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# **Gendered accounts of managing diabetes in same-sex relationships: A discursive analysis of partner support**

## **Abstract**

The gendered dimensions of partner support in relationships where one partner has a chronic condition has been a recurring focus within the literature on gender and health. Such literature however typically focuses exclusively on heterosexual couples while same-sex relationships are rendered invisible, leading to the discourse around partner support being heteronormative. This article examines gendered dimensions within accounts of lesbian, gay and bisexual people with diabetes using a discursive psychological approach. The analysis identifies how participants drew upon a range of interpretative repertoires including notions that women are more caring; that men can take control in an emergency; gay men are more caring; grown men can take care of themselves and; gay men are more independent. It is argued that rather than simply dismissing heteronormative repertoires of gender and health, non-heterosexuals draw upon them in ways that display ideological tensions.

**Keywords:** lesbian and gay; diabetes; gender; partner support; discourse analysis

## **Introduction**

The involvement of supportive others has been found to improve adherence to diabetes regimens (Martire et al., 2004; Ohman and Soderberg, 2004) through directly influencing self-management by providing hands-on help (e.g. administering insulin or managing medications) and other kinds of tangible support (e.g. serving as an exercise partner) as well as indirectly through emotional and appraisal support (e.g. verbal encouragement) (Gallant, 2003). A particular focus of the empirical literature has been the support of partners within heterosexual relationships where one member of a couple has diabetes.

Within this body of literature gender inequalities between the support provided by men and women within heterosexual relationships have been noted. For example, Wong et al. (2005) examined the gendered pattern of partner support in the dietary management of type 2 diabetes. They interviewed heterosexually married people with diabetes and their partners from which three trends were identified. Men with diabetes were described as being 'actively supported' by their wives, providing tangible assistance such as meal preparation and food shopping, as well as significant appraisal support in the form of verbal encouragement to eat healthily. Women, on the other hand, more often described receiving 'passive' support from their husbands, in the form of acceptance of meal changes. The men with diabetes in the study more often ate the same meals as the rest of the family while women with diabetes more often adjusted their own meals, for instance by reducing their portion size or preparing separate meals.

Although the qualitative component of the study was based on a small sample, it was supported by a larger quantitative component consisting of 561 people with diabetes which found a significant gender division of household labour; with women more often taking responsibility for meal preparation and food shopping irrespective of which partner had diabetes. Wong et al conclude that men are the primary beneficiaries of this social arrangement while women disproportionally take responsibility for the dietary management of diabetes. This gendered pattern of dietary management among couples where one has diabetes has also been found elsewhere (e.g. Gallant et al., 2007; Maclean, 1991; Miller and Brown, 2005) and is consistent with broader literature on gender and health which suggests that women more often supervise their male partner's health and exert greater social control over their health behaviours than vice versa (Umberson 1992; Norcross et al. 1996). However, Kemmer (2000) cautions against making generalisations regarding gender and dietary management, claiming there to have been a considerable shift in domestic roles in

recent decades. There is thus a tension within the scholarly literature between highlighting the gendered dimensions of dietary management and partner support while also acknowledging that the enactment of gender roles is far from universal.

Within the literature described above, heterosexuality is usually the unmarked norm. Such studies report on the differential effects of gender for how chronic illness is managed within heterosexual relationships while the management of chronic illness within same-sex relationships is ignored (Jowett and Peel, 2009; Jowett et al, 2011a). An exception has been partner support within male same-sex couples in the context of HIV medication adherence (e.g. Goldenberg et al., 2013; Wrubel et al., 2010). For example, Wrubel et al., (2010) interviewed 20 male couples in which at least one partner was HIV positive and found various dyadic support 'styles'. A minority of the couples viewed adherence to HIV medication as the sole responsibility of the individual with HIV, with partner support being neither desired nor offered. Meanwhile the majority were described as having integrated the management of their condition into their relationships in one of two ways; either one partner (consensually) took charge of their own and/or their partner's medication adherence or through offering support to their partner. Wrubel et al. (2010) argue that most research that explores heterosexual couples creates a 'confound' of gender roles (e.g. caregiving role for wives and autonomy for husbands) and that examination of partner support within same-sex relationships can examine such processes free from gender expectations. However, the gendered nature of practices within same-sex relationships are often neglected (Clarke and Peel, 2007).

