

ANTECEDENTS OF THE PSYCHOLOGICAL ADJUSTMENT OF CHILDREN AND
GRANDPARENT CAREGIVERS IN GRANDPARENT-HEADED FAMILIES

Jane Louise Jooste, M.A.

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APPROVED:

Bert Hayslip, Major Professor
Vicki Campbell, Committee Member
Becky Glover, Committee Member
Greg Smith, Committee Member
Linda Marshall, Chair of the Department of
Psychology
Sandra L. Terrell, Dean of the Robert B.
Toulouse School of Graduate Studies

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Grandparent-headed families are diverse in nature and represent a rapidly growing family type. While challenges facing grandparent caregivers are well documented, less is known about the well-being of their grandchildren, with many early studies relying on small samples of convenience. This study used an existing large national database, the National Survey of America's Families (NSAF), to compare differences in well-being of both children and grandparent caregivers across the independent variables of family type, ethnicity, gender, and age. Findings suggested better mental health and less parental aggravation for caregivers in traditional two parent intact families as compared to grandparents co-parenting in a multi-generation home, skipped generation grandparents (raising their grandchild with no parent present) or single parents. Skipped generation grandparents in particular reported most caregiver aggravation. Child physical health was reported to be worse by skipped generation grandparent caregivers. Behavior problems were reported to be worse for children in grandparent headed households than those in traditional families, particularly for teenagers raised in skipped generation households by their grandmothers. Specific results, limitations and future directions for research on grandparent-headed households were discussed.

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CHAPTER 1

AN OVERVIEW OF CUSTODIAL GRANDPARENTS

The traditional American family ideal consists of a single-earner married couple rearing its biological children, yet many structural changes have occurred in American families since the 1950s and 1960s, leading to a much greater diversity in family structure (Demo, 1992). In addition to dual-earner families, divorce, and single parent families, grandparents are increasingly re-assuming parenting roles, many becoming their grandchild's primary caregivers. The social phenomenon of grandparent-headed families is growing rapidly in American society (Fuller-Thomson & Minkler, 2000a; Mills, 2001; Pinson-Millburn, Fabian, Schlossberg, & Pyle, 1996), with these families representing a diverse population who experience many complex issues (Hicks Patrick & Hayslip, 2006). Custodial grandparents range widely in age, health, economic levels, and ethnicities. The number of grandchildren they care for varies, as does the duration of the time they are responsible for their grandchildren and the constellation of their families. It is possible differences in the family structure of grandparent-headed households may affect a grandchild's well-being (Casper & Bryson, 1998).

The Prevalence of Grandparent-Headed Families

As an indicator that the trend of the grandparent-headed family is growing in the U.S., the Census 2000 was the first decennial census to include questions related specifically to this type of caregiving. According to the U.S. Census 2000, 5.8 million grandparents live in households that included one or more of their grandchildren under the age of 18 (U.S. Census Bureau, 2003). Of these grandparents, 42 %, or 2.4 million,

were defined as grandparent caregivers, having primary responsibility for their co-resident grandchildren under the age of 18. Almost 94 % of grandparent caregivers were either the householder or spouse of the householder, that is, the person in whose name the house is owned or rented. Further, 34 % of grandparent caregivers were living in skipped generation households, without the presence of the parents of their grandchildren (U.S. Census Bureau, 2003). In the United States in the late 1990s, 6 % of all children were living in households maintained by grandparents (Fuller-Thomson & Minkler, 2000b). Using the National Survey of America's Families data from 2002, the Urban Institute (2005) estimated that 1,360,000 children in kinship care lived with their grandparents.

Evidence that this is not merely a temporary trend can be seen in the significant length of time some grandparents are taking responsibility for their grandchildren, as it is estimated that 39 % of grandparents responsible for their co-resident grandchildren will be responsible for their grandchildren for 5 years or more (U.S. Census Bureau, 2003). Using data from the National Survey of Families and Households, Fuller-Thomson, Minkler, and Driver (1997) established that over 50 % of the grandparent caregivers surveyed had cared for their grandchildren for at least three years. Such persons were relatively young; the mean age of grandparent caregivers in Fuller-Thomson et al.'s (1997) sample was 59.4 years. Three quarters of the grandparent caregivers lived in urban areas and more than half had completed high school (Fuller-Thomson & Minkler, 2000b). Fuller-Thomson and Minkler also estimate approximately half of grandparent caregivers are married and slightly more than three-quarters are women.

Prevalence of Different Demographic Profiles of Grandparent-Headed Households

There are distinct ethnic differences in the prevalence of grandparent caregivers. In terms of sheer numbers, the typical grandparent caregiver is a white married woman living above the poverty line (Fuller-Thomson et al., 1997). However, being African American (and single and living in poverty) increases the odds of becoming a grandparent caregiver (Roe & Minkler, 1998-1999). From a national sample of grandparents who had reported they had raised a grandchild for at least 6 months during the 1990's, Fuller-Thomson and Minkler (2000b) reported African-Americans had 83 % higher odds of being a grandparent caregiver than respondents from other races, while the majority of caregivers (62 %) were non-Hispanic White. The U.S. Census 2000 reported 2 % of non-Hispanic Whites aged 30 and over lived with their grandchildren. The U. S. Census Bureau (2003) also reported on the percentages of other ethnic groups living with grandchildren. These included 6 % of Asian grandparents, 8 % of American Indian and Alaskan Native grandparents, 8 % of African American grandparents, 8 % of Hispanic grandparents, and 10 % of Pacific Islander grandparents. Of these co-resident grandparents, American Indian and Alaskan Natives were most likely (56 %) to be responsible for their grandchildren, followed by African Americans (52 %), Hispanics (35 %), and Asians (20 %) (U.S. Census Bureau, 2003).

