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THE EFFECT OF INTERGENERATIONAL FAMILY RELATIONSHIPS ON SELF-RATED HEALTH AMONG THE POLISH POPULATION AGED 50 AND OVER*

Abstract

Self-rated health (SRH) is an important indicator of healthy aging, and intergenerational relationships are key factors in that process. However, little is known about the association between these aspects over time. Thus, the

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study aimed to verify the effect of intergenerational family relationships on SRH among the Polish population aged 50 and over.
The results covered data from 930 older adults who participated in a panel survey performed in two waves (COURAGE in Europe – 2011; COURAGE-POLFUS – 2015/2016). Face-to-face interviews were conducted in the respondents' homes using a structured questionnaire. SRH was measured by a single-item scale. Intergenerational relationships were assessed by frequency of face-to-face contact, the strength of social ties, and perceived social support. The presence of conflicts was also verified.
The results showed that in 2011, around 31% of people aged 50+ indicated somewhat weak relationships with children or grandchildren; after four years, strengthening (weakening) of the relationships was observed among 16% (13%) of the population. Differences in the SRH during the follow-up were not statistically significant. There were also no significant differences in SRH between those for whom the weakening of intergenerational relationships, strengthening of solidarity, or no such changes were observed. The cross-lagged model showed that the relationships between solidarity and SRH were significant only on the cross-sectional level.

Keywords: intergenerational relationships, self-rated health, panel survey, elderly people

INTRODUCTION

Several studies conducted on different populations of older people have confirmed the relationship between self-rated health (SRH) and mortality patterns in older age. The results indicated a higher risk of death in older people with poor SRH and, by contrast, a higher chance of survival in older individuals when it is very good or good [Idler, Benyamini 1997; Jylhä 2009; Murata et al. 2006; Litwin, Shiovitz-Ezra 2006].

The role of SRH in a multidimensional approach to healthy aging measured by functional status, general physical health, psychological well-being, and participation in social life has been well documented in recent decades [Grant 1995]. SRH is a multifaceted phenomenon. Many studies have focused on the nature of this subjective measure and its stability, and on the role of health and psychosocial experiences that influence the poor self-assessment, in particular, of a person's health [Wu et al. 2013; Mulsant, Ganguli, Seaberg 1997]. Many studies have also tried to recognize various social determinants that significantly

influence observed differences in SRH in relation to various demographic and psychosocial characteristics of older people, as well as their social environment [Koutsogeorgou et al. 2015; Piłat, Wilga, Zawisza 2019; Tobiasz-Adamczyk, Zawisza 2017]. The results of studies showed that, among other things, women assess their health worse than men in Poland [Maciąg 2019]. Several sociological concepts have been developed to explain the nature of SRH concerning the stability of this assessment, influenced not only by self-concept and personality characteristics, but also from a sociological perspective, affected by social networks [Bailis, Segall, Chipperfield 2003]. The model developed by Berkman and Glass [2000], which conceptualizes the role of interpersonal relationships from social networks created during the life span in SRH in older age, made it possible to explain the pathways of this relationship.

Victor et al. [2000] defined social networks as social relationships that surround a person, their characteristics, and the individual's perception of them. Achat et al. [1998] showed that social networks refer to the structural aspects of social relationships: "they are the channels through which pragmatic help as well as emotional and psychological support can be exchanged between individuals." Moren-Cross and Lin [2006] indicated that social networks encompass interactions among individuals, characterizing it as "a set of nodes […] that are tied to one another by types of relations between them." The structure of networks has been distinguished from their interactional characteristics (e.g., frequency of interaction and degree of reciprocity) and from the functions of the networks (e.g., the provision of information, practical aid, emotional support, and affirmation of personal worth) [Hawe, Shiell 2000].

Social networks were widely discussed and analyzed in sociology from many perspectives and concepts, and it is worth mentioning the classical sociological approaches developed by Durkheim, Tonnies, and Simmel. Durkheim underlined that any social phenomenon can only be understood when it is considered in relation to other individuals and to the wider social context. Tonnies compared the relationships in the community (Gemeinschaft) and in society (Gesellschaft). He argued that the relationships in large, modern societies tend to be weaker, more impersonal, indirect, and more instrumental. People living in cities tend to be more isolated and less involved with their neighbors. Simmel concentrated on micro-social interactions, discussing differences in the relationship between two people (a *dyad*) and a group of three (a *triad*). For example, in a *triad,* it is possible to form an alliance, to mediate in a dispute, and to coerce through group pressure. Thus, in a *tried,* one is likely to observe relationships that may occur in larger structures, e.g., institutions or cultures [Prell 2012, Sztompka 2012, Turner 2010].

