Who Cares?:

Familial Care Norms and Caregiver Well-being in Europe*

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Abstract

This paper analyzes a multi-national sample to assess self-reported well-being of individuals who provide dependent care. We pair individual-level data from the 2004 European Social Survey (ESS) for respondents in 22 nations (*n*=42,523) with country-level measures of attitudinal support for familial caregiving from the Eurobarometer, and economic development (GDP). Using multi-level modeling, we examine the association between country-level familial attitudes and caregiver well-being, comparing effects by gender. We find that: (1) caregiving is differentially associated with well-being for men and women; (2) women in countries with support for familial caregiving report worse well-being than men; (3) in countries with attitudinal support for familial caregiving, female caregivers report worse well-being than male caregivers. Our results demonstrate that caregivers, notably female caregivers, are significantly disadvantaged in well-being. Moreover, country-level familial care norms impact caregiver well-being beyond individual characteristics; caregivers in country with greater support for familial care report worse well-being. These findings are important in the context of Europe's delayed population structure and political climate emphasizing cuts to caregiver benefits.

Keywords: aging, care, caregiving, familial care, well-being

Providing dependent care has far-reaching consequences for caregiver well-being (Marks *et al.*, 2002, Pavalko and Woodbury, 2000), yet it remains unclear whether the social organization of caregiving, particularly familial care norms, structure caregiver well-being in Europe. Familial care norms, or the expectation for care to be provided by one's family, may burden caregivers by constraining their care decisions. This link between familial norms and caregiver well-being is especially pertinent considering Europe's changing demographics. Europe has 19 of the world's 20 countries with the oldest populations, and estimates project that nearly 30% of the European population will be over the age of 65 by 2060 (Eurostat, 2013). Adult children in Europe are increasingly called upon to provide care for their aging parents as a substitute for formal care (Bonsang, 2009). Further, the "sandwich generation" provide care to children and older adult(s) concurrently (Miller, 1981). The number of individuals who provide dependent care to elders, children, or both concurrently, will continue to increase (Eurostat, 2013), as shifting demographics of aging populations and low fertility create unprecedented challenges for policy-makers and families alike (Bengtson and Lowenstein, 2003, Billari and Kohler, 2004). This gap is even more troubling in the context of a global financial crisis whereby potential cutbacks in government support to caregivers will place greater pressure on informal caregivers (Bolin *et al.*, 2008).

Despite the important policy implications of the varying social organization of care in European countries and caregiver well-being, there is a dearth of literature examining the multi-level effects of familial care norms on caregiver well-being. The "social organization of caring" (Glenn, 2010), including how caregiving responsibilities are assigned in a society, may impact caregiver well-being. For instance, individuals may be coerced into caregiving through normative care expectations assigned based on social status. Indeed, women and minorities in America are often coerced into caregiving (Glenn, 2010), and in Europe care work also disproportionately falls to women; for example, in Spain 84% of caregivers are women (IMSERSO, 2004). In the European context, countries differ in familial care norms and social organization of caring (Daatland, 2001). Notably, studies examining data from the 5-country European OASIS study (Old Age and Autonomy: The Role of Service Systems and Inter-generational Family Solidarity) found a north-south gradient in which southern countries have stronger filial obligations, including providing help and support for aging parents (Daatland, 2001, Lowenstein and Daatland, 2006). While these studies identified important variation in familial norms and social organization of care, they did not examine the multi-level effects of familial care norms on caregiver well-being.

This study addresses this gap by using the 2004 European Social Survey dataset to: (1) compare the well-being of caregivers to those not providing dependent care, (2) examine whether the association between caregiving and well-being varies for men and women, and (3) assess the importance of attitudes toward familial caregiving in relation to caregiver well-being. We contribute to existing literature by using multi-level modeling to examine how country-level familial caregiving norms in 22 countries are associated with individual-level caregiver well-being. Well-being, as measured in this study, reflects positive psychological aspects and the absence of depressive symptoms (Bech, 2004, Bech *et al.*, 2003). Familial caregiving norms, specifically the expectation that children should provide dependent care for an aging parent, may reflect a coercive social environment in which individuals, even those who prefer not to, are called on to provide dependent care (Glenn, 2010). Specifically, strong attitudinal norms supporting familial caregiving may make all families, even those who are unable to care for additional family members, pressured to provide care. We argue that well-being may be lower among caregivers in coercive contexts, where there is strong social pressure to provide care even for those with insufficient resources to be able to provide the care. Generally, we expect that caregivers in countries with stronger attitudinal support for family to provide in-home care for older adults will report worse well-being than those in countries with less familial caregiving attitudes. Moreover, we expect a more severe penalty for female caregivers, who disproportionately shoulder these responsibilities based on their social status. The results highlight important country differences in caregiver well-being, as well as the association between country-level familial care norms and caregiver well-being.

