Health lifestyle behaviors among U.S. adults

Jarron M. Saint Onge\textsuperscript{a,b}* , Patrick M. Krueger\textsuperscript{b}

\textsuperscript{a} University of Kansas, 716 Fraser Hall, 1415 Jayhawk Drive, Lawrence, KS, USA
\textsuperscript{b} University of Colorado at Denver | Anschutz Medical Campus, Denver, CO, USA

\textbf{ARTICLE INFO}

Keywords:
Health behaviors
Health lifestyle
Mortality
Latent class analysis
United States

\textbf{ABSTRACT}

Existing research that studies individual health behaviors and conceive of behaviors as simplistically reflecting narrow intentions toward health may obscure the social organization of health behaviors. Instead, we examine how eight health behaviors group together to form distinct health behavior niches. Using nationally-representative data from U.S. adults aged 18 and over from the 2004–2009 National Health Interview Survey (NHIS), we use Latent Class Analysis to identify classes of behavior based on smoking status, alcohol use, physical activity, physician visits, and flu vaccination. We identify 7 distinct health behavior classes including concordant health promoting (44%), concordant health compromising (26%), and discordant classes (30%). We find significant race/ethnic, sex, regional, and age differences in class membership. We show that health behavior classes are associated with prospective mortality, suggesting that they are valid representations of health lifestyles. We discuss the implications of our results for sociological theories of health behaviors, as well as for multiple behavior interventions seeking to improve population health.

1. Introduction

Unhealthy behaviors are implicated in up to 40% of premature deaths in the U.S. (Mokdad, Marks, Stroup, & Gerberding, 2004) and contribute to persistent disparities in health (U.S. Department of Health and Human Services, 2015). But public health and behavioral research routinely focuses on single behaviors or small subsets of behaviors with shared functional meanings (e.g., both drinking and smoking to alleviate stress). Health lifestyle theories suggest that focusing on single behaviors or small subsets of either risky or low-risk behaviors offer limited insight into the organization of meaningful health behavior patterns that reflect broader social forces (Frohlich, Corin, & Potvin, 2001). From an applied standpoint, interventions that target single behaviors may do little to create enduring changes in broader health behavior patterns or in related health outcomes (Spring, Moller, & Coons, 2011). Indeed, the Institute of Medicine (2001) suggests the need for models and interventions that consider multiple behaviors simultaneously, as a strategy for creating larger and more enduring behavioral changes.

We advance existing research by drawing on health lifestyle theories that link broad patterns of health behaviors to social conditions, and using nationally representative data on diverse health behaviors among U.S. adults to identify typologies of health-related behavior that encompass both healthy and unhealthy behaviors. A detailed description of major health behavior typologies among U.S. adults is a necessary first step in addressing disease prevention and health promotion. In addition, we examine how health behavior typologies are associated with sociodemographic characteristics (i.e., age, race/ethnicity, sex, and region) and test a link with prospective mortality as a measure of the predictive criterion validity of including both healthy and unhealthy behaviors in typologies.

1.1. Health lifestyles

Health lifestyles are broad and potentially unobservable orientations that organize patterns of behaviors that derive from knowledge and norms about what constitutes healthy, stress relieving, or pleasurable behaviors (Bourdieu, 1984; Cockerham, 2005). Health lifestyle perspectives emphasize that individual choices about health behaviors are influenced by the social, cultural, and economic forces that frame and constrain individual choices (Bourdieu, 1984; Cockerham, 2000a). For example, cultural diffusion and cultural preferences (Pampel, 2005; Saint Onge, & Krueger, 2011), racial and economic stratification (Harris, 2010; Krueger, Saint Onge, & Chang, 2011), and geopolitical forces (Cockerham, Hinote, Cockerham, & Abbott, 2006; Krueger, Bhalloo, & Rosenau, 2009) have been linked to the organization of health behavior patterns. In contrast, frequently used behavioral theories such as the Health Belief Model or the Theory of Planned Behavior focus narrowly on individuals and offer little insight into how behaviors are shaped by broader social contexts (see Abel and Frohlich

\begin{itemize}
  \item \textsuperscript{*} Corresponding author.
  \item E-mail address: jsaintonge@ku.edu (J.M. Saint Onge).
\end{itemize}

