Work-family spillover stress predicts health outcomes across two decades

Dmitry Tsukerman\textsuperscript{a,*,} Kate A. Leger\textsuperscript{b}, Susan T. Charles\textsuperscript{a}

\textsuperscript{a}University of California, Irvine, USA
\textsuperscript{b}University of Kentucky, USA

ARTICLE INFO

Keywords:
- Work-family spillover
- Job stress
- Chronic stress
- Health

ABSTRACT

Rationale: Work is a common source of stress for many adults, arising from situations that occur at work (e.g., job demands) as well as the worries and responsibilities that people take home with them (negative work-family spillover). Over time, work-related stress may impact physical health.

Objective: The current study prospectively examined the effects of job demands and negative work-family spillover (NWFS) on three self-reported physical health measures.

Method: Participants in the Midlife in the United States (MIDUS) survey (\textit{N} = 4200) reported their job demands and negative work-family spillover at wave 1. They also reported on their health across three waves of data collection.

Results: Higher levels of NWFS at baseline were related to a higher number of self-reported chronic illnesses, greater functional limitation, and poorer self-rated health approximately 10 and 20 years later. In contrast, job demands were unrelated to any health indices at baseline or at the approximately 10- and 20-year follow-ups.

Conclusions: Findings suggest that NWFS is a unique form of stress with long-lasting and detrimental effects on physical health.

Credit author statement

Dmitry Tsukerman: Conceptualization, Methodology, Formal analysis, Writing - original draft. Kate Leger: Formal analysis, Writing - review & editing. Susan T. Charles: Conceptualization, Methodology, Formal analysis, Writing - review & editing, Supervision

1. Introduction

Americans report high levels of stress in their daily lives, with much of this stress stemming from work-related issues (American Psychological Association, 2015). Work-related stress includes both the stress experienced at the workplace, such as work-related pressures and demands, as well as the concerns that often spill over into the evening and weekends as people worry about issues such as job security, financial stressors, and upcoming deadlines (Lambert, 1990). A growing number of studies have found that stress experiences during the workday accumulate over time and lead to worse health outcomes (Chandola, Brunner and Marmot, 2006; Ferrie, Kivimaki, Shipley, Smith and Virtanen, 2013). The spillover of work and of work-related stress to the home (negative work-family spillover; NWFS) is also related to poorer health behaviors (e.g., Gryzwacz and Marks, 2003) and an increased likelihood of having a chronic condition (Segel-karpas & Agrigoroaei, 2017). The current prospective study examined how both perceived stress reported on the job (job demands) and NWFS – are each related to reports of chronic health conditions, disability, and overall health 10 and 20 years later among working men and women in the United States using data from the Midlife in the United States (MIDUS) Survey.

1.1. Workplace stress

Workplace stress is common in the United States (American Psychological Association, 2015). High levels of stress at work are reported across a broad range of occupations and linked to negative outcomes, including greater alcohol use and greater risk for cardiovascular disease (Nyberg et al., 2013). Workplace stress may arise for many reasons, such as high work demands; poor inter-employee/management relations; lack of control and decision making at work; feelings of job insecurity; and the emotionally taxing nature of many service jobs (Cooper and Marshall, 1976; Ferrie et al., 2013; Johnson et al., 2005; Karasek et al., 1981). The frequent experience and buildup of stressful work demands may accumulate over time and lead to worse health outcomes.
obesity, and increased risk for chronic illness (Allen et al., 2000; Buxton et al., 1995). These findings imply that the resulting lingering effects of NWFS are not doing the actual work after hours may carry their worries and unwind more difficult (e.g., Derks and Bakker, 2014). Even people who are not doing the actual work after hours may carry their worries and negative feelings about both previous and anticipated adverse work events.

Researchers have established links between NWFS and poorer physical and emotional health conditions including anxiety, depression, psychosomatic health complaints, sleep disruption, fatigue, poor sleep, obesity, and increased risk for chronic illness (Allen et al., 2000; Buxton et al., 2016; Demerouti and Geurts, 2004; Frone, Russell and Cooper, 1997; Geurts et al., 1999; Grzywacz, 2000; Grzywacz et al., 2002; Williams et al., 2006). Moreover, researchers have found that NWFS accounts for the relationship between reported job stress and adverse health outcomes in a cross-sectional study (Geurts et al., 1999; Geurts et al., 2003). These findings imply that the resulting lingering effects of work stress compound over time, yet are limited by the lack of longitudinal information (Geurts et al., 2003). A recent longitudinal study examined the role of NWFS using MIDUS data, finding that higher levels were linked to a greater number of chronic illnesses and worse self-perceived health ten years later (Lee et al., 2015). Yet, this study did not adjust for any measure of workplace stress, so it is unclear whether NWFS is uniquely predictive of health beyond the effects of work-related stress.

