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Introduction to the Special Issue "Families, health, and well-being"

A century of scientific research on the family-health nexus notwithstanding, the last decade has witnessed a renewed interest in elucidating the complex interplay of family, well-being and health. Several recent overview articles on the topic have appeared over the last decade, reflecting an attempt to sum up the main results from 'first-generation' research (Arránz Becker et al. 2017; Carr/Springer 2010; Carr et al. 2014; Hank/Steinbach 2018; Rapp/Klein 2015; Dolan et al. 2008; Hansen 2012) and to point to persistent gaps in the literature and directions for future research. We take this as an indication that we are witnessing the emergence of a 'second-generation' era of research that more closely follows the well-known tenets of life course theory (Mayer 2009), according to which individuals actively take age-graded, path-dependent life course decisions based on their available material and intangible resources within specific sociohistorical contexts. Consequently, recent studies are beginning to take a longitudinal perspective in a more rigorous manner (Arránz Becker et al. 2017) and are addressing issues of causality and social context effects more carefully than before (Hank/Steinbach 2018).

Ever since the seminal work from the 19th century (Farr 1859), the family-health nexus has almost continuously received scholarly attention, which underlines the pervasiveness of the topic. The closely intertwined connections between families and well-being can be traced back to fundamental functions of the family. Family is one of the main socialisation agents, shaping health perceptions and health behaviours, as well as happiness-inducing habits of its members. Adults' own family formation behaviour and related transitions (e.g., marriage) have been shown to determine a plethora of health and well-being outcomes and, ultimately, mortality (Carr et al. 2014; Zimmermann/Easterlin 2006). On the other hand, health and well-being themselves may have important implications for partnering and family development processes, because they signal fecundity and the ability to provide the necessary resources for maintaining a family (Stutzer/Frey 2006). In sum, although family status is traditionally considered as a horizontal dimension of social diversity, family transitions can also be seen as catalysts of inequalities in health and well-being (Arránz Becker et al. 2017). For instance, if individuals with poorer health (or those who are less happy) exhibit lower marriage rates and higher divorce rates, then

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Johannes Stauder, Ingmar Rapp & Thomas Klein

Couple relationships and health: The role of the individual's and the partner's education

Abstract
A positive correlation between couple relationships and health is well established. However, recent studies indicate that the beneficial effects of couple relationships on health vary substantially according to the characteristics of the relationship and of the partners involved. The present paper examines to what extent partnership effects on physical and mental health differ based on the individual's education, the partner's education and educational homogamy between partners. Our database is the German Socio-Economic Panel for the period of 2002 to 2016. Based on fixed effects analysis, our results show that a highly educated partner is more beneficial for mental and physical health than a partner with low education. In contrast, the effects of partnerships on health do not depend on whether the partners have same or different educational levels. The results also indicate that partnership effects on health depend on mate choice and on the potential to find a highly educated partner. Education-specific partnership effects on mental health are more prevalent for women, and effects on physical health are more prevalent for men.

Key words: mental health, physical health, couple relationship, partnership, cohabitation, marriage, education, partner's education, homogamy, educational homogamy

Introduction

Previous research has shown a strong and robust positive correlation between health and education (Ross & Mirowsky 2013). A higher educational level is associated with better economic circumstances (Cutler/Lleras-Muney 2006), more social-psychological resources (Ross/Wu 1995), and healthier lifestyles (Rapp/Klein 2017) and therefore improves individuals' health. It is also well known that being in a couple relationship is, on average, positively associated with mental and physical health (Arránz Becker/Loter/Becker 2017; Hank/Steinbach 2018; Rapp/Klein 2015). Both issues – health differences by education and by partnership status – are often examined separately. However, there are good reasons to assume that these two issues are mutually dependent on each other. For example, one explanation for why being in a partnership improves health is that the partner facilitates economic security and well-being (Bünnings/Kleibrink/Weßling 2017; Waite/Gallagher 2002), although this effect obviously depends on the partner's additional

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economic resources. For this reason, the present study examines the question of how partnership effects on mental and physical health vary based on the individual's education, the partner's education and educational homogamy between partners.

