951); spouses may compare their health behaviors to similar others (i.e., married people) to obtain health behavior norms (e.g., not smoking) (Hughes & Gove, 1981). Social control, also known as "health behavior work" (Reczek & Umberson, 2012), operates directly with attempts to regulate a spouse's unhealthy behavior or encourage healthy behavior (Umberson, 1987). Few empirical studies examine how social control processes shape *unhealthy* habits. Some research suggests that direct social control efforts may promote unhealthy habits by backfiring, creating resistance to health behavior change and promoting unhealthy habits (Hughes & Gove, 1981; Lewis et al., 2006). Additionally, it may be that spouses use social control tactics to encourage their partner to engage in unhealthy habits as an act of sabotage. Spouses may also inadvertently promote their partner's unhealthy habits through a failure to utilize social control in the face of an unhealthy behavior (Wilson,

2002). Additionally, indirect social control may promote unhealthy behavior, as reference group norms are not unilaterally healthy. For example, a spouse may be indirectly encouraged to stop going to the gym because norms of marriage dictate increased time spent at home.

Behavior diffusion theory suggests that one spouse's health behavior directly influences the other's health behavior (Lewis et al., 2006). Diffusion is evidenced by spouses' concordant and convergent health behavior independent of selection effects (Meyler et al., 2007). For example, several studies show that spouses become more similar in weight (Katzmaryzk, Perusse, Rao, & Bouchard, 1999), fruit and vegetable intake (Macario & Sorensen, 1998), exercise (Homish & Leonard, 2008), smoking frequency (Homish & Leonard, 2005), and alcohol use (Leonard & Mudar, 2003). While substantial evidence suggests that behavior diffusion occurs, the *mechanisms* through which diffusion promotes unhealthy habits remain unclear (Monden, 2007; Wilson, 2002). It may be that because of proximal and emotional closeness and domestic shared resources (e.g., economic), married people have interdependent lives that mutually influence both partners' health behavior (Wilson, 2002). For example, the sharing of economic resources to buy food prompts the food choices of one partner to directly shape the choices of the other (Smith & Zink, 2004). Alternatively, one partner may model certain unhealthy behaviors, and such behavior may be diffused on to the other spouse (Lewis et al., 2006). However, few empirical studies explore these possibilities (Meyler et al., 2007).

Theorizing gendered mechanisms in gay, lesbian, and straight relationships

Health habits are highly gendered. On average, men smoke, drink, and exercise more often than women, and women eat more fruits and vegetables and seek health care more frequently than men (Reeves & Rafferty, 2005). A "doing gender" theoretical perspective suggests this is the case because men strive to enact hegemonic ideals of masculinity by partaking in risky health behaviors such as alcohol use and smoking, while establishing their physical virility via exercise (Courtenay, 2000; Gough & Conner, 2006). In contrast, performing cultural ideals of femininity involves avoiding risky behavior and adhering to physical appearance and weight norms (Bordo, 1993). A gender relational approach adds that gendered health behaviors persist as social practices that are constitutive of—and constitute—gender inequality (Schofield, 2010). Like health behavior, direct social control processes are also highly gendered in straight marriages; straight women provide higher levels of social control than do straight men (Reczek & Umberson, 2012; Umberson, 1992). Following previous work, it is likely that the ways in which *unhealthy* habits are directly promoted via social control in intimate ties may also be gendered. Because men partake in more risky behaviors as part of enacting masculinity (West & Zimmerman, 1987), they may in turn explicitly encourage their wives to partake in similar behaviors, promoting women's health habits in negative ways. Diffusion processes may also be gendered, wherein men's riskier habits inadvertently promote women's unhealthy habits. Some empirical research supports a view of gendered social control and diffusion processes; men's alcohol use is more influential on their wives' drinking habits than vice versa (Demers, Bisson, & Palluy, 1999; Homish & Leonard, 2005). Additionally, it may be that different types of health behavior have unique gendered dynamics. For example, because of the unequal division of

household labor, women are more likely to do the grocery shopping and make meals, in turn shaping men's eating habits via social control and diffusion processes (Bove, Sobal, & Rauschenbach, 2003).

