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Healthcare Work in Marriage: How Gay, Lesbian, and Heterosexual Spouses Encourage and Coerce Medical Care

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Abstract

Marriage benefits health in part because spouses promote one another's well-being, yet how spouses facilitate formal healthcare (e.g., doctor's visits, emergency care) via what we call *healthcare work* is unknown. Moreover, like other aspects of the marital-health link, healthcare work dynamics likely vary by gender and couple type. To explore this possibility, we use in-depth interviews with 90 midlife gay, lesbian, and heterosexual spouses to examine how spouses perform healthcare work. Our results show that in heterosexual marriage, women perform the bulk of healthcare work and typically do so in coercive ways. A minority of heterosexual men provide instrumental healthcare work for their wives. Gay and lesbian spouses appear to commonly use both coercive and supportive healthcare work strategies to effectively promote healthcare use. Our findings demonstrate the ways spouses are central to supporting and coercing one another to obtain medical care and how these patterns are gendered.

Keywords

gay; healthcare; lesbian; marriage; physical health

Marriage enhances health in part because spouses help each other recover from physical illness and injury and regulate each other's diet, exercise, sleep, and substance use (Reczek et al. 2016; Waite and Gallagher 2002). Collectively called *health work* (Reczek and Umberson 2012), these actions are highly gendered, with heterosexual women performing the bulk of spousal health work relative to heterosexual men (Pinquart and Sorensen 2007). In contrast, gay men and lesbians appear to perform health work in more egalitarian ways (Reczek and Umberson 2012). Past research primarily examines spousal health work inside the home. Yet, midlife adults (ages 40 to 60) increase their encounters with healthcare systems due to routine physical health screenings and the onset of age-related physical health events (Case and Deaton 2015; Parker and Thorslund 2007), and thus marital health work likely extends into the healthcare domain.

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Spouses may support or even initiate medical encounters for each other. However, spousal efforts to promote and regulate physical health via engagement with healthcare—what we term *healthcare work*—have not been fully theorized as part of the broader swath of marital health work. Further, health work processes are gendered, with empirical research suggesting that heterosexual men do less than heterosexual women to monitor and promote their spouse's physical health (Reczek 2012; Reczek and Umberson 2012). Moreover, compared to women, men are more reluctant to obtain medical care and are more frequent recipients of their spouse's encouragement to visit the doctor for physical ailments (Courtenay 2000). However, the ways men and women differentially use healthcare work to get their spouse to see the doctor is largely unexplored. We follow a gender-as-relational approach (Umberson et al. 2015), which suggests that both one's own gender *and* whether one is married to a man or a woman will shape the dynamics of spousal influence on individual physical healthcare use. Accordingly, gendered interactions between gay men, between lesbian women, and between heterosexual men and women are likely to unfold in unique ways that differentially influence healthcare work.

To better understand the gendered marital dynamics that influence healthcare utilization for physical health, we analyze spousal healthcare work within qualitative data from 90 in-depth interviews with midlife gay, lesbian, and heterosexual spouses. This sample construction allows us to theorize on the previously understudied healthcare work engaged in by heterosexual, gay, and lesbian spouses. Uncovering how both gender and couple type shape spousal healthcare work can provide unique insights into how gendered marital dynamics affect physical health in marriage.

BACKGROUND

The US healthcare system relies on individuals to monitor their health status, recognize when a physical health symptom requires medical attention, and seek appropriate medical care (Thompson 2007). Because individuals are embedded in families, this responsibility extends to family members, including spouses (Spencer 2018). As individuals approach midlife, spouses become increasingly likely to take up this responsibility due to the onset of physical illness and recommended health screenings. Indeed, one of the underlying principles of marriage is attending to one's spouse in sickness as well as health (Waite and Gallagher 2002). In this study, we provide an account of how spouses encourage each other's engagement in medical care for physical health via what we call *healthcare work* We conceptualize healthcare usage in the broadest of terms to include routine and emergency physical healthcare as well as healthcare for chronic and serious physical health concerns to capture spousal interactions relating to multiple facets of care for physical health.

To analyze marital healthcare work processes, we use a gender-as-relational approach, which theorizes that marital dynamics are structured by the gender of both spouses. The gender-as-relational approach argues that a man married to a man may have different marital and health dynamics than a woman married to a woman (Umberson et al. 2015). Specifically, research on heterosexual marriage shows that spouses promote one another's health in ways that are highly gendered. For example, married heterosexual women do more caregiving during times of illness and health behavior regulation relative to heterosexual men

(Courtenay 2000; Pinquart and Sorensen 2007; Reczek and Umberson 2012). Structural opportunities, obligations, and constraints that differ for men and women in the context of heterosexual relationships promote and reinforce women's greater provision of care, including healthcare work. Yet, research on gays and lesbians suggests that both men and women perform caregiving and health behavior regulation, suggesting unique dynamics of healthcare work not solely based on gender but rather on gender in relational context (Reczek and Umberson 2012; Umberson et al. 2017). In the following, we draw on prior work to theorize gendered healthcare work in two general domains: (1) routine physical medical care and (2) care during physical illness or injury.

Spousal Healthcare Work: Routine Healthcare for Physical Health

Public health protocols extol the importance of annual physicals and routine health screenings at midlife to identify emerging disease and encourage preventive care (Centers for Disease Control and Prevention 2017). Public health efforts have primarily focused on individual-level encouragement and incentives to schedule these appointments. However, one's spouse may encourage attendance at annual or routine screening appointments when they are aware of both routine health needs and public health protocols. For example, spouses may encourage medical engagement for routine care by assuming aspects of the "structural burden" of care (Taylor and Quesnel-Vallee 2016), such as encouraging or directly making appointments for each other or physically accompanying their partner to an appointment (Kane and West 2005; Penrod et al. 2012). Yet, despite the increase in calls for routine healthcare needs at midlife, surprisingly few studies examine how spouses prompt one another to obtain annual physicals, screenings, and other preventive care. This is in part because the vast majority of research conceptualizes getting to the doctor as an individualized experience, with little attention to the social context of marriage and the spousal interactions that might prompt an individual to get to the doctor.

We theorize that spousal encouragement to obtain routine medical care is not only a key form of health work that has been previously unexplored but that spousal influence also varies for men and women both within and across gay, lesbian, and heterosexual unions. From a gender-as-relational perspective, it may be that women in both heterosexual and lesbian marriages are more likely than gay and heterosexual men to urge routine medical care for their spouse because women view healthcare work as central to their responsibilities and skills as wives (Gibbons et al. 2014). Blumberg, Vahratian, and Blumberg (2014) show heterosexual married men are more likely than cohabiting and non-cohabiting non-married men to have had at least one healthcare visit in the last month and are more likely than all other groups to have routine screenings. In turn, lesbian women may enact normative femininity and their status as wives in ways similarly to heterosexual women, whereas gay men may fail to do healthcare work due to their enactment of normative masculinity and their status as husbands. However, gender-as-relational theory further suggests that gay men and lesbian women may enact gender and thus healthcare work in unique ways due to alternative norms of masculinity and femininity in the gay and lesbian community (Courternay 2000; Reczek and Umberson 2012). Thus, it is possible that gay men perform healthcare work in ways similarly to heterosexual women.

