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Caregiving and caring with pride: Health behavior work among older gay married couples

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ABSTRACT

The focus of this qualitative study was to explore the perspectives of older gay married individuals around caregiving and health behavior work with their partners. The study used data from five long-partnered male couples who were recruited from a larger quantitative study of the health behaviors of gay married men and their partners. Thematic analysis identified three salient themes derived from the interview guide: (1) the health benefits of marriage, (2) what constitutes caregiving and health care work in marriage, and (3) the impact of caring for an ill or injured spouse on the marital relationship. Policy and practice implications for working with older gay married couples and LGBT couples generally are discussed.

KEYWORDS

Caregiving; caregiving with pride; gay couples; health behaviors; health care work; marital relationships

Introduction

Activities that promote positive health behaviors, often called *health behavior work,* are an important function of social relationships; the term refers to the mutual influence of partners on each other's health-related actions (Reczek, Gebhardt-Kram, Kissling, & Umberson, 2018). Past research has found that in heterosexual couples, the female partner is most often the individual who performs health promotion and health behavior work, which may be one reason why marriage so often benefits men to a larger extent than women (Gast & Peak, 2011; Reczek et al., 2018; Umberson, Donnelly, & Pollitt, 2018). Previous research has hypothesized that female socialization has encouraged women to be caretakers and health-related decision makers (Gast & Peak, 2011; Reczek et al., 2018; Umberson et al., 2018). What is not as well-known is whether male same-sex relationships follow a similar health-promotion pattern (Cherlin, 2013). For example, if no female partner is present, does health behavior work assume the same one partner arrangement, or is *mutual care* the expectation? When asked

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this question, it appears that many partnered lesbian, gay, bisexual, or transgender (LGBT) adults both provide and receive care, in a mutual, reciprocal arrangement; in fact, the percentage of mutual caregiving in same-sex couples is higher than in the general population (Anderson & Flatt, 2018; Knauer, 2016), but this phenomenon does not appear to be well known outside of the LGBT community.

Caregiving in an intimate relationship is a component of health behavior work that embodies devotion as well as caring (Collins & Ford, 2010; Poulin et al., 2010; Umberson et al., 2018). Whereas health behavior work is often performed jointly in same-sex couples and connected to routine activities of daily living, e.g., I nag you about your diet and you encourage me to engage in physical activity (Reczek & Umberson, 2012), caregiving tasks may involve responding to more critical health needs with one person assuming the caregiver role and helping the individual who needs assistance with activities of daily living or a specific health need (e.g., medication adherence). In any case, recent research has found that caregiving in same-sex relationships is less tied to gendered role expectations and is more mutual and egalitarian (Garcia & Umberson, 2019; Reczek et al., 2018; Reczek & Umberson, 2012; Umberson et al., 2018).

Also important in the LGBT community is informal caregiving by friends and neighbors, a caring connection that is sometimes referred to as *chosen family* (Kennedy, Dalla, & Dreesman, 2018; Muraco & Fredriksen-Goldsen, 2011). In a chosen family the relationship of caregiver to care recipient is different than in either same-sex or heterosexual couples which might bring the expectation that one member of the couple will undertake the role of caregiver if that is needed (Knauer, 2016). With chosen families the expectation of who will fulfill the caregiver role is more fluid and not as gender-conforming; in fact, research has found that in the LGBT community nonrelative caregiving is the norm (Kennedy et al., 2018; Knauer, 2016). Statements such as "friends are the family we choose ourselves" represent the high levels of social and psychological support friends provide in the LGBT community (Kennedy et al., 2018, p. 17). Friends as caregivers reflect the different realities experienced by LGBT adults. Chosen families provide support and instrumental assistance because the LGBT community has a history of relying on friends and neighbors, in part for the reason that extended family members may not be as willing to help as they might for relatives in opposite-sex relationships (Anderson & Flatt, 2018; Kennedy et al., 2018; Knauer, 2016; Muraco & Fredriksen-Goldsen, 2011; Seelman, Lewinson, Engleman, & Allen, 2019; Shiu, Muraco, & Fredriksen-Goldsen, 2016).

Research is limited on the dynamic of caregiving and health care work with men who are married to men. As the LGBT population ages, it is

important to explore how couples negotiate healthy behaviors, medical compliance, and the impact of gender on health care work. Qualitative research is often used to explore emerging topics such as this. The purpose of the paper was to use in-depth qualitative interviews to study how gay men in same-sex marriages approach health behavior work and caregiving.