Relatively few studies have examined whether the effects of being in a partnership on health differ based on individual characteristics. However, the major exception is gender differences because some but not all studies suggest that men have greater health benefits from a partnership than women (Kiecolt-Glaser/Newton 2001; Wood/Goesling/Avellar 2007). Previous research has also considered some characteristics of the spouse, with a focus mostly on obvious disadvantages, such as health impairment or unemployment. A large number of studies have consistently found that having an ill partner is negatively associated with individuals' mental and physical health (Bourassa/Memel/Woolverton/ Sbarra 2015; Hagedoorn/Sanderman/Bolks/Tuinstra/Coyne 2008; Polenick/Martire/ Hemphill/Stephens 2015; Westman/Keinan/Roziner/Benyamini 2008). In addition, there is some evidence that the spouse's job insecurity negatively affects the individual's health, particularly for women (Bubonya/Cobb-Clark/Wooden 2017; Bünnings et al. 2017; Mendolia 2014). Additionally, several studies have examined the effects of the partner's education on the individual's overall health status and mortality. Their results showed that the partner's level of education is positively associated with the individual's overall health, even after controlling for the individual's education (Brown/Hummer/Hayward 2014; Huijts/ Monden/Kraaykamp 2010; Li/Fu/Zhao/Luo/Kawachi 2013; Monden/van Lenthe/De Graaf/Kraaykamp 2003), and that it is also negatively associated with the individual's mortality (Egeland/Tverdal/Meyer/Selmer 2002; Jaffe/Eisenbach/Neumark/Manor 2006; Skalická/Kunst 2008).

The present study adds to this literature in two ways. First, we focus on mental and physical health separately. Couple relationships and partners' education may affect health through various pathways, some of which may be more important for physical health, whereas others may be more important for mental health. Therefore, a distinction between mental and physical health may help to better understand why the effects of couple relationships on health may vary by the individual's and partner's education and by educational homogamy. Second, it is difficult to determine whether the association between partnership status and health represents causation or health selection (Kalmijn 2017). The main reason for this difficulty is that people are not randomly allocated to various relationship statuses. People's selection of partners depends on various factors that may also affect health. In contrast to previous studies on the association between the couple relationship, the education of partners and health, we analyse longitudinal data with fixed effects (FE) regression models. Hence, we control for time-constant heterogeneity between people who did and did not start a couple relationship while being observed in the survey.

Background and hypotheses

Controversial mechanisms have been proposed to explain why having a partner is positively associated with mental and physical health. On the one hand, healthier people may be more likely to start a relationship because they are more attractive as partners and may have better meeting opportunities (Guner/Kulikova/Llull 2016; Rapp 2018; Rapp/Gruhler

Katharina Loter, Oliver Arránz Becker, Małgorzata Mikucka & Christof Wolf

Mental health dynamics around marital dissolution. Moderating effects of parenthood and children's age

Abstract
Our study is the first that aims at estimating the intra-individual effect of marital dissolution on mental health, conditional on parenthood status and age of the youngest biological child. We rely on the set point model that predicts a nonlinear, homeostatic self-regulation process with an anticipatory effect and a subsequent recovery phase. Assuming heterogeneous effects, we expect both parenthood status and age of the youngest biological child grouped into five distinct categories to moderate the strength of the dissolution-health nexus. We use GSOEP data and restrict our sample to women and men who were at risk for first marital dissolution within the observational period 2002 to 2016. The dependent variable is the mental health component of the SF-12 survey instrument. We estimate distributed fixed-effects (dummy impact functions), covering the time span from three (or more) years before marital dissolution up to six (or more) years afterwards. Compared to the baseline, childless women exhibit a considerable impairment in mental health after dissolution, experiencing a slower recovery than childless men. Our most unambiguous result is the negative anticipation and a subsequent downward trajectory of mental health among mothers of infants and toddlers, whereas in the respective group of fathers we do not observe any change over time. In all other parent groups, mental health reacts mostly in a short-term manner to dissolution, except for fathers of pre- and primary school children whose mental health remains unchanged. Our study provides new evidence on mental health dynamics around marital dissolution and raises the awareness of mental distress, loneliness and potential social exclusion faced by childless and parents, in particular by lone mothers of young children.

