Dyadic Associations Between Self-perceptions of Aging and Health Behaviors Among Middle-aged and Older Couples

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Abstract

Background and Objectives: Research and theory suggest that older adults' self-perceptions of aging (SPA) are associated with their health behavior engagement. Likewise, romantic partners often play a key role in shaping each other's health behaviors. This study aims to explore the longitudinal dyadic associations between SPA and health behaviors among couples in midlife and older adulthood.

Research Design and Methods: Data were drawn from 3,330 couples ages 50-96 (M_{men} = 67.22 [9.43]; M_{women} = 65.42 [8.96]) from the Health and Retirement Study, using pooled samples from 2010/2012 to 2012/2014. We estimated actor-partner interdependence models with moderation to assess whether and to what extent a partner's SPA moderated the links between positive and negative SPA and engagement in preventive and risky health behaviors two years later.

Results: Women's SPA moderated the association between men's SPA and men's risky health behaviors only when women reported extreme levels of negative or positive SPA. In contrast, men's SPA did not moderate the associations between women's SPA and women's health behaviors.

Discussion and Implications: This study's findings emphasize that links between SPA and health behaviors operate within the broader social environment and in the context of romantic relationships. The results highlight how couples' perceptions of aging relate to their own and their partners' health behaviors. This work contributes to the literature on the gendered and social nature of health behaviors and has implications for designing interventions targeting SPA.

Keywords: subjective aging, views on aging, dyads, physical activity

Marriage and committed partnerships confer substantial health benefits to their members (Kiecolt-Glaser & Newton, 2001; Umberson & Thomeer, 2020). On average, partnered individuals have longer lifespans (Lawrence et al., 2019), higher cancer survivorship rates (Krajc et al., 2022), fewer risk factors for cardiovascular disease (Gallo et al., 2003), and better post-surgical recoveries (Neuman & Werner, 2016), among other favorable outcomes. In midlife and older adulthood, romantic partnerships are associated with better functional ability, lower disease burdens, fewer depressive symptoms, and less risk of cognitive impairment (Håkansson et al., 2009; Hughes & Waite, 2009). Further, as the majority of older adults (57.4%) are currently married and few report having never married (6.6%; Loo & Brown, 2024), it is likely that most individuals will experience a committed partnership during their lives.

Romantic relationships contribute to health, in part, via health behaviors, including preventive actions, such as regular exercise or physician visits, or risky behaviors like substance use (Short & Mollborn, 2015). Couples share environments related to health behaviors (Hoppmann & Gerstorf, 2014) and push one another to engage in such actions (Lewis & Butterfield, 2005), which are ultimately associated with a variety of health outcomes. For instance, Bosnes et al. (2019) found that engaging in more preventive and fewer risky health behaviors at baseline was linked with lower disease burden, higher cognitive performance, and better physical functioning 20 years later ($N = 4,497$; $M_{age} = 53$). Similarly, a meta-analysis covering 5.3 million respondents ages 40+ suggested that health behaviors were strongly associated with cardiovascular function and survival (Colpani et al., 2018). Thus, as modifiable antecedents of health in later life, health behaviors are important public health targets.

Psychological factors, such as self-perceptions of aging (SPA), or evaluations of one's experience with aging, shape health behavior engagement (Levy, 2009; Short & Mollborn,

2015). Research shows that more positive SPA is linked with more engagement in preventive health behaviors, whereas more negative SPA is associated with fewer such behaviors (Warmoth et al., 2016). Despite robust evidence that the social environment shapes health behavior engagement, the links between romantic partners' SPA and health behaviors remain unexamined. Exploring these associations dyadically can reveal how shared views of aging relate to healthy aging. Thus, the purpose of this study was to examine how interactions of both partners' SPA shape health behavior engagement among couples in midlife and older adulthood.

Theoretical Frameworks

Stereotype embodiment theory posits that individuals internalize sociocultural messages about aging across the life course, and these ideas form the foundation for evaluating one's aging (Levy, 2009). These beliefs—called SPA once they become self-relevant—impact health outcomes in older adulthood, in part through health behaviors. For instance, individuals who believe that functional limitations are an inherent part of older adulthood (i.e., high negative SPA) may be less likely to work on improving their balance or strength, considering such actions to be futile. Importantly, messages about aging are constructed and reinforced through the individual's environment, including social interactions.

Interdependence theory suggests that romantic partners' attitudes and behaviors are interlinked and, consequently, one partner's internal beliefs may predict the other partner's behavior (Rusbult & VanLange, 2008). This interdependence may be particularly salient at later ages, as more time spent in a relationship and a shared household can heighten mutual influence. For instance, evidence suggests that physical activity concordance is stronger in longer relationships (Pauly et al., 2020) and the dyadic impact of SPA on functional ability increases alongside marital duration (Mejía & Gonzalez, 2017). Further, older couples receive fewer

health-promoting messages from friends and other family members, compared to younger adults

(Tucker et al., 2004). Thus, whereas partner influences increase over time, other sources of

health-related pressures may dissipate. Altogether, examining the dyadic context in which both

partners age is critical to understanding each individual's health trajectory.