Patterns of health behavior, social control, and diffusion are likely to operate differently in gay and lesbian couples. Gender relations theory highlights that there are differences *among* men and *among* women (Connell, 2012), and mounting evidence suggests that gays and lesbians have non-normatively gendered health behavior. For example, lesbian women are more likely than straight women to currently smoke (Conron, Mimiaga, & Landers, 2010), drink alcohol (Burgard, Cochran, & Mays, 2005), and be overweight (Yancey, Cochran, Corliss, & Mays, 2003). Gay men are more likely than straight men to smoke cigarettes and report substance use (Gruskin, Greenwood, Matevia, Pollack, & Bye, 2007; Trocki, Drabble, & Midanik, 2009). These findings may reflect alternative or hyper performances of "doing" gender (Courtenay, 2000), wherein gay men enact hyper masculinities and lesbian women enact alternative femininities through unhealthy behaviors. These health behavior disparities may also be due to broader institutional contexts that differentially structure health behavior practices of gay, lesbian, and straight individuals (Conron et al., 2010; Courtenay, 2000). For example, gays and lesbians face stressors due to their sexual minority status, which may in turn promote higher levels of substance use and higher body weight (Mays & Cochran, 2001; Meyer, 2003). In the context of intimate relationships, a report from the U.S. Institute of Medicine (2011) suggests that health behavior disparities are related to gay and lesbian couples' lack of access to federal and state legal marriage (Lau & Strohm, 2011). While intimate relationships provide emotional support across couple types (Kurdek, 2006), gay and lesbian cohabiters do not receive marriage's financial and social benefits that may deter unhealthy habits (Huebner, Rebchook, & Kegeles, 2004; Meyer, 2003) such as medical leave to care for a partner, tax breaks (i.e., greater economic resources), and access to spousal health insurance benefits (Heck, Sell, & Sheinfeld, 2006; Ponce, Cochran, Pizer, & Mays, 2010).

Because of alternative health behavior and gender norms, as well as varying institutional and social structures (Courtenay, 2000), gay and lesbian couples may have unique social control and diffusion processes. For example, a lack of access to health insurance may require greater social control efforts by one partner to prevent illness. Alternatively, because of overall higher substance use rates in the gay and lesbian population, the likelihood of at least one partner being a smoker or drinker is higher, increasing the likelihood of substance use diffusion. Moreover, preliminary research suggests that gay men enact alternative masculinities through social control of their partner's health behavior in ways that straight men—who may be compelled to enact more strictly hegemonic ideals in marriage—do not (Courtenay, 2000; Lewis et al., 2006; Reczek & Umberson, 2012). This suggests that gay men are more attentive to their own—and their partner's—healthy habits in ways that may deter from diffusion of unhealthy behavior. In contrast, lesbian women may enact alternative notions of femininity through the diffusion of risky behaviors and lack of social control on to their partner's health behavior (Reczek & Umberson, 2012; Yancey et al., 2003). Few empirical studies examine these possibilities.

Method

This present study draws upon a convenience sample of 120 in-depth interviews with individuals in 60 long-term intimate relationships. Interviews took place in a midsized southwestern city in the U.S. With Institutional Review Board approval, the author and two research team members interviewed 60 individuals in 30 straight couples, 30 individuals in 15 gay couples, and 30 individuals in 15 lesbian couples who have been in a committed relationship between eight and 52 years. The terms “gay” and “lesbian” are used instead of “homosexual” because of the historical legacy of the term homosexual, and because respondents in this study identify in this way. “Straight” is utilized instead of “heterosexual” to be consistent with the use of “gay” and “lesbian.” The sample was restricted to couples of seven years or longer because the median duration of marriage is 7 years and the goal of this project was to capture the dynamics of long-term relationships. Because gay and lesbian marriage is not legal where the study took place, gay and lesbian couples who were cohabiting and saw themselves as having a life-long commitment were included.