Caregiver Well-being

Providing care, whether to older adults or children, may have both positive and negative consequences for well-being (Pinquart and Sorensen, 2003, Pinquart and Sörensen, 2003, Stanca, 2012, Walker *et al.*, 1995). On one hand, social exchange theory points to the rewarding aspects of caregiving, suggesting it may improve the caregiver's relationships with the elder receiving care (Hinrichsen *et al.*, 1992, Walker and Allen, 1991). In addition, elderly dependents may provide help in the home for the caregiver's family, especially when children are present (Ingersoll-Dayton *et al.*, 2001). However, a larger literature points to the negative effects of caregiving on well-being, especially for women, based on issues related to role strain, caregiver burden, and economic factors, among others (for review, see Carretero *et al.*, 2009). For example, women who provide care for elderly parents have increased depression (Schulz *et al.*, 1995), and parents, especially mothers, have greater distress and lower well-being (Bird, 1997). Female caregivers with parents who need care have adverse mental health, while their male counterparts do not (Amirkhanyan and Wolf, 2006). Examining 94 countries from the World Values Survey, Stanca (2012) found lower well-being (measured by life satisfaction and happiness) among parents. Role strain theories explain these findings by focusing on conflicting demands of work and caregiving (Pavalko and Woodbury, 2000). Indeed, those who provide dependent care for an elder family member report greater pressure balancing work and family demands (Walker and Allen, 1991). Economic approaches examine the impact of care on well-being through its effect on employment and earnings (Aassve *et al.*, 2005, Wakabayashi and Donato, 2006).

A limitation of existing research is that many studies of caregiver well-being compare caregivers and non-caregivers within a single or a few countries and thus are unable to examine multi-level, cross-national differences (Borg and Hallberg, 2006, Daatland *et al.*, 2010, Llacer *et al.*, 2002, Nordberg *et al.*, 2005). Caregivers' experiences may vary by country context because European countries differ in norms and systems of care that may impact caregiver well-being. For example, only a small percentage of Norwegians provide sandwiched care (3%), yet they benefit from these arrangements through improved life satisfaction (Daatland, Veenstra and Lima, 2010). This relationship is explained, in part, by generous institutional support for the care of aging or disabled family members (Daatland, Veenstra and Lima, 2010, McGill Institute for Health and Social Policy, 2011). Notably, countries vary in their approaches to the care of dependent populations, one aspect that classifies welfare state clusters (Cousins and Tang, 2004, Esping-Andersen, 1990). For example, Scandinavian countries have policies supportive of family caregiving, including guaranteed child care coverage and older adult care subsidies (Esping-Andersen, 1990, Gornick *et al.*, 1997). In the Scandinavian context, dependent care is considered a social issue that should be addressed collectively through government support. Although marketization has been increasing recently even among Scandinavian welfare states (Szebehely, 2005), they remain much more supportive of publically-funded child and older adult care than do more conservative welfare states that favor family-centered caregiving, either in the child or parents' home (Daatland, 2001). More conservative welfare states rely more heavily on informal home-based care for dependent populations than more expansive welfare states (Daatland, 2001). Finally, many of the liberal welfare states, such as the United States and Great Britain, provide few institutional supports for dependent caregiving, focusing instead on market-driven interventions, which reflects ideological support for individualistic approaches to care and tendencies towards marketization (Freeman and Schettkat, 2005, Gornick, Meyers and Ross, 1997).

In response to the limited comparative research, a growing body of cross-national research investigates between-country variation in caregiver experiences, including the economic and psychological impacts of providing informal care in the home (Bolin, Lindgren and Lundborg, 2008, Wahrendorf *et al.*, 2006). These studies identify important cross-national patterns and highlight the need to investigate multi-level effects. Supporting the need for more cross-national research, Bolin and colleagues (2008) examining a larger 10-country European sample, find that providing long-term care severely impacts caregivers' work and family decisions, thus hindering families' economic prosperity. While Bolin et al. (2008) identify between-country differences in the level of publicly financed long-term care programs, these relationships are not explicitly modeled.

Familial Caregiving Norms as Coercive Care

Since cultural preferences are reflected through institutions, these welfare systems may reflect normative expectations for care (Bolin, Lindgren and Lundborg, 2008). Normative expectations, in turn, may influence individuals’ abilities to opt-out of care arrangements through structural impediments constituting “coerced care.” Indeed, Menaghan (1989) found that norms surrounding childbearing affect the association between parenthood and psychological well-being. Investigating attitudinal support for child-to-parent transfers more broadly, Lowenstein and Daatland (2006) find that adult children in Europe expect to provide more support to parents in more familistic societies compared to more individualist societies. Collectively, these studies suggest that normative expectations for caregiving influence caregiver experiences. Yet an explicit analysis of this issue is conspicuously absent from the literature.

