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Love and lifestyle: how 'relational healthism' structures couples' talk of engagement with lifestyle advice associated with a new diagnosis of coronary heart disease.

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ABSTRACT

Objectives: Healthy lifestyle change improves outcomes in coronary heart disease (CHD), but is rarely sustained. To better understand barriers to lifestyle change, we examined couples' talk of engaging with lifestyle advice after one partner receives a diagnosis of CHD.

Design: A longitudinal qualitative design, in which a poststructuralist discourse analysis was performed on 35 interviews, conducted with 22 heterosexual British people in a long term relationship. The interviews occurred over three months after one partner was referred to a cardiac rehabilitation programme designed to support lifestyle change.

Results: Couples understood their health as a shared practice underpinned by an ideological framework of healthism, creating a form of 'relational healthism'. Practicing relational healthism was not straightforward because the practices of surveillance, control, and discipline related to healthism often contravened relationship norms of support, acceptance and respect for the other's autonomy. Couples struggled to resolve this tension, dynamically adopting, resisting, and occasionally transforming discourses of health and love in ways that worked for and against engagement in lifestyle change.

Conclusion: In foregrounding the discursive and relational contexts of behavioural change engagement, we show the considerable complexity for couples, including costs related to engagement with lifestyle advice.

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Lifestyle change; couples health; coronary heart disease; discourse; healthism

Introduction

Coronary heart disease (CHD) is a global health priority because it is a leading cause of illness and death (World Health Organization (WHO), 2020). Adherence to lifestyle change advice related to diet, exercise, and smoking significantly improves health

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outcomes related to mortality and reducing future cardiovascular events (Mentrup et al., 2020). Patients diagnosed with CHD are thus offered cardiac rehabilitation programs that focus on supporting lifestyle change (Steg et al., 2012), which in the UK usually includes a 'comprehensive exercise, education, and behavioural modification programme designed to improve the physical and emotional condition of patients with heart disease' (British Heart Foundation (BHF), 2020, n.p.). Yet less than 50% of patients globally complete cardiac rehabilitation or maintain lifestyle changes to diet and exercise at six-month follow-up (BHF, 2020; Dalal et al., 2015). This pattern, found across multiple investigations, including large-scale international studies (Bennett et al., 2016; Kotseva et al., 2019), suggests an urgent need for new directions for health advice.

Healthy lifestyle campaigns and clinical communication and interventions are often predicated on socio-cognitive approaches to behaviour change. Originally based on information-processing models that assume individuals change their behaviour on receipt of medical information about risks (Bandura, 2004; Baum & Fisher, 2014; Mentrup et al., 2020), socio-cognitive approaches have developed to encompass and highlight the importance of patients' representations, understanding, motivation, coping strategies, and health behaviours, as well as identifying some affective and interpersonal contextual factors (Hagger et al., 2017; Leventhal et al., 2011). This framework aims to enhance self-efficacy and therefore commonly presents lifestyle change in terms of simple and rational choices (such as swapping from high- to low-fat snacks) (Robson & Riley, 2019; Mayes & Thompson, 2015).

Despite important insights from this research, and examples of successful interventions (Rhodes et al., 2019), socio-cognitive approaches have important limitations that can reduce their effectiveness in practice (Hackett et al., 2018; Theis & White, 2021). Critics suggest that the problem lies with the individual focus of these approaches and their associated failing to address the complexities of wider social, governmental, environmental, and relational contexts in which lifestyles are lived and health related behaviours practiced (Crossley, 2001; Kelly & Barker, 2016). Reviewing behaviour-change models, Rhodes et al. (2019), for example, argue for the need to look beyond individual-level factors and interventions.

Responding to this, we draw attention to the importance of discursive contexts and associated social norms that structure sense-making (Riley et al., 2018; Mayes & Thompson, 2015). There is now a body of work showing how multiple discourses intersect in complex ways that structure the conditions of possibility for people's engagement in health practices (see for example, Riley et al., 2018; del Río Carral & Lyons, 2020; Ellis & Cromby, 2012; Jeffries & Grogan, 2012; Sloan et al., 2010). Here, we extend this work into the field of CHD management, by foregrounding 'healthism'.