Key words: mental health dynamics; marital dissolution; parenthood; distributed fixed-effects, GSOEP

Introduction

During the year 2016, almost one million couples divorced in Europe, and over 160 thousand of them in Germany (Eurostat 2018). From all German divorces, 83% occurred just after the obligatory "separation year", 16% on average three years after separation, and the remaining 1% terminated exceptionally before the expiration of the separation year (Federal Statistical Office 2018). 51% of all divorce applications were filed by women, 41% by men and 8% by both spouses. About half of divorcing German couples had minor children (Federal Statistical Office 2018).

Separations and divorces have a multitude of effects for those involved. In this paper, we study temporal dynamics of mental health around marital dissolution. We are particularly interested to learn more about gender specific differences of these dynamics and the moderating role of (non)parenthood. Whether a couple has a child or not, may strongly influence the decision to separate and divorce. Couples having children are less likely to divorce, especially when they have several children (with 2-3 children minimizing the risk of divorce, Andersson 1997) and/or young children (Waite/Lillard 1991; Steele et al. 2005). Part of the effect may be causal, meaning that children increase partners' commitment to the (marital) union, but it may also reflect selection, as partners less committed to a union are less likely to have children together (Coppola/Di Cesare 2008; Lyngstad/Jalovaara 2010).

Presence of a child may also affect partners' experience of divorce. Although research from past decades accumulated vast evidence that divorce is detrimental to mental health (Amato/Keith 1991; Hank/Wagner 2013), the question of moderating effects of parenthood has been addressed by only a handful of papers (Blekesaune/Barrett 2005; Williams/Dunne-Bryant 2006; Leopold/Kalmijn 2016). Unfortunately, most previous studies use less than ideal research designs, making it difficult to draw firm conclusions. First of all, viewing marital dissolution as a dynamic process rather than an enduring state requires analyses of panel data and an adequate longitudinal modelling approach that considers anticipatory effects and subsequent adaptation (Amato 2000). Second, past research rarely accounts for the ages of children and typically pools together childless people in one category with parents of adult children. Our analysis overcomes these methodological limitations. First, we use fixed-effects regression for panel data to control for time-invariant intra-individual unobserved heterogeneity around marital dissolution. Second, we account for baseline age-related dynamics of mental health. And third, we distinguish five categories of (non)parenthood, from childless, through parents of infants and toddlers to those having pre- and primary school children, to those having adolescent or adult children.

Mental health—the outcome variable studied by us—is defined by the WHO as "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" (WHO 2018). The question whether presence of children aggravates the consequences of marital dissolution for mental health is important from a substantive point of view: divorces affecting both parents and children are common and have long-reaching consequences. The experience of marital dissolution and conflict affects partners' well-being for several years afterwards (Lucas 2005), influences their children's well-being (Amato/Loomis/Booth 1995), and shapes family ties and behaviour among children and grandchildren of divorcees (Amato/Cheadle 2005). Moreover, we consider mental rather than physical health because mental health is more sensitive to life events in a short- and mid-term perspective.

Our study aims at the existing research gap on the role of diverse stages of parenthood in explaining mental health of parents around marital dissolution. Examining the complex role played by children at different developmental stages improves our understanding of negative consequences of marital dissolution as well as of benefits derived from marriage. Negative consequences of marital dissolution for mental health are typically interpreted in terms of being deprived of a protective effect of marriage itself. However, such reasoning

Aïda Solé-Auró & Clara Cortina

Exploring the role of family ties on life satisfaction in later life in Europe

Abstract:
We analyzed the relationship between family ties and the life satisfaction of people between the ages of 50 and 85 years in 13 European countries. We aim at determining the effects of partnership (being currently in a partnership) and parenthood (having remained childless). We use individual-level data from the sixth wave of the Survey of Health, Ageing and Retirement in Europe (SHARE). The analyses are restricted to respondents who are partnered or who have ever been married. We apply a multivariate analysis to examine the association of life satisfaction with family ties for men and for women. We add controls for age groups and education level, and we pay special attention to the role of individuals' network size. Our findings indicate that in all countries, having no partner has the strongest and most negative association with life satisfaction. However, there was no clear association between not having children and life satisfaction across countries. We also find an important role of some protector variables, such as having a strong network which, in most countries, significantly increase one's life satisfaction. We find that there is a relationship between individuals' family situation and life satisfaction, but it is restricted to being in a partnership. The protection factor of having a partner improves one's life satisfaction at older ages much more than protection by having children. This finding can reduce the concern about the long run implications of increasing childlessness among younger cohorts as it is not necessarily associated to a higher risk of low life satisfaction.