Unlike in heterosexual relationships, those in same-sex relationships have no recourse to gender roles in making decisions about, for example, who should do the cooking or food shopping and we know comparatively little about what happens when these 'off-the-shelf' roles are not available (Clarke et al., 2005: 356). Nevertheless, one relatively consistent

finding in research about same-sex relationships is that such couples see themselves as having, and appear to achieve, a greater degree of equality within their relationships in relation to household labour (Dunne, 1997; Kurdek, 2007). However, gender differences may exist between male-male and female-female relationships. For example, Kurdek (2007) found that, although household labour tended to be divided equitably within same-sex relationships, when compared with gay male partners, lesbian partners reported that more household tasks were done equally often by each partner whereas gay male partners were more likely to specialize in particular tasks.

Lesbian, gay and bisexual (LGB) people are surrounded by the same gender discourses as heterosexuals in a world in which gender differences are widely believed in and reflected in popular culture (Clarke et al, 2005). If gender difference is (widely seen as) inescapably part of heterosexual relationships, then gender similarity may equally be understood as being part of same-sex relationships (Kitzinger, 2001). At the same time, lesbians and gay men might not be expected to conform to gender role expectations given the widely held notion that lesbians and gay men are gender non-conforming or 'gender inverted' (i.e. that lesbians are masculine and that gay men are feminine) (Peel, 2005). As such, lesbians and gay men are presented with conflicting sets of discourses within which they can understand and talk about themselves and their relationships. As Clarke and Peel (2007) note, there is a need to examine lesbians and gay men (to which we could add bisexuals) as gendered beings. As such, the present study aims to examine the intersection of gender and sexuality with regards to diabetes management and partner support within same-sex relationships.

The current study adopts a discursive psychological approach in order to examine how LGB people construct partner support within their talk about diabetes self-management. In contrast to much of the literature on diabetes discussed above, discursive psychologists do

not view talk about health as a transparent medium for revealing individuals' (or couples') health behaviours, but rather as socially constructed and action-oriented *accounts*. Talk is viewed as 'doing' things within an interaction, such as presenting oneself positively. Furthermore, talk about health is understood as both ideological and dilemmatic (Radley and Billig, 1996). In particular, this study adopts what has been described as a 'critical' or 'synthetic' approach to discursive psychology which combines a focus on the action-orientation of talk (what the talk is 'doing') within the immediate interaction with an interest in broader social and ideological concerns (Wetherell, 1988). Gough (2006: 2479) describes this approach as focusing "both on discursive practices (how discourse is used to perform specific functions within a text) and discursive resources (how texts are informed by wider cultural norms)".

An example of such discursive resources are interpretative repertoires. Interpretative repertoires refer to culturally familiar ways of talking about and constructing a given subject (Wetherell, 1998). The concept first appeared within the sociology of scientific knowledge (Gilbert and Mulkay, 1984) but was later developed and applied more broadly by social psychologists Wetherell and Potter (1987). As Edley (2001) notes, when people talk about things they do so using the linguistic resources provided to them by history and rely on certain shared social understandings (e.g. what men and women are like and how they differ). Thus when people talk they commonly recite culturally familiar ideas, tropes and maxims. Interpretative repertoires then have been described as "part and parcel of any community's common sense" (Edley, 2001: 198). However, there are often multiple (and contradictory) repertoires that can be used when talking about a given subject. The repertoires deployed will often depend upon what the speaker is doing within the interaction as repertoires are "drawn upon to characterize and evaluate actions and events" (Wetherell and Potter, 1987: 138) in particular ways. Thus, interpretative repertoires are used as discursive resources to do things

such as constructing oneself or others in a particular way or managing issues of accountability (e.g. apportioning blame and responsibility).

Discursive psychological principles have been widely applied to health-related topics (Seymour-Smith, 2015) including the gendered patterning of talk about health and diabetes management. For instance, in a study examining how men and women with type 2 diabetes construct dietary management, Peel et al (2005) noted that the women in their study tended to construct their diet as an individual concern, while men generally constructed their dietary management as a 'broader familial issue' (p. 788), implicitly placing responsibility on their female partners. Similarly, discursive studies have identified how men are commonly constructed within the media and by health professionals as unable to take care of themselves and requiring the supervision of their female partners (Lyons and Willott, 1999; Seymour-Smith et al, 2002). Seymour-Smith et al (2002) also observed when interviewing health professionals about male patients, that men were consistently constructed as heterosexual and that the discursive environment in relation to men's health appears to render gay men invisible. The current study seeks to extend this literature by examining how partner support is constituted in talk about diabetes management by LGB people and how gender is made relevant within such discussions.