Healthism refers to contemporary understandings of health as primarily located in the individual and achievable through lifestyle management (Cheek, 2008; Crawford, 1980, 2006; Turrini, 2015; Zola, 1977). Healthism constructs health as a personal responsibility, requiring individuals to manage their risk of illness by choosing activities associated with optimizing health, a process demanding self-surveillance and discipline (Cheek, 2008). Healthism is pervasive, evident in public, government and media discourse across many countries (Turrini, 2015), and is a framing of health that is central to the discursive context of lifestyle advice.

Healthism makes health an important site of identity formation, because 'in a health-valuing culture, people come to define themselves in part by how well they succeed or fail in adopting healthy practices' (Crawford, 2006, p.402-3). As such, health and healthy behaviour becomes 'a signifying practice', a measure of being a good person and living a good life, and 'a badge of honour by which we can claim to be responsible and worthy both as citizens and individuals' (Cheek, 2008, p.974). Healthism thus has a moral dimension relating to appropriate care of the self and fulfilling requirements of good health citizenship by not wasting health resources (Brandt & Rozin, 1997; Carr, 2009; Turrini, 2015).

Healthism's morality elicits judgement of the self and others according to how well healthy living injunctions are followed, resulting in affective responses that can include satisfaction, but also shame or guilt (Galvin, 2002; Willig, 2011). Lifestyle advice can evoke resistance (Crossley, 2003) and has potential to harm through eliciting stigma and self-blame, especially for people diagnosed with lifestyle-related diseases such as CHD (Hodgetts & Chamberlain, 2000; Puhl et al., 2013). Harm is also identified in anxieties related to self-surveillance and disciplinary work that are normalised in healthism because such intense focus on health paradoxically increases awareness of illness, risk, and death (Riley et al. 2018; Cheek, 2008; Crawford, 2006), or can lead to unhealthy behaviours, such as drug use or smoking in the pursuit of slimness as a marker of health (Burns & Gavey, 2008; Hall et al., 2016). This complexity, including how unhealthy behaviours might 'constitute important strategies of "survival" and ways of adapting to life in contemporary society' (Crossley (2001, p. 161), means that lifestyle advice has the potential to both 'empower and undermine the self' (Löfvenmark et al., 2013, p.120), and is thus a complicated clinical and ethical issue.

Research specifically considering the intersections of healthism, cardiovascular disease, and engagement with lifestyle advice is rare but points to the importance of healthism as structuring patient experience and understanding. York and Tang (2021) identify how individualistic discourses of personal responsibility for lifestyle and health negatively impacts on African Americans by discounting the inequalities they experience related to the structural determinants of health; while Clark et al. (2018), Gonsalves and McGannon (2020) and Gonsalves et al. (2021) describe similarly problematic gendered discourses of healthism in social media and public health campaigns related to women's cardiovascular health. We consider that another area where healthism may be problematic is the field of couples' health, as partners in long-term relationships negotiate individualistic health discourses and their inherent logic of blame.

Recent large-scale studies on couples' health confirm longstanding evidence for better health and greater longevity than for individuals not in long-term relationships, but also for concordance for risk factors for CHD (Carter et al., 2017; Shiffman et al., 2020), and wide variability exists in the nature and efficacy of couples' joint engagement in health (Holt-Lunstad & Smith, 2012; Kiecolt-Glaser & Wilson, 2017). Research seeking to explain these patterns show that relationship quality and satisfaction (Meyler et al., 2007; Robles et al., 2014); attachment and communication styles (Pietromonaco et al., 2013); and styles of influence-attempt (Lewis & Butterfield, 2007; Tucker & Anders, 2001) are all associated with health benefits in couples. Overall, this research suggests that relationships characterised by support and openness to a

partner's needs are associated with health benefits, while relationships characterised by conflict, hostility and tension are associated with poorer health outcomes, including some markers for CHD (Robles et al., 2014; Smith & Baucom, 2017). Other studies suggest that conflict and control may nudge partners towards lifestyle change (Umberson & Thomeer, 2020).

Qualitative research highlights other considerations, such as the potential for lifestyle change itself to cause conflict. For example, individuals may undermine their partner's efforts to lose weight or maintain a healthy diet (MacLean et al., 2014; Novak et al., 2021); negative emotions can arise from divergent beliefs about lifestyle change after a diagnosis of CHD (Köhler et al., 2017); and difficulties can arise when a partner's caring attempts are interpreted as unwanted, controlling or producing undesired illness (Goldsmith et al., 2012).

