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Living with parents or grandparents increases social capital and survival: 2014 General Social Survey-National Death Index



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ABSTRACT

Introduction: After nearly a century-long trend toward single-family living arrangements, people in wealthy nations are increasingly living in multi-generational households. Multi-generational living arrangements can, in theory, increase psychological, social, and financial capital—factors associated with improvements in health and longevity.

Methods: We conducted a survival analysis using the 2014 General Social Survey-National Death Index, a prospective multi-year survey. We explored whether single generational living arrangements were associated with a higher risk of mortality than multi-generational living arrangements.

Results: We explored this association for different groups (e.g., the foreign-born and those with high self-reported stress in family relationships). Healthy subjects who live in two-generation households were found to have lower premature mortality (hazard ratio 0.9, 95% confidence interval = 0.82, 0.99). Otherwise, we found little evidence that living arrangements matter for the respondents' risk of premature mortality.

Conclusions: Healthy people living in two-generation households have longer survival than healthy people living on their own.

Introduction

After a long post-war decline in households with multiple generations of family members living under the same roof, the proportion of multi-generational households in the US and other wealthy nations is now again increasing (Bengtson, 2001; Taylor, Passel, & Fry, 2010). In the US and other commonwealth nations, this increase has been attributed to growing numbers of foreign-born groups for whom it is more normative to live with one's relatives. More recently, the Great Recession and housing crises brought many generations together out of economic necessity, promoting adult children and their parents to move in together. By 2014, 19% of the U.S. population lived in multi-generational housing (Bengtson, 2001; Taylor et al., 2010).

Historically, as nations industrialized, it became common for children to strike out on their own after reaching adulthood, often leaving for towns far from their families as they went to college and then work. Ferrarini (2006) Some have hypothesized that this process of individualization led to the dissolution of family ties, and that this reduced structural social capital may have impacted health (Kawachi, Subramanian, & Kim, 2010; Szreter & Woolcock, 2004).

Multi-generational households share common resources, such as

food, childcare, eldercare, heat, electricity, transportation, and rent, thereby reducing the cost of living relative to individual or single family living arrangements. In multigenerational households with parents and adult children, if one individual has a greater share of the resources there tends to be a redistribution of these resources to other family members (Glick & Van Hook, 2011). By sharing resources, multi-generational living arrangements can, in theory, allow families to “upgrade” their lives, moving to safer neighborhoods and in closer proximity to loved ones, thus increasing well-being. In addition, multi-generational living arrangements might improve financial resources, buffer stress, reduce loneliness, enhance intellectual sharing, and generate structural social capital, thereby elevating the level of one's health (Adler & Kwon, 2002; Anonymous, 2013; Cohen & McKay, 1984; Kawachi et al., 2010; Kemper & Murtaugh 1991; McFall & Miller, 1992; Minkler, 1999; Putnam, 1995; Woolcock & Narayan, 2000; Zarit, Reeve & Bach-Peterson, 1980).

However, there are also reasons to believe that health and longevity would not be positively affected, or could even be negatively influenced by multi-generational living. While some have lamented the loss of the traditional multi-generational household in the post-war era, others rejoice in the freedom that it brings to the individual (Oyserman, Coon,

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& Kemmelmeier, 2002). With this freedom comes autonomy and the ability to avoid unwanted interpersonal conflict (including inter-generational cultural differences) which may lead to stress and have deleterious health effects. Multi-generational households may also be more crowded than single generational households, a risk factor for poor health in its own right (Gove, Hughes, & Galle, 1979). When one person becomes ill, it can affect the entire household, and this can be fatal when, for instance, a child with influenza infects an elderly adult (Anonymous, 2001). Sharing of food from a common bowl, sharing utensils, or sharing toothbrushes and razors differ by culture, and can also lead to the spread of infectious agents, such as meningitis or hepatitis B.

Whether induced by or reduced by multi-generational living arrangements, emotional states and stressors have been hypothesized to influence health and longevity by causing the “fight or flight” response to be active for longer than is “normal” by evolutionary standards (McEwen, 1998). Specifically, by experiencing constant psychological stress in modern society, rather than short-term stress in response to a predator, the body’s stress regulatory systems become disrupted in ways that predispose one to heart disease, infection, and other maladies. In theory, there could be distributional effects, by which the stress response is activated among some within multi-generational households but not others.

For instance, those who perceive themselves to be unhappy might benefit from the additional emotional support and environmental structure provided by living with family members, while those who otherwise perceive themselves to be content might not. Those who have fewer intellectual resources (e.g., a lower IQ or educational attainment), who are sick (measured by self-rated health), or who are poor might benefit more from multigenerational living arrangements than those who are not. This is because vulnerable populations might benefit from resource sharing to a greater extent than the average person.