Partner Influences on Health Behaviors among Middle-Aged and Older Couples

Among older couples, research has documented partner concordance across health

behaviors, including physical activity (Li et al., 2023) and substance use (Jackson et al., 2015).

Further, individuals are more likely to change their health behaviors when their partner also does

so. For example, dyadic evidence ($M_{age} = 62$) suggests that smoking cessation and increased

physical activity are more likely when one's partner has recently engaged in these behaviors

(Jackson et al., 2015), underscoring that partners' health behaviors are interlinked. Beyond direct

behaviors, partners' internal beliefs are associated with one another's health behaviors. Among

couples ages 50-94, for example, partners' mastery beliefs and happiness were linked to

individuals' physical activity (Chopik & O'Brien, 2017; Drewelies et al., 2018). This indicates

that health behaviors are shaped not only by partners' observable behaviors, but also their

psychological resources.

One explanation for the link between partners' health behaviors centers on *social control,*

a dyadic process in which partners influence one another's health behaviors through methods

like modeling, encouragement, or pestering (Craddock et al., 2016; Lewis & Butterfield, 2005).

In different-gender relationships, women tend to shape men's behaviors to a greater degree than

men shape women's (Lewis et al., 2004), perhaps due to societal expectations of women as

caretakers and men as risktakers (Reczek & Umberson, 2012). Overall, these studies suggest that

individuals, particularly women, are effective agents at shaping the health behaviors of their

partners, particularly men.

SPA and Health Behaviors

At the individual level, research shows that more positive SPA is associated with more

frequent engagement in preventive health behaviors and less engagement in risky health

behaviors (Levy & Myers, 2004). For example, more positive views on aging are associated with

more frequent physical activity, nutrient dense diets, and preventive health screenings over time

(Kim et al., 2014; Klusmann et al., 2019; Nakamura et al., 2022), whereas more negative

expectations for aging are linked with less frequent exercise (Sarkisian et al., 2005).

However, each of these studies assesses SPA with a unidimensional measure. Because

aging is characterized by both gains and losses, views on aging are best captured with multiple

scales (Kornadt et al., 2020; Turner et al., 2021). Among HRS respondents ($N = 7,500$), more

positive SPA was associated with a greater likelihood of weekly physical activity two years later,

whereas more negative SPA predicted a lower likelihood (Hooker et al., 2019). Further, the

impact of positive SPA on physical activity was stronger than that of negative SPA, suggesting

that the motivation of feeling better about one's aging process may outweigh the hindering

impacts of appraising aging poorly. Associations between multidimensional SPA scales and

substance use are inconsistent across studies (Hooker et al., 2019; Villiers-Tuthill et al., 2016).

SPA and Romantic Relationships

The nascent literature examining SPA within intimate partnerships suggests that couples'

SPA are positively correlated (Cohn-Schwartz et al., 2021; Kim et al., 2018; Skoblow et al.,

2023) and this link may grow stronger with time (Mejía et al., 2020). Additionally, individuals'

(M_{age} = 68) SPA indirectly predicts their partner's health eight years later via the partner's SPA (Cohn-Schwartz et al., 2021). It is unknown how the dyadic interaction of both partners' beliefs relates to health behaviors. For instance, couples in which both partners report more positive SPA may show stronger links to health behavior engagement compared to those with discordant beliefs. Therefore, the purpose of the present study was to test the interaction between partners' positive and negative SPA on their health behaviors.

Hypothesis 1: When examining the link between actors' positive SPA and health behaviors, we expect that partners' SPA will moderate the association between individuals' own SPA and their health behaviors. Specifically, we expect that partner's positive SPA will strengthen the positive association between actors' positive SPA and preventive health behaviors and the inverse association with risky health behaviors (H1a). We also expect that partners' negative SPA will weaken positive associations between actors' positive SPA and preventive health behaviors and inverse associations between positive SPA and risky health behaviors (H1b).

Hypothesis 2: Likewise, when examining the link between actor's negative SPA and health behaviors, we expect that partners' SPA will moderate the association between individuals' own SPA and their health behaviors. Specifically, we expect that partners' negative SPA will strengthen the positive associations between actors' negative SPA and risky health behaviors and inverse associations with preventive health behaviors (H2a). Finally, we expect that partners' positive SPA will weaken inverse associations between actors' negative SPA and preventive health behaviors and positive associations between negative SPA and risky health behaviors (H2b).

Methods

Data were drawn from the Health and Retirement Study (HRS), a biennial panel survey
aimed at understanding the health and well-being of older adults. The HRS uses a multi-stage
area probability sample design to select respondents from all U.S. community-dwelling adults
ages 50+ and their spouses or cohabiting partners, regardless of age (Heeringa & Connor, 1995;
Sonnega et al., 2014). Oversampling Black and Hispanic respondents, the HRS is ethnoracially
representative of the U.S. population (Schroeder et al., 2023). The HRS is supported by the
National Institute on Aging and approved by the University of Michigan's Institutional Review
Board.