The perseverative cognition hypothesis suggests that engaging in repetitive thoughts about either a past or future stressor has negative impacts on physiological processes and future health outcomes (Broschot et al., 2006). Ongoing worries about work stressors, rather than the work stressor itself, may cause prolonged activation of a wide range of biological systems, leading to long-term wear on the body and downstream physical health consequences (Lundberg, 2005). Additionally, NWFS is associated with poor health behaviors, including smoking, short sleep duration, and unhealthy eating, independent of job demands and work conditions (e.g. Buxton et al., 2016; Laflin et al., 2010). Thus, NWFS may predict future physical health above and beyond job demands, but this question is currently untested.

1.3. The current study

The current study represents the first known examination of the unique longitudinal relationships of NWFS and job demands with self-reported health across approximately 20 years, offering a test of these relationships across a longer time frame than previous studies. We used data from the Midlife in the United States (MIDUS) to examine the long-term effects of NWFS and job demands among people who worked at least 20 h a week on three self-reported physical health outcomes: chronic illness, functional limitations, and self-rated health status. In addition to the number of chronic illnesses, functional limitations was included given its ability to predict important health-related outcomes, particularly later in life, including hospitalization, medical care, dependency of living, and mortality (Avelino-Silva et al., 2014; Hirani et al., 2014; Wiener et al., 1990). Self-rated health was also included in the study of health outcomes due to its strong relationships with both morbidity (Mavaddat et al., 2014) and mortality (DeSalvo et al., 2006).

We hypothesized that higher levels of NWFS would predict a greater number of chronic illnesses, greater functional limitations, and poorer self-rated health nearly ten and twenty years later after adjusting for baseline health status and baseline job demands.

2. Methods

2.1. Participants and procedure

This study examined a subset of participants from the Midlife in the United States (MIDUS) Survey. The MIDUS was approved by the Institutional Review Board of the University of Wisconsin, and participants provided informed consent. The MIDUS study included a national probability sample of U.S. adults, aged 20 to 74 at baseline, and took place across three separate waves approximately ten years apart: MIDUS I (1995–1996), MIDUS II (2004–2006), and MIDUS III (2013). A total of 7108 participants completed both phone interviews and self-administered questionnaires at Wave 1.

To be eligible for the current study, participants had to have reported working at least 20 h per week. From the 7108 participants, 4200 participants (59%) reported working at least 20 h per week. These 4200 participants comprised the final analytic sample for this study. Of these 4200 eligible participants from Wave 1, 3221 participated in Wave 2 (77%). Of these 3221 participants, 2318 (72% from those at Wave 2) also participated at Wave 3. Comparing the eligible participants at Wave 1 who did not participate through all three waves (n = 1882) to those who participated at all three waves (n = 2318), those who participated at all three waves were more likely to be Caucasian, χ² (1, N = 4200) = 58.30, p < .001, female, χ² (1, N = 4200) = 12.54, p < .001, and were slightly older at Wave 1 (44.09 ± 10.18 vs. 43.34 ± 11.66, t(4198) = 2.25, p < .05). Those participating in all three waves also reported greater NWFS (10.70 vs. 10.41, t(4198) = 3.35), but less functional disability (2.43 vs. 2.59, t(4190) = −5.90) and better self-rated health (3.74 vs. 3.57, t(4196) = 6.14) at Wave 1 than those who did not participate at all three waves (all ps < .01). These two groups did not differ in job demands or levels of chronic illness at Wave 1.

We used multiple imputation to handle missing data. We first checked to see if the data were missing completely at random (MCAR) using Little’s test (Little, 1988). The assumption of MCAR was violated (e.g. data were not missing completely at random). As a result, we imputed missing data using the Markov chain Monte Carlo (MCMC) approach. We imputed five data sets and pooled parameter estimates across imputations. There was a successful convergence for the mean and variance of all imputed variables.

Participants (N = 4200) ranged in age from 20 to 74 years (M = 43.75, SD = 10.88) and 68% were married at Wave 1. The subsample for the current study had a slightly lower percentage of women (47%) compared to the 7108 MIDUS I sample, which were 52%, 53% and 55% across Waves 1, 2, and 3, respectively. MIDUS I was predominantly Caucasian (91%), with a small number of African Americans (4.9%), Native American or Alaskan Natives (0.6%), Asian or Pacific Islanders (0.9%), and people reporting other (2%). The final subsample was similar, with 89.5% Caucasian. The subsample for the current study also had a higher percentages of college graduates (36.1%) compared to the MIDUS I sample (31%).

