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**Social Ties and Physical Activity Patterns over the Life Course: Gender,
Race, and Age Variations**

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Race, and Age Variations**

by

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Dedication

For Mom and Dad and Seamus and Penelope, who've been there since the beginning.

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Social Ties and Physical Activity Patterns over the Life Course: Gender, Race, and Age Variations

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Abstract: In this dissertation I explore the lived experiences and meanings underlying population patterns linking social ties and exercise. To do so, I frame an analysis of qualitative data from 60 in-depth interviews with 15 white women, 15 black women, 15 white men, and 15 black men with life course theory and critical perspectives on gender, race, and age. In Article 1, I examine how parental influence matters for individuals' exercise trajectories (i.e., lived experiences of change or stability in exercise patterns) from childhood into adulthood, how adult life course transitions (e.g., parenthood) and turning points (e.g., injury) matter in relation to this influence for exercise trajectories, and how they matter differently at the intersection of race and gender. I develop the concepts of *disrupted advantage* and *disadvantage* to refer to my key finding that adult life experiences can disrupt processes of cumulative (dis)advantage around exercise in ways that differ at the intersection of race and gender. In Article 2, I examine the gendered processes through which intimate relationship formation and dissolution result in shifts in exercise habits and find that relationship formation shapes men's and women's exercise habits in distinctive ways. Further, these gendered processes are shaped by men's and women's relational gendered performances, which reveal the importance of a gender-as-relational perspective for understanding the links between

relationship formation and gendered changes in exercise habits. Finally, in Article 3 I examine how body image, as socially constituted, shapes individuals' motivation to exercise in ways that differ by gender, age, and race. I further examine how, through exercise intentions and practices, individuals craft meanings about the body, gender, race, and age.

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Introduction

Previous quantitative research clearly demonstrates that social ties matter for physical activity¹ levels and that social ties shape exercise patterns in ways that differ by gender and race (Beets, Cardinal, and Alderman 2010; Nomaguchi and Bianchi 2004; Umberson, Crosnoe and Reczek 2010; Wallace and Young 2010). And while this research provides some indication of the mechanisms linking social ties to exercise, little is known about the lived experiences and meanings underlying these population patterns or how experiences and meanings differ by gender and race. Thus, in this dissertation I analyze qualitative data from 60 in-depth interviews with 15 black men, 15 black women, 15 white women, and 15 white men (see Appendix A for a description of the demographic characteristics of the sample) to examine the lived experiences and meanings linking social ties and exercise patterns and whether and how these experiences and meanings differ by gender and race. Qualitative data are ideally suited to this task as they provide important insight into processes and meanings (Esterberg 2002). A life course perspective further informs this dissertation in that I also examine how lived experiences and meanings shift over time within individuals' lives.

This is an important topic because physical activity, or exercise, is one of the most important behavioral predictors of health and well-being (Shaw et al. 2010). People who

¹ I define physical activity broadly to encompass all activities that involve bodily movement or physical exertion and, therefore, can include not only purposive exercise but also physical activities that occur through daily living (e.g. housework). In general, however, I follow my respondents' lead in focusing on purposive exercise.

regularly participate in moderate physical activity have lower rates of anxiety, depression, cardiovascular disease, stroke, hypertension, type 2 diabetes, osteoporosis, obesity, and several types of cancer (Haskell et al. 2007). Unfortunately, less than half of U.S. adults meet the Centers for Disease Control and Prevention’s public health recommendation that adults engage in 30 minutes of moderate intensity physical activity at least five days a week (Haskell et al. 2007). Indeed, 20 percent of premature mortality in the United States could be prevented through regular engagement in physical activity (CDC 1998). Further, men have higher levels of exercise compared to women, whereas whites have higher levels of exercise compared to blacks (Haskell et al. 2007), although these patterns shift over the life course. Gender disparities in exercise widen over the life course while the white-black exercise gap declines with age (Shaw et al., 2010). Thus, an understanding of the processes and meanings through which social relationships shape physical activity patterns over the life course and whether and how those differ by gender and race is important not just for theory and research but from a public health standpoint as well.

DISSERTATION OUTLINE

This dissertation is composed of three independent articles. Below I outline the topics, theoretical frameworks, and key findings and contributions of these articles.

Article 1: “Family of Origin and Exercise Patterns over the Life Course: An Intersectional Analysis.”

In this article I examine whether and how family of origin influence in childhood matters for exercise habits in adulthood and how adult life course transitions to new

social roles (e.g., the transition to parenthood) and other adult life course events (e.g., illness, injury) matter in relation to early life influence for exercise trajectories (i.e., lived experiences of change or stability in exercise patterns). I further examine how the processes through which turning points in exercise trajectories (i.e., shifts from an inactive to active trajectory or from an active to inactive trajectory) occur vary at the intersection of gender and race.

To do so, I merge life course and critical perspectives on gender and race; merging these perspectives advances knowledge about social ties and exercise in new ways. While life course theory guides an analysis of how shifting social contexts shape patterns of change and stability in physical activity, critical perspectives on gender and race reveal how and why these shifting social contexts shape individuals' lived experiences of exercise in ways that differ by race and gender. Critical perspectives further reveal how the processes through which social ties shape exercise are embedded in power and inequality.

In this article I develop the concepts of *disrupted advantage* and *disrupted disadvantage* to refer to my key finding that adult life course turning points can disrupt cumulative advantage and disadvantage processes in exercise patterns. Disrupted disadvantage refers to a process of developing health behavior advantage (and thus, the disruption of cumulative disadvantage) — and in this case, refers specifically to when an individual adopts a physically active trajectory in adulthood, despite health-detering early life parental influence around exercise (i.e., parents did not exercise regularly, did not provide support for exercise, and/or had negative attitudes toward exercise [e.g., did

not believe exercise was important for health, viewed exercise as unenjoyable]).

Disrupted advantage refers to a process of developing health behavior disadvantage (and thus, the disruption of cumulative advantage) — and in this case, refers specifically to when an individual adopts an inactive trajectory in adulthood, despite health-enhancing early life parental influence around exercise (i.e., parents exercised regularly, provided support for exercise, and/or had positive attitudes toward exercise [e.g., believed exercise was important for health, viewed exercise as enjoyable]). Findings further suggest that the processes through which disrupted (dis)advantage occur vary at the intersection of gender and race. For example, disrupted advantage occurs in response to motherhood for black women and injuries and substance abuse for men. Applying critical perspectives on gender and race, I develop arguments and evidence to explain why these processes vary by gender and race. The concepts of disrupted advantage and disadvantage make a substantial contribution to life course theory by illustrating how processes of cumulative advantage and disadvantage can be disrupted and can be used to inform health policy and future theoretical and empirical work.

Another key finding from this article is that one process through which disrupted disadvantage occurs is what I term *aversion*, which refers to a life course process by which adults adopt active exercise trajectories in response to witnessing their parents experience health and weight problems which they attribute to inactivity. This process also differed by gender and race in that black respondents were more than twice as likely as white respondents to cite their parents' health concerns while women were more than twice as likely as men to cite their parents' weight concerns.

The concept of aversion makes an important contribution to research and theory on health behaviors, by revealing a new process by which social ties shape health behaviors. Future research should investigate whether and how aversion operates within other social relationships (beyond parent/child relationships) and with other health behaviors. Further, future quantitative data collections should develop survey measures to examine the prevalence of aversion among nationally representative populations.

Article 2: “Intimate Relationship Transitions and Change in Exercise Patterns: An Examination of Gendered Processes.”

In this article, I examine how intimate relationship transitions (i.e., transitions into and out of intimate relationships) lead to changes in exercise habits. From a life course perspective, life course transitions, such as marriage and divorce, matter for health and health behavior change. Further, previous research suggests that relationship formation and dissolution matter for exercise habits (Eng et al. 2005). However, little is known about the qualitative processes linking relationship transitions to changes in exercise habits. Quantitative research further shows that relationship transitions may shape men and women’s health and health behaviors in different ways (Williams and Umberson 2004). Thus, in this article I examine if the processes linking relationship transitions and changes in exercise habits are gendered². To do so, I employ a gender-as-relational perspective, which emphasizes that gender performances (i.e., how individuals “do”

² Although analyses based on race were conducted, the small sample sizes did not allow me to ascertain distinctive patterns.

gender in relation to cultural ideals of femininity and masculinity) are dynamic and vary by context (Springer, Hankivsky, and Bates 2012).

Supporting prior quantitative research, my qualitative findings suggest that relationship formation leads to an increase in exercise levels through three processes: direct social control (i.e., direct attempts to shape another individual's exercise habits), social support (i.e., the provision of emotional and instrumental support for another person's exercise) and diffusion (i.e., a process whereby one partner's health habits directly contribute to their partner's health habits). These findings go further in that they reveal that these processes are gendered and primarily reported by women (who entered into relationships with men). Relationship formation led to declines in exercise levels via four processes: loss of social support from peers for exercise (for men), diffusion (for women), stress (for women), and indirect social control (i.e., the internalization of norms related to a social role – in this case that partners should spend time together engaged in sedentary behavior) (for men and women).

Relationship dissolution led to an increase in exercise habits through three processes: appearance related concerns, as a means of coping with distress, and a greater focus on the self and an increase in personal control (i.e., beliefs related to the extent to which an individual can control their health outcomes). Relationship dissolution led to declines in exercise levels through three processes: distress, loss of direct social control and social support, and loss of resources that facilitate exercise. No gendered patterns were found for relationship dissolution processes.

To understand why the processes linking relationship formation and change in exercise habits differ for men and women, I apply a gender-as-relational perspective to examine how performances of masculinity and femininity within intimate relationships operate in tandem with one another. For example, research suggests that in heterosexual intimate relationships male partners position themselves as experts around exercise in order to demonstrate their masculinity (Reczek and Umberson 2012). Thus, some women who enter into unions with men may adopt active habits because they are influenced by their partner's masculinity performances around exercise. Women may also be more open to processes of social control, social support, and diffusion around exercise because of a desire to please their partner, given that norms of femininity emphasize accommodation to the desires of others (Connell 1987). Thus, women's performances of femininity (accommodation to partner) operate alongside men's performances of masculinity (as exercise experts in heterosexual relationships) to explain the processes through which intimate relationship formation leads to an increase in women's exercise levels.

A third contribution of this dissertation then is the theoretical insight that performances of masculinity and femininity within heterosexual unions operate in tandem to shape men and women's exercise habits in unique ways. This advances understanding of how intimate relationship formation matters in ways that are shaped both by an individual's and their partner's gender performances. Thus, future research should not only examine how an individual's gender performances matter for health behavior change upon entering a union, but how they do so in relation to the gender performances of their partner.

Article 3: “Exercise as a Body Project at the Intersection of Gender, Age, and Race.”

In this article I examine how gender, age³, and race intersect to shape how individuals are motivated to exercise by body image concerns (as socially constituted) — that is how exercise is part of a body project (i.e., something that *must* be constantly worked on as well as something through which individuals craft a sense of identity and social and moral worth (Giddens 1991; Gill, Henwood and McLean 2005; Orbach 2009; Shilling 2012). I further examine how, in discussing bodily appearance concerns and exercise motivations, individuals construct meanings around gender, race, age, and the body. While this topic falls outside of the traditional scope of research on social ties and health, as I detail within this article, this research is innovative because research on health behaviors, such as exercise, often ignore the body and embodiment (i.e., how individuals think, feel, and talk about their bodies [Lodge and Umberson 2013]), despite the fact that health behaviors, such as exercise, are done in service of *the body*. Further, this research is important for understanding how social meanings and inequalities around the body shape exercise motivations.

Findings suggest that gender, race, and age shape how individuals talk about body projects around exercise. For example, while both men and women described exercising for the purpose of body transformation, only men described transforming their bodies into larger, more muscular bodies (and this was particularly true for black men). Further,

³ In this article, young and midlife adults are compared to examine how the aging of the body shapes body projects around exercise. Later life adults (20 cases) are excluded from this analysis because too few later life adults discussed body image concerns as a motivation for exercise.

only women described exercising for the purpose of body maintenance — that is, to maintain thin and youthful-appearing bodies. The aging of the body further shapes body projects — some midlife women discuss the difficulty that aging poses to weight loss and in doing so construct the aging female body as unruly and not amenable to exercise as a body project. In contrast, some midlife black respondents note that aging imposes limits on how thin they would like to be via exercise and construct alternative body projects rooted in an acceptance of larger, older bodies. These findings provide a new way of thinking about how the body and embodiment matter in relation to health behaviors. Thus, a fourth contribution of this research is a greater understanding of how individuals exercise as part of body projects in ways that vary across gender, race, and age. Body projects are socially constituted and reveal important insights into meaning making around the body, gender, race, and age. Future research on health behaviors should continue to examine the importance of the body.

Article 1: Family of Origin and Physical Activity over the Life Course: An Intersectional Analysis

ABSTRACT

Parental influence matters for minor children’s exercise levels, yet research has not examined how this influence in childhood matters in adulthood, how adult life course events matter in relation to this influence for exercise trajectories, or how these processes may differ by gender and race. To answer these questions, the present research innovates by merging life course and intersectionality perspectives to frame a qualitative analysis of 60 in-depth interviews with black and white men and women. Results suggest that for individuals who experienced health-enhancing early life parental influence around exercise (i.e., parents exercised regularly, provided support for exercise, and/or had positive attitudes toward exercise [e.g., believed exercise was important for health, viewed exercise as enjoyable]), a large minority experienced adult life course turning points (e.g., transition to parenthood, injury) that led to declines in exercise levels — a process I term *disrupted advantage*. For respondents who experienced health-detering early life parental influence around exercise (i.e., parents did not exercise regularly, did not provide support for exercise, and/or had negative attitudes toward exercise [e.g., did not believe exercise was important for health, viewed exercise as unenjoyable]), the vast majority described adopting an active lifestyle in early adulthood or midlife in response to personal or parental health or weight concerns or peer or intimate partner influence. In doing so they develop health behavior advantage – a life course process I term *disrupted*

disadvantage. These processes vary at the intersection of gender and race. By integrating life course and intersectionality perspectives, these findings add to a greater understanding of how life course events in adulthood can disrupt cumulative (dis)advantage processes differently at the intersection of gender and race.

Physical activity, or exercise, is one of the most important behavioral predictors of health and well-being (Shaw et al. 2010). Individuals who engage in moderate levels of exercise have lower levels of mortality risk, morbidity, and depression (Haskell et al. 2007). Research using a life course perspective demonstrates that both early life experiences and social ties are fundamental for individuals' long-term trajectories (i.e., stable patterns) of health and health behaviors, such as exercise (Goosby 2013; Umberson et al. 2010; Umberson et al. 2011). In particular, parents are critical in shaping their children's exercise levels and do so through three central processes: modeling of active or sedentary behavior (i.e., parents who are regularly physically active are more likely to have children who are also regularly physically active), social support or lack thereof for exercise (i.e., emotional and instrumental support for physical activity — including encouragement, paying for sporting fees, providing transportation for physical activity, etc.), and meanings and attitudes toward exercise (e.g., whether parents find exercise enjoyable or important for health or not) (Beets et al. 2010). Research on this topic, however, has focused on minor children and it remains unclear how parental influence in childhood may matter for exercise trajectories over the life course or how adult life course events (e.g., transition to parenthood) matter in relation to early life parental influence.

There are racial/ethnic and gender disparities in levels of exercise (whites report higher levels than other racial/ethnic groups and men report higher levels than women) (Haskell et al. 2007) that emerge in adolescence (Van Der Horst et al. 2007) and, in the case of gender, widen over the life course (Shaw et al. 2010). There are also differences

in how parents shape their children's exercise levels that may privilege boys and white children (Grieser et al. 2008; Raudsepp 2006). Further, adult life course events may alter exercise patterns in different ways by race and gender. For example, the transition to parenthood is more detrimental for women's exercise levels than it is for men's (Bellows-Riecken and Rhodes 2008) and this may be particularly true for women of color (Huang, Frisby, and Thibault 2012). Similarly, the transition to adulthood shapes men's and women's exercise habits in different ways (Wright and Lavery 2010). It remains unknown, however, if there are racial and gender differences in how parental influence in childhood matters for exercise habits in adulthood or if adult life course events matter in relation to parental influence in ways that vary by race and gender.

To understand how parental influence in childhood matters in adulthood and how adult life course events matter in relation to parental influence in ways that differ by race and gender, this study merges life course and intersectionality perspectives to frame an analysis of: 1) whether and how family of origin influence in childhood matters for exercise habits in adulthood and 2) whether and how adult life course events matter in relation to that influence in ways that vary by gender and race. To accomplish this, I analyze 60 in-depth interviews with 15 black women, 15 black men, 15 white women, and 15 white men. Past research on this topic has not integrated life course and intersectionality perspectives, but doing so can reveal how life course processes that shape exercise in relation to family of origin may differ at the intersection of gender and race. Further, qualitative data are particularly useful in revealing processes and meanings (Esterberg 2002) and thus are well suited to revealing the processes through which life

course events and family relationships shape lived experiences of exercise trajectories at the intersection of race and gender.

THEORETICAL BACKGROUND

Life Course Theory

A life course perspective is useful for guiding an analysis of how social contexts shape patterns of change and stability in exercise levels (MacMillan and Copher 2005). Life course theory examines the linkages between dynamic social contexts and individual and group patterns of growth and adaptation (Elder and Shanahan 2006). The life course concept of *linked lives* highlights that individuals' lives are embedded in social relationships (Elder and Shanahan 2006) and points to the importance of social relationships in shaping exercise patterns. Moreover, the life course emphasis on the *long arm of childhood* (Hayward and Gorman 2004), whereby early life experiences and relationships are consequential for adult health outcomes and behaviors (Ferraro and Shippee 2009; Goosby 2013), suggests that family of origin would be consequential for exercise habits in adulthood.

Trajectories

Trajectories refer to stable patterns of behavior (e.g., smoking) (Elder and Shanahan 2006) or “the temporal continuity of roles or experience that vary in duration” (MacMillian and Copher 2005:859). Inspired by quantitative research that examines how trajectories in family statuses shape trajectories of health and health behaviors (Umberson et al. 2011; Umberson, Liu and Powers 2009), I utilize a qualitative view of trajectories whereby I focus on “trajectories of experience” (Diamond 2005). Specifically, I focus on

respondents' lived experiences of change and/or continuity in exercise habits over the life course as well as the processes underlying individuals' narratives of the linkages between family of origin and personal trajectories of physical activity. Focusing on individuals' life course narratives and their lived experiences of trajectories can inform future quantitative research to examine if these processes help to explain physical activity levels at the population level. In doing so, I aim to bridge the gap between sociological work on structure and meaning, by using qualitative work to reveal the processes and meanings underlying structural disparities in health behaviors (Pearlin 1992).