The above literature points to a complexity that needs further investigation. We suggest that a consideration of the cultural norms and discourses of both romantic relationships and health offers important insights into the complexities of couples' engagement with lifestyle advice. In late modern cultures, positive romantic relationships are characterised by shared lives, mutual support and care, acceptance of each other, and respect of each other's autonomy (Giddens, 1992; Thoits, 2004). In contrast, healthism requires self-surveillance, control and criticism. So although norms of romantic love can be enacted through health-related practices (Giddens, 1992; hooks, 2000), healthism risks conflicting with romantic ideals of acceptance, support, and respect for each other's autonomy.

There are contradictions within healthism (e.g. a focus on health brings attention to ill health) and within relationship norms (e.g. ideal relationships involve shared yet autonomous lives). There are also contradictions between healthism and relationship norms since ideals of mutual support and acceptance might clash with surveillance, criticism and discipline. These contradictions mean that attempting lifestyle change when in a long-term relationship is likely to involve negotiating a complex and contradictory discursive landscape, with implications for couples' engagement in lifestyle advice.

To explore this proposition, and develop understanding of barriers to engagement with lifestyle change, we asked: What discourses structure couples' talk of engaging with health-related lifestyle advice after one of them has a diagnosis of CHD, and with what effect? In addressing these questions, we aim to advance our understanding of the limits of current behaviour change intervention by exploring some of the complexity in how lifestyle advice is negotiated in relationships. In so doing, we also offer important directions for research on how lifestyle advice may be developed to better support patients' behaviour change.

Method

Design

A longitudinal qualitative design was employed, in which people with a new, recent diagnosis of CHD were interviewed once a month for three months after enrolment in a CHD rehabilitation program designed to support lifestyle change. Participants were given the option of interviewing with their partner or individually, most interviewed as a couple. Multiple longitudinal interviews afforded in-depth insights into

their collective sense-making during the immediate time period of trying to apply clinical lifestyle advice into their everyday lives. Analysis, however, did not focus on tracking change, but used multiple interviews to explore in-depth the sense-making of this ongoing process. A total of 35 interviews were conducted.

The literature review suggested significant complexity in how couples might negotiate lifestyle advice. Quantitative methods identify patterns in couples' health behaviours and outcomes, but more fine-grained qualitative analysis can provide insights into the often subtle processes that underlie such patterns. Therefore, qualitative methods of data collection and analysis that centre complexity through detailed analysis of sense-making processes were chosen (Riley et al., 2021). The project was designed by a research team with significant expertise in poststructuralist epistemologically oriented research and a senior cardiologist who affirms the value of post-structuralism in understanding health behaviours and clinical interactions.

Participants

Recruitment was through a National Health Service (NHS) cardiac rehabilitation programme in rural Wales that offers exercise classes, and lifestyle and self-management advice to patients with CHD. Convenience sampling occurred by inviting all patients referred to the programme to participate, regardless of their gender, or the gender of their romantic partner, if they had a new diagnosis of CHD and if they were in a cohabitating relationship of at least 2 years. The length of the recruitment period was 9 months, determined by the NHS ethical approval, by which time a substantial data set was achieved for a discourse analysis of prevalent forms of sense-making. NHS ethics also stipulated that invitations to participate were sent out by the CR team, not the researchers, so the number of people potentially eligible to participate was not known. One couple withdrew from the study without giving a reason after one interview and were not included in analysis.

Interviews

The audio-recorded interviews were conducted by the first author, a heterosexual, white woman from Wales in her early 50 s with past experience as a nurse and counsellor. The first and second authors developed the interview guide in discussion with the CR team lead, and the questions were piloted with a volunteer patient. Questions related to whether and how patients and partners had made lifestyle change, how they talked about any change attempts (see supplementary file for interview schedule). An open interview structure was used to allow participants to direct the content and direction of talk. The schedule was re-used at each serial interview, revisiting these questions, but also referring to previous experiences participants had shared.

Ethics and procedure

UK NHS ethical approval was granted. The counselling service Relate gave guidance, and the researchers undertook NHS Good Clinical Practice training. Project-specific

ethical issues included being sensitive to the potentially stigmatising experience of talking about engagement (or not) with lifestyle advice, so relatively unstructured interviews were used, allowing participants to direct the talk more on their own terms. Written and ongoing verbal consent was gained. Interviewing couples raises ethical issues of mutual consent, protecting both partners' right to withdraw, and the potential to cause or expose tensions between partners.