## **Method**

The data for this study consisted of interviews with 20 LGB people with diabetes either face-to-face or online. The sample comprised of six women and fourteen men. Of the women four identified as lesbian and two as bisexual, and of the men eleven identified as gay and three as bisexual. Their ages ranged from 25 to 69 (mean age 47) years old and none of the participants were members of ethnic minority groups. Twelve had type 1 diabetes (mean duration of 25 years) and eight had type 2 (mean duration of 5 years). Although types 1 and 2

are clinically different in a number of ways, Campbell et al., (2003) who include both types in their meta-ethnography of diabetes research, suggest that qualitative health research should not necessarily be driven by medical classifications. Both are metabolic conditions that result in elevated levels of blood glucose which require dietary management, the surveillance of blood glucose levels and a medication regimen (injecting insulin and/or oral medication). There are therefore likely to be a number of similarities in how partners offer or receive support.

Participants were recruited either through an online survey they had previously participated in (Jowett and Peel, 2009) or through an advertisement published in a diabetes magazine. The only requirements for participation were that they had either type 1 or type 2 diabetes and that they identified as lesbian, gay or bisexual. Participants did not have to currently be in a relationship although all of them had been in relationships since their diabetes diagnosis and four of the participants had been in both different sex and same-sex relationships. All participants were informed that, if they were currently in a relationship, their partners were welcome to be present and participate in the interview but only one participant chose to involve their partner. The seven participants interviewed online were from the USA while the other participants resided in England and Wales. Approval by a University ethics committee was granted prior to recruitment and the participants' anonymity was assured through the use of pseudonyms.

The interview was semi-structured, loosely following an interview schedule informed by a review of the literature. Questions covered the day-to-day management of diabetes, how diabetes affected their relationships and social life, as well as their interactions with health professionals. Effort was made to tailor the interviews to individuals by following up on participants' responses in order that the interviews were at least partly driven by participants' concerns. Verbatim transcripts were dynamically produced in the process of conducting the



online interviews (see Jowett et al, 2011b for further details), meanwhile face-to-face interviews were audio recorded and transcribed verbatim using a simplified version of the Jeffersonian transcription notation (see Appendix A).

For the present analysis the data corpus was worked through and instances where gender was made relevant by the participant or taken to be relevant by the author were selected for more detailed analysis. Most of these examples came from the section of the interview about how diabetes affected their personal relationships. Particular attention was paid to the interpretative repertoires deployed by participants, the positioning of speakers within such repertoires and ideological dilemmas (contradictory or conflicting ideas) evident within their talk (Edley, 2001). Data was coded for the positioning of self and others and how the participants constructed their relationships and the support of their partners. Effort was taken to make analytic claims that are internally demonstrable within the data itself (e.g. what the participants appear to be attending to within the interaction) while also drawing on how such talk relates to the broader context of gender relations (Wetherell and Edley, 1999). As is often the case in discursive analyses, extracts are unpacked in detail here. It is not claimed that these extracts are 'illustrative' of all the participants, let alone that they can be generalised more broadly. Rather than offering generalized 'truths' about same-sex partner support, the analysis is concerned with mapping how shared cultural understandings are used within particular local contexts (Seymour-Smith and Wetherell, 2006) and what such talk reflects about the way society constructs these issues more broadly (the ideological context) (Radley and Billig, 1996).

## **Analysis**

Within accounts of partner support, the participants deployed various interpretative repertoires rehearsing common sense understandings about gender, sexuality and health. The

repertoires examined below include: i) Women as more caring than men vs it depends on the individuals; ii) Men take control vs women worry; iii) Gay men as caring; iv) Grown men can take care of themselves; and v) joint responsibility vs spousal control. In the range of repertoires examined within this analysis, participants negotiate heteronormative understandings about what men and women are like and how support operates within relationships.

The first interpretative repertoire examined here, only evident in lesbian accounts, was the notion that women are more caring than men and, as such, a lesbian with diabetes may receive more support from her partner than might a heterosexual woman. In Extract 1 Becky, who has type 2 diabetes, is talking about the support she receives from her partner Jo in response to a question concerning whether she feels being in a lesbian relationship has any bearing on the support she receives:

Extract 1: *Women as more caring than men vs it depends on the individuals*

1. **Becky:** I mean you wouldn't have had the support I give you from Matthew (Jo's
2. ex-husband) would you?
3. **Jo:** No
4. **Becky:** But Phil would give that support to Sally (a heterosexual couple they
5. know)
6. **Jo:** But you don't know that (.) men are different don't forget
7. **Becky:** I could see him doing that
8. **Jo:** Some men don't show their feelings do they (.) they're not very understanding
9. of any illness (.) that a woman has (.) are they?
10. **Becky:** I can't comment on that
11. **Jo:** When he's got a cold, he's got the flu