2.2. Measures

2.2.1. Negative work-family spillover

At Wave 1, negative work-family spillover was assessed with four items (Grzywacz and Marks, 2000). Items were: (1) job reduces the effort you can give to activities at home; (2) stress at work makes you irritable at home; (3) your job makes you feel too tired to do the things
that need attention at home; (4) job worries/problems distract you when you are at home. For each of these items, participants rated their importance in their daily life; (5) you have too much to do; and (6) you have a lot of interruptions. A composite score for NWFS reflects the summed total of the four items (α = 0.81). Only the Wave 1 assessment of NWFS was used in the current study.

2.2.2. Job demands
The job demands scale (Karasek et al., 1981) was originally developed to create an objective measure of psychological stress in the workplace. Five items ranging from 1 (all the time) to 5 (never) measure the extent to which a participant finds his or her job responsibilities to be demanding. Items include how often: do you work very intensively – that is, are you very busy trying to get things done?; do different people or groups at work demand things from you that you think are hard to combine?; you have too many demands made on you?; you have enough time to get everything done?; and (7) you have a lot of interruptions? The composite score was constructed by calculating the sum of the reverse-coded values of the items in the scale (α = 0.74). Only the Wave 1 assessment of job demands was used in the current study.

2.2.3. Functional limitations
Functional limitations were assessed at all three waves with the summed scores of two modified measures: activities of daily living (ADLs; Katz, Ford, Moskowitz, Jackson and Jaffe, 1963) and instrumental activities of daily living (IADLs; Lawton and Brody, 1969). For both ADLs and IADLs, the subscales were modified by only including a subset of the total items from each original scale in MIDUS. The three items measuring ADL reflect a person’s functional abilities that are commonly limited with chronic illness or disability and include bathing or dressing; climbing one flight of stairs; and walking one block. The seven items measuring IADLs describe activities involved in everyday physical functioning and include lifting or carrying groceries; climbing several flights of stairs; bending, kneeling, or stooping; walking more than a mile; walking several blocks; vigorous activities (e.g., running, lifting heavy objects); and moderate activities (e.g., bowling, vacuuming). For both ADLs and IADLs, participants rated their abilities to engage in each activity from 1 (a lot) to 4 (not at all) and summary scores reflect the mean of all reverse-coded items so that higher scores reflect greater functional limitation. Summing ADLs and IADLs to measure functional limitation has the advantage of a greater response range and parsimony, while continuing to measure the unidimensional construct of functional limitation (Spector and Fleishman, 1998).

2.2.4. Chronic illness
Participants reported at all waves whether or not they had experienced each of 27 chronic health conditions including stomach trouble, arthritis, ulcer, and high blood pressure, among others, during the past twelve months. The total of all endorsed conditions was summed to create a composite score for number of chronic illnesses, consistent with previous studies (e.g., Leger et al., 2015; Piazza et al., 2007). Over 90% of participants reported 5 or fewer chronic illnesses. To correct for the positive skew, those reporting 5 or more chronic conditions were recoded to a winsorized score of 5.

2.2.5. Self-rated health
At each wave of data collection, participants were asked, “In general, would you say your physical health is excellent, very good, good, fair, or poor?” using a scale from 1 (poor) to 5 (excellent) in Wave 1 and from 1 (excellent) to 5 (poor) in Waves 2 and 3. Responses were reverse coded for Waves 2 and 3 so that for all waves, higher scores reflect better self-rated health.

2.2.6. Covariates
Sociodemographic variables included age, gender (1 = male, 2 = female), education level (using an ordinal scale from 1 = none or some grade school to 12 = a doctorate or professional degree), ethnicity (0 = non-Caucasian; 1 = Caucasian), marital status (0 = not married; 1 = married), and income. Participants reported their individual total income using a rating scale that reflected 30 different ranges of monetary values, with the lower levels represented with 1000 increments and higher levels representing wider increments (e.g. 1 = $1000–$1,999, 2 = $2000–$2999, ..., 40,000–$44,999, to 30 = $300,000 or higher).

2.3. Statistical analyses
We ran a series of multiple regressions to test the hypotheses that higher Wave 1 NWFS and job demands would each uniquely predict each of the health outcomes nearly ten and twenty years later. For each health index (chronic illness, functional limitation, self-rated health), three regression models were computed. In each model, NWFS and job demands at Wave 1 were included as the independent variables, and all models included gender, ethnicity, age, marital status, education, and income as covariates.