The term "social network" was introduced by Barnes in 1954 and defined as "a set of points some of which are joined by lines. The points of the image are people, or sometimes groups, and the lines indicate which people interact with each other." Nowadays, when the concept of network society was developed, which is closely related to the social implication of globalization and the development of new communication technologies, social networks are less frequently created by systems of norms and values. They are defined as "highly empirical representations of actual human interaction; as such, networks represent the entire social structure as it actually happens, rather than in some idealized form of roles, institutionalized values, or other conventional glosses" [Collins 1986, Prell 2012].

The theory of social networks is also strictly related to the concept of social capital, which is understood as "a resource possessed by an individual or by a group or society and could be defined as the good that is available to both individuals and communities through membership of social networks and social participation" [Zawisza et al. 2021, see also Alvarez, Romani 2017; Nguyen 2020]. Social capital can be used to provide access to health information or better health care [Valenthe 2010]. Granovetter's [1973] seminal study showed the strength of weak ties, which might be very valuable as a source of information and resources. Similarly, Burt's structural holes theory underlines the role of weak ties, which might be the ability to bridge between networks [Burt 2000].

Nonetheless, the closest relationships remain relatively stable over the life course, and the social networks that focus on the family tend to be even more important in older age. Studies indicate a decline in the presence of non-family members in the social network of older people [Schwartz, Litwin 2018]. The family social network is one of the most important psychosocial resources for most people, coming from generation to generation and developing long-lasting patterns and behaviors of family life based on common values and cultural rules. From the life span perspective, it is important to seek the mechanism responsible for the role of a family network during different periods of the older stage of life on the SRH of older family members. Social relations are universally recognized key resources throughout life [Antonucci et al. 2014], but the multidimensional approach to family social networks showed many differences in structure and patterns of daily functioning within different families.

The differences in the social characteristics between nuclear families and families that consist of three or even more generations made it possible to describe the role of structure and quality of social ties of the family from the perspective of the conceptual model developed by Berkman and Glass [2000]. Assessing the social structure of the family network characterized by size, density, reachability,

and strong or weak social ties (frequency of person-to-person contacts based on close personal contacts, face-to-face contacts, reciprocity of ties, intimacy, and duration) suggests that there is a link between families' psychosocial resources regarding the objective and subjective assessments of health.

The strengths of family psychosocial resources focus on the individual role in providing different forms of social support (instrumental, financial, emotional, informational, appraisal, and norms toward help-seeking). The role of social support significantly influences older people's quality of life in advanced age by caring, helping with everyday activities, and showing positive emotions such as sharing time with the older member, and younger members showing respect and love to the older member. Such support gives older people a strategy for coping with the loss of meaning in life, loneliness, and other negative emotions associated with stressful life events. The quality of social bonds significantly influences the relationships between older and younger generations within the family. Changes in family size and structure significantly influence the ability of the family system to execute family functions effectively and to achieve expected tasks that focus on supporting family members to achieve well-being and satisfaction in life. Ageing proces of family members (parents – dealing with retirement, dependency) defines family responsibility and tasks towards the sick and older relatives, which are depend on the system of family interactions, values and everyday family life.

Based on the sociocultural orientation of the family, several concepts that refer to exchange theory have been developed to define the relations between older and younger generations within the family. The Classic Intergenerational Solidarity Model was developed by Bengtson and Robert [1991], based on a multidimensional approach. It consisted of six components that consider demographic and social characteristics, such as the number of family members, age differences, places of residence, and geographical distance between the younger and older generations. It also included the quality of social relations developed in previous stages, such as social ties, frequency of social contacts, and the different forms of social support (especially emotional support) that were given and received. They defined various types of solidarity:

– associational solidarity was understood as the frequency and pattern of interactions;

– affectual solidarity referred to the type or degree of emotional attachment;

– consensual solidarity referred to the degree of agreement on values, beliefs and attitudes;

– functional solidarity was the degree of help and the exchange of resources

– normative solidarity is the strength of commitment to performing roles and obligations;

– structural solidarity referred to the number, type, and geographical proximity of family members.

The definitions of those dimensions were based on empirical research. They agreed that the dimensions might be interrelated and are not exhaustive. Other researchers later pointed out that intergenerational solidarity does not exclude the presence of conflicts between generations; on the contrary, conflicts are more likely among those who live with each other. The continuum of intergenerational solidarity was considered from complete solidarity, where all dimensions of solidarity are always present, through broken solidarity, when only associational and affectual solidarity exist, to complete general autonomy (the opposite of complete intergenerational solidarity). The degree of conflicts differentiates the level of intergenerational solidarity [Silverstein, Bengtson 2015; Szydlik 2008].