Prevalence of Different Types of Grandparent Caregiving

Grandparents caring for their grandchildren are referred to variously in the research literature as custodial grandparents, kinship foster care, or grandparent caregivers. Baydar and Brooks-Gunn (1998) estimate about 43 % of grandmothers

provide some care to grandchildren on a regular basis. Comparable figures for grandfathers appear not to have been published. Different family structures of grandparent-headed households are evident. The two major types of grandparent-headed households which are prominently covered in research literature are skipped-generation households, in which a grandparent and grandchild co-reside but no parent is present, and three generation co-parenting households, in which grandparent, parent and child all live together and the grandparent claims primary responsibility for the grandchild (Mutchler & Baker, 2004). Research is not as well established for grandparents who provide co-parenting in multigenerational homes as it is for custodial grandparents (Musil & Ahmad, 2002). It has been suggested parents may be transient and frequently absent in some multigenerational homes, caring for children on an inconsistent basis, with grandparents underreporting these situations to the Census Bureau for the sake of family preservation (Woodworth, 1996).

In terms of physical housing arrangements, however, it seems to be more typical for grandchildren to move into their grandparent's homes, or to have always lived with their grandparents, versus grandparents moving into the grandchild's home to assume care (Pruchno & McKenney, 2002). It has been suggested (Minkler, Berrick, & Needell, 1999) the introduction of Temporary Assistance to Needy Families (TANF) as part of the welfare reform of the mid-90s may have contributed to the increase in multigenerational homes since it requires teenage mothers to live at home as a condition of receiving aid. Multigenerational homes appear to be more common among Non-White families (Bryson & Casper, 1999). Some grandparents provide informal care for their grandchildren, whereas others may assume legal custody (Burnette, 1997).

A Life-Span, Contextual Perspective on Custodial Grandparenting

Framing grandparent-headed households in theoretical terms will assist in guiding the research that relates to this field, in addition to having relevance for interventions, and help in the setting of policy. Hayslip and Patrick (2003) have recommended that, given their heterogeneity, grandparent-headed families may best be viewed from a life-span developmental (Baltes, 1997) perspective, organizing what is known about these families into antecedent and consequent factors. A life-span developmental perspective also emphasizes contextualism (Bronfenbrenner, 1977; Lerner, 1985), which would suggest changes for grandparents and their grandchildren over their life span will arise from an ongoing relationship between intrapersonal changes and a changing environment. Any changes in grandparents as a result of caregiving are likely to result in changes in the environment of the children for whom they care, and changes in these children will, in turn, alter the environment for their grandparent caregivers. According to a contextual perspective, these interchanges will go on continuously. The development of children being cared for by grandparents will take a variety of forms, depending on the individual grandchild and the cultural and social context in which he/she lives.

Bronfenbrenner (1977, 1979) formulated an ecological approach to development, more recently referred to as a bioecological approach (Bronfenbrenner, 2005), where a developing person is understood to be embedded in a series of interacting environmental systems. Dolbin-MacNab and Targ (2003) and Cox (2003) view the ecological perspective as an appropriate framework for the study of grandparent-headed households. Not only are these families very complex and require attention at

different levels of functioning and social influence (Dolbin-MacNab & Targ, 2003), but it is difficult to separate the individual grandparent caregiver and grandchild from their environment and they, thus, should be considered jointly. From an ecological perspective, people are continually shaped by their physical and social environments, but they also shape and change these environments in a dynamic relationship of reciprocal influence.

Accordingly, from the ecological perspective, one needs to consider the different levels of systems within which grandparent caregivers and their grandchildren are embedded. Bronfenbrenner (1977) referred to the environmental systems closest to the individual as the microsystems, which for most children is likely to be the family and may include places such as school or their grandparents' homes. Microsystems nest within the mesosystem, which refers to linkages and interrelationships between microsystems. A difficulty in one of the child's microsystems (for example, having parents with substance abuse difficulties) may have repercussions for other microsystems (such as spending more time at a grandparent's house, or withdrawing from peers at school). Similarly, the mesosystem nests within the exosystem, an environment of social systems the individual never experiences directly but which still influence his or her development. The child is embedded in a larger system of relationships beyond the grandparent-headed household. For example, a child can be affected by his mother's drug dealer or boss, even though he never has contact with them. The macrosystem, or broader cultural, historical, and social context for development, encompasses the microsystem, mesosystem and exosystem.

The above discussion suggests that multiple issues need to be considered when trying to understand grandparent-headed families (Dolbin-MacNab & Targ, 2003). Reflecting an antecedent - consequent perspective, Bronfenbrenner (2005) describes how each of the above environmental systems shapes and is shaped by the developing person, both in continual flux. Change in one part of the system will produce changes in the other parts of the system. Varied antecedent factors may contribute to the heterogeneity of outcomes. These are likely to include, but are also not limited to: the circumstances leading up to and reasons for becoming a grandparent-headed household; different racial and ethnic backgrounds; the age of grandparent and grandchild; gender expectations and roles; economic and family resources; education; family structure; intergenerational relationships within the family (including patterns of attachment); pre-existing parenting skills of the grandparent; pre-existing physical and mental health of grandparent, parent and child; coping resources of the family, such as social support; and legal issues.

