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The Effect of Family Style on Health Behavior, Subjective Health Status and Depression- A Comparative Study of more than One Household and Two Households

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Abstract

The purpose of this study is to examine the actual condition of health care and to suggest the direction of the solution of the problems than the family of two or more who are continuously increasing to examine the change of the family type according to the demographic change trend of Korea Health behaviors, subjective health status, and depression. The method of the study was secondary data using the 6th source data of the National Health and Nutrition Survey, and analyzed by composite sample frequency analysis, descriptive statistics, t-test, crossover analysis, and logistic regression analysis. Results showed that health status, subjective health status, and depression were higher (p <.001) when compared to the one with two treatment groups. The conclusion is that it is necessary to revitalize home nursing activities that can carry out projects to unearth individual households and provide support tailored to individual situations and promote health promotion activities. A plan for the health care of a single person who does not have a care support system is needed so that it can act as a factor to lower the health risk behavior.

Keywords: *Family style, health behavior, subjective health status, depression*

1. Introduction

The Korean family has been experiencing rapid social, economic and cultural changes in various aspects since the 2000s [1]. As the number of non-marriages increases and the number of marriages increases, the birth rate declines naturally. As the number of dual-income families increases, the quality and quantity of household labor changes and the role and value of [1]traditional family structure are changing.

The increase in the number of single-person households is one of the most representative forms of family change, resulting in changes in social values and culture as well as demographic changes [2]. In addition, the number of people living in a single household exceeds the nuclear family, and there is a growing interest in improving the quality of life for the increase of one person [3].

One-person households are more polarized, aged, and feminized than general households [2][3]. The increase of one person is an inevitable social phenomenon in terms of social structure. However, since most of the social service systems in Korea are built around general households, there is a problem that one person is excluded or disadvantageous. Therefore,

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households that are not prepared for retirement are more likely to be at higher risk than households with more than two households in the area of life [2][3].

The purpose of this study was to investigate the effects of family structure on health behaviors, subjective health status and depression according to the changes in family type structure and the increase of one family according to demographic change trends in Korea, We propose a task.

2. Research method

1. Research Design and Purpose

The purpose of this study was to investigate the factors affecting the health behaviors, subjective health status and depression of family structure by using the National Health and Nutrition Examination Survey (2013-2015) It is a correlation study.

2. Research subjects and tools

In this study, among the total of 7,320 people who were 19 years old or older among the raw data of the National Health and Nutrition Examination Survey (2013-2015) Respectively. The results of this study were as follows: 1. The study items were health related items such as gender, marital status, age, final educational background, economic activity, household income and sleep pattern, current smoking rate, monthly drinking rate, aerobic physical activity practice rate, Family structure and more than two family structure).

3. Data collection and analysis

The data collection of this study was secondary data collected through the National Health and Nutrition Survey. The statistical program was using IBM SPSS Statistics version 23.0, and the factors affecting health behavior, subjective health status, Logistic regression analysis.

3. Results

1. Health behavior, subjective health status, depression difference according to general characteristics of family structure

Health behaviors, subjective health status, and depression differences according to general characteristics of family structure are shown in [Table 1]. All variables were statistically significant (p <.001>).

2. Factors influencing health behavior, subjective health status and depression

The number of male singers was more than that of female singers, and the number of male singers decreased with age. Household income was low in household income of one household, education level was high in one household, and average drinking rate in one household was higher than that in two households. Smoking rate, depression rate, aerobic physical activity practice respectively [Table 2].

Table 1. Health behaviors, subjective health status, depression difference according to general characteristics of family structure

(N=5,632)

variable	Category	One-person households n(%)	more two-person households n(%)	χ^2/t	*p*
Gender	Male	214(7.60)	2243(92.40)	2.70	*p*<.001
	Female	386(8.80)	2789(91.20)		
Age(years)	20's	33(6.20)	579(93.80)	1.42	*p*<.001
	30's	36(5.80)	733(94.20)		
	40's	48(5.20)	939(94.80)		
	50's	94(6.40)	1070(93.60)		
	More than 60	388(16.30)	1631(83.70)		
Household income	low	305(21.50)	801(78.50)	2.70	*p*<.001
	Middle -low	148(8.40)	1218(91.60)		
	Middle-high	75(5.00)	1450(95.00)		
	High	65(4.10)	1529(95.90)		
Educational level	< Primary school	281(19.00)	917(81.00)	154.15	*p*<.001
	Middle school	60(9.20)	490(90.80)		
	High school	120(6.40)	1585(93.60)		
	≥University	86(5.50)	1538(94.50)		
Economic Activity	Yes	257(7.70)	2718(92.30)	0.06	.035
	No	293(9.70)	1798(90.30)		
Sleeping time	Less than 6 hr/day	290(9.40)	2115(90.60)	8.52	.022
	7-8 hr/day	229(7.20)	2350(92.80)		
	≥9hr/day	81(8.80)	506(91.20)		
Subjective health status	Very good	28(9.10)	217(90.90)	49.12	*p*<.001
	Good	111(6.90)	1141(93.10)		
	Usually	241(7.30)	2342(92.70)		
	Poor	125(12.30)	695(87.70)		
	Very bad	55(19.00)	173(81.00)		
Depression rate		1.21(.02)	1.13(.01)	171.06	*p*<.001
Current smoking rate		.24(.02)	.21(.01)	27.07	*p*<.001
Monthly drinking rate		.53(.03)	.59(.01)	66.06	*p*<.001
Aerobic physical activity practice rate		.48(.03)	1.51(.01)	44.05	*p*<.001