Interviews

Each partner in the couple was interviewed separately. Interviews lasted on average one and a half hours and were conducted in the respondent’s home or at University offices. All respondents were recruited through a variety of convenience methods (e.g., newspaper story, flyers, word of mouth, referrals). Respondents were chosen on a rolling basis with attention to racial and socioeconomic diversity until 60 couples were interviewed. Interviews, conducted from 2003 to 2007, were recorded and transcribed. The main purpose of the semi-structured interviews was to obtain narratives that focused on general relationship dynamics; topics included life-threatening illnesses, health behavior, unemployment, children, mental health, sex, and overall relationship satisfaction. The present study focuses primarily on responses to two open-ended questions: Tell me about times your partner may have had a negative effect on your health habits; Tell me about any times you may have had a negative effect on your partner’s health habits. Interviewers did not suggest specific health habits for discussion.

Sample

Fifty (83%) of the straight respondents are white, six are African American (10%), one is Asian American, two are Latina, and one identifies as multiracial. Nineteen (63%) of the gay and lesbian respondents are white, eight are Hispanic, Latino, or Latina (4%), one is Black, one is Native American/Hispanic, and one is South American. Household income ranged from $40,000 to $120,000. The average age for straight couples is 53 years, 49 years for gay couples, and 43 years for lesbian couples. The average relationship duration for straight couples is 25 years, for gay couples 21 years, and for lesbian couples 14 years. This difference in relationship duration is consistent with previous research (Andersson, Noack, Seierstad, & Weedon-Fekjaer, 2006). Additional sample information is available upon request (also see Reczek, Eliott, & Umberson, 2009 and Reczek & Umberson, 2012).

Analysis

The interviews were coded by the author using Nvivo software and qualitative procedures developed by Charmaz (2006) for the purpose of developing analytical, theoretical, and abstract interpretations of data. The author used inductive reasoning to guide the analysis, identifying patterns and conceptual categories that emerged from transcript readings. Following the reading of each interview transcription, the author conducted line-by-line, data-driven categorization in order to summarize each piece of data. Next, the author used "focused" coding, which involved constructing categories by connecting initial codes together for the development of themes around partners' influence on unhealthy habits. In the final stage of analysis, the author examined how the categories and subcategories relate to one another on a conceptual level. These conceptual themes are developed in the findings section below. The term "unhealthy habits" is used to describe any behavior that respondents believe contributes to greater incidence of disease, illness, or poor health. This is not a reflection of a medical evaluation of actual behavior. A majority of respondents discussed eating and exercise; other habits discussed include alcohol, smoking, sleep, and drug use. Pseudonyms were given to all respondents.

Findings

This analysis aims to uncover how relationship dynamics promote unhealthy behavior. Respondents identify three distinct themes to explain how this occurs. First, respondents identify a process of *unilateral health habit diffusion* wherein one partner's health habits have a direct influence over the other partner's habits. Second, respondents describe *bilateral health habit diffusion*, wherein both partners' unhealthy habits are mutually reinforced. Third, respondents adhere to a discourse of *personal responsibility* in order to explicitly reject responsibility for their partner's health. Variation in how women and men promote unhealthy habits across gay, lesbian, and straight couples is highlighted.

Unilateral health habit diffusion

In the first theme of the analysis, respondents describe how one individual's unhealthy habits directly contribute to the other partner's unhealthy habits—referred to as *unilateral health habit diffusion* hereafter. Nearly all respondents who discuss this theme view *themselves* as being the "bad influence"—rarely did the partner of the "bad influence" mentioned this dynamic. One partner in nearly half of the straight couples (14) identified a "bad influence," and husbands were nearly exclusively identified as the influencer. Nathan, married to Karen, says: "I am the queso influence. And she will eat with me." Nathan explicitly links his own habits to his wife's, suggesting that he believes he is culpable for his wife's eating habits. Others not only recognize the unilateral diffusion dynamic, but also describe how they *could* change this dynamic if they desired, but fail to do so. Bruce, married to Wei, says: "I think my metabolism is so high, so fast. I eat a lot of sweet things. I don't think that's good for her….not encouraging proper eating enough." Bruce is self-critical of his promotion of Wei's unhealthy habits, but is not willing to change this habit. Similarly, Jason discusses how his health habits shape his wife Maria's habits:

> I drink a Dr. Pepper every morning. It is like a ritual. She has actually gotten to the point where she actually drinks soda now and then. Not very often, but she would never drink soda before I met her. So she eats a lot more I would say, junk food now after you know, through the processes of our marriage versus of when I first met her. I can definitely bring her health down, if she ever let herself get on the band wagon, so to speak.