Transitions and Turning Points

Over the life course individuals experience *transitions* — “life events that index changes in state or role” (MacMillian and Copher 2005:859) — (e.g., marriage, illness). These transitions may alter exercise trajectories. For example, the transition to parenthood (Bellows-Riecken and Rhodes 2008) and the transition to adulthood (Wright and Lavery 2010) are associated with declines in exercise levels. *Turning points* refer to “a substantial change in the course of a behavioral trajectory, often during transitions” (Elder and Shanahan 2006:684). Thus, although family of origin likely matters for exercise habits, life course transitions may lead to turning points that alter those trajectories. For example, for individuals who experience health-enhancing early life parental influence around exercise (i.e., parents exercised regularly, provided support for exercise, and/or had positive attitudes toward exercise [e.g., believed exercise was important for health, viewed exercise as enjoyable]), what life course transitions might result in a decline in exercise levels? Similarly, what transitions might lead to an increase

in exercise levels for individuals who experienced health-detering early life parental influence around exercise (i.e., parents did not exercise regularly, did not provide support for exercise, and/or had negative attitudes toward exercise [e.g., did not believe exercise was important for health, viewed exercise as unenjoyable])? Identifying these turning points is critical not only for policy and intervention efforts around exercise, but also for developing a greater understanding of change and continuity in health disparities over the life course.

Timing

The concept of *timing* whereby, “consequences of life course transitions, events, and behavior patterns vary according to their timing in a person’s life” (Elder and Shanahan 2006:694) suggests that the timing of adult life course events matter for exercise trajectories. For example, illness in early adulthood may be “off-time” in a way that illness in mid- to later life is not and this may spur individuals to adopt an active exercise trajectory due to disability and mortality concerns. Timing may also be important because age structures physical activity levels. Longitudinal research suggests that individuals become less active with age (Shaw et al. 2010). While 18 percent of 18-24 year-olds engage in no leisure-time exercise, this increases to 33 percent among individuals ages 65 and older (CDC 2008). As a result, turning points that result in an increase in exercise levels may be less common in midlife, compared to young adulthood. Thus, the present analysis considers the timing of turning points in the life course.

Cumulative (Dis)advantage

From a life course perspective, structural advantage or disadvantage is transmitted intergenerationally (Ferraro and Shippee 2009) and accumulates over the life course, to produce patterns of *cumulative advantage or disadvantage* — whereby “a successive addition of circumstances lead [...] to diverging patterns or increasing inequality over time” (Hatch 2005:131). Family of origin is a primary conduit through which life course disparities in health and well-being are produced (Ferraro and Shippee 2009; Goosby 2013) and early life parental influence could set individuals on trajectories of advantage or disadvantage or — active or inactive trajectories.

Family of origin influence occurs within a macro-level social order stratified by race and gender. Studies applying behavioral perspectives to this topic, although providing a framework for understanding the processes through which parents’ shape their children’s exercise habits, have failed to take into account that parental influence occurs within a larger stratified context. For example, black children are more likely to have inactive parents than white children (Shaw et al. 2010), due to a variety of structural factors, and this may lead to cumulative disadvantage processes. Further, adolescents are more likely to adopt the exercise habits of their same-gender parent (Wickrama et al. 1999) and because women have lower levels of exercise than men (Shaw et al. 2010), this may result in cumulative disadvantage for girls and for boys who do not live with their fathers, which is much more common for black compared to white boys (The Federal Interagency Forum on Child and Family Statistics 2013). Thus, *early life chances* (Cockerham 2005) (e.g., health-enhancing or health-detering early life parental influence

around exercise) are shaped by macro-level systems of race and gender. However, adult life course transitions may disrupt cumulative (dis)advantage processes and therefore the present analysis will consider whether and how adult life course events disrupt cumulative (dis)advantage processes and if turning points in exercise trajectories are inflected by gender and race as intersecting structural and cultural determinants.

Intersectionality Theory

Intersectionality theory combines insights from gender theory and critical race theory to emphasize the importance of intersecting structural inequalities and cultural meanings associated with those inequalities (Choo and Ferree 2010; Crenshaw 1991; Shields 2008). This perspective is key for understanding how 1) family of origin influence occurs within a context simultaneously stratified by gender and race and 2) how this influence matters in relation to adult life course events that are experienced differently at the intersection of gender and race and thus may differentially shape exercise trajectories.

One of the central tenets of gender theory is that gender is performed (West and Zimmerman 1987) in response to culturally constructed gender ideals, termed *hegemonic masculinity* and *emphasized femininity* (Connell 1987; 1995). From an intersectionality perspective, however, gender and race are co-constitutive and relational (Shields 2008), such that these ideals have been constructed in relation to whiteness, while black masculinity and femininity have been constructed in opposition to these ideals in the West (Collins 2000). Thus, how individuals “do” gender differ based on race and gender positionalities both because cultural ideas about gender have been constructed in relation

to racial hierarchies and because race as a structural system shapes the resources and opportunity structures with which people are able to do gender.

In the contemporary West, hegemonic masculine ideals include traits such as bodily strength, toughness, and control (Wood 2000) and this may have implications for men's exercise trajectories. For example, sports and several other forms of physical activity are culturally defined as masculine and through sports men enact their own masculinity as well as uphold cultural ideas about men's bodies as tough and invulnerable (Messner 2002). Thus, for individuals who experience health-enhancing early life chances around exercise, men may be more likely than women to continue on active trajectories over the life course. Further, for individuals who experience health-detering early life family of origin influence around exercise, men may be more likely than women to adopt active trajectories, particularly given evidence that parental influence may matter more for girls' activity levels than boys' levels (Gottlieb and Baker 1986).

Critical race theorists argue that black masculinity is constructed as hyper-masculine, hyper-athletic and in relation to the body, while white masculinity is defined in relation to the mind and as normatively masculine and athletic (Carrington 2010; Joseph 2012). Sports have also played a key role in racial struggles for equality and through sport black athletes may challenge racist beliefs about black inferiority (Carrington 2010; Joseph 2012). For these reasons enacting masculinity through the bodily practice of sport may be more salient for black men than white men, such that for men who experience health-detering early life family of origin influence around

exercise, black men may be more likely than white men to adopt active habits. Similarly, for men who experience health-enhancing parental influence, black men may be more likely than white men to continue on active trajectories into adulthood. Performances of masculinity, however, are constrained by structural inequalities (Connell 1995). Thus, for example, stress from racial discrimination or living in racially segregated, disadvantaged neighborhoods may accumulate to limit black men's exercise.

Theoretical work also suggests that in performing masculinity men may engage in behaviors that are harmful for their health, including drug use, heavy drinking, and engaging in high-contact sports and other high-risk activities (Courtenay 2000). These performances of masculinity, premised on displays of bodily toughness, could result in injuries or substance abuse problems that limit exercise, and thus are a gendered process through which men may experience a decline in exercise levels — that is a turning point in an otherwise active trajectory. Given cultural constructions of black masculinity and that on average white men have more institutional power than black men, displays of *bodily* toughness may be a more salient way of doing masculinity for black men (Joseph 2012; Majors and Billson 1992). As a result, black men may be more likely than white men to experience injuries from high-contact sports, which may result in declines in exercise trajectories.

Emphasized femininity rests on accommodation to the desires and interests of others (Connell 1987). For example, successful performances of femininity rest on self-sacrifice and care for others (Collins 2000) and as a result women are more likely than men to emphasize responsibility for others, particularly children (Gilligan 1982; Martin

and Lippert 2012). These performances of femininity, however, may result in sacrificing leisure-time exercise and as a result, for individuals who experience health-enhancing parental influence the transition to parenthood may be more likely to interrupt women's active trajectories. Further, gendered performances occur within a context where the gendered division of labor impedes women's leisure (Sayer 2005).

Racist ideologies position black women as "bad" mothers and to combat these ideologies black mothers emphasize sacrifice for their children (Elliott, Powell, and Brenton 2013). As a result of these performances of femininity, however, the transition to parenthood may be particularly detrimental for black mothers' exercise trajectories. Black women may also be disadvantaged by structural factors (e.g., higher likelihood of living in neighborhoods not conducive to exercise) that make continuing active exercise trajectories more difficult, particularly in combination with motherhood. For example, research suggests mothering in a social context of disadvantage is associated with greater weight gain compared to fathering in a disadvantaged context or parenting in more advantageous contexts (Martin and Lippert 2012).

Another theoretical possibility is women who have active social ties may exercise to please them because accommodation to the interests of others is a cornerstone of emphasized femininity (Connell 1987). Thus, for individuals who received health-detering early life parental influence in childhood, women may be more likely than men to adopt the active habits of their peers or intimate partners. Further, black women may adopt the active habits of their peers or intimate partners to counteract racist stereotypes about black women as not appropriately feminine, although they may also resist adopting

active habits, given that many forms of sport and exercise are defined as masculine (Huang et al. 2012).

DATA AND METHODS

Grounded theory methods were used to analyze in-depth interviews. Grounded theory analyses go beyond description to develop theoretical insights from respondents' lived experiences (Charmaz 2006). Inductive reasoning guided the analysis — concepts, categories and codes emerged from the data, rather than from predetermined hypotheses. The data for this paper come from an in-depth interview study (N=60) with 15 black women, 15 black men, 15 white women, and 15 white men. The purpose of this study was to assess how social ties shape health behaviors (i.e., nutrition, body weight, exercise, smoking, alcohol consumption, sleeping habits) over the life course. Respondents were recruited through posted flyers, distribution of flyers to local organizations (e.g., churches, African American Chamber of Commerce), and snowball sampling methods. Interviews took place in a large city in the Southwestern United States in 2008 and 2009 and lasted on average 1.5 hours. Interviews were recorded, transcribed, and all respondents were assigned pseudonyms.

Throughout the data collection and analysis personal, inter-personal, and contextual reflexivity were considered (Collins 1986; Holstein and Gubrium 2002). Interviews were conducted by a team of white women and the gender and racial positionalities of the interviewers likely intersected with the gender and racial positionalities of the respondents to shape results. Social science research has historically been used against communities of color (van Dijk 1993) and this may have shaped what

black respondents did and did not say to white interviewers, particularly given that public health discourses on obesity may stigmatize people of color (Azzarito 2009). However, black respondents may not assume shared understandings with white interviewers, and may be more explicit in revealing insights into racial stratification processes. In terms of gender, some research suggests that both men and women are more comfortable and forthcoming with female interviewers (Arendell 1997), although other research suggests that men are more revealing to male interviewers (Williams and Heikes 1993). Post-interviews, interviewers wrote memos to document their reflexive thoughts.

This paper focuses on questions related to how parents, or family of origin, shaped respondents' exercise patterns. Respondents focused largely on leisure-time exercise. The terms "family of origin" and "parents" are used interchangeably because respondents were asked how their family "growing up" shaped their physical activity patterns. While most respondents referenced their parents, some respondents included aunts, uncles, and grandparents in their narratives. Respondents were asked about their parents' exercise levels in childhood and how their parents influenced their exercise levels in childhood and adulthood. Respondents were also asked about how their personal exercise patterns have changed over time and how other social ties (e.g., children, intimate partners) have shaped those patterns. Data are respondents' subjective lived experiences of exercise patterns and are not based on objectively defined criteria; therefore what constitutes an "active" or "inactive" trajectory is based on respondents' subjective interpretations. Respondents ranged in age from 25 to 89, with a mean sample age of 52. The median household income was \$46,875, which is similar to the median

household income in the city where the data was collected. Overall, the sample was highly educated – 2/3rds had a college degree or higher level of education.

Analysis

After multiple readings of the transcripts, I conducted line-by-line open coding. In this step I divided the sample into respondents who described health-enhancing and health-detering early life parental influence around exercise and identified the processes through which this influence mattered for respondents' exercise habits. Within these two categories, I developed concepts to describe different life course trajectories of exercise and identified turning points (sensitive to the life course concept of timing) that altered respondents' exercise trajectories as shaped by their family of origin. I then engaged in axial coding, where I examined how these processes differed by gender and race. For example, among respondents who described health-enhancing parental influence around exercise, but experienced life course turning points that led to declines in exercise levels, black women were more likely than other groups to cite the transition to parenthood. Finally, I engaged in selective coding, where I identified a key category to form an explanatory whole. In this step, I developed the concepts of *disrupted advantage* and *disadvantage* to refer to the key finding that life course turning points can disrupt cumulative advantage and disadvantage processes in terms of exercise trajectories.

RESULTS

Results are organized in terms of whether respondents reported experiencing health-enhancing or health-detering family of origin influence around exercise. Among respondents who described experiencing health-enhancing early life influence (i.e.,

parents modeled an active lifestyle, provided social support for activity, and/or held positive meanings toward exercise [e.g., viewed exercise as enjoyable or important for health]), over half reported that they were active over the life course. However, over 40 percent of these respondents reported experiencing turning points that led to declines in their exercise levels. The life course processes through which respondents became inactive differed by gender and race. I develop the concept of *disrupted advantage* to refer to this life course process of developing health behavior disadvantage in ways that differ at the intersection of gender and race.

For respondents who reported experiencing health-detering early life influence (i.e., had inactive parents, parents did not provide social support for exercise, and/or whose parents held negative attitudes toward exercise [e.g., did not view exercise as enjoyable or important for health]), 16 percent reported this led to an inactive trajectory. More commonly, respondents reported adopting active habits in early or mid-adulthood. In early adulthood, respondents reported that they developed active trajectories in response to personal health and weight concerns, peer and intimate partner influence, enjoyment of exercise, and through a process I term *aversion*, whereby respondents witnessed parents' health and weight issues associated with inactivity and respondents then became active to avoid personally experiencing health or weight issues. Respondents also reported diverging from their parents' exercise habits and attitudes in midlife, although this occurred exclusively in response to personal or parental health concerns. The processes through which respondents reported diverging from a sedentary lifestyle differed by gender and race and therefore I develop the term, *disrupted disadvantage* to

refer to a life course process of developing health behavior advantage in ways that differ at the intersection of gender and race.

Health-Enhancing Early Life Influence

The Consistent Exerciser

Twenty-five percent of the sample (n=15) described themselves as active over the life course. These respondents reported that they maintained active trajectories because their family of origin was active, they received social support from their family of origin, and/or their family of origin had positive attitudes toward exercise. Six white women, four black men, three white men, and two black women reported this pattern. Kimberly (51, white), for example, who reported that she has been consistently active over the life course, said that her family of origin was active, provided support for her to be active, and as a child exercise was an enjoyable form of family leisure:

We...loved to exercise. Everybody was skiing and riding horses and playing in the countryside...we spent all of our time on the beach, on the water, and we sailed and swam...I had one stepfather who...was very athletic. And we had horses, we always rode. He taught me how to ski...and my grandmother was a big gardener...we gardened together. That was huge...your family is really important to forming your basic health habits.

Naomi (26, white), also described being consistently active and said that as child her father was active and that she received social support from her father to be active:

In high school [I did] tennis...cheerleading and club volleyball on the side. I loved it all... Tennis I was pretty good at because I played with my dad growing

up, he taught me. Growing up, ages 9-14 or so, I'd gone to some tennis clinics over winter break...So when I made the team I was like, "Cool. Sounds good." This support from her family to be active has extended into adulthood: "I'll still go exercise at their gym...I always have a personal training session, they get one for me when I go there just for fun."

The Lapsed Exerciser

Eighteen percent of the sample (n=11) reported that despite health-enhancing parental influence in childhood, adult life course events led to turning points that resulted in declines in their exercise levels — a process I term disrupted advantage. Although all groups described this pattern in roughly equal numbers, the processes through which this occurred differed by gender and race. White women were more likely to cite marriage and black women were particularly likely to cite the transition to parenthood as an explanation for "lapsing" into a sedentary lifestyle, while men (black and white) were more likely than women to cite substance abuse and black men were more likely than other groups to cite injuries. For example, Rhonda's (52, black) mother was a health teacher and Rhonda reported that they exercised together when Rhonda was a child: "Because my mother taught it [health] we always exercised. My mother and I used to go walking all the time." Rhonda said that she continued to be active, regularly exercising at a gym, until her mid-30s when she had her son: "When I had him I stopped going [to the gym]... Having a child just really changed everything for me...I was too tired."

Katherine (28, black) said that she received social support for exercise from her

father as a child (i.e., he enrolled her in sports) but that the transition to parenthood led to a decline in her exercise levels: “When I had her I didn’t pay attention to myself because it was all about her. I stopped exercising...and that’s how it’s been since.”

Billy (52, black) said that he grew up in an active family and was an active teenager and young adult, but a period of drug abuse, followed by an injury led to an inactive trajectory:

We used to play a lot of sports...it wasn’t until I picked up the drugs...it took away that desire to...get out and do things like that...I can’t play sports anymore. The doctor told me that...I was playing basketball in a tournament and...a six-foot something brother and I were going for the lay-up and we collided in mid-air. I fell first and he fell on my leg and broke my leg. I landed on his arm and broke his arm...that’s when I got the first injury.

Phil (64, black) said that he was an avid basketball player as a young adult and almost played basketball professionally, but that over the past fifteen years he has had three hip operations from basketball injuries that have led to a decline in his exercise habits:

Three operations, hip operations within the last 14 years...It has altered the way I walk. I will eventually have a limp and may even be in a wheelchair or on crutches... I would say those operations were probably the biggest deterrent in my life because they altered me altogether.

The Rebounder

A small proportion of lapsed exercisers (n=3), “rebounded” back onto active

trajectories. Subsequent life course events — namely, divorce, sobriety, and health concerns — led to a return to an active trajectory. For example, the transition to marriage resulted in a sedentary lifestyle for Audrey (41, white), but she noted that getting divorced facilitated a return to an active lifestyle: “I’m trying to lose my marriage weight...I started going to yoga several times a week, walking my dogs every day.”

After an active childhood and adolescence, Thomas (35, white) battled drug and alcohol addictions which led to inactivity: “It definitely declined. I would say in mid-20s it disappeared.” However, Thomas has been sober for a few years and noted: “I’m actually exercising regularly again.”

Mabel (54, black) also described a process of “rebounding” back onto an active trajectory in response to health concerns. Although Mabel reported that she had active parents and an active childhood, Mabel described being sedentary for most of her adult life, as a result of time constraints related to parenting young children. After being diagnosed with high blood pressure two years ago, however, Mabel began to engage in regular physical activity:

I started exercising, so now my blood pressure medicine I’m taking half because he [doctor] says if you can knock off another 25 or 30 pounds, you wouldn’t need to take the ...medicine. My girls [daughters] really want me to get healthy so they encourage me to exercise.

Although Mabel’s primary motivation for exercising is to her improve her health, she reported that she also motivated by her husband and adult daughters’ desire for her to be healthy:

That's why I try to do it [exercise], for them. They say...and my husband tells me too...that the family would never run if I was not around so that's why they are always telling me "mom, you are the nucleus that holds everything together. You must be here."