Literature review

Several characteristics differentiate older same-sex couples from older heterosexual couples in relation to caregiving. These are reliance on chosen family and mutual care, and an elevated sense of self-esteem, well-being, and self-efficacy connected to their mutual health behavior work (Anderson & Flatt, 2018; Kennedy et al., 2018; Knauer, 2016; Muraco & Fredriksen-Goldsen, 2011; Seelman et al., 2019; Shiu et al., 2016). In heterosexual couples, it is common for women—typically wives, adult daughters, and other female relatives—to assume the bulk of caregiving activities; this dependence on female family members is much less common in same-sex couples (Knauer, 2016; Reczek & Umberson, 2012; Shiu et al., 2016). As described in the literature cited here, LGBT older adults are more likely to depend on each other as partners, rather than relying on an adult daughter, daughter-in-law, or wife, as with opposite-sex couples (e.g., Goldsen et al., 2017; Reczek & Umberson, 2012).

The current generation of LGBT older adults came to adulthood closeted and stigmatized, fearful of public recognition of their same-sex relationships, fearful of the formal helping system, and often banned from being with partners in health care settings (Knauer, 2016). Family members may not have felt comfortable helping as they would have with a relative in a heterosexual partnership. The term *chosen family* has been used to describe same-sex relationships and friendships generally (Knauer, 2016), thus, instead of relying on relatives, same-sex couples rely on each other and others in the LGBT community for assistance. Consequently, caregiving appears to follow a different pattern in the LGBT community such as not leaning on family members and adult children as is common in heterosexual couples (Knauer, 2016). The fact that mutual caregiving is the new norm in same-sex couples may influence the societal perception of who is the expected caregiver, from adult daughters, daughter-in-laws, and wives or other female relatives, to same-sex partners.

Also hypothesized to apply specifically to unmarried same-sex couples is higher stress attributed to the stigma associated with the lack of public recognition of their couple-hood (Hash & Rogers, 2013; Kennedy et al., 2018; Kurdek, 2005). It is projected that the existence of legal marriage will reduce the minority stress previously linked with the lack of public

acknowledgment as a couple and is one reason legal marriage is expected to improve overall health in same-sex couples (Kennedy et al., 2018; Kurdek, 2005). Legal same-sex marriage brings public and official acknowledgment which may promote the provision of social support from previously resistant family members and the health care system; that legal acknowledgment, present in heterosexual married couples, is missing in unmarried same-sex relationships (Hash, 2006; Kennedy et al., 2018;; Kurdek, 2005).

Methods

A semi-structured interview guide was used to conduct in-depth interviews that addressed health behaviors in married same-sex couples (see Appendix A for interview guide). Five same-sex married male couples ($n = 10$) agreed to participate in this exploratory study. Participants were recruited from a larger quantitative survey of gay married men and their partners across the U.S. who were diverse in terms of ethnicity, religion, and socioeconomic status ($n = 228$). Qualtrics constructed the survey panel to adhere to these metrics to fit the needs of the original quantitative study.

Procedures

Upon completion of the survey, participants were asked if they would like to enroll in a second, separate study involving interviews with them and their partners. If they responded affirmatively, they received a link to a separate survey that asked for their email address—this was separate so as not to be connected to the responses from the original survey. Upon receipt of the email address, members of the research team provided a letter of consent and details of the study. Individuals who agreed to participate in the qualitative interview process received a $20 Amazon gift card. Couple interviews were conducted via Zoom. Interviews were recorded and then transcribed verbatim by trained undergraduate and graduate students. Methods for both the Qualtrics survey and the qualitative interviews were approved by the IRB at Utah State University (Protocol #8806 for the survey & #7144 for the follow-up Interview). This paper focuses only on the qualitative interview results.

Participants

Interview participants ranged in age from 43 to 69, with a median age of 57. This is a broad age range but any within-dyad age differences did not appear to influence couple health-related interactions, at least as reported in their interviews. Eight participants identified as White, one was African

American/Pacific Islander and one identified as Latino. All participants had at least a high school education, one had some college, four had a college degree, and three participants had graduate degrees. All 10 were male, partnered and then later married for a length of time that ranged from 15 to 42 years with an average coupled length of time of 28.6 years. One of the participants had four children; the rest of the sample reported no children. Their yearly incomes ranged from $50,000 to $1,00,000 with a median of $80,000. Two participants were still working and eight were retired. Four participants had what they described as serious health problems: major depression, diabetes, a liver transplant due to nonalcoholic fatty liver disease, and compromised health due to a previous stroke.