Key words: family ties, life satisfaction, Europe, old people

Introduction

Family life and family history play an important role in health conditions and in mortality differentials in later life. The relationship between family life and subjective indicators of well-being (i.e. life satisfaction) is an increasingly interesting issue in a context in which new family arrangements along with an aging population are undergoing important changes that could have an impact on people in their advanced stages, according to the life-course perspective. The implications of childlessness on social isolation and lack of support in their later life has already been explored and might imply an increasing demand for the public provision of long-term care services (Albertini/Mencarini 2014).

In this article we analyse the relationship between family ties and life satisfaction for people 50 years of age and older in 13 European countries. We are specifically interested in distinguishing between partnership and parenthood ties: whether people have remained childless or have had any children and how far away they live, as well as whether they are currently in a partnership. We restricted our analysis to a sample of people who have ever been married in order to overcome the association between not having children and never having had a partner.

The importance of this investigation is to establish how quality of life is shaped by the family situation. Our aim is to understand whether the presence of a co-residing partner and/or the presence of children living in proximity, interact with other components of elderly people's social life. Therefore, we explore the role of mediator factors offering protection at older ages, such as the size of the social network. Finally, we explore gender differences in order to understand to what extent the relationship of the family constellation and social networks and support work differently for men versus for women.

The article is structured as follows: First, we review the latest findings on life satisfaction and subjective wellbeing indicators. Second, we present the key elements of new family trends in Europe in the last decades. Third, we formulate our main research hypotheses based on the theoretically complex relationship between family life and life satisfaction. After presenting the data and methods used, we report the findings of our analyses and we discuss their implications.

Life satisfaction: The importance of subjective well-being indicators

Concerns about quality of life, particularly in old age, have been investigated during the last decades in the social and behavioral sciences (George 2006; Solé-Auró/Lozano 2019). Population well-being has been largely examined by computing trends in healthy life expectancy. Particularly, at the population level, healthy life expectancy is more than a measure of health. It is an indicator of an important dimension of well-being as quality of life. Today, subjective indicators such as life satisfaction are commonly used by quantitative social scientists to better understand our societies' well-being.

Health is always a dimension of well-being and quality of life. High levels of happiness might influence longevity by reducing mortality through several direct and indirect mechanisms. Koopmans et al. (2010) found that increased levels of happiness predicted a lower mortality rate, and therefore happier people live longer. Being happy has been associated with having lower incidence of chronic conditions (Siahpush et al. 2008). Some empirical analyses have indicated that happier people have lower levels of hypertension (Blanchflower/Oswald 2008) and are able to manage stress better than their unhappier counterparts (Papousek et al. 2010). On opposite side, low levels of life satisfaction, or dissatisfaction, are associated with increased morbidity and mortality (Mojon-Azzi/Sousa-Poza 2011; Koivumaa-Honkanen et al. 2000). Individuals with low levels of happiness are also more likely to have poor self-rated health, physical disabilities, depressive symptoms, and other common health conditions (Strine et al. 2008).

Thijs van den Broek, Marco Tosi & Emily Grundy

Offspring and later-life loneliness in Eastern and Western Europe

Abstract
Later-life loneliness is increasingly recognized as an important public health issue. In this study, we examine whether having more children and grandchildren is protective against later life loneliness in a group of Eastern and Western European countries. Drawing on data from the Generation and Gender Surveys, we estimated logistic regression models of the likelihood of being lonely among men and women aged 65 and older. The results showed a negative association between number of children and loneliness among men and women in both Eastern-European and Western-European countries. A mediation analysis performed using the KHB decomposition method showed that grandparenthood status partly explained differences in the loneliness risks of childless women, mothers with one child and those with two or more children. Among men, the mediating role of grandparenthood was significant in Eastern Europe and marginally significant in Western countries. Given the relatively strong reliance of older people on the family in Eastern Europe, we expected that the protective effects of offspring on loneliness would be stronger in Eastern-European countries than in Western-European countries. This hypothesis was supported only in part by our results. The protective effect of having four or more children was larger in the East than in the West. Overall, our findings indicate that having close family members, including more children and at least one grandchild, has a protective effect against later-life loneliness in both country clusters considered.

