THE ROLE OF RESILIENCE IN MEDIATING OUTCOMES ASSOCIATED WITH GRANDPARENTS RAISING THEIR GRANDCHILDREN

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The occurrence of custodial grandparents is increasing greatly. These grandparents face added stress and many adversities that arise from caregiving. Findings of current research tends to be mixed on the effects of grandparents raising grandchildren experience. Much research concludes that grandparent caregivers experience negative declines in overall health and well-being, while other research points out that the caregiving role may actually be a positive experience for the grandparent. The current study hypothesizes that mixed research may be a result of varying levels of resilience in the custodial grandparent population. The model proposed in this study looks at resilience as a mediator between several variables that effect custodial grandparenting. The current sample consisted of 239 custodial grandparents. A regression/correlation analysis was conducted on the data, and it was found that resilience levels were significant in mediating the effects of grandparent caregiving.
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INTRODUCTION

Grandparents Raising Their Grandchildren

According to the U.S. Census Bureau (2001), as of the year 2000, nearly 2.4 million children were being raised by their grandparents. This number has been steadily increasing over the past decades and has now reached enormous proportions. According to Hayslip and Kaminski (2005), since 1990 there has been a 30% increase in the number of children being raised in grandparent-headed households. Grandparents are usually asked to take custody of their grandchildren due to a variety of serious issues within the family that include death of a parent, divorce, child neglect, child abuse, drug addiction and alcoholism, teen pregnancy and AIDS (Cox, 2000; Edwards, 1998; Bowers & Myers, 1999; Connealy & DeRoos, 2000; Hayslip & Kaminski, 2005; Hayslip, Temple, Shore, & Henderson, 2006; Thomson, Minkler, & Driver, 2000).

Research on the effects of grandparents raising their grandchildren has been mixed. Many studies focus on and report that it is a highly stressful, negative experience, while other studies have pointed out that many grandparents perceive their new role as parent to their grandchild as very rewarding and positive (Brown & Mars, 2000; Cox, 2000; Giarrusso et al., 2000; Hayslip & Kaminski, 2005; Marx & Solomon, 2000; Musil, Schrader, & Mutikani, 2000). Giarrusso et al. found that roughly one-third of grandparents found parenting stressful, another third found it to be only mildly stressful, and the other third found it to be not stressful at all. They also reported that about half of their sample found caregiving to be equally stressful and rewarding, 27% found it mostly rewarding, and only 19% found it to be mainly stressful. Giarrusso et al. also reported they found no difference in stress levels across demographic
factors, which indicates the level of stress experienced by a grandparent as a caregiver to grandchildren is universal and consistent.

Impact on the Grandparent

Grandparents who assume the role of care provider for their grandchildren are at risk for many problems, including social isolation, stress and issues related to it, and financial strain (Cox, 2000; Hayslip & Kaminski, 2005). Stresses associated with grandparents raising grandchildren are related to lack of social interaction, conflict with spouses and friends, lack of energy and time, fear about health issues and what will happen to the grandchildren if they are unable to care for them, issues regarding not being able to spend their “golden years” enjoying what they like, the strain on relationships with other non-resident grandchildren, and financial burdens (Giarrusso et al., 2000; Hayslip & Kaminski, 2005; Hayslip, Temple, Shore, & Henderson, 2006; Musil, Schrader, & Mutikani, 2000; Silverstein & Vehvilainen, 2000). Financial burdens are the most often cited issue of concern, especially among minority grandparents. On average, government assistance covers only ¼ of the expense of raising a child (Brown & Mars, 2000). Brown and Mars reported the most stressful issue for grandparents was issues regarding their own health, followed by their ability to provide a good life for the grandchild. Stress was also related to fears about the biological parents involvement with the child and fears about the neighborhood and society (Brown & Mars; Musil et al.). Research has found that grandparents who are called on to provide care for their grandchildren are more likely to be poor, on some form of welfare, less likely to have insurance, and more likely to have less education (Cox, 2000; Hayslip, Temple, Shore, & Henderson, 2006; Thomson et al., 2000). Cox
suggested that many grandparents may feel obligated to accept their grandchildren when they really do not want to. Contrary to Cox, Sands and Goldberg-Glenn (as cited in Musil et al., 2000) reported that 40% of the grandmothers in their study felt they actively chose to take on the caregiving role. Hayslip and Kaminski (2005) reported that nearly one-third of caregiving grandparents felt taken advantage of by their children and another one-third resented their children for putting them in the situation of caregiver. Silverstein and Vehvilainen (2000) found that most grandparents perceived the arrangement of caretaker for their grandchildren as a permanent situation where as about 15% saw it as temporary until the parent was able to care for the child again. Brown and Mars (2000) found nearly half of caregiving grandparents had some form of legal responsibility and the other half did not. Grandparents often are confused and unsure of their role as a primary caretaker of their grandchildren because the actual role of grandparent itself is ambiguous (Cox). Not only is the role new, but grandparents are usually forced to take it on in the wake of some tragedy. This causes extra strain because the grandparent must learn the aspects of their new role while coping with the loss of a child usually (either literally or metaphorically) and at the same time dealing with the child’s issues (Cox; Musil et al., 2000). This new role as a caretaker is often a less desired role and occurs while the grandparent is trying to redefine his/her life as an elderly person in society. Grandparents are often physically unable to carry out demands of parenthood (Cox).

However, taking on the caregiver role to ones grandchild is not always a negative or stressful event; pros to raising ones grandchildren that have been reported include a sense of being needed, opportunity to improve the grandchild’s life, establishing closer bonds to the child, and ensuring the well-being of biological descendants. (Edwards & Daire, 2006; Hayslip &
Kaminski, 2005). Hayslip and Kaminski reported that approximately to 90% of custodial grandparents would choose to take on the caregiver role again if asked to make the decision a second time.

**Impact on the Grandchild**

Some studies have shown that children raised by their grandparents had worse physical health, increased behavioral problems, and lower academic scores than children raised by biological parents (Bowers & Myers, 1999; Edwards & Daire, 2006; Edwards, 1998; Hayslip, Silverthorn, Shore, & Henderson, 2000). Other research has shown that children who are raised by their grandparents are often at risk for psychological problems, especially insecurity and trust issues which can be compounded by fears that their grandparents may not be able to care for them (Cox, 2000). Edwards (1998), stated on average grandchildren raised by their grandparents only made up about 10% of the school population, yet they accounted for nearly 70% of the behavior problems. One reason as to why this may be true is that these children experience an almost total loss of their social support network at a young age (Edwards & Daire, 2006). Contrary to the grim results found in previous studies, some studies report that children raised by grandparents actually perform better in school, show more autonomy in decision making, and participate in fewer deviant behaviors (Hayslip & Kaminski, 2005).