Each partner completed the core interviews separately, in-person during baseline
interviews and either in-person or via phone during follow-up interviews. At each wave, in
addition to the core interviews, a random half of the sample was eligible to complete the self-
administered questionnaire (SAQ) either via phone or on paper and returned by mail (Smith et
al., 2023). The other half of the sample was eligible to complete the SAQ at the following wave.
In the current study, we drew data from the SAQ and the RAND Longitudinal Files (Bugliari et
al., 2023), cleaned versions of many HRS core variables. Response rates for our target waves
were >80% for the core variables and >70% for the SAQ variables (HRS Staff, 2023; Smith et
al., 2023). Combining data from the 2010 and 2012 SAQ waves, Time 1 data were collected in
2010/2012 and Time 2 data in 2012/2014.

At baseline, 8,566 partnered individuals aged 50+ were eligible for and completed the
SAQ. Of these, there were 7,152 cases in which both partners responded to all SPA items. We
excluded the 426 cases in which partners died or were widowed between waves and the 48
individuals in same-gender relationships (due to statistical restrictions with distinguishability).

When two couples shared a household, we randomly dropped one (excluded 18) to avoid dependencies for a final sample of 6,660 individuals (N = 3,330 dyads).

Measures

Health Behaviors (T2)

Preventative behaviors. Following past work (Nakamura et al., 2022), *frequent physical activity* was coded as engaging in moderate or vigorous exercise at least once weekly (0 = *not active;* 1 = *active*). *Physician visits* (excluding hospitalizations) and *dentist visits* were coded as having seen a doctor or dentist, respectively, in the past two years (0 = *no;* 1 = *yes*). Preventive health behaviors (0-3) were the sum of physical activity, physician visits, and dentist visits.

Risky behaviors. *Heavy alcohol consumption* was defined as 15+ weekly alcoholic drinks for men and 8+ for women (0 = *not heavy drinking;* 1 = *heavy drinking*; U.S. Department of Agriculture & U.S. Department of Health and Human Services, 2020). This variable is the product of drinking days per week and the number of drinks consumed on each drinking day. Cigarette *smoking* was binary (0 = *non-smokers*; 1 = *smokers*). Risky health behaviors (0-2) were the sum of heavy alcohol consumption and smoking.

Self-Perceptions of Aging (T1)

SPA was measured with items from the Attitudes Toward Own Aging subscale of the Philadelphia Geriatric Center Morale Scale and the Berlin Aging Study (Lawton, 1975; Liang & Bollen, 1983; Smith et al., 2023). Four items represent positive SPA (e.g., "As I get older, things are better than I thought they would be.") and four represent negative SPA (e.g., "The older I get, the more useless I feel.") on a scale from 1 (*strongly disagree*) to 6 (*strongly agree)*. We created separate mean scores for positive and negative SPA; higher scores indicate higher levels of that

construct. Alphas for men were .78 (positive SPA) and .75 (negative SPA). For women, alphas were .78 (positive SPA) and .75 (negative SPA).

Covariates (T1)

All models accounted for baseline indicators that may be associated with SPA or health behaviors. *Age* and *educational attainment* were measured in years. *Race* (0 = *White*; 1 = *Black*; 2 = *Other*), e*thnicity* (0 = *non-Hispanic*; 1 = *Hispanic*), and *health insurance status* (0 = *insured*; 1 = *uninsured*) were coded as dummy variables. To assess *relationship quality,* respondents rated the closeness of their relationship (1 = *not at all close*; 4 = *very close*). Respondents rated their *health* from 1 (*poor*) to 5 (*excellent*).

Household wealth was measured as the sum of assets minus the sum of debts. Because it was skewed and kurtotic, we took the natural log of positive wealth values. When debts exceeded assets, we log-transformed the absolute value of wealth, then multiplied the result by −1, preserving the representation of debt.

Depressive symptoms were measured with the eight-item version of the Center for Epidemiological Studies Depression (CES-D) Scale (Radloff, 1977). Respondents reported whether they have experienced a symptom "much of the time during the past week." We summed endorsed symptoms into a score ranging from 0 to 8 in which higher scores indicate more depressive symptoms (men α = .76; women α = .80).

Additionally, we controlled for baseline levels of preventive and risky health behaviors. Models using positive SPA as the predictor controlled for negative SPA and vice versa.

Analytic Plan

Analyses were conducted using structural equation modeling in Mplus Version 8.7. We

estimated actor-partner interdependence moderation models (APIMoM; Garcia et al., 2015),

which can accommodate the statistical nonindependence of dyadic data (Kenny et al., 2006).

Dyads were treated as distinguishable by gender. Missing data were addressed using full

information maximum likelihood. We evaluated models using the comparative fit index (CFI;

≥0.95), root mean square error of approximation (RMSEA; ≤0.06), standardized root mean

square residual (SRMR; ≤0.08), and chi-square tests (Hu & Bentler, 1999).