Data analysis

Interview transcripts were analyzed by the research team which performed qualitative content analysis of the data based on the research questions that focused on health behaviors in same-sex couples (see Appendix A). The research team conducted independent analyses of the data and came together after this initial independent coding to create a common code book for the project. Codes created by each team member were reviewed and discussed until agreement was reached on final codes and eventual themes. Thematic analysis identified common themes derived from the original research questions in the interview guide starting with (1) the health benefits of marriage, (2) what constitutes caregiving and health care work in marriage, and (3) the impact of caring for an ill or injured spouse on the marital relationship.

Results

These interviews focused on health behaviors, including health care work, of same-sex couples generally and on caregiving and health behavior work specifically and the interview transcripts were re-analyzed for that purpose. Our sample of male same-sex married couples fits the general characteristics of LGBT older adults as described in the literature cited above in that they depended on each other as partners, rather than relying on other family members, nor did they appear to assume that other relatives would step in to help when help was needed as might occur with opposite-sex couples. Interestingly, our sample did not mention relying on *chosen family* for assistance as has been suggested in the literature (e.g., Kennedy et al., 2018; Muraco & Fredriksen-Goldsen, 2011). Instead, they described mutual couple-centered health-related caring behavior and reciprocal encouragement of wellness activities, including attention to physical activity and diet.

When serious illness was a factor, these couples relied on their partners for recovery, compliance, and support—rarely mentioning outside assistance.

In response to the introductory interview question: ***What is your approach to health***, four couples replied that both were health conscious and one couple said that one was more health conscious than the other. This general attention to health was reflected throughout the findings in that all the respondents seemed to engage in *health behavior work*. This was true even in the couples in which one partner had an ongoing medical condition, both partners engaged in some form of general caregiving or health behavior work activities. Our sample depended on each other as partners, used the plural pronouns *we* or *us* consistently, and seemed cognizant of the health effects of aging and the potential future benefits of present-day healthful behaviors.

Theme one: the health benefits of marriage

All of the couples interviewed reported marriage had a positive impact on their health as a result of the caring and support they provided to each other.

> P9: I'm sure it does because you've got somebody to support you and help you out when, in the good times and the bad times, you know, you need someone to share the good news with. Or, even when you're sick like me, you need somebody to do everything, you know. But in return, I do everything for him even when he's healthy, so now it's his turn to try and take care of me …

> P1: … we're always watching each other to make sure we make healthy food decisions … we support each other in maintaining health and doing what we can to improve our health … are you taking care of yourself, if you're not or you've got a problem, we need to get you to the doctor.

> P5: I think his mental health is better because none of his family travels or goes anywhere. We've been all over the world twice and I think that, like, explodes your consciousness as far as you relate to other people … and he is significantly different than his other siblings … I think that's how I influenced him.

Other benefits of marriage included health accountability. Several participants mentioned that their health would no doubt be worse without their partners possibly because someone is monitoring "bad behavior" as well as encouraging positive behavior change. This may not be a unique aspect of same-sex marriages, but simply part of being coupled. Research has shown that generally marriage promotes less risk-taking behavior and overall better health habits (e.g., Gast & Peak, 2011).

> P1: … but the only thing I can think of is staying away from ice cream and cookies, cause like I said I'm a sugar maniac, um, so I think, you know like sometimes he'll say to me, oh you're eating ice cream again? That's not good for you.

P4: the support and the companionship of the other party is being part of a couple … I think, again, it's the healthier, it eliminates tendencies, I think, for doing poor behaviors …

Another positive aspect of marriage was ensuring medical compliance and medical seeking behavior. Spouses kept a watchful eye on each other for signs of illness and injury and encouraged medical encounters.

P1: … just average conversation like, how are you feeling today, well my back is still bothering me, or he'll say, I've got this problem that's been nagging me for a while, so we get after each other to make sure that we go to the doctor, and get things that are, um, seem serious, checked out, um. So, we support each other in maintaining health, and doing what we can to improve our health.