http://dx.doi.org/10.1016/j.ssmph.2016.12.009
Received 13 July 2016; Received in revised form 14 November 2016; Accepted 13 December 2016
2352-8273/ © 2016 The Authors. Published by Elsevier Ltd.
This is an open access article under the CC BY-NC-ND license (http://creativecommons.org/licenses/by-nc-nd/4.0/)
Although some behaviors are likely undertaken with health toward health, we expect to identify some health behavior typologies have diverse implications for health, and that reenly undertaken or avoided for non-health related reasons (e.g., age, gender, socioeconomic, regional, and race/ethnic identities—time for work and family obligations, alleviating stress, and expressing cultivate diverse motivations (Kvaavik, Batty, Giske, Huxley, & Gale, 2010; Saint Onge, Krueger, & Rogers, 2014), and combinations of low-risk behaviors reduce the likelihood of death (Khaw, Wareham, Bingham, Welch, Luben, & Day, 2008; Spencer et al., 2005; Ford, Zhao, Tsai, & Li, 2011).

Our second aim is to examine how these meaningful health behavior typologies vary across sociodemographic factors including race/ethnicity, age, gender, and geographic region. Those sociodemographic factors reflect structural positions that shape the practice of health behaviors (Cockerham, 2005). Indeed, sociodemographic circumstances may define settings within which behavioral niches can develop and provide norms and resources that support specific types of health lifestyles.

We expect that health lifestyles typologies will be associated with sociodemographic factors. We remain agnostic about how specific behaviors will cluster with others, or how the resulting lifestyles will be associated with specific sociodemographic factors. But research that focuses on single behaviors suggests that we should expect to see disparities in health lifestyles by race/ethnicity, age, gender, and region. For example, although non-Hispanic blacks are slightly less likely than non-Hispanic whites to smoke and tend to smoke at lower levels (NCHS, 2013), they are more likely than whites to either binge drink or abstain, while whites are more likely to drink in moderation (Dawson, 1998). Compared to whites, Hispanics are less likely to be current frequent drinkers, but also have lower levels of physical activity and are less likely to receive regular medical exams (Schiller, Lucas, Ward, & Peregoy, 2012). Gender differences can be equally challenging. For instance, counts of low-risk behaviors do not show differences by gender (Ford et al., 2011), although examination of specific behaviors shows potential discordance, with women consistently drinking less than men, but also exercising less than men (NCHS, 2013).

While aging may coalesce behaviors into more static and potentially less-risky patterns (i.e., concordance), the social and biological process of aging may also influence discordant behaviors. Most adults who currently smoke began smoking in early adulthood, and alcohol consumption at older ages is related to drinking earlier in life (Bobo, Greek, Klepinger, & Herting, 2013). Biologically, exercise becomes more difficult with age as cardiovascular function and balance decline, and the prevalence of joint problems increases. The utilization of medical care may also increase with age as the prevalence of chronic conditions increases. But social factors are also important. Middle aged adults may have higher health care utilization than younger adults, because they are more likely to have jobs that provide high quality health care, have more health recommendations, or have access to health insurance through Medicare.

Regional variations and heterogeneity in health behaviors are substantial. The U.S. South is marked by increasing mortality rates among women over time, lower levels of physical activity, and elevated rates of chronic conditions including diabetes and stroke (Centers for Disease Control & Prevention, 2014; Kindig & Cheng, 2013). Regional differences in health behaviors partially result from socioeconomic factors (i.e., poverty, low education), but also result from cultural norms, structural limitations, and disparities in health care
دریافت فوری متن کامل مقاله

امکان دانلود نسخه تمام متن مقالات انگلیسی
امکان دانلود نسخه ترجمه شده مقالات
پذیرش سفارش ترجمه تخصصی
امکان جستجو در آرشیو جامعی از صدها موضوع و هزاران مقاله
امکان دانلود رایگان ۲ صفحه اول هر مقاله
امکان پرداخت اینترنتی با کلیه کارت های عضو شتاب
دانلود فوری مقاله پس از پرداخت آنلاین
پشتیبانی کامل خرید با بهره مندی از سیستم هوشمند رهگیری سفارشات