Data analysis

The epistemological approach is based on the concept that discourses are 'practices which form the objects of which they speak' (Foucault, 1972, p. 49), producing taken-for-granted knowledge and normative forces through which people understand themselves and others. Discourses structure what can be said, thought, felt or done, generating affective experiences that impact on people's capacities to act and be in the world (Davies, 2013). A poststructuralist-informed discourse analysis was performed on the data, with a focus on discourse, norms and subjectivity.

Our discourse analysis combined Willig's (2013) and (Riley et al., 2021) guidelines for a Foucauldian-informed discourse analysis. Each transcript was read multiple times, coding direct and indirect references to health and healthy lifestyle. Each 'health talk' extract was then analysed in terms of 1) what issues, objects, or people were described; 2) what reality was constructed in these descriptions; 3) the wider discourses informing this sense making; 4) rhetoric strategies, which offers important insights into the action orientation of talk (for example, extreme case formulations and active voicing can strengthen an argument, while careful discursive work highlights an issue of social sensitivity; and 5) the consequences in these accounts for subjectivity and healthy lifestyle practices. Combined, these analytics enable a theoretically informed, multi-layered psychological poststructuralist discourse analysis (Riley et al., 2018, 2021; Willig, 2013).

Extracts coded for similar discourses were considered together using the above analytics in an iterative process that produced an increasingly conceptual understanding of participants' sense making. The complexity of multiple interviews with the same participants was managed through dynamic movements between and across participants' transcripts, using excel sheets for systematic and comprehensive coding management. Other quality criteria appropriate for interpretive qualitative research included reflexive journal keeping, which did not form part of the analysis, but were used to reflect on the interview and analytic process; iterative cycles of separate and collective data analysis by the authors allowing for multiple interpretations and in-depth discussion of any different interpretations; searching for alternative interpretations or patterns in the data; and interrogating our analysis with peer review and reflexivity. The first and second authors met approximately fortnightly during the analysis process. Peer review of analysis-in-progress occurred through a research centre's activities designed to support qualitative research (weekly meetings and 'data days') and at key milestones, analysis was discussed with the third author who had expertise in poststructuralist analysis and a fourth author, a senior cardiologist. Consensus was achieved through a collaborative and iterative process of discussion, reflection, and revision. These practices produced a conceptual, rigorous, in-depth

discourse analysis performed on complex data that found coherent and consistent patterns across the dataset.

Below, specific participant quotes are used to illustrate a discursive pattern we called 'relational healthism'. The quotes are transcribed verbatim, were chosen as indicative of the dataset, and analysed in detail using the analytics described above. Transcription notation includes short pauses (.), overlap in talk denoted with single square brackets [;, and double square brackets showing where quotes have been condensed [data cut]. The data that support the findings of this study are available on request from the first author. The data are not publicly available due to its sensitivity and information that could compromise the privacy of research participants.

Results

Table 1 displays the demographic characteristics of the 22 study participants, who were 11 men and 2 women with a recent diagnosis of CHD and nine of their partners (seven women and two men; four male participants diagnosed with CHD chose to be interviewed alone). All were people in long-term cohabiting relationships (relationship length 15 to 50 years). Most participants were interviewed three times, but two couples did only one due to health reasons. All participants identified as heterosexual, with age range 50-82 years (mean 63.3); 19 of the 22 participants were white British, reflecting the recruitment region's population. Sixteen were retired, six were working (employment backgrounds include 15 from public service or professional, 7 from skilled or manual work). A total of 35 interviews were conducted, ranging from 31 to 89 minutes in duration (with an average of 64 minutes).

The demographic information about the participants is outlined in the table below:

Table 1. Participant demographic information.