Health-Deterring Early Life Influence

The Inactive Life Courser

A small percentage of the sample (7 percent, n=4; 2 white women, 1 black woman, and 1 white man) reported that their parents' inactivity, a lack of social support for exercise, and/or parents' negative attitudes toward exercise explained their own inactivity over the life course. For example, Beverly (58, white) said that her parents were inactive and that this influenced her own activity levels:

I think they influenced me...I never saw my family, my mom or dad, exercise...I never knew there was a difference...and when my dad came home, he was just tired...put his feet up and rested. I think it influenced the way I feel about my own health habits today.

Similarly, Kevin (36, white) said that his parents did not exercise and that this had an impact on his own activity patterns: "I never grew up thinking about we could go for a hike or walk down to the store instead of drive because my dad was very sedentary."

Patty (60, white) also reported that her parents were not active and this influenced her: "I didn't go looking for it [exercise]. And it just didn't appear to be that important." Further, when asked if her parents encouraged her to exercise, Patty noted: "No, not really. I took ballet when I was young, and then I'm not an athlete, so that was a joke. I tried. And

neither one of them had ever been an athlete either.” A much more common pattern, however, was for respondents to diverge from their parents attitudes and practices.

The Early Life Diverger

About 28 percent of the sample (n=17) reported that they diverged from their parents’ inactivity or negative attitudes toward exercise by beginning to exercise regularly in adolescence or early adulthood. Various adult life course events led to turning points that disrupted inactive trajectories — a process I term disrupted disadvantage. Respondents cited several reasons for adopting active habits, including: peer and intimate partner influence, enjoyment of exercise, personal health and weight concerns, and, witnessing their parents’ health and weight concerns — a process I term aversion.

Although all groups described this pattern in roughly equal numbers, the processes through which this occurred differed by gender and race. Only women in this sample cited the influence of peer and partner influence, while only men cited enjoyment of exercise. Further, women were twice as likely as men to cite their parents’ weight problems, whereas black respondents were twice as likely as white respondents to cite their parents’ health problems. This pattern meant different lived experiences of aversion at the intersection of gender and race with white women being primarily motivated to adopt an active lifestyle in response to parental weight concerns, while black women were motivated by both their parents’ health and weight concerns.

Jessica (33, white), said her parents were inactive, held negative attitudes toward exercise and as a result she did not engage in sports or other physical activities as a child

or teenager, but became active in college as a result of a boyfriend's influence: "He encouraged me to exercise. He went to the gym with me. He wanted me to learn martial arts because he was concerned about me being a small woman...he had a very positive influence on my health."

Sharon (53, black) said being exposed to new peers in college led to an adoption of an active lifestyle: "My family wasn't very active...I became more active in college because...I was around active people, a lot of athletes who were always on the track, just working out, walking, jumping hurdles, we were always active."

In this section I develop the life course concept of aversion to describe a process whereby individuals report witnessing the health and weight problems faced by their parents and engaging in regular exercise to avoid facing the same problems. For example, Kathy (31, white) said that her parents' health problems motivated her to exercise:

They didn't exercise...I guess I've been trying to do more exercise as a result of knowing that they didn't...I have been exercising more because of mom's stroke...she had high blood pressure...and she didn't exercise...I was sitting around with my aunt and uncle and dad...complaining about diabetes and their health problems. I was like I don't want this to happen to me. That's probably what got me to exercise...I need to take care of myself...I want to start these habits now.

Jennifer (35, black) similarly said her parents' inactivity and health problems inspire her to exercise:

They don't exercise...I try to break out of that...I am concerned because diabetes does run in my family...so does high blood pressure and heart problems and heart disease ...and then I see my parents. My dad has had an angina attack and uses all these pills. My mother has high cholesterol...I just don't want to be fifty and on a whole bunch of pills.

Although less common, some respondents, particularly women, described their parents' weight problems as a motivation to be active. For example, Naomi's (26, white) mother's weight problems motivate her to exercise:

My mother gained a lot of weight after she had me and my sister...and that kind of worries me...I have the ability to gain weight, so I have to work really hard at it...with her genes I have the ability to take after her...and now I work out a lot.

Similarly, Karen (42, black) noted: "I learned that I have to exercise because heaviness runs in my family on both sides. And I learned early on to exercise to stay in shape and not be where they are."

The Midlife Diverger

Another set of respondents (12 percent of total sample; n=7) reported that they diverged from their parents' exercise habits and attitudes, but that they did not begin regular exercise until midlife and only did so in response to personal or parental health concerns. This pattern was more commonly reported by black women (n=3) and men (n=2) than by white women (n=1) and men (n=1). Meredith (54, white), for example, reported that her parents were inactive and that she was inactive until her mid-30s:

They didn't exercise...and I didn't exercise...except for when I really made a point to since I got to be about thirty-five...just realizing that it would be good for my health ...before I... had gotten so heavy...walking one block would make me tired...I realized exercise is a good thing.

Rosa (63, black) also described her parents as inactive and believed that this shaped her exercise habits. This recently changed, however, when she experienced concerns about diabetes:

I went to the doctor...and she said your blood sugars are a little high...I said I'm not taking anymore pills. I already take one for high blood pressure and one for cholesterol ...so we will just have to do exercise and diet. So I...started...at the gym and...I came back in six months and all my levels were in normal range.

The process of aversion was also apparent for midlife divergers. For example, Mark (57, black) said:

My mom, all of my aunts and uncles have this history of heart disease, diabetes and stroke...most of my uncles died in their early 50s...they didn't take care of themselves ...so when I started seeing that, I made a conscious effort to not be caught up in that. I...started really exercising a lot in my late-30s...I joined gyms, I bought treadmills. I really focused on health and trying to take care of myself to avoid getting into those situations where I would die young.

DISCUSSION

Based on an analysis of 60 in-depth interviews I developed the concepts of disrupted advantage and disrupted disadvantage to refer to a change in health behavior

trajectories that diverge from early life chances around exercise. These analytic concepts add to life course theory by illustrating how processes of cumulative advantage and disadvantage can be disrupted. An intersectionality perspective further suggests the ways that disrupted (dis)advantage occur are shaped by race and gender as intersecting structural and cultural systems, which research using a life course framework has not considered. These findings are critical for developing a greater understanding of how health behavior disparities emerge and/or are disrupted over the life course in ways that differ by gender and race, which in turn are key for understanding and addressing health disparities.

Disrupted advantage operates differently at the intersection of gender and race. For example, among respondents who described health-enhancing early life chances around exercise, the transition to motherhood was the only reason that black women reported that they stopped exercising. Emphasized femininity involves placing others' needs above one's own (Connell 1987; Martin and Lippert 2012). Black femininity has been constructed in opposition to this ideal and black women are defined as "bad mothers," who do not adequately sacrifice for their children (Collins 2000). To combat these ideologies, black mothers place strong emphasis on sacrifice for their children (Elliott et al. 2013), but findings suggest these performances of femininity may disadvantage them in terms of health if this results in little time for exercise. The gendered division of labor, whereby women are responsible for the bulk of childcare duties, alongside black women's higher rates of unmarried or unpartnered motherhood (in this sample and in the U.S. population) (Rendell 1999) may also structurally disadvantage

black women during the transition to parenthood, despite health-enhancing early life chances around exercise. Bird and Rieker (2008) argue that “choices” made about health behaviors are constrained by a variety of structural factors and this finding illustrates one way that black women’s exercise may be constrained in ways that disrupt cumulative advantage processes around exercise.

For black men, disrupted advantage occurred primarily through the acquisition of injuries. Race and gender as intersecting structural and cultural systems may produce this pattern of disrupted advantage. Black masculinity has been constructed as hypermasculine and hyperathletic, and characterized by bodily toughness and invincibility (Carrington 2010; Joseph 2012). Although demonstrations of athletic prowess may be a way to combat racist stereotypes about black inferiority (Carrington 2010; Joseph 2012), performing masculinity in line with these ideals may pose a threat to men’s health (Courtenay 2000). Results suggests that in engaging in high-contact sports and/or other high-risk activities men risk injury, which can result in a turning point in exercise trajectories, despite health-enhancing early life chances. These performances of masculinity may be influenced by racial structural inequalities in that bodily displays are a more common means of performing masculinity for men who lack institutional power (Courtenay 2000; Majors and Billson 1992). Further, injuries may have worse implications for black men’s exercise trajectories due to racial disparities in health care quality and access (Williams 2012). This contributes to a greater understanding of how cumulative advantage processes may be disrupted in unique ways at the intersection of gender and race.

For respondents who developed health behavior advantage, this often occurred through aversion, a life course process by which, as adults, individuals observe their family of origin's health and weight problems associated with inactivity and in turn, engage in regular exercise out of a fear that should they be inactive, they too will face health and weight problems. This concept adds to theory and research on family ties and health by advancing an understanding of the dynamic and complex ways family ties shape exercise within contexts structured by systems of advantage and disadvantage.

Aversion differed by gender, race, and life course stage. Aversion in response to parental weight concerns was twice as common among young women than young men in this sample. Further, black respondents were twice as likely to adopt an active trajectory in response to parental health concerns, such that white women rarely exercised in response to parental health concerns while black women exercised in response to *both* parental weight and health concerns. I argue that race and gender as both structural and cultural systems intersect to shape aversion. Racial disparities in health and well-being (Williams 2012) and exercise levels (Haskell et al. 2007) intersect with gender as culture, whereby emphasized femininity involves being thin and/or working on one's weight and appearance to shape how aversion operates differently for black and white women. These findings add to a greater understanding of how cumulative disadvantage can be disrupted via aversion, a process that operates differently by gender and race.

Only young women in this sample developed health behavior advantage due to the influence of peers or intimate partners. Although the normative feminine emphasis on connection and others' needs and desires (Gilligan 1982) may be a detriment to women's

health behaviors (Martin and Lippert 2012), it may also explain why women in this sample were more likely than men to become active in response to the influence of peers and male partners. That is, in performing femininity women may adopt active habits to please their active social ties. This resonates with research findings that in heterosexual marriages, husbands do “health work” around exercise (e.g., encouraging their wives to exercise) — a masculine arena (Reczek and Umberson 2012). In contrast, men in this sample became active in early adulthood because they enjoyed exercise, which fits with cultural understandings of exercise as a form of self-fulfillment and men’s greater prerogative to engage in self-fulfillment (Gilligan 1982). This finding adds to an understanding of how cumulative disadvantage processes can be disrupted in gendered ways.

There are several policy implications of this research. Results point to the importance of the accessibility and affordability of quality childcare and mental and physical health services that address injuries and substance abuse problems. Additionally, the finding that individuals “rebound” onto active trajectories in response to particular life events suggests possible points of intervention. This research further points to the importance of gendered intervention efforts. In particular, given that young women are more apt to adopt the active habits of their peers and intimate partners, whereas young men are more likely to adopt active habits if they enjoy exercise, intervention efforts can be developed that are sensitive to these gendered patterns. Further, intervention efforts should be tailored to particular points in the life course, given that the reasons that individuals adopt an active lifestyle may differ in early and mid- adulthood.

Limitations

This research has some limitations. First, there is considerable cohort variability in this sample. This is an important limitation because different cohorts become adults in contexts characterized by differing sets of political, economic, and social factors that may impede or facilitate exercise. For example, the rise of a fitness culture in the 1970s and 1980s (McKenzie 2013) alongside the development of a cultural milieu wherein exercise and other health behaviors are an indicator of morality (Cockerham 2005) may mean baby boomers and later-born cohorts are more likely to diverge from their family of origin's inactivity than earlier-born cohorts. Social desirability bias (i.e., overestimation of exercise levels) may also be an issue because of the cultural link between health behaviors and morality. The large age range of the sample is also problematic because not all respondents who will likely experience transitions (e.g., transition to marriage or parenthood) have done so yet.

This sample was highly educated, although many of the black respondents did not have correspondingly high incomes, likely because they faced discrimination in the labor market. This made social class analyses difficult. Given research that socioeconomic status (SES) shapes individuals' exercise habits and attitudes toward exercise (Raudsepp 2006), future research on this topic should investigate how SES shapes these life course processes as well as how SES intersects with race and gender. Further, there are multiplicities of black and white masculinities and femininities (Joseph 2012), and thus future research should attend to the diversity of experiences within racial and gender groups.

CONCLUSION

Findings from the current study make a substantial contribution to life course theory by revealing how processes of cumulative advantage and disadvantage can be disrupted in ways that differ at the intersection of gender and race. The concepts of disrupted advantage and disadvantage advance a greater understanding of how health behavior disparities emerge or are disrupted over the life course in ways that vary by gender and race. These findings are important for advancing a greater theoretical and empirical understanding of the processes that shape change and continuity in health behavior disparities over the life course. Research should continue to examine whether and how processes of cumulative advantage and disadvantage around health and health behaviors are disrupted in ways that vary systematically across social statuses.

Article 2: Intimate Relationship Transitions and Change in Exercise Patterns: An Examination of Gendered Processes

ABSTRACT

Previous research suggests that relationship transitions matter for health and health behaviors but has rarely explored the processes through which intimate relationship formation and dissolution shape exercise patterns, nor how these processes may differ by gender. In this article I merge theoretical work on gender and the life course to frame an analysis of 60 in-depth interviews to examine the gendered processes through which intimate relationship formation and dissolution result in changes in exercise patterns for better or worse. Results suggest that relationship formation positively (i.e., leads to an increase in exercise levels) and negatively (i.e., leads to a decrease in exercise levels) shapes exercise patterns through a variety of gendered processes. For example, relationship formation positively shapes women's exercise levels via social support, social control, and diffusion from their male partner and negatively shapes exercise patterns through indirect social control (for men and women), the loss of social support from friends (for men) and stress and diffusion (for women). Relationship dissolution positively and negatively shapes exercise through several processes, but none of these processes operate in gendered ways. This suggests that the performance of gender within the context of intimate relationships matters more for exercise patterns than "doing gender" outside of these contexts and that within heterosexual intimate relationships the

simultaneous and co-constitutive nature of performances of masculinity and femininity
shape exercise habits.

Longitudinal research demonstrates that intimate relationship transitions (e.g., the transition to marriage, divorce, widowhood) have important implications for health and health behaviors (Haldane, Mincy, and Miller 2010; Umberson et al. 2009; Williams and Umberson 2004). For example, the transition to marriage is associated, on average, with a boost in self-assessed health (Williams and Umberson 2004) as well as weight gain (Umberson et al. 2009) and a decrease in exercise levels (Bell and Lee 2005; Brown and Trost 2003; Eng et al. 2005; Schmitz, French, and Jeffrey 1997). In contrast, divorce and widowhood are, on average, associated with weight loss (Umberson et al. 2009) and an increase in exercise levels (Eng et al. 2005). Despite evidence that relationship formation and dissolution are important for health and health behaviors, previous research provides little information about the underlying processes through which intimate relationship formation and dissolution shape health behaviors, although this is an important question for research and theory on relationships and health.

Research further suggests that the ways in which relationship transitions shape health and health behaviors vary by gender. For example, the transition to marriage is associated with a boost in self-assessed health and divorce and widowhood are associated with declines in self-assessed health for men but not women (Williams and Umberson 2004). Research also suggests that marriage exerts a greater negative effect on men's exercise levels (Nomaguchi and Bianchi 2004). Thus, while previous quantitative research suggests that relationship transitions matter for health and health behaviors and in ways that differ by gender, it remains unknown what qualitative gendered processes

may help to explain these population patterns. This is an important question, however, for theory and research on gender, health and intimate relationships.

Thus, in this article I examine the gendered processes through which relationship formation and dissolution shape *exercise* patterns. Exercise is associated with lower risk of morbidity, mortality, depression, and anxiety and thus is a key behavioral indicator of health and well-being (Haskell et al. 2007; Shaw et al. 2010). However, there are large gender disparities in exercise, with women having lower levels than men and gender disparities in exercise widen over the life course (Shaw et al. 2010). Further, one study found that marriage exerts a greater negative impact on men's exercise levels compared to women's (Nomaguchi and Bianchi 2004), although it is not clear why this is the case — that is what processes underlie this gendered population pattern. Thus, I frame an analysis of 60 in-depth interviews with an equal number of African American and white men and women (15 in each race/gender group) with life course and gender theoretical frameworks to examine the following research questions: 1) What are the gendered processes through which intimate relationship formation (i.e., the transition to marriage and cohabiting relationships) shapes exercise patterns for better or worse? 2) What are the gendered processes through which intimate relationship dissolution (i.e., divorce, “break-ups⁴,” and widowhood) shape exercise patterns for better or worse? By obtaining a greater understanding of the gendered processes through which life course transitions shape individuals' exercise patterns, I respond to calls to provide insight into the

⁴ I examine relationship formation and dissolution broadly speaking and therefore do not limit this analysis to marriage, as marriage is increasingly non-normative (Bookwala 2012) and may not reflect the reality of many Americans' intimate relationships.

mechanisms through which social ties shape health behaviors in ways that may contribute to health disparities (Umberson et al. 2010).

THEORETICAL FRAMEWORK

Life Course Theory

A life course perspective can help to guide an analysis of how shifting social contexts — such as relationship formation and dissolution — shape change and stability in exercise patterns. The life course concepts of *linked lives* and *social convoys* bring attention to the fact that individuals' lives are shaped in profound ways by their relationships with other people (Elder and Shanahan 2006; Moen and Hernandez 2009). Further, emotionally intimate and identity relevant ties (e.g., intimate partners) are particularly important for health and well-being (Simon 1992; Simon 1997).

From a life course perspective *transitions* to new social roles (e.g., marriage, cohabitation) or the loss of existing social roles (e.g., divorce) have important implications for health and health-related behavior (Elder 1998; Wethington 2005). Longitudinal research generally suggests that the transition to marriage is associated with declines in physical activity levels (Bell and Lee 2005; Brown and Trost 2003; Eng et al. 2005; Schmitz, French, and Jeffrey 1997). For example, Bell and Lee (2005) found that young Australian women who made the transition to marriage or cohabitation had lower levels of physical activity at 4-year follow-up, than women who did not. Another longitudinal study found that divorced and widowed men who remarried had lower levels of physical activity than men who remained unmarried (Eng et al. 2005). Taken together, limited research on this topic suggests that the transition to marriage and cohabitation are

associated with declines in exercise levels and divorce and widowhood are associated with an increase in exercise levels.