Some of the consequences of system changes faced by grandparent caregivers might include, but not be limited to, changes in: disposable income and employment opportunities; family structure; family relationships (with the grandchildren for whom they assume responsibility, their adult child who is parent to their grandchild, other grandchildren not living in the household); relationships with peers; convoys of support; legal difficulties; physical and mental health (due to both the aging process and potentially as a result of caregiving burden); and roles. Similarly, potential system changes and consequences faced by the child of a grandparent-headed household might include changes in: housing; caregivers; economic and family resources; parental

figures' rules and boundaries; school; peers; and their own physical and mental health and well-being.

A difficulty of the contextual approach is that of complexity. Given the multidimensional nature of the phenomenon of grandparent-headed households, with the intricate interactions and reciprocal determinism that continuously take place, the antecedents to and consequences of grandparent caregiving will be difficult to unravel. While a contextual perspective also implies that both the grandparent caregiver and the grandchild should be studied, most studies to date have focused exclusively on the grandparents themselves. For this reason, this review of existing research may be more grandparent-focused. The following discussion, therefore, focuses on variables which, alternatively, may be seen as antecedents or consequences of the custodial grandparent role.

Reasons for the Assumption of the Grandparent Caregiving Role

The reasons for grandparents to assume responsibility for raising their grandchildren are many. These can be treated as an antecedent to becoming a grandparent-headed household, although it is likely most of these reasons themselves have predisposing factors that might be important (such as the intergenerational relationships within the family or socioeconomic influences) in understanding their impact. Indeed, the many circumstances under which grandparents assume a caregiving role are seldom positive (Glass & Huneycutt, 2002; Thomas, Sperry, & Yarbrough, 2000). Grandparents generally assume caregiving responsibilities for their grandchildren following a traumatic event, such as the loss or incapacity of their own

child (Cox, 2000), or longer term problems that have affected their adult child's ability to parent. Some grandparents may feel compelled to assume the parenting role by a biological connection to their grandchildren (Kivett, 1991) or by moral or religious beliefs (Burton, 1992). The precipitating factors that grandparents highlight, however, for assuming direct responsibility over their grandchildren, may be viewed as primary stressors for the grandparents (Giarrusso, Feng, Silverstein, & Marengo, 2000) and, more than likely, the affected grandchildren as well.

As part of a national survey, Giarrusso, Feng, Silverstein and Marengo (2002) analyzed and coded an open ended question about the initial reasons 146 grandparents took on the caregiver role. They reported that 14 % stated something about the grandchild served as a catalyst for caregiving, for example, the grandchild's health or school-related issues. A further 16 % mentioned something about themselves as reasons for assuming responsibility, while 2 % reported they became caregivers as a result of addictive, illegal or lethal behaviors of the parent. These were the grandparents who experienced significantly higher levels of caregiver stress and negative affect than grandparents who did not mention this as a reason for assuming care. Most of the sample, 64 % of the grandparents, described assumption of care due to changes experienced by the parent that were not a result of addictive, illegal or lethal behavior, but instead were due to a change in the adult child's family structure (such as divorce), the adult child's financial hardship, or, in just 1 % of cases, when the adult child became physically or mentally ill. In contrast, some regional studies may highlight difficulties more common to a specific geographic location, such as those found by educational program for grandparent caregivers in Michigan, where 62 % of the 110 grandparents

reported substance abuse as the reason for assumption of caregiving (Jones & Kennedy, 1996).

Waldrop and Weber (2001) investigated the problems that precipitated grandparent caregiving in a relatively small sample of 38 families, and while participants often cited more than one problem, substance abuse (66 %) emerged as the most common problem, followed by child abuse / neglect (39 %), parental abandonment (39 %), divorce / breakup (37 %), teen pregnancy (26 %), mental health problems of adult child (18 %), and death of adult child (8 %). This research is supported by the work of Pruchno and McKenney (2002) who interviewed a national sample of 867 custodial grandmothers and reported the most common reason for assumption of caregiving was due to drug addiction on the part of the grandchild's mother (42.7 %) or father (27.3 %). Other common reasons for having assumed care were given as the child's mother being emotionally (33.6 %) or physically (32.2 %) neglectful. Both mothers (20.2 %) and fathers (20.2 %) being addicted to alcohol also accounted for some of the grandmothers' assumption of grandchild care. To a lesser extent, parent's death, imprisonment, mental illness, or being physically or emotionally abusive were given as reasons why the parents were no longer raising their children.

Further, Woodworth (1996), in a survey of 479 grandparent caregivers who had contacted the Grandparent Information Center sponsored by the American Association of Retired Persons (AARP), investigated the reasons for the assumption of caregiving. As in other studies, many grandparents (44 %) reported the child's parent/s to have severe or significant substance abuse problems. If a drug of choice was cited, it was most frequently cocaine, crack or powder (Minkler, 1994; Poe 1992). Other reasons

given were: child abuse, neglect or abandonment (28 %); teenage pregnancy or parent unable to handle the children (11 %); death of the parent (5 %); parental divorce (4 %); or other reasons, including incarceration and HIV/AIDS (4 %). Of the grandparents surveyed, 71 % believed their role as primary caregivers would be permanent.

Different reasons for assuming care may be related to different family structures. For example, Musil (2000) reported primary caregivers often assumed caregiving following parental drug abuse or health problems or child neglect or abandonment. In contrast, grandparents providing partial caregiving were more likely to have become involved in caregiving due to the work or school schedules of parents, the young age of parents, or simply because the family lived together. Further, Goodman and Silverstein (2002) found grandmothers in skipped generation households most often assumed care due to a parent's drug use, mental or emotional problems, child abuse and/or neglect, to avoid foster care, a parent's legal difficulties, physical illness, or the grandchild's medical problems. In contrast, co-parenting grandmothers assumed care more often to assist parents financially, working parents, or as a result of parents divorcing. Reasons that appeared equally prevalent in both structures of grandparent-headed households included assisting teenage parents, parents attending school, unmarried parents, assisting the grandchild attend school in a better district, avoiding day care, and giving the grandparent "something to do" (Goodman & Silverstein, 2002).