P3: Okay, I, I think that there, from my perspective, there is a, the support of each other. Um, a couple years ago I was, um, diagnosed with an elevated sugar, blood sugar count, so pre-diabetic state, my doctor who had been monitoring it for a couple years, said okay, this isn't getting any better, I want you to go see a nutritionist. He, I was still working at that point, I dragged him along to the nutritionist with me, um, say okay so this is how we need to plan meals and stuff like that, and so I had him as being on board, it couldn't, if I was single well it could have just been easy just to do some, you know, not so interesting meals, or, continue some of my old habits, and having him around there's the support.

P5: I think we both come from the same basic belief which means we're going to stay on top of preventative things, we have semi-annual doctor visits, we have semi-annual dermatologist visits … we keep up with our colonoscopies and bloodwork …

Theme two: what constitutes caregiving and health care work in marriage

There were several subthemes in the health care work mentioned in the interviews, such as a focus on food and nutrition, awareness of the potential dangers associated with family history of disease, and reminding (nagging) about medical appointments.

P6: We both had skin cancer removed, so looking at each other's backsides, I mean you can see things back there that the other person can't see. Um, and …

P5: And every time we get real excited about something we run to the dermatologist and she says, "well that's nothing" but then she says "but I'm worried about something right here."

P6: That's probably where we're the most, uh (P5, agreeing: yeah), nervous … because we both have skin issues.

P5: Hereditarily, as well.

P1: "He stays after me to make sure that I eat, that I get my meals, and to eat healthy, and stay away from the bad stuff and I get after him when he's got a nagging pain or something that's bugging him., I get after him all the time, make an appointment with Dr. __ … "

P5: "We go to each other's appointments with each other, which is helpful because I won't remember what the doctor said to me and the same is true for me and that's probably the thing that helps us the most."

P6: "we find that when we're together we both process the different parts better and we can put it together better and really know what the doctor said."

P5: "And the other one will ask questions that the other one may not think of at the time when you are sitting in the hot seat … And I can answer the question about his sleep and he can answer about mine."

Theme three: the impact of caring for an ill or injured spouse on the marital relationship

Many of the couples had past or current experience providing direct care to their partners due to health issues. All the participants noted that their spouses were instrumental in their recovery and improved quality of life. For example, one interview subject who experienced a prolonged period of depression, relied heavily on the support of his spouse.

P1: So, that's part of health too, mental health obviously is a big part of health, and um he has such a positive outlook on life, and he's so committed to us, that um, he bends over backwards, like now he's working two jobs, and he just graduated from uh, school, he was going to uh, English classes twice a week. Working two jobs, going to school twice a week, and still doing all the cooking, most of the cooking for us, so you know, he's incredible and I'm very lucky.

The day-to-day needs of caring for an ill spouse was often mentioned.

P7: Um, I've got somebody who can help me deal with the problems and the crises and uh, the making doctor's appointments. I'm not allowed to drive anymore, so, um, he drives. Um … I have some short-term memory problems because of uh, the cirrhosis from before the transplant. And, um, he reminds me to take medications and keeps track of all of that and remembers doctor's appointments and those kinds of things. So, it helps me a lot to have someone to take care of me.

P3: "so when we had to do the diet change and initially it was an issue with me and then about six weeks later, he was in a similar circumstance, but it was okay this is what I need to do, and we talked about it, how we would achieve this … and it's companionship … it's the communication … and we jointly plan meals I mean we cook at home a lot, and we share that, we modify breakfast behaviors … and that was sort of the situation of how we managed it … communication with each other."

P9: I think since I fell, I think it's not so much a bother, but an imposition. He's used to me doing everything and now I have to ask him to start doing things and you know, I feel bad that he has to do it even though I shouldn't feel that way, but …

In fact, the stress of caregiving on both patient and caregiver was noted in the interviews as well.

P9: … as long as he's healthy to work, he will be alive and I'll be good. No working, not good. He'll drive me crazy when he retires and I'm not looking forward to that.

P8: Oh, absolutely it has sometimes. It's usually when he is not feeling well, um, because that puts a lot of strain and stress on me. Um, and even as much as I try not to have it affect the way that I, you know, interact with him and relate to him, there's times that I don't do that very well so I say it definitely has. Now on the scale of things, is it more good than bad, absolutely, but there are times when, like I said, I could just strangle him and I know that doesn't affect our relationship – that that affects our relationship negatively.