In addition, homophobia and discrimination in healthcare settings may play a role in how routine healthcare work is deployed in gay and lesbian couples (Scott, Pringle, and Lumsdaine 2004). Sexual minorities have a lower likelihood of receiving routine healthcare and are more likely to report unmet and delayed medical care than heterosexuals (Buchmueller and Carpenter 2010; Harvey and Housel 2014). Gays and lesbians experience healthcare discrimination due to their sexual minority status, thus, spouses may be less willing and able to promote routine healthcare engagement (Eliason and Schope 2001). In contrast, one study shows that gay men are more likely to have seen a medical provider in the last 12 months compared to heterosexual men (Tjepkema 2008), potentially because of social embeddedness of highly medicalized networks due to the legacy of the HIV/AIDS crisis (Brennan-Ing et al. 2014), which may in turn increase healthcare work processes. Notably, research on healthcare utilization of sexual minority populations does not typically take the marital status of individuals into account, which may shape healthcare use via healthcare work (Frost et al. 2017).

Spouses' Healthcare Work: Care during Illness or Injury

Individuals experience aches, pains, and symptoms that require medical attention. Determining when it is time to address issues medically has been conceptualized as an aspect of *medicalization*, or the identification of symptoms as a medical problem that can be addressed by medical professionals (Conrad 2005). While medicalization typically focuses on individual-level experiences, medicalization processes may also occur through social interactions with significant others, especially spouses (Dillaway 2008). Studies exploring medicalization processes within couples are highly specialized in terms of health outcome and rarely speak to how spouses *mutually* come to understand a symptom as needing professional medical attention. For example, Potts et al. (2004) suggest erectile dysfunction is identified as a health issue in the couple context but theorize that the actual medicalization process is highly individualized, wherein each member of the couple constructs a "Viagra story" informing medication seeking and use. Similarly, research on fertility and prenatal care shows that heterosexual men attend certain types of women's doctor's visits to facilitate care (Figueiredo and Conde 2015; Meerabeau 1991; Wolff and Roter 2008). Further, Trief and colleagues (2003) describe couples' medicalization of diabetes after initial involvement within the medical community, not before. Thus, research clearly shows spousal work to ensure proper treatment once in the medical setting but has not examined these processes prior to healthcare engagement (Koehly et al. 2014; Ward-Griffin and Marshall 2003; Wolff and Spillman 2014). Spouses may first influence the identification of an illness or symptom that potentially poses a health threat (e.g., identifying sneezing as a cold) and then encourage a spouse to seek medical care. Spouses may also transport each other to and from appointments when a spouse is sick or injured to facilitate care, as has been shown in aging populations (Caputo, Pavalko, and Hardy 2016).

These processes again likely vary for men and women in gay, lesbian, and heterosexual marriages. Reczek and Umberson (2012) use qualitative data to demonstrate how married gay men, lesbian women, and heterosexual women routinely encourage their spouses to lose weight by promoting habits such as exercise, yet heterosexual men rarely engage in this kind of encouragement. Thus, women (regardless of couple type) and men in same-sex

relationships may work to promote healthcare for a sick spouse. Alternatively, Umberson and colleagues (2017) show that women in both lesbian and heterosexual relationships do more care work for a sick spouse than men in gay or heterosexual relationships. This suggests that heterosexual and gay men may be less attentive to health problems and therefore less likely than women to encourage a spouse to go to the doctor for health problems regardless of the gender of their spouse. Further, gays and lesbians may have unique health needs that shape healthcare work during times of illness and injury (Reczek, Liu, and Spiker 2014). Pfeffer (2010) shows cisgender women transport their transmen partners to visit the doctor and assist in navigating the bureaucracy of physician visits, taking an immersive role in the medical interactions of transmen. However, beyond the trans context, virtually no research articulates how unique health needs may shape healthcare work across gender and couple type within the broader context of health and well-being.

In sum, although previous studies suggest that spouses may be involved in each other's healthcare in a variety of ways, there is no systematic theoretical or empirical examination of *how* spouses do healthcare work, including (but not limited to) encouraging routine healthcare and healthcare during times of illness and injury. In this study, we analyze qualitative data to examine how spouses do healthcare work to promote care for physical health and how these processes vary by gender and couple type.

DATA AND METHODS

This study relies on qualitative data from in-depth interviews with 90 individuals in 15 gay male, 15 lesbian, and 15 heterosexual couples (45 couples) who were legally married residents in Massachusetts. Data were collected in 2012 through 2013, and Massachusetts was chosen as the study site because it was the first state to legalize same-sex marriage (in 2004; Lofquist 2011) and thus had the longest term midlife married gay and lesbian couples. In addition, Massachusetts has a high incidence of health insurance and relatively even access to quality medical care (Attorney General 2007). This allowed us to more clearly articulate differences across couple type by not rendering our findings beholden to healthcare variation across the sample. The majority (over 80%) of gay and lesbian couples in the in-depth interview sample were identified through Massachusetts vital records. Gay and lesbian marriages were sorted by vital records staff, with information on the names, birth years, addresses, and occupations from every same-sex couple married in Massachusetts between 2004 and 2012. Letters were mailed to the address listed to solicit participation, and therefore respondents living in the same home since their marriage were more likely to receive the letters. In the case of letters that were returned for being undeliverable, we did Internet searches to find new addresses for these respondents and resent letters to those who had moved. Lower socioeconomic status individuals are less likely to marry and may be more likely to change residences and thus are underrepresented in our sample. The remaining gay and lesbian couples were recruited through snowball sampling and informational flyers distributed in local community centers and public spaces, such as coffee shops, in areas with high concentrations of gay and lesbian couples.

A majority (about 75%) of the heterosexual couples were identified through referrals from gay and lesbian couples. The remaining 25% of heterosexual couples were identifying

through fliers in the same neighborhoods as described previously for the gay and lesbian sample. Same-sex married couples are a highly select group—particularly in Boston and the surrounding metro areas—and the aim of qualitative research is to obtain appropriate comparison groups to make theoretical claims rather than representativeness. Therefore, we aimed to obtain a comparison group of heterosexual couples so we could control for variables other than couple type, such as income, race, occupation, insurance status, and other unknown factors. Because social networks are often homogenous, obtaining similar others through social networks allowed us to narrow in on differences based on relationship status. Because same-sex marriage was not legalized prior to 2004, total relationship duration for comparability across groups was taken into account during recruitment. Midlife heterosexual, gay, and lesbian couples with the same total relationship duration differ in total number of years cohabiting compared to total years married. We sampled men and women aged 40 to 60 to keep the focus on midlife couples. We incorporated a dyadic design wherein data were collected from both spouses within each couple; spouses were interviewed separately, and $50 gift cards were given to each individual.

Analysis

In-depth interviews were conducted separately with each spouse to ensure confidentiality and privacy. Interviews included open-ended questions about illness experiences within marriage. Interviewers followed the same open-ended guide for all respondents, with follow-up questions. Open-ended interview questions included questions about interactions in healthcare settings, such as, “Describe the most recent health event you’ve experienced; did you go to the doctor? If so, tell me that story.” Then, more focused questions were asked, such as, “Did your spouse encourage you to go to the doctor? How so and did it work?”; “Did your spouse accompany you to the doctor? Why or why not?”; and “What did your spouse do to help with getting to the doctor?” Interviewers encouraged respondents determine what types of events to discuss to let the most salient encounters emerge.