Here, Jason, Bruce, and Nathan suggest that by being witness to their unhealthy habits, their wives are drawn into the same unhealthy behavior. While respondents recognize that their unhealthy habits can "bring [their wives'] health down," they do not attempt to end this diffusion.

One partner in a third of gay and lesbian partnerships (10) describe unilateral health habit diffusion in a similar way as straight spouses. Melissa, partnered to Kristen, says: "I like to eat late at night. It is one of my addictions. But I will make a big bowl of popcorn and it smells so good, she will eat some. It is not chocolate chip cookies, but still, it is popcorn." Similarly, Elaine partnered to Jody says: "I have…nothing other than introducing junk food into her life. She is not a junk food eater and I am a junk food eater. And so introducing things like that. She wasn't a big dessert [person] before I met her. And so she eats dessert at night time." Max also recognizes how his own health habits shape his partner Aidan's: "I'm known to keep sweets around. And I can just nibble just a little bit and stretch them out over weeks. He doesn't have that discipline, so if I have them in the house, and he finds them, he'll eat them all."

Elaine, Melissa, and Max, like straight men, each suggest that they introduced their own unhealthy habits to their partner—and this bad influence has shifted their partner's health habits for the worse. While respondents recognize this dynamic, very few describe any attempt to prevent this influence from happening—either by curtailing their own habits or by attempting to perform social control for their partners. Straight men, gay men, and lesbian women were all described as the influencer promoting unilateral health habit diffusion, yet very few straight women implicated themselves—or were implicated—as the source of such diffusion.

Bilateral health habit diffusion

In the second theme of the analysis, respondents describe how both partners' unhealthy habits are a result of the mutual promotion of concordant unhealthy habits—called *bilateral health habit diffusion* hereafter. The theme was described in just over half of the interviews with gay and lesbian respondents (31), but in only 3 interviews with straight respondents. Unlike unilateral health habit diffusion, wherein the "bad influencer" primarily describes the dynamic, *both* partners tend to independently describe bilateral health habit diffusion. Bilateral diffusion was understood as a consequence of two primary relationship dynamics: (1) pleasure seeking through concordant unhealthy habits, and (2) a concordant lack of motivation to be healthy.

Pleasure seeking through concordant unhealthy habits

A majority of respondents who describe bilateral diffusion emphasize they are mutually interested in pleasure seeking via concordant unhealthy habits, creating a relationship dynamic wherein both partners' unhealthy habits are simultaneously promoted. This subtheme is nearly exclusively described by gay and lesbian respondents. Paige describes her and Karen's concordant habits: "When we're good we are so good. You know. Like diets are followed. But when we are bad we are so bad." Karen also describes this dynamic in her interview:

> We will both be really good and both be bad together. And it is fun to be bad together. We will agree and then it is fun. She makes the most evil brownies that are delicious and we will agree that she will make those brownies. We are either positive together or negative together.

Both Paige and Karen think similarly about health habits in their relationship, and see their choices about what to eat as interdependent and reliant on both partners' desire for pleasure.

Janice describes a similar dynamic of mutually reinforcing both her and her partner Marissa's unhealthy habits:

> I think that we can be mutually negative influencing, in our eating habits, in our drinking habits. We can feed each other. Sometimes we can be strong for each other and other times we are just that little devil on your shoulder, personified. It is like, 'But you really want that cookie. Go ahead'. So we can kind of enable bad behaviors.

Janice's notion of being "strong" to be healthy together, countered with "feeding" one another's desire for unhealthy behavior, suggests a belief that both she and Marissa are interrelated in their pleasure seeking decisions. David also discusses how he and his partner Stanley occasionally "breakdown" together:

> If we're going to have a breakdown, we both decide that we're doing it. We go to the store and get a gallon of ice cream or a half gallon of ice cream and eat the whole thing. But we both agree. There's not one that will go out and do it on their own.