We estimated the associations and interactions between both partners' positive and

negative SPA at T1 and their health behavior engagement at T2 (see Figure 1). Four models

covered all possible interactions of actors' and partners' positive and negative SPA (i.e., both

positive, both negative, actor positive and partner negative, actor negative and partner positive).

Models with significant interaction terms were probed with the Johnson-Neyman technique

(Johnson & Fay, 1950; Lin, 2020).

Results

Sample characteristics are presented in Table 1. Men reported higher levels of negative

SPA than women but there was no difference between partners' reports of positive SPA. Women

were more likely to have seen a physician or dentist in the last two years but less likely to be

physically active. Men were more likely to be smokers but less likely to drink alcohol heavily. At

the bivariate level (Table 2), positive SPA was positively correlated with actor and partner

preventive health behaviors for both men and women. Similarly, men's and women's negative

SPA were inversely related to actor and partner preventive health behaviors. Men's positive SPA

was inversely correlated with men's and women's risky health behaviors, whereas women's positive SPA was only inversely correlated with men's risky health behaviors. Men's and women's negative SPA were positively correlated with men's risky health behaviors, and men's negative SPA was inversely related to women's risky health behaviors. Most effect sizes were small to moderate in magnitude, ranging from $r = -.039$ (men's positive SPA and women's risky health behaviors) to $r = -.467$ (women's positive and negative SPA).

Models with statistically significant moderation terms are shown in Tables 3 and 4. Other models are presented in Supplementary Tables 1 and 2. Given the stability of coefficients between models, findings are summarized hereafter. Full models were saturated, $\chi^2(0) = 0.000$, $p < .001$, CFI = 1.000, RMSEA = 0.000 [0.000, 0.000], SRMR = 0.000. To obtain more meaningful fit statistics, we computed more parsimonious models. Parsimonious models retained all actor covariates except health insurance status (> 90% of respondents were insured), and only the partner covariates of SPA, baseline health behaviors, self-rated health, and relationship quality. Correlations between predictors that did not significantly contribute to the full models were constrained to zero. All parsimonious models fit the data well (CFIs = .980–.997; RMSEAs = .010–.024; SRMRs = .010–.020; Tables 3–4 and Supplementary Tables 1–2).

Positive SPA (Hypotheses 1a and 1b). There were significant actor effects between positive SPA and preventive health behaviors, with more favorable views predicting greater engagement in preventive health behaviors for men (β's = 0.025) and women (β's = 0.027 to 0.029). There was a significant partner effect for women only as men's more positive SPA was associated with lower levels of women's preventive health behaviors (β's = –0.024 to –0.025). Women's positive SPA was not related to men's preventive health behaviors, nor were there significant actor X partner SPA interactions for preventive health behaviors.

There were no main effects between actors' and partners' positive SPA and risky health behaviors, but there was an actor X partner interaction (see Table 3). Women's negative SPA moderated the association between men's positive SPA and men's risky health behaviors ($\beta =$ 0.010, $p = .002$). The boundaries of significance for women's centered negative SPA were approximately 1.25 standard deviations below and 1.4 standard deviations above the mean, aligning with raw scores of 1.62 and 4.77, respectively (Figure 2A). Possible and actual sample scores range from 1 to 6. When women reported high levels of negative SPA, the link between men's positive SPA and his risky health behaviors was positive and significant; when women reported low levels of negative SPA, the link between men's positive SPA and his risky health behaviors was negative and significant. In this sample, 11.7% of women reported negative SPA scores falling below 1.62 and 5.0% of women reported scores above 4.77 (data not shown). There was no moderation for the remaining 83.3% of cases in which women reported negative SPA values between 1.62 and 4.77.

Negative SPA (Hypotheses 2a and 2b). For men only, higher levels of negative SPA were associated with less engagement in one's own preventive health behaviors (β's $= -0.030$). Although there were no direct links between negative SPA and risky health behaviors, as shown in Table 4, women's positive SPA moderated the link between men's negative SPA and men's risky health behaviors ($\beta = 0.007$, $p = .021$). The boundary of significance for women's centered positive SPA was approximately 1 standard deviation above the mean (Figure 2B), corresponding to a raw score of approximately 5.34. Possible and actual sample scores range from 1 to 6. When women reported very high levels of positive SPA, the association between men's negative SPA and his risky health behaviors was positive and significant. In this sample, 11.3% of women reported positive SPA scores higher than 5.34 (data not shown). At lower

levels of women's positive SPA, her favorable views on aging were unrelated to the association between men's negative SPA and his risky health behaviors.

