



Spread of health behaviors in young couples: How relationship power shapes relational influence



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ARTICLE INFO

Article history:

Received 25 January 2016

Received in revised form

21 July 2016

Accepted 22 July 2016

Available online 26 July 2016

Keywords:

Health behaviors
Relationship power
Partner influence
Adolescents
Couples

ABSTRACT

Introduction: Romantic relationships provide a context in which partners can influence each other's health behaviors (e.g., weight-related behaviors, substance use). Partner influence may be especially pronounced among newly parenting adolescent and young adult couples because of the desire to maintain relationships (and therefore openness to influence), and because parenting-related challenges can pose risk for uptake of unhealthy behaviors. Two understudied factors that might affect partner influence on health behaviors include relative power within the relationship and prior levels of engagement in health behaviors.

Methods: The current study explored longitudinal partner influence effects in a sample of newly parenting adolescent and young adult females and their male partners ($N_{couples} = 157$) recruited from four obstetrics/gynecology clinics in Connecticut between July 2007 and February 2011. Five health behaviors in two domains were explored: weight-related behaviors (unhealthy eating, exercise) and substance use (cigarette, alcohol, and marijuana use). Relationship power and previous levels of health behaviors were examined as moderators. Variations across gender were also examined.

Results: Results of dyadic analysis showed partner influences for alcohol use. Partner influence depended on relationship power for eating, alcohol, and marijuana use, and on previous behavior for cigarette use. Results also varied by gender – only female-to-male influence was found for unhealthy eating and cigarette use. Higher relationship power was protective against smoking escalation for females.

Discussion: These results differ from previous research findings mainly on male-to-female influences. Such asymmetries may reflect traditional female dominance in food preparation, as well as shifts in power balances postpartum. Targeting relational power dynamics may buffer the spread and escalation of unhealthy behaviors in young parents, with implications for the health of both members of a couple as well as their children.

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1. Introduction

Health behaviors tend to cluster within social groups and to spread through social contacts. Social clustering and influence around health behaviors such as weight-related behaviors (e.g., exercise, eating; de la Haye et al., 2010; Fletcher et al., 2011; Jackson et al., 2015) and substance use (Desrosiers et al., 2015; Fleming et al., 2010) are consistently found in populations of all ages (see also Meyler et al., 2007). In particular, the influence of the social

environment, including romantic relationship partners, on individual health behaviors is strong during adolescence and young adulthood (Fleming et al., 2010; Furman and Simon, 2006). Understanding how romantic partners influence each other's health behaviors may offer novel targets for interventions and long-term behavioral change. Two factors that may impact such influence effects include *romantic relationship characteristics* and *prior levels of engagement in health behaviors*.

Although many studies have shown that romantic partners influence each other's health behaviors, little is known about “for whom” or “under what conditions” these influences occur. For example, several studies found that influence effects are asymmetric – one partner may be influenced by but not influence the

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other. This suggests that a nuanced view of partner influence on health behavior is needed. Examples of asymmetries in the substance use domain include moderation by gender in couples (e.g., males influenced female substance use but females did not influence male substance use, Desrosiers et al., 2015; Leonard and Mudar, 2003), or moderation by relationship characteristics (e.g., relationship satisfaction, Fleming et al., 2010). Relational asymmetries may be particularly pronounced during adolescence because relationships tend to be fragile and vulnerable to break-ups (Furman, 2002; Youniss and Smollar, 1985), and adolescents may be more receptive to romantic partner influences in an attempt to preserve relationships (Giordano et al., 2002; Haynie et al., 2005).

1.1. Relationship power and partner influences

Relationship power, here defined as *power over others' outcomes* (e.g., Fiske and Berdahl, 2007; Keltner et al., 2003; see also Galliher et al., 1999), is one factor that might affect how romantic partners influence each other's health behavior. Ostensibly, a more powerful partner has greater ability to influence the other member of a couple. One approach to investigating power within romantic relationships is through assessing decision-making dominance (Pulerwitz et al., 2000). This broad measure of relationship power may affect romantic partner influence processes across numerous health behaviors. Research specifically examining this possibility, however, is lacking.