From a contextual perspective, the circumstances that lead to grandparents becoming caregivers would also be influenced by historical and current societal factors. For example, Minkler and Roe (1993) have described how the spread of crack cocaine abuse in the 1980s led to an increase in African American grandmothers raising their

grandchildren. Similarly, increasing divorce rates, teenage pregnancies, the rise in single-parent families, the HIV / AIDS epidemic, and substantial increases in female incarcerations have played a role in grandparents assuming responsibility for their grandchildren (Burnett, 1997; Burton, 1992; Fuller-Thomson & Minkler, 2000a; Joslin, 2000; Joslin & Harrison, 1998; Roe & Minkler, 1998/1999). Further, increases in grandparent caregiving have been partly attributed to changes in federal and state laws and policies that promote formal kinship care (Roe & Minkler, 1998/1999). Thomas et al. (2000) have suggested cultural norms and the availability of peer models and support may also influence grandparents' willingness and ability to become primary caregivers for their grandchildren.

Whatever the reasons for the assumption of caregiving, the new living arrangements tend to arise out of stressful circumstances, which may create adjustment difficulties for both grandparents and grandchildren (Edwards, 1998). Edwards has described a type of reciprocal determinism which takes place in which the grandparents' adjustment difficulties negatively affect the grandchild and the grandchild's adjustment difficulties negatively affect the grandparents. However, grandparents' responses to the precipitating events surrounding the assumption of care generally originate from positions of strength and the desire to help their vulnerable grandchildren (Conway & Stricker, 2003).

Ethnic Differences and Cultural Diversity in Grandparent-Headed Households

Cultural variation in traditions, values, ideals and norms can make a difference in assuming custodial and co-parenting roles (Goodman & Silverstein, 2002), as well as

affect the experiences of grandparents (Pruchno & McKenney, 2002). Cultural factors may provide protection from some of the stresses inherent in grandparent-headed households, perhaps influencing the resources and support they may have at their disposal from within the community, helping the family to adapt to change to a greater or lesser extent.

Grandparent-headed families from different ethnic groups are likely to have varied expectations, traditions and experiences (Dolbin-MacNab & Targ, 2003). While Caucasian American culture emphasizes individuality and democracy, African-American and Hispanic cultures place much more emphasis on the family and are more accepting of extended family models. Few studies have looked at differences between grandparent caregivers of different ethnicities. Pruchno and McKenney (2002) reported the caregiving role has greater centrality for African American grandmothers than Caucasian grandmothers. They also noted caregiving burden and negative affect are greater for Caucasian grandmothers than African American grandmothers. In considering the well-being of an ethnically diverse sample of 149 Californian grandmother caregivers, Goodman and Silverstein (2001) reported the African-American grandmothers demonstrated greater life satisfaction and lower negative affect than either Hispanic or Caucasian grandmothers. Together, these two studies suggest grandparent caregiving may be a less stressful role and more of a normative event for African-American grandmothers.

Caucasian Families

It is difficult to generalize specific traditions and experiences of Caucasian

American families who have originated from a wide variety of countries. Since approximately one-fourth of all Americans have ancestors descended from English colonists (McGill & Pearce, 1996), it may thus be helpful to look towards what is known about Anglo American families to see how culture may influence many Caucasian families. Anglo Americans are most distinguished by an emphasis on individualism and independence, tending not to view their family of origin as a resource when it comes to child-rearing, a style leading to isolation from the support and guidance of extended family (McGill & Pearce, 1996). In interviews with Jewish and Polish American grandparents, Cherlin and Furstenberg (1986) noted strong themes of sensitive boundaries and norms of non-interference, especially with regard to how their adult children were raising their grandchildren. Cherlin and Furstenberg also described Caucasian grandmothers as being less likely to discipline and correct their grandchildren than African-American grandmothers. All of these values, norms, and expectations may mean that when Caucasian grandparents do become responsible for their grandchildren, it is viewed as more of a non-normative event and, thus, may be a more stressful experience than for cultures with greater family interdependence.

Hispanic Families

According to Garcia-Preto, many Hispanic families struggle with poverty. Hispanic grandparent-headed households are no exception to this issue, as evidenced by research by Burnette (1999a) and Goodman and Silverstein (2002). Hispanic families tend to have lower education, recent immigrants, acculturation and language gaps that make it difficult for them to access resources for their families (Cox, Brooks, &

Valcarcel, 2000; Goodman & Silverstein, 2002). Cox et al. (2000) have described frequent concerns with respect to immigration status has compounded the stresses faced by Hispanic grandparent caregivers. In particular, they may be reluctant to seek welfare resources in the event this may jeopardize their immigration status in the United States.

Hispanic culture has a strong base in familism, or *familismo*, a family interdependence whereby the needs of the family and group are emphasized over those of the individual (Cox et al., 2000; Falicov, 1996; Garcia-Preto, 1996). Familism involves, among other areas, a sharing by extended family members of the nurturing and disciplining of children. The tradition of family unity and close family ties (Falicov, 1996) may explain some of the dedication Hispanic grandparents bring to their caregiving relationships with grandchildren. There is a deep sense of family commitment, responsibility and obligation in the Hispanic culture, with the family guaranteeing protection and caretaking for life (Garcia-Preto, 1996). The family can be extended to godparents (*compadres*) in addition to those related by blood and marriage. In times of crisis, the practice *hijos de crianza* involves transferring children from one nuclear family to another within the extended system (Garcia-Preto, 1996). It is, thus, likely to be viewed as a more normative event when Hispanic grandparents are called upon to assume responsibility for raising their grandchildren. Co-parenting appears to be more normative for Latino families in that co-parenting in comparison to skipped generation caregiving has been related to higher well-being among Hispanic grandmother caregivers (Goodman & Silverstein, 2002; Goodman & Silverstein, 2005).