Bengtson [2001] developed a hypothesis that the extension of families across generations, as the result of population aging and more years of linked lives between generations, has extended family functions of help and support across time. The multi-locality extended family has become the standard family constellation. An assessment of intergenerational family solidarity over time showed affectional solidarity between adult generations. Other researchers have shown that the number of years that grandparents share with their grandchildren has increased over time, and combined with increasing life expectancy and declines in fertility, the grandparent phase has moved to later in life [Skopek 2021]. Some studies have also shown that despite the individualization in the West, intergenerational family relationships still play a key role in modern societies [Dykstra 2018].

RESEARCH AIMS AND METHODS

Aim of the study

As already mentioned, SRH and intergenerational relationships are key factors for healthy aging, but little is known about the association between these aspects over time. Thus, the first aim of the study was to compare SRH as well as intergenerational family relationships between two observed periods. The second and main aim of the study was to verify the effect of intergenerational family relationships on SRH among the Polish population aged 50 and over.

Method

A population-based panel survey was performed in two waves. The first was the Polish part of the COURAGE in Europe study (2011) [Leonardi et al. 2014], with participants randomly sampled from a non-institutionalized adult population. The second wave, the COURAGE – Poland Follow-Up Study (COURAGE--POLFUS), was in 2015/2016. In both waves, face-to-face computer-assisted personal interviews using a structured questionnaire were conducted at the respondents' homes by specially trained interviewers. Overall, 1,850 respondents participated in the study [Zawisza et al. 2021]. The analysis was based on a group of people aged 50 years or older for whom characteristics of intergenerational family relationships and SRH from both waves were available. Thus, the final sample was 930 participants. Data were weighted to generalize the study sample to the reference population [Zawisza et al. 2021]. The study was approved by the Bioethical Committee, Jagiellonian University, Krakow, Poland (No. KBET/208/B/2010; No. 122.6120.26.2015).

Measures

Intergenerational family relationships were measured by four items related to interactions with children and four related to interactions with grandchildren. The items assessed three components of intergenerational relationships according to Bengston's model [Bengston, Roberts 1991]: 1. associational – measured as frequency of face-to-face contacts with children/grandchildren with a five--point Likert response scale ranging from *never* to *daily*; 2. affectual – measured as social ties by the questions: *With how many children/grandchildren would you say you have a close relationship?* with a three-point response scale: *with nobody, with some people from this group, with all people from this group;* and by questions about the presence of serious conflicts with children/grandchildren that caused breaking emotional ties with them with *yes/no* answers; 3. functional – measured as perceived social support from children/grandchildren by question regarding ease of getting help from children/grandchildren with a five--point Likert response scale ranging from *very easy* to *very difficult* and with the option *not applicable* when children or grandchildren who were too young to provide support.

SRH was measured by a single-item question (*In general, how would you rate your health today?)* on a 5-point Likert scale (from *very good* to *very bad*).

Statistical analysis

The characteristics of respondents were compared at the baseline and in the second wave of the study using McNemar's test, Bowker's test of symmetry, or the Wilcoxon test. Two-step cluster analysis was used to derive the typology of intergenerational family relationships. The BIC criterion was used to establish the number of clusters. The analysis was done separately for those who have children but not grandchildren and those who do have grandchildren. The typology was established only for wave 1, and then their results were adapted to wave 2.

Differences between groups of typologies of intergenerational relationships in SRH status at a cross-sectional level were assessed using the chi-square test. To assess the effect of perceived intergenerational family relationships on SRH among the Polish population aged 50 and over, cross-lagged models were performed.

The analysis was done on IBM SPSS Statistics or SAS.

RESULTS

Table 1 presents the characteristics of the participants at baseline and in follow-up. About 52% had completed high school or had a university degree. During the analyzed period, there were changes in marital status ($p<0.001$); the percent of people who were married decreased by about 8%, and simultaneously, the percent of people who were widowed increased. There was also a decrease in the total household income ($p<0.001$), which might be related to the fact that, at the time, women under 60 and men under 65 in the baseline study were retiring. There were no statistically significant changes in SRH.

TABLE 1. Sociodemographic characteristics and self-rated health of participants at baseline and in the second wave of the study. Weighted data.