**Health/Well-Being**

Stress and illness have repeatedly and consistently been shown to be positively correlated; stress produces illness, and in turn, illness produces more stress (Marx & Solomon,
2000). Marx and Solomon found that on average custodial grandparents had poorer health than non-custodial grandparent, with nearly 80% report fair to bad health. Silverstein and Vehvilainen (2000) reported that nearly a quarter of their sample reported worse health since taking on the caregiving role. Marx and Solomon also suggest that health may improve due to parenting responsibilities; Minkler, Roe, and Price (as cited in Marx & Solomon, 2000) reported that one-third of grandmothers experienced a decline in health that they related to caregiving but half indicated no change in health, and one-fifth reported improved health due to caregiving. Marx and Solomon found that married grandparents had better health than single grandparents. This could be because the immediate social support helps mediate the effect of stress. They also found that women who lived alone had better health than single women living with grandchildren, lending credence to the idea that raising ones grandchildren does provide increased stress; but in the same study Marx and Solomon found that well behaved grandchildren positively influenced grandparents’ health. Uchino, Cacioppo, and Kiecolt-Glaser (as cited in Marx & Solomon, 2000) provided evidence that social support positively affects cardiovascular and endocrine health, as well as overall immunity. Marx and Solomon suggest that some grandparents’ health may improve because they change their lifestyles to set a better example for their grandchildren. Musil et al. (2000) report that regardless of physical health, grandparents raising their grandchildren report more emotional and physical exhaustion related to the parenting process. Rodgers-Farmer (1999) reported that grandmothers raising grandchildren did, in fact, experience elevated levels of parenting stress and that parenting stress was positively correlated to higher levels of depression, which, in turn, produced more inconsistent parenting practices. Musil (1998) also reported significantly higher levels of
depression and anxiety in grandmother caregivers. Rodriguez & Crowther (2006) found that grandparents who felt they had no choice in raising their grandchildren had lower subjective views of their well being and that a grandparents self efficacy was positively related to subjective well being. Rodriguez and Crowther also found that taking medication to relax oneself negatively impacted subjective well being, which could result from a finding in Bonanno’s (2004) study that suggested that individuals who had higher levels of resilience may actually have more difficult times adjusting to stressful circumstances when typical forms of therapeutic treatment for stress and trauma were introduced (as cited in Maddi, 2005). It has also been found that grandparents experience less role satisfaction when the grandchild is perceived to have emotional or behavioral problems (Hayslip, Temple, Shore, & Henderson, 2006).

However, not all grandparents’ health is negatively impacted by raising a grandchild. (Hayslip, Shore, & Emick, 2006). Caregivers who are married, in good health, and have a satisfactory income are more satisfied with their caregiving role than are those who are single, of low income, and poorer health (Goodman, 2006). Goodman also found that role satisfaction among grandmothers increased with age. Hayslip, Temple, Shore, and Henderson (2006) found that grandparents caring for only one child experienced less stress than those caring for multiple children and that the more meaning and value a grandparent associated with the caregiving role, the greater their satisfaction was in taking on that role.

An interesting finding by Kaminski, Hayslip, Wilson, and Casto (2007) showed that in regards to difficult or problem children, grandparents do not experience any more stress than parents with the same type of children. This finding was duplicated by Oburu (2005), in which
he reported that he did not find a positive correlation between grandparent’s levels of stress and the child’s incidences of negative behavior in Kenyan children. Oburu then theorized that coping styles and social support may play a role in mediating the effects of raising grandchildren, and that this could explain why no positive correlation between grandparent stress levels and a child’s negative behaviors was found.

Role of Stress

Identity theory suggests when a person feels he/she can adequately perform a specific role he/she is then better able to meet the demands of that role and limit the stresses associated with it, as well as find that role rewarding (Giarrusso et al., 2000). Musil et al. (2000) and Cox (2000) suggest that grandmothers may feel insecure because they feel that they failed at raising their own children; this could affect the way in which they perceive their new role and the stress they experience from it. Musil et al. also suggest that grandmothers’ insecurities in raising their grandchildren may arise because the world has changed drastically from when they were parents and they are not sure how to relate to new societal norms for children. Cox adds that many grandparents fear that their grandchildren will fall prey to peer pressures like drugs, sex, and gang violence. Many grandparents may minimize the psychological and physical difficulties of parenting they experience because they fear losing their grandchildren (Cox; Giarrusso et al.).

Role of Ethnicity

Although it has been established that caregiver stress for grandparents is universal,
there are differences in the way different cultures and/or ethnicities view the issue. Contrary to American grandparents, Mexican-born grandparents view raising their grandchildren as a privilege, and when this option was taken from them they seemed to experience a loss of purpose (Hayslip, Baird, Toledo, Toledo, & Emick, 2006). Mexican grandparents also reported higher levels of meaning and purpose even though they reported more stress and less role satisfaction than their American counterparts (Toledo, Hayslip, Emick, Toledo, & Henderson, 2000). Kohn and Smith (2006) found that African American grandmothers reported less loneliness and more social support than their white counterparts. Kohn and Smith attributed this to the closeness of African American families and the idea that raising ones grandchildren was a normative process experienced by many of their peers. However, Baird, John, and Hayslip (2000) found that African American grandparents overwhelmingly reported a need for financial assistance that they felt they could not get in most cases, and contrary to Kohn and Smith, they reported that their participants did indeed experience feelings of isolation and a lack of social support.

Role of Social Support

Social support has consistently been linked to better psychological health and well being, and has been shown to buffer the effects of stress (Cox, 2000; Giarrusso et al., 2000; Hayslip, Temple, Shore, & Henderson, 2006; Musil et al., 2000). Musil and Ahn (as cited in Musil et al.) found grandmothers who perceived they had greater social support were less depressed than those who perceived little social support. Cox suggests that social support is lacking in grandparents who raise their grandchildren and that, in fact, accepting the children
may extinguish any existing social support networks they have in place. Musil et al. report that many grandmothers tend to isolate themselves from peers due to embarrassment, inability to participate in social events due to time or money, and fear of judgment and criticism. Contrary to this, Brown and Mars (2000) found that nearly half of the participants in their study stated they had a large supportive social network with only 10% saying they had no social support on which to rely. Grandmothers who were employed reported less stress than those who were unemployed; this could be due to more social support and interaction (Musil et al.).