All interviews were analyzed by the authors using a standardized method of inductive data analysis that emphasizes the dynamic construction of codes for the purpose of developing analytical and theoretical interpretations of data (Silverman 2006). NVivo qualitative software was used to house and organize the data, and no NVivo programs were run to code the data. The authors used inductive reasoning to guide the analysis, identifying patterns and conceptual categories as they emerged from the transcripts. In line with a standard approach to qualitative data analysis, the authors read each transcript to ensure understanding of interview content. Thereafter, the authors took a three-step coding process. First, each of the authors conducted line-by-line, data-driven categorization to summarize each piece of data as it related to spousal engagement in medical care. Next, the first author, in consult with the other authors, independently performed “focused” coding to develop categories regarding perceptions of marital dynamics pertaining to healthcare interactions by connecting initial line-by-line codes together for conceptual purposes. In the final stage of analysis, the first author, again in consult with the other authors, created conceptual memos to develop categories and subcategories that related to one another on a theoretical level. The themes from this final stage are discussed in the following. The utilization of one primary data analyst is part of a standardized qualitative methodology that draws on interpretivist and

constructionist epistemology (Roy et al. 2015). The systematic and rigorous interpretation of conceptual findings by one data analyst is a highly reliable and valid approach to qualitative research (Esterberg 2002).

RESULTS

Table 1 shows demographic characteristics of the sample on key variables. A recruitment priority was to match couples as closely as possible on age, relationship duration, and insurance status. Heterosexual respondents had an average age of 52 and an average relationship duration of 24 years compared to an average age of 50 and average relationship duration of 19 years together for gay men and an average age of 51 and average relationship duration of 20 years together for lesbians. In line with national statistics (Carpenter and Eppink 2017; Fisher, Gee, and Looney 2018), gay men in our sample out-earned their lesbian and heterosexual counterparts and were less likely to be in low-income categories. Gay respondents reported fewer children than lesbian and heterosexual couples; heterosexual couples reported the most children (Gates 2013). Table 1 shows that all couples in the sample had health insurance and most reported seeing a doctor in the past five years.

The in-depth interview data provide accounts of how spouses work to promote one another's healthcare—what we call healthcare work. We took a broad view of healthcare to include all visits for physical healthcare services. Analysis of the data revealed three broad themes: (1) healthcare work to make routine appointments, (2) healthcare work to identify physical health problems, and (3) healthcare work to get to the doctor. Within each theme, we call attention to the ways in which spousal facilitation of medical engagement varied by gender and couple type. Percentages are reported in the following to provide relative context in our sample and are in no way meant to imply representativeness or generalizability beyond this sample.

Healthcare Work to Make Routine Appointments

Contemporary public health regimens have attempted to routinize yearly checkups, and about 60% of respondents described how at least one spouse played a major role in ensuring routine care was obtained via: (1) coerced checkups and (2) mutual check-ins.

Coerced checkups.—First, heterosexual women, gay men, and lesbian women described pressuring their spouses to obtain yearly checkups and screening appointments. The dynamics for heterosexual couples were strongly gendered, with over half of heterosexual women but few heterosexual men performing coercive healthcare work. Heterosexual women often described going to great lengths to coerce men's checkups, in part because their heterosexual spouse did not value their own routine medical care. Curtis (age 55), married to Annette (age 59), explained:

> My wife is the list maker and she'll say, "Oh Curtis, you got to [go to the doctor]. It's time for this, it's time for this. I saw doctor [name omitted]; have you had your appointment?" "Nope." "Go, I signed you up." "Good for you." "It's totally illegal but I don't care I signed you up and you got an appointment."

Heterosexual men often recognized that it took strong-arm techniques to get them to the doctor, but men were rarely involved in coercing checkups for women. Peg (age 52), married to Nick (age 53), said, “Well I’ll remind him. He usually doesn’t remind me but I remind him. … I don’t know that he would remind me.” Reggie (age 53), married to Jasmine (age 49), also articulated this inequality when he noted that his wife knew his appointment schedule but he did not know hers: “I don’t know if she had hers done. I know she should.” While Dean, Nick, Reggie, and other heterosexual men sometimes recognized this lack of attention placed added burden on heterosexual women, this acknowledgement did not alter their behavior. In a final example among heterosexual spouses, Diane (age 41), married to Gary (age 42), explained why she does healthcare work:

> I’m just more of a worrywart. … Gary didn’t really grow up in a place where he was constantly kept after. I want him to know that I’m watching out and … “Hey, it’s a year. You should go get your blood work done.” And you know, “Oh it’s Fall. I know sometimes you get bronchial stuff, [you should go to the doctor].” He’s a man and that goes along with just being a man anyway. [I] have to kind of keep on him. He might not admit it, but I think he appreciates it. Someone’s looking out for him.

Diane directly related Gary’s lack of desire to get “checked up” and his lack of interest in either of their healthcare as a result of his being a man. Diane explains that she is just a worrywart, thus it is her job to ensure he gets checked in on by a medical professional annually while he has no obligation to do the same for her.

Just over half of gay and lesbian couples discussed coercive techniques to get their spouse to attend annual and routine checkups. Coercion was enacted on the spouse seen as most at risk for health concerns screened for at annual exams rather than driven by gender. In contrast to accounts from heterosexual spouses, this healthcare work was often appreciated. Colleen (age 41) noted that it is she who paid attention to the public health recommendations because she believed Maureen (age 55) was at risk for breast cancer:

> She knew she should do it, but it was hard for her. … She had to go for her baseline mammogram because her mother had breast cancer … the AMA and different doctors started having different opinions about really when a baseline mammogram should be. … I had to get really like, “I want you to go. … I know there’s no consensus on what’s the right age, but now, at this point I want you to go. You have to go do this.” And she did.

Some gay and lesbian spouses made appointments for each another. For example, long after Patrick’s (age 55) cancer treatment was complete, Roger (age 54) was in charge of making sure that Patrick went to his annual checkups, at times making the appointments himself. Roger said:

> I was talking to the doctors. This is a place where being the same gender really worked to our advantage. Somebody [on the phone] would say, “Patrick?” You know I could see it was [local health providers] or whoever it was and I would say “Yes?” and they would go, “Can you verify your social?” and I would verify the last four digits of his social. And they would say, “Okay do you know that you. …”

> And I would say “Yes.” Or they would say, “We’re trying to schedule an appointment for you, but it’s not working out,” and I said, “What are the options?” and they would tell me.

Because Patrick was at an increased risk for health problems following his experience with cancer, Roger took charge of making Patrick’s appointments and holding him accountable to ensure Patrick’s continued health.