The first model established the cross-sectional association (for descriptive purposes and to reaffirm prior findings in the literature showing concurrent associations between stress and health-related variables) using the health index at baseline as the dependent variable. The second model tested the main hypotheses by entering the health index 10 years later, keeping the baseline (Wave 1) score for the respective health outcome as a covariate. In the third model, the health index almost 20 years later was entered as the dependent variable, again adjusting for its baseline level at Wave 1.

3. Results

3.1. Descriptive analyses
Across the waves, overall means suggested that physical health declined over time: number of chronic illnesses and functional limitations increased, and self-rated health was similar across the first two waves but then was rated more poorly at Wave 3 (see Table 1 for means). Women reported significantly higher levels of chronic illness than men at all three waves (Wave 1: 1.91 vs. 1.49, t(4198) = –8.39; Wave 2: 1.97 vs. 1.63, t(4198) = –6.58; Wave 3: 2.37 vs. 1.94, t(4198) = –6.58, all ps < .001), and greater functional limitation (Wave 1: 2.60 vs. 2.42, t(4198) = –6.87; Wave 2: 3.02 vs. 2.75, t(4198) = –5.39; Wave 3: 3.47 vs. 3.20, t(4198) = –4.38, all ps < .001). Women and men did not differ in their self-rated health at any wave. Women reported greater job demands than men at Wave 1 (16.30 vs. 16.12, t(4198) = –2.45), but men and women did not differ from one another on baseline NWFS scores.

Ethnic minorities did not differ from Caucasians in reported levels of chronic illness at any wave. Ethnic minorities reported greater functional limitation than Caucasians at Wave 1 (2.65 vs. 2.49, t(4198) = 3.59, p < .001) and Wave 2 (3.02 vs. 2.87, t(4198) = 2.07, p < .05) only. Ethnic minorities also reported worse self-rated health than Caucasians at all three waves (3.47 vs. 3.69, t(4198) = –4.88; 3.43 vs. 3.63, t(4198) = –3.10; 3.21 vs. 3.45, t(4198) = –3.34, all ps < .01). Ethnic minorities did not differ from one another on baseline NWFS scores.

Table 1
Means and standard deviations of key variables across all three waves.

<table>
<thead>
<tr>
<th>Variables</th>
<th>Baseline (Wave 1)</th>
<th>10 years later (Wave 2)</th>
<th>20 years later (Wave 3)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
</tr>
<tr>
<td>Number of chronic illnesses</td>
<td>1.68</td>
<td>1.60</td>
<td>1.79</td>
</tr>
<tr>
<td>Functional limitation</td>
<td>2.50</td>
<td>.89</td>
<td>2.89</td>
</tr>
<tr>
<td>Self-rated health</td>
<td>3.67</td>
<td>.90</td>
<td>3.61</td>
</tr>
<tr>
<td>Job Demands</td>
<td>16.20</td>
<td>2.34</td>
<td>–</td>
</tr>
<tr>
<td>Negative work-family spillover</td>
<td>10.57</td>
<td>2.80</td>
<td>–</td>
</tr>
</tbody>
</table>
also reported lower baseline levels of NWFS (10.07 vs. 10.63, t(4198) = −4.01, p < .001) and lower baseline job demands (15.80 vs. 16.25, t (4198) = −3.77, p < .001) than Caucasians.

Those who were not married reported higher levels of chronic illness than married individuals at all three waves (Wave 1 = 1.79 vs. 1.63, t (4198) = 2.99; Wave 2 = 1.90 vs. 1.74, t(4198) = 2.57; Wave 3 = 2.25 vs. 2.11, t(4198) = 2.10, all ps < .05). Non-married individuals reported greater functional limitation than those who were married at Wave 1 (2.58 vs. 2.47, t(4198) = 3.60, p < .001) and Wave 2 (2.98 vs. 2.85, t(4198) = 2.87, p < .01) only. Those who were not married also reported poorer quality of life at Wave 1 (3.59 vs. 3.70, t(4198) = −3.76, p < .001) and Wave 3 (3.37 vs. 3.44, t (4198) = −2.06, p < .05) only. Married and non-married individuals did not differ from one another on baseline scores of NWFS or job demands.

All intercorrelations among study variables can be found in Table 2. At each of the three waves, being older was associated with more reported chronic illnesses, greater functional limitation, and poorer self-rated health. Having less education and a lower income was related to more reported chronic illnesses, greater functional limitation, and poorer self-rated health at each wave. At Wave 1, greater NWFS and job demands were both related to decreases of age but increases of education and income. Based on these findings, all analyses included gender, ethnicity, age, marital status, education, and income as covariates.