Musil et al. found that active coping styles were related to less stress and depression, whereas avoidant and minimizing coping styles were found to be related to more anxiety, stress, and depression. Active coping includes talking, making plans of action, following ones plans, whereas avoidance coping is wishing the situation would change or avoiding dealing with it, and minimizing includes downplaying the situation and its effects (Musil et al.). Grandparents also mentioned a sense of humor as an effective way of dealing with and coping with the stresses they experienced as caregivers (Musil et al., 2000). Giarrusso et al. found that family obligation was negatively correlated with the amount of stress experienced by the grandparent caregiver.

Cherlin and Furstenberg (as cited in Giarrusso et al., 2000) identified five types of grandparenting: detached, passive, supportive, authoritative, and influential. They found that supportive grandparenting was associated with being most rewarding and detached grandparenting was associated with most stress.

A major contributor to social support that is often overlooked is religion and spirituality (Musil et al., 2000). Brown and Mars (2000) reported that church was a major area of social support, especially among African American women; in fact, it appeared to be the major
institute for social support among African American grandmothers. Musil (1998) reported 90% of Black grandmothers used religion as a coping strategy. Picot et al. (as cited in Musil, Schrader, & Mutikani, 2000) found that religion was associated with perceiving the role of caregiving for the elderly as more rewarding, and Levin, Chatters, and Taylor (1994) found that organized religion was associated with improved physical health.

**Summary**

The fact that some grandparents are willing to take on the role of caregiver suggest that these individuals have some strength and resiliency. Where some grandparents feel they have no real choice in their circumstances, others actively take the role on and challenge current systems that make the job of raising ones grandchild more difficult (Cox, 2000). Silverstein and Vehvilainen (2000) reported many grandparents found raising their grandchildren very rewarding. These grandparents felt that by raising their grandchildren they were able to improve the lives of these children. Many also indicated that raising their grandchildren made them feel young and more vivacious. Cox suggests that caring for ones grandchildren is a means of adding to and improving ones legacy and this can lead to it being seen as a rewarding process. Caring for a grandchild also allows the grandparent to simultaneously help his/her adult child and his/her grandchild and this to can attribute to the rewards one experiences (Giarrusso et al., 2000). Giarrusso et al. reported that 98% of grandparents in their study found caregiving to be rewarding and only a minimal 2% found it not rewarding. Grandparents that were more active in the child’s life reported less stress than those that took a more passive, detached role (Giarrusso et al., 2000). Silverstein and Vehvilainen found in their study that
most grandparents took an active role in parenting and education and over three-fourths were involved in school activities and functions. They also reported that 79% helped their grandchildren with homework regularly and of those, 77% felt confident in doing so.

Grandmothers who were able to view their parenting role as meaningful and having purpose were reported to have less negative effects of caregiving (Musil et al., 2000). Family obligation and education level were also found to be positively correlated with the rewards of caregiving (Giarrusso et al., 2000). Goodman and Silverstein (as cited in Musil, Schrader, & Mutikani, 2000) reported that the closer a grandmother was to her child, the less stress she would experience related to caring for her grandchildren. Cox (2000) suggests that those who enjoyed being parents more are more likely to view the role of raising ones grandchildren as a positive occurrence rather than a negative one. It could be that finding caregiving as rewarding increases psychological well being, but it could also be that psychologically healthy people tend to experience caregiving as more rewarding (Giarrusso et al.) Brown and Mars (2000) reported that in their study almost 15% of participants reported that they wanted to care for their grandchildren out of pure love for the child and wanting to provide a better life for the child, and only 3% of grandparents felt they had no choice in whether or not to care for the child.

Resiliency

There is much work to support resilience as a mediator of stress-adjustment relationships among custodial grandparents. Bartone (1999) found that military personnel who exhibited higher levels of hardiness were less likely to report symptoms of PTSD and depression than those who were viewed to have lower hardiness (as cited in Maddi, 2005). Maddi also
found that individuals who underwent a hardiness training course showed improvement in several areas of their lives, including college GPA, health, job performance, and job satisfaction. It was also found that individuals with higher levels of hardiness had fewer and less severe mood fluctuations and tended to recover faster from trauma (Maddi, 1999). Since hardiness is a main component of overall resilience, it is more than plausible to expect that higher levels of resilience would have the same positive effects on grandparents caregiver’s lives.

Bonanno (as cited in Kelley, 2005; Linley, 2005) viewed resilience as an innate personality component among all individuals and supported this via the relatively low rate of psychopathology resulting from trauma and stress. According to Bonanno, resilience could be likened to the immune system, a form of psychological immunity all people posses, but like the physical immune system, psychological immunity (resilience) varies greatly from individual to individual (as cited in Kelley, 2005; Linley, 2005). A similar notion was also suggested by Aaron Antonovsky’s concept of salutogenesis, or the origin of health, in which it was discussed that mental health/resilience was not built up through avoiding stress and trauma, but rather through active coping, problem solving and use of resources to manage and deal with the stressor appropriately (Almedon, 2005). This mirrors the way in which the human physical immune system is exposed to disease and illness and grows stronger from limited exposure to pathogens.

However, there is little research on the role resiliency plays on the negative effects the grandparents experience as a result of having to raise their grandchildren. A grandparent’s ability to mediate the negative effects of raising grandchildren would increase his/her ability to provide a loving and stable home to the child, and this, in turn, would foster better behavior in
the child by allowing the child to develop secure attachments and build a strong, supportive social network, which, in turn, would then positively contribute to the well-being of the grandparent. It has been shown that the grandchild’s behavior can influence the grandparent’s attitude and that this relationship can go the other way in which the grandparent’s attitude influences the child’s behavior (Edwards, 1998). A study by Rogers and Henkin in 2000 stated that a grandparent’s emotional stability/outlook was significantly correlated to the child’s behavior (as cited in Edwards & Daire, 2006).

Statement of the Problem

The purpose of the current study was to determine why some grandparents are better able to deal with the stresses and hassles of raising a grandchild than are others, and what role resiliency plays in mediating these stressors and negative effects.

The model, shown in Figure 1, demonstrates how resilience may mediate the effects of role demands and life disruptions on overall health and stress levels. Added demands, life disruptions and daily hassles and difficulties negatively impact ones health by creating more stress. The model suggests that resilience may mediate these negative effects; in essence, people with higher levels of resiliency will be less prone to experience the negative effects caused by added stress, and those who have lower levels of resiliency will be more prone to the negative impact of life disruption and added stressors.
Figure 1. Resilience as a mediator.
METHOD

Participants

Participants were recruited from samples located within and around the Dallas, Texas, area, as well as from other states and Canada, using available resources that included support groups, the community at large, and contacts through undergraduate students. In the latter example strict rules were enforced to ensure the reliability of survey data; all participant surveys were sealed and signed by the participant with contact information present and participants were contacted and verified by telephone. Some participants had previously participated in studies focused on custodial grandparents. Participants were recruited if they were currently caring for a grandchild on a full-time basis. Participants could be either skipped-generation families, meaning the child’s biological parents should not be currently residing with the grandparent and child, although the child and grandparent may still be in regular contact with the parent/s. Or participants could be co-parenting families, where the biological parent lived with the grandparent and grandchild but was not the primary caretaker. There were no restrictions on gender; however, it was expected to have more female (grandmothers) than male (grandfathers) participants.