Name	Age	Work	Relationship length	Interview numbers
Paul*	Early 80 s	Retired agricultural	50 years	1.1, 1.2, 1.3
Ellen	Early 80 s	Retired agricultural		
Carl*	Late 60 s	Retired public service	39 years	2.1, 2.2, 2.3
Elsa	Mid 60 s	Retired public service		
Henry *	Mid 60 s	semi-retired skilled	32 years	3.1, 3.2, 3.3
Catherine	Mid 60s	retired office		
Robert*	Late 70s	Retired skilled	45 years	4.1, 4.2, 4.3
Richard*	Mid 60s	Business professional	29 years	5.1, 5.2, 5.3
Louise *	Late 60s	self-employed professional		
Dan	Late 60s	Working professional	44 years	6.1, 6.2, 6.3
Harry*	Early 80s	Retired professional	48 years	7.1, 7.2, 7.3
Holly *	Early 50s	Retired public service	26 years	8.1
Graham	Early 50s	Retired public service		
George *	Mid 60s	Retired professional	15 years	9.1, 9.2, 9.3
Susan	Early 60s	Retired skilled		
Alun*	Early 50s	Public service	27 years	10.1, 10.2, 10.3
Eddie *	Mid 60s	Retired public service		
Lily	Early 60s	Retired public service	30 years	11.1, 11.2, 11.3
Jack*	Late 60s	Retired skilled	20 years	12.1
Deb	Early 60s	Retired skilled		
Tom*	Late 70s	Self-employed professional	43 years	13.1, 13.2, 13.3
May	Mid 60s	Home maker		

Note: * indicates partner who has diagnosis of CHD.

We conceptualised participants' understanding of health as a shared practice underpinned by an ideological framework of healthism - a form of 'relational healthism'. In relational healthism, couples extended individual healthism to encompass their partner, making health a joint endeavour. Norms of health and relationships aligned in the sharing of responsibility for their own and their loved one's healthy lifestyle practices. Yet as the couples' talk below shows, practicing relational healthism was not straightforward because the practices of surveillance, control, and discipline of healthism contravened relationship norms of support, care, acceptance, and respect for the other's autonomy.

Relational healthism: 'we're in it together'

Participants' talk of engaging with healthy lifestyle advice was structured by norms of both healthism and of intimate relationships which created shifting boundaries between caring and control. Healthism was a taken-for-granted construct, evident across participants' sense making of CHD, as George said about his illness '*of course there are things you can do about it*' (Susan and George, early/mid 60 s, retired skilled/professional workers).

Participants also constructed intimate relationships as characterised by shared lives and mutual support. This could align with healthism to create an understanding of health as a joint endeavour, evidenced in Graham and Holly's talk below (early 50 s, retired public service workers, Holly diagnosed with CHD), when Graham says:

> we discuss everything fully between us there's no erm (.) there's nothing to do with hers that's nothing to do with me or mine's got nothing to do with her because we're in it together

Above, Graham uses extreme case formulation and repetition to construct their health and illness as comprehensively interdependent, '*there's nothing to do with hers that's nothing to do with me*'. Graham constructs health through relationship norms of shared, interconnected lives that blur the boundaries of individuality, legitimising mutual concern for each other's health.

But this interdependence sat alongside respect for each other's autonomy, also an ideal of contemporary romantic relationship (Giddens, 1992). So Graham could not, for example, demand that Holly eat the salad that he bought as part of their attempts to engage with lifestyle change. Instead, Graham employs indirect persuasion (that ultimately fails), as Holly describes below, using active voicing that performs their domestic interactions:

> Graham'll come in and say 'do you know how long this [salad] has been in the fridge', 'no but you're going to tell me anyway' 'it's off' 'oh better throw it out then'

Across the data set, contradictory demands of healthism to control and discipline, and relationship norms of support and autonomy were evident. This created an inherent tension in the enactment of relational healthism that led partners – both men and women – to engage in careful discursive work. For example, in the extract above, Graham articulated his desire for Holly to eat salad indirectly, by discussing how long it had been in the refrigerator. His talk exemplifies recognition of the risks of giving

lifestyle advice by using indirect approaches that avoid overt control. In a further example of this technique, Catherine engages in careful rhetorical work when discussing Henry's eating in the context of a nurse's advice that he eat red meat only twice a week (Catherine and Henry, mid-60s, semi-retired skilled and retired office worker):

> Catherine: you know really in in theory you shouldn't eat any more meat until Sunday, because Saturday morning he loves bacon fry up you see
>
> Henry: ah but but I did cut down to one little piece of bacon and uh two eggs and toast instead of fried bread and tomatoes, so I mean that's cut down a lot [really
>
> Catherine: [I think I saw a fried bread but I'm not sure
>
> Henry: (.) oh there might have been (.) but there was a toa I had a slice of toast uh and the rest of the week I have porridge I have porridge every morning
>
> Catherine: and honey