The need to understand the “social organization of caring” (Glenn, 2010), including how caregiving responsibilities are assigned in a society, is essential for caregiver well-being. In some societies, individuals are “coerced” into providing care through normative expectations, often based on social status (Glenn, 2010). Risk for coercive care is not gender neutral. Women are disproportionately responsible for caregiving based on their statuses as wives, mothers and daughters (Glenn, 2010). That female caregivers report lower well-being than male caregivers is neither novel nor surprising (Daatland, Veenstra and Lima, 2010, Dautzenberg *et al.*, 1999, Freeman and Schettkat, 2005). However, situating women’s experiences within broader societal norms for family care highlights the compounding effect on individual-level well-being of "coercive care" at the structural-level. Normative expectations for care provided within the home limits the availability of care options, leading to institutional constraints that limit formal care (Daatland, 2001). As a consequence, families with limited caregiving abilities and/or desires may be called upon to provide dependent care, which may have detrimental effects on caregiver well-being. Females, especially, may be "coerced" into care by way of their status as women, and therefore may be limited in their abilities to decline providing care. Given the diversity in caregiver regimes, the need to understand caregiving cross-nationally is pertinent as country-level differences in attitudes toward caregiving may have implications for well-being above and beyond individual-level resources.

To summarize, this study builds on existing literature to expand the models to large country sample and explicitly tests the impact of familial norms on caregiver well-being. Further, we apply a representative urban and rural sample which improves upon previous urban-only research (Lowenstein and Ogg, 2003). Our novel approach assesses the multi-level effects of caregiving and country context on well-being by combining individual-level data from 22 nations from the 2004 ESS, with country-level measures of attitudinal support for familial caregiving from the Eurobarometer.

Research Questions and Hypotheses

We examine three empirical questions: (1) Do caregivers report lower well-being than non-caregivers net of sociodemographic differences? (2) Does the association between caregiving and well-being differ for males and females? (3) Do country-level attitudes toward familial caregiving impact individual caregiver well-being?

Based on this literature, we derive three hypotheses:

Hypothesis 1: Caregivers report lower levels of well-being compared to those who do not provide dependent care.

Hypothesis 2: Female caregivers report lower levels of well-being than male caregivers.

Hypothesis 3: Caregivers in countries with more familial caregiving attitudes report worse well-being than those in countries with less familial caregiving attitudes, an effect magnified for female caregivers.

Method

Data and Sample

This study combined individual-level data from the 2004 ESS module on family, work and well-being, with country-level data from the 2007 Eurobarometer (for familial caregiving attitudes) and CIA World Factbook (2004), for per capita Gross Domestic Product [GDP] in 2004 dollars. The ESS is an academically-led general composite social survey of European nations, designed to be representative of all persons ages 15 and over residing in private households in each country. The sample was selected based on strict random probability methods at each stage of the survey design, and respondents were interviewed face-to-face. The ESS sample includes urban and rural residents, going beyond previous studies that only sampled urban residents

(Lowenstein and Ogg, 2003). Our sample included data for (n=42,523) respondents from the following 22 countries: Austria, Belgium, Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Ireland, Luxembourg, Netherlands, Norway, Poland, Portugal, Slovakia, Slovenia, Spain, Sweden, Switzerland, Turkey, and United Kingdom. Three countries were excluded from our sample because they were missing data on the country-level measures: Estonia (missing the individual-level income measure), Iceland and Ukraine (missing the familial caregiving attitudes measure).

Country-Level Measures

Our country-level measure of familial caregiving attitudes is from the Eurobarometer report on Health and Long-term Care (2007) in the European Union. Initially, we explored preferences for familial provided childcare (from the 2002 International Social Survey Programme) and parental care (from the 2007 Eurobarometer). However, we found these preferences to be highly correlated ($\alpha = 0.90$). Thus, we apply one measure - preferences for family-provided parental care. Yet, in light of the very strong correlation between these variables, our main country-level measure captures attitudinal preferences for family-centered parental *and* childcare arrangements. Familial caregiving attitudes is measured using the following question:

> "Imagine an elderly father or mother who lives alone and can no longer manage to live without regular help because of her or his physical or mental health condition. In your opinion, what would be the best option for people in this situation?"

Respondents selected one of six options: (1) they should live with one of their children; (2) public or private service providers should visit their home and provide them with appropriate help and care; (3) one of their children should regularly visit their home, in order to provide them with the necessary care; (4) they should move into a nursing home; (5) it depends; (6) none of these. We coded familial caregiving to reflect the percent of respondents in each country who reported that the dependent should live with his/her child. Switzerland and Norway were excluded from the Eurobarometer, thus we imputed the values using a measure of attitudes toward childcare from the 2002 International Social Survey Programme, which was highly correlated ($\alpha = 0.90$) with attitudes toward elder care. Specifically, we averaged three Eurobarometer familial care values for countries with the most similar values to Switzerland and Norway's child care measure. We then ran our models with and without these imputed countries; results were robust. To control for the confounding effect of country-level economic development, we include per capita GDP (in 2004 US dollars).