While this research is useful for understanding how relationship transitions shape exercise levels at the population level, it provides little information on the *gendered processes* through which relationship transitions matter for exercise patterns. Social ties shape health behaviors in both health-enhancing and health-detering ways and in ways that vary for men and women (Umberson et al. 2010) and thus both relationship formation and dissolution may have both positive (i.e., lead to an increase in exercise levels) and negative (i.e., lead to a decrease in exercise levels) implications for exercise patterns and in different ways for men and women. Previous research on intimate partner ties and health behaviors suggest several potential processes through which relationship transitions may result in changes in exercise patterns in distinctly gendered ways. An understanding of the processes through which relationship formation and dissolution shape exercise patterns in different ways for men and women is critically important for research and theory on gender, intimate relationships, and health. Thus, I now examine these processes and apply a gender relational theoretical framework to frame a discussion of how these processes may differ by gender.

Gender-as-Relational Perspective

A key tenet of theoretical work on gender is that individuals are constantly engaged in gendered performances whereby through interaction with the social world they rely and reproduce (although sometimes contest) dominant cultural understandings of masculinity and femininity (West and Zimmerman 1987). Thus, from this perspective

the processes through which relationship transitions matter for exercise patterns will be shaped by these gendered performances. More recently, gender theorists emphasize the importance of a “gender-as-relational” perspective, which holds that the ways that individuals “do” or perform gender are dynamic and situational (Springer, Hankivsky, and Bates 2012). A key context in which individuals perform gender is within intimate relationships, wherein individuals enact gender in relation to the gender performances of their intimate partner (Goldberg 2013). Thus, for example, the gendered processes through which intimate relationship formation matters for women’s exercise patterns may matter not just in terms of women “doing” femininity but “doing” femininity in relation to a male partner “doing” masculinity. Likewise, upon relationship dissolution, gender performances that matter for exercise may shift if individuals are no longer doing gender in relation to an intimate partner simultaneously doing gender. Thus, the proceeding discussion on how gender may shape the processes by which relationship transitions matter for exercise is informed by a gender-as-relational perspective.

Social Control

Previous research suggests that social control is a key mechanism through which intimate partners shape each other’s health and health behaviors (Reczek and Umberson 2012; Umberson 1992; Umberson et al. 2010). Social control in intimate relationships occurs both directly — when one partner attempts to shape the health and health behaviors of their partner — and indirectly whereby intimate relationships impose a sense of meaning and responsibility that encourage individuals to adopt health-enhancing behaviors (Umberson 1987; 1992). Thus, relationship formation may lead to

an increase in exercise levels either directly or indirectly, while relationship dissolution may result in the loss of social control and in turn, lead to a decline in exercise levels. However, some research suggests that social control efforts can backfire when these attempts are resented and resisted (Lewis et al. 2006; Reczek 2012). For example, if an individual pushes their partner to exercise too hard, they may grow to dislike and avoid exercise. Additionally, norms around intimate partnerships encourage partners to stay at home together (often engaged in sedentary behaviors) and this may limit the time that individuals spend on individual pursuits, such as exercise (Reczek 2012).

Social control processes are gendered (Umberson 1992). For example, because healthy behavior is culturally defined as feminine and tending to the health of others is considered “women’s work,” women are more likely than men to exert direct social control efforts, and as a result marriage exerts a larger positive effect on heterosexual men’s health behaviors, compared to women’s (Reczek and Umberson 2012; Umberson 1992). In contrast, in performing masculinity men distance themselves from health work and healthy behavior norms (Courtenay 2000; Reczek and Umberson 2012) Thus, upon entering into heterosexual unions gendered relational performances (i.e., performances of masculinity in relation to performances of femininity) may result in an increase in exercise levels for men but not women, while relationship dissolution may lead to a decline in exercise habits via the loss of social control for men but not women. Relationship dissolution may also free up the time and energy with which women have to focus on their own health habits, as a result of no longer providing social control to their partner.

On the other hand, the gendered social control processes through which intimate relationship transitions shape exercise patterns may differ from other health behaviors because, unlike other types of healthy behaviors, physical activity is associated with masculinity (Messner 2002). Through sports men enact masculinity (Messner 2002) and within heterosexual intimate relationships men are considered to have more exercise expertise than their partner (Reczek and Umberson 2012). Thus, for example, upon entering into a relationship with a man, women may increase their exercise levels via direct social control processes shaped by their partner's performances of masculinity. This suggests the importance of a gender-as-relational perspective, whereby the gender performances of both an individual and their partner will simultaneously matter for how relationship transitions shape men's and women's exercise patterns.

Indirect social control processes may also be gendered. Research suggests that women often do not feel entitled to personal, leisure time (Henderson and Dialeschki 1991) because norms of femininity emphasize prioritizing others' needs and desires over one's own (Connell 1987). In turn, the loss of indirect social control processes that encourage partners to engage in joint (often sedentary) activities may lead to higher levels of exercise for women upon relationship dissolution.

Social Support

Social support (defined as emotional and instrumental efforts that that make an individual feel supported) is a key mechanism through which social ties shape health and health behaviors (Umberson et al. 2010). Further, studies demonstrate a robust association between social support and exercise (Courneya et al. 2000; Dowda et al.

2003), although research has not examined this in the context of relationship transitions. Relationship formation, however, may lead to the acquisition of more social support, which in turn could lead to an increase in exercise levels. Socially supportive partners may provide encouragement for exercise, instrumental support for exercise (e.g., gym memberships), and further provide someone to exercise with. Additionally, partners may make individuals feel loved and cared for, which in turn may motivate individuals to exercise out of a desire to be healthy for their partner. Subsequently, the loss of a key source of social support via relationship dissolution could result in a decline in exercise levels.

Sporting activities are one of the key ways that men bond with one another (Messner 2002) and therefore for many men in American society male peers are a key source of social support for physical activity. The transition to intimate relationships, however, has the potential to limit the amount of time that men are able to spend with male peers playing sports. Thus, although relationship formation involves a new form of social support (i.e., support from a partner), it may also disrupt existing forms of social support (e.g., friends) in ways that negatively interrupt men's exercise habits, perhaps particularly for men entering heterosexual unions because ideologies about gender do not support the notion that women are suitable substitutes for male peers in the context of sport. Conversely, although relationship dissolution may lead to a loss of social support from a partner, men may have more time to engage in physical activity with male peers (thus gaining other forms of social support for physical activity). For women, however, given that men are often considered the "exercise experts" in heterosexual relationships

(Reczek and Umberson 2012), relationship dissolution may result in the loss of a key source of social support for physical activity. These theoretical possibilities further suggest the importance of a gender-as-relational perspective, as they strongly point to the possibility that gendered processes will be shaped by an individuals' gender performances *in relation* to the gendered performances of their partner.

Health Habit Diffusion

Social ties shape individuals' health behaviors, including exercise, via the process of health habit diffusion or modeling (Lewis et al. 2006; Reczek 2012). Unilateral health habit diffusion refers to a process whereby one partner's health habits directly contribute to their partner's health habits (Reczek 2012). This process is gendered in that men, but rarely women, diffuse *unhealthy* habits (e.g., eating more fatty and sugary foods, drinking more alcohol) onto their partner (Reczek 2012). This likely stems from the fact that performances of masculinity are predicated on displays of bodily toughness that are often harmful for health (e.g., binge drinking, drug use, eating unhealthy food, and engaging in other high-risk activities, including full contact sports) (Courtenay 2000). In contrast, norms of femininity encourage women to protect their health and to avoid risky behavior (Reczek 2012). As a result, women may influence men's exercise habits in ways that are health-enhancing upon entering an intimate partnership, whereas men may influence women's exercise habits in ways that are health-detering. Alternatively, because men have higher rates of physical activity compared to women (Haskell et al. 2007) and sports are gendered masculine (Messner 2002), women may be positively influenced by men's exercise habits (i.e., they may engage in more

exercise). Women may also be more susceptible to health habit diffusion (in terms of both health-enhancing and health-detering habits) upon entering into an intimate relationship because of women's relational orientation and because norms of femininity encourage women to please others and "go-along-to-get-along" (Connell 1987; Gilligan 1982). These theoretical possibilities, all point to the importance of a gender-as-relational perspective, whereby performances of masculinity matter in relation to performances of femininity. Another possibility is that relationship formation leads to a process of *bilateral unhealthy habit diffusion*, whereby partners jointly engage in failed motivation to exercise, although research suggests that this process is more common in same-sex than different-sex relationships (Reczek 2012).

Stress

Stress is linked to lower levels of exercise (Steptoe et al. 1996) and is a key mechanism through which social ties negatively shape health and health behaviors (Umberson et al., 2010; Umberson, Liu & Reczek 2008). The transition to intimate relationships may be stressful because it involves new social roles and responsibilities and this stress may result in a decline in exercise levels. Additionally, relationship quality moderates the association between intimate relationships and health (Jaremka et al. 2013) and the transition to a low-quality, strained relationship may be more likely to lead to higher levels of stress and in turn lower levels of exercise. Relationship dissolution is also stressful (Umberson et al. 2010) and may lead to a decline in exercise levels; although for individuals in low-quality relationships, relationship dissolution may result in stress relief (Williams and Umberson 2004), which may in turn lead to an increase in exercise levels.

Experiences of stress during relationship transitions may be gendered, thus shaping men and women's exercise habits in different ways. In heterosexual relationships, women do the bulk of household labor and this can be stressful, particularly in combination with paid work (Erickson 2005; Lennon and Rosenfield 1994). Additionally, women entering into relationships with men may increase their time spent doing emotional labor, that is attempts to make their partner feel better about himself or herself and emotion work can be stressful, particularly when not reciprocated which is typically the case in different-sex relationships as emotion work is feminized labor (Erickson 2005). Thus, performances of femininity, in relation to performances of masculinity, within intimate relationships may make relationship transitions particularly stressful for women, which may in turn reduce their exercise levels. In contrast, men may experience a reduction in stress upon entering into a relationship with a woman and exercise more. Relationship dissolution may mean a reversal of these gendered patterns, whereby women's stress levels are reduced and men's are increased, shaping their exercise patterns in different ways.

Distress

Distress is another key mechanism through which relationships negatively impact individuals' health and health behaviors (Umberson et al 2010). Further, high levels of distress are linked to lower levels of exercise (Kaplan et al. 2001). However, it may not only be that less distressed people are more likely to exercise but also that exercise reduces distress (Salmon 2001). Thus, while distress from relationship dissolution likely leads to a decline in exercise levels, it is possible that upon relationship dissolution some

individuals exercise more as a means of coping with distress. Men and women express distress in different ways, whereby women are more likely to internalize distress (e.g., cry) whereas men are more likely to externalize distress (e.g., drink alcohol) (Rosenfield 1999), given that these expressions of distress are in line with conventionally gendered performances of emotion. And although exercise is not usually conceptualized as a means of externalizing distress, gender differences in expressions of distress suggest that men may be more likely to exercise in response to distress stemming from relationship dissolution.

DATA AND METHODS

Data from this study come from the Relationships and Health Habits Study, a retrospective in-depth interview study designed to assess how social ties shape health behaviors over the life course. Respondents were asked a series of open-ended questions related to social relationships and health behaviors over the life course, particularly those related to exercise habits, body weight, eating habits, and alcohol consumption. Data related to exercise patterns and intimate relationship transitions were analyzed in particular depth for the current study. Interviews took place from 2008 to 2009 in a Southwestern city in the United States. Interviews lasted roughly one and a half hours and most were conducted either in the respondent's home or in university offices. Respondents were recruited through various methods including snowball sampling, flyers to local organizations (e.g., senior centers, African American Chamber of Commerce), and postings on listservs. The sample consists of 15 white men, 15 white women, 15 black men and 15 black women. The data were analyzed for racial differences but no

clear racial patterns emerged (likely due to the small sample size). Three respondents identified as lesbian or gay, while the remaining identified as straight. Thus, analyses are based on relationship transitions within the context of heterosexual unions. Further, analyses are based on respondents' subjective lived experiences of changes in exercise patterns and not on any objectively-defined criteria.

The sample was on average 52 years old and mean household income was \$46,875. Respondents were on average highly educated: 2/3rds of the sample had at least a college degree. Forty-nine respondents were employed full or part-time, eight respondents were retired, three respondents were unemployed, and one was receiving disability payments. Twenty-one respondents were married, twenty-two were divorced, eleven were never married, four were widowed, and three were cohabiting.

Analysis

Analysis followed grounded theory methods for analyzing qualitative data, which seeks to go beyond description to develop theoretical insights from respondents' lived experiences (Charmaz 2006). After numerous readings of the transcripts, I engaged in line-by-line open coding, whereby I identified potential codes for analysis. I then engaged in focused coding where initial codes were scrutinized for their analytic potential and categories were developed for analysis. Here categories related to relationship formation (i.e., transition to marriage and cohabiting and committed relationships) and change and stability in exercise patterns and relationship dissolution (i.e., transition to divorce, break-ups, and widowhood) and change and stability in exercise patterns emerged. Lastly, I engaged in theoretical coding where I examined how these analytic categories related to

each other theoretically, how they related to concepts from the literature on social ties and health behaviors (e.g., social support) and how analytic categories differed by gender. I found that relationship formation positively shaped exercise patterns (i.e., led to a reported increase in exercise levels) via the following processes: social support, social control, diffusion and negatively shaped exercise patterns (i.e., led to a reported decrease in exercise levels) via the loss of social support from friends, diffusion, and stress. Relationship dissolution positively shaped exercise through an increase in appearance-related concerns, as a means to cope with distress, loss of social control and an increased responsibility to protect one's health (i.e., personal control) and negatively shaped exercise through the loss of social control, social support, resources for exercise and depression. Further, I found that the processes through which relationship formation (but not relationship dissolution) shaped exercise patterns differed by gender. For example, women who entered into unions with men started exercising via the processes of social support, social control, and health habit diffusion while the men who entered into unions did not describe an increase in their exercise levels. This suggests the importance of a gender-as-relational framework whereby an individual's gender matters in relation to the gender of their partner.

RESULTS

Relationship Formation and the Adoption of Active Exercise Habits

Respondents described three key processes through which the transition to relationships led to the adoption of active exercise habits — social support, social control, and health habit diffusion. Further, these processes often occurred simultaneously. These

processes were gendered in that predominately women reported that these processes led to an increase in their exercise levels.

Social Support and Social Control

Although separate processes, I present social support and social control together because respondents often described these processes simultaneously. For example, Naomi (age 26) described how her boyfriend provided both social support and social control around her exercise, which led to an increase in exercise:

It wasn't until college until I met my boyfriend that...I didn't start working out in a gym until I met him.... He was a huge workout guy and he just got me working out with him at a gym... he would help me, you know, teach me all the bench pressing. He would motivate me and get me to do things I normally wouldn't do in the gym, bench pressing, and say, "Come on. You can do it. You can do it. Five more pounds"...I would do the elliptical and then I would just do some weights; whatever he would take me around and show me to do... It was neat because I never had done it before. I never had belonged to a gym in high school or growing up...because I was never that athletic and into sports. I think I was always kind of slow and klutzy. So I really enjoyed it, I liked it.

Jessica (33) also said that she exercised more as a result of her boyfriend providing social support and social control around physical activity:

I would go [to the gym] with my boyfriend. He was really into working out...and he encouraged me to exercise. He went to the gym with me. He wanted me to learn martial arts because he was concerned about me being a small woman,

safety and all that. I didn't end up learning but he tried. He had a very positive influence on my health.

Kathy (30) also said that she started running because her partner provided encouragement to go running with him:

We started exercising more...he got me to the park but he's just a much faster runner. So we did it together in the sense that he got me there but we don't ever run together because he's just so fast...so we would go and we would come back and that's what really got me in the habit...I definitely wouldn't be running if it weren't for him.

Exercise Diffusion

Some women in this sample also described a process of diffusion, whereby they began exercising simply because their partner was exercising. Diffusion is distinct from social support and social control because respondents' partner did not directly encourage them to exercise or provide support for them to be active. For example, Dionna (55) described how she started exercising because of an active boyfriend, illustrating a process of diffusion:

I got to go to the gym because the boyfriend I was dating at the time, he was younger than me, and because of him I went to the gym. He drank water all day. I drank water. And I think your behavior has a lot to do with who you associate with. It's nature versus nurture. The nature is your environment. And my environment consisted of this younger guy who I was crazy about. Big football

player. It was great. He worked out. He had big muscles...I went to the gym everyday. I worked out every morning.

Similarly, Patty (60) reported that she started exercising upon entering into a union with a man who was diagnosed with diabetes. Patty said that his diagnosis inspired him to exercise, which in turn led Patty to exercise: “when we were together...because he had started trying to do something about the diabetes, so that meant the exercise was needed too, so I went with him.”

Although these processes were more common among women, one man, Barry (60), in this sample also described his partner positively shaping his exercise habits via the process diffusion:

My lady is a constant walker. She is a real exercise genie. She goes to these fitness centers. She’s got me walking everywhere...She walks a whole lot faster than I do. So I have to run to keep up with her almost. So she’s a health nut... She’s about five years older than I am. She’s got a stake in health. That made me realize so do I.

Relationship Formation and the Adoption of Inactive Exercise Habits

Respondents reported four processes through which the transition to intimate relationships led to the adoption of unhealthy exercise habits: 1) loss of social support from friends (for men), 2) indirect social control around the meaning of intimate relationships (for men and women), 3) unhealthy health habit diffusion (for women), and 4) stress (for women).

Loss of Social Support from Friends

Several men in this sample noted that relationship formation led to a decline in exercise levels because the transition to an intimate partnership conflicted with the time they had available to exercise with their male friends (formally a key source of social support for exercise). For example, Donald (56) noted that the transition to marriage negatively shaped his exercise habits because he lost social support for exercise from his peers:

When I was young...I lived...on the baseball field or the basketball court...and when I was at college, I was always out playing football or basketball with people...it was very much the center of my social activity...till I was 25 or so. And then you know, you get a job and I got married and I had kids...so what happened was my social life changed...the way I spent my day and engaged myself with other people suddenly was completely different....so I think it became to the point where...I had to go out of my way to do it [exercise]...It was a social event and not a conscious effort to exercise. And then it got replaced by other social centers, which were music, family.

Jared (31) also reported that the transition to marriage led to the loss of social support for exercise from his male friends, which in turn contributed to a decline in his exercise levels:

We moved out here. It's farther...I don't have my friends stopping out here, "hey, let's go play ball"...That has made it a lot harder. Those guys would always be like, "hey, let's go. We're going to go play basketball, come on. Hey, I'm going

to the gym to workout. Why don't you come partner up with me?"...I just stay here and save gas money.

Indirect Social Control

Men and women in this sample described exercising less upon entering into an intimate relationship due to indirect social control processes. Specifically, respondents said that they exercise less because meanings of intimate relationships emphasize spending time together – which often involves sedentary behaviors. For example, Katherine (28), noted that she has exercised less since being in a long-term relationship with her partner since they spend time together engaged in sedentary activities:

You know how you nest and you just sit under each other and just eat. I do that a lot now because we'll just look at movies or cuddle and eat...it's just like you're nesting. You just want to sit in the nest all day and eat and not do anything, not be active together.