Originally, 270 survey packets were mailed. The present sample consisted of 239 participants who returned the survey, yielding a response rate of 88.1%. The sample consisted of 42 male participants and 196 female participants; one survey omitted gender. Seventy-nine percent of the sample was composed of Caucasian participants, with the next highest frequency being African American, making up 13.8% of the total sample. The age of the participants in this study ranged from 38 to 90 years in age, with the mean age being 58.06,
with a standard deviation of 8.167. The number of grandchildren being cared for by a
grandparent caregiver ranged from 1 grandchild to as many as 13, with the average number of
grandchildren being cared for at 1.61 with a SD of 1.19. The mean age of the grandchild in care
was 9.44 with a SD of 4.65 and ranged from less than a year to 24 years of age. The average
length of time that a grandparent had been caring for his/her grandchild was 6.44 years, with
the SD of 4.68 years, and length of time in care ranged from less than a year to 24 years.

Measures

Participants completed a basic demographic information form (DIF) that assessed
variables such as gender, age, education level, and SES; in addition to the DIF, participants were
asked to complete the following surveys.

Life Disruption and Role Demands

Life Disruption Scale: The extent of life disruption experienced was measured by
applying items proposed by Jendrek (1993) in research relative to grandparents raising
grandchildren. The scale consisted of 20 items addressing the extent to which caring for a
grandchild has affected the caregiver. The items were rated on a 5-point Likert scale ranging
from 1 = Not at all to 5 = A great deal. An internal consistency reliability coefficient of .93 was
calculated based on a study of grandparents raising grandchildren (Hayslip, 2003). Examples of
items in this scale include: “doing things for fun or recreation,” “worrying about things,” and
“having contact with friends.” Higher scores indicated more life disruption.

Appraisal of caregiving: Grandparents appraisal of caregiving toward their grandchild
was assessed via a 19-item and a 9-item measure adopted from scales developed by Pearlin, Mullan, Semple, and Skaff (1990). According to Pearlin et al., appraisal was measured by economic (i.e., reduction in household income, increase in expenditures related to the care and treatment of the care recipient, and assessment of whether there is enough money to subsist month to month) and intrapsychic strain (i.e., role captivity, loss of self, caregiving competence, and personal gain) questionnaires. Role captivity was a 4-item scale that measured the reluctance of the caregiver to perform the role. Loss of self was assessed by a 2-item scale that measured the sense of personal identity the caregiver may have lost because of the caregiving role. Caregiving competence was measured by a 4-item scale, and asked caregivers to rate their level of competence in the caregiving role. Personal gain was a 4-item scale that assessed whether the caregiver has “grown” from the caregiving experience. The response categories for the 19-item scale was continuous for each item and ranged from 1 to 5, where 1 = *Strongly disagree*, to 5 = *Strongly agree*; for the 9-item scale the items ranged from 1 to 5, where 1 = *Disagree a lot*, to 5 = *Agree a lot*; the higher the score, the higher the appraisal of caregiving.

*Grandparents perceptions of relationships with grandchildren:* Grandparents’ perceptions of their relationships with grandchildren were measured by the Positive Affect Index (10 items) and Negative Affect Index (10 items) (Thomas, 1990). Positive Affect Index asked grandparents to describe the extent (in Likert format) of their mutual understanding with, trust in, respect for, and affection for their grandchildren, whereas the Negative Affect Index measures the extent of the grandparents’ negative feelings toward irritating behaviors of the grandchild (alpha = 0.79). The Positive and Negative Affect Indices predicted well-being in samples of grandparents. An additional question asked the participants to rate the quality of
the grandchild relationship (Likert 5-point scale, with 1 = *None* and 5 = *A great deal*).

*Strengths and Difficulties Questionnaire:* The Strengths and Difficulties Questionnaire (SDQ; Goodman, 2001; Palmieri & Smith, 2007) was a self-report measure that consisted of 25 items ranked on a 3-point Likert scale. With 1 = *Not true* and 3 = *Certainly true*. The SDQ was used to assess psychological adjustment of children and adolescents. It can be administered to adolescents aged 11 to 16, or it may be given to parents, guardians, or teachers of children 4 to 16. The 25 items are divided into 5 sub-scales that look at pro-social behavior, emotional symptoms, conduct problems, hyperactivity-inattention, and peer problems. Satisfactory internal reliability has consistently been demonstrated on all scales except peer problems, which has been shown to have low internal consistency (.41 to .62) Retest stability was found to have a lower bound of .62 at 4 to 6 months.

*Parental role strain:* Custodial grandparent’s parental role strain was assessed via a 17-item measure derived from the Structure of Coping Scale (Pearlin & Schooler, 1978) and used to identify potential strains in grandparent’s roles as parents, as well as to identify emotional stress experienced by grandparents connected to this role. Each item is scored on a 4-point, where 1 = *Never* to 4 = *Very often*. Higher scores indicted the grandparent experienced more stress and strain associated with the caregiving role.

*Social Support*

*Multidimensional Scale of Perceived Social Support (MSPSS):* The MSPSS (Zimet, Dahlem, Zimet, & Farley, 1988) is a 12-item self-report inventory that measured perceived social support from family, friends, and significant others. For example, “There is a special person who is
around when I am in need.” Each item is scored on a Likert-type scale, where 1 = *Very strongly disagree*, to 5 = *Very strongly agree*, and higher overall scores are associated with more perceived social support. The reliability coefficient for the MSPSS is .88.

**Resilience**

*The Resilience Scale*: The Resilience Scale (Neill & Dias, 2001) is a 15-item self-report survey modified from Wagnild and Young’s (1993) Resilience Measure used to measure themes of resilience. All items are worded positively and responses are on a 4-point Likert scale. Concurrent validity has been supported by significant correlations between RS scores and measures of morale, life satisfaction and depression, and a Cronbach’s alpha of .91. Higher scores represent higher levels of resilience.