As a sensitivity test, we also explored respondents' attitudes towards family-provided care within the parental home through support for the following arrangement: "one of their children should regularly visit their home in order to provide them with the necessary care" (2007 Eurobarometer). Responses are on an equivalent scale to familial caregiving attitudes. In models not shown, we find familial and child-provided care measures are not correlated indicating these reflect specific cultural care preferences. We then ran equivalent multi-level models for the child-provided care measure which was non-significant when entered alone and net of individual-controls. Finally, we explored these care attitudes measures net of each other and found the familial results to be robust net of the non-significant child-provided care measure. Collectively, these results indicate that country-level attitudinal support for familial in-home care, rather than merely being a caregiver, is associated with lower well-being.

Individual-Level Measures

Dependent Measure

We examine the WHO-5 Well-being Index (Bech, Olsen, Kjoller and Rasmussen, 2003), a measure used in previous research (Boye, 2011, Layte, 2011). Self-reported well-being over the past two weeks is assessed by the following statements: (1) I have felt cheerful and in good spirits; (2) I have felt calm and relaxed; (3) I have felt active and vigorous; (4) I have woken up feeling fresh and rested; (5) My daily life is filled with things that interest me. Respondents were included in the overall well-being measure if they responded to all scale items. Responses are on a six-point scale ranging from one ("at no time") to six ("all of the time"). The index has high internal consistency (Cronbach's $\alpha = 0.85$), and is both a measure of emotional well-being and can be used as a screener for depression (Heun *et al.*, 1999). We computed a well-being measure by taking the mean of the previous five items, with higher values reflecting reports of greater well-being. The total effective individual-level sample size is 42,523 respondents. We also investigated our dependent measure as a factor score which produced equivalent results. For simplicity, we present the results for mean well-being.

Main Independent Measures

Providing dependent care. Respondents reported whether they were "currently providing care for a small child, someone ill, someone disabled or the elderly in the home." This measure was dichotomously coded (1 = *respondent is providing dependent care in the household*). Given the wording of this measure, we are unable to distinguish between those providing long-term versus intermittent care for dependents in the home. While we can capture some of this variation through our household composition measures, this dependent care measure likely underestimates the impact of long-term caregiving and does not speak to differences by type of dependent.

Gender. Respondent gender was measured dichotomously (1 = *female*).

Independent Controls

We control for household composition through a series of dichotomous measures. A limitation of the ESS is that it does not ask for whom the respondent was providing dependent care; therefore, we instead measured household composition. We used the household roster to identify dependents by age and relationship (not mutually exclusive categories): child ages 5 and under, child ages 6 to 15, spouse ages 65 to 74, spouse ages 75 plus, parent ages 65 to 74, parent ages 75 plus, other adult ages 65 to 74, and other adult ages 75 plus. We also coded the presence of a disabled partner in the home (1= *disabled partner present*) which is asked in a separate one-item measure and shown to significantly impact caregiver well-being (Marks, 1998) (Schulz and Beach, 1999). Previous research focuses on the sandwiching of care (Daatland, Veenstra and Lima, 2010, Grundy and Henretta, 2006, Loomis and Booth, 1995, Van Gaalen and Dykstra, 2006). To measure the “sandwich” households, we collapsed the child and adult over 65 measures into single dichotomous measures, then multiplied the terms. Given the gender distribution of care, we include gender interactions for each of these measures (Freeman and Schettkat, 2005). Thus, the gender effect is net of the gender distribution of household composition.

Sociodemographic controls include issues that have been tied to well-being: employment status, household income, education, marital status, religiosity, age. For employment status, respondents reported their current main activity: employed in paid work (reference group), unemployed, student, disabled, retired, and housewife/househusband. We also examined household income (relative to others in one's country) on a twelve-point scale, with higher values representing higher household income relative to others in the same country. We imputed missing values for those missing income data. As 26.8% of our sample are missing or failed to report household income, we explored models with and without the imputed respondents. These produced largely equivalent results, but are discussed in more detail in the subsequent section. For education, respondents reported their highest completed education level on a categorical scale (standard ISCED classification), which we recoded into four dichotomous categories: no primary, basic, secondary (completed high school, some college) and tertiary (college or higher, reference group).

Current marital status was coded into five dichotomous measures: married (reference group), separated, divorced, widowed, and never married. Religiosity, a moderator of caregiver well-being (Moen *et al.*, 1995), was measured through the following question: "Regardless of whether you belong to a particular religion, how religious would you say you are?" Responses were on a 10-point scale ranging from "not at all religious" to "very religious" with higher values represent higher self-reported religiosity. Age was included as a continuous variable ranging from 18 to 100.