P10: I think the secret to our success is that we've been together and we know each other and we're there for each other … I'm there for him till the end … just the key to our marriage … he's smart when it comes to marriages, he's smart, he knows what he's doing …

A happy marriage may provide a buffer against the negative effects of societal stigma and discrimination (Fredriksen-Goldsen, 2018; Thomas, Liu, & Umberson, 2017) as well as a bulwark against negative health events associated with aging or just life in general.

P1: of all the same-sex couples that we know, there's always at least one in the relationships that is quote naggy unquote, it's usually that way … And even in the lesbian relationships that we're familiar with … I think people are people, and I don't think that who you choose to have intimate relationships with has any bearing on those kinds of issues … I think everybody today realizes that health is very important … so I think gay or straight, those issues are the same, people are people …

Discussion

Widespread among our sample was the response that being married or partnered made participants feel good about themselves in terms of well-being and feeling supported (Fredriksen-Goldsen, 2018; Fredriksen-Goldsen, Kim, McKenzie, Krinsky, & Emlet, 2017; Fredriksen-Goldsen, Kim, Shiu, Goldsen, & Emlet, 2015; Goldsen et al., 2017; Reczek, Thomeer, Gebhardt-Kram, & Umberson, 2020; Thomas et al., 2017). This is consistent with the LGBT literature, for example, "LGBT older adults benefit from being partnered … being partnered or married was found to be protective for physical and mental health and associated with lower levels of stigma and loneliness" (Goldsen et al., 2017, p. S51). Thomas et al. (2017) concur and add, "Being married, especially happily married, is associated with better mental and physical health and the strength of the marital effect on health is comparable to that of other traditional risk factors such as smoking and obesity" (p. 2). It is also necessary to acknowledge the continuum of caregiving relationships. This sample were all coupled well before legal marriage was available, however, it appears that no matter where on the

continuum the relationship falls, caregiving benefits both caregivers and care recipients (Fredriksen-Goldsen et al., 2015; Shiu et al., 2016). In addition, caregiving has the ability to promote personal growth in the caregiver and strengthen relationships with others (Hash & Rogers, 2013; Shiu et al., 2016; Thomas et al., 2017). "LGBT caregivers provide social and emotional support to their friends and partners … and receive positive gains such as an elevated sense of self-esteem and self-efficacy" (Shiu et al., 2016, p. 4).

Our sample voiced complete dedication to each other and each other's health as well as the tasks required to ensure future health. Participants paid attention to ordinary health behaviors such as physical activity and healthy eating, and also influenced routine and non-routine medical encounters (Anderson & Flatt, 2018; Goldsen et al., 2017; Knauer, 2016). These findings are all consistent with the existing research on same-sex male couples. What was uncommon is that the sample did not refer to *chosen family* for health support—which may be because this was a study with married couples and health was not specifically asked about. However, as there were several subjects with serious and ongoing health problems, it is curious as to why other potential helpers were not referred to in the interviews. In addition, as many participants were retired or approaching retirement, it was interesting that plans for long-term care were also not discussed. Again, this was not specifically addressed in the interview guide but might be of interest to future researchers as it is a noted concern in long-term care planning for same-sex couples. Finding a nursing home or social service agency that is sensitive to the concerns of LGBT older couples can be difficult (e.g., Knochel et al., 2011; Sprik & Gentile, 2020). As baby boomers continue to age, this will become even more salient; Bell, Bern-Klug, Kramer, and Saunders (2010) found very few nursing home directors had received or were interested in cultural competency training.

Implications

Historically there has not been much recognition of the distinctive needs of LGBT older adults (Hughes, Harold, & Boyer, 2011); this lack of recognition is coupled to a long history of overt service discrimination and social stigma for this community (Hash & Rogers, 2013; Seelman et al., 2019). While our sample of long-partnered couples did not appear bothered by their earlier lack of legal recognition and did not refer to any caring activities as unfairly burdensome, it might be beneficial to reconceptualize spousal caregiving to acknowledge important differences and support the LGBT community's many strengths and resilience (Fredriksen-Goldsen et al., 2014). Fredriksen-Goldsen and colleagues have proposed the *Health Equity Promotion Model* to guide consideration "of the multiple levels and intersecting influences on the full continuum of LGBT health, especially as they

