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The association between membership in the sandwich generation and health behaviors: A longitudinal study[☆]

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ABSTRACT

The current study examined the association between membership in the sandwich generation, defined as providing care to both children and parents or in-laws, and five health behaviors: checking the food label for health value when buying foods, using a seat belt, choosing foods based on health value, exercising regularly, and cigarette smoking. Participants ($N = 4943$) were from a longitudinal study of a midwestern community-based sample. Regression analyses tested the unique effect of sandwich generation membership on health behaviors above and beyond demographic factors and prior levels of the same behavior. Compared to other caregivers and noncaregivers, multigenerational caregivers were less likely to check food labels and choose foods based on health values. Multigenerational caregivers were less likely than noncaregivers and those who cared for children only to use seat belts, and they smoked marginally more cigarettes per day than those groups. Multigenerational caregivers were less likely than noncaregivers and those who cared for parents/in-laws only to exercise regularly. Thus, in general, healthy behaviors were diminished for multigenerational caregivers.

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1. Introduction

Midlife has been defined as the period between ages 40 and 60, although there is wide variation both across research studies and individual self-labeling (Lachman, 2004). Midlife is an important developmental period both because it is the second fastest growing segment of the U.S. population and because it provides opportunities for behavioral changes that can improve future physical health and quality of life (Lachman, 2004). For many midlife adults, “wake up” calls in the form of early health problems in themselves or others in their social networks lead to interest in changing health behaviors (Lachman, 2004). For example, most attempts at smoking cessation are made in the mid-40s (Agrawal, Sartor, Pergadia, Huizak, & Lynskey, 2008).

However, the developmental significance of health behaviors at midlife must also be placed in the context of midlife role occupancies and conditions. One view is that, for mature adults, successfully coping with the midlife demands of work and family leads to resolution of the developmental conflict between generativity and stagnation, thus influencing later well-being (Erikson, 1980). A related view of the midlife demands of work and family is that of life-span development theory (Staudinger & Black, 2001), which provides the theoretical framework for the current study. According to this theoretical perspective, all individuals have limited resources, but the nature of the resources changes over the life span, both in terms of their magnitude and variability. According to Staudinger and Black (2001), midlife individuals generally have high levels of internal and external resources, but also

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many demands that threaten to exceed those available resources. Specifically, for many people, midlife is a time when multiple roles and responsibilities begin to compete with each other. Therefore, midlife adults are forced to make choices regarding the allocation of their available resources.

In addition, although there is considerable individual variation in roles and responsibilities at midlife, there are also important general trends. In terms of career, for many this age period is a time of career “peaking” and of women returning to the workforce (Moen & Wethington, 1999). In terms of caregiving, midlife can be a time of both parenting adolescent children and caring for aging parents. This combination of providing care to both children and aging parents has led to labeling these individuals as members of the “sandwich” generation (Hamill & Goldberg, 1997; Hunter, Sundel, & Sundel, 2002).

Several demographic trends have led to an increase in the number of midlife adults caring for multiple generations (Lachman, 2004). These trends include longer life expectancy, delayed marriage and childbearing, and more adult children choosing to live at home and returning home after divorce (Riley & Bowen, 2005). Recent estimates are that 33.9 million Americans, or 16% of the population, provide care for an older family member (National Alliance for Caregiving and the AARP, 2004), and among a nationally representative sample, 44% of those who were married and in early midlife (ages 35–44) both lived with children and had at least one parent in fair to poor health (Marks, 1996).