David points to the way both he and Stanley agree that they will "have a breakdown" and partake in behaviors they consider unhealthy *together*. This is an enjoyable mutual act done when they are breaking from their normally rigorous routine of working to be healthy together. David, like others, suggests both partners are culpable in one another's unhealthy behavior via their mutual desire for pleasure seeking.

Concordant lack of motivation to be healthy

While respondents typically describe bilateral health habit diffusion as a pleasurable aspect of their relationship, some respondents frame this theme as a result of mutual failed motivation. Respondents in this subtheme believe that mutual motivation to be healthier *should* be a focus of their relationship, yet, they do not have the motivation to make this occur. When Paul was asked how he promotes his partner Adam's unhealthy habits, he says,

"Only when I am feeling lazy and he is feeling lazy at the same time. So, neither of us manage to motivate the other. That is probably really the worst." Similarly, Diana discusses how she and her partner Emilia promote bilateral diffusion: "Wine consumption. We both have increased our wine consumption, so we are not good helpers there with each other." Paul and Diana identify times when both partners are not good "helpers" or "motivators"—which in turn promotes both partners' unhealthy habits. Ann also discusses how she and Julian have mutually failed to stay motivated to be healthy:

> And at the beginning I was running, and so she was running, and we both played sports, plus we played tennis. We, in the recent years, have declined to either one take care of our health. So I would say that that's something that's on our chart for this year, and next year. Making us work it into our routine. I see it being something that we have to actually schedule and make part of our day.

Ann and others in this theme views both partners as failing to perform social control to take care of their (joint) health—her remedy is to make both partners work on this issue through mutual motivation. Additionally, Ann's use of the term "our" suggests that she views their health habits as bilaterally intertwined.

The three straight interviewees that describe bilateral health habit diffusion view this pattern as a source of stress that occurs as a result of their mutual lack of attention to health. Kinsey, married to Robert, says: "We can get ourselves into a routine of drinking too much beer on the weekends. I think it is something that both of us worry about. We also both have alcoholic parents and were raised in alcoholic families." Kinsey calls attention to the notion of a mutual "routine," wherein both partners fear they drink too much but are not motivated to manage this mutual habit. In this way, partners reciprocally fail to promote one another's health because of their mutually reinforcing unhealthy habits, or because they "enable" one another's failed motivation. Respondents believe mutual motivation to be healthier *should* be the focus of their relationship, yet, there is a reciprocal failure to enact on this belief.

Discourse of personal responsibility

In the final theme of the analysis, respondents emphasize that they have no responsibility to promote their partner's healthy habits or deter risky habits because their partner is accountable for their own health. While previous themes identify the notion that one *should* do something to shape the health habits of a partner (even if there is a failure to do so), this theme suggests that some respondents believe they are not responsible for their partner's unhealthy habits—abrogating responsibility to perform social control. While these respondents refuse to attempt to change a partner's health habits, abrogating social control makes them complicit in unhealthy habits. This theme was described by nine straight respondents in five marriages and one lesbian respondent. Keith is asked if he ever does anything to make his wife, Valerie, healthier. He says:

> Not really. I mean there have been occasions. But we go back to that thing I have said all throughout this [interview], we are adults, we are responsible for our own decisions. I have to trust my wife has enough common sense and I know she has enough compassion and well-wishing for the children and myself that she wouldn't do anything to recklessly endanger herself.

Keith notes that "there have been occasions" where he attends to his wife's health, but because she has "common sense," social control is not his responsibility. Keith's wife Valerie discusses a similar view in her interview:

> He is overweight and he doesn't always eat right. Him and my nine year old can finish a box of cookies. But I never tell him not to eat it, ever. Ever. I am not his mother. I don't care what he eats. You know and he has gained weight, and he has lost weight. And he has to do that himself. I am not going to do that for him.

Later on in the interview, however, Valerie states that she is in fact expected to perform social control:

> Sometimes I cook. If I don't cook, I don't. I think he thinks…like he will say, "If you cooked I would eat healthier." And I will go, "Okay, blame me then. You can blame me for that dear. I am not making your choices off the menu."