Discussion

The purpose of this study was to examine the longitudinal and dyadic associations between SPA and health behaviors among couples aged 50+. Overall, the findings support stereotype embodiment theory, as respondents' positive and negative SPA were associated with their engagement in health behaviors two years later. Supporting interdependence theory, findings also suggested that health behavior engagement is shaped not only by one's own SPA, but also that of one's partner. In some contexts, the link between men's SPA and his engagement in risky health behaviors was dependent on his partner's SPA, although these effects were limited to women's extreme SPA levels. Notably, such views are not rare; significant moderation was found for 994 couples (30%) in this sample. Past work with the HRS found no significant links between SPA and smoking or alcohol use (Hooker et al., 2019; Nakamura et al., 2022), yet our findings suggest that these constructs may be related within the dyadic context.

Men's more positive SPA was linked with men's greater engagement in risky health behaviors when their partner reported high levels of negative SPA. Contrary to H1b and previous research with individuals (e.g., Levy & Myers, 2004), these results suggest that more positive SPA is not protective for men whose partners view their aging negatively. Perhaps women's high negative SPA reflects experiences with age-related stressors. The Strength and Vulnerability Integration model suggests that older adults are motivated to avoid stressful encounters yet more susceptible to negative stress responses (Charles, 2010). Further, more negative SPA is associated with heightened stress reactivity (Bellingtier & Neupert, 2018) and strengthens the links between stress and perceived ill-health (Witzel et al., 2022), possibly reinforcing negative

views. Women's stress may extend to their partner, leading men to engage in risky coping mechanisms. Links between stress and alcohol consumption are stronger among some men than women (Armeli et al., 2000; Horta Esper & Furtado, 2013). Thus, even if men do not view aging unfavorably, they may be reacting to their partners' stress responses to aging.

Contrary to H2b, men's more negative SPA was positively associated with his engagement in risky health behaviors only when their partner held extremely high levels of positive SPA. Women who feel positively about their own aging may exert less health-related social control, possibly due to unrealistically optimistic aging expectations and insufficient preparation for the future (Kornadt & Rothermund, 2014). Evidence suggests that whereas high levels of negative SPA are generally detrimental, some realism may help prepare for and recover from health shocks, as older adults with more negative SPA reported less negative affect following a serious health event (Wolff et al., 2017). Over time, however, more negative SPA predicted poorer functional abilities. Likewise, the unexpected partner effect from men's more positive SPA to women's less frequent engagement in preventive health behaviors may appear counterintuitive, yet surprising results have been found in other past work with SPA (e.g., Hooker et al., 2019). It is also plausible that our limited preventive health behavior items are more individually focused, whereas other behaviors may be more likely to operate dyadically. Thus, future replication work will be important in determining whether our findings are anomalies or a consistent pattern within a dyadic context.

Partially supporting H1b, this study also showed that men's more positive SPA was linked with men's lower engagement in risky health behaviors when women held extremely low levels of negative SPA. Hence, women's negative SPA may be a barrier to engaging in health-related social control. A bidirectional association may also be present, such that women whose

partners do not engage in risky behaviors have fewer health concerns and are more likely to evaluate aging positively.

There was no evidence of interaction in the actor Positive x partner Positive or actor Negative x partner Negative SPA models. Perhaps partners' SPA interact to predict health behavior engagement only at discordant and extreme levels. How these constructs interact within and between individuals will be an important area of future research in the social context of SPA.

Finally, contrary to hypotheses, there was no evidence that partners' SPA interacted to predict preventive health behaviors. In line with previous work (Levy & Myers, 2004; Nakamura et al., 2022; Wurm et al., 2010), individuals with more positive SPA engaged in preventive health behaviors more frequently. For men only, more negative SPA predicted less engagement in these behaviors. These findings suggest that links between individuals' view of aging and preventive health behaviors may operate independently of their partners' SPA, whereas risky behaviors are more dependent on a partner's views. Evidence suggests that older couples do not often exercise together (Barnett et al., 2013), whereas drinking and smoking may be shared activities (Birditt et al., 2019). Because our analysis focused solely on physical activity and medical and dental visits, future work should use a broader range of preventive health behaviors (e.g., dietary choices, stress reduction, sleep optimization) to determine whether partners' SPA is associated with different health-promoting behaviors.

Limitations

First, couples in which both partners participate in research may have higher relationship satisfaction than those who decline (Barton et al., 2020), and emotionally closer couples tend to have the greatest interdependence in SPA (Mejía et al., 2020). Thus, it is possible that the SPA of participants in the current sample is more interlinked than average.

Second, the HRS does not include measures of health-related social control, which may mediate associations between individuals' SPA and partner's health behaviors. Future work should assess how SPA relates to social control strategies and whether these efforts have differential effects based on the target's SPA (Craddock et al., 2015). Moreover, other variables we included as covariates, such as health status and age, may shape the magnitude of these effects. Competing models examining three-way interactions may reveal greater nuances in the understanding of partners' SPA and health behaviors.

Third, many eligible respondents did not complete the SPA items. Previous research suggests that those missing respondents reported poorer health and were more likely to be non-White (Cohn-Schwartz et al., 2020). Additionally, the predominantly White ($> 80\%$) sample curtails generalizability to the broader population of couples ages 50+.