Characteristics		COURAGE in Europe – Poland Wave 1 – 2011	COURAGE -POLFUS Wave 2 – 2015/16	p-value
Female gender [%]		56.8		
Age (in years) [median (Q1-Q3)]		62.8 (56.0-71.0)		
Level of education [%]	Primary	20.8		
	Secondary	27.1		
	High school	33.3		
	University	18.8		

Characteristics		COURAGE in Europe – Poland Wave 1 – 2011	COURAGE -POLFUS Wave 2 – 2015/16	p-value
Marital status [%]	Never married (and not cohabiting)	7.8	7.1	<0.001[B]
	Currently married/cohabiting	70.6	62.6	
	Separated/divorced	5.1	6.1	
	Widowed	16.5	24.2	
Total household income in 1000 PLN per year per head [median (Q1-Q3)]		26 (18–42)	24 (24–72)	<0.001[W]
Self-assessment of health [%]	Very good	4.3	4.9	0.062[B]
	Good	29.5	35	
	Moderate	47.9	42.4	
	Bad	16.2	15.4	
	Very bad	2.2	2.3	

Note: Data were weighted for the 2011 Polish population; B – Bowker's test of symmetry; M – McNemar's test; W – Wilcoxon Signed-Rank Test; Q1 – first quartile; Q3 – third quartile

Source: Own study

Changes in intergenerational family relationships during the observed period

TABLE 2. Changes in characteristics of intergenerational family relationships (parents – children; grandparents – grandchildren) at baseline and in the second wave of the study.

Characteristics		COURAGE in Europe – Poland Wave 1 -2011	COURAGE -POLFUS Wave 2 -2015/16	p-value
		%	%	
With children	Yes	83.9	83.5	0.528[M]
With grand-children	Yes	68.7	73.0	<0.001[M]
Help from children (if any)	Very easy	71.7	62.6	<0.001 [B]
	Easy	22.9	31.4	
	Possible	2.7	4.4	
	Difficult	0.9	0.9	
	Very difficult	1.4	0.7	
	NA[1]	0.3	0.0	

TABLE 2. (cd.)

Characteristics		COURAGE in Europe – Poland Wave 1 -2011	COURAGE -POLFUS Wave 2 -2015/16	p-value
		%	%	
Help from grandchildren (if any)	Very easy	51.2	44.7	<0.001[B]
	Easy	22.3	33.0	
	Possible	5.9	13.0	
	Difficult	3.3	2.5	
	Very difficult	2.5	1.5	
	NA[1]	14.9	5.4	
Ties with children (if any)	With none	2.8	2.1	<0.001[B]
	With some	8.3	3.2	
	With all	88.9	94.6	
Ties with grandchildren (if any)	With none	3.6	2.1	0.009[B]
	With some	9.9	7.6	
	With all	86.5	90.2	
Face-to-face contact with children (if any)	Never	0.6	0.7	0.125[B]
	Once/a few times per year	5.6	5.4	
	Once/a few times per month	19.2	17.8	
	Once/a few times per week	32.9	40.0	
	Daily	41.7	36.1	
Face-to-face contact with grandchildren (if any)	Never	0.4	0.4	0.001[B]
	Once/a few times per year	9.8	7.2	
	Once/a few times per month	30.5	28.3	
	Once/a few times per week	34.0	45.5	
	Daily	25.2	18.7	
Conflicts with children (if any)		1.0	0.0	
Conflicts with grandchildren (if any)		0.0	0.0	

Note: Data were weighted for the 2011 Polish population; B – Bowker's test of symmetry; M – McNemar's test; [1] – further analyses are conducted treating NA values as missing data

Source: Own study.

Changes in intergenerational relationships of older people during the observed period are presented in table 2. The percentage of people who have grandchildren increased from 69% to 73%. A lower percentage of older people found it very easy to get help from children (72% – wave 1; 63% – wave 2) and from grandchildren (51% – wave 1, 45% – wave 2). At the same time, they seldom indicated that it is difficult to get help from their children (1.4% – wave 1; 0.7% – wave 2) and grandchildren (2.5% – wave 1; 1.5% – wave 2). The percentage of people who reported a close relationship with all of their children (89% – wave 1; 95% – wave 2) and all of their grandchildren (87% – wave 1; 90% – wave 2) increased. There were no statistically significant changes in the frequency of face-to-face contact with children. Simultaneously, the study showed that a lower percentage of older people had daily contact with grandchildren in wave 2 than in wave 1 (25% – wave 1; 19% – wave 2), in contrast to face-to-face contact once or a few times per week (34% – wave 1; 46% –- wave 2). The study shows that about 1% of the older population had a serious conflict with their children at the baseline study.