12. ((interviewer laughs))
13. **Becky:** Yeah but-
14. **Jo:** When a woman has a cold y'know she's just got to get up and get on with it
15. whereas a man will lie down (.) if a man's got diabetes he'll play on it
16. **Becky:** I think it depends on the partner I think it depends on the partner
17. **Jo:** I'VE JUST SAID THAT
18. **Becky:** No I don't mean a same-sex couple I mean it depends on the relationship
19. that they've got (.) who they are (.) male and female male and male or what
20. **Jo:** I don't know
21. **Becky:** It's hard innit
22. **Jo:** You can't say that because (.) erm
23. **Becky:** Every relationship I'm thinking of-
24. **Jo:** It's hard
25. **Becky:** I [think-]
26. **Jo:** [I react] I react different to everything anyway
27. **Becky:** I think it's beneficial
28. **Jo:** I don't act the way a woman would act (.) it's like Becky says I'm not this
29. kissy touchy feely y'know what I mean
30. **Becky:** You're a bloke with female genitalia
31. ((interviewer laughs))
32. **Jo:** Yeah
33. **Becky:** That's how I describe her (.) she thinks like a man she walks like a man (.)
34. you look butcher than I do
35. **Jo:** And tits (.) erm I dunno
36. **Becky:** Yeah I think-

37. **Jo:** I react different

38. **Becky:** Thinking of it now (.) looking into it deeper yeah I think you get more

39. support female to female (.) because generally women are more caring (.) so I

40. think I think you would

41. **Jo:** I think it does too

42. **Becky:** But then I'm not saying it wouldn't be in a heterosexual relationship (.) it

43. depends on those individuals

In this extract, Becky begins by providing two contrasting examples of supportive and unsupportive husbands (lines 1-5). In so doing, Becky implies that the kind of support she would receive in a heterosexual relationship, would depend on the man in question. Jo then challenges Becky's knowledge of her friends' (Phil and Sally's) relationship (line 6), which results in Becky downgrading her previous statement, to a more speculative: "I could see him doing that" (line 7). Jo's assertion that "men are different don't forget" (line 6), presents the idea of gender differences as common sense. She then offers examples that "some men don't show their feelings" and "they're not very understanding of any illness". She then invokes the cultural notion of 'manflu' whereby men are pejoratively understood to exaggerate the symptoms of the common cold to gain sympathy (line 11). This functions as anecdotal support for the claim that there are differences between men and women with regards to illness. At this point Becky attempts to interject with an opposing argument ("yeah but-", line 13) but Jo maintains the conversational floor and extrapolates her argument about men and illness to diabetes in particular ("if a man's got diabetes he'll play on it", line 15).

So there is disagreement between the couple as they espouse conflicting common sense repertoires. Becky suggests that the kind of support given within a relationship will depend on the individuals while Jo draws on a repertoire of gender differences (lines 4-15).

They initially respond to this disagreement by producing statements of uncertainty (“I don’t know” line 20, “it’s hard innit” line 21, “it’s hard” line 24). Discourse and conversation analysts have argued that statements disclaiming knowledge, such as ‘I don’t know’, should be considered in relation to the interactional work they perform (Potter, 1996). Here these statements appear to function as a strategy for conflict resolution; the statements repair the interactional trouble of having conflicting opinions by each presenting themselves as not overly committed to their position.

Following this, Jo backtracks by offering herself as an example of an exception to the gender differences she previously claimed (“I react different to everything anyway” line 26; “I don’t act the way a woman would act”, line 28). Becky aligns with this statement drawing upon a repertoire of the gender inverted ‘butch’ lesbian (“You’re a bloke with female genitalia”, line 30). In doing so, Becky does not take the opportunity to argue that this proves her point (that we are all individuals). Rather, by claiming that Jo “thinks *like a man*” and “walks *like a man*” (line 33) she constructs Jo as not a typical woman and aligns herself with Jo’s repertoire of gender difference (i.e. that men generally think and act in ways different from women).