Sharon (53) also described stopping exercising regularly once she married her husband due to norms around intimate relationships that involve spending time together at home:

Before I got married I was actively involved. I was taking tennis lessons...I was always on the go...But when I got married you're home everyday...you stayed at home and you watched TV. Sedentary lifestyle...we stayed home most of the time. And those pounds started creeping and creeping and creeping...that sedentary lifestyle. And then I married someone who loves to watch sports. Even though I don't it meant he was home watching TV...It was bad.

Jared (31) said that he no longer has time for exercise because his wife wants him to be at home spending time with her engaged in sedentary activities:

She wanted me home...she doesn't want to be stuck at home with the kids all the time. She wants to have quality time with me as well. I have to figure out a way to balance that where it's [exercise] not on her time or find things for her to do.

Unhealthy Health Habit Diffusion

Several respondents said that their exercise levels declined upon transitioning to an intimate relationship because their partner did not exercise and these sedentary habits were in turn diffused upon them. Unhealthy health habit diffusion was more commonly reported by women. For example, Audrey (41) said that the transition to marriage led to a decline in her exercise levels because of her husband's inactivity: "In my 20s, I was ripped, I had a six-pack stomach...took a serious dive in my marriage.. my husband was a hedonist and that's when I started...drinking and not exercising and just seriously out of shape."

Rhonda (52) described a process of bilateral health habit diffusion, whereby her and her partner reinforced an inactive lifestyle for one another:

The guy I was with those three years. He wasn't heavy like me but he was heavy. And he was eating just like me. And he wasn't exercising either. So we were being unhealthy for each other. [I: Did you feel like you were enabling each other] I did.

Stress

Finally, some women in this sample said that the transition to an intimate relationship led to a decline in exercise because their partners introduced considerable stress in their lives. Thus, relationship quality appears to moderate the association between relationship formation and change in exercise habits. Natalie (43) for example described how the transition to marriage led to a decline in her exercise levels due to an increase in stress stemming from her husband's unemployment and substance abuse problems:

No more exercise. When I got married my lifestyle changed...Because I spent more time with him and...there wasn't that time, you know, no more walking, none of that kind of stuff anymore...And no more Natalie time. So all of the things that I used to do for me... after James moved in I really stopped doing it... I think that because I'm so caught up with being with him that I just haven't given myself permission to say "he's okay, go take a walk. He said it's okay."

Karen (42) described a similar process whereby a low quality marriage contributed to a lack of physical activity:

The second [marriage]...I think, kind of contributed, you know, didn't help me get back into shape... because it was like I was, I don't exercise. It's like the last thing on my mind. It was like no thanks, although my counselor would be like "exercise relieves stress." "Yeah, yeah." But it was like that's the last thing you think about doing. Throughout the marriage it was stressful. Again it was like it's like the last thing on your mind.

Relationship Dissolution and the Adoption of Active Exercise Habits

Respondents described several processes through which relationship dissolution led to the adoption of active exercise habits or an increase in already existing levels. Namely, respondents reported that they began exercising more because 1) they wanted to be attractive post-relationship dissolution 2) exercise provided a means to cope with distress and 3) relationship dissolution led to a greater focus on the self and the development of greater personal control.

Looking Good

Both men and women in this sample said that they exercised more upon relationship dissolution in order to attract another partner. For example, Naomi (26) described how she exercised more after a break-up in order to find another partner:

After we broke up...I would work out every single day and...I don't know if subconsciously I wanted to look better. You know, it was at the time that I was doing the [alcohol distributing] stuff so I had to go downtown in a skimpy outfit and look my best and that was right around the time we broke up that I was doing that job so I felt like I wanted to look good and I wanted to go out and impress people and go find another mate or something and I think subconsciously I think that's what was going on with me.

Allison (30) described a similar process:

I put on weight in college...and...after my...almost engaged boyfriend, after we broke up I...decided I needed to lose some weight so...I exercised a lot back then. I don't lift weights now but I did back then, lift weights and would run and do...I

did spin, whatever...I did aerobics there, did a lot of aerobics, really...I was in my mid-twenties and single...and my... friends started getting engaged...I mean, I had been single for awhile... and I was tired of being single...So I think that just...it makes...you feel better if you look good but it's flattering to get noticed.

Coping with Distress

Both men and women in this sample described exercising more post-relationship dissolution as a means of coping with distress. Rick (30), for example described how even though he stopped eating he exercised to cope with his distress:

We broke up, and that was really hard on me, and I didn't go to work, and I didn't do anything, sit around the house and squall...I probably lost a few pounds and didn't eat...but I did exercise though still because, I mean, it kept me from thinking about it.

Similarly, Kimberly (51) described how she exercised to cope with her distress after a break-up:

When I was breaking up...with the fireman, the guy who has got me into rowing. I learned very quickly that you cannot cry and row at the same time. Because you'll tip your boat. There's no way. And I did it [laughs]. So...there's this level of focus that happens in good exercise that...precludes anything else.

Audrey (41), who earlier described how she stopped exercising once she married her husband further said she started exercising after they divorced "After my divorce...was journaling every day, going to yoga several times a week, walking my

dogs every day, meditating, doing affirmations and all of that combined with counseling... to help me get through it.”

Margie (70) described a similar process:

I think exercise helped me keep my sanity through both of the divorces ...Both running and working in the garden, because we had a vegetable garden and I had planted roses. I think all of those things help me work out the tensions and frustrations and my anger in the course of doing things.

Greater Self-Focus and Personal Control

Finally, respondents said that relationship dissolution spurred a focus on their own health. For some this meant tending to their health — that is developing more personal control, because they realized that no one else was going to look after their health having lost social control sources. For other respondents, relationship dissolution freed up time and energy that they put towards focusing on their health. For example, Beverly (58), reported that she started exercising upon separating from her husband:

I’m healthier with my body right now more than I’ve ever been in my life. And probably because my focus is now on me... starting back on losing more and trying to kind of watch what I’m doing and exercising more than I did before... because of my husband being away from me. And it’s been to an advantage. I think some of it sort of kick-started my looking at myself and saying my health is important and...reminded me that I need to take better care of myself because I’ve neglected it for too long.

Similarly, Donald (56) said he exercises more since his divorce because he can concentrate on his own health rather than his spouse or children's needs:

I'm...probably exercising more than I have since I was 25...exercising became convenient because I now live alone...so I'm not having to put...I'm not having to be concerned with other people's needs. ...I'm no longer married. So I don't have to...have other persons' needs ahead of my own.

Margie (70), who earlier described exercising after her divorce, said that relationship dissolution led to the realization that no one else would protect her health:

I think my health got better when I was single... I realize that it's up to me to take care of it. There's not anybody else that's going to look after me, but me. And living by yourself ...gives you that outlook.

Relationship Dissolution and the Adoption of Inactive Exercise Habits

Respondents described three processes through which relationship dissolution led to a decline in their exercise habits: 1) the loss of social control and social support 2) distress and 3) loss of resources that facilitate exercise.

Loss of Social Control/Social Support

Several respondents described exercising less post-relationship dissolution because they lost social control and social support. For example, Patty (60) said that a break-up meant that she no longer had anyone to walk with:

One good thing he did was...we used to take a walk in the evening, because he had two dogs. And so we'd go out and take a walk, it was fun. And I quit doing that because I...didn't have anyone to walk with.

Similarly, Ernest (89) described how since his wife died he dances less often because his wife was not there to encourage him to dance with her, although he does dance because of his friends encouragement (albeit less often): “My wife was a dancer...and she had me dancing eight nights a week... it did temporarily [decline] but I kept running into different people and they would say ‘you need to come back.’”

Distress

Some respondents said that relationship dissolution led to a negative change in their exercise habits because of distress. For example, Terry (41) described how he stopped exercising after his divorce:

You stop kind of thinking about...how you are eating and stuff like that, you kind of start posing...your social issues and stuff like that so I kind of think I was more focused on that...And some of the things I may have done before, I may have started doing, like I may have stopped working out just because of that.

Rosa (63) also said that she didn't eat or exercise after her most recent divorce: I got divorced I didn't eat... I got down to maybe one-hundred and thirty pounds...I just didn't have any appetite at all. I wouldn't exercise and I just wouldn't eat... I took this one harder because I was older and wiser and should have known that there were some issues there.

Natalie (43), also described how she stopped taking dance lessons after a break-up because she was depressed:

I stopped belly dancing after he and I broke up. I really tried but I became socially reclusive. I didn't have any friends. And so I pretty much didn't do anything. I stopped belly dancing... I did at that time start counseling again.

Loss of Resources

Lastly, some respondents said that they exercised less post-relationship dissolution because of a loss of resources that enabled exercise. For example, Patty (60) who earlier noted that she exercised less post-relationship dissolution because she no longer had someone to walk with also noted that because she had to move out from her boyfriend's house she "was in a less safe neighborhood, our apartment was a weird place" which made walking more difficult and less practical.

Similarly, Terry (41) described how he lost access to his weight equipment post-relationship dissolution and as a result exercised less:

I used to have the weights, but I didn't have the things to exercise with so now I have to go somewhere and actually go workout, where I used to workout at home... That kind of changed as far as the amount of workout.

DISCUSSION

Although research suggests that relationship transitions matter for health and health behaviors and that the ways in which they do so differ for men and women (Haldane et al. 2010; Umberson et al. 2009; Williams and Umberson 2004) little is known about the gendered processes linking relationship transitions to health and health behavior change. Using data from 60 in-depth interviews, in this article I explored the gendered processes through which relationship transitions shape exercise habits for better

or worse. Results suggest that relationship formation and dissolution can result in both an increase and decrease in exercise levels, but that in the case of relationship formation this occurs in uniquely gendered ways. Findings further reveal the importance of a gender-as-relational framework, whereby performances of femininity and masculinity occur in relation to one another in heterosexual unions, for understanding how relationship formation shapes changes in exercise patterns. This suggests that gendered performances around exercise may be particularly salient when they occur *within the context of a relationship* wherein partners are performing gender in relation to one another. These findings contribute to research and theory on intimate relationships, health behaviors, and gender.

The importance of a gender-as-relational theoretical framework for understanding relationship formation and changes in exercise patterns is highlighted by the finding that women (but very few men) in this sample said that relationship formation led to a positive change in exercise habits via social support, social control, and diffusion. Although research suggests that women are more likely to exert direct social control on their male partners (Umberson 1992) and that heterosexual marital relationships generally have a more positive effect on men's health and health behaviors (Kiecolt-Glaser and Newton 2001; Reczek and Umberson 2012; Umberson 1992), the gendered processes through which relationship transitions matter for exercise may be unique because sports and exercise are gendered masculine (Messner 2002; Reczek 2012). Indeed, research suggests that in heterosexual intimate relationships male partners position themselves as experts around exercise in order to demonstrate their masculinity (Reczek and Umberson

2012). Thus, some women who enter into unions with men may be influenced by their partner's masculinity performances around exercise, wherein male partners "teach" women to exercise. Women may also be more open to processes of social control, social support, and diffusion around exercise because of a desire to please their partners, given that norms of femininity emphasize accommodation to the desires of others (Connell 1987). This also points to the possibility that women's health habits may be more mutable and open to the influence of others — for better or worse — which is a key finding for research and theory on gender and health. Thus, women's performances of femininity (accommodation to partner) operate alongside men's performances of masculinity (as exercise experts in heterosexual relationships). This finding contributes to a greater theoretical understanding of how relationship formation shapes men and women's health habits in unique ways that depend on both an individual's gender as well as their partner's gender. This also suggests the possibility that relationship formation may shape gay and lesbian individuals' exercise habits in different ways, a possibility that future research should explore.

The importance of a gender-as-relational perspective is also highlighted by the finding that only men reported that their exercise levels declined as a result of the loss or decline of social support from male friends. Because sports and exercise are gendered masculine (Messner 2002), men often exercise with male peers. Indeed, sporting activities are one of the key ways in which men bond with other men in American culture (Messner 2002). Relationship formation may limit the time men are able to spend with male friends, which in turn may limit the time they spend engaged in physical activity.

This may be particularly true for men partnered with women, as women may not stand in as suitable sporting peers given notions about the inferiority of women's athletic ability and because of gender socialization women may be less interested in sports (Messner 2002).

The finding that women may exercise less upon entering an intimate relationship due to negative health habit diffusion from their male partner also reveals the importance of a gender-as-relational perspective. Research suggests that in straight relationships men are more likely to shape women's health behaviors in health-detering ways, than vice versa (Reczek 2012). Successful performances of femininity rest on accommodation to others (Connell 1987) and research suggests that women are more likely to sacrifice their health for the needs and desires of others (Martin and Lippert 2012). Thus, women who were active prior to relationship formation may be less likely than men to continue to exercise if their partner has an inactive lifestyle. Further, research suggests that women often feel like they have no entitlement to personal, leisure time (Henderson and Dialeschki 1991) and this may be particularly true in intimate relationships. Further, in performing masculinity men often engage in unhealthy habits (Courtenay 2000; Reczek and Umberson 2012) and these performances of masculinity appear to operate in tandem with women's performances of femininity (i.e., accommodation) to shape gendered processes around diffusion and exercise.

Stress related to relationship formation may also lead to a decline in women's exercise levels. Thus, relationship quality likely moderates the relationship between relationship transitions and exercise habits. Relationship quality is a key factor

moderating the association between relationships and health (Jaremka et al. 2013). However, research on relationships and health behaviors has less often considered the impact of relationship quality. This study suggests that stress from low-quality relationships are deleterious for exercise and this may be especially true for women because they are often responsible for the bulk of household and emotional labor within heterosexual unions (Erickson 2005; Lennon and Rosenfield 1994) or it may be that relationship stress affects women in more adverse ways. Research suggests that women are kin keepers who attempt to “work” on relationships (Erickson 2005; Gerstel 1988) and as a result they may feel especially stressed if that work is not effective and their male partner is not reciprocating (which may be likely given the feminized nature of such labor). Thus, men’s masculinity performances (i.e., avoiding feminized work) may operate alongside women’s femininity performances (i.e., engaging in emotion work) to explain the gendered ways that stress upon relationship formation shapes exercise habits.

Although gendered patterns were not observed for relationship dissolution processes, understanding these processes contributes to a greater understanding of how relationship dissolution shapes exercise levels and can be used to inform intervention efforts around exercise. Further, the lack of gendered patterns bolsters the claim that it is the relational nature of gender within intimate relationships that is particularly important for exercise habits. Respondents reported three key processes through which relationship dissolution positively shaped their exercise habits: a desire to be attractive to find another partner, as a means to cope with distress related to relationship dissolution, and a newfound focus on the self that at times led to an increase in personal control. Concern

with appearance is an understudied and under-theorized process linking relationships and health behaviors but it is clear from previous research that body image concerns do motivate individuals to exercise and eat right (Ross and Wu 1995). The finding that appearance-related concerns motivate exercise upon relationship dissolution is important for future research on relationship transitions and health.

Another key finding is that the loss of social control, upon relationship dissolution, may result in greater personal control and focus on one's health. Social ties are important for personal control and they may either enhance or deter an individuals' sense of control over their health (Mirowsky and Ross 2003; Umberson et al. 2010). However previous research has not revealed that relationship dissolution may lead to enhanced personal control over health, although this finding may help to explain in part why divorced individuals often exercise more than the continuously married (Eng et al. 2005). Future research should explore the role of this process in relationship dissolution and health behavior change.

Relationship dissolution negatively shaped individuals' exercise habits through three processes: the loss of social control and social support, distress, and the loss of resources that facilitated exercise. Psychological distress from relationship dissolution led to decreased levels of exercise for some individuals, but others increased their levels of exercise in order to cope with distress. This is an important finding that reveals the complex relationship between mental health and exercise. Although distressed people may be less likely to exercise, exercise has a positive effect on mental health and may be a way to cope with distress. More research is needed to understand if certain social and

personal characteristics distinguish individuals who reduce their exercise upon experiencing distress from relationship dissolution from individuals who use exercise as a means to cope with distress.

Limitations

There are some limitations of this research and these limitations suggest avenues for future research. First, given the small sample size and non-representativeness of the sample, the findings on gendered patterns must not be interpreted as generalizable. Future quantitative research should develop measures to tap the processes identified here and use nationally representative data to test if the gendered patterns identified in this research exist at the population level. Another important limitation is that although this sample included an equal number of white and black respondents, given the small sample size no distinguishable racial patterns emerged. However, this does not necessarily mean that race/ethnicity does not shape the gendered processes through which relationship transitions shape exercise patterns and future research should examine this question with racially and ethnically diverse samples. Finally this sample was composed predominately (although not exclusively) of heterosexual individuals. Thus, in analyzing gendered patterns I focused on the relational context of male-female relationships. Given research that the relational context of same-sex relationships (i.e., man and man, woman and woman) shapes the performance of gender within relationships (Goldberg 2013; Reczek and Umberson 2012), the gendered processes linking relationship transitions and exercise likely differ for gay and lesbian individuals. This is an important avenue for future research.

CONCLUSION

This research adds to a greater empirical understanding of the processes linking relationship transitions and changes in exercise patterns. Findings further suggest that gender performances *within* relational contexts, whereby men and women perform masculinity and femininity in relation to one another, are particularly important for understanding the link between relationship transitions and changes in exercise and other health habits. This is an important theoretical and empirical finding for research on gender and health. Future research should continue to examine how gendered relational contexts shape the processes linking relationship transitions and health behavior change and further extend this work to examine how these processes may differ for different gendered relational contexts (e.g., men entering unions with men, women entering unions with women) and for different health habits.

Article 3: Exercise as a Body Project at the Intersection of Gender, Age, and Race

ABSTRACT

Individuals are often motivated to exercise by a desire to align their bodily appearance with culturally ideal bodies — that is as part of a body project. Yet we know little about what this looks like for different social groups. This study analyzes 40 in-depth interviews to examine how individuals talk about exercise and bodily appearance and how in doing so they construct meanings around gender, age, race, and the body. Results suggest that gender, race, and age shape how individuals talk about body projects around exercise. For example, some midlife women discuss the difficulty that aging poses to weight loss and construct the aging female body as unruly and not amenable to exercise as a body project, while some midlife black respondents note that aging imposes limits on how thin they would like to be via exercise and construct alternative body projects rooted in an acceptance of larger, older bodies.