The orientation toward familism may mitigate some of the stresses of raising a grandchild (Toledo, Hayslip, Emick, Toledo, & Henderson, 2000). Toledo et al. (2000) reported poorer mental health (evidenced by higher depression scores), more parental and financial stress, less satisfaction in grandparenting, lower incomes, less formal support and lower self-esteem in a sample of native born Mexican grandparent caregivers relative to a U.S. group of grandparent caregivers. Despite these difficulties, the Mexican grandparents demonstrated enhanced grandparental meaning over the comparison group, suggesting that perhaps the Mexican grandparents subjugated some of their individual needs to those of the family unit (Toledo et al., 2000). From a more qualitative perspective, Hayslip, Baird, Toledo, Toledo and Emick (2006) examined the same sample data collected in the Toledo et al. (2000) study, highlighting the role of familism and the cultural differences in the perception of the centrality of the family. The Mexican and American samples could be differentiated by themes of separateness and boundary-bound roles. American grandparents, whether custodial or traditional, emphasized the separateness and autonomy of the parent and grandparent roles. Mexican grandparents appeared to have a greater sense of family involvement and continuity, with many grandmothers expressing that caring for their grandchildren added a greater sense of purpose and meaning to their lives. While the American custodial grandparents expressed issues of loss associated with the grandparent role and emphasized the negative impact of caregiving, the Mexican custodial grandparents valued the salience of their role, welcomed the opportunity to parent again, and looked forward to the joys they had yet to experience with their grandchildren.

The level of cultural assimilation will impact how grandparent caregivers will perceive and enact their re-parenting role (Dolbin-MacNab & Targ, 2003). Goodman and Silverstein (2005) examined the relation of acculturation (as measured by language preference for Spanish) and family factors to the well-being of 357 Latina grandmother caregivers. Well-being in this study was measured by the Positive and Negative Affect Scale (PANAS) (Watson, Clark, & Tellegen, 1988) and the Satisfaction with Life Scale (Diener, Emmons, Larsen, & Griffin, 1985). Goodman and Silverstein found evidence for a multidimensional view of well-being. Spanish-preferred (that is, assumed to be the less acculturated) grandmothers had lower positive affect but higher life satisfaction and lower negative affect than the English-preferred grandmothers. Co-parenting with a co-resident parent was related to higher well-being for the Latina grandmothers. An increase in the grandchild's behavior problems, as measured by the Behavior Rating Index for Children (BRIC) (Stiffman, Orme, Evans, Feldman, & Keeney, 1984), was also associated with increased negative affect among grandmothers.

Burnette (1999a) collected data on 74 urban Latino custodial grandparents, measuring depression using the Geriatric Depression Scale (GDS). Females comprised 93% of the sample, while 81% of the sample was at or below the poverty level. Most (70% of the sample) reported their health status as fair or poor. Higher GDS scores were associated with younger age, poorer health, greater life stress, lower levels of informal support, rearing children with special needs and having unmet service needs. Using the same sample of Latino custodial grandparents, Burnette (1999b) measured formal health and social services, such as child nutrition services or aging health care services used during the preceding year. While grandparents reported an average use

of 6 services each, 80 % still reported unmet needs. Lack of knowledge emerged as the major barrier to service use, with other obstacles being ineligibility, unaffordability, and language and cultural barriers. As the above studies demonstrate, Hispanic grandparent caregivers may be fulfilling some cultural values and expectations, yet still struggle with issues like poverty, well-being, and acculturation.

African American Families

As noted above, African-American grandparents are much more likely to assume a primary caregiving role than Hispanic or Caucasian grandparents. Sociohistorical influences may partially explain the disproportionate number of African American grandparent-headed households (Crowther & Rodriguez, 2003; Fuller-Thomson & Minkler, 2000c), whereby older family members step in to care for children whose parents are unable to do so (Brown & Mars, 2000). African-American families appear to value intergenerational ties and surrogate parenting is considered to be an important tradition (Brown & Mars, 2000).

Even when not directly responsible for raising grandchildren, African-American grandparents appear to be prepared to be involved with parenting their grandchildren, as the next study suggests. From a sample of 542 African-American grandmothers in Chicago with varying degrees of responsibility for raising their grandchildren, Lee, Emsinger and La Veist (2005) reported that of the 396 grandmothers were not currently living with their grandchildren, over half were still moderately or highly involved in rearing their grandchildren. Similarly, Watson, Randolph and Lyons (2005) reported that in a recent study of 105 African-American grandmothers, over 80 % of whom were not

their grandchildren's' primary caregivers, 100 % of the grandmothers said they would correct their grandchildren if they saw them misbehaving. These studies, in addition to the findings of Gibson (2005; see below) highlight the importance of education as a traditional African-American value.