Finally, our data were collected from 2010 to 2014 to avoid the potential confounding effects of the COVID-19 pandemic, and therefore, more recent data may show different patterns. Evidence suggests that heightened ageism during the pandemic may have elevated negative SPA (Kornadt et al., 2021), while pandemic-related stress may have increased engagement in risky health behaviors (Zvolensky et al., 2020). Exploring the long-term effects of the pandemic on older couples' SPA and health behaviors will be a valuable endeavor for future work.

Implications and Conclusion

These results have implications for SPA interventions. Notably, only women's extreme levels of SPA moderated the actor effects between men's SPA and health behaviors, in line with past research showing that women often serve as health role models in a couple (Lewis et al., 2004). Thus, interventions aimed at women's SPA may be particularly important for promoting health behaviors within romantic relationships.

Our findings also suggest that extreme views—even very high positive SPA—may have adverse consequences. Specifically, women's extremely high positive SPA may be detrimental for their partners' ability to reduce or abstain from cigarettes and heavy drinking. Although promoting more favorable views on aging is broadly valuable, perhaps interventions should aim to foster more realistic, rather than evermore positive, views of aging. Of course, usually realistic views will be more positive than dominant ageist stereotypes. As the field continues to address widespread ageism, we must also be cognizant that a rose-colored vision of aging may be harmful. Overall, these results underscore that views on aging are embedded within a social context, particularly romantic partnerships, often the most intimate unit of one's social ties.

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Tables

Table 1

*Sample Descriptive Statistics (*N = *3,330 Dyads)*

Variable	M_{men} (*SD)* / %	M_{women} (*SD)* / %	t / χ^2	*d,* 95% CIs
T2 Preventive health behaviors (0-3)	2.29 (0.79)	2.36 (0.77)	4.01***	.07 [.04, .11]
Physically active	70.27%	67.00%	86.18***	
Physician visit	84.80%	85.95%	77.68***	
Dentist visit	60.93%	68.41%	499.16***	
T2 Risky health behaviors (0-2)	0.14 (0.38)	0.15 (0.38)	0.35	.01 [–.03, .04]
Heavy alcohol use	5.23%	6.34%	103.53***	
Current smoker	8.17%	7.06%	310.41***	
T1 Positive SPA (1-6)	4.09 (1.15)	4.13 (1.21)	1.43	.03 [–.01, .06]
T1 Negative SPA (1-6)	3.23 (1.16)	3.11 (1.19)	–7.02***	–.12 [–.16, –.09]
T1 Age (years)	67.22 (9.43)	65.42 (8.96)	–31.95***	–.55 [–.59, –.52]
T1 Education (years)	13.10 (3.14)	13.11 (2.83)	–0.21	.00 [–.03, .04]
T1 Race				
White	82.19%	82.85%	1864.30***	
Black	10.39%	10.30%	2827.82***	
Other	7.15%	6.58%	731.44***	

T1 Hispanic ethnicity	11.56%	11.86%	2300.90***	
T1 Health insurance	93.9%	93.1%	663.74***	
T1 Relationship quality (1-4)	3.60 (0.63)	3.46 (0.71)	−10.70***	−.19 [−.22, −.15]
T1 Household wealth	$545,266.54 ($860,923.01)			
T1 Depressive symptoms (1–8)	0.94 (1.54)	1.20 (1.82)	7.05***	.13 [.09, .16]
T1 Self-rated health (1–5)	3.23 (1.00)	3.31 (1.01)	3.68***	.06 [.03, .10]

Note. CIs = confidence intervals; *d* = Cohen's *d;* SPA = Self-perceptions of aging; T1 = Time 1;

T2 = Time 2.

*p < .05; **p < .01; ***p < .001.

Table 2

Bivariate Correlations of Key Variables

Variables	1	2	3	4	5	6	7
1. Men's positive SPA (T1)							
2. Women's positive SPA (T1)	.233***						
3. Men's negative SPA (T1)	−.449***	−.192***					
4. Women's negative SPA (T1)	−.183***	−.467***	.303***				
5. Men's preventive health behaviors (T2)	.177***	.125***	−.255***	−.172***			
6. Women's preventive health behaviors (T2)	.089***	.169***	−.179***	−.214***	.369***		
7. Men's risky health behaviors (T1)	−.043*	−.052**	.044*	.059***	−.134*	−.085***	
8. Women's risky health behaviors (T2)	−.039*	−.029	−.031*	−.007	.012	−.031	.269***

Note. $N = 3,330$ dyads. SPA = self-perceptions of aging; T1 = Time 1; T2 = Time 2.

*p <.05, **p <.01, ***p <.001.