While both spouses emphasize that health is one's personal responsibility, Valerie's second quotation suggests Keith blames Valerie for his unhealthy habits. Valerie states that she does not do social control to change Keith's eating habits, in turn failing to promote good health, yet her subsequent quote suggests that Valerie *should* be performing social control.

When Kyle is asked how he promotes his wife Jenn's health, he says: "The food and exercise and things like that is self-initiated. Probably the only time I am useful is if she's sick or getting sick." Jenn is asked how she shapes her husband's health in her own interview, responding: "Uh, take your vitamins [laughs]. That's about it. We both take care ofthat on our own and we both handle that kind of stuff." Kyle and Jenn view each other's health habits as personal responsibility, except when one partner is ill. However, later on Kyle says of Jenn:

> She is very health conscious of food and exercise and things like that. And I am as well, although I admit I have a fondness for McDonald's French fries, it's an addiction. But she reminds me of stuff like that.

Both Kyle and Valerie point to how a shared discourse of personal responsibility obscures the expectation that women perform, or at least are supposed to perform, social control. Only one lesbian partner in this sample describes a discourse of personal responsibility. Jody partnered to Elaine says: "Well, I have learned to keep my mouth shut in that regard. I try to make sure she doesn't have excuses for not exercising or eating right. But I just had to step back and let Elaine make her own decisions." While Jody says that she has let Elaine make her own decisions, she would prefer to do social control to make her healthier. However, because Elaine has not responded well to Jody's social control efforts, Jody no longer attempts to change this dynamic.

Respondents in this theme believe that each partner's health is their personal responsibility. Thus, even when they perceive their partner as having an unhealthy habit, they abrogate doing social control and, in turn, contribute to unhealthy behavior. Straight respondents were more likely to discuss this theme than gay and lesbian respondents, wherein both partners in four couples (and one partner in a fifth) independently agree that each spouses' health was

their own personal responsibility. Yet, despite this pervasive discourse, straight women were still understood as responsible for the health habits of their husbands.

Discussion

It is a well-accepted social fact that marriage has positive consequences for individual health through the promotion of healthy habits, yet recent work suggests that intimate ties may also promote *unhealthy* habits (Carr & Springer, 2010). In line with this growing body of research, the present study uncovers three interpersonal mechanisms through which gay, lesbian, and straight partners contribute to one another's unhealthy habits—*unilateral health habit diffusion, bilateral health habit diffusion*, and a discourse of *personal responsibility*. These mechanisms operate in distinct ways for men and women across gay, lesbian, and straight couples, providing insight into literature on health and intimate ties in three important ways.

First gay, lesbian, and straight respondents alike describe unilateral health habit diffusion. In straight couples, men most commonly viewed themselves as being the "bad influence." These men were acutely aware of their negative impact, yet they explicitly failed to change their behavior—possibly because such influence has long been a pattern and understood as unchangeable at the time of the interview. This suggests that not only are straight men less likely to promote the healthy habits of straight women through social control or health behavior work processes (Reczek & Umberson, 2012; Umberson, 1992), they also promote the *un*healthy habits of their wives through a failure to regulate their *own* health behavior. According to a "doing gender" approach, men strive to perform hegemonic ideals of masculinity through risky health habits in order to reinforce cultural beliefs their bodies are more robust than women's (Courtenay, 2000). It may be that men's performance of masculinity not only manifests in men's unhealthy habits, but also has consequences for women's health habits (Homish & Leonard, 2005; Leonard & Mudar, 2003). This provides new insight into why women's health is not found to be as consistently and strongly enhanced by marriage as men's health (Umberson, 1992; Waite & Gallagher, 2000). However, it is notable that women rarely identify their husbands as a unilateral bad influence. It may be that, in line with hegemonic enactments of masculinity, men overemphasize their own unhealthy habits and the subsequent negative impact on their wives. In turn, women in long-term marriages may understand men's bad influence as assumed and normative, and thus not be able to clearly articulate this invisible influence. Women may also underestimate their own unhealthy habits or attempt to avoid vilifying their husbands as the negative influence (Courtenay, 2000).