Key words: loneliness, psychosocial wellbeing, isolation, mental health, ageing, intergenerational relations, grandparenthood

Introduction

Loneliness is not an inevitable part of later life, nor is the experience of loneliness restricted to older people. Nevertheless, later life is marked by an increased chance of experiencing events and circumstances, such as widowhood, onset of health limitations and financial hardship, which are associated with increased risks of loneliness, and the prevalence of loneliness among adults is often higher in older than in younger age groups (Nicolaisen/Thorsen 2014; Yang/Victor 2011). Not only is loneliness – a perceived deficit in the quality or quantity of social interaction – distressing and stigmatised, it is also asso-

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ciated with adverse health conditions, including stress and inflammation, depression, heart disease, a range of other diseases and increased mortality risks (Cacioppo/Hughes/Waite/Hawkley/Thisted 2006; Courtin/Knapp 2017; Hawkley/Cacioppo 2010; Holt-Lunstad/Smith/Baker/Harris/Stephenson 2015)

Levels of reported later-life loneliness tend to be higher in Southern than in Northern European countries (Fokkema/De Jong Gierveld/Dykstra 2012; Vozikaki/Papadaki/Linardakis,/Philalithis 2018), but an even more marked difference has been noted between Eastern and Western European countries (De Jong Gierveld/Dykstra/Schenk 2012; Hansen/Slagsvold 2016; Yang/Victor 2011). Explanations for these differences include a range of cultural, health related and socio-economic factors and the effects of the upheaval following the collapse of the Soviet Union; these may have been most challenging for older adults, especially as previous care systems and pensions were eroded (Botev 2012; Marmot/Bobak 2005).

Dykstra (2009) has argued that, when looking into regional loneliness differences, it should be recognised that the importance of particular individual-level predictors might vary across (clusters of) countries. As elaborated later, there are reasons for supposing that the protective role of offspring against later-life loneliness might be more pronounced in Eastern Europe than in Western Europe, given that Easter-European societies tend to be more family-oriented. In this study, we assess whether there are differences between Eastern-European and Western-European countries in the protective effects of having children and grandchildren against later-life loneliness. Disentangling the roles of children and grandchildren in shaping older adults' mental health is of increasing relevance. As a consequence of increasing longevity, family generations spend longer parts of their lives together, during which they may provide support for each other (Bengtson 2001).

Theoretical background

Next to partners and spouses, adult children are the most important source of emotional and practical support for older people (Dykstra 2015; Wolff/Kasper 2006). The presence of children increases opportunities for exchange and companionship, and may reassure parents that they have potential providers of support that they can fall back on in case of need (Evenson/Simon 2005; Grundy/Read 2012; Tosi/Grundy 2018). It is therefore not surprising that parents, and particularly mothers (Van den Broek 2017; Van den Broek/Grundy 2017), tend to be less lonely than their childless counterparts (De Jong Gierveld/Broese van Groenou/Hoogendoorn/Smit 2009; Pinquart/Sörensen 2001).

Having children also implies that one can eventually become a grandparent. The potential protective effect against loneliness of having grandchildren has received much less scholarly attention than the effects of having children. However, some studies have reported positive effects of providing grandchild care on health and subjective indicators of well-being. A longitudinal Chilean study, for example, found that provision of help to grandchildren benefited grandfathers' (but not grandmothers') psychosocial health (Grundy et al. 2012). In a European study, Di Gessa et al. (2016) found that providing grandchild care was associated with better self-rated health among older people, although they did not find any association with depressive symptoms. Other studies have suggested that

Valeria Bordone & Bruno Arpino

Grandparenthood, grandchild care and depression among older people in 18 countries

Abstract
Due to the increasing central role of grandparenthood in later life, sound knowledge about its effects on older people's health is more and more important. This paper examines the impact of becoming a grandparent, having more grandchildren, and engaging in grandchild care on depressive symptoms. Moreover, based on the structural ambivalence theory, we expect that such effects differ across contexts as (grand)childcare is differently organised across Europe. Taking advantage of the longitudinal structure of the Survey of Health, Ageing and Retirement in Europe (SHARE), we estimate fixed-effects models. Our results show that women face a decline in depressive symptoms when becoming grandmothers, but neither an increase in the number of grandchildren nor changes in grandchild care are associated with changes in depressive symptoms. The analyses by country highlight differences across Europe, without, however, drawing a clear pattern. Our results show that depression consequences of grandparenthood also vary between countries characterised by similar roles of grandparents. This suggests the need to make available more refined questions about grandparenthood in surveys on older people.