Table 3

Results of APIMoM with Men's Positive SPA x Women's Negative SPA Interactions

	Men's PHB			Women's PHB			Men's RHB			Women's RHB		
	b	*SE*	*p*	*b*	*SE*	*p*	*b*	*SE*	*p*	*b*	*SE*	*p*
M Positive SPA x W Negative SPA	–0.001	0.008	.910	–0.006	0.008	.392	**0.010**	**0.003**	**.002**	–0.006	0.003	.052
M Positive SPA	**0.025**	**0.012**	**.035**	**–0.025**	**0.011**	**.025**	–0.001	0.005	.878	–0.008	0.005	.068
M Negative SPA	**–0.030**	**0.012**	**.013**	0.000	0.012	.993	0.006	0.005	.248	–0.001	0.005	.912
M T1 PHB	**0.460**	**0.017**	**< .001**	**0.110**	**0.016**	**< .001**	–0.008	0.007	.233	0.004	0.007	.578
M T1 RHB	**–0.127**	**0.028**	**< .001**	–0.035	0.027	.198	**0.641**	**0.012**	**< .001**	**0.025**	**0.011**	**.026**
W Positive SPA	0.008	0.011	.456	**0.028**	**0.011**	**.010**	0.003	0.005	.515	–0.001	0.005	.808
W Negative SPA	0.006	0.012	.614	0.000	0.012	.992	0.006	0.005	.214	0.001	0.005	.799
W T1 PHB	**0.115**	**0.017**	**< .001**	**0.480**	**0.017**	**< .001**	–0.008	0.007	.264	0.005	0.007	.439
W T1 RHB	**0.058**	**0.029**	**.044**	–0.021	0.028	.446	**0.055**	**0.012**	**< .001**	**0.687**	**0.012**	**< .001**
Fit statistics	$\chi^2(90)$ = 126.492, *p* = .007, CFI = .996, RMSEA = .011 [.006, .015], SRMR = .010											

Note. Parsimonious models and unstandardized coefficients are presented above. SPA is measured at T1 and health behaviors are measured at T2. APIMoM = actor-partner interdependence moderation model; CFI = comparative fit index; M = men; PHB = preventive health behaviors; RHB = risky health behaviors; RMSEA = root mean square error of approximation; SRMR = standardized root mean square residual; T1 = Time 1; T2 = Time 2; W = women.

Table 4

Results of APIMoM with Men's Negative SPA x Women's Positive SPA Interactions

	Men's PHB			Women's PHB			Men's RHB			Women's RHB		
	b	*SE*	*p*	*b*	*SE*	*p*	*b*	*SE*	*p*	*b*	*SE*	*p*
W Positive SPA x M Negative SPA	–0.004	0.008	.610	0.006	0.008	.423	**0.007**	**0.003**	**.021**	0.003	0.003	.280
M Positive SPA	**0.025**	**0.012**	**.037**	**–0.025**	**0.011**	**.025**	0.000	0.005	.962	–0.009	0.005	.063
M Negative SPA	**–0.030**	**0.012**	**.013**	–0.001	0.011	.944	0.007	0.005	.182	–0.001	0.005	.802
M T1 PHB	**0.460**	**0.017**	**< .001**	**0.109**	**0.016**	**< .001**	–0.008	0.007	.219	0.004	0.007	.594
M T1 RHB	**–0.126**	**0.029**	**< .001**	–0.036	0.027	.188	**0.641**	**0.012**	**< .001**	**0.024**	**0.011**	**.030**
W Positive SPA	0.009	0.011	.434	**0.027**	**0.011**	**.013**	0.003	0.005	.569	–0.002	0.005	.723
W Negative SPA	0.006	0.012	.598	0.000	0.012	.970	0.005	0.005	.256	0.001	0.005	.851
W T1 PHB	**0.115**	**0.017**	**< .001**	**0.479**	**0.017**	**< .001**	–0.008	0.007	.262	0.005	0.007	.451
W T1 RHB	**0.058**	**0.029**	**.044**	–0.021	0.028	.454	**0.055**	**0.012**	**< .001**	**0.687**	**0.012**	**< .001**
Fit statistics	$\chi^2(87)$ = 114.888, *p* = .024, CFI = .997, RMSEA = .010 [.004, .014], SRMR = .010											

Note. Parsimonious models and unstandardized coefficients are presented above. SPA is measured at T1 and health behaviors are

measured at T2. APIMoM = actor-partner interdependence moderation model; CFI = comparative fit index; M = men; PHB =

preventive health behaviors; RHB = risky health behaviors; RMSEA = root mean square error of approximation; SRMR =

standardized root mean square residual; T1 = Time 1; T2 = Time 2; W = women.

Figures

Figure 1

Conceptual Model of Actor x Partner SPA Interactions on Dyads' Health Behaviors
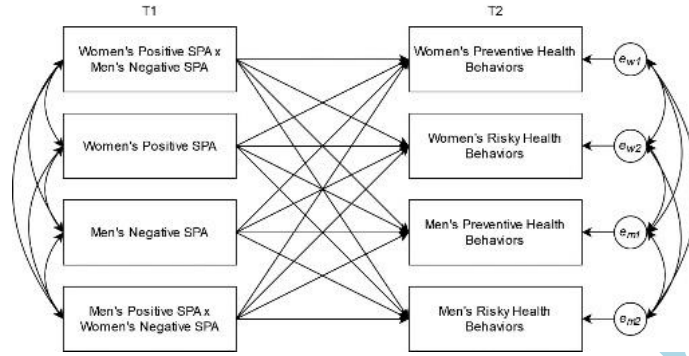
Note. Sample figure of actors' positive SPA interacting with partners' negative SPA. Separate models estimated all combinations of actors' and partners' positive and negative SPA. Time points are two years apart. Covariates are excluded from this figure for simplicity. SPA = self-perceptions of aging.