In the next step, a typology of intergenerational family relationships was derived, taking together the structure of the participants' families (i.e., with children or grandchildren) and the result of the cluster analysis. The participants were categorized into the following groups at baseline:

1. Respondents who do not have any children or grandchildren [N = 155 (16.7%)],
2. Participants who have children but do not have grandchildren [N = 144 (15.5%)]. In this group, the following clusters were defined:
   - 2.1. Very strong relationships with children (daily face-to-face contact with children; very easy to get help; close relationship with all children; no conflict with them) [N = 62 (6.7%)]
   - 2.2. Quite a strong relationships with children – less frequent than daily face-to-face contact (once or a few times per week or month; very easy or easy to get help; a close relationship with all children; no conflict) [N = 31 (3.3%)]
   - 2.3. Quite strong relationships with children – easy (not "very easy") to get help (daily face-to-face contact; easy to get help; close relationship with all children; no conflict) [N = 21 (2.3%)]
   - 2.4. Quite weak relationships (respondents were more likely to have no face-to-face contact or infrequent contact; getting help may be difficult; in most cases no close relationship with all or some of children; some of this group had conflicts with children in) [N = 30 (3.2%)].

3. Respondents who have grandchildren [N = 631 (67.8%)]. Two groups were distinguished:

3.1. Moderate or strong relationships (participants who reported it was very easy or easy to get help from children; most also reported it was very easy or easy to help from grandchildren; daily face-to-face contact with children, or at least a few times per week, and for most respondents also with their grandchildren; a close relationship with all or some children; lack of conflict with grandchildren and children) [N = 390 (41.9%)]

3.2. Quite weak relationships (respondents were more likely to report less frequent face-to-face contact with children or grandchildren than respondents from group 3.1.; some had conflicts with children; reported a lack of close relationship with children or grandchildren) [N = 241 (25.9%)]

TABLE 3. Changes in the typology of intergenerational family relationships in older people during the observed period. Weighted data.

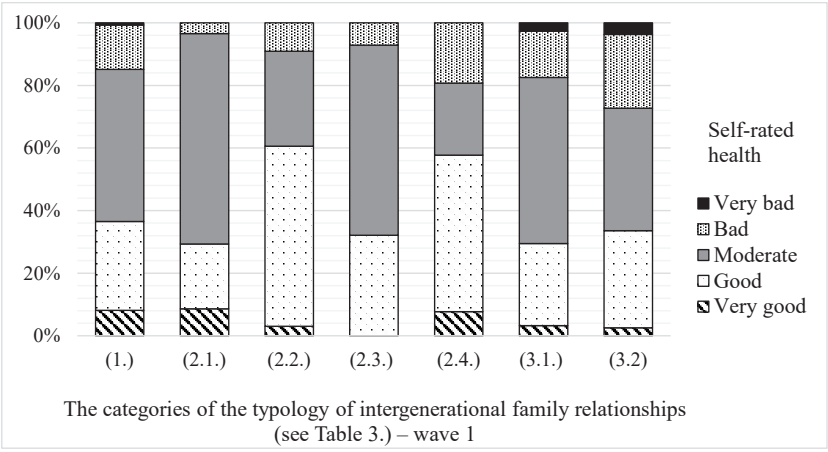
The categories of the typology of intergenerational family relationships	Wave 1 (2011)	Wave 2 (2015/16)
	%	%
Lack of children and grandchildren	15.8	16.2
(2.1) Presence of children and very strong relationships with them	6.3	2.9
(2.2) Presence of children and quite strong relationships with them – less frequent than daily face-to-face contact	3.5	3.0
(2.3) Presence of children and quite strong relationships with them – easy (not "very easy") to get help	2.9	1.3
(2.4) Presence of children but quite weak relationships	2.8	3.8
(3.1) Presence of grandchildren and moderate or strong relationships	39.8	48.7
(3.2) Presence of grandchildren but quite weak relationships	28.9	24.2

Note: Data weighted for the 2011 Polish population; $p < 0.001$ for B – Bowker's test of symmetry
Source: Own study.

Changes in the described typology of intergenerational family relationships during the observed period are presented in Table 3. The results show that in 2011, around 32% of people aged 50 or older indicated quite weak relationships with children or grandchildren (groups: 2.4 and 3.2); four years later, it was about 28%. Additionally, it was estimated that family relationships strengthened with children or grandchildren (changes from group 2.4 or 3.2 to 2.1-2.3 or 3.1) among 16% of the population; around 13% of relationships (changes from group 2.1–2.3 or 3.1 to 2.4 or 3.2) weakened.

Association between intergenerational family relationships and self-rated health

FIGURE 1. Self-rated health across the intergenerational relationship groups. Weighted results from the first wave of the study (data were weighted for the 2011 Polish population).