*Personal Views Survey (PVS)*: Hardiness was assessed via the PVS (Kobasa, 1985), a 50-item scale assessing hardiness which is comprised of three subscales: Control (feeling that all events are a consequence of one's own actions), Commitment (active attempts to infuse meaning into one's life), and Challenge (where changes in life are defined as exciting and stimulating, rather than stressful experiences). Each item is scored on a Likert-type scale, where 1 = *Not at all true* to 4 = *Completely true*. Higher scores indicated higher levels of hardiness. The Chronbach’s alpha of the PVS composite measure is .88 (Funk, 1992).

**Parental Efficacy**

*Parental efficacy*: To measure parental efficacy, a 9-item scale (Bachicha, 1997) of generalized parental efficacy was given to assess the grandparents’ perceptions of their ability
as parents to solve problems and understand their grandchild. Each of the nine items were answered on a 5-point Likert-type scale, where 1 = Strongly disagree to 5 = Strongly agree. Higher scores indicated a higher level of parental efficacy, whereas lower scores were associated with less parental efficacy. This scale has been successfully used to assess the impact of a psychosocial intervention targeting grandparent caregivers (Hayslip, 2003).

**Parenting practices:** The Parenting Practices Scale (Robbins, Briones, Schwartz, Dillon, & Mitrani, 2006) is a self-report measure that can be given to both the caretaker and the child. The caretaker portion consists of 30 questions, whereas the child’s portion consists of only 23 questions; this is because children are not given the sub-scale that deals with discipline avoidance. These questions are used to measure four factors that make up Parenting Practices Scale: 1) positive parenting/ parental involvement, 2) discipline effectiveness/ behavioral control, 3) avoidance of discipline, and 4) monitoring/ knowledge of child’s activities. All items on the scale have been shown to have satisfactory internal consistency, with a low of .57 on behavioral control to a high of .89 on discipline avoidance.

**Attachment to grandchild:** Custodial grandparent’s attachment to their grandchild was assessed via a 28-item measure modified from Armsden and Greenberg’s (1987) Inventory of Parent and Peer Attachment (IPPA). All items were reworded to reflect custodial grandparents’ view of their attachment to their grandchild. For example, “I respect my grandchild’s feelings.” Each item was ranked on a 5-point Likert-type scale, where 1 = Never true to 5 = Greatly true. Higher scores indicated deeper attachments and bonds than did lower scores.
Stress

Parenting Stress Index/Short Form (PSI/SF): The PSI/SF (Abidin, 1990) is a 36-item self-report measure consisting of three subscales: the Parental Distress Factor, the Parent-Child Dysfunctional Interaction Factor, and the Difficult Child Factor. The Parental Distress Factor measured parental distress; the Parent-Child Dysfunctional Interaction Factor evaluated whether the parent derives satisfaction from interactions with the child and whether the child meets parental expectations. The Difficult Child Factor measured the child’s ability to self-regulate. The PSI/SF demonstrates high internal consistency (alpha = .91), high test-retest stability (r = .84), adequate construct, discriminant and predictive validity, acceptable concurrent validity with clinical and self-report criteria, and acceptable cross cultural validity (Abidin, 1990). PSI/SF Total Stress scores was used. All PSI/SF items were reframed to apply to “my grandchild.” The scale was measured with a 5-point Likert scale ranging from 1 = Strongly disagree to 5 = Strongly agree. The custodial grandparents completed the PSI/SF as it related to their acquired roles as the grandchild’s functional parent.

Grandparenting satisfaction: Satisfaction with grandparenting was assessed using 15 questions (alpha = 0.79) used in the Thomas (1990) study. Each question was answered on a 5-point Likert-type scale (1 = Strongly disagree to 5 = Strongly agree), and higher scores indicated greater satisfaction. The scale’s alpha coefficient is .79.

Psychological and Physical Health

Short Form-36 (SF-36) General Health Survey: The SF-36 (Ware, 1993) is a 36-item self-report measure that was used to assess physical and mental health. The SF-36 had scales
measuring physical functioning, role disability due to physical health problems, bodily pain, general health perceptions, vitality, social functioning, role disability due to emotional health problems, and general mental health. Estimates of score reliability for the SF-36 scales in 14 studies conducted in the United States and the United Kingdom exceeded accepted standards for measures used in group comparisons. For each scale, the median of the reliability coefficients across studies equals or exceeds .80. Validity with other widely used health surveys has been established (Ware).

*Psychological well-being:* Psychological well-being (Liang, 1985) was assessed via a 15-item self-report scale that was designed to measure respondents’ feelings about their lives. The scale integrated items from the Bradburn Affect Balance Scale (Bradburn, 1969) and the Life Satisfaction Index A (Neugarten, Havighurst, & Tobin, 1961). The Liang Scale allows for the assessment of positive and negative affect (transitory affective components), happiness (long-term affective component), and congruence (long-term cognitive component).

*Center for Epidemiologic Studies Depression Scale (CES-D):* Psychological distress/depression was assessed via the CES-D (Radloff, 1977), a 20-item self-report scale designed to measure current level of depressive symptomatology with an emphasis on depressed mood. Participants were asked to endorse the response that best describes how often they feel a particular way in the past week. Questions were answered on a 4-point Likert-type scale, where 1 = *Rarely or some of the time* (less than 1 day) to 4 = *Most or all of the time* (5 to 7 days). Higher scores indicated more health problems, while lower scores indicated overall better health. The scale exhibits high internal consistency (alpha = .85), adequate test-retest stability
(correlations range from .45 to .70), exceptional concurrent validity with clinical and self-report criteria, and substantial evidence of construct validity (Radloff, 1977).

**Mental Health Attitudes**

*Attitudes towards psychological help:* Attitudes towards psychological help (Hayslip, Temple, & Currin, 2007) were assed using two combined scales. The first measured openness to seeking psychological help; this is assessed using a list of 24 problems such as deep depression, forgetfulness, and arguments with children. Participants were asked whether they would seek help from a counselor or therapist for each problem. The number of items each participant endorsed is then summed to give an openness score, wherein higher scores indicated greater openness towards seeking mental health services. Alpha coefficients in the 1991 and 2000 samples were .81 and .85 for younger adults, and .87 for older adults. The second part measured professional and mental health bias; this was measured on a 5-point Likert scale (1 = *Strongly disagree* and 5 = *Strongly agree*) where items described various negative attitudes one might hold towards mental health care issues. Agreement with the statements indicated a negative attitude towards the value of mental health care, the stigma attached to seeking mental health services, and to mental health care professionals themselves. Higher scores indicated more positive attitudes (less negative biases). Alpha coefficients for the 1991 and 2000 samples were .80 and .78 for younger adults and .67 and .84 for older adults.