Statistical Models

We estimate our coefficients through hierarchical linear modeling (HLM 6.08) analyses. The data are weighted using the design weights provided by ESS. Multilevel models allow simultaneous estimation of a micro-level model (here, an individual-level model predicting reports of well-being) and a set of macro-level (here, country-level familial caregiving expectations) equations (Guo and Zhao, 2000, Raudenbush and Bryk, 2002). Unlike OLS models that assume the observations are independent, HLM accounts for the nesting of individuals at multiple-levels (here, a two-level model of individuals within countries) and models the standard errors accordingly (DiPrete and Forristal, 1994, Guo and Zhao, 2000) In effect, our modeling approach is similar to estimating the individual-level model predicting the probability of reporting well-being separately in each of the 22 countries (Fuwa, 2004). Our individual-level coefficients, which express the relationship between individual-level variables and the reports of well-being, become the outcome variables in the country-level equations. This allows us to evaluate the effects of county-level variables on not only the likelihood of reporting well-being, net of individual-level factors, but also the effect of country-level variables on the female, caregiver, and female x caregiver slopes. As such, the models permit direct examination of cross-level interaction effects.

Results

Table 1 provides a descriptive overview of each country's mean well-being, familial caregiving attitudes, and GDP. For the overall sample, respondents in Denmark report the highest well-being and those in Turkey the lowest. Among caregivers, respondents in Switzerland report the highest and those in Turkey the lowest well-being. In half of the countries, caregivers report worse well-being than the general population, indicating that caregivers report varying levels of well-being by country. At the country-level, Turkey shows the greatest support of familial caregiving attitudes, and Sweden the least. Respondents in post-communist and traditional welfare states are generally the most likely, and those in the Scandinavia least likely, to support familial care. The per capita GDP is highest in Luxemburg and lowest in Turkey. Collectively, the descriptive statistics indicate that Turkey reports the lowest well-being, strongest familial caregiving attitudes and lowest GDP. Given its outlier status, we model our HLM effects with a sample that includes and excludes Turkey; the results were equivalent.

Table 2 provides a description of the sample. Approximately 25% percent of respondents report providing dependent care within their household, and two-thirds of those are females. The household composition measures reflect who lives in the home and may provide some insight into the types of dependent care provided by the respondent. With regard to the presence of a child in the home, 11% of the sample report having a child under 5 years of age, and 22% report having a child ages 6 to 15 in the home. It is important to note that these categories are not mutually exclusive. Having an older adult in the home is also not uncommon; 7% of respondents report living with a spouse ages 65 to 74; 3% with a spouse ages 75 or older; 1% with a parent ages 65 to 74 or 75 plus; and 0.6% with another adult 65 to 74 and 1% with another adult ages 75 plus. Roughly 1% of the sample make-up the “sandwich generation,” those with both an adult age 65 or older and a child present in the home, and 1% report having a disabled partner in the home. These descriptive statistics indicate that a large portion of the sample have either children or an adult age 65 or older in the home, but few respondents live with both groups in the home concurrently.

Do Country-Level Familial Care Norms Matter for Caregiver Well-Being?

Table 3 examines the relationship between attitudes towards familial caregiving and well-being. In an initial analysis of the null model (results not shown), we find that well-being varies by country (intercept = 4.08, $p<0.001$; country-level variance = 0.05, $p<0.001$; ICC=.049) indicating that multi-level modeling is appropriate for our data. We then estimate the effect of familial caregiving attitudes and GDP on the model intercept, gender slope, caregiver slope and female x caregiver slope. Model 1 estimates the multi-level effects without the full-set of controls; model 2 introduces the full-set of controls including gender interactions for household composition. The results are consistent across models 1 and 2. Supporting our first hypothesis, we find caregivers report lower well-being than those not providing care (β = -.051 $p<0.01$) yet caregiver experiences do not vary by country-level estimates. Consistent with our second hypothesis, we find that female caregivers report worse well-being than male caregivers yet this is a consequence of the gender effect (β = -.149 $p<0.001$) rather than the interaction between caregiver status and gender which is non-significant. Supporting our third hypothesis, we find women report significantly worse well-being in countries with stronger attitudinal support for familial caregiving (β =-.002 $p<0.05$), an effect that is magnified for female caregivers (β =-.002 + -.004 = -.006). Moreover, female caregivers in more economically-developed countries also report worse well-being (β= -.009 $p<0.05$). Economic development may provide families with additional resources to outsource dependent care, and thus, those who remain primary caregivers may already have lower well-being reflecting a selection effect. Or, female caregivers may experience a subsequent well-being disadvantage associated with their caregiver status. Disentangling this causal relationship is beyond the scope of this study, but our results indicate a well-being disadvantage for female caregivers in more economically-developed countries net of individual-level economic resources.