Returning to the question posed by the interviewer, from line 38, Becky then also backtracks and alters her position in alignment with Jo’s repertoire of gender differences. Becky accounts for this shift as being down to “thinking about it” and “looking into it deeper” (line 38). It is worth noting that within couple interviews, discourse analysts have noted a tendency for couples to negotiate a unified position (Seymour-Smith and Wetherell, 2006). By altering her account Becky is able to repair the conflict and accomplish a shared assessment with Jo. By suggesting that “generally women are more caring” (line 39), Becky is also able to present lesbian relationships as being more supportive. However, the dilemmatic nature of speaking of gender difference is still evident in Becky’s turn. Her

statement is qualified by “*generally*” (line 39) and followed with a further qualification (“it depends on those individuals”, lines 42-43). Becky is engaged in a delicate balancing act here between two competing and contradictory repertoires; one based on the notion of taken for granted gender differences and another based on the notion that we are all unique individuals.

So in this extract support for a partner with diabetes is constructed as being caring and empathetic. By associating these qualities with women, Becky and Jo are able to position their lesbian relationship as naturally caring and supportive. However, there is a tension between the notion that men and women are different and the principle that one should not make generalisations based on gender. The extract also illustrates how, as lesbians, these women are able to construct themselves as possessing qualities typically associated with their gender (e.g. lesbian relationships are more supportive because women are more caring) or draw on a repertoire of gender inversion to position themselves as atypical category members.

This discursive flexibility was also evident in interviews with gay men when talking about the support they receive from their male partners as will be illustrated in the next two extracts taken from an interview with a gay male participant. Gordon has type 1 diabetes and only ‘came out’ late in life after his wife passed away. In Extract 2 he compares his late wife’s response to his episodes of low blood sugar (hypoglycaemia) to that of his subsequent boyfriends:

*Extract 2 Men take control vs women worry*

1. **Interviewer:** Has there been any specific differences between how your wife was
2. about the diabetes and your boyfriends or=
3. **Gordon:** =oh yes oh absolutely big difference (.) my wife was panicky (.)
4. desperate sometimes (.) er anxious nervous (.) er kept on and on and on to make

5. sure I was doing the right things (.) boyfriends just take it as it comes (.) if you
6. have a bad time they notice it (.) they point it out to you (.) and if you deny it they
7. insist (.) they say “sit down you’re gonna eat something” and you just do it
8. because y’know they’re not panicking and it’s much easier
9. **Interviewer:** Yeah so less panicking
10. **Gordon:** Less panicking (.) I couldn’t stand the panics she used to get into
11. **Interviewer:** But they still encourage you to eat and things like that?
12. **Gordon:** Oh yeah they still take control (.) make you sit down (.) make you eat
13. even though you’re protesting (.) and a man can do that (.) a man can do that
14. without worrying about it
15. (some talk omitted)
16. **Interviewer:** And do you put that down to them being men and your wife a
17. woman or is it that your wife was a particular-
18. **Gordon:** I put it down to men (.) no I think all women would be like that (.) most
19. women would be panicky (.) that’s my experience of women (.) women just panic
20. (.) whereas men don’t panic (.) they just take things much more rationally and
21. easily (.) I could be wrong about that because my wife was especially anxious and
22. nervous

In Extract 2 Gordon also contrasts men and women but in a different way to Becky and Jo. In lines 3-8, Gordon constructs his late wife’s response as “panicky”, “desperate”, “anxious” and “nervous” when dealing with his low blood sugar. Meanwhile, his male partners are constructed as calm and composed in their response. He constructs men as assertive and able to “take control” through reported speech of a male partner calmly issuing an order (“sit down you’re gonna eat something” line 7) and referring to them “making” him eat something

(line 12). Despite Gordon clearly offering a gendered account (e.g. “a man can do that” line 13), the interviewer explicitly asks if he believes this difference is attributable to gender or the individual traits of late wife (“is it that your wife was a particular-” lines 16-17). Gordon continues with his gendered account drawing on a repertoire of women as over emotional and men as ‘rational’ (lines 19-20), although he qualifies this by acknowledging that the dispositional explanation offered is plausible (line 21). Seymour-Smith et al (2002: 262) have similarly noted how this binary construction of “male versus female and positive (stoical) versus negative (overly worried) – work in tandem” in talk about gender and health.