Key words: grandparenthood, grandchild care, depression, Europe.

Introduction

As a consequence of the socio-demographic changes in terms of increasing longevity, decreasing fertility, and postponement of childbearing, the role of grandparents has become more and more a central feature of later life (Leopold/Skopek 2015; Margolis 2016). Its benefits have been shown, in line with the active ageing framework (WHO 2002; Zaidi et al. 2013), mainly in terms of engagement in grandchild care as an activity that positively affects health and subjective wellbeing (e.g., Arpino et al. 2018; Arpino/Bordone 2014; Di Gessa et al. 2016). In this study, we extend the knowledge in this field by investigating whether the broader concept of grandparenthood (including becoming a grandparent, having additional grandchildren, and changes in the engagement in grandchild care) affects older people's mental health. In particular, we analyse changes in depressive symptoms

by relying on longitudinal data from the Survey of Health, Ageing and Retirement in Europe (SHARE). Depression has been estimated to be the fourth leading cause of the global burden of disease (Ustün et al. 2004), it is the second leading cause of disability worldwide (Ferrari et al. 2013) and is expected to become the leading cause of disability in later life by 2030 (Kok et al. 2012). Such a debilitating condition, characterised by the presence of specific symptoms as anxiety, insomnia, fatigue and a number of psychosomatic disorders that can be triggered by biological, psychological and socio-economic factors, places a substantial burden in terms of public health systems and beyond, to include decline in the quality of life, increased risk of heart disease and stroke, worsening overall health status, and earlier mortality (Blazer 2003; Gallagher et al. 2012). The importance of studying depression rests also on its influence on health behaviours (e.g., Kuo et al. 2011) and other health measures (e.g., Moussavi et al. 2007).

The association between social support and mental health is well established in the literature (e.g., Dalgard et al. 1995; McCabe et al. 1996). It is usually hypothesised that altruistic behaviours and (balanced) intergenerational exchanges are beneficial to mental health (Fujiwara/Lee 2008; Hayslip/Kaminski 2005). Yet, grandchild care can also be stressful and might limit participation in other activities. This, in turn, might negatively impact on health (Jendrek 1993; Szinovacz et al. 1999).

Our contribution is threefold. First, we investigate the effect of grandparenthood on depression by accounting for the multidimensionality of the concept of grandparenthood. In doing so, we test whether such an effect is driven by becoming a grandparent (i.e., grandparenthood *per se*), an increase in the number of grandchildren, and provision of grandchild care. Moreover, we add to previous literature (e.g., Brunello/Rocco 2019; Di Gessa et al. 2016) by considering more waves of the same dataset, and investigating gender differences. To the best of our knowledge, only one study so far examined the effect of the transition to grandparenthood on grandparents' depression (Condon et al. 2018), based however on one single country (Australia) and a small sample (262 female and 168 male grandparents). Second, we explore the role of context in the association between grandparenthood and depression. As the grandparental role varies across countries (Bordone et al. 2017; Hank/Buber 2009), the effect of grandparenthood on depression may also vary. This heterogeneity could be related to the broader cultural context (i.e., norms and values), as well as to the institutional setting (i.e., policies and, more in general, welfare regimes) in which grandparents and grandchildren are embedded. Previous studies on this topic have mostly relied on a single country (e.g., Condon et al. 2018; Grundy et al. 2012) or pooled together data from different countries (e.g., Di Gessa et al. 2016). Third, from a methodological point of view, we examine the effect of grandparenthood on depression using fixed-effects models. Previous studies in the related literature have often employed cross-sectional data, with a few exceptions that investigated the effect of grandchild care on health outcomes drawing on longitudinal data (Chung/Park 2018; Di Gessa et al. 2016; Grundy et al. 2012). To our knowledge, only Ates (2017) relied on fixed-effects models to study whether grandchild care affects self-reported health. By using fixed-effects models we can exploit the longitudinal dimension of SHARE data and additionally account for time-invariant unobserved confounders.