3.2. Hypothesis testing

3.2.1. Chronic illness

Results for the multiple regression models predicting the number of chronic illnesses are displayed in Table 3. As hypothesized, higher NWFS was related to concurrent chronic illness (Model 1) and predicted greater numbers of chronic conditions 10 years later (Model 2) and 20 years later (Model 3). In contrast and contrary to the hypothesis, job demands was unrelated to functional limitation. NWFS accounted for 1% of the variance in Models 2 and 3. Being older, having a lower educational level, and having a lower income were each related to poorer self-rated health across all waves. Being unmarried and being an ethnic minority was related to poorer self-reported health at Wave 1 only.

3.2.2. Functional limitation

Results for the multiple regression models predicting functional limitation are displayed in Table 4. NWFS was related to concurrent functional limitation (Model 1), and as predicted by the hypothesis, was associated with greater functional limitation 10 years later (Model 2) and 20 years later (Model 3). Contrary to the hypothesis, job demands was unrelated to functional limitation. NWFS accounted for 1% of the variance in Model 2 and in Model 3. Being older, having a lower educational level and a lower income were associated with greater functional limitation in all three models. Being an ethnic minority, female and being unmarried were related to functional limitation only at Wave 1.

3.2.3. Self-rated health

Results for the multiple regression models predicting self-rated health are displayed in Table 5. Greater NWFS at Wave 1 was concurrently associated with poorer self-rated health and predicted poorer self-rated health 10 years later (Model 2) and 20 years later (Model 3). In contrast and contrary to the hypothesis, job demands was unrelated to self-rated health. NWFS accounted for 1% of the variance in Models 2 and 3. Being female, older, having a lower educational level, and having a lower income were each related to poorer self-rated health across all waves. Being unmarried and being an ethnic minority was related to poorer self-reported health at Wave 1 only.

4. Discussion

Work-related stress is common among U.S. adults. Although a number of studies have established concurrent associations between both job demands and NWFS with poorer physical and mental health (e.g., Allen et al., 2000; Geurts et al., 2003), fewer studies examined long-term relationships between both aspects of work-related stress and physical health outcomes. The current study confirmed the hypothesis that higher NWFS significantly predicted greater numbers of chronic illnesses, greater functional limitation, and worse self-rated health 10 and 20 years later. These findings remained even after adjusting for job demands, baseline levels of health, and relevant covariates. In contrast, job demands – a measure that was designed to assess during the time at work – was not an independent predictor of long-term health outcomes. This finding is consistent with the theoretical conceptualization that stress when physically at work is most likely a causal contributor to NWFS (and in this study was moderately related to NWFS). Thus, NWFS represents a unique source of stress that has a stronger association with health outcomes.

NWFS predicted three different self-reported health measures across 10- and 20-year periods. Several mechanisms may account for the significant relationship between greater NWFS and worse physical health over time. Greater NWFS may lead to physiological dysregulation by wearing down multiple bodily systems in what scientists refer to as allostatic load (McEwen, 1998). When people encounter an acute psychological stressor, multiple systems including the autonomic nervous system, the hypothalamic-pituitary-adrenal (HPA) axis, and the cardiovascular system are differentially activated in response to the stressor. This is a protective and regulatory physiological response to an

---

Table 2: Correlation matrix.

<table>
<thead>
<tr>
<th>Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>−.05**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income</td>
<td>.01</td>
<td>.32***</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NWFS</td>
<td>−.13***</td>
<td>.14***</td>
<td>.14***</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Job Demands</td>
<td>−.08***</td>
<td>.11***</td>
<td>.19***</td>
<td>.39***</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic Ill 3</td>
<td>.17***</td>
<td>−.09***</td>
<td>−.11***</td>
<td>.15***</td>
<td>.04***</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic Ill 2</td>
<td>.22***</td>
<td>−.11***</td>
<td>−.14***</td>
<td>.11***</td>
<td>.02</td>
<td>.52***</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic Ill 1</td>
<td>.20***</td>
<td>−.14***</td>
<td>.15***</td>
<td>.09***</td>
<td>.04</td>
<td>.47***</td>
<td>.59***</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Func Lim W1</td>
<td>.18***</td>
<td>−.13***</td>
<td>−.14***</td>
<td>.10***</td>
<td>.03</td>
<td>.35***</td>
<td>.33***</td>
<td>.33**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Func Lim W2</td>
<td>.21***</td>
<td>−.21***</td>
<td>−.19***</td>
<td>.08***</td>
<td>.01</td>
<td>.34***</td>
<td>.48***</td>
<td>.46***</td>
<td>.55***</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Func Lim W3</td>
<td>.22***</td>
<td>−.25***</td>
<td>−.17***</td>
<td>.06***</td>
<td>.01</td>
<td>.33***</td>
<td>.43***</td>
<td>.53***</td>
<td>.48***</td>
<td>.68***</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sr Health W1</td>
<td>.08***</td>
<td>.20***</td>
<td>.13***</td>
<td>−.10***</td>
<td>.02</td>
<td>.33***</td>
<td>.29***</td>
<td>.30***</td>
<td>.37***</td>
<td>.33***</td>
<td>.34***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sr Health W2</td>
<td>.12***</td>
<td>.24***</td>
<td>.17***</td>
<td>.08***</td>
<td>.05**</td>
<td>.27***</td>
<td>.40***</td>
<td>.38***</td>
<td>.33***</td>
<td>.51***</td>
<td>.44***</td>
<td>.49***</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sr Health W3</td>
<td>.10***</td>
<td>.24***</td>
<td>.17***</td>
<td>.05*</td>
<td>.02</td>
<td>.26***</td>
<td>.34***</td>
<td>.43***</td>
<td>.33***</td>
<td>.45***</td>
<td>.58***</td>
<td>.43***</td>
<td>.56**</td>
<td></td>
</tr>
</tbody>
</table>