*Social desirability:* To control for response bias, social desirability was measured by a short form of the Crowne and Marlowe (1960) Personal Reaction Inventory. This instrument
consisted of 10 statements with which the respondent either agreed or disagreed to a series of statements that described common behaviors often seen as socially undesirable (i.e., “I like to gossip at times”). Scores can range from 10 to 20, with higher scores indicating high social desirability.

Procedure

A letter of invitation, informed consent, the DIF, and the packet survey, along with two reply envelopes were mailed to each participant. The participants were asked to sign and return by mail the consent form separate of the DIF and survey packet.

Statistical Analysis

A regression/correlation analysis was conducted to explore the meditational role that resilience may play in explaining the relationship between, for example, child demands and parental efficacy. As per the recommendation of Baron and Kenny (1986), hierarchical regression was used to establish relationships between, for example, a) child demands and parental stress, b) resilience and child demands, and c) parental stress and resilience. In this case, if resilience serves as a mediator, then controlling for it will lessen the relationship between child demands and parental stress. This regression analysis was repeated for each measure of child difficulties, parental stress, life stress, resilience and adjustment/mental health. In this light, exploratory factor analyses were carried out for measures relating to the above constructs to examine if each were better described by a common factor(s).
cases, factor scores were used to avoid the attenuation of relationships that accompany measurement error, as recommended by Baron and Kenny (1986).
RESULTS

In order to examine the factor structure defining key components in the model, principle component analysis with varimax rotation to a terminal solution was carried out in each case.

Independent Variables

Grandchild Difficulties was composed of 3 components (grandchild problems, grandchild difficulty score, and overall difficulty score) and produced 1 factor titled Child Difficulties (Fac1.1). Fac1.1 had an eigenvalue of 2.45, and accounted for 81.84% of total variance shared among the three measures. Factor loadings are found in Table 1.

Table 1

Factor Loadings

<table>
<thead>
<tr>
<th>Components</th>
<th>Loadings (Fac1.1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GC problems</td>
<td>.869</td>
</tr>
<tr>
<td>GC difficulty score</td>
<td>.919</td>
</tr>
<tr>
<td>Overall difficulty</td>
<td>.924</td>
</tr>
</tbody>
</table>

The next two factors were composed of 5 measures; grandparent satisfaction, life disruption, overall physical health, mental health, and limitation. The two factors derived from these measures are labeled Life Stress 1 (Fac1.2 – greater everyday physical and mental health) and Life Stress 2 (Fac2.2 – greater role satisfaction and life stability). Life Stress 1 had an eigenvalue of 2.69, and accounted for 53.8% of the shared variance, while Life Stress 2 had an eigenvalue of 1.06 and accounted for 21.26% of the shared variance among the five measures.
Table 2 demonstrates the factor loadings for the components in both factors.

Table 2

*Factor Loadings*

<table>
<thead>
<tr>
<th>Components</th>
<th>Loadings (Fac1.2)</th>
<th>Loadings (Fac2.2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP satisfaction</td>
<td>-.012</td>
<td>.912</td>
</tr>
<tr>
<td>Life disruption</td>
<td>-.423</td>
<td>-.684</td>
</tr>
<tr>
<td>Physical health</td>
<td>.866</td>
<td>.055</td>
</tr>
<tr>
<td>Mental health</td>
<td>.834</td>
<td>.260</td>
</tr>
<tr>
<td>Limitations</td>
<td>.863</td>
<td>.123</td>
</tr>
</tbody>
</table>

**Mediator - Resilience**

A resiliency factor was formed using 2 measures. These measures included the 3 sub-scales of hardiness, challenge, commitment, and control, as well as a measure of self-efficacy that was used to measure resilience. The resiliency factor, labeled Fac1.5, had an eigenvalue of 2.33, and accounted for 58.38% of the shared variance among the measures. Factor loadings are found in Table 3.

Table 3

*Factor Loadings*

<table>
<thead>
<tr>
<th>Components</th>
<th>Loadings (Fac1.5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Challenge</td>
<td>.672</td>
</tr>
<tr>
<td>Commitment</td>
<td>.882</td>
</tr>
<tr>
<td>Control</td>
<td>.817</td>
</tr>
<tr>
<td>Resilience</td>
<td>.661</td>
</tr>
</tbody>
</table>
Dependant Variables (DVs)

The first DV factor created was Parental Stress, labeled Fac1.3. Parental Stress was comprised of 4 measures (parental strain, positive affect, negative affect, and parental stress), and had an eigenvalue of 2.57, with 64.48% of shared variance accounted for. The factor loadings for the 4 components are displayed in Table 4.

Table 4

*Factor Loadings*

<table>
<thead>
<tr>
<th>Components</th>
<th>Loadings (Fac1.3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parental strain</td>
<td>.867</td>
</tr>
<tr>
<td>Positive affect</td>
<td>-.841</td>
</tr>
<tr>
<td>Negative affect</td>
<td>.812</td>
</tr>
<tr>
<td>Parental stress</td>
<td>.678</td>
</tr>
</tbody>
</table>

The DV of Adjustment was composed of 5 measures: mental health openness, mental bias, mental health breadth, the CESD, and well being. Two factors were created: first was lack of well-being (Negative Well-Being, labeled Fac1.4); second (labeled Fac2.4) was Positive Mental Health Attitudes. Fac1.4 had and eigenvalue of 1.61, with total shared variance accounted for being 32.33%. Fac 2.4 had an eigenvalue equal to 1.45, with 29.17% of shared variance being accounted for between the five measures. loadings are found in Table 5.

Table 5

*Factor Loadings*

<table>
<thead>
<tr>
<th>Components</th>
<th>Loadings (Fac1.4)</th>
<th>Loadings (Fac2.4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH openness</td>
<td>.309</td>
<td>-.333</td>
</tr>
<tr>
<td>MH bias</td>
<td>-.100</td>
<td>.860</td>
</tr>
<tr>
<td>MH breadth</td>
<td>.221</td>
<td>.784</td>
</tr>
<tr>
<td>CESD</td>
<td>.854</td>
<td>.015</td>
</tr>
<tr>
<td>Wellbeing</td>
<td>-.852</td>
<td>-.044</td>
</tr>
</tbody>
</table>
Correlations

Table 6 presents the correlations among the principal IVs and DVs in this sample.