However, Gordon did not consistently construct his male partners in ways consistent with hegemonic masculinity (Connell, 1987). For instance, in the following extract Gordon draws upon cultural notions of gay men being drawn to occupations traditionally considered feminine to position his male partner’s as ‘caring’:

Extract 3: *Gay men as caring*

1. **Gordon:** I had a guy called Tim who was just absolutely lovely with me (.) he
2. was the guy who moved in for a week after I came out of hospital just to look
3. after me (.) and he was in his forties (.) I thought it was just perfect (.) absolutely
4. lovely (.) but it’s not for me to question why they feel like that
5. **Interviewer:** And that kind of caringness, did that come as a shock?
6. **Gordon:** Well I always knew that gay men were very caring (.) generally they
7. went for the caring professions (.) they’re male nurses, they’re flight attendants,
8. they’re social workers, they’re housing officers (.) they’ve got loads of gay men in
9. the city council that do all these sorts of caring profession jobs so I knew there
10. was a thing about gay men in the caring professions
11. (some omitted talk)



12. **Interviewer:** Yeah so do you find that about y'know gay men in particular?
13. **Gordon:** I do I do (.) I find plenty of gay men who have got very good caring
14. professional jobs and I don't find them at all aggressive (.) there's no macho stuff
15. with them (.) there's no pretence about them (.) trying to show that they're
16. masculine

In this extract Gordon appears to present his male partners' caring behaviour as out of the ordinary in some way ("it's not for me to question why they feel like that", line 4) which leads the interviewer to ask if this came as a shock to him. Gordon then asserts prior knowledge that gay men are "caring" (line 6) and evidences this with a four-part list of "caring professions" which he suggests that gay men are drawn to. The first two professions mentioned arguably draw upon widely held notions that these are feminine occupations and that men in these roles tend to be gay (Barry, 2007; Harding, 2007). The latter two professions (social workers and housing officers) meanwhile are arguably offered as evidence of insider knowledge, from his professional involvement with the city council. Whereas heterosexual men displaying 'feminine' traits would commonly be positioned as deviant (Seymour-Smith et al., 2002), here being caring is constructed as a normative trait of gay men. He then goes further to construct gay men as not invested in "macho" forms of masculinity (lines 13-16).

So in these two extracts Gordon draws on contradictory interpretative repertoires when talking about his male partners. When constructing partner support as taking control in an emergency (Extract 2), Gordon refers to his partners as *men* and positions them as possessing characteristics traditionally associated with masculinity, such as assertiveness and rationality. However, when partner support is constructed as being caring (Extract 3), Gordon refers to his male partners as being *gay* and positions them as possessing a quality more

typically associated with femininity. In both cases, these culturally familiar repertoires are used to construct his partners and his relationships as supportive.

Within the sample, few of the participants suggested that they *needed* their partners' support to manage their diabetes and many of the men in particular presented themselves as independent and self-reliant. In the following two extracts this is done in different ways.

Extract 4 is taken from an online interview with Justin, a gay man with type 1 diabetes who was single at the time of being interviewed:

Extract 4: *Grown men can take care of themselves*

1. **Interviewer:** ok. You said in the survey that your ex-partner was really very over
2. protective. In what way, did you mean?
3. **Justin:** well I was with him when I went on the (insulin) pump. He came to all of
4. the diabetes classes with me, came to my doctors' appointments and was
5. constantly asking if I was OK. Did I check my sugar? and when I did go low, he
6. was always there hovering. I appreciated it, but I'm a grown man. I can take care
7. of myself

Here Justin constructs his ex-partner's attempts at support as undesirable. He uses a three-part list of things his ex-partner used to do to construct him as overly involved (lines 3-5). He also uses extreme case formulations that his partner was "constantly" (line 5) asking if he was alright and that he was "always" (line 6) under surveillance. This form of exaggeration is commonly used to maximize the rhetorical force of a description (Pomerantz, 1986). He provides a disclaimer that he "appreciated" his ex-partner's concern, warding off possible readings of him as ungrateful, before constructing such behaviour as undesirable and unnecessary. By referring to himself as a "grown man" who is capable of caring for himself,

the idea of a partner's (excessive) involvement in the management of diabetes is constructed as infantilising. In the process, he also manages to adopt a position consistent with hegemonic masculine ideals of autonomy and independence.