Note. NWFS = negative work-family spillover, Chronic III = number of chronic illnesses, Func Lim = functional limitation, Sr Health = self-rated health. *p < .05; **p < .01; ***p < .001.
acute stressor, but chronic activation is believed to lead to long-term dysregulation and wearing down of multiple bodily systems (Lundberg, 2005; McEwen, 1998, 2004). NWFS may be a potent form of chronic stress for those with stressful and demanding jobs for whom effort to recover from this daily stress once at home are ineffective (Geurts and Sonnentag, 2006). In contrast, demands experienced on the job may also place wear and tear on the physical system, yet their influence ends when people leave the workplace. As a result, the predictable, time-delimited nature of this stress may be less pernicious for their physical health. Job demands predicted functional limitation and wearing down of multiple bodily systems (Lundberg, 2005; McEwen, 1998, 2004). NWFS may be a potent form of harmful health practices including smoking, eating a high-fat diet, increased alcohol intake, and infrequency of exercise (Hellerstedt and Jeffery, 1997; Ng and Jeffery, 2003; Payne et al., 2014). The current study suggests that it is not the workplace stress itself that may be related to these behaviors, but the extent to which people continue to worry about their jobs long after their workday is over. NWFS has also been associated with unhealthy eating, smoking, and increased alcohol consumption (e.g., Lallukka et al., 2010). Sleep is another health behavior that likely plays a critical role in the relationship between

### Table 3

Regressions of the cross-sectional associations between NWFS and chronic illness at baseline (Wave 1) and NWFS predicting chronic illness 10 years later (Wave 2) and about 20 years later (Wave 3).

<table>
<thead>
<tr>
<th>Variables</th>
<th>Concurrent Chronic Illness (Wave 1; N = 4200)</th>
<th>Chronic Illness 10 years later (Wave 2; N = 4200)</th>
<th>Chronic Illness about 20 years later (Wave 3; N = 4200)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>b</td>
<td>SE</td>
<td>95% CI</td>
</tr>
<tr>
<td>Gender</td>
<td>.30***</td>
<td>.051</td>
<td>[.20, .40]</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>-.16*</td>
<td>.079</td>
<td>[-.32, -.01]</td>
</tr>
<tr>
<td>Age</td>
<td>.03***</td>
<td>.002</td>
<td>[.02, .03]</td>
</tr>
<tr>
<td>Education</td>
<td>-.05***</td>
<td>.010</td>
<td>[-.07, -.03]</td>
</tr>
<tr>
<td>Income</td>
<td>-.02***</td>
<td>.004</td>
<td>[.03, -.01]</td>
</tr>
<tr>
<td>Marital Status</td>
<td>.14*</td>
<td>.053</td>
<td>[-.24, -.03]</td>
</tr>
<tr>
<td>Number of chronic illnesses W1</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Job Demands</td>
<td>.01</td>
<td>.012</td>
<td>[.02, .03]</td>
</tr>
<tr>
<td>Negative work-family spillover W1</td>
<td>.11***</td>
<td>.009</td>
<td>[.09, .13]</td>
</tr>
</tbody>
</table>

*R2 = .10*

*p < .05. **p < .01. ***p < .001.

### Table 4

Regressions of the cross-sectional associations between NWFS and functional limitation at baseline (Wave 1) and NWFS predicting functional limitation 10 years later (Wave 2) and about 20 years later (Wave 3).