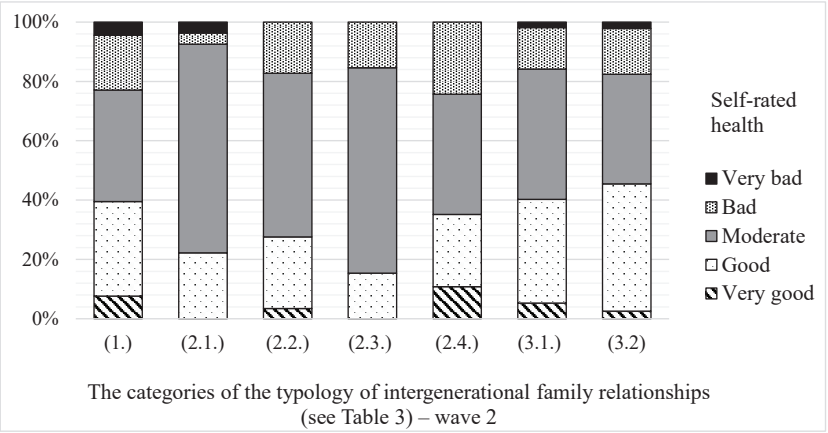
Source: Own study.

The results of the cross-sectional analysis presented in Figure 1 show that the highest percent of people who assessed their health as poor or very poor was among those who had grandchildren and children but reported quite weak relationships with them (27.3%, group 3.2), and among those who only had children (no grandchildren), but also quite weak relationships with them (19.2%, group 2.4). The lowest percentage of people with poor or very poor health was among those who had strong relationships with children (3.4%, group 2.1). On the other hand, the highest percentage of people who assessed their health as good or very good was among those with quite strong relationships with their children (60.6%, group 2.2 – they have less frequent than daily face-to-face contact) and who did not have grandchildren. Additionally, people who only had children and a rather weak relationship with them mostly assessed their health as at least good (57.7%, group 2.4).

A similar analysis was conducted among the same group of people after four years. The results showed that 24.3% of people who only had children and quite a weak relationship with them (group 2.4) assessed their health as poor. Similarly, those with no children or grandchildren (group 1), about 23%, assessed their health as poor or very poor. Simultaneously, the highest percentage of people with a good or very good assessment of their health was found among those who

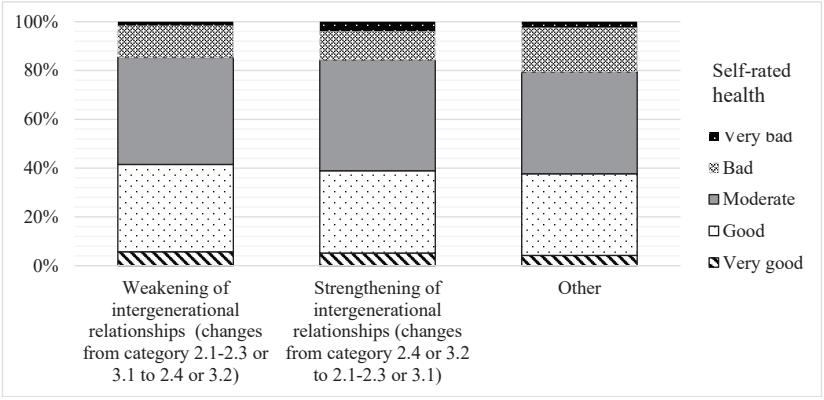
had children and grandchildren but quite a weak relationship with them (45.5%, group 3.2.) (Figure 2).

FIGURE 2. Self-rated health across the intergenerational relationships groups. Weighted results from the second wave of the study (data were weighted for the 2015 Polish population).



Source: Own study.