Mutual check-ins.—In addition to coercive techniques, about 25% of gay and lesbian respondents but no heterosexual respondents described encouraging each other to obtain checkups via mutual appointment making. Due to sex segregation of some medical specialists and needs, spouses in gay and lesbian couples often had the same doctor. Together, partners scheduled physicals, mammograms, or colonoscopies at the same time—sometimes doing this for each other. Tammy (age 51) discussed how she and her partner Cynthia (age 53) both make appointments: “Cynthia makes the mammograms [appointments and] I make the regular doctor [appointments]. Or if I’m making them, I’m saying, ‘Do you want me to make yours?’” Cheryl (age 55), married to Anne (age 50), described making mammogram appointments together: “It helps with the mammograms. I don’t know that I would have been as good about it, but because her mother had breast cancer, [Anne] was always really good about going. It definitely got me into [taking care of my health].” Similarly, Carlos (age 52) and Keith (age 50) see the same doctor, with Carlos reporting, “My doctor is his doctor. … We [had] an appointment with the primary care physician on the [same day]. So, we go one after the other.” Because gay and lesbian spouses were more likely than heterosexual spouses to experience aging in similar ways to one another in alignment with biological sex, they held each other accountable via mutual appointment making.

Healthcare Work to Identify Physical Health Problems

About 65% of respondents identified times when they believed a spouse’s physical health event merited healthcare. Spouses used three main approaches, which varied by gender and couple type, in their effort to identify and pressure each other to seek treatment for a perceived health problem: (1) mutually determining health risk, (2) pressuring a reluctant spouse, and (3) identifying relationship strain as a symptom.

Mutually determining health risk.—About 60% of gay and lesbian respondents but less than 10% of heterosexual respondents described working together to determine medical risk. In some couples, this mutual risk assessment occurred when the spouse with symptoms directly asked their partner if they should go to the doctor. For example, Monica (age 42), married to Colleen (age 41), said, “We sort of check in with each other, is this a doctor thing or not?” Here, spouses take the extra step to hear the complaint of their spouse and mutually decide health risk. Sharon (age 56) shared a story about her partner, Sandy (57), “She was 50 and yelled out in the room, ‘I’m spotting.’ It’s unusual. And I’m going like, ‘Call the doctor. Call!’ and she calls [the doctor].” Sandy recounted this event as well:

> Right after my 50th birthday, I had some spotting in between periods. I mentioned it to Sharon, and she said you know, why don’t you call the doctor? It’s probably

> nothing but why don't you call? The doctor said probably nothing but I'm going to send you to the gynecologist. I had a biopsy and I wound up having endometrial cancer.

Healthy spouses sometimes also directly told their spouse that a symptom is not normal and they are concerned about their well-being, formulating health risk mutually. David (age 55) views it as his duty to be aware of any potential medical harm that may come to Michael (age 57), who had skin cancer: "Whenever we see something on him now, if I see something anywhere on his body, we'll watch it for a little while and then I might say, 'Michael, I think you might need to go to the dermatologist for that,' and he will." Michael's bout with skin cancer makes David even more aware of potential skin issues, in turn making Michael more vigilant about medical risk. Similarly, Samuel (age 58), married to Bradley (age 54), said:

> I think that we are both good prods for the other person. If I get a cold that's going on too long and it's turned into the flu or whatever, [he will ask], "Did you call the doctor?" Neither one of us likes to go to the doctor, maybe it's a guy thing. And being gay has nothing to do in changing that. We're the one for each other who is sort of doing the check-in stuff.

Taken together, whether instigated by the sick or healthy spouse, gay and lesbian partners work together to mutually construct a physical health symptom or concern as serious enough for medical attention.

Pressuring a reluctant spouse.—Regulating spouses in this subtheme described pressuring a symptomatic spouse to go to the doctor once risk was determined, in part because of a spouse's fear of the doctor. This type of coercion was described by about 35% of gay men, 15% of heterosexual women, but no lesbian women or heterosexual men. Kevin (age 41) describes his role in getting Joe (age 51) to see his doctor: "Joe, unless forced, won't [call the doctor]. No, no, no. I have to tell him, 'You're very sick. I'm concerned about this. I need you to call the doctor or, or you need to call the doctor.'" Similarly, Jeremy (age 51) got a hip replacement because his wife strongly encouraged him to do so:

> It's been dragging for a long time; as a matter of fact, she was kind of pushing me like, "You should get this done," because it doesn't make much sense to be in pain at all times. … She was kind of supportive, but she was telling me occasionally, "Why don't you get it fixed? Why don't you get it fixed?" … I knew it was a problem, I have known many years ago but it became increasingly worse and worse and … And so, she decided—she was the major factor there that we decided—yes, let's do this thing.

Steve (age 46), married to Seth (age 55), discussed his need to pressure for healthcare because his partner would not go to the doctor:

> It's funny because he won't go to the doctor or he'll just like try to deal with it. We have the same doctor and we've had him for at least 15 years. I can e-mail him and say, "This happened with Steve, should he come in?" I usually make the appointment 'cause he probably wouldn't make the appointment. I usually try to do that sort of thing, help him to take care of himself.

Aaron (48), partnered with James (42), provides another example of this dynamic, illustrating the coercive nature of his partner's healthcare work:

> He'll often say to me, go to the doctor. Because like I said, I don't like doctors. I had a rash on my foot for months. And he's like, honey, go to the dermatologist, I'm like, no, it'll get better … and he had to push me to go to the doctor. It was a fungal infection and like a cream and like two weeks later it was gone. I'm like, oh my God, I should have gone earlier. He always [says] "you pay for healthcare, go to the doctor. …" His first impulse is to go to the doctor; my last impulse is to go to the doctor, so he will often push me to go to the doctor.

In this way, while a sick person—all men in this theme—may know they are sick and be convinced of the health risk, they may not make the leap to obtaining medical care. Thus, identifying a problem in a partner *as* a medical problem and subsequently suggesting that a doctor may help fix this problem is one key way spouses attempt to get each other to go to the doctor.

Identifying relationship strain as a symptom.—About 20% of heterosexual respondents—primarily heterosexual women and some heterosexual men—but no gay and lesbian respondents recounted that their partner had untreated problems that were annoying to the point of creating strain in the relationship. In these cases, the respondent forced a spouse to get their health issue checked out by a medical professional. Several heterosexual women discussed how much men's consistent complaining about health caused them personal stress. Annette (age 59), married to Curtis (age 55), said:

> I was angry because he was sleeping and not doing the stuff [he should do]. After I had a few temper tantrums I realized … you must have a sleeping disorder. … All I have to do is call my doctor and say, "Doctor he needs a sleep study." I have to make him make the appointments. Otherwise he'll tell me he can't go the time I make it. I say, "Well you need to call right now and you make the appointment." He allowed me to kind of make sure that he did that.

Similarly, Miranda (age 54), married to Bill (age 56), recounted:

> He has back problems, I'll be like, "Look, you should really go [to the doctor]." Or, he had knee problems and we were trying to hike and I'm like, "You should really go and see the sports medicine guy. You don't try and then you're all complaining …" So then, he did. So, I kind of occasionally have to nag him to go.

In turn, a minority of heterosexual men also described doing this work for their wives when complaining occurs. Miyu (age 37), married to Cliff (age 41), said:

> I have the joint pain from arthritis, so I'm saying, "Something hurts, something hurts and I have migraine." First thing he'll do is ask me, "Did you take medicine?" Then if I still say something hurts, [he will say] "Did you make doctor's appointment?" I make appointment. I tend to whine. So, he is tired with me, so he just tells me to take medicine, make [an] appointment.