The variance components from model 1 indicate that country-context, gender and caregiver status explain 66% of the variance in well-being (variance in null model = .053; reduction = .053 - .019 / .053 = .66 or 66%). The inclusion of the individual-level controls in model 2 explains an additional 2% of the total variance. In sum, the reduction in variance indicates that familial caregiving norms, GDP, gender and caregiver status explain the bulk of variation in well-being. But, the model fit statics indicate that the models are significant improvement compared to the null and with the inclusion of individual controls. To better understand how our imputed income measures impact our results, we re-ran these models excluding respondents missing on household income to assess the robustness of our findings. The results are equivalent with one exception – the gender effect of familial caregiving attitudes is nonsignificant for the restricted sample. This suggests a reporting bias whereby respondents in more familial contexts more often omit income. Yet, the exclusion of these respondents due to missing income masks the gender effect of familial caregiver norms on women’s well-being. In both the restricted and full-model, however, the negative effect of familial caregiving norms on female caregivers’ well-being is robust indicating that this effect is not sensitive to missing income.

To better understand these relationships, figure 1 graphically depicts the significant country-level effects for four groups: (1) men not providing dependent care; (2) women not providing dependent care; (3) male caregivers; (4) female caregivers. At the intercept, the results are consistent with expectations with men not providing dependent care reporting the highest well-being followed by male caregivers, females not providing dependent care and female caregivers. Given the non-significant effect of familial caregiving at the intercept (men not providing dependent care) and for the caregiver slope (male caregivers), these lines are flat and largely similar with both groups reporting average well-being of 4.3 and 4.2, respectively, which corresponds to positive well-being more than half of the time. Women not providing dependent care report lower well-being than their male counterparts, an effect that is exacerbated in more familial caregiving contexts. Among the groups, female caregivers report the worst well-being, a relationship intensified in more familial contexts. While the size of the effects appear minimal, it is important to note that the difference in coefficients between men not providing care (mean=4.3) and female caregivers (mean=3.6) in the most familial contexts corresponds to reporting well-being more than half (value=4) versus less than half (value=3) of the time. As such, even small decreases in well-being coefficients correspond to large differences in lived experiences.

Discussion

This study is one step towards deepening our understanding of the social organization of caregiving on caregiver well-being. We compared well-being for a multi-national sample of caregivers and non-caregivers in Europe to provide insight into how the social organization of caregiving, specifically normative attitudes toward familial caregiving, are associated with individual-level caregiver well-being. Using the 2004 European Social Survey, we answer questions about how caregivers' well-being compares to those who do not provide dependent care, and gender differences in the relationship between caregiving and well-being. The results of this study are provocative in that they reveal that caregivers report worse well-being, especially in countries where there are strong normative expectations for care to be provided within the family home. Three broad conclusions address our hypotheses: (1) caregivers report lower levels of well-being compared to those who do not provide dependent care; (2) female caregivers fare worse than do male caregivers; (3) familial caregiving norms disadvantage women's, most notably female caregiver's well-being but have no consequence for men. Our findings are particularly important for policy considering Europe's changing demographic composition and government threats to caregiver support.

Our results support the argument that caregivers have lower levels of well-being than non-caregivers. These results are consistent with a wealth of research that finds caregivers report greater strain and conflict between work and family which deteriorates well-being (Pavalko and Henderson, 2006, Pavalko and Woodbury, 2000). Indeed, a meta-analysis of the caregiver literature finds the level of assistance caregivers provide to dependents is positively associated with burden and depression (Pinquart and Sörensen, 2003). We build on this research by documenting a negative association between caregiving and well-being. We also find that female caregivers report worse well-being than male caregivers, a finding consistent with previous research (Freeman and Schettkat, 2005) (Daatland, Veenstra and Lima, 2010, Dautzenberg, Diederiks, Philipsen and Tan, 1999, Freeman and Schettkat, 2005). Women shoulder a disproportionate housework burden in more traditional and conservative welfare states (Fuwa, 2004, Fuwa and Cohen, 2007, Geist, 2005, Ruppanner, 2010) . Our results suggest that these relationships extend to caregiver well-being as well. Yet, our models do not capture the impact of long-term caregiving on well-being. Specifically, we are unable to assess the level, or intensity of assistance which is shown to moderate the impact of caregiving on health (Pavalko and Woodbury, 2000). In the short-term, the strain of caregiving has deleterious impacts on well-being, but it may be that as the duration increases, caregivers adapt to the circumstances and are resilient. Alternatively, the detrimental effect of caregiving on well-being may compound over time, as suggested by previous research examining cumulative disadvantage a relationship supported in previous research (Wakabayashi and Donato, 2006). Further, we cannot assess the impact of reverse causality whereby respondents with lower well-being select into caregiving status. Indeed, previous research indicates that caregivers' deteriorated well-being is associated with scarcity rather than multiplicity or roles suggesting those with limited social roles select into caregiving (Dautzenberg, Diederiks, Philipsen and Tan, 1999). Additional longitudinal research is needed to untangle these relationships.