Exercise is one of the most important behavioral predictors of health and well-being (Shaw et al. 2010), yet many individuals do not engage in exercise solely, or even primarily, for health reasons (Allender, Cowburn and Foster 2006; Furnham, Badman and Sneade 2002). Rather, body image concerns — defined as “the product of the individual’s perceptions and internalization of the cultural body ideal, individual body ideal, current body image, and actual body shape” (Myers and Biocca 1992, as cited by Hurd Clarke, Griffin, and the PACC Research Team 2008: 1085) — motivate many individuals to exercise and this often occurs in gendered ways: women are primarily motivated to exercise by a desire to be thin, whereas men tend to be motivated to exercise by a desire to gain muscle mass and/or to lose body fat in an attempt to achieve a v-shaped body ideal (Allender et al. 2006; Furnham et al. 2002). Previous research, however, has not investigated if these gendered motivations for exercise may differ for different groups of men and women.

To address this gap the current study synthesizes critical perspectives on gender, race, and age to frame an analysis of 40 in-depth interviews with a middle-class, early adulthood to midlife sample of 10 black men, 10 black women, 10 white men, and 10 white women. I utilize an intersectional lens (Choo and Ferree 2010; Collins 2000) to develop a richer understanding of the ways in which body image concerns motivate individuals to exercise by examining if gender, race, and age — as both social-structural locations and systems of meaning — intersect to shape discourses around exercise and body image. The following questions are addressed: 1) What are the different ways in which a middle-class, young adult to midlife sample of black and white men and women

talk about body image concerns as a motivation for exercise and 2) In doing so how do they construct, reproduce, and/or challenge cultural meanings around gender, race, age and the body?

THEORETICAL FRAMEWORK

Theoretical work on gender emphasizes that individuals perform gender in response to cultural ideals of masculinity and femininity (Connell 1995; West and Zimmerman 1987) and that the body is an integral part of performing gender. Through our bodies we construct, reconstruct, and sometimes disrupt cultural ideas about gender (Connell 1995; Martin 1998). Scholars working from a critical race perspective have also emphasized the importance of the body in ideological conceptions of race and racial difference, as well as the ways in which individuals use and mold their bodies in ways that both reproduce and disrupt these ideologies (Carrington 2010; hooks 1994). Further, there has also been a recent turn in gerontology to emphasize the importance of the aging body and issues of embodiment in relation to aging and ageism (Calasanti and Slevin 2006; Lodge and Umberson 2012; 2013; Slevin 2010). While this work is theoretically rich, few empirical studies have examined individuals' embodied experiences or how individuals construct, reproduce and/or challenge systems of meanings around gender, race, age, and bodies (Calasanti and Slevin, 2001; Hurd Clarke and Korotchenko 2011).

At the same time, sociological work on health behaviors — particularly research on exercise — has largely ignored the body and issues of embodiment, despite the fact that health behaviors are quite literally performed in service of the body. Further, although research in psychology has focused on body image concerns as a motivator for

exercise, this work rarely incorporates sociological theory on the body and tends to focus on adolescents and young adults, ignoring the ways in which the aging body and cultural meanings around aging bodies may shape motivations, meanings, and practices around bodily appearance and exercise (Hurd Clarke and Korotchenko 2011; Reel et al. 2008). Thus, in this paper I merge critical perspectives on gender, race, age, and the body to examine how individuals' conceptions of their bodily appearance, as socially and culturally constituted, shape how individuals talk about body image and exercise and how this varies at the intersection of gender, race, and age — as both social-structural locations and cultural systems of meaning. Further, I examine how these discourses around body image and exercise reproduce and/or challenge ideologies around gender, age, race, and the body. In doing so, this paper provides a new way of thinking about how the body and embodiment matter in relation to health behaviors, such as exercise.

Exercise as a Gendered Body Project

Sociologists of the body argue that in contemporary Western societies, the body is now a “project,” that is something that *must* be constantly worked on as well as something through which individuals craft a sense of identity and social and moral worth (Giddens 1991; Gill, Henwood, and McLean 2005; Orbach 2009; Shilling 2012). Orbach (2009), for example, writes: “we are encouraged to see the body as a place of personal accountability and truth. [...] Bodies become our personal missions to tame, extend, and perfect” (31). A key aspect of “body projects” is that they are gendered, meaning that in constructing gendered identities, individuals engage in body projects in an attempt to align their bodies with culturally idealized masculine and feminine bodies (Connell 1995;

Lorber and Martin 2011). Exercise can thus be considered a gendered body project (Lorber and Martin 2011) in that many individuals engage in exercise in order to obtain culturally ideal feminine (i.e., very thin) and masculine (i.e., trim and muscular) bodies (Allender et al. 2006). This may be especially true in recent decades, due both to the rise of a fitness culture in the 1970s and 1980s as well as the fact that cultural and personal body ideals have become increasingly muscular for men (Pope et al. 1999) and thin for women (Rubinstein and Caballero 2000).

In addition to the fact that men and women exercise for different, or gendered ends (i.e. very thin vs. lean and muscular bodies), men and women may talk about body image concerns and exercise in other gendered ways. Notably, appearance is more important for women's social worth (Jones and Pugh 2005; Slevin 2010) and self-esteem (Furnham et al. 2002) and women may be more vigilant than men about the need to engage in exercise as part of a gendered body project. Indeed, some studies find that men, particularly white heterosexual men, are more concerned with the *functionality*, rather than the appearance, of their bodies (Hurd Clarke et al. 2008; Slevin 2010). However, evidence also suggests that recent cohorts of men are increasingly preoccupied with their bodily appearance due to an increase in the commodification and sexualization of the male body (Grogan and Richards 2002), and that men are just as likely as women to say that they are motivated to exercise for appearance-related concerns (Strelan and Hargreaves 2005). However, we cannot assume that body image concerns shape motivations and practices around exercise for all men and women in the same way, as other social locations may intersect with gender to shape how they do so.

Importantly, the ways in which exercise operates as a gendered body project may shift from young adulthood to midlife. Most existing research on body image and exercise focuses on young adults (Hurd Clarke and Korotchenko 2011; Reel et al. 2008) and has failed to examine how appearance-related concerns may serve as a motivator for exercise in different ways over time *within individuals*. A life course perspective, however, emphasizes the dynamism of individual lives (Elder and Shanahan 2006) and suggests that the ways in which body image concerns motivate exercise likely differ in young adulthood and midlife. For example, the appearance of the aging body may become a motivator for exercise in midlife, given that midlife bodies are generally considered less attractive than young bodies and that ideal feminine and masculine bodies are based on youthful bodies (Calasanti and Slevin 2001; 2006; Slevin 2010). Indeed, consumerist discourses implore mid- to later life individuals to “manage” the appearance, health, and functionality of their aging bodies through a variety of individualistic, consumptive practices, including health and fitness regimes, the use of cosmetics, plastic surgery, and prescription drug use (Katz and Marshall 2003). These discourses, which target ever-younger individuals may create anxiety in midlife individuals and implore them to exercise to avoid “looking old.” Alternatively, midlife individuals may view their bodies as already outside the realm of acceptable, ideal bodies and thus craft alternative discourses around exercise, not grounded in the appearance of the body (e.g., they may articulate a discourse of exercise for health). Or, midlife respondents may attempt to disrupt ageist discourses around the body by articulating a discourse of the aging body as

attractive and not in need of alteration. Indeed, some research suggests that aging is protective of body image shame and disturbances (Greenleaf 2005).

A great deal of previous research suggests that the *appearance* of the aging body is more problematic for women than men (Hurd Clarke and Korotchenko 2011; Lodge and Umberson, 2012; Slevin 2010). While very little research exists on mid- to later life men's body image concerns, one study found that while women were motivated to exercise out of a desire to avoid *looking* old, men exercised in large part to avoid *feeling* old (Slevin 2010). This limited research suggests that motivations and practices around exercise as a body project will differ by social locations of gender and age and may either reproduce or disrupt ageist and sexist meanings around the body.

Race, Body Image, and Exercise

A large body of literature has assessed black-white differences in body image ideals and body satisfaction and in general this literature suggests that blacks have both larger body ideals than whites (Aruguete, Nickleberry, and Yates 2004; Hesse-Biber et al. 2004; Thompson, Sargent, and Kemper 1996) and are more satisfied with their body size and shape than whites (Hebl, King, and Lin 2004; Stevens et al. 2004), although research further suggests that a great deal of heterogeneity exists within these groups based on social class differences (McLaren and Kuh 2004; Snooks and Hall 2002) and differences in racial identity (Hesse-Biber 2010). In contrast to the large body of research on racial differences in body image we know little about how blacks and whites, as differentially located in a racial stratification system, may talk differently about body image concerns as a motivation for exercise, nor how in doing so they may construct notions around race

and the body. Further, it remains unclear how gender and age may intersect with race to shape these processes, although previous empirical and theoretical work on race and the body provide some possibilities.

Previous research suggests that black boys and men prefer more muscular physiques than white boys and men (Aruguete, Nickleberry and Yates 2004; Thompson et al. 1996) and black girls and women prefer normal weight bodies, while white girls and women prefer underweight bodies (Flynn and Fitzgibbon 1998; Hesse-Biber et al. 2004; Thompson, Corwin, and Sargent 1997). From a critical race perspective, blacks' gendered bodily ideals may stem from a desire to disrupt racism and racist ideologies. For example, scholars have argued that black men prefer more muscular bodies because they have, on average, less access to institutional power than white men and because real manhood has been defined in relation to whiteness (Connell 1995), such that some black men may feel a need to literally reassert their hardness (i.e., their masculinity) through their bodies (hooks 1994). As a result, black men may be more likely than white men to describe being motivated to exercise out of a desire to have very muscular bodies. Further, given that middle-class, able-bodied white male bodies are *the* culturally ideal bodies, white men may construct their bodies as already acceptable in appearance, even in midlife. Alternatively, the aging of the body may change men's body projects vis-à-vis exercise in different ways based on social locations of race — for example, the appearance of the aging body may be more salient for white men as it may represent a disruption of their embodied hegemonic status. However, given that black men are more body image conscious than white men (Calasanti and Slevin, 2001) and large muscular

bodies may be a means of disrupting racist ideologies (hooks 1994), midlife black men may be more likely than midlife white men to describe exercising for the purpose of maintaining or achieving a muscular, youthful appearance.

Black women have historically encountered racist ideologies that they are not “real” women or not appropriately feminine (Brown 2011; Collins 2000). Thus if black women do have larger body ideals than white women and are more likely to eschew the underweight, more angular body ideal of many white women (Flynn and Fitzgibbon 1998), this may stem from a desire to embody femininity vis-à-vis having curves. In turn, this may shape how women, differently positioned by race, talk about body image concerns as a motivator for exercise. For example, black women may be less likely to describe exercising fanatically in response to body image concerns and may craft alternative body projects grounded in a greater acceptance of larger bodies.

Limited research on mid and later life women suggest that body image concerns motivate both mid- to later life black and white women to exercise (Reel et al. 2008; Stevens et al. 1994). However, black and white midlife women may construct different meanings around exercise as a body project and in doing so disrupt or reproduce ideologies around race, gender, age, and the body. On the other hand, the social class homogeneity of this middle-class sample may mean that black and white men and women talk about body image concerns and exercise in similar ways. Taken together, we know little about how different social groups talk about body image concerns and exercise. Thus, the present study informs an understanding of how gender, race, and age as social locations intersect to shape how a sample of middle-class, young adult to midlife

individuals talk about body image concerns and exercise. Further, I examine how, in doing, so they construct meanings around gender, age, race and the body.

DATA AND METHODS

Data from this study come from the Relationships and Health Habits Study, a retrospective in-depth interview study designed to assess how social ties shape health behaviors over the life course. Retrospective data were used to examine how social ties impacted respondents' health behaviors over time — an examination of within person change. Further, there was considerable age variation within the analytical sample (respondents ranged in age from 25 to 65) in order to assess age differences. Respondents were asked a series of open-ended questions related to social relationships and health behaviors over the life course, particularly those related to exercise habits, body weight, eating habits, and alcohol consumption. Data related to exercise patterns and body weight were analyzed in particular depth for the current study. Interviews took place from 2008 to 2009 in a large, Southwestern city in the United States. Interviews lasted roughly one and a half hours and were conducted in private locations chosen by respondents.

Respondents were recruited through various methods including snowball sampling methods, flyers to local organizations (e.g., African American Chamber of Commerce), and postings on listservs. The analytical sample consists of 10 white men (mean age=47), 10 white women (mean age=45), 10 black men (mean age=46) and 10 black women (mean age=46)⁵. Mean household income was \$46,875. Respondents were

⁵ 20 later life respondents were eliminated from the current analysis because too few later life adults in this sample discussed body image concerns as a motivation for exercise.

on average highly educated: 2/3rds of the sample had at least a college degree. Highly educated and middle to upper-middle class individuals tend to be overrepresented in in-depth interview studies, given that social class advantages produce more freedom and autonomy over individuals' schedules (Cannon, Higginbotham and Leung 1988). Thirty-seven respondents were employed full or part-time, one respondent was retired, one respondent was unemployed, and one was receiving disability payments. Ten respondents were married, eighteen were divorced, eleven were never married, and one was widowed.

Narrative constructionism (Sparkes and Smith 2008) informed my analytical approach to the data. I conceived of respondents' narratives of body image and exercise as not only reflecting their positionality in society in terms of gender, race, and age but as further reflective of the broader social-structural and cultural context (Phoenix and Sparkes 2008; Sparkes and Smith 2008). Therefore, respondents' narratives around the body and exercise were analyzed in relation to larger social-structural inequalities and cultural systems of meaning surrounding gender, race, age, and bodies.

RESULTS

Body Maintenance

Women in this sample described exercising to *maintain* the appearance of their body. For young women this centered on maintaining a *thin* body but some midlife women exercised to maintain a *youthful-looking* body. Thus, exercise as a feminine body project shifted for some women over the life course as they aged into midlife.

Maintaining a Thin Body

Women described exercising to *maintain* a thin figure or exercising to lose weight when they were already thin. For example, Kathy (30, white) said that she runs to maintain her weight: “I even did it when I started [running] but now I mostly do it just to...keep in shape and be able to eat what I want to eat and feel like I’m not gaining too much weight.” And although she considered herself to be thin, she reported being motivated to continue to exercise by even thinner actresses:

For a long time we didn’t have a scale. Then...we get a scale and I get obsessed with the scale and I put it away and I won’t get it out anymore. So I do have that...women in society...it’s hard...Even though I know I’m reasonably thin you see the actors or whoever. They have those really flat tummies. I’m like I want to be like that even though it’s really not reasonable. I know that intellectually but still. So it is definitely a sign of perfection.

Similarly, Naomi (26, white) described how she exercises in part because she is afraid she could gain weight in the future:

My mother gained a lot of weight after she had me and my sister...and that kind of worries me in that I know these days I have the ability to gain weight, so I have to work really hard at it. I think, with her genes that I have the ability to take after her...I used to be like no hips and now after grad school I gained childbearing hips and now I work out a lot.

Additionally, after a break-up Naomi described how she began to exercise compulsively to “look better” even though she described herself as already thin:

After we broke up, I was working out unhealthy, I would work out every single day and wouldn't eat very much and I remember there were times when...my legs gave out...I don't know if subconsciously I wanted to look better...I was doing the [alcohol distributing] stuff so I had to go downtown in a skimpy outfit...I wanted to look good and I wanted to go out and impress people and go find another mate.

Mary (43, black) also described exercising compulsively in her teens and twenties out of a fear she would become overweight:

I did tons of aerobics because I was always afraid that I was going to have a weight problem. I think it's because my thighs have always been big...my grandmother on my dad's side...she was heavy. And I was like, "oh my god." And my aunt on my dad's side was a little thick, a little chunky. And people would say "oh you're built just like your aunt." And I'm like, "no!" ...so that would freak me out.... I remember doing aerobics four times a day. Just working out and just eating very little. Just worried about the weight thing.

Feminine body projects for the young and midlife black and white middle-class women in this sample thus involved hyper-vigilance to the possibility of falling outside frame of acceptable feminine — that is thin — bodies. That this was true regardless of race, speaks to the importance of social class in body image ideals (Snooks and Hall 2004). Middle-class women, regardless of race, are more likely to favor underweight bodies and to be dissatisfied with their bodies than lower socioeconomic status women (McLaren and Kuh 2004; Snooks and Hall 2002).

Maintaining a Youthful, Thin Body.

For some midlife women the appearance of the *aging* body and the desire to maintain a youthful appearance was a motivator for exercise. This suggests that if we take a life course view of gendered body projects that age is key to understanding feminine body projects. Women reported exercising not only to maintain thin bodies, but also to maintain *youthful* bodies. For example, Kimberly (51, white) described how she exercises more as she has aged:

As I got older, I started to exercise more and be much more conscious. I don't like looking in the mirror and seeing my knees drooping and....this happened...it's funny...I remember looking in the mirror and not really recognizing myself...and thinking, wow, I'm almost 50. This is craziness. What happened? You know, where did it go?! Where's that 30...I'm stuck at 33 in my head. So... I started to be more conscious and I wanted to exercise.

Patty (60, white) also noted that the appearance of her aging body motivates her to exercise:

It's this weight down here, that what you sit on is where I still feel like it looks bad. Maybe I only weigh 122 but I don't like the way it looks...it can look better...I don't like to look flabby and...old...I'm having a big problem with the big...60 thing nowadays.

Although Patty reported that her aging body motivates her to exercise, she has not been exercising regularly lately because she said that her body also makes her self-conscious about exercising in front of others:

The one [gym] that's at my complex...I've never been to because...I don't have any appropriate clothes for doing something like that...And I'm old. I'm not but... in certain ways I am, and look at...flabby skin. And that makes me kind of self-conscious.

Non-youthful bodies, particularly older women's bodies, are culturally deemed unattractive (Calasanti and Slevin 2006; Slevin 2010) and this may explain why some women in this sample exercise to combat the feeling that their bodies appear "old" and thus unattractive. This finding, however, suggests that exercise as a feminine body project is based not only on maintaining or achieving thin bodies, but also youthful, thin bodies.

Body Transformation

The young and midlife black and white men in this sample said that they exercised in order to achieve or maintain muscular, trim bodies. For some men this meant losing weight, while for other men this meant gaining weight in order to achieve a hard, masculine ideal. In this way, men describe exercising as a part of a gendered body project. Theory and research on gender and embodiment suggest that larger, muscular bodies signal masculine power and strength (Bridges 2009). However, these larger bodies must be hard rather than soft, such that men often exercise out of a desire to reduce body fat, while increasing muscle mass (Bridges 2009). Thus, men in this sample exercised for weight loss when they considered themselves overweight. For example, Mitch (48, white) described how he was motivated to exercise when he gained weight and didn't like the way he looked:

I got tired of my clothes not fitting very well...and then...I just decided that it becomes more of a priority... I would look in the mirror every morning and I would see extra weight on my stomach and...around the sides of my stomach, love handles. I would say I don't like what I see. That image of having a fat stomach in the morning I would try to remember when it came time to have lunch not to eat so much...and, also, running, long distance running can help take weight off. If you just run your upper body tends to shrink.