Table 6

Correlation Matrix Including All Variables

<table>
<thead>
<tr>
<th></th>
<th>Child Difficulty (Fac1.1)</th>
<th>Parental Stress (Fac1.3)</th>
<th>Life Stress I (Fac1.2)</th>
<th>Life Stress II (Fac2.2)</th>
<th>Adjustment I (Fac1.4)</th>
<th>Adjustment II (Fac2.4)</th>
<th>Resilience (Fac1.5)</th>
<th>Parental Efficacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>638**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>-.435**</td>
<td>-.505**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>.121</td>
<td>.458**</td>
<td>.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>.317**</td>
<td>.396**</td>
<td>-.687**</td>
<td>.038</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>-.175*</td>
<td>-.094</td>
<td>.145</td>
<td>.066</td>
<td>.000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>-.178*</td>
<td>-.413**</td>
<td>.494**</td>
<td>-.144</td>
<td>-.604**</td>
<td>-.13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>.121</td>
<td>-.646**</td>
<td>.263**</td>
<td>-.242**</td>
<td>-.269**</td>
<td>-.103</td>
<td>.396*</td>
<td></td>
</tr>
</tbody>
</table>

*p ≤ .05; **p ≤ .01

Table 7 presents bivariate zero order and partial r's exploring the mediating roles of resiliency and parental efficacy.

Table 7

Zero Order and Partial r

<table>
<thead>
<tr>
<th>IV - DV</th>
<th>Zero order r</th>
<th>Partial r</th>
<th>Parental Efficacy Zero order r</th>
<th>Partial r</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Difficulty – Parental Stress</td>
<td>.638**</td>
<td>.545</td>
<td>.638**</td>
<td>.694</td>
</tr>
<tr>
<td>Child Difficulty – Adjustment I</td>
<td>.317**</td>
<td>.259</td>
<td>.317**</td>
<td>.367</td>
</tr>
<tr>
<td>Child Difficulty – Adjustment II</td>
<td>-.175*</td>
<td>-.234</td>
<td>-.175*</td>
<td>-.221</td>
</tr>
<tr>
<td>Life Stress I – Parental Stress</td>
<td>-.505**</td>
<td>-.455</td>
<td>-.505**</td>
<td>-.507</td>
</tr>
<tr>
<td>Life Stress I – Adjustment I</td>
<td>-.687**</td>
<td>-.564</td>
<td>-.687**</td>
<td>-.642</td>
</tr>
<tr>
<td>Life Stress I – Adjustment II</td>
<td>.145</td>
<td>.229</td>
<td>.145</td>
<td>.234</td>
</tr>
<tr>
<td>Life Stress II – Parental Stress</td>
<td>.458**</td>
<td>.436</td>
<td>.45</td>
<td>.375</td>
</tr>
<tr>
<td>Life Stress II – Adjustment I</td>
<td>.038</td>
<td>-.077</td>
<td>.038</td>
<td>-.086</td>
</tr>
<tr>
<td>Life Stress II – Adjustment II</td>
<td>.066</td>
<td>.115</td>
<td>.066</td>
<td>.092</td>
</tr>
</tbody>
</table>

*p ≤ .05; **p ≤ .01
Regression analysis were conducted by first entering the antecedent and then entering the mediator to examine what roles the mediator may play in the relationships between the independent and dependant variables in this study. Thirteen of 18 regressions run suggested that resilience does in fact play \( p \leq .05 \) a meditational role and, in addition, supports the role of parental efficacy as a mediator. The eighteen regressions can be found in Table 8.
Table 8

*Regression Table for Both Resilience and Parental Efficacy as Mediators*

<table>
<thead>
<tr>
<th>IV</th>
<th>DV</th>
<th>Resilience (Fac1.5) as Mediator</th>
<th>Parental Efficacy as Mediator</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Beta1</td>
<td>Beta2</td>
</tr>
<tr>
<td>Child Diff</td>
<td>Par. Stress</td>
<td>.64</td>
<td>.58</td>
</tr>
<tr>
<td>(1.1)</td>
<td>(1.3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Diff</td>
<td>Adj. I (1.4)</td>
<td>.63</td>
<td>.56</td>
</tr>
<tr>
<td>(1.1)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Diff</td>
<td>Adj. II (2.4)</td>
<td>.63</td>
<td>.63</td>
</tr>
<tr>
<td>(1.1)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life Stress</td>
<td>Par. Stress</td>
<td>-.50</td>
<td>-.39</td>
</tr>
<tr>
<td>(1.2)</td>
<td>(1.3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life Stress</td>
<td>Adj. I (1.4)</td>
<td>-.70</td>
<td>-.54</td>
</tr>
<tr>
<td>(1.2)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life Stress</td>
<td>Adj. II (2.4)</td>
<td>.19</td>
<td>.31</td>
</tr>
<tr>
<td>(1.2)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life Stress</td>
<td>Par. Stress</td>
<td>.47</td>
<td>.43</td>
</tr>
<tr>
<td>(2.2)</td>
<td>(1.3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life Stress</td>
<td>Adj. I (1.4)</td>
<td>.06</td>
<td>-.03</td>
</tr>
<tr>
<td>(2.2)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life Stress</td>
<td>Adj. II (2.4)</td>
<td>.06</td>
<td>.05</td>
</tr>
<tr>
<td>(2.2)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. ¹Direct; ²Adjustment for mediator; ³Mediator/DV; ⁴Direct; ⁵With mediator; ⁶R² change with mediator; ⁷F value with mediator; *p ≤ .05; **p ≤ .01
DISCUSSION

Mixed research on the effects of grandparent caregiving led to the current study. Studies to date have been split fairly equally as to whether raising one’s grandchild has predominantly negative or positive effects on the grandparent caregiver (Brown & Mars, 2000; Cox, 2000; Giarrusso et al., 2000; Hayslip & Kaminski, 2005; Marx & Solomon, 2000; Musil, Schrader, & Mutikani, 2000). There are a number of reasons as to why studies have found such mixed results; one of those reasons being differences in resilience among grandparent caregivers.

Staudinger, Marsiske and Baltes (1995) suggested that because older individuals are more likely to experience intense stressors (i.e., the deaths of family members and friends, illness, chronic pain and discomfort, and facing one’s own mortality), they are also more likely to call on their own resilience to help maintain normal functioning in everyday life. Because older individuals may be forced to call upon resilience more regularly, it is important to equip such persons with ways in which to help them enhance and add to their existing resiliency reserve (Staudinger, Marsiske & Baltes, 1995). Bergeman and Wallace (1990) echoed Staudinger, Marsiske and Baltes, stating that because adversity is unavoidable, especially in later life, optimal functioning can only be achieved through the development and enhancement of resiliency.