<table>
<thead>
<tr>
<th>Variables</th>
<th>Concurrent Functional Limitation (Wave 1; N = 4200)</th>
<th>Functional Limitation 10 years later (Wave 2; N = 4200)</th>
<th>Functional Limitation about 20 years later (Wave 3; N = 4200)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>b</td>
<td>SE</td>
<td>95% CI</td>
</tr>
<tr>
<td>Gender</td>
<td>.10***</td>
<td>.028</td>
<td>[.04, .16]</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>-.19***</td>
<td>.043</td>
<td>[.27, -.10]</td>
</tr>
<tr>
<td>Age</td>
<td>.02***</td>
<td>.001</td>
<td>[.01, .02]</td>
</tr>
<tr>
<td>Education</td>
<td>-.04***</td>
<td>.006</td>
<td>[.05, -.03]</td>
</tr>
<tr>
<td>Income</td>
<td>-.01***</td>
<td>.002</td>
<td>[.02, -.01]</td>
</tr>
<tr>
<td>Marital Status</td>
<td>-.10**</td>
<td>.029</td>
<td>[.15, -.04]</td>
</tr>
<tr>
<td>Functional limitation W1</td>
<td>-.07***</td>
<td>.027</td>
<td>[.62, .73]</td>
</tr>
<tr>
<td>Job Demands</td>
<td>.01</td>
<td>.006</td>
<td>[.00, .02]</td>
</tr>
<tr>
<td>Negative work-family spillover W1</td>
<td>.05***</td>
<td>.005</td>
<td>[.04, .06]</td>
</tr>
</tbody>
</table>

*R2 = .09*

*p < .05. **p < .01. ***p < .001.

### Table 5

Regressions of the cross-sectional associations between NWFS and self-rated health at baseline (Wave 1) and NWFS predicting self-rated health 10 years later (Wave 2) and about 20 years later (Wave 3).

<table>
<thead>
<tr>
<th>Variables</th>
<th>Concurrent Self-Rated Health (Wave 1; N = 4200)</th>
<th>Self-Rated Health 10 years later (Wave 2; N = 4200)</th>
<th>Self-Rated Health about 20 years later (Wave 3; N = 4200)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>b</td>
<td>SE</td>
<td>95% CI</td>
</tr>
<tr>
<td>Gender</td>
<td>.06*</td>
<td>.029</td>
<td>[.01, .12]</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>.22***</td>
<td>.044</td>
<td>[.13, .30]</td>
</tr>
<tr>
<td>Age</td>
<td>-.01***</td>
<td>.001</td>
<td>[.01, -.01]</td>
</tr>
<tr>
<td>Education</td>
<td>.07***</td>
<td>.006</td>
<td>[.06, .08]</td>
</tr>
<tr>
<td>Income</td>
<td>.01***</td>
<td>.002</td>
<td>[.01, .02]</td>
</tr>
<tr>
<td>Marital Status</td>
<td>.11***</td>
<td>.029</td>
<td>[.06, .17]</td>
</tr>
<tr>
<td>Self-rated health W1</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Job Demands</td>
<td>.01</td>
<td>.006</td>
<td>[.00, .02]</td>
</tr>
<tr>
<td>Negative work-family spillover W1</td>
<td>-.05***</td>
<td>.005</td>
<td>[.07, -.04]</td>
</tr>
</tbody>
</table>

*R2 = .08*

*p < .05. **p < .01. ***p < .001.
NWFS and long-term health. Getting enough good quality sleep is crit-
icical for maintaining good health (Imerti and Opp, 2009; Kamel and
Gam-mack, 2006), but NWFS has been related to shorter sleep duration
and poorer sleep quality (Buxton et al., 2016; Demerouti and Geurts,
Although NWFS uniquely predicted chronic illness, functional limi-
tation, and self-rated health at both follow-ups, NWFS’s relationship
with these health outcomes was quite modest. However, given that a
number of demographic, psychosocial, and behavioral factors influence
people’s physical health and functioning such as genetic predispositions,
diet, physical activity, health behaviors, sleep quality (Åkerstedt, 2006),
socioeconomic status, social support (Reblin and Uchino, 2008), and
positive (Pressman and Cohen, 2005) and negative affect (Charles et al.,
2008), the fact that NWFS was significant across such a long time period
is noteworthy. With so many factors influencing physical health, it is not
surprising that NWFS yielded only a small effect on long-term health
outcomes. Furthermore, this small effect is consistent with other studies
predicting longitudinal health outcomes from psychosocial variables (e.
.g., Rasmussen et al., 2009).