Bigger is Better?

Masculine body projects often involved exercising out of a desire to lose weight, but these were often accompanied by exercising to increase musculature — that is to have larger, more powerful bodies. For example, Terry (41, black) who regularly lifts weights, described his motivation for exercise:

To me, I think I look better when I'm larger, but that can be the mindset of people that actually tend to think the body is better the more mass it has...some people say "hey, you stop lifting...no need to gain anymore. You're good where you are." I will be saying, "I want to gain a couple more pounds and I want to reach this goal right here."

Terry further described how he is invested in obtaining a larger body, despite the fact that the women he dates often comment on the fact that he is large enough already:

I said, "well, I want to gain some more." They're like "oh, no, you don't need to gain more, you're fine where you're at. You shouldn't get any bigger than that." I hear that quite a bit, "okay, you're big enough now, just let it go."

Billy (52, black) was also motivated to engage in regular exercise because he would like to gain more muscle mass:

When I came out of the Marine Corps I was real cut, had definition. I want to go back to the gym so I could do that same thing again. Get a little muscle. One time I was bodybuilding so I did get larger, much larger...I...worked out with weights and had trainers.

Kevin (36, white) also described exercising to build up muscle mass, but also noted that he had no desire to be “like Schwarzenegger”:

Actually, I was 155 [pounds] when Jill and I started dating...then she started exercising and I started exercising with her and I figured it was a good time to...I had always thought I was a little too thin so I tried to balance the weight so I ate a little bit more and I exercised in a combination to hopefully put on muscle mass. That put me up to about 175 [pounds]... I've always thought I was kind of skinny, sort of slim. I always wanted to be a little more muscular, a little more toned. I didn't want to be like Schwarzenegger but a little more toned...Since I've been doing mostly exercise, I felt like it was a good mixture. I liked having a little extra weight. It made me feel a little bit more solid but not too solid.

Although Kevin reported that he was motivated to start exercising regularly to build muscle mass, he also emphasized that he was “not too solid.”

Similarly, Rick (30, white) described regularly lifting weights in an attempt to gain muscle mass, which was motivated in part by the desire to look good: “I...didn't have a girlfriend, so I knew I needed another one, so I was going to have to exercise to

get back in shape.” Rick, like Kevin, however, noted that he was not motivated by the desire to be very large: “not necessarily weightlifting to get huge, just to do something, to be active” and “[I’m] obviously not going to be...Arnold [Schwarzenegger] with my type of build.”

Thus, while both black and white men were motivated to exercise to obtain larger, more muscular bodies, some white men further emphasized that there was a limit to how muscular they wished to be. That is not, of course, to say that black men didn’t have a limit to how large they wanted their bodies to be only that this didn’t emerge unprompted in the interviews, as it did in the case of some white men. This suggests that masculine body projects may rely on conceptions of race and racial difference. While both white and black men are motivated to exercise out of a desire to obtain larger, more muscular bodies, young to midlife middle-class able-bodied white men embody a hegemonic masculine ideal. This affords them the luxury of not having to be “too large,” as they are able to draw upon their privilege. Further, these white men are discursively defining the white male body as only needing minor transformation — that is that they define their body as largely acceptable prior to bodily intervention. At the same time, however, the fact that they are heavily invested in masculine body projects illustrates the extent to which embodiment is key to hegemonic gender relations. Black men in this sample, in contrast, although privileged by class, age, sexuality, and gender, are disadvantaged by race. Gender and race scholars emphasize that because hegemonic masculinity has been constructed in relation to whiteness (Connell 1995), achieving masculinity vis-à-vis hard, large bodies may be more imperative for black men (hooks 1994). This may help to

explain why middle-class white men in this sample emphasized limits to their desired muscularity, whereas middle-class black men did not. Further, that this preference is not simply shaped only cultural body ideals — but likely also very racial real differences in power — is also clear in Terry’s account, whereby he demonstrates that his dating partners do not desire the very large body that he desires.

The Aging (Female) Body and Body Transformation Difficulties

Several midlife women in this sample discussed the difficulty they had with weight loss via exercise as they have aged. In doing so they advanced a discourse of the aging (female) body as unruly, difficult to control and not amenable to exercise as a body project. For example, Dionna (55, black) described how aging has made it harder to lose weight via exercise:

The times that I have been successful [at losing weight]...was when I was eager to go to the gym everyday...I lost weight well. But then I was younger...is that going to work now in my 50s? It doesn’t seem to work now. And I’m like, “what is different?” My body is changing. In my early 30s I was able to go to the gym... I lost weight. It was easy.

Dionna defined her aging, midlife body in direct contrast to her body in young adulthood, which was framed as easily malleable and receptive to exercise as a body project. In this way, she frames the aging female body as unruly.

Karen (42, black) also said that aging made weight loss via exercise more difficult:

It [aging] makes it harder to lose it...back then...walking and walking...you immediately saw the results...and then you have a slip and then five, ten pounds. It was like, “okay. You just let me cut back here and walk a little further. You can get back.” And now you can go a week...oh, you lost a pound. Getting older it’s a lot harder to lose it. And that is very discouraging.

Karen, thus, also advances a discourse of the aging female body as unruly and not amenable to exercise as a body project.

The Aging Body and Limits to Body Transformation

The final subtheme that emerged was that for some midlife black respondents aging meant that there were limits to how thin they wanted to be. While they desired to transform their bodies through exercise, they also drew on understandings of the aging body as mature to place limits on their desired body transformation. For example, Mary (43, black) who was quoted earlier and noted that in her twenties she exercised compulsively to avoid gaining weight later reported that aging has changed this:

Now I’m just like it is what it is...I guess once you get in the forties you’re like whatever... I got big thighs. Like it or leave it... And I always thought oh, if I could just lose twenty pounds then I would like my look better. At this age I firmly believe that at a certain age you don’t need to be so thin because it makes you look sick.

Mary frames her greater acceptance of her body and the fact that she no longer feels compelled to compulsively exercise to maintain a thin body, as stemming from aging. For Mary, aging signals a reversal of cultural feminine body ideals, whereby thin bodies are

no longer ideal but rather, appear sickly. Aging therefore is a means by which Mary is able to advance a counter-discourse of the ideal feminine body. Further, she does not demean the appearance of the aging body per se, but rather asserts that aging imposes counter-ideals and logics for the body, whereby too thin bodies in midlife are less than ideal. In this way, Mary makes space for a greater acceptability of larger, aging bodies while also defining some aging bodies as unacceptable (i.e., thin aging bodies).

Similarly, Jennifer (35, black) noted that she is unhappy with her weight, both due to health and appearance-related concerns, and that this motivates her to exercise:

My weight makes me more likely to exercise...I hate the way I look naked...I don't like the way my stomach looks. I can't...keep buying clothes because I can't fit the ones I could fit last summer. Those are things that make me want to lose weight. I get short of breath a lot faster now...So that contributed to my wanting to lose weight.

At the same time, however, Jennifer emphasized that she doesn't want to be "too skinny" and that she finds value in her appearance, despite not being as thin as she would like to be:

When I was in high school I thought I was heavy. I kept thinking I need to lose weight...But then I saw a picture of me and I was like "damn, I was that skinny"...I don't think I want to be that skinny...a size three. A hundred and ten pounds. I don't want to be that skinny... now I'm over two hundred pounds. I was like I cannot believe that...now I would like to be down to...one fifty, one sixty. I want to be healthy because I kind of like my weight a little bit. Okay. I'm kind of

vain. I like my big thighs and I like my big breasts. And I'm afraid I'm going to lose all that. That looks good on a woman. I don't want to be too skinny and I don't want to be obese. I want to be fine.

Jennifer implicitly draws on conceptions of age and aging as she contrasts her experience as a midlife “woman” who would like to retain womanly curves with her experience as a high school “girl” who was very thin and yet worried she was overweight. Jennifer thus frames her older body as acceptable at a higher weight than her younger body.

Similarly, Timothy (36, black) said:

Now...sometimes I exercise and sometimes I don't...[my wife and I are] gaining a little more weight. But it's also giving us a little more character. We were both really thin in college because we were always walking here or walking there... I don't like to see my bones in certain areas like I did before. I would look in the mirror, sometimes I could see my ribs.

The notion of “more character” implicitly relies on notions of aging and maturity and Timothy contrasts his midlife body as more acceptable at a heavier weight. Culturally ideal masculine and feminine bodies are not only white but also youthful. Midlife black respondents who are neither white nor youthful may craft alternative gendered body ideals and body projects that are grounded in greater acceptance of both larger and older bodies. This also reflect a greater acceptance of aging and respect for elders in the black community as well as cultural discourses that associate aging with weight gain.

DISCUSSION

Findings from the current study suggest that the ways in which individuals talk about body image concerns as a motivation for exercise depend on their social locations in intersecting structures of gender, race and age. Further, in talking about body image concerns and exercise respondents construct meanings around gender, age, and race. At times these meanings reproduce hegemonic ideologies, while at other times they disrupt these ideologies. This research adds to a greater understanding of how exercise is a body project — that is a way through which individuals craft identities based on gender, race, and age and in doing so reproduce, but also sometimes contest, dominant ideologies about gender, race, age, and appropriate and ideal bodies.

Exercising for the purpose of *maintaining* the appearance of the body appears to be something that women primarily do. Scholars have long argued that women's social worth is more dependent on their appearance than men's (Jones and Pugh 2005; Slevin 2010) and this might explain why several women in this sample were hyper-vigilant about the possibility of their bodies falling outside the frame of feminine acceptability, in terms of both weight and a youthful appearance. Findings further emphasize the importance of taking a life course perspective, as exercise as a form of body maintenance shifts for some women as they age into midlife in that they begin to exercise not just to maintain a thin body but a *youthful and thin* body. These differences in feminine body projects illustrate how gender and age intersect to shape exercise motivations and practices. Non-youthful bodies, particularly older women's bodies, are culturally deemed unattractive (Calasanti and Slevin 2006; Slevin 2010) and this may explain why some

women in this sample exercise to combat the feeling that their bodies appear “old” and thus unattractive. Aging women may experience both age-related and weight-related assaults to their gendered identities, which they attempt to mediate through exercise. While feminist analyses rarely examine issues of age, ageism, and the aging body (Calsanti and Slevin, 2001; 2006), doing so is important for a fuller understanding of how gender inequality operates and is sustained across the life course.

Findings on the importance of *maintaining* thin bodies for feminine body projects can be further linked to gendered power relations in terms of the fact that ideal feminine bodies have become thinner (and thus stricter) in recent decades (Rubinstein and Caballero 2000), which is possibly a pushback to the strides women have made in other social, political, and economic realms (Wolf 2002). Not only are thinner body ideals harder to attain and body image dissatisfaction linked to low self-esteem and depression (Franko and Striegel-Moore 2002; Furnham et al. 2002), but whereas feminine body ideals are the embodiment of fragility and submission (Bordo 1993), large, hard, muscular bodies signal masculine power (Bridges 2009) and for many men in this sample masculine body projects center around the achievement of trim, yet muscular bodies through exercise.

For the middle-class men in this sample, racial differences were salient in that white men drew upon hegemonic masculine privilege to rhetorically claim that they did not need to be too muscular. As men privileged based on race, class, age, sexuality and ability, they are afforded the privilege of not needing to embody hyper-masculinity. In contrast, some black middle-class men in this sample attempted to embody a hyper-

masculine ideal, despite feedback from partners that they were already muscular enough. This illustrates how gender and race intersect to shape masculine body projects around levels of muscularity. From a critical race perspective, these differences may stem from the fact that white men have on average more institutional power than black men and therefore may have less of a need to assert their bodily strength. That is, because black men are oppressed *as men*, they may wish to reassert their hardness — in embodied ways — to counter racial subjugation (hooks 1994). Conversely, because white men have not faced threats to their manhood vis-à-vis racial subjugation, their bodies do not need to look “like Schwarzenegger’s.” In this way, white men construct meanings around white male bodies as in need of little “body work.” Said otherwise, in engaging in exercise as a body project white men rely on a discourse of the white male body as needing little modification.

For some midlife women the aging body presented a challenge to weight loss vis-à-vis exercise. While weight loss via exercise was framed as largely effortless when they were young adults, midlife bodies were framed as not amenable to these body projects. In this way, midlife women constructed the aging female body as unruly and unmanageable. Previous theoretical work suggests that some bodies have been deemed unruly in Western societies — particularly female and non-white bodies (Bordo 1993). At the same time, aging bodies have been historically constructed as physically declining beyond individuals control (Gullette 1998), although more recent consumerist discourses emphasize that individuals have a moral responsibility to prevent aging (framed as physical decline) (Katz and Marshall 2003). Taken together, these findings suggest that

some midlife women frame the midlife body as unruly and declining in terms of responsiveness to exercise as a body project. On the other hand, these midlife women may provide a counter-discourse to consumerist discourses that midlife individuals can and should prevent or reverse aging.

For some midlife black respondents in this sample the aging body led to limits to their desired weight loss via exercise. Although they described being motivated to exercise by a desire to lose weight, they rejected doing so to obtain very thin bodies. Further, this rejection was framed in contrast to their younger selves who were motivated to exercise in order to obtain very thin bodies. In doing so they relied on notions of aging and maturity to advance a discourse of greater acceptability of larger, older bodies. This suggests that some respondents may challenge ideologies about the unacceptability of larger, older, and non-white bodies.

Taken together this research advances an understanding of the diverse ways that individuals engage in exercise as a body project. While previous research assumes that women are driven to exercise to achieve thin bodies and men are driven to exercise to achieve a v-shaped, muscular ideal, previous research has not considered how the ways in which individuals “do” and talk about exercise as a body project may vary for different groups of men and women. This research not only contributes to a greater understanding of how gender, race, and age — as both social-structural locations and cultural systems of meaning — shape how individuals conceive of exercise as a body project, but it further contributes to a greater theoretical understanding of how individuals construct meanings around the body that at times challenge but at other times reproduce ideologies about

gender, race, age, and the body. Notions of the ideal feminine body as both thin and youthful and the ideal masculine body as muscular reproduce hegemonic gender discourses, while understandings of the female, aging body as unruly reproduce ageist discourses that the midlife body is inferior to young bodies. However, notions of heavier, aging bodies as acceptable and in fact superior to thin, aging bodies challenge notions of culturally ideal feminine and masculine bodies. Through body projects then individuals sometimes reproduce but at other times contest dominant ideologies about age, gender, race, and the body.

While this research focused on gender, race, and age differences, the sample was very homogenous in terms of social class in that the sample was overwhelmingly middle-class and had above-average levels of education. This likely shaped the results given that previous research suggests that social class shapes individuals' attitudes toward body image (McLaren and Kuh 2004) and exercise (Wardle and Steptoe 2003). For example, research suggests that more affluent women prefer thinner bodies than their lower socioeconomic peers, regardless of race (Snooks and Hall 2004).

This research may help to explain gender, race, and age disparities in exercise levels and may be useful for intervention efforts around exercise. For example, the gender gap in exercise levels increases with age (Shaw et al. 2010) and this may stem, in part, from midlife women's conceptions of the aging female body as unruly and not amenable to weight loss via exercise. Targeted intervention efforts around this understanding of the body may, in turn, help to reduce these large gender disparities in exercise levels in mid- to later life. Findings from the current study further suggest that

midlife blacks may be more likely to find value in larger, older bodies, even if they do not conform to personal and cultural body ideals. Research suggests that the black-white gap in physical activity levels declines over the life course (Shaw et al. 2010) and this may be because health and fitness goals are a better predictor of long-term engagement in physical activity than are appearance-related concerns (Ingledeew and Markland 2008).

Limitations

This study has some limitations that suggest avenues for future research. Future research should investigate how social class intersects with gender, race, and age to shape the ways in which body image concerns serve as a motivation to exercise. Additionally, all but two individuals in this study identified as heterosexual. However, sexual identity shapes individuals' body image (Slevin 2010) and the ways in which individuals talk about their bodies (Lodge and Umberson 2013) and thus future research on exercise and body image should examine how exercise motivations and practices may differ for LGBT individuals. Future research should also examine these questions with samples of Hispanic and Asian and Asian American men and women as well as later life individuals.

CONCLUSION

In conclusion, this study innovatively synthesizes critical perspectives on gender, race, and age to examine how individuals differently positioned in stratification systems of gender, race, and age talk about body image concerns and exercise. This research further provides theoretical insight into the ways in which individuals construct meanings around gender, race, age and the body. Future work on health behaviors should investigate additional ways in which the body matters in terms of individuals' decisions

to engage in health behaviors as well as how individuals craft meanings around social locations in their decisions to engage in particular health behaviors. For example, issues of bodily functioning, control and mastery are likely important in understanding individuals' motivation for and decisions to engage in exercise, and may differ in important ways for different social groups.

Conclusion

KEY CONTRIBUTIONS

Article 1: Disrupted Advantage and Disadvantage

The theoretical concepts of disrupted advantage and disadvantage — defined as life course processes of developing health behavior disadvantage or advantage (and thus, the disruption of cumulative advantage and disadvantage) in ways that differ at the intersection of gender and race — provide a new lens for assessing how health behavior trajectories may shift over the life course as individuals experience adult life course transitions to new social roles (e.g., parents) and other adult life events (e.g., injury) in ways that vary by gender and race. This provides a new way of thinking about how cumulative advantage and disadvantage processes that begin in childhood can be disrupted in ways that vary at the intersection of race and gender. Future research should examine how early life advantage and disadvantage around other health habits (e.g., diet, smoking) may be disrupted by adult life course events and experiences and if they do so in different ways by gender, race, social class, sexuality, and other social statuses.

Article 1: Aversion

The concept of aversion — defined as a process by which adults adopt healthy habits in response to avoid facing the health problems that their parents experience — provides new insight into how social ties shape health behaviors in dynamic and unexpected ways over the life course. Further, my research suggests that aversion may operate in ways that vary by gender and race. Future research should explore the role of aversion in other social ties and with other health behaviors as well as examine if

aversion operates differently across gender, race, social class, age, and sexuality. For example, future research could examine if aversion operates within intimate relationships — whereby one partner adopts health-enhancing habits to avoid experiencing the health or weight concerns that their partner is experiencing — and in different ways for men and women.

Article 2: Gender-as-Relational Framework

Analyses from Article 2 reveal the importance of a gender-as-relational perspective when examining how relationship formation shapes health habits, whereby the gendered performances of both partners matter for change in exercise habits. This is an important finding for research and theory on gender, relationships, and health. Future research on health and health habit change within intimate relationships should therefore adopt this theoretical framework. Further, analyses from Article 2 provide key insight into the processes through which relationship formation and dissolution shape exercise habits. These findings are critical for understanding why relationship transitions matter for exercise habits in gendered ways and for gendered intervention efforts around exercise. Future research should examine the processes through which relationship transitions matter for other health behaviors and if such processes differ across gender, race, age, sexuality, and socioeconomic status. Further, research should explore if these processes differ based on relationship type (e.g., if processes differ for individuals divorcing vs. ending a cohabiting union).