The purpose of the current study was to examine the mediating role of resiliency to help better understand why some grandparent caregivers are better able to adjust to and handle the added stresses of caring for their grandchild, while others experience more negative effects associated with the caregiving role. The model (Figure 1), suggests the mediating role of...
resilience on 6 factors: child difficulty, parental stress, physical and mental health, stability and role satisfaction, mental health attitudes, and adjustment. This study was based on the assumption that resilience possibly mediated the negative effects of caring for a grandchild, and that those individuals with higher scores on the resilience measure would report fewer negative effects and less stress than those individuals who scored lower on the resilience measure.

When this study was begun, there was little research on the role of resiliency and how it may or may not impact grandparent caregivers; however, Oburu (2005) suggested that social support and coping styles possibly mediated the effects raising one’s grandchild could have on a grandparent. It may be that both coping styles and social support can be attributed or linked to a person’s level of resilience.

The sample in the current study consisted of 239 individuals from the Dallas Texas metroplex, as well as a few other states and Canada. The majority of the sample was Caucasian females with an average age of 58 years old. Participants were asked to complete a survey that was made up of 18 measures, as well as a demographic information form.

Factor analysis was performed on the 18 measures to produce 8 factors; 3 independent variables (IVs), 3 dependant variables (DVs) and 2 mediators. Child difficulty, physical and mental health and life stability and role satisfaction composed the 3 IVs. The DVs consisted of parental stress, adjustment and mental health attitudes. Resilience and parental efficacy were the 2 mediators. Parental efficacy was run as an exploratory measure, in which it was used as a mediator in place of resilience.

The findings indicate that resilience does appear to partially mediate the relationship between grandchild difficulty and parental stress. Resilience also seems to partially mediate
the relationship between life stress and adjustment 1 (negative adjustment), and life stress and parental stress. Of the dependant variables here, mental health attitudes was the only one that was not affected by resilience as a mediator. When exploring parental efficacy as a mediator, the same conclusion was reached, only mental health attitudes were unaffected. Again, child difficulties and parental stress, as well as life stress and adjustment 1 all showed that parental efficacy was at least partially mediating such relationships. These results support the original hypothesis that resilience mediates the negative impact raising one’s grandchild can have on grandparent caregivers. These results thus suggest that individuals with more resilience experience less stress and less negative effects of caring for a grandchild. They also indicate that parental efficacy may also act as a mediator to buffer the negative impact caregiving has on grandparents. Thus, individuals with higher levels of resiliency, as well as individuals with higher parental efficacy report less stress associated with raising a grandchild, as well as less overall adjustment difficulties.

Knowing that resilience helps to mediate negative experiences and effects may have beneficial implications for both grandparent caregivers and grandchildren. Rogers and Henkin (as cited in Edwards & Daire, 2006) proposed that grandparent caregivers’ emotional stability and outlook were significantly correlated to the grandchild’s behavior. In this context the more resilient a grandparent is, the better able he/she will be to deal with the impact of managing a grandchild as well as cope with a changed life situation and, therefore, maintain a positive outlook on life, in turn providing a more caring and stable atmosphere for the child, fostering positive behavior in the child.

There has also been extensive research on the relationship between stress and illness
among grandfamilies (Marx & Solomon, 2000), with results showing that increased stress leads to an increase in illness. If grandparents are able to modify the negative effects of caregiving, then they could reduce the stress they are experiencing and, in turn, possibly ward off future health declines and illness. In addition to the positive effects resiliency may have on both caregiver and grandchild, it has been shown that good mental health can add years to a person’s life; people with good mental and emotional health tend to outlive those with poor mental and emotional health (Hayslip, Panek & Patreick, 2007). Thus, grandparents may live longer if they are more resilient.

Life span developmental theory argues that even older adults maintain the ability and resources to adapt, learn, and modify their coping and problem solving skills, thereby enhancing their resilience levels (Bergeman & Wallace, 1999). Grandparents can do a multitude of things to help improve their resiliency as a caregiver (Hayslip, 2008):

* Educate themselves about the challenges of raising a grandchild; knowledge is power and strength. Learn to assess their own strengths and weaknesses, and ask for help when necessary.

* Seek out the support of others; do not allow themselves to become isolated from friends as they are a source of strength. Talk with others who are raising grandchildren; create a weekly get together or perhaps join a support group.

* Take care of their self physically; grandparents cannot care for their grandchild unless you are caring for their selves too.

* If married, nurture the relationship; purposefully make time for the both of them to spend alone time together.

* Do not ignore their own needs; do what gives them pleasure. Do not ignore the impact that raising a grandchild has on their marriage or relationships.

* Enroll in classes or programs that teach assertiveness and decision making skills.

* Do things everyday that empower them personally.
* Become their own advocate, let people know about their needs.

Limitations

One limitation of this study is that it is not longitudinal. Therefore assumptions cannot be made about how resiliency causally affects grandparents’ parental or personal adjustment in the long run, or even the near future. Another limitation here is that the surveys were self-report measures; this is always an issue in studies that rely on self-reports because there are no controls for reporting bias and consequently, no means by which to ensure that all questions are answered in the appropriate manner are available. Also, the present study relied on volunteer grandparent caregivers; this is a limitation because grandparents who choose to participate are very likely more resilient to begin with than grandparents who choose not to participate; the fact that they are willing to participate suggests a desire to help and to be helped. The sample was also composed of predominantly Caucasian grandmothers; grandparents of different ethnicities, as well as grandfathers, may experience the impact of resilience on caregiving role in a significantly different manner.

Future Research

Future studies that examine resilience in grandparent caregivers may benefit from exploring the longitudinal aspect of resilience on caregivers, as well as on the grandchild. It would also be of interest to look at the differences across gender in caregivers as well as to explore the impact of ethnicity and SES. Another direction that future research might take would be to examine the impact that the gender of the grandchild may have on the caregiver.
Summary

This study began with the hypothesis that grandparents who exhibited higher levels of resilience would be better able to effectively cope with the negative effects of raising a grandchild, and would therefore report less stress and less negative health effects due to becoming a grandparent caregiver. This hypothesis was supported by the data collected. Resilience was found to mediate the negative effects that caregivers reported. Along with resilience, parental efficacy was also examined as an exploratory mediator, and it too was shown to act significantly in mediating the negative effects of custodial grandparenting. The current study supports and expands past research, cited earlier in the text, examining custodial grandparenting and the effects it has on the caregiver’s physical and mental health. The issue of grandparent caregivers and the adversities they face is important due to the increasing number of grandparent headed households. Empowering grandparents and educating them on methods in which to increase their level of resiliency is beneficial to both the caregiving grandparent and the grandchild that is living in a grandparent headed household.
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Cox, C. B. (2000). Why grandchildren are going to and staying at grandmother’s house and what happens when they get there. In Carole B. Cox (Ed.), *To grandmother’s house we go and stay* (pp. 3-19). New York: Springer.