The increased likelihood that midlife individuals will be caring for multiple generations of family members raises an important question about whether such multigenerational caregiving has effects on physical health and health behaviors. There are several reasons why multigenerational caregiving could compromise health and health behaviors. First, caring for multiple generations may impair health behaviors simply because such caregiving reduces the amount of time available for engaging in health behaviors. Given the time demands of adult roles, adding more hours of caregiving responsibility may make it difficult to spend time on exercise or food preparation. Second, multigenerational caregiving may negatively influence health behaviors because of reduced salience of personal health goals. That is, those who are preoccupied with meeting the needs of others may be less likely to focus on their own health. The addition of a second generation of caregiving responsibility may increase cognitive complexity in a simple quantitative way (for example, increasing the number of medical appointments that need to be scheduled). However, caring for two generations may also create complex cognitive demands in that it requires multiple skills and the ability to address a very broad range of life challenges. In either case, those who are preoccupied with caregiving tasks may be less likely to focus on their own health needs. Finally, multigenerational caregiving could increase stress, which in turn leads to poor health behaviors (Aldwin & Levenson, 2001).

Thus, there are several reasons to hypothesize that multigenerational caregiving could impair health behaviors. Moreover, there are data linking individual health behaviors to increased risk of morbidity and mortality (Glanz, Rimer, and Lewis, 2002). Indeed, behavioral factors such as tobacco use, diet, physical activity, alcohol and drug use, sexual practices, and preventable injuries are the most important contributors to mortality in the United States (McGinnis & Foege, 1993). According to Glanz et al. (2002), improving such health behaviors can substantially reduce suffering, premature mortality, and medical costs. Thus, a potential impact of multigenerational caregiving on health behavior also has public health implications.

Although to our knowledge no studies have directly examined the effects of multiple generation caregiving on health behaviors, there is an extensive literature comparing those who are and are not engaged in caregiving. These findings have been inconsistent. Some studies find that caregivers are less likely than noncaregivers to engage in regular exercise (Burton, Newsom, Schulz, Hirsch, & German, 1997) and healthy eating (Acton, 2002; Castro et al., 2007). Other studies report no differences between caregivers and noncaregivers for health behaviors such as physical activity and cigarette smoking (Acton, 2002; Castro et al., 2007; Scharlach, Midanik, Runkle, & Soghikian, 1997). Similarly, findings from research exploring the link between caregiving and health outcomes have been mixed. Although studies have found poorer immune status in caregivers as compared with noncaregivers (Kiecolt-Glaser et al., 2003; Vedhara et al., 1999), results from a meta-analysis indicate that differences between caregivers and noncaregivers on measures of physical health are relatively small (Pinquart & Sorensen, 2003).

Why would health behaviors and health outcomes be preserved even in the face of such task demands as caregiving for multiple generations? First, this could reflect a selection effect such that, when there are multiple possible caregivers, those individuals who are themselves the healthiest and engaging in the healthiest behaviors are also most likely to assume multiple caregiving roles. Second, it is possible that caregivers receive some benefits from their responsibilities, and this leads to better health behaviors. Indeed, some studies have suggested that, for middle-aged adults, multiple roles and responsibilities have a beneficial effect on caregivers (Chisholm, 1999; Loomis & Booth, 1995). Likewise, other researchers have argued that the stereotype of a frantic and overloaded “sandwiched” individual may be overstated (Aldwin & Levenson, 2001). Third, caregivers may be particularly motivated to maintain their own health because others depend on them for care or because they observe the declining health of others. Finally, middle-aged adults may have developed the skills to better deal with task demands as compared to other age groups, thereby offsetting any negative effects (Lachman, 2004). Given the inconsistent findings about caregiving in general, the goal of the current study was to test whether membership in the “sandwich” generation was associated with lower or higher levels of positive health behaviors.

However, it may be overly simplistic to think that all health behaviors would be affected in the same way by multigenerational caregiving, and the breadth of the hypothesized sandwich generation effect on multiple health behaviors is unknown. Therefore, this study explored the association between membership in the sandwich generation and five health behaviors: checking the ingredient label for health value when buying foods, choosing foods to eat based on health value, using a seat belt, exercising regularly, and cigarette smoking. Moreover, different mechanisms underlying sandwich generation effects are likely to affect different health behaviors. For example, if the effect of multigenerational caregiving operates through

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