Cliff recounted how these interactions unfold from his perspective:

> It's like, "Hon, you have to take some Tylenol or make a doctor's appointment." She is notorious for not wanting to make the doctor's appointment and asking me, "What should I do? What should I do?" I'm not a doctor. Call the doctor. If you're this uncomfortable, call the doctor. Make an appointment and let them tell you what needs to be done. A couple of weeks ago, she was talking about how bad her wrists were acting up and things like that and it was like, "Miyu, you're going to have to go [to the doctor's office] for this." [She'll go] after a lot of prodding, she will.

Cliff described that he gets frustrated that his wife asks him for advice because he sees this as "super high maintenance." Thus, he pressures her to get her ailments checked out by a medical professional so he does not have to listen to her complaining.

Respondents in this subtheme described their encouragement to go to the doctor as a result of their own frustration with their spouse's symptoms and complaints. While one may be concerned for the health and well-being of a sick spouse, constant complaining is the primary mechanism triggering the respondent's pressure on their spouse to go to the doctor.

Healthcare Work Getting to the Doctor

Findings reveal that about half of spouses in the sample encouraged medical care by actively facilitating getting to the doctor, primarily via instrumental support for the logistics of obtaining or attending an appointment. Instrumental support included any effort to make engagement with medicine possible, such as providing transportation, physically attending a spouse's appointment, and help navigating insurance. Although instrumental support was reported by about 35% of gay and lesbian respondents and 20% of heterosexual respondents, the character of facilitation differed by couple type.

In gay and lesbian couples, instrumental facilitation made it possible for each member to participate in the health seeker's medical experience *together* and often included components of emotional support. This instrumental support occurred most predominantly for routine care, such as when a spouse needed a ride for a colonoscopy. Michael (age 57), married to David (age 55), stated, "Obviously for things like a colonoscopy, we take care of each other getting to and from and all that stuff." This form of instrumental work in getting a spouse to a doctor also occurred for more serious health concerns that required hospital or emergency doctor's visits. When asked what he and his partner's roles are during a healthcare encounter, Michael said, "I sort of go into coping mode. I'm probably not as emotionally attentive as David at the doctor. I think I'm pretty good at asking; listening to the doctor and asking follow up questions and trying to figure out exactly what the next steps are." Here, Michael's participation in David's engagement with the medical community, and vice versa, was not limited to simply getting him to the right location. Michael used this initial logistical support as a catalyst for further support in helping David understand both what the doctor's orders were and determining if any other information was needed from the medical interaction. Further, Michael suggests that David is skilled at emotional support.

Heidi (age 52) similarly described her wife Sally's (age 54) instrumental and emotional support after Heidi's cancer diagnosis:

> She started a little folder. She'd take notes of all the appointments. And helping me, at a time when I really needed somebody helping me make decisions. She helped me sort of weed through decisions. She found a surgeon who wound up doing the surgery. So just kind of every step of the way she was with me, she went to all my follow-up appointments, all my radiation treatments.

Sally's instrumental involvement in Heidi's care did not stop at attending the appointment to help Heidi keep track of medical information. Sally also assisted Heidi in processing the information needed to make medical decisions, including the research to find a new doctor for Heidi's continued care.

In contrast, heterosexual spouses frequently described instrumental assistance to ensure the health seeker's *independent* involvement in a medical interaction. For example, when asked if he and his wife attend appointments together, Cliff (age 41) described a situation where he made the appointment logistically possibly for Miyu (age 37) by providing child care, but he encouraged his wife's independence in receiving care:

> I would prefer to go by myself. She likes to come with me. I prefer to do this myself. She likes people to go with her to the doctor's appointment and I usually tell her, "I'll take the kids. We'll pick you up. I'll drop you off and we'll pick you up." [She says], "No, you should come." "No, you go to the doctor." Last thing I want to do is be wrangling two kids in a waiting room. I'd rather not hang out in a doctor's office if I don't need to.

In contrast to gay and lesbian couples who often viewed one instance of providing instrumental and sometimes emotional support as an opening to further integrate themselves in their partner's medical interactions, heterosexual couples tended to treat opportunities for facilitation as static events to encourage medical independence.

DISCUSSION

Midlife is characterized by increased encounters with formal healthcare systems due to routine health screenings and the onset of serious physical health concerns that require formal medical care (Case and Deaton 2015; Parker and Thorslund 2007). Yet, research on marital health work has not included spousal efforts to prompt engagement with formal healthcare, a process we refer to as *healthcare work*. Moreover, a great deal of prior research points to gendered marital dynamics that promote health within heterosexual marriage, with women doing more than men to promote the health of their spouse and gays and lesbians exhibiting more egalitarian health work processes (Pudrovska 2015; Reczek and Umberson 2012; Reczek et al. 2016). Yet these studies have not explored the gendered dynamics of healthcare work. We fill these gaps by using a gender-as-relational perspective and qualitative data from in-depth interviews with 90 midlife gay, lesbian, and heterosexual spouses to detail how healthcare work processes operate by gender and couple type. In the following, we discuss how our findings contribute to research on gender, sexuality, and health and more specifically to a broader understanding of marital influence on healthcare utilization.

Spousal Healthcare Work

Our study contributes more broadly to research on marriage and health as well as research on healthcare use by detailing how spouses facilitate spousal healthcare work for physical health concerns. We find that spouses do healthcare work to facilitate routine appointment making, get to the doctor, and identify illness and injury as needing medical attention. The robust presence of healthcare work in our sample demonstrates that spouses are a key influence in medical engagement, especially when one spouse is unaware of the need for healthcare or is resistant to care. While previous work has theorized that the US healthcare system is dependent on individuals' recognition of their own need for medical care, our conclusions highlight that spouses play an important role for each other in healthcare engagement (Cheek 2008; Yoder 2002). Healthcare work is a previously underrecognized yet vital type of spousal labor in the constellation of work done in the home that enhances health. Because men and women expend considerable effort determining when it is time for not only themselves but also a spouse to address medical issues (Conrad 2005), we emphasize the importance of going beyond the focus on healthcare use as an individual-level process to consider healthcare utilization also as a couple-level process. Notably, our results may be distinct to midlife, long-term relationships. Older spouses in longer-term marriages who may face more severe health problems in their 70s and beyond may have even greater influence on one another's healthcare, while younger spouses under 30 in short-term relationships may rarely have serious health events and may not influence one another's healthcare use. Future work should explore these possibilities to determine whether healthcare work dynamics are similar or different for age and relationship length. Taking this limitation into account, by examining the ways which long-term spouses determine health needs within the realm of formal healthcare, we contribute new insight into how and when adults seek medical advice in an increasingly medicalized environment (Dillaway 2008).