While surrogate parenting may be more of a normative event for African American families, grandparent caregivers may still struggle with their responsibilities. Brown and Mars (2000) suggest the circumstances of grandparent caregiving in African-American families is likely to differ to White grandparent caregivers, due to both cultural and sociodemographic circumstances. They interviewed 140 African-American grandparent caregivers. Most were female (93.5 %) single householders, with an age range of 38 to 80. Many were assuming care for the children of other kin and non-kin, in addition to their own grandchildren, highlighting the importance of kinship bonds for African-American families. Overall, religious involvement was an important source of social support for the grandparents, and most caregivers appeared to have a substantial network of social resources for assistance. The most frequently mentioned concerns were about their own health. Inadequate financial resources were an additional source of stress for the families (Brown & Mars, 2000). Further, a focus group study by Baird, John and Hayslip (2000) of 21 African-American grandparent caregivers from the Dallas / Fort Worth area in Texas revealed these families were frequently in flux, with children, grandchildren and great grandchildren being incorporated as part of the households when necessary.

According to Lee, Bowles and Darlington (1998), since many African American women become mothers and then grandmothers at an early age, they may experience

additional stress in that they may not have completed their own developmental tasks, resulting in role strain and confusion. As an additional stressor, if a minor child has a child, the grandmother may be confronted with a dual role, possibly complicated by role confusion if the grandchild is abandoned into the care of the grandmother.

Strengths of African-American grandparent caregivers have been studied qualitatively by Gibson (2005). She reports the strengths of the parenting styles in a convenience sample of 17 grandmother caregivers include: maintaining effective communication; taking a strong role in the education of their grandchildren; providing socioemotional support, including encouragement and one-on-one attention for grandchildren; involving extended family for additional support; involving grandchildren in carefully selected community activities; acknowledging the absence of the biological parents; and working with the vulnerabilities of grandchildren, such as teaching them to stay away from drugs and violence (Gibson, 2005).

Other Ethnicities

While there have been studies that include Caucasian (non-Hispanic), Hispanic and African American grandparents, there appears to be very little research that addresses other ethnicities. More recently, Fuller-Thomson and Minkler (2005) have considered the profile of American Indian / Alaskan Native grandparent caregivers based on data from the American Community Survey / Census 2000 Supplementary Survey (C2SS). Of the respondents, 31 % lived on Indian reservations, and slightly more than half lived in skipped generation households with neither of the child's parents present. Almost one half of the grandparents had been raising their grandchildren for 5

years or longer. They were 3 times more likely than their non-caregiving peers to live in overcrowded housing and twice as likely as their peers to be living in poverty, with more than a third of grandparent caregivers living below the poverty line. Only one quarter of the American Indian / Alaskan Native grandparent caregivers who were living in poverty were receiving public assistance or other services for which they were eligible. There is little information on how these grandparents cope on such limited incomes (Fuller-Thomson & Minkler, 2005).

Fuller-Thomson (2006) also analyzed the 1996 Canadian Census figures with a specific focus on Native Canadian / First Nations grandparent caregivers. As for the Native Americans in the above study, she concluded this group is considerably disadvantaged when compared to other grandparents, including being more likely to be economically disadvantaged, have a disability, be single, spend more time in caregiving with more grandchildren, and to have less education and limited opportunities in the work force.

Age

According to Census 2000 figures, over 1.7 million co-resident grandparents responsible for their grandchildren were younger than 60, compared to 700,000 aged 60 and over (U.S. Census Bureau, 2003). This age distribution of grandparent caregivers was somewhat younger than that of co-resident grandparents not responsible for grandchildren. While it seems most grandparent caregivers tend to be in their mid to late fifties, they do span a wide age range, and some may be in the caregiving role for several years (Burnette, 1999a; U.S. Census Bureau, 2003). Some of the above

discussion on ethnic differences between grandparent caregivers is interwoven with age-related factors. Goodman (2006), for example, reported that in a sample of over a thousand African-American, Caucasian and Hispanic grandmother caregivers, the proportion of Caucasian grandmothers increased with age, whereas the proportions of both Hispanic and African-American grandmothers decreased with age.

In general, one might expect that as the incidence of chronic health conditions and disabilities increases with age, the stresses associated with the caregiving role may aggravate health concerns. A review of the physical health of grandparent caregivers by Marx and Solomon (2000) supports this view. They reported that generally, as one might expect, self-ratings of physical health as fair to poor increase with age. Goodman (2006) found the functional health of a large heterogeneous sample of both skipped generation and co-parenting grandmother caregivers tended to decrease with increasing age.

Age may also prove to be an important influence for psychological well-being if grandparenthood and re-parenting occurs at an early age. For example, Lee et al. (1998) describe how young grandmotherhood in particular may represent a crisis period. It can result in grief at the loss of freedom, denial (feeling too young to be a grandparent), anger at daughters for prematurely making them grandparents, and sadness and depression at having their dreams and goals disrupted. Burnette (1999a) identified younger age as a correlate of higher depression in a study of 74 urban Latino custodial grandparents, and suggested younger grandparents may have more multiple and competing role demands, such as employment and caring for their own children still at home.

These findings of poorer psychological well-being in younger grandparent caregivers appear to be supported by the findings of Goodman (2006), who reported an increase in life satisfaction with increased age. When she controlled for the losses associated with age (lower income, disabilities, not having a spouse), Goodman found lower negative affect, which she interpreted as a gain in well-being, with increasing age. It is, however, difficult to disentangle age effects from cohort differences and selective mortality from this study (Goodman, 2006), as it would be for similar cross-sectional studies. From three independent samples of grandparent caregivers, Hayslip, Shore, and Emick (2006) found that, despite anticipated age-related declines in health, older age was associated with more positive role meaning, greater personal well-being, less parental stress, a more adaptive stance towards a grandchild's disruptive behavior, and more positive feelings towards the grandchild.