relate to equity and resilience in LGBT communities" and based on the premise that "all individuals have a right to good health, and [that] it is a collective responsibility to ensure all obtain their full health potential" (Fredriksen-Goldsen et al., 2014, p. 655). Fredriksen-Goldsen and colleagues also suggest policy changes that would address the specific needs and strengths of LGBT older adults while promoting health equity, some of which have already occurred (e.g., marriage equality) and others that still need political action (e.g., nondiscrimination policies in housing and employment), as well as formal recognition of non-kin caregivers (Fredriksen-Goldsen et al., 2014; Hash, 2006; Knauer, 2016; Seelman et al., 2019). The proposed *Federal Equality Act* targets similar policy concerns and would "prohibit discrimination on the basis of sex, gender identity, and sexual orientation … " was passed by House of Representatives on May 17, 2019 (H.R. 5 in the 116th Congress) and is languishing in the Senate awaiting further action. We concur with the suggestion that families of choice and non-kin caregivers should be included in any policy decision-making and that appropriate evidence-based research should be undertaken and utilized to direct applicable policy change (Fredriksen-Goldsen et al., 2017; Hash, 2006; Valenti & Katz, 2014).

Limitations and directions for future research

Although the study sample was derived from targeted outreach to 228 partnered male same-sex older adults, an obvious limitation is the small number of participants who agreed to the in-depth follow-up qualitative interview. Thus, it is unlikely that these results are generalizable to all partnered male older adults, and also unlikely to generalize to partnered female older adults. It would be very useful to explore the impact of gender in same-sex lesbian couples to see if female gender is as influential in same-sex lesbian couples regarding caregiving expectations as it is in heterosexual older couples. In addition, given these findings, there is an obvious need to look at health behavior work in same-sex couples generally to explore how policy actions might be helpful in encouraging/supporting such behaviors.

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Appendix A. Discussion guide for joint couple interviews

Hey there, thank you both for being here today. Where are you guys videoing in from? (brief small talk).

INTRODUCTORY QUESTION:

Let's get to know each other, please introduce yourself by telling us your **first** name (again this will not be included in the transcript), how long have you and your partner been married, and what do you each like most about being married?

Thanks so much! Now I'm going to briefly go over what the interview is about, along with some guidelines, then we will begin with the questions.

INTERVIEW PROMPT: We are going to be discussing how your relationship has impacted your health, for better or worse or at all. The interview will last approximately 60 min. Before we begin our discussion, let me make a few requests of you. First, you should know we are tape recording our session so that we can refer back to your comments when writing up our report. If anyone is uncomfortable with this please say so, and

of course you are free to leave. We will not mention your name in the report and everything is kept confidential. During our discussion do speak up and try to let one person speak at a time. Finally, say exactly what you think. Don't worry about what I think or what your partner thinks—there is no right or wrong answer that we are looking for. Negative comments are as helpful as positive ones. Just be clear and honest about what you think or feel.

Great! Let's move on to our questions …
Transition Question, Let's talk about health:

- How do you two perceive health similarly or differently? (How?)
- How do you two react to being ill similarly or differently? (How?)

Relationship and health questions—spend most time here, use suggested probes

1. In what ways does marriage help/hurt your health?
   - How do you two negotiate/interact around health and wellness?
   - How do you two make decisions about nutrition, food purchase, meal plans/times, etc.?
   - How do you two make decisions/choices about exercise or physical activity? Together, or separately?
   - How do you make decisions/choices around sleep, bed time, waking time, etc.?
   - How do you make decisions about/discuss choices around alcohol, recreational drugs, or other substances?
2. Are there any ways in which you may feel pressured or like your health/image is a hindrance or upsetting to your partner? (each partner responds)
   - How do you deal with that? How does it affect you? Does your partner know about it?
   - How do you try to change or influence your partner's health behavior (examples, such as diet/nutrition, exercise, stress management, substance use, etc.)? Why?
   - Can you give an example?
   - How did you think your partner feels about and perceives those efforts?
   - How do you feel that influences you? Your relationship?
3. What are the specific strategies you each use to support one another's health change efforts? (each partner responds)
   - Do they work?
   - How do you notice that your partner responds/reacts to those?
   - What times are those same strategies more helpful and what times are they not as helpful?
4. Are there ever times when your health takes priority over your relationship (e.g., not doing something together to manage diet/exercise, etc.)?
5. Are there ever times your relationship takes priority over your health (e.g., skipping the gym to do something else together)?
6. Last Question: What could your spouse do differently to help you improve your health?

ENDING: thank you so much for your willingness to participate and for responding to our questions. I think we really got some great things here. Our next step includes transcribing and then analyzing the data. Would you both like to be informed of the findings?
YES NO