Figure 2

Region of Significance for Moderation of Women's SPA on the Association Between Men's SPA and Men's Risky Health Behaviors
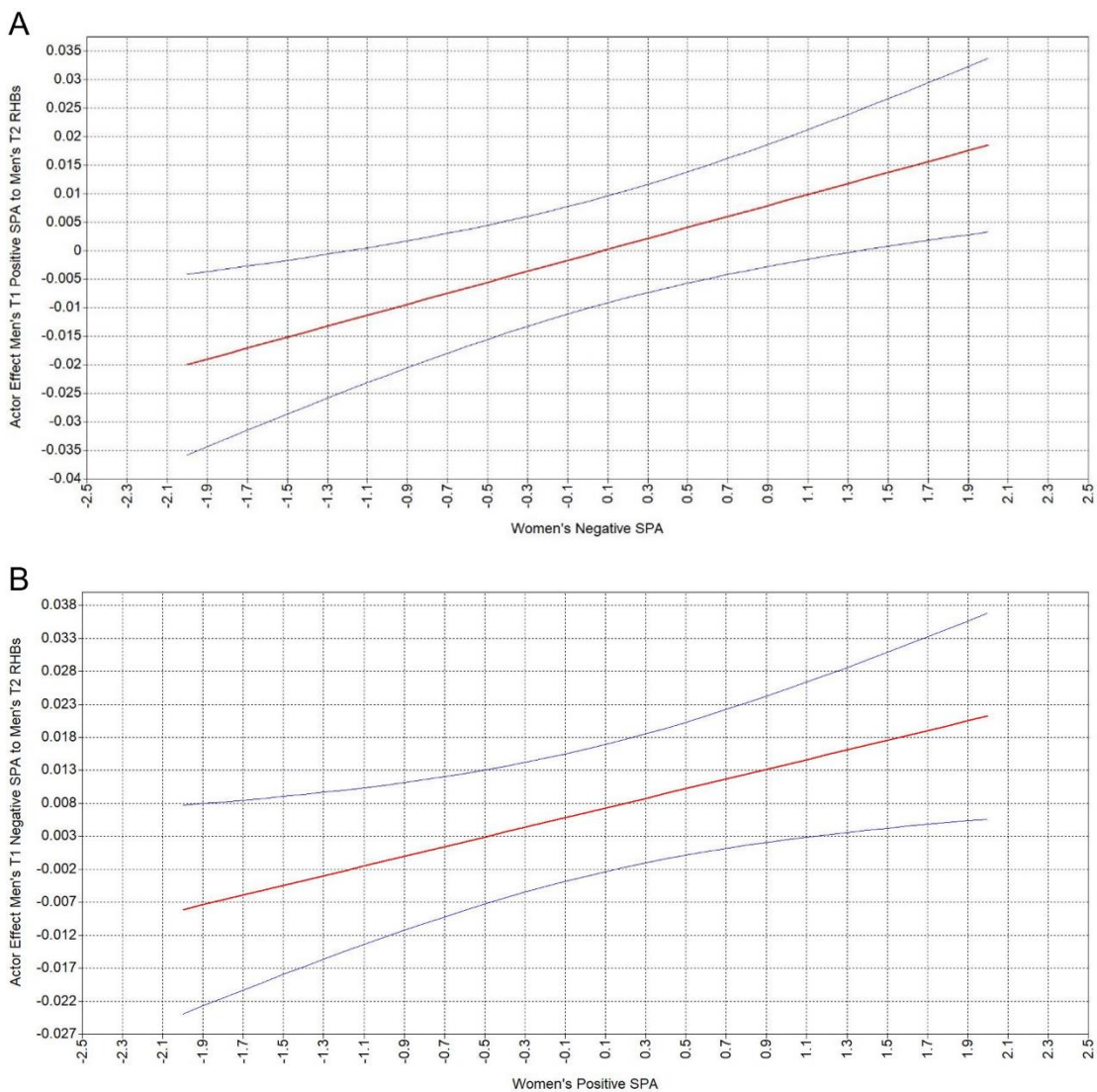
Note. The central red line is the regression line between men's SPA and men's risky health behavior engagement. The exterior blue lines represent the 95% confidence interval. Panel A: The interaction of women's negative SPA is significant at approximately 1.25 units below and 1.40 units above the mean. Panel B: The interaction of women's positive SPA is significant at approximately 1 unit above the mean. RHBs = risky health behaviors; SPA = self-perceptions of aging.

Figure 1

Figure 2