The next extract also demonstrates a male participant emphasising autonomy and independence, however this time it is done by contrasting gay relationships with heterosexual relationships. Extract 5 is taken from an interview with Michael, a gay man with type 1 diabetes who currently lives with his male partner:

*Extract 5: Gay men are more independent in relationships*

1. **Michael:** I think generally a gay relationship is not quite (.) quite the same as a lot
2. of straight relationships where there is this y'know almost a change from
3. mother to wife scenario for them because that's- they're not independent they've
4. been controlled by their mother they've left home got married and now being
5. controlled by the wife and then the kids come along and they just end up in
6. drudgery and following what they're supposed to do (.) so I can see that being a
7. lot more of an issue
8. **Interviewer:** Yeah and in what way do you think a gay relationship is different to
9. that?
10. **Michael:** Erm (.) I think you find they're more equal (.) I mean I'm sure there are
11. some that are not >don't get me wrong it's not gonna be everyone< but I just think
12. in general in gay relationships you tend to be two people- two independent people
13. that live together and do various things together

Here Michael contrasts 'straight' relationships ("they're not independent", line 3) with gay relationships ("you tend to be two people- two independent people", line 11) in terms of

men's independence. He does this by constructing a rather derisory picture of heterosexual relationships, and wives in particular, whereby heterosexual men are under women's control. To lend weight to this assertion, Michael deploys a script formulation embedding the claim that heterosexual men are controlled by their wives within a (hetero)normative series of life events – leaving the parental home, getting married and having children (lines 2-5). Such script formulations help to characterise what is being described as predictable and sequential (Edwards, 1995). For instance, stating that “the kids come along” (line 5), endows this script with a sense of inevitability. Embedding claims in such scripts are convincing precisely because they sound culturally familiar to the listener.

By describing heterosexual men as transitioning from being “controlled by their mother” (line 4) to being “controlled by their wife” (line 5), not only are women constructed as exerting social control but such control is also constructed as infantilising; wives act like mothers and husbands are treated like children. In other research, health professionals and women have also been found to commonly position men as childlike, constructing them as unable to take care of themselves, thus conflating the roles of wife and mother (Lyons and Willott, 1999; Seymour-Smith et al., 2002; Seymour-Smith and Wetherell, 2006). Michael draws on this cultural understanding of heterosexual relationships in order to position his own same-sex relationship as being more “equal” (line 10) and himself as more “independent” (line 12).

The next extract shares a number of characteristics with the previous one. However, unlike Michael, whose account was told in an observational style in which the dynamics of his own relationship were merely implied, Martin, a gay man who has type 2 diabetes and lives with his civil partner (James), constructs his same-sex relationship as equal and contrasts this with his previous relationship with his ex-wife:

Extract 6 Martin – *Joint responsibility vs spousal control*

1. **Martin:** I think we're jointly responsible for what we eat and erm (.) I suppose
2. there are times when James will say "let's have this" and I say "no hang on that's
3. not as healthy as this alternative"
4. **Interviewer:** yeah
5. **Martin:** but I think generally speaking we try to take equal responsibility (.) erm
6. when you were talking about kids as I was saying earlier I was married and I've
7. got three children and when the marriage broke down they used to come round for
8. a meal and I would cook
9. (some text omitted regarding the details of what he would cook)
10. **Interviewer:** And when you were married was it joint then?
11. **Martin:** No it was entirely my wife who used to plan the meals and I just used to
12. help her to buy the food (.) and it wasn't planned as much or with as much care (.)
13. it's probably difficult with children anyway I think you probably do tend to buy
14. more than perhaps you need (.) but yeah that was the pattern we followed
15. **Interviewer:** Yeah so perhaps slightly different had you been with her today do
16. you think?
17. **Martin:** Yeah probably (.) I think she would exercise sterner discipline than I
18. exercise on myself I think (.) she was that kind of person anyway
19. **Interviewer:** Yeah so your partner doesn't try to exert any control?
20. **Martin:** No no
21. **Interviewer:** Any encouragement or
22. **Martin:** Encouragement certainly and discouragement from buying the wrong
23. things or eating the wrong things but we both I think accept that it's entirely up to
24. each of us what we eat and what we do really

Here Martin generally constructs dietary management within his relationship with James as one of “joint” (line 1) and “equal” (line 5) responsibility. Building on Martin’s mention of having previously been married, the interviewer asks Martin if dietary responsibility was also jointly shared within his previous marriage. In contrast to the account of equality within his current relationship, Martin constructs his previous wife as having been “entirely” responsible (line 11). Martin does not explicitly attribute this to differences between heterosexual and gay relationships but his reference to family life with children (“it’s probably difficult with children anyway”, line 13) and his comment that “that was the pattern we followed” (line 14), has some semblance with a script formulation, in which they were simply following a predictable (gendered) “pattern”. In line with the construction of wives as ‘controlling’ that was evident in the previous extract, here Martin suggests his wife would exercise discipline (lines 17-18), although he offers a gender-neutral dispositional explanation for this (“she was that kind of person”, line 18).