Our country-level results reveal that filial care norms are associated with lower caregiver well-being, which suggests that filial normative expectations may be a form of coerced care (Glenn, 2010). Living in a country with strong normative support for familial caregiving is associated with lower female caregivers' well-being net of individual-level characteristics. These findings are consistent with recent research. For example, Akpınar et al. (2011) found negative effects of caregiving among females in Turkey, which may reflect strong support for familial care in Turkey. More broadly, our results suggest that familial caregiving norms encourage women to assume caregiving responsibilities at the expense of their well-being. This could function through two processes. First, countries with stronger familial caregiving attitudes may have few market or government options to outsource care. Thus, families who cannot support an additional dependent, and would outsource this care, may assume greater caregiving responsibilities at the expense of female caregivers' well-being. Second, providing care in a country with strong normative expectations for familial care may be associated with lower female caregiver well-being. For example, familial caregiving may reflect higher standards of care for all family members, of which women assume a larger burden. In other words, familial cultural norms may preclude women from outsourcing any care –cooking, cleaning, washing, childcare, etc. – thus increasing women's overall care burden. Thus, "good" care may equate "mom's/daughter's" care, in these more familial centered contexts. This increased strain may harm female caregiver well-being with no consequence for male caregivers, a claim supported, in part, by the negative impact of caregiver attitudes on women's well-being. Because we examine cross-sectional data, we are unable to assess these causal relationships but our results hint that familial caregiving may truly reflect female provided caregiving.

Ultimately, this study contributes the following conclusions: caregivers report lower well-being than non-caregivers, and women caregivers experience a well-being disadvantage by country-level familial caregiving attitudes. The demographic transitions of delayed marriage and fertility, and longer life expectancy typical in most European countries imply that the number of families at-risk for providing dependent care for children and older adults may be higher today than ever before, and will continue to increase. What is more, current political emphasis on austerity and cuts to government-provided caregiver benefits may have disastrous effects on female caregiver well-being. Considering these demographic and political' realities, this study is especially pertinent, taking a step toward understanding how dependent care is associated with well-being in a multi-national context in which the social organization of care varies.

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Table 1: Unweighted Descriptives of Individual-level Well-being (Dependent Variable) and Country-level Independent Measures

	Individual-level					Country-level	
	Well Being[a]		(Mean)			Family Caregiving[b] (%)	GDP ($)[c]
Country	n	Whole Sample	S.D.	Caregivers	S.D.		
Austria	2217	4.08	1.01	4.07	0.98	17	30,000
Belgium	1776	4.22	0.98	4.16	0.97	17	29,100
Czech Republic	2937	3.95	0.97	4.00	0.91	36	15,700
Denmark	1471	4.44	0.85	4.33	0.90	7	31,000
Finland	1998	4.03	0.90	4.07	0.89	7	27,400
France	1806	4.11	1.09	4.12	1.06	18	27,600
Germany	2848	4.07	0.96	3.96	0.93	25	27,600
Greece	2403	3.82	1.24	3.87	1.24	49	20,000
Hungary	1486	3.73	1.13	3.76	1.13	36	13,900
Ireland	2246	4.39	0.99	4.32	0.94	19	29,600
Luxemburg	1632	4.36	0.98	4.26	1.00	21	55,100
Netherlands	1873	4.17	0.97	4.09	0.96	4	28,600
Norway	1756	4.37	0.92	4.21	0.88	6	37,800
Poland	1702	4.05	1.10	4.11	1.07	59	11,100
Portugal	2033	3.75	1.14	3.80	1.16	44	18,000
Slovakia	1504	3.83	1.11	3.82	1.05	47	13,300
Slovenia	1409	4.01	0.94	4.05	0.87	29	19,000
Spain	1644	4.19	0.98	4.24	0.90	39	22,000
Sweden	1924	4.22	0.92	4.18	0.87	4	26,800
Switzerland	2131	4.39	0.86	4.41	0.82	16	32,700
Turkey	1847	3.51	1.26	3.28	1.23	74	6,700
UK	1880	3.82	1.05	3.65	1.06	20	27,700

Source: Well-being data from 2004 European Social Survey on n=42,523 individuals in 22 countries. Family Centered Caregiving measure from the Eurobarometer 2007. GDP from the CIA World Factbook 2004.

Note: [a]Well-being scale ranges from 0 to 6. [b]Family centerd-caregiving is the percent of respondents who answered that an elderly father or mother who can no longer live without regular help because of a physical or mental health condition should live with his/her child. [c]GDP is in 2004 constant US dollars.