Table 2. Factors affecting family status on health status, subjective health status, and depression (N=5,632)

Fectors(referencevalue)	**Category**	**OR(95%Cl)**	***p***
Gender(ref:Female)	Male	1.50(1.22~1.86)	*p*<.001
Age(year, ref: 20)	30's	38.61(2.15~7.98)	
	40's	9.94(5.48~18.01)	
	50's	4.49(2.87~7.03)	
	More than 60	1.7(1.28~2.27)	
Household income(ref:low)	Middle -low	.20(0.14~.29)	*p*<.001
	Middle-high	.44(.31~.62)	

	High	.86(.60~1.25)	
Educational level(ref:< Primary school)	Middle school	.67(.47~.97)	.035
	High school	1.05(.69~1.58)	
	≥University	1.02(.73~1.41)	
Economic Activity(ref:No)	Yes	.9(0.72~1.12)	.336
Sleeping time(ref:Less than 6 hr/day)	7-8 hr/day	.80(1.57~1.11)	.184
	≥9hr/day	.95(.67~1.33)	
Subjective health status(ref:Very good)	Usually	.95(.63~1.45)	.813
	Poor	1.23(.84~1.80)	
	Very bad	.87(.85~1.30)	
Depression rate		1.52(.41~.65)	p<.001
Current smoking rate		1.74(.58~.95)	.020
Monthly drinking rate		1.48(1.22~1.79)	p<.001
Aerobic physical activity practice rate		1.27(1.05~1.52)	.013

OR=oddsratio, Cl=confidenceinterval. p<.001 R^2=11.3%, Cox&Snell=11.5%, Nagelkerke=23.5%

4. Discussion and suggestions

The purpose of this study is to analyze the effects of family structure and family structure of two Koreans on health behavior, subjective health status and depression in the 6th period (2013 ~ 2015) It was attempted to make suggestions. The results of this study are as follows. First, the effects of last family structure on health behavior, subjective health status and depression are discussed.

According to the data of the National Statistical Office in 2010, the proportion of males in one person is high, and that of one person in males increases gradually with increasing age [5]. Increased divorce due to increased participation of women in economic activities and changes in marriage is also a cause of increase in the number of middle-aged males. The proportion of divorced men in their 50s increased from 3.3 percent to 7.6 percent during the same period. Because divorce often leads to women living with their children, the increase in divorce increases the number of middle-aged men, rather than women [5]. Therefore, the increase in the number of men in the early and middle aged adolescents, whose health care is important, will have a great impact on the health problems of the male elderly in the age of the coming aging.

The rate of assets is low and the ratio of people with low incomes is higher than that of households with two persons. This study has been supported by the fact that the economic status of a person under 65 who is influx recently is low overall, leading to a deepening of economic poverty in one person [4][7]. In the case of education level, there was a significant difference in the family structure. The education level of one person was higher than that of two or more people. This is supported by research that the higher the level of education, the more physical activity should be prioritized in the plan for health promotion [7].

The results of this study are supported by the results of the study. The results of this study are as follows: 1) The consumption of drinking and smoking by one person is 50% higher than that of per capita 2) . Considering that males tend to drink and smoke more frequently, males who live alone than females of married couples see more smoking and drinking more, whereas after marriage, drinking and smoking Of the total number of patients [5][4].

Recently, one new socially vulnerable group has been reported to have poor mental health level compared to non-single-family households. In one accredited group, social participation rate is low compared to two or more households, and high level of illness and depression is due to lack of social support And suicide ideation was higher in the 1-person household than in the 1-person household, as well as the depression level [9] and [12].

This study aims to improve the quality of life by improving the health behavior, subjective health level, and to find the cause of depression in one household and to use it as an objective basic data to prevent suicide It is important to have a plan for the health care of a single person who does not have a caring support system so that family support and control can act as a factor for the individual to take care of themselves and lower health risk behavior.

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