Gender, Couple Type, and Healthcare Work

Beyond advancing a theory of healthcare work more broadly, this study aimed to understand how healthcare work dynamics differ by gender and couple type. Supporting a gender-as-relational perspective that emphasizes that relationship dynamics are shaped by both partners' genders (Umberson et al. 2017), we find that women married to women, women married to men, and men married to men consistently describe doing healthcare work. Yet men married to women rarely reported performing healthcare work, with one notable exception: instrumental efforts to facilitate getting their wife to healthcare appointments (e.g., driving their spouse to an appointment or taking care of children during the appointment). Our findings are consistent with previous research showing that heterosexual men primarily perform instrumental care work during times of illness in lieu of intensive emotional support or health behavior regulation (Reczek and Umberson 2012; Trief et al. 2003). Instrumental healthcare work performed by men is often acute and/or episodic, requires minimal involvement, and is prompted by a timely need (e.g., when a partner needs to get to an appointment at a determined time) rather than other forms of healthcare work that are marked by prolonged monitoring of a spouse's health status over time. This finding is in line with previous research showing heterosexual married women contribute more intensively to men's health than heterosexual men (Umberson et. al 2017).

Moreover, as a gender-as-relational approach suggests, we find other notable variations by couple type in the way healthcare work is enacted by men and women. We find that heterosexual women, gay men, and lesbian women often describe methods of coercion to get their spouse to the doctor. Heterosexual women in particular force routine appointments on their reluctant husbands, consistently "nagging" a spouse to make an appointment. Further, heterosexual women uniquely impose coercive pressure on their resistant husbands to seek medical care for an acute problem by emphasizing how the husband's health symptoms cause the wife to have personal distress. These findings are consistent with gender research, which shows that part of heterosexual masculinity includes men's resistance to seeking medical care, buttressed by the notion that men do not require medical care but instead cope with physical health problems on their own (Courtenay 2000). In turn, heterosexual women take on the responsibility for pressuring reluctant men to obtain medical care as part of their duties as wives (Blumberg et al. 2014; Norcross, Ramirez, and Palinkas 1996).

Based on heterosexual marriage literature, we may expect women but not men in same-sex couples to attempt to do coercive healthcare work. However, as suggested by gender-as-relational theory, our data demonstrate that both gay men and lesbian women do coercive work to influence their reluctant spouses to seek healthcare. Like heterosexual men, gay men and lesbian women sometimes avoid making their own routine doctor's appointments and gay men further avoid healthcare treatment when ill, making them the targets of spousal healthcare work. Our findings suggest that gay men simultaneously confirm heterosexual stereotypes about men's reluctance to go to the doctor but also rebuke hetero-masculine notions that men do not attend to their partner's physical health needs (Connell 2005). Similarly, our finding that lesbian women follow some of these same patterns of both avoiding routine doctor appointments and using coercion to influence their partners suggests that being a woman partnered to a woman creates dynamics of both avoidance (similar to heterosexual men and gay men) and regulation (similar to heterosexual women and gay men). Thus, it is not gender that determines healthcare work processes, but the gender of both spouses in relation to one another that informs who performs and receives healthcare work. Overall, our findings suggest lesbian women and gay men are less gender conforming in their gendered norms around healthcare work than heterosexual men and women (Li, Pollitt, and Russell 2016).

Additionally, while coercive techniques are used across couple type in different ways, our findings suggest that gay and lesbian respondents most consistently and intensively perform healthcare work through *mutually supportive* methods. Gay and lesbian respondents in our sample jointly determined whether a health event requires medical care, mutually making appointments for one another, attending appointments with their spouse to alleviate stress, and acting as counselors with regard to healthcare concerns. In this way, both gay men and lesbian women viewed themselves as cooperatively invested in one another's health and saw their duty as not only to get a spouse to the doctor for treatment but to facilitate their spouse's emotional wellbeing when doing so (Pfeffer 2010). This finding is consistent with research and gender-as-relational theory, suggesting that both partners in gay and lesbian relationships, compared to partners in heterosexual relationships, may be more attuned to one another's emotional needs in ways that facilitate recovery from illness and injury (Umberson et al. 2015). In the gender-as-relational approach, the reciprocal techniques seen

in same-gender relationships emerge when spouses see each other as sharing responsibility for both partners' healthcare—perhaps because same-sex couples experience one another as similar, whereas heterosexual couples rely on notions of men and women being "opposite" (Schippers 2007). By rejecting heteronormative gendered notions of women as caregivers and men as care recipients, gay men and lesbian women in same-sex relationships appear to create new enactments of gender that support this mutual healthcare work dynamic. Thus, our study of gay, lesbian, and heterosexual couples provides a more complete view of healthcare processes, suggesting that gay and lesbian couples may offer a more reciprocal form of healthcare work as a result of their relational gender composition.

In addition, gay and lesbian spouses may provide this unique form of support in the context of discrimination and prejudice that influence the likelihood of going to the doctor (Sabin, Riskind, and Nosek 2015) as previous research has shown that gays and lesbians are more likely to report healthcare discrimination than their heterosexual counterparts (Scott et al. 2004). Notably, respondents did not directly link discrimination and homophobia in healthcare to spousal healthcare work in this study. We theorize that many of the gay and lesbian midlife respondents currently do not have discriminatory interactions with healthcare providers today because they screen healthcare providers for potential homophobia due to past experiences and now visit LGBTQ-friendly clinics and because their legal marriage offers protections against this discrimination (Hatzenbuehler et al. 2010).

Limitations

While the present study provides new insights into the critical role spouses play in obtaining healthcare, limitations must be noted. First, our sample was collected from Boston, Massachusetts, and the surrounding suburbs. Sample respondents were of mid- to high income, all respondents had health insurance, and few experienced financial insecurity (see Table 1). Thus, this study is limited in its ability to understand healthcare work among lower SES couples. Future research should address how these processes may differ for individuals whom do not have health insurance and those who experience lower income. Second, our sample consists of individuals between the ages of 40 and 60 in 2012–2013. Thus, this sample represents a particular cohort and age group who only very recently obtained the legal right to marry federally, and thus dynamics in our gay and lesbian couples may significantly differ for a different age range or cohort, as discussed previously. Third, the majority of our heterosexual sample had children, while less than one-quarter of our gay and lesbian sample had children (Lofquist 2011). Children were not a salient feature in relation to healthcare work processes but may play a role in these processes that future research should explore. Fourth, because this is a qualitative data set meant to inform our understanding of the processes and meanings of spousal influence on healthcare utilization, we cannot assess generalizability of findings to the broader population. We call on future work to assess how frequently spouses coerce each other into obtaining medical care in gendered ways with national data.

CONCLUSION

Our findings demonstrate that spouses are central in supporting and coercing one another to obtain healthcare and that these dynamics are shaped by gender and couple type. Our study shows that heterosexual women, lesbian women, and gay men are highly efficient in getting one another to address medical needs, with heterosexual women performing more coercive techniques and gay and lesbian spouses performing both coercive and supportive healthcare work techniques. Our findings further highlight that heterosexual women perform a great deal of healthcare work within marriage yet are the least likely spouses to be recipients of such healthcare work (with the exception of instrumental healthcare work to get to appointments). It may be that the healthcare system and healthcare professionals rely on and even encourage heterosexual women to get men to the doctor, increasing heterosexual women's burden of healthcare work. Gay and lesbian spouses appear to both mirror heterosexual women's dynamics but also have somewhat unique dynamics, including an emphasis on supportive health work strategies to promote their spouse's healthcare. In this way, gay and lesbian couples offer an alternative to highly gendered norms within intimate relationships. We call on future research to further investigate how gays and lesbians interact with formal healthcare systems and providers to motivate, sustain, or deter these unique dynamics.