When considering health behaviors and relationship power of both members of a couple, many possibilities for influence arise. It is therefore important to assess the perceptions and behaviors of both members of a couple rather than focusing solely on one individual. Using a dyadic lens in a comprehensive review of theoretical approaches to power, Simpson et al. (2015) discuss a common theme suggesting that an individual with lower relative power in a relationship is more likely to act in accordance with the behaviors and wishes of a higher-powered partner. Simpson et al. (2015) also suggest that someone with lower power may be less likely to act in accordance with their own intentions and/or past behavior. This pattern has been demonstrated in condom use within couples: individuals reporting lower relative power show greater influence of partner condom use intentions on their own condom use intentions (VanderDrift et al., 2013). The effect of power on the spread of health behaviors has not been tested explicitly within the context of romantic relationships.

1.2. Prior level of engagement in health behaviors and partner influences

It is unlikely that partner influences will occur across all levels of a given health behavior. For example, studies have shown that partners influenced a person who engaged in low levels of drinking, but not someone who already engaged in higher levels of drinking (Gudonis-Miller et al., 2012). This suggests partner influence may be limited when there are upper limits on behaviors. If a person uses alcohol daily, a drinking partner may not further increase individual alcohol use. Similarly, in the domain of weight-related behaviors, upper limits on exercise may create a ceiling for partner influence effects.

1.3. Partner influences in young couples transitioning to parenthood

The influence of romantic partners on individual behavior is particularly strong during adolescence and young adulthood (Fleming et al., 2010; Furman and Simon, 2006), and adolescents may be more susceptible to the impact of relationship power

differentials with respect to decision-making around health behaviors. Major life transitions, such as the transition to parenthood, may also upset relationship power balances, leading to a renegotiation of established relationship patterns (Simpson et al., 2015), and creating avenues for partner influence. Because the transition to parenthood among adolescents and young adults is typically a stressful period associated with increases in relationship difficulties and greater parenting-related stressors than among older parents (Doss et al., 2009; Manzi et al., 2010; Quinlivan et al., 2004), young parents are at greater risk for engaging in health-harming behaviors (Hodgkinson et al., 2014) and may also be more susceptible to partner transmission of these behaviors. In light of the increased strains and role adjustments accompanying parenthood, as well as findings documenting an increase in substance use during the first year postpartum in both males and females (Spears et al., 2010), understanding how partners influence health behaviors, and how relationship power and behavioral patterns impact these influences have important implications for promoting healthy behaviors among young families.

2. Current study

To date, most studies of partner influence dynamics have focused exclusively on isolated domains of health behaviors (e.g., examining only weight-related behaviors or only substance use; for an exception see Aalsma et al., 2012), and many use cross-sectional samples. The current study expands upon earlier work by investigating multiple domains of health behaviors and investigating more precisely *how* romantic partners influence each other's health behaviors over time. Specifically, we examined *reports of relationship power and existing levels of a health behavior* as moderators of partner influence on five health behaviors across two domains: weight-related behaviors (unhealthy eating, exercise) and substance use (cigarette use, alcohol use, marijuana use). We hypothesized that, a) as relative partner relationship power increased, partner influences on health behaviors would increase, b) as relative partner power increased, the relationship between actor health behaviors over time might be attenuated, and c) higher existing levels of a health behavior may be less susceptible to partner influence over time. We also explored whether these effects varied across gender, although we had no specific directional hypotheses given conflicting results in previous research (see Rhule-Louie and McMahon, 2007). Understanding such relationship dynamics may offer insights for new points of intervention. Programs to assist young parents may, for example, be designed to alter relationship dynamics and provide a buffer against the spread of negative health behaviors, or to promote the spread of positive behaviors between partners.

3. Methods

3.1. Participants

The current study utilizes data obtained at six- and 12-months postpartum from a longitudinal study of adolescent and young adult females and their male partners recruited from obstetrics and gynecology clinics and an ultrasound clinic in four university-affiliated hospitals in Connecticut between July 2007 and February 2011 (see Kershaw et al., 2013 for further details). Of 944 couples screened for participation, 413 were eligible, and 296 enrolled in the study (72.2%). Data from 157 unique couples ($N_{\text{Male}} = 149$, $N_{\text{Female}} = 154$) with full actor and partner data at six months and who responded at 12 months were used in the current analyses.

Inclusion criteria were a) pregnant partner in the second or third

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