Above, individual healthism is evident in Henry's constructions of food as risk and the strategy of 'healthy swaps' (toast for fried bread, porridge most days) as suggested in health promotion on lifestyle change. Relational healthism is evident too in the couples' joint consideration of Henry's diet after his diagnosis of CHD. The extract also demonstrates the need for careful discursive work implicated in negotiating competing norms. Catherine problematises Henry's eating while softening her injunction (in theory *you shouldn't*). She also justifies Henry's food choices even as she problematises them, (*he loves bacon fry up you see*) and tentatively frames the knowledge she gained from surveillance of Henry's eating (I think *I saw a fried bread but I'm not sure*). The outcome is a subtle, nuanced critique of Henry's eating, balanced with a recognition of his individuality in his food preferences, as Catherine carefully negotiates the shifting boundary between caring and control.

Unresolved tensions: 'I can't do everything'

Sometimes couples were unable to even partially resolve the tensions inherent in relational healthism. These transgressions in health and relationship norms produced identity threats, such as in the extract below, where May accounts for not joining Tom in his cardiac rehabilitation classes (May and Tom, early 60 s/late 70 s, retired/self-employed professional workers):

> May: my confession time, I haven't been for the last weeks [data cut] it's just there's so much to do and I just thought 'I can't do it', I can't do everything [you know and when that has gone but I I intend
>
> Tom: [all the things, all the things to do, no she does a lot I mean she's not just
>
> May: to start again after Christmas it's not that oh I can't be bothered it's er it's just there's been so much on

May's use of the word '*confession*' establishes a moral framework for couples to practice health as a joint endeavour, which problematises her as a partner for not attending Tom's exercise classes. This transgression is evident in her need to account

for it, which she does with an extreme case formulation '*I can't do everything*', constructing this task as impossible. Tom supports her case by confirming how busy she is, but his defence leaves unchallenged the normative assumption that, outside of May's exceptional case, partners should support each other in their attempts at healthy lifestyle change. Not doing so remained dispreferred, a potential source of guilt and blame and a source of distress for May, who raised the issue of her not attending Tom's exercise classes in all three of their interviews.

The extract below offers another example of unresolved conflicts and spoilt identities produced within the logic of relational healthism (Dan and Louise late 60 s, manager and academic). Dan responded to Louise's illness by advocating an approach of them collectively making informed behavioural choices based on medical, pharmacological and psychological information about health risks and illness risk management. But his attempts to do relational healthism were met with resistance. These tensions took material form when Dan bought Louise a medical alert bracelet. In the extract below, Dan offers his rationale for wanting Louise to wear the bracelet:

> that's support and important acceptance of the fact that you've had a problem and and er (.) it's something that people need to know about in case er (.) you know you have another problem

Above, Dan represents the bracelet as a form of support from him as a loving partner, and as instrumental in Louise's psychological recovery in helping her do the '*important acceptance*' work in relation to her ill health. As such, the bracelet functioned to indicate the severity of Louise's condition, reminding Louise to modify her health behaviours, and enacting appropriate risk management through its role of alerting other people to help, given the possibility of recurrence. Louise, however, does not construct the bracelet so positively:

> this bracelet I mean it's really nice my husband let me pick it out, I picked out exactly the one I wanted and everything, and every now and then I look down, and I and I say 'see your husband's love, see your husband's love, see your husband's love' because (.) it has that little (.) sign on it, that means there's something wrong with you, you are different you know, one of these things doesn't belong, like on Sesame Street

Louise describes instructing herself to see the bracelet as an expression of Dan's love. But her mantra-like, three-part repetition of '*see your husband's love*' indicates the huge effort this perspective requires, and that it is hard for her to see love in this bracelet. Her struggle to see love in Dan's enactment of relational healthism through this health-protecting bracelet is explained in terms of it positioning Louise in a dispreferred illness identity (*that means there's something wrong with you*).

Willig (2011, p. 900) describes how people are 'captured' in a 'spoilt identity' when they experience ill-health in a health-valuing (and blaming) society. Louise signals such a capture in a three-part list, when she states that the bracelet marked her out as '*wrong*' '*different*' and someone who '*doesn't belong*'. Louise's desire to escape a negative identity cannot be supported by Dan while he is interpellated by relational healthism that requires him to focus on illness risk management. The outcome is that Louise enacts good health citizenship by wearing the bracelet, but struggles to experience her relationship as one of mutual support, acceptance and respect for her autonomy.