Table 2: Weighted Characteristics of Sample Respondents in 22 European Countries

Variable	**Percentage or Mean**[a]	**Standard Error**	**Range**
Dependent Variable			
Mean Well-Being (scale 1-6)[b]	4.04	1.05	1-6
Independent Variables			
Dependent Care			
Respondent provides dependent care	24.93	0.43	0-1
Female respondent provides dependent care	15.00	0.36	0-1
Types of Dependents in Household			
Child, under age 5	11.70	0.32	0-1
Child, ages 6 to 15	22.75	0.42	0-1
Spouse, ages 65 to 74	7.64	0.27	0-1
Spouse, ages 75 plus	3.37	0.18	0-1
Parent, ages 65 to 74	1.86	0.13	0-1
Parent, ages 75 plus	1.74	0.13	0-1
Other adult, ages 65 to 74	0.67	0.08	0-1
Other adult, ages 75 plus	0.91	0.09	0-1
Sandwich Household	1.51	0.12	0-1
Disabled partner	1.39	0.12	0-1
Female	53.77	0.50	0-1
Employment Status			
Employed in paid work	47.42	0.49	0-1
Unemployed	5.49	0.22	0-1
Student	9.38	0.29	0-1
Disabled	2.00	0.14	0-1
Retired	22.50	0.41	0-1
Housewife/househusband	11.30	0.31	0-1
Other	1.33	0.11	0-1
Relative Household Income (mean)[c]	6.08	2.24	1-12
Educational Attainment			
No primary education	4.63	0.21	0-1
Basic education	35.16	0.48	0-1
Secondary education	41.38	0.49	0-1
Tertiary education	18.30	0.38	0-1
Marital Status			
Married	53.47	0.50	0-1
Separated	1.56	0.13	0-1
Divorced	7.10	0.27	0-1
Widowed	9.46	0.29	0-1
Never Married	28.05	0.44	0-1
Self-reported Religiosity (mean)[d]	4.92	2.98	0-10
Age (mean)	47.07	17.74	18-100

Source: 2004 European Social Survey.

Notes: Weighted to account for sample design. [a]Mean is presented for continuous variables, and percentages for dichotomous (0,1) variables. [b]Well-being scale ranges from 0-6, with greater numbers indicating greater well-being. [c]Coded by ESS with range 1-12, representing household income relative to others in the same country, with a higher values indicating greater relative income. [d]Responses were on a 10-point scale ranging from "not at all religious" to "very religious." Higher values represent higher self-reported religiosity.

Table 3. Hierarchical Linear Model Coefficients Predicting Well-Being among respondents in 22 European countries: Individual-level and Country-level Estimates

	Model 1		**Model 2**	
	Estimate	**SE**	**Estimate**	**SE**
Intercept				
Intercept	4.196 ***	0.030	4.325 ***	0.033
Family centered caregiving (per 1% increase)	-0.004	0.002	-0.003	0.002
GDP (per $1,000 increase)	0.001 **	0.004	0.008	0.004
Female				
Intercept	-0.190 ***	0.012	-0.149 ***	0.015
Family centered caregiving (per 1% increase)	-0.002 *	0.001	-0.002 *	0.001
GDP (per $1,000 increase)	0.001	0.002	0.001	0.002
Caregiver				
Intercept	-0.051 **	0.020	-0.054 *	0.022
Family centered caregiving (per 1% increase)	0.002	0.001	0.003	0.002
GDP (per $1,000 increase)	0.000	0.003	0.002	0.003
Female x Caregiver				
Intercept	0.033	0.026	0.014	0.029
Family centered caregiving (per 1% increase)	-0.004 *	0.002	-0.004 *	0.002
GDP (per $1,000 increase)	-0.009 *	0.000	-0.009 *	0.004
Individual-Level Variance	1.020	1.009	0.972	0.986
Country-Level Variance	0.019 ***	0.138	0.018 ***	0.132
Inter-Class Correlation	0.018		0.017	
Model Fit (-2 ln likelihood function value)	411 ***		2050 ***	
Reduction in Variance	64%		66%	
n	42523		42523	

*Source:*2004 European Social Survey.

Notes: *p < 0.05; **p < 0.01; ***p < 0.001 (two-tailed tests). Estimates weighted to account for sample design. Standard errors reported. n=42,523 individuals nested in 22 countries. Model 1 includes no individual-level controls. Model 2 controls for the full set of individual controls including: employment, marital status, education, relative household income, religiosity, age, the presence of dependents in the home and the gender interaction terms for household dependents.

Figure 1: HLM Results for Well-Being by Caregiver Status, Gender and Family Centered Caregiving Norms (2004 ESS; n=42,523)