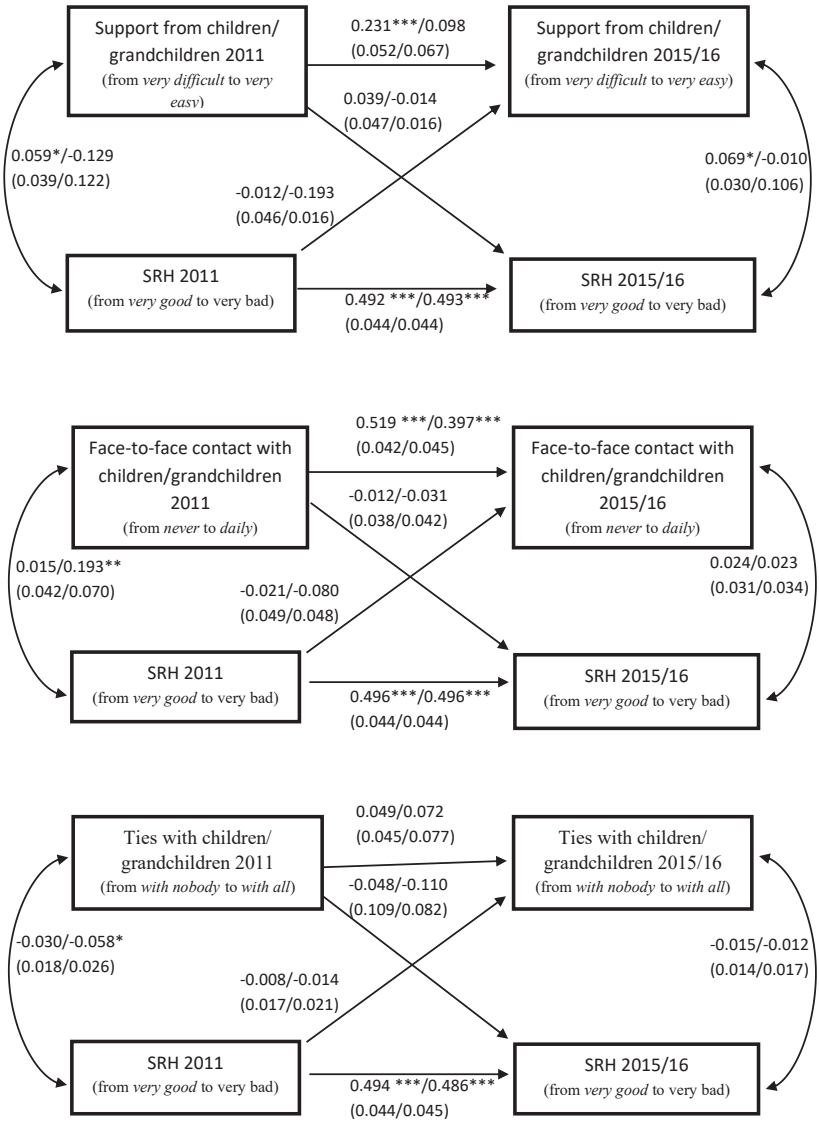
FIGURE 3. Self-rated health (wave 2) across the group of people defined by changes in intergenerational family relationships. Data were weighted for the 2011 Polish population. The category names are related to those presented in Table 3.



Source: Own study.

There were no statistically significant differences in self-reported health between those for whom a weakening or strengthening of intergenerational family relationships occurred, or for whom no such changes were observed ($\chi^2 = 6.98$, df = 8, p = 0.539). The results are presented in Figure 3.

FIGURE 4. Results of the cross-lagged analysis of the relationships between self-rated health and support from children or grandchildren, face-to-face contact with children or grandchildren, and ties with children or grandchildren. Unstandardized coefficients are presented with standard errors in brackets. Note: *p<0.05; **p<0.01; ***p<0.001



Source: Own study.

Finally, Figure 4. presents the results of the cross-lagged models. The models were just identified, so there was no information about fit. The analysis showed that the level of perceived support from children was statistically significantly positively correlated with SRH at baseline (0.06, $p<0.05$) and in the second wave of the study (0.07, $p<0.05$), but neither cross-lagged effect was significant. Perceived support with grandchildren was neither significantly correlated with SRH at the cross-sectional level nor was the cross-lagged effect significant. The frequency of face-to-face contact with grandchildren was significantly but negatively correlated with SRH (0.19, $p<0.01$) only at the cross-sectional level in wave 1; no cross-lagged effect was significant. Ties with grandchildren were significantly positively correlated with SRH (-0.06, $p<0.05$) at baseline. None of the cross-lagged pathways were statistically significant. Additionally, the cross--lagged models made it possible to estimate autoregressive effects and showed that the SRH was stable over time (0.49, $p<0.001$). For the intergenerational relationship indicators, the autoregressive effects were statistically significant for perceived support from children (0.23, $p<0.001$) and face-to-face contact with children (0.52, $p<0.001$) and grandchildren (0.40, $p<0.001$).

SUMMING UP

The results of the study showed quite a stable assessment of SRH in the Polish population aged 50 years or older over the four-year period. The results of other studies showed that self-rated health slightly declines during the life course [Cullati et al. 2014, Lamidi 2020]. Other studies indicate that changes in SRH vary in relation to, e.g., marital status, where an assessment of SRH is somewhat stable among married and cohabiting respondents, and there is a decline among single (previously married and never married) adults [Lamidi 2020]. The lack of significant differences during the four years between the SRH assessment supports the theory of individuals' self-concept of health. [Bailis, Segall, Chipperfield 2003]. Other studies have indicated that the relatively high stability of SRH might illustrate that with increasing age, older people adapt to their worsening health conditions [Leinonen, Heikkinen, Jylha 2002].