In the extracts above, Holly, Graham, Catherine, and Henry offer examples of trying to manage the tensions in relational healthism by prioritising their relationships over their health behaviours. Holly's salad is thrown out uneaten, and, despite some dietary change, Henry continues to eat fried bacon. In contrast, Louise, Dan, May, and Tom's accounts describe prioritising health. Louise wears her medical bracelet and Tom goes to his prescribed exercise classes alone, but to do so is to prioritise health over their relationship. Managing relational healthism harmoniously was clearly a goal and potential source of satisfaction in its demonstration of both responsible health citizenship and good romantic partnership. Recognition of each other's autonomy and individuality could occur, for example, through indirect approaches and prioritising relationship norms over imperatives of health, such as accepting a partner's resistance to change. However, no couple easily enacted both relationship norms and healthism, as May says, she '*can't do everything*'. Relational healthism could produce a range of unresolved, dispreferred subjectivities related to illness identities or to being a bad partner. So while participating in heath behaviours had affirmative possibilities for supporting change, they came at psychological and interpersonal cost.

Discussion

Our analysis shows how healthism and relationship norms structure couples' talk of engaging with health-related lifestyle advice after one of them has a diagnosis of CHD. Participants constructed health as a joint endeavour, with shared health practices a normative part of their interconnected lives and caring relationships. These health practices were, in turn, understood through the lens of healthism, constructing health as an individual responsibility and outcome of healthy lifestyles enacted through surveillance, control and discipline. Our contribution is to conceptualise this configuration of healthism and relationship norms as 'relational healthism', showing how this hitherto individualised construct also structures interpersonal, intimate relationships with implications for subjectivity and practice including those related to behaviour change.

Practicing relational healthism could be experienced as affirmative when norms of coupledom (care, support, and a concern for the other's wellbeing) aligned in cooperative management of diet and exercise. However, the surveillance, control and discipline that characterise healthism frequently clashed with relationships norms of support, acceptance, and respect for autonomy. Participants responded to these contradictory demands through delicate discursive work, oscillating between caring and control; prioritising the relationship over health practices by recognising a partner's autonomy or accepting their resistance to lifestyle change; or prioritising health, but risking transgressing relationship ideals. The tensions inherent in relational healthism meant these solutions were only partially successful. Thus, rather than being simple or benign, lifestyle advice after CHD involved psychological and interpersonal costs for couples that represent a significant barrier to engagement with, and enactment of, health related behaviour change.

Our findings support research on couple's health management by demonstrating couples' intimate involvement in each other's health, and the impact of their relationship on their health interactions and outcomes (Kiecolt-Glaser & Wilson, 2017;

Robles et al., 2014). The concept of relational healthism develops this work by offering a novel account for the wide variability in the nature and efficacy of joint engagement in health and the complexity and dynamism of couples' health behaviours (Uchino, 2013) by connecting this complexity to the discursive context in which couples are located. This is important because the discursive context is often absent in research on concordances of health in couples.

In particular, we highlight the discursive context of healthism and its intersections with relationship norms. Discursive work on healthism has, to date, focused on the individual, highlighting the prevalence of healthism as a dominant discourse structuring individual sense-making across a range of populations and countries including UK, USA, Australia, New Zealand, and with translated equivalents in French, Italian and Spanish (Riley et al., 2018; Crawford, 2006; Graham et al., 2017; Hodgetts et al., 2005; Turrini, 2015). In 'relational healthism' we significantly expand this concept, showing how healthism also structures couples' health interactions with important implications for subjectivity and practice. In so doing, our findings suggest we should extend the concerns of the potential for harm in healthism to couples as well as individuals (Puhl et al., 2013). The global prevalence of healthism suggests significant transferability of our findings onto other populations whose discursive context includes western relationship norms and neoliberal healthism.

This study also makes a significant contribution to research on people's engagement with lifestyle advice. Where researchers have shown people resist advice because they have different individual or shared beliefs to their clinicians (Leventhal et al., 2011), we show that even when participants agree with clinical advice, they find it difficult to do. To debates on whether giving information empowers people to make informed choices or disempowers them through the language of individual responsibility and associated blame (Cheek, 2008), we show that these two things can happen simultaneously.