Second, a narrow focus on straight married couples would lead to the conclusion that men's unhealthy habits unilaterally diffuse on to women's habits. Including gay and lesbian couples in this study demonstrates how dynamics around health behavior differ *among* men and *among* women (Connell, 1995; Schofield, Connell, Walker, Wood, & Butland, 2000). This occurs in the description of both *unilateral* health habit diffusion and *bilateral* diffusion. In regards to unilateral diffusion, gay men and lesbian women describe unilateral diffusion in ways that are analogous to straight men—disrupting the notion that *only* men are a bad influence. If not gender, what, then, shapes the direction of unilateral diffusion in gay and

lesbian couples? Gays and lesbians exist in very different structural contexts (e.g., non-heterosexual, non-married) that blur what is commonly understood as the "natural" man/woman dichotomy found in the institution of straight marriage (Schofield et al., 2000). Because the "bad influence" is not clearly linked to a traditionally perceived man/woman binary, other notions of *difference* may structure who is considered the influencer. It may be that gay men and lesbian women perform masculinities and femininities in alternative ways (Pfeffer, 2010); these alternative performances may free up at least one woman in a lesbian partnership or one man in gay partnership to partake in risky behaviors, influencing unhealthy habits (Yancey et al., 2003). Alternatively, differences in gender performance between partners may prompt the more masculine partner's health habit diffusion in gay and lesbian couples, as found in straight couples. The present study is unable to address this possibility directly because measurements of respondents' masculinity and femininity beyond self-identification as a "man" or "woman" were not obtained; this possibility should be explored in future research.

The incorporation of gay and lesbian respondents also reveals the unique dynamic of *bilateral diffusion*, where the unhealthy habits of both partners are simultaneously produced. Bilateral health habit diffusion provides new insight into the mechanisms through which health habits become concordant over time in two distinct ways (Lewis et al., 2006; Merline, Schulenberg, & O'Malley, 2008). First, partners explicitly reject being healthy as an act of mutual pleasure. This suggests that partners have similar health habits not only because they share an environment or because only *one* partner is a bad influence as previously theorized (Lewis et al., 2006), but also because health habit concordance is a reinforcing component of a relationship. Further, these long-term gay and lesbian couples exist in a social and institutional context that may be homophobic, heteronormative, and generally discriminatory toward their relationship. A turn inward toward the sharing of unhealthy habits may be one of many relationship-specific mechanisms through which intimate ties are sustained in the face of external stress (Meyer, 2003). Therefore, while such habits may deter an individual's physical health, partaking in mutual unhealthy habits may be a positive endeavor for the health of an intimate tie—perhaps especially for gays and lesbians. Second, some partners believe they have concordant unhealthy habits due to a mutual lack of motivation to be healthy—suggesting that synchronistic modes of motivation to "be healthy together" is one key to deterring unhealthy habits. Both types of bilateral diffusion were discussed predominantly in gay and lesbian relationships, suggesting relationship dynamics unique to gay and lesbian couples may precipitate bilateral diffusion. For example, "doing gender" theory suggests that gays and lesbians may perform gender in alternative ways due to their non-heterosexual identities and relational context (West & Zimmerman, 1987) outside the context of legal marriage. These alternative gendered norms emphasize the performances of "doing similarity"—rather than "doing difference"—between men and women, in turn facilitating bilateral unhealthy habits between women and between men in gay and lesbian couples. Moreover, because health habits are gender stratified (Reeves & Rafferty, 2005) partners of the same gender may be more likely to enjoy similar types and levels of the same unhealthy habit, contributing to bilateral diffusion.

Third, respondents utilized a discourse of *personal responsibility* to suggest that even when they believe their spouse is partaking in an unhealthy habit, it is not their responsibility to perform social control to change the habit. This discourse was described primarily by both spouses in straight marriages, who purposefully abrogated responsibility to perform social control—even when doing so meant their partner would be less healthy. If social control processes are a main mechanism through which marriage promotes healthy behavior (Umberson, 1992; Waite & Gallagher, 2000), the theme of "personal responsibility" suggests a previously unarticulated mechanism through which intimate partners promote one another's unhealthy habits—abrogated social control. This theme contradicts normative discourses of marriage that suggest one should attempt make one's spouse healthier. However, it is in line with broader neoliberal public policies that promote personal responsibility for a healthy lifestyle and view health as an individualized feature of life dependent on "personal choice" (Carr, 2009; Metzel & Kirkland, 2010; U.S. DHHS, 2010). Moreover, a contradiction arises in this theme. While both spouses in straight marriages suggested they should *not* perform social control, straight married women were still *expected* to perform social control. This double standard acts as a "family myth," promoting the perception of gender equality in order to obscure the reality that women are expected to do more social control than men in straight marriages (Pfeffer, 2010).