Many foreign-born groups may also be more accustomed to such living arrangements and, on average, find them to be less stressful than native-born groups do. Thus, foreign-born households might reap the benefits of multi-generational living arrangements, while suffering fewer stressors associated with living with relatives. If so, foreign-born households might also benefit to a greater extent than native-born households.

Likewise, race and culture may play an outsized role in determining the benefits or harms associated with living arrangements among the foreign-born. As one example, Latino immigrants having higher rates of residence with extended family than non-Hispanic White immigrants (Sarkisian, Gerena, & Gerstel, 2006; Wilmoth, 2001). In such households, older adults tend to provide a disproportionate share of the household resources. Recent immigrant parents heralding from Asian and Central and South America, on the other hand, are more likely to live in homes in which their adult children provide the majority of the household income (Glick & Van Hook, 2011). Thus, culture can influence the way that financial resources are shared, leading to different impacts associated with multi-generational households for different groups.

Finally, cultural expectations play a role in the living situations of older immigrants for whom normative arrangements often involve co-residing with family. Such co-habitation may improve the social integration of this older, immigrant population (Pillemer, 2000). On the other hand, multigenerational living may also negatively affect the mental health of the foreign-born, since it tests familial ties, which may be strained across the generations due to changing cultural identity and beliefs (Thomas, 1995).

In this paper, we set out to understand the relationship between multi-generational household arrangements on health as well as longevity. We explore the impact of various factors as predictors in this relationship, such as immigration status, race, ethnicity, stress, happiness, and IQ. We hypothesize that those with fewer intellectual, emotional, health, or financial resources might benefit more from living

with other family members than those with a greater support system. For example, single people may benefit more than married couples. We also explore the impact of demographic characteristics: age, race, and ethnicity (Hispanic or non-Hispanic), on multi-generational living arrangements. To the extent that there are differing norms by different sub-groups, we wish to capture such effects.

Methods

Data

Our analysis was performed using the 2014 General Social Survey-National Death Index (GSS-NDI) dataset, which links annual and bi-annual GSS survey data from the 1978–2010 GSS surveys to NDI data through 2014 (Anonymous, 2011). The 2014 GSS-NDI provides 36 years of data representative of the US (non-institutionalized) civilian population. It includes a total of 44,174 participants – 12,558 of which were deceased as of 2014. After excluding participants living in households with children under 18 years of age and removing those with missing data on income, age, gender, race, education, and immigration status, 25,882 participants remained.

We previously published a manuscript describing the GSS-NDI data, its validity, and how it can be downloaded (Anonymous, 2011). It is important to note that, within the GSS-NDI, it is common for questions to be skipped in some years. While the resulting missing values reduce statistical power, they do not introduce bias associated with compositional changes within the cohort. For example, while multi-generational family variables were asked in all years, our measure of psychological stress was asked of only 716 few respondents. However, the respondents were nonetheless representative of the broader panel samples as a whole. This can influence survival follow-up, and introduce period or cohort bias in the analysis. This is addressed in the statistical analysis section below.

Measures

Our primary outcome of interest was all-cause mortality hazards. Our primary independent variable was the number of generations of “direct” family members residing in the participant’s household at the time of the questionnaire, for which we have data from 1978–2010. These “direct” family members include grandparents, parents, children, parents-in-law, and children-in-law, but not collateral relatives such as nieces, nephews, aunts, and uncles.

Our variable of interest, famgen, had over nine different classifications in the GSS. For example, a child living with his or her parents was classified differently than a child living with his or her grandparents. Because these sub-groups tend to be small in number (and therefore have limited statistical power), we recoded the predictor variable to an ordinal categorical variable with three levels: one-, two-, or three- or more direct family generations living in the household with the participant. Initially, there were 7 categories in famgen variable: 1 generation (19,500 subjects); 2 generations, children (5122 subjects); 2 generations, grandchildren (147 subjects); 2 generations, parents (227 subjects); 3 generations, children, parents (253 subjects); 3 generations grandchildren (617 subjects); and 4 generations (26 subjects).

Because there the number in some subgroup is small, we collapsed them into three categories.

The health and longevity of the participant was the outcome of interest.

By law, those under the age of 18 are required to live with a parent or guardian, so we excluded households with members under the age of 18 within the two-generational category. However, we ran the analyses, both with and without those under the age of 18 in the definition of the three- or more generational category, as a sensitivity analysis. Examples of two-generational households include a parent and child, where the child is over the age of 18, or one that contains children and

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