The panel study also brings important information about changes in multigenerational relationships in families of people aged 50 and over in Poland. The study showed a decreased percentage in those who had the highest level of perceived social support from their children (about 6 percentage points) and grandchildren (about 6 percentage points). Simultaneously, the percentage of older adults who had the lowest level of social support also decreased (about

1 percent point). Additionally, the frequency of daily face-to-face contact with grandchildren decreased, which might result from grandchildren growing up and the fact that childcare is less frequently needed. There were no significant differences in face-to-face contact with children.

Similarly, in the cross-lagged model, face-to-face contact with children was assessed as the construct stable over time. The percentage of people with close relationships with all of their children and grandchildren increased (about 6 percentage points and 4 percentage points, respectively). Additionally, a comparison of the frequency of groups of people created based on the developed typology of intergenerational family relationships showed the strengthening of relationships in families during the observed period was found among 16% of the population, while weakening concerned around 13%.

The analysis of the association between SRH and intergenerational family relationships (based on the developed typology) showed a positive association between them at the cross-sectional level. The results showed that people with weak intergenerational relationships with children or grandchildren more frequently had poor SRH. Simultaneously, there was a lack of clear patterns of the relationships between the presence of strong intergenerational relationships with children or grandchildren and good self-assessment of health. It might indicate that the measure of the SRH better reflects the health status on the low continuum (the spontaneous assessment view); a negative SRH is correlated with future deterioration in functional limitation and the occurrence of diseases.

The results did not show that the strengthening of intergenerational relationships between older people and their children or grandchildren positively affects SRH. The findings might also support the theory of individuals' self-concept of health, in contrast to the spontaneous assessment view. According to the latter theory, the self-assessment of health should reflect a change not only in other measures of health status but also a change in one's performance of health-related behaviors, e.g., social support [Bailis, Segall, Chipperfield 2003].

Finally, the results did not support a possible causal effect between intergenerational family relationships and SRH in either direction over the four-year period.

Further work is needed to verify whether there are differences in the presented results across various characteristics of people aged 50 years and older in Poland. There is also a need to assess the verified relationships after controlling for some demographic, health-related and psychosocial possible confounding variables. Additionally, the parameter estimates of cross-lagged relationship might depend on the time-interval of observation; thus, further research, e.g., a third wave of the study, is needed.

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WPŁYW MIĘDZYPOKOLENIOWYCH RELACJI RODZINNYCH NA SAMOOCENĘ STANU ZDROWIA POLAKÓW W WIEKU 50+

Streszczenie

Samoocena stanu zdrowia (SSZ) jest ważnym wyznacznikiem procesu zdrowego starzenia się, jak również relacje międzypokoleniowe są kluczowym determinantem tego procesu. Mniej znane są zależności między wymienionymi aspektami uwzględniające ich zmiany w czasie. Stąd, celem badania była ocena wpływu relacji międzypokoleniowych występujących w rodzinach i zachodzących w nich zmian na samoocenę stanu zdrowia osób w wieku 50 lat i więcej z populacji polskiej.

Wyniki obejmują dane od 930 osób starszych, które wzięły udział w badaniu przeprowadzonym w dwóch falach (COURAGE w Europie – 2011; COURAGE-POLFUS – 2015/2016). Wywiady bezpośrednie przeprowadzono w domach respondentów za pomocą ustrukturyzowanego kwestionariusza. SSZ mierzono jednopytaniową skalą. Międzypokoleniowe relacje w rodzinach dokonano w odniesieniu do częstości kontaktów bezpośrednich, siły więzi społecznych oraz postrzeganego wsparcia społecznego. Uwzględniono również występowanie konfliktów.

Wyniki pokazały, że w 2011 roku około 31% osób w wieku 50+ wskazywało na raczej słabe relacje z dziećmi lub wnukami, po 4 latach obserwacji wzmocnienie (osłabienie) relacji zaobserwowano u 16% (13%) populacji. Nie zaobserwowano różnic istotnych statystycznie w SSZ między kolejnymi falami badania. Nie stwierdzono istotnych statystycznie różnic w SSZ pomiędzy tymi, u których zaobserwowano osłabienie relacji, ich wzmocnienie lub brak takich zmian. Wyniki modelu cross-lagged pokazały istotne zależności między międzypokoleniowymi relacjami w rodzinie a SSZ tylko na poziomie przekrojowym.

Słowa kluczowe: relacje międzypokoleniowe, samoocena stanu zdrowia, badanie panelowe, osoby starsze