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Biography

Corinne Reczek is an associate professor in the Department of Sociology at The Ohio State University. Her research examines how family relationships shape health and well-being, with a focus on gender and sexual minority, or LGBTQ, families. Her current project explores gender and sexual minority young adults' transition to adulthood, specifically examining how family of origin influences young adult well-being. She also studies gender and sexual minority adult interactions in healthcare. Her previous work on same-sex unions and their consequences for adult and child health can be found in *Social Science & Medicine, Journal of Marriage and Family*, and *Demography*, among others.

Lauren Gebhardt-Kram is a PhD candidate in the Department of Sociology at The Ohio State University. Her research explores health, aging, and death and dying. Her dissertation examines the experience of death and dying in both family and medical contexts and works

to reveal the production, consumption, and evaluation of medical knowledge through the dying process.

Alexandra Kissling is a PhD candidate in the Department of Sociology at The Ohio State University. Her research explores gender, health, and reproduction. Her dissertation examines how people decide to undergo tubal ligation and vasectomy and the gender dynamics and consequences of these decisions. Her previous work can be found in *Addictive Behaviors, Journal of Community Medicine and Health Education*, and *Family and Community Health*.

Debra Umberson is professor of sociology and director of the Population Research Center at The University of Texas-Austin. Her research focuses on social determinants of health across the life course, with attention to social relationships and health disparities. With support from the National Institute on Aging, she is currently studying racial/ethnic differences in exposure to the death of family members over the life course and implications for health. Recent publications also consider how spouses influence each other's health-related behavior, mental health, and healthcare and how these processes vary across gay, lesbian, and heterosexual unions.

REFERENCES

Attorney General, Commonwealth of Massachusetts. 2007 "Mandatory Health Insurance." Retrieved 9 25, 2018 (http://www.mass.gov/ago/doing-business-in-massachusetts/health-care/health-insurance-mandate.html).

Blumberg Stephen J., Vahratian Anjel, and Blumberg Joseph H.. 2014 "Marriage, Cohabitation, and Men's Use of Preventive Health Care Services." Retrieved 9 25, 2018 (https://www.cdc.gov/nchs/products/databriefs/db154.htm).

Brennan-Ing Mark, Seidel Liz, London Andrew S., Cahill Sean, and Karpiak Stephen E.. 2014 "Service Utilization among Older Adults with HIV: The Joint Association of Sexual Identity and Gender." Journal of Homosexuality 61(1):166–96. [PubMed: 24313258]

Buchmueller Thomas, and Carpenter Christopher S.. 2010 "Disparities in Health Insurance Coverage, Access, and Outcomes for Individuals in Same-sex Versus Different-sex Relationships 2000–2007." American Journal of Public Health 100(3):489–95. [PubMed: 20075319]

Caputo Jennifer, Pavalko Eliza K., and Hardy Melissa A.. 2016 "The Long-term Effects of Caregiving on Women's Health and Mortality." Journal of Marriage and Family, 78(5):1382–98. [PubMed: 27795579]

Carpenter Christopher S., and Eppink Samuel T.. 2017 "Does It Get Better? Recent Estimates of Sexual Orientation and Earnings in the United States." Southern Economic Journal 84(2):426–41.

Case Anne, and Deaton Angus. 2015 "Rising Morbidity and Mortality in Midlife among White Non-Hispanic Americans in the 21st Century." Proceedings of the National Academy of Science 112(49):15078–83.

Centers for Disease Control and Prevention. 2017 "CDC Prevention Checklist." Retrieved 9 25, 2018 (https://www.cdc.gov/prevention/index.html).

Cheek Julianne. 2008 "Healthism: A New Conservatism?" Qualitative Health Research 18(7):974–82. [PubMed: 18552323]

Connell Raewyn. 2005 Masculinities. Berkley, CA: University of California Press.

Conrad Peter. 2005 "The Shifting Engines of Medicalization." Journal of Health and Social Behavior 46(1):3–14. [PubMed: 15869117]

Courtenay Will H. 2000 "Constructions of Masculinity and Their Influence on Men's Well-being: A Theory of Gender and Health." Social Science & Medicine 50(10):1385–401. [PubMed: 10741575]

Dillaway Heather E. 2008 "'Why Can't You Control This?' How Women's Interactions with Intimate Partners Define Menopause and Family." Journal of Women and Aging 20(1–2):47–64. [PubMed: 18581700]

Eliason Michele J., and Schope Robert. 2001 "Does 'Don't Ask Don't Tell' Apply to Health Care? Lesbian, Gay, and Bisexual People's Disclosure to Health Care Providers." Journal of the Gay and Lesbian Medical Association 5(4):125–34.

Esterberg Kristin G. 2002 Qualitative Methods in Social Research. Boston, MA: McGraw-Hill.

Figueiredo Bárbara, and Conde Ana. 2015 "First- and Second-time Parents' Couple Relationship: From Pregnancy to Second Year Postpartum." Family Science 6(1):346–55.

Fisher Robin, Gee Geof, and Looney Adam. 2018 "Same-sex Married Tax Filers after Windsor and Obergefell." Demography 55(4):1423–46. [PubMed: 29949084]

Frost David M., LeBlanc Allen J., de Vries Brian, Alston-Stepnitz Eli, Stephenson Rob, and Woodyatt Cory. 2017 "Couple-level Minority Stress: An Examination of Same-sex Couples' Unique Experiences." Journal of Health and Social Behavior 58(4):455–72. [PubMed: 29172770]

Gates Gary J. 2013 LGBT Parenting in the United States. Los Angeles, CA: UCLA, The Williams Institute.

Gibbons Carrie, Creese Joy, Tran Mun, Brazil Kevin, Chambers Lori, Weaver Bruce, and Bedard Michel. 2014 "The Psychological and Health Consequences of Caring for a Spouse with Dementia." Journal of Women and Aging 26(1):3–21. [PubMed: 24483280]

Harvey Vickie L., and Teresa Heinz Housel, eds. 2014 Health Care Disparities and the LGBT Population. Lanham, MD: Lexington Books.

Hatzenbuehler Mark L., McLaughlin Katie A., Keyes Katherine M., and Hasin Deborah S.. 2010 "The Impact of Institutional Discrimination on Psychiatric Disorders in Lesbian, Gay, and Bisexual Populations." American Journal of Public Health 100(3):452–59. [PubMed: 20075314]

Kane Robert L., and West Joan C.. 2005 It Shouldn't Be This Way: The Failure of Long-term Care. Nashville, TN: Vanderbilt University Press.

Koehly Laura M., Ashida Sato, Schafer Ellen J., and Ludden Amanda. 2014 "Caregiving Networks—Using a Network Approach to Identify Missed Opportunities." Journals of Gerontology Series B: Psychological Sciences and Social Sciences 70(1):143–54.

Li Gu, Pollitt Amanda M., and Russell Stephen T.. 2016 "Depression and Sexual Orientation during Young Adulthood." Archives of Sexual Behavior 45(3):697–711. [PubMed: 25868403]

Lofquist Daphne. 2011 Same-sex Couple Households. Washington, DC: US Department of Commerce, Economics and Statistics Administration, US Census Bureau.

Meerabeau Liz. 1991 "Husbands' Participation in Fertility Treatment." Sociology of Health and Illness 13(3):396–410.