While this study offers unique insight into relationship dynamics around unhealthy behavior, several limitations must be considered. First, there are inconsistencies in the study sample, as this analysis compares legally married straight couples to long-term cohabiting gay and lesbian couples. However, with the exception of one respondent, all gay and lesbian cohabiters would legally marry if they could, and thus this is a relevant comparison group. In this vein, nearly all of the straight couples had children while a minority of gay and lesbian couples had children, and research shows there are significant health behavior changes with parenthood (Sobal et al., 2003). Despite this sample inconsistency, children were rarely discussed in conversations regarding health habits. This is most likely because a majority of children were adult and nonresidental. Moreover, the importance of age and relationship duration differences among couple types, and age discrepancy between partners, were not found to be relevant in this study. Future research should examine how these factors, particularly the social context of parenthood, matter for the promotion of unhealthy habits. Second, these findings are based on a non-representative U.S. sample of long-term intimate relationships. Long-term relationships have different dynamics than those of shorter durations. Thus, the findings in this study reflect patterns that have developed across the course of a long-term tie. Respondents answered interview questions with their present phase of the relationship in mind, rarely drawing attention to how current dynamics developed over time. This may be because more recent examples were readily accessible and salient in their memory. Future research should examine how unhealthy habits are promoted in the transition to a relationship to more fully understand how these dynamics become solidified.

Third, respondents in this study were not prompted to discuss specific health habits. This allowed respondents to decide which health habits were important to discuss. While this approach is informative, it resulted in a heavy reliance on food and exercise. Food and

exercise habits are perhaps the most salient habits for individuals as they tend to occur regularly—in the case of eating several times per day. Moreover, contemporary public discourses and health campaigns emphasize the importance of food and exercise choices for a healthy "lifestyle" and an attractive body (Carr, 2009; Cockerham, 2004). Individuals may interface with these messages about food and exercise in ways that heighten their self-awareness; thus they may be able to more clearly articulate their relationship to an idealized healthy lifestyle. Additionally, discussion of unhealthy behaviors such as heavy alcohol or drug use may not arise in a sample of long-term couples because individuals with substance use problems are more likely to dissolve their relationships (Bachman et al., 2002). Future research should directly ask partners about specific health habits in order to more fully understand these dynamics.

Despite these limitations, this study provides a significant contribution to existing literature on intimate ties and health. While previous research focuses nearly exclusively on how marriage promotes healthy habits (Carr & Springer, 2010), this analysis is among the first to demonstrate how gay, lesbian, and straight partners promote one another's *unhealthy* habits. This analysis moves beyond large-scale associations to provide evidence of the mechanisms though which these processes occur. Future research should continue to explore how marriage is not only health promoting, but also, often simultaneously, health deterring—perhaps especially for straight women. Additionally, this study highlights the importance of including gay and lesbian couples in future research for two primary reasons. First, bilateral health habit diffusion was most clearly described in these couples. Second, the inclusion of gay and lesbian couples sheds suggestive light on the connection between institutional structure and interpersonal negotiations of health behavior; processes related to unhealthy habits may be symptomatic of (a lack of) institutional support and gendered norms of, for example, legal marriage. Finally, this study brings forth questions regarding the nature of intimate ties in relation to proliferating notions of personal responsibility for health in the public sphere (Metzel & Kirkland, 2010). For example, how might spouses' (lack of) social control efforts or diffusion processes change over time in line with shifting terrains of neoliberalism around health? Do gay, lesbian, and straight individuals negotiate these discourses in similar ways? Such questions should be explored in future research, building on the present study's insight into the health behavior dynamics within gay, lesbian, and straight intimate relationships.

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