Interestingly he does not directly compare his ex-wife with his male civil partner; but instead asserts that “she would exercise sterner discipline than *I exercise on myself*” (line 18). This lack of comparison with his current partner James is attended to in a follow-up question in which the interviewer orients to an understanding that his current partner does not exert such control. Martin confirms this but fails to elaborate, leading to a further probing question in which the interviewer re-frames support from exerting control to “any encouragement or-” (line 21). In doing so, the interviewer’s question offers a candidate answer (Pomerantz, 1988) regarding what other kind of support his partner might offer, and ends with a trail-off ‘or’ (“any encouragement or”, line 21) in an attempt to delete any preferred or expected response that might be inferred from the question (Stokoe, 2010). Martin responds with an agreement (“Encouragement certainly”, line 22), to which he adds “discouragement” from eating and

buying unhealthy food. However, this is followed by a discontinuity marker (“but”, line 23) with a subsequent assertion that he and his partner have a mutual understanding that they are ultimately responsible for their own behaviour (“it’s entirely up to each of us what we eat and what we do”, lines 23-24). So in this extract Michael constructs his partner’s support as consisting of encouragement and discouragement while allowing for personal responsibility. It is interesting to note that in both Extracts 5 and 6 not only are their (same-sex) relationships constructed as based on ‘equal’ or ‘joint’ responsibility but also mutual independence and autonomy.

## **Conclusions**

In this analysis I have unpacked some of the gendered dimensions of partner support in LGB people’s accounts of diabetes management. By examining the talk of those typically rendered invisible within heteronormative discourse surrounding health, the current study builds on work that reveals the gender dynamic of talk about diabetes management (e.g. Peel et al, 2005). Gender was made relevant in the participants’ accounts in a number of ways. The participants did not simply dismiss heteronormative repertoires as irrelevant but rather drew on these discursive resources in ways that positioned themselves and their relationships favourably. The notion of women as natural caregivers was incorporated into accounts of female same-sex relationships, notwithstanding an opposing repertoire that one should not generalise based on gender. Gay men, meanwhile, constructed partner support in a number of ways. They constructed male partners as able to take control in a health emergency by virtue of masculine traits and constructed excessive partner surveillance and control as undesirable. As such, partner support was framed in ways that were consistent with hegemonic masculinity. At the same time, the construction of gay men as feminine within hegemonic notions of masculinity (Jowett, 2010) allowed for them to position their relationships and

partners as caring.

Gay male participants also contrasted an image of the infantilised heterosexual husband controlled by their wife with their own more equal same-sex relationships. The emphasis on joint responsibility within many of these participants' accounts is consistent with research that finds an ethic of equality within same-sex relationships (Dunne, 1997; Kurdek, 2007). Furthermore, gay men have little to gain from representations of men requiring the health supervision of female partners, unlike heterosexual men who may benefit from a trade-off between the disempowering infantilisation of men and the practical benefits they receive by positioning women as responsible for their health (Lyons and Willott, 1999). However, within some of the men's accounts this notion of joint responsibility for tasks associated with diabetes management (e.g. food shopping, meal preparation) was combined with a relational ideal of mutual autonomy and personal responsibility. What implications such a relational ethic may have for those in later stages of chronic illness, where one partner in a male same-sex relationship may become more dependent on the other, is worthy of further study.

As the majority of the participants in the current study were male, research specifically examining partner support within female same-sex relationships would usefully extend this analysis, as would more interviews with the same-sex partners of those with diabetes. More couple interviews may also extend our understanding of how such couples co-construct and negotiate their accounts of partner support. In this analysis accounts have been examined as *accounts* rather than as transparent reflections of how partner support operates within these relationships. Indeed, as the analysis demonstrates, what constitutes partner support can itself be constructed in various ways. Nevertheless, further research could examine how partner support is given and received within same-sex relationships where one partner has a chronic condition. Such research would require a different epistemological



stance than the one adopted here and might wish to combine verbal accounts of what participants say in interviews with ethnographic observations of how same-sex couples manage a chronic condition in practice.

## **Appendix: Transcription conventions**

(.)	Dot in parentheses indicates an untimed pause
(Words)	Clarification by the author
((Words))	Transcribed action
[Words]	Overlapping speech is placed in square parentheses
Wor-	Marks the abrupt termination of word or sound
>Word<	Marks speech faster than surrounding speech
WORD	Capitalisation marks speech louder than surrounding speech
“Word”	Speech marks indicate reported speech
Word=word	Where one word runs into another
<u>Word</u>	Underlining indicates emphasised word or part of word

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