4.1. Limitations
Several limitations of the present study should be addressed in future
research. First, although this study used a large national sample, the
sample was predominantly Caucasian and so these findings do not
represent the current ethnic/racial composition of the U.S. workforce.
Moreover, ethnic minorities may be even more susceptible to experi-
ing job stress due to feelings of discrimination or varying cultural
pressures (Capasso et al., 2016; Wadsworth et al., 2007) and the effects
of spillover stress may be even more pronounced. Capturing greater
ethnic diversity is a priority for future studies examining NWFS. In
addition, although temporal relationships were established between
NWFS and three separate health indices, these relationships were
correlational and no causal inferences could be made from this data.
Nonetheless, these results provide stronger evidence of the longitudinal
relationships between NWFS and health than could be demonstrated
through only cross-sectional work; higher NWFS predicted multiple
health outcomes many years later even when adjusting for baseline
levels of each self-reported health outcome. Future studies could also
examine specific types of workplace stress or what occurs at home that
may explain why higher NWFS is related to later poor health.
Finally, all three measures of health used in this study were self-
reported. Self-reported health outcomes are subject to a self-report
bias, the same bias that may also conflate reports of stress. Despite
this limitation, however, each of the self-reported health measures
included in this study has been shown to predict important objective
health outcomes. Chronic illness continues to cost Americans billions of
dollars annually in healthcare expenses and is the leading cause of
disability and death in the U.S. (Centers for Disease Control and
Prevention, 2016). Functional limitation predicts further critical health
outcomes including hospitalization, increased need for medical care,
independent living, and mortality in elderly samples (Avelino-Silva et
al., 2014; Hirani et al., 2014; Wiener et al., 1990). Self-rated health
predicts multiple chronic health conditions (Mavaddat et al., 2014;
Moller et al., 1996) and is a strong predictor of mortality (e.g., DeSalvo
et al., 2006). Still, future research should utilize objective measures of
health to provide more concrete evidence of long-term relationships
with NWFS.

5. Conclusions
Negative work-family spillover is a form of stress that is becoming
increasingly common as more U.S. households have two working part-
ners. Stress in general, and NWFS in particular, is related to a number of
chronic health conditions including cardiovascular disease, Type 2
diabetes, and poor immune functioning. Past research has established
cross-sectional relationships between higher levels of NWFS and poor
physical health outcomes, but the current study was the first to
demonstrate these relationships across 20 years. Greater initial NWFS,
but not necessarily the demands during the workplace itself, was related
to a higher number of chronic illnesses, greater functional limitation,
and poorer self-rated health after 20-years after adjusting for initial
health. These findings underscore the importance of being able to escape
– both physically as well as psychologically – from the stress of the
workplace when the actual workday is over.

Acknowledgements
The authors would like to acknowledge John D. and Catherine T.
MacArthur Foundation Research Network; National Institute on Aging
(P01-AG021666); National institute on Aging (U19-AG051426).

References
Health 32 (6), 493–501.
work-to-family conflict: a review and agenda for future research. J. Occup. Health
Psychol. 5 (2), 278–308. https://doi.org/10.1037//1076-899B.5.2.278.
Avelino-Silva, T.J., Farfel, J.M., Cusiati, J.A.E., Amaral, J.R.G., Campora, E., Jacob-
Filho, W., 2014. Comprehensive geriatric assessment predicts mortality and adverse
review of worry, prolonged stress-related physiological activation, and health.
jpsychores.2005.06.074.
family conflict and employee sleep: evidence from IT workers in the work, family
Capasso, R., Zurlo, M., Smith, A., 2016. Ethnicity and stress at work: a literature review
and suggestions for future research. British journal of Education, Society &
Centers for Disease Control and Prevention, 2016. Chronic Disease Prevention and
org/10.1037/0278-6133.27.3.369.
relating to coronary heart disease and mental ill health. J. Occup. Psychol. 49 (1),
Community Work. Fam. 7 (3), 285–309. https://doi.org/10.1080/
1366880042000295727.
four-years longitudinal study of employed parents. Journal Occupational and
Organizational Psychology 70, 325–335.
Geurts, S., Rutte, C., Peeters, M., 1999. Antecedents and consequences of work-home
org/10.1016/S0277-9536(98)00425-0.
Geurts, S.A.E., Sonnentag, S., 2006. Recovery as an explanatory mechanism in the
relation between acute stress reactions and chronic health impairment. Scand. J.
reports of work and family stress in the adult labor force. Fam. Relat. 51 (1),
org/10.1093/ije/26.3.575.
Hiraoka, V., Nagazath, V., Blyth, F., Le Couteur, D.G., Gnjidic, D., Stanaway, F.E., et al.,
2014. Multiple, but not traditional risk factors predict mortality in older people: the
concord health and ageing in men project. Age 36 (11). https://doi.org/10.1007/
11357-014-9732-2.
References
D. Tsakerman et al.
Social Science & Medicine xxx (xxxx) xxx