We also show how health practitioners' communication (Mentrup et al., 2020) is taken up by partners in diverse and complex ways that belie understandings of lifestyle advice as simple and benign. Acknowledging the power relations that lifestyle advice sets in motion between patients, partners, and clinicians, might enable more effective clinical communication strategies by disrupting the logic of blame inherent in lifestyle advice. Our study also suggests that recognising patients' relational context, values, and identity in relation to their diagnosis could avoid reductionist advice and help the development of more meaningful and sustainable goals relating to lifestyle change (Arborelius, 1996; Mayes & Thompson, 2015).

An implication of relational healthism and health practices being performative of coupledom is the potential for lifestyle advice to destabilize intimate relationships. Health information and advice needs to be considered in the light of health discourses and practices as productive not just of individual health identities, but of the ways that couples define themselves and their relationships. Our findings strongly indicate that lifestyle advice itself forms a source of conflict, in part because it requires participants to negotiate contradictory ideals and practices. Raising clinicians' and patients' awareness of this inherent tension is a first step to supporting them to manage its impact. This is in line with a Foucauldian standpoint that recognizing the discourses within which you are constituted enables more conscious negotiations of them (Foucault, 1972).

Future research could focus on developing strategies to support patients in engagement with lifestyle change advice while minimising relationship threat, as well as exploring affirmative strategies that couples might employ to take care of both their relationship and their health when undertaking health-related lifestyle change. The couples' strategies of balancing health imperatives with relationship norms of collaboration, recognition of autonomy and individuality, and acceptance could be considered in clinical lifestyle advice interactions. This aligns with Crossely's (2001, p. 161) argument for recognising the importance of creating 'survival' strategies to negotiate the complex, moral, and value laden meanings of health behaviours.

In line with broader limitations in health-related research, it is the 'better and better off', the more physically and psychologically well and socioeconomically secure, who tend take part in most health-related research (Buckley et al., 2007). This study had no participants from the lowest socioeconomic groups, or who had limited literacy or English. The couples we interviewed were also in stable relationships. Future research is therefore needed on how challenges related to significant economic hardship or unsafe, unsupportive, or unstable relationships might intersect with relational healthism. Similarly, against a backdrop of research showing the intersections of gender with health practices (Medved & Brockmeier, 2011) strongly gendered patterns were absent in our data. Our participants included more men with a diagnosis of CHD than women. While this reflects differences in incidence of heart disease in age groups up to 75, future studies could aim to recruit more men who care for women with CHD to capture their experiences (BHF, 2020). The study included men and women carers and patients, and the patterns of relational healthism were aligned with those roles as partners negotiated boundaries between caring and control. Whether gender is more subtly done or is being overridden by the ideological strength of healthism in the context of long-term relationships and CHD is another direction for future work.

In the context of urgently needing new understandings of the barriers to health-related behavioural change, this paper makes a significant contribution to understanding couples' engagement with lifestyle advice by focusing on the discursive context of both intimate relationships and health. This context creates a form of 'relational healthism' where the cultural imperatives to work on the self are extended to the other, but within which are inherently conflicting demands. Couples' attempts to engage in lifestyle advice therefore mean negotiating a complex and contradictory discursive landscape and involve identity and relationship costs. Affirmative directions for health promotion and clinical practice related to lifestyle advice include taking better account of the discursive and relational dimensions of health behaviour, and subsequent complexity of peoples' engagement with lifestyle change. These findings extend beyond both CHD and couples to recognise the logic of blame and potential for harm and resistance in health advice more generally. Lifestyle advice is one of the most common interventions and is universally recommended in health policies to address lifestyle disease (WHO, 2020). This study shows that it is important to develop a framework that recognises the potential for harm as well as benefit, and which takes into account wider social and discursive contexts, including healthism and relationships norms, for ethical and effective communication with patients and partners about lifestyle change.

Conflict of interest

We have no conflict of interest to disclose.

Data accessibility statement

The data that support the findings of this study are available on request from the first author and accessed via a depository: DOI 10.20391/fd33f764-ffd6-45ea-9cf0-528a1c335fac. The data are not publicly available due to its sensitivity and information that could compromise the privacy of research participants.

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