Overall, the research therefore seems to indicate a relationship of age to the psychological well-being of grandparent caregivers (that is, older grandparents tend to experience better psychological health) which appears to be quite different to that of the relationship of physical and functional health to age. Little can probably be concluded about old-old grandparent caregivers, however, as many may have simply given up caregiving as a result of their advanced age and declining health (Goodman, 2006). Older grandparents might be concerned about their ability to care for their grandchildren as they age and their health deteriorates (Kolomer, McCallion & Overeynder, 2003; Roe, Minkler, & Saunders, 1995; Shore & Hayslip, 1994).

In addition to the above, the age of the grandchild is likely to be a factor in the adjustment of grandparent-headed households. While there is little direct research on

this factor, Sawyer and Dubowitz (1994) found, from a large inner-city sample of children in kinship care, that those who entered kinship care as adolescents did better on math and reading tests than the children who had entered kinship care before first grade. This suggests that the age at which a grandchild enters into the care of a grandparent may affect subsequent adjustment, at least in terms of educational outcomes, for the grandchild. One might reasonably expect that a child that joins the grandparent-headed households at birth may experience fewer adjustment difficulties than, for example, an older child who may have to move homes and schools, in addition to experiencing the loss of a parent caregiver. From the grandparent's perspective, however, an infant requiring intensive round the clock care may be more demanding and taxing to care for than a school-aged child who is out of the house for a good deal of the day. While Hayslip and Kaminski (2006) have suggested that the relative age of both a grandparent and grandchild is likely to affect the caregiving relationship (and thus the grandchild's subsequent development), there is simply a lack of research which has explored these relationships or focused on the developmental concerns of custodial grandchildren.

Gender

Gender, specifically being female, has been identified as a risk factor for the health of caregivers (Burnette, 1999a), yet this is probably because most grandparent caregivers tend to be women. Many grandparent caregiver studies focus exclusively on grandmothers, or their samples consist primarily of women (for example, Caputo, 2001; Fuller-Thomson & Minkler, 2000a; Goodman & Silverstein, 2002; Musil & Ahmad, 2002;

Pruchno & McKenney, 2002). As a result, little is known about grandfathers as caregivers.

Greenberger and O'Neil (1990) report role strain, depression and ill health can become more prevalent in men who view their children's behavior as problematic. It is not known at this point if a similar gender effect applies to grandfather caregivers.

Bullock (2005) conducted qualitative research with a sample of 26 grandfather caregivers from rural North Carolina and identified a common theme of powerlessness among most of the men (81 %), particularly with respect to coping with the activities of daily parenting. In addition, 60 % claimed their health had declined since they assumed their caregiving responsibilities. The respondents who did not report feelings of powerlessness had better self-reported physical health than those who experienced powerlessness. It, thus, appears that, like grandmother caregivers, these grandfathers also experience caregiver stress.

Szinovacz, DeViney and Atkinson's (1999) analysis of the effect of grandparent caregiving on caregiver's wellbeing showed that when grandchildren move into the household, both grandmothers and grandfathers experience less life satisfaction, as measured by a single item, "Taking all things together, how would you say things are these days?" (Rating from 1=very unhappy to 7=very happy). Grandmothers, however, experienced significant increases in symptoms of depression, as measured by the CES-D (Radloff, 1977), which did not decline when grandchildren moved out. On the other hand, grandfathers did not experience significant increases in depression when grandchildren moved in, but did experience increases in their depressive symptoms when the grandchildren moved out. Szinovacz et al. also noted when grandchildren

move in, there are significant increases in bar/tavern visits among grandfathers, and significant increases in perceived instrumental support from friends and relatives for grandmothers. The experiences of the different grandparent genders, thus, seem to differ to some extent.

Kolomer and McCallion (2005) and McCallion and Kolomer (2006) report, using the same data of a matched a sample of 33 grandfather caregivers and 33 grandmother caregivers, a significant difference between the genders on CES-D scores. While grandmothers' mean scores were above the cutoff score for depression, suggesting high levels of symptoms of depression, the grandfathers' mean scores were below the traditional cutoff score for depression. Despite this, grandfathers still demonstrated some difficulty with their caregiving role as they were somewhat less likely than grandmothers to feel in control over their caregiving situation, as measured by an adapted version of the Caregiving Mastery Scale (CMS; Pearlin & Schooler, 1978), relating to expectations about one's ability to influence events in life (McCallion & Kolomer, 2006). Until more studies include a greater number of grandfather caregivers, the potential role of grandparent gender will remain relatively unexplored.

Gender also appears to play a role in the perceptions grandchildren have of their grandparents' parental salience. In a study of the perceptions of 181 adolescents and young adults of their grandparents, Hayslip, Shore and Henderson (2000) reported female grandchildren attributed more parental salience to their grandmothers, while male grandchildren saw grandmothers and grandfathers as equally involved in their upbringing. Overall, the findings suggest grandfathers are less likely to be perceived as salient in their grandchildren's lives. Future studies of the experience of grandparent-

headed households clearly need to include more grandfathers to further explore the influence of gender.

Income

Poverty is both an antecedent and consequence for grandparent-headed households. There appears to be substantial evidence to suggest the well-being of children may be more profoundly influenced by socioeconomic resources than family structure (Demo, 1992; Sun, 2003), making economic and financial issues important considerations for grandparent caregivers. Poverty can be a particular concern for grandparent caregivers (Bryson & Casper, 1999; Roe & Minkler, 1998/1999; Scarcella, Ehrle, & Geen, 2003), especially minority grandparents (Goodman & Silverstein, 2002), and caregiving grandparents are more likely than their non-caregiver peers to report incomes below the poverty line (Fuller-Thomson & Minkler, 2000b). In the U.S. in 1999, on average, 19 % of grandparent caregivers had incomes below the poverty level, with a higher proportion (21 %) of grandparent caregivers in the South living in poverty (U.S. Census Bureau, 2003). These Census Bureau figures were as high as 30 % for Louisiana and Mississippi.