Article 3: Exercise as a Body Project

In Article 3, I explored how gender, age, and race shape individuals' motivation to exercise as part of a body project and how through exercise motivations, intentions, and practices individuals construct meaning around gender, race, age, and the body. These analyses provide key insight into how bodily appearance concerns, as socially constituted, matter for exercise in ways that differ by gender, race, and age. This is an important contribution to research and theory on exercise because most work on this topic fails to examine the importance of the body or how social meanings around different bodies shape exercise intentions. Future research should therefore examine how body image concerns shape individuals' motivation to engage in other unhealthy and healthy habits in ways that differ across social statuses.

LIMITATIONS

A key limitation of this research, particularly in combination with a life course perspective is that I am unable to disentangle the effects of age, cohort, and period effects. As previously noted, this limitation is important for several reasons but most notably because of vast changes in family life as well as meanings around exercise and other health behaviors over the 20th and into the 21st century.

Another important limitation of this research is my inability to examine social class effects. Some research suggests that socioeconomic status is the most important predictor of exercise levels and other health behaviors (Cockerham 2005). The sample used for the present analysis, however, was overwhelmingly middle-class and highly educated. And although there were a few respondents with lower levels of education and

income, the number of such individuals was too small to merit analysis. The strength of this social class homogeneity, however, is that gender and race likely were not confounded with social class.

Finally, data were based on self-report and subjective accounts of exercise habits. Although this allowed me to assess what was most important for individuals' lived experiences of exercise, it is limited in some ways. For example, it means that the data are particularly vulnerable to social desirability and retrospective biases. Exercise is considered a healthy habit and is an indicator of morality (Cockerham 2005; Giddens 1991). As a result, respondents may be inclined to rate their exercise habits in favorable ways to interviewers, although this is an issue with all self-report data. Despite these limitations, however, this research makes several key theoretical and empirical contributions to the study of social ties and health.

FUTURE RESEARCH

As mentioned above, the findings of this dissertation suggest several avenues for future research. One line of research that I am particularly interested in pursuing in the future is how the body and embodiment matter for health behaviors. In particular, I am interested in exploring how experiences and meanings of the gendered aging body shape health behavior intentions and practices. Findings from Article 3 suggest that the gendered aging body shapes exercise intentions and behaviors, but the data used for this analysis were not originally intended to examine the relationship between embodiment and health behaviors. Therefore, my future research plans include collecting qualitative in-depth interview data that more fully explore how the gendered aging body shapes not

just exercise intentions and practices, but also intentions and practices around other health behaviors, including smoking, diet, and alcohol consumption. Prior research suggests that the body and body image concerns matter for health behaviors throughout the life course (Slevin 2010), but I am unaware of any existing studies that directly examine how concerns around the appearance and functionality of the aging body shape health behaviors. This is an important question, however, for theory and research on health behaviors.

Appendix A: Demographic Characteristics

Pseudonym	Age	Marital Status	Parenthood Status	Education	Household Income and employment status
WHITE MEN					
Donald	56	Divorced	Parent	Graduate degree	76-90K/Full time
Rick	30	Single	Nonparent	College degree	20-40K/full time
Kevin	36	Married	Nonparent	College degree	70+K/full time
Dave	31	Single	Nonparent	College degree	20-40K/full time
Fred	66	Divorced	Nonparent	Some college	100,000/full time
Bart	74	Married	Parent	Graduate degree	80+K/part time
Thomas	35	Divorced	Nonparent	College degree	20-40K/full time
George	47	Single	Nonparent	Some college	Under 15K/part time
Steven	65	Divorced	Nonparent	College degree	Under 15K/retired
Charlie	87	Married	Parent	College degree	60-70K/retired
Jeffrey	57	Divorced	Nonparent	Some college	Under 19K/part time
Jim	68	Married	Parent	College degree	40-60K/retired
Dan	84	Married	Parent	Some college	40-60K/retired
Ernest	89	Widowed	Parent	College degree	40-60K/retired
Mitch	48	Married	Parent	College degree	40-60K/full time
WHITE WOMEN					
Kimberly	51	Divorced	Parent	Associate's degree	42K/full time
Beverly	58	Divorced	Parent	High school diploma	20-40K/full time
Tonia	60	Widowed	Parent	Some college	20-40K/full time
Alison	30	Married	Nonparent	Graduate degree	70+K/full time
Patty	60	Divorced	Parent	College degree	31-45K/full time
Kathy	30	Single	Nonparent	College degree	40-60K/part time
Audrey	41	Married	Nonparent	College degree	46-60K/full time
Naomi	26	Single	Nonparent	Graduate degree	31-45K/full time
Jessica	33	Married	Nonparent	College degree	70K+/full time
Meredith	54	Divorced	Parent	Some high school	12K/full time
Margie	70	Divorced	Parent	College degree	31-40K/part time
Carol	75	Divorced	Parent	Graduate degree	20-40K/full time
Wendy	82	Widowed	Parent	Some college	16K/retired

Darcy	78	Widowed	Parent	Some college	20-40K/part time
Anna	52	Divorced	Parent	College degree	20-40/part time
Evelyn	68	Single	Nonparent	Graduate degree	60-70K/retired

BLACK MEN

Matthew	25	Single	Nonparent	College degree	20-40K/part time
Jerry	55	Married	Parent	Associate's degree	60-70K/full time
Duane	59	Cohabiting	Parent	College degree	60-70K/full time
Doug	55	Divorced	Parent	Some college	17K/part time
Mark	57	Married	Parent	Some college	100+/full time
Terry	41	Divorced	Parent	Some college	40-60K/full time
Timothy	36	Married	Nonparent	College degree	70+K/full time
Andrew	51	Married	Parent	High school diploma	20-40K/full time
Jared	31	Married	Parent	Some college	60-70K/full time
James	42	Married	Parent	Some college	20-40K/ unemployed
Billy	52	Divorced	Parent	Some high school	9K/disabled veteran
Allen	78	Divorced	Parent	College degree	20-40K/retired
Karl	61	Cohabiting	Parent	College degree	60-69K/full time
Phil	64	Divorced	Parent	Some College	70+/full time
Barry	60	Divorced	Parent	College degree	Below 14K

BLACK WOMEN

Dionna	55	Divorced	Parent	Graduate degree	20-40K/full time
Sharon	53	Married	Parent	College degree	60-70K/full time
Charlene	53	Single	Foster parent	College degree	40-60K/full time
Katherine	28	Cohabiting	Parent	College degree	20-40K/full time
Rosa	63	Divorced	Parent	College degree	41-60K/part time
Mabel	54	Married	Parent	Graduate degree	41-60K/full time
Elyse	38	Married	Parent	Some college	20-40K/full time
Jennifer	35	Divorced	Parent	College degree	20-40K/full time
Mary	43	Single	Nonparent	College degree	Below 19K/ unemployed
Rhonda	52	Divorced	Parent	College degree	81K/full time
Karen	42	Single	Parent	College degree	50-60K/full time
Paula	42	Married	Parent	College degree	40-60K/full time
Kara	30	Married	Parent	Some college	40-60K/full time

Natalie	43	Married	Parent	College degree	40-60K/full time
Gail	61	Divorced	Parent	Graduate degree	Below 19K/

Appendix B: Interview Schedule

INTRODUCTION

I'm especially interested in how your health habits have changed over time and how other people may have influenced your health habits at different times in your life.

When I say health habits, I'm referring to things like smoking, drinking, eating, and exercising. But I'm also interested in any other habits or behaviors that you think of as important.

LIFE EVENT AND HEALTH HISTORY

I'd like for you to tell me a bit about your personal history to help guide our discussion. Let's begin by charting some of the major events in your life. Let's start with the most significant events during childhood—things like a parents getting divorced or maybe a time when you had a serious injury. Were there any major events like this during your childhood?

Now let's talk about major events that occurred when you were older. Have you ever been married or lived with a partner? (plot when started living together).

Ever divorced, widowed, or experienced the breakup of a significant relationship? (plot what, when)

Any other major events that have had a big impact on your life—like job loss, births, or important deaths? Any major illness or injuries? Any significant periods of depression or other mental health issues?

Now I'd like for you to think about your overall health at different points in your life. Please just make a line showing your overall health at different ages—from excellent health to very poor health. [GRAPH HEALTH.]

We'll talk more in-depth about the ups and downs of your overall health, but first tell me a little bit about what was going on during these periods of time. Why did your health shift for better or for worse?

CHILDHOOD HISTORY

Now let's talk about your family's health habits when you were a child. Who did you live with when you were growing up? What were your (parents'/or whoever) general health habits like—in terms of smoking, drinking, exercise, and so on?

How do you think your (parents'/siblings'/other people growing up) habits may have influenced your own health habits? How so?

Now I'd like to look back at some major transitions in your life (FROM GRAPH).

FOR THOSE WHO ARE DIVORCED/WIDOWED/EXPERIENCED MAJOR BREAKUP:

Did getting divorced/breaking up/becoming widowed lead to any changes in your health habits—for example, in terms of eating habits, gaining or losing weight, exercise, or any other habits? **IF YES, GET THE ENTIRE STORY: HOW IT CHANGED, WHY IT CHANGED, HOW R FELT ABOUT IT.**

FOR THOSE WHO ARE MARRIED/COHABITING:

Did getting married or does being married influence your health habits in any way? — for example, in terms of eating habits, gaining or losing weight, exercise, or any other habits? **IF YES, GET THE ENTIRE STORY: HOW IT CHANGED, WHY IT CHANGED, HOW R FELT ABOUT IT.**

FOR THOSE WHO HAVE CHILDREN:

Has having children ever affected your health habits—for example, in terms of eating habits, gaining or losing weight, exercise, or any other habits? **IF YES, GET THE ENTIRE STORY: HOW IT CHANGED, WHY IT CHANGED, HOW R FELT ABOUT IT, BE SURE TO ASK HOW THIS HAS CHANGED AS CHILDREN GOT OLDER.**

SPECIFIC HEALTH HABITS

Now we're going to talk about several **specific** health habits. We'll start with exercise.

EXERCISE

Exercise can be any physical activity like gardening, walking, and physical labor, as well as sports.

(Get the story as to when they exercised more/less and why they exercised more or less at different times)

- Starting with childhood, tell me what sorts of things you did for exercise and how that changed over time?
- Again, starting with childhood, tell me how you felt about exercise and how your feelings about exercise changed as you got older.
- At what times in your life were you most likely to exercise? Least likely to exercise?
- What sorts of things made you **more** likely to exercise at certain points in your life. (Probes: stress, other people, health—be sure you know **WHY** this person exercises.).

- What sorts of things made you **less** likely to exercise at other times? (Probes: stress, other people, health). [Be sure to refer to graph as a guide. What was going on...]
- Has your health ever affected your exercise habits (e.g., doctor told R to exercise for health reasons; injury or illness interfered with ability to exercise)? IF YES: how... (probe for the entire process and the consequences for HHs.).

<p>BODY WEIGHT AND EATING HABITS</p>
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Now let's talk about eating habits and body weight.
(Get the story of weight fluctuations—times when they gained or lost; explain the ups and downs in weight.)

- Starting with childhood, tell me you felt about your body weight and how that changed over time? (probes: guilty, proud, didn't think about it, etc.)
- What sorts of things do you think contributed to gaining more weight at certain points in your life? (Probes: stress, other people, health. Be sure to cover how this changed over time).
- What sorts of things made you more likely to lose weight at other times? (Probes: stress, other people, health. Be sure to cover how this changed over time.).
- Have you ever tried to intentionally gain or lose weight? IF YES: Tell me about those times and what sorts of things helped or got in the way of your goal. (probe: relationships)
- Do you think, or has anyone ever suggested, that you might have had an eating disorder, such as anorexia, bulimia, or compulsive eating? (get the story: when, why, how, etc.)
- How do you think other people have viewed your weight? How do you feel about that?
- Overall, how healthy do you think your diet has been throughout your life and how has that changed with age? (probe: why diet changed/what led to change/consequences of change).

<p>ALCOHOL</p>

Now, let's talk about drinking alcohol. Starting with childhood, tell me how you viewed alcohol and how your views about alcohol changed as you got older.

- Tell me about your overall level of alcohol consumption over time—about how much do you typically drink and how has this changed over your lifetime?
- Tell me about when you first started drinking—why you started drinking, who you drank with, and how it felt.
- FOR THOSE WHO NEVER DRANK: Get the story: why, role of relationships (pressure to drink/not drink).

- Let's talk about times when you drank more. Why do you think you drank more at these times? Probe: Was there anything else going on in your life that may have influenced your drinking habits at those times?
- For many people, drinking alcohol can have some negative consequences. For example, sometimes drinking a lot can leave one feeling sick or unhealthy the next day. Have the consequences of your drinking changed over time. I'm thinking of the physical, emotional, and social consequences. (Be sure to get consequences for relationships.)
- Have you ever felt like you were drinking too much or has anyone else ever thought that you drank too much (when, why, how did it turn out, social ties...).
- Have there been times when you stopped drinking or starting drinking less intentionally? IF YES: What led to this change?
- IF R EVER STOPPED DRINKING: what helped, what made it harder. IF R STARTED DRINKING AGAIN: why?
- Have you ever thought about how others view your drinking? IF YES: Who are these "others" and how do you think they viewed your drinking habits?
- Has drinking ever affected any of your relationships?

SMOKIN

Starting with childhood, tell me how you viewed smoking and smokers and how your views changed as you got older?

- Have you ever smoked **cigarettes**? IF YES: get history in terms of how much and when they smoked.
- People smoke for lots of different reasons. Why do you think you started smoking? (probes: What was going on in your life when you started smoking? role of other people, stress, etc.). Did your reasons for smoking change as you got older? (IF YES, ask how they changed.)
- Let's talk about times when you smoked more often. Describe how much you were smoking at this time, and how it different to your smoking habits at other times. Why do you think you smoked more at these times? Probe: Was there anything else going on in your life that may have influenced your smoking habits at those times? (Probes: stress, other people, health. Be sure to cover how this changed over time).
- What about times when you stopped smoking or smoked less? What was going on that may have affected your smoking? [Be sure to cover different reasons at different times.] [probes: IF INTENTIONAL: Tell me what sorts of things helped or got in the way of your goal.]
- People who smoke often talk about positive and negative effects for them. How does/did smoking make you feel? [Probe: Be sure to get at both positive and negative ask about physical effects of smoking.]
- Has smoking ever affected any of your relationships? IF YES, how?

- How do you think other people view/viewed your smoking? (who?) How do/did you view your smoking?

DRUG

Many people use recreational drugs—like marijuana, cocaine, amphetamines or narcotics—at some point in their lives.

- Starting with childhood, how did you view drugs and drug users and how has that changed over time?
- Have you ever tried any kind of recreational drug?
- IF YES: When was this and what kinds of drugs did you take?
- Why do you think you starting experimenting with drugs? (probe: relationships)
- During the times that you used drugs more often, what was going on that may have led to more drug use? Why do you think you used drugs less often during these other periods?
- [IF R EVER stopped using] What led you to stop or helped you stop using drugs?
- Has using drugs ever affected any of your relationships? How?

SLEEP: Have you ever experienced a period of time lasting longer than a month when you had significant problems with the amount or quality of your sleep, or had trouble falling or staying asleep at night? [If yes, just get the story. When, why, how long, major causes, solutions if any. Role of relationships for better or worse. Effects on relationships.]

RX: Have you ever been concerned that you were taking too many prescription drugs or harmful prescription drugs? IF YES, probe for full story: when, why concerned, side effects and consequences, how it turned out.

SEXUAL BEHAVIOR: Sexual behavior can be an important component of health. For example, unprotected sex may lead to pregnancy or sexually transmitted diseases and infections. Has there ever been a time when you felt as if your sexual practices were more risky than at other times? Have you ever felt as if your health was compromised by your sexual practices? (get full story).

OTHER HHs: Are there any other things you do that you think of as being particularly important to your health—that might have been good or bad for you at different points in your life? IF YES: Get the story: what it is, how it's changed over time, reasons for change.

DOCTORS: Has there ever been a time when a doctor or other health professional led you to change any of your health habits? IF YES: get the full story: when, what, why, consequences.

-
- Has there ever been a time we haven't talked about where you were concerned or worried about any of your health habits? (get the story: what, when, why...)
 - Has there ever been a time that someone else was concerned or worried about any of your health habits (who, what did they do, how did you react, how did it affect your habits?).
-

STRESS

Lots of people say that when they feel stressed out, they drink, eat, or use other health habits more than usual. Tell me how stress affects your HHs. [Probes: when, which habits, how habits were affected.]

When you _____ when you're stressed, does this help to relieve the stress you feel? [Probe how and why; be sure to get at short vs long-term effects.]

Were you more likely to use other HHs when you felt stressed out at younger ages or have you always been more likely to respond to stress by _____?

Sometimes, HHs like drinking or overeating can actually increase the amount of stress in our lives. For example, drinking more may irritate a partner or friends and create conflict in our relationships. Have your HHs ever created stress for you? IF YES: how did this happen? story.

MENTAL

(If mentioned depression earlier...) Have you ever had a significant period of depression or other mental health problems?

- IF YES: Could you tell me when that was and what you think led you to feel depressed (other MH problem)?
- How did being depressed (or whatever the problem was) affect your health habits?
- What do you think helped you get over this/these periods of depression (MH problem)?
- Did your HHs change as you felt less depressed (MH problem)? IF YES, TELL HOW.

SOCIAL TIES

I have a few questions about significant people in your life—for example, a spouse or partner, parents, kids, and close friends. [For each of these questions, get the whole story: who, what, when, how, consequences for target AND R.]

- Tell me about times when you may have influenced other people’s HHs in a good way. This might have been intentional or unintentional. (get complete story including consequences for R).
 - Tell me about times when other people influenced your HHs in a good way.
 - What about times when you may have influenced other people’s health habits in a bad way.
 - Tell me about times when other people may have influenced your own HHs in a bad way.
 - Have you ever been in a relationship with someone who had a health habit that was a problem? How did this affect your relationship?
 - Have your health habits ever caused problems in any of your relationships? [get the story]
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SOCIAL TIES TO ORGANIZATIONS:

Have your health habits (smoking, drinking, drugs, sleeping) ever caused you to have a problem at work or to lose a job.

How does/did your job/working influence your health habits?

How have religious beliefs or attending religious services influenced your health habits?

Are there any other important issues about health practices that we haven’t discussed but that you would like to tell me about?

Thank you for your time... [give respondent card and ask for referrals]

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