Norcross William A., Ramirez Carlos, and Palinkas Lawrence A.. 1996 "The Influence of Women on the Health Care-seeking Behavior of Men." Journal of Family Practice 43(5):475–81. [PubMed: 8917147]

Parker Marti G., and Thorslund Mats. 2007 "Health Trends in the Elderly Population." The Gerontologist 47(2):150–58. [PubMed: 17440120]

Penrod Janice, Baney Brenda, Loeb Susan J., McGhan Gwen, and Shipley Peggy Z.. 2012 "The Influence of the Culture of Care on Informal Caregivers' Experiences." Advances in Nursing Science 35(1):64–76. [PubMed: 22293611]

Pfeffer Carla A. 2010 "'Women's Work'? Women Partners of Transgender Men Doing Housework and Emotion Work." Journal of Marriage and Family 72(1):165–83.

Pinquart Martin, and Sorensen Silvia. 2007 "Correlates of Physical Health of Informal Caregivers: A Meta-analysis." The Journals of Gerontology Series B 62(2):126–37.

Potts Annie, Grace Victoria, Gavey Nicola, and Vares Tiina. 2004 "'Viagra Stories': Challenging 'Erectile Dysfunction.'" Social Science & Medicine 59(3):489–99. [PubMed: 15144760]

Pudrovska Tetyana. 2015 "Gender and Health Control Beliefs among Middle-aged and Older Adults." Journal of Aging and Health 27(2):284–303. [PubMed: 25227213]

Reczek Corinne. 2012 "The Promotion of Unhealthy Habits in Gay, Lesbian, and Straight Intimate Partnerships." Social Science & Medicine 75(6):1114–21. [PubMed: 22703888]

Reczek Corinne, Liu Hui, and Spiker Russell. 2014 “A Population Based Study of Alcohol Use in Same-sex and Sifferent-sex Unions.” Journal of Marriage and Family 76(3):557–79. [PubMed: 24860195]

Reczek Corinne, Pudrovska Tetyana, Carr Deborah, Thomeer Mieke Beth, and Umberson Debra. 2016 “ Marital Histories and Heavy Alcohol Use among Older Adults.” Journal of Health and Social Behavior 57(1):77–96. [PubMed: 26957135]

Reczek Corinne, and Umberson Debra. 2012 “Gender, Health Behavior, and Intimate Relationships: Lesbian, Gay, and Straight Contexts.” Social Science & Medicine 74(11):1783–90. [PubMed: 22227238]

Roy Kevin, Zvonkovic Anisa, Goldberg Abbie, Sharp Elizabeth, and LaRossa Ralph. 2015 “Sampling Richness and Qualitative Integrity.” Journal of Marriage and Family 77(1):243–60.

Sabin Janice A., Riskind Rachel G., and Nosek Brian A.. 2015 “Health Care Providers’ Implicit and Explicit Attitudes toward Lesbian Women and Gay Men.” American Journal of Public Health 105(9):1831–41. [PubMed: 26180976]

Schippers Mimi. 2007 “Recovering the Feminine Other: Masculinity, Femininity, and Gender Hegemony.” Theory and Society 36(1):85–102.

Scott Susan Douglas, Pringle Alastair, and Lumsdaine Colin. 2004 Sexual Exclusion—Homophobia and Health Inequalities: A Review. London: Health First.

Silverman David. 2006 Interpreting Qualitative Data: Methods for Analyzing Talk, Text and Interaction. Thousand Oaks, CA: Sage.

Spencer Karen Lutfey. 2018 “Transforming Patient Compliance Research in an Era of Biomedicalization.” Journal of Health and Social Behavior 59(2):170–84. [PubMed: 29443620]

Taylor Miles G., and Quesnel-Vallee Amelie. 2016 “The Structural Burden of Caregiving: Shared Challenges in the United States and Canada.” The Gerontologist 57(1):19–25. [PubMed: 27521577]

Thompson Andrew G. 2007 “The Meaning of Patient Involvement and Participation in Health Care Consultations.” Social Science & Medicine 64(6):1297–310. [PubMed: 17174016]

Tjepkema Michael. 2008 “Health Care Use among Gay, Lesbian and Bisexual Canadians.” Health Reports 19(1):53–64.

Trief Paula M., Sandberg Jonathan, Greenberg Roger P., Graff Keri, Castronova Nina, Yoon Miyoung, and Weinstock Ruth S.. 2003 “Describing Support: A Qualitative Study of Couples Living with Diabetes.” Families, Systems, and Health 21(1):57–67.

Umberson Debra, Thomeer Mieke Beth, Kroeger Rhiannon A., Lodge Amy Caroline, and Xu Minle. 2015 “Challenges and Opportunities for Research on Same-sex Relationships.” Journal of Marriage and Family 77(1):96–111. [PubMed: 25598552]

Umberson Debra, Thomeer Mieke Beth, Reczek Corinne, Donnelly Rachel, and Kroeger Rhiannon A.. 2017 “Do Gay, Lesbian, and Heterosexual Spouses Differ in the Ways They Care for Each Other During Physical Illness?” PRC Research Brief 2(4).

Waite Linda, and Gallagher Maggie. 2002 The Case for Marriage: Why Married People Are Happier, Healthier and Better off Financially. New York, NY: Random House.

Ward-Griffin Catherine, and Marshall Victor W.. 2003 “Reconceptualizing the Relationship between 'Public' and 'Private' Eldercare.” Journal of Aging Studies 17(2):189–208.

Wolff Jennifer L., and Roter Debra L.. 2008 “Hidden in Plain Sight: Medical Visit Companions as a Resource for Vulnerable Older Adults.” Archives of Internal Medicine 168(13):1409–15. [PubMed: 18625921]

Wolff Jennifer L., and Spillman Brenda. 2014 “Older Adults Receiving Assistance with Physician Visits and Prescribed Medications and Their Family Caregivers.” Journals of Gerontology Series B: Psychological Sciences and Social Sciences 69(Suppl 1):S65–72.

Yoder Scott D. 2002 “Individual Responsibility for Health.” Hastings Center Report 32(2):22–31.

Table 1.

Descriptive Statistics of Respondents.

N = 90	Gay (n = 30)	Lesbian (n = 30)	Heterosexual (n = 30)
Age (mean, years)	49.70	50.73	51.7
Relationship duration (mean, years)	19.4	20.13	25.53
Race (%)			
White	97	93	90
Hispanic	3	0	0
Black	0	7	7
Asian and Native American	0	0	3
Children (%)	13	40	80
Education (%)			
High school/some college	7	13	23
College degree	40	17	30
Postgraduate/professional	53	70	47
Individual income (%)			
None[a]	0	3	10
$1–$24,999	3	10	10
$25,000–$49,999	7	14	14
$50,000–$74,999	10	23	20
$75,000–$99,999	20	27	17
$100,000–$149,999	33	13	13
$150,000 and above	20	3	13
Missing	7	7	3
Insurance status (%)	100	100	100
Last visited doctor (%)			
Within past year	90	87	87
Past two years	7	10	7
Past five years	3	0	3
Don’t know	0	3	0
Missing	0	0	3

[a] *None* reflects individual income of a stay-at-home spouse or retirement.