There appears to be a decrease in income for grandparents assuming a caregiving role, in addition to the likelihood of increased expenses related to caring for a grandchild (Crowther & Rodriguez, 2003; Pruchno & McKenney, 2006). More than a third of a sample interviewed by Silverstein and Vehvilainen (2000) agreed that they “worried about making ends meet” (pp.273). Retired grandparent caregivers may have to spend their life savings or make financial sacrifices, while younger grandparents may

have to quit a job, cut back on hours, or make job-related sacrifices that risk their future economic security (Roe & Minkler, 1998/1999). Many custodial grandparents continue to work, however, either out of necessity or because they have not yet reached retirement age, resulting in schedule overloads (King, Hayslip & Kaminski, 2006) that, in turn, could exacerbate other difficulties, such as minimizing time for self-care or engaging in socially supportive activities. In a survey of 479 grandparent caregivers, Woodworth (1996) reported 46 % were on a fixed income, 42 % were working, and 12 % were on a fixed income but also working (some out of necessity in order to make ends meet).

In a telephone survey of 506 grandmothers who were primary caregivers to grandchildren in households not including either the grandchild's mother or father, Pruchno and McKenney (2006) found support for the assertion that grandparent caregiving may have undesirable economic consequences. Almost three-quarters of the grandmothers in the study reported both working and providing care to a dependent grandchild. The annual personal income of grandmothers raising grandchildren who quit their jobs in order to assist their grandchild was less than that of grandmothers who did not quit their job for this reason. There was also support for the following relationships: a) grandmothers who were divorced were more likely to miss work for reasons associated with caregiving than grandmothers who were not; b) grandmothers with higher education levels were more likely to miss work for caregiving reasons; c) grandmothers with higher education levels were likely to be working more hours; d) grandmothers with higher education were more likely to have to quit their jobs in order to take care of their grandchild (Pruchno & McKenney, 2006).

The ramifications of an inadequate income or living in poverty are serious. For one, access to adequate and affordable housing is a concern for many grandparent caregivers and particularly problematic for those who rent their housing and live below the poverty line (Fuller-Thomson & Minkler, 2003). Using data from the Census 2000 Supplemental Survey, Fuller-Thomson and Minkler estimate that of the 2,350,000 grandparent caregivers in the U.S., 26 % live in rented housing and a third of these households spend 30 % or more of their income on rent. More than a quarter of grandparent caregiver renters were living in overcrowded conditions. Fuller-Thomson and Minkler expressed particular concern about these monthly costs, as grandparent caregivers are usually faced with many other expenses related to the needs of the children in their care.

Woodworth (1996) reported the most likely sources of financial assistance for grandparent-headed families who had contacted the Grandparent Information Center of the AARP in 1994 were state agency programs such as child welfare, foster care, Aid to Families with Dependent Children (AFDC) and Medicaid, although 64 % of the grandparents surveyed reported no involvement with any state agency. Despite being eligible for many welfare benefits and services, it would seem few children in grandparent-headed households receive them (Cox, 2003; Mullen, 2000). Grandparent caregivers also face increased expenses for healthcare for both themselves and their grandchildren. They may have difficulty accessing medical care for their grandchildren or listing the grandchild as a dependent on their medical insurance (Crowther & Rodriguez, 2003; Woodworth, 1996). A grandchild younger than 6 will become eligible for Medicaid if the family income is below 133 % of the federal poverty level, and those

aged 6 through 18 with family incomes under 100 % of the poverty level (Mullen, 2000). Bryson and Casper (1999) noted 1 in 3 children in the care of their grandparents lack access to health insurance, compared to 1 in 7 of their peers from the general population.

Mullen (2000) has noted welfare reform, in the form of the Personal Responsibility and Work Opportunities Act of 1996 (PRA), has made it difficult for grandparents to obtain public benefits for their grandchildren. For example, to obtain Temporary Assistance for Needy Families (TANF), the grandparent has to, amongst other requirements, prove he or she is a caretaker relative, which can be difficult for a paternal grandparent if the father's name does not appear on the grandchild's birth certificate. There is also a lifetime limit whereby TANF cannot be used to provide assistance to a family including an adult who has received TANF assistance for 60 months. Grandparent-headed households are excluded from this time limit only if the grandparent applies for "child-only" benefits, which can significantly lower the cash assistance amount. Grandparents may also be required to engage in a job search prior to gaining approval for TANF benefits. Mullen predicts the time-limit on TANF may even become a factor in encouraging more parents to turn over custody of their children to grandparents. In other areas of benefits, the PRA has established a stricter definition of disability for children, making it more difficult for grandchildren with psychological disorders to obtain benefits. Welfare reform has also made most illegal aliens ineligible for public benefits (Mullen, 2000).

Family Structure

Differences in the family structure of grandparent-headed households may well be related to the outcomes for grandparents and their grandchildren. Three (or more) generation families, where grandparents are co-parenting, are likely to have special needs that differ from skipped generation families. Stresses for co-parenting families could include role conflicts over the extent of shared parenting, in addition to conflict over child-rearing and parenting techniques themselves. Jendrek (1994) suggested that since the supplemental caregiver's role is less defined, these grandparents may experience stress related to their role ambivalence.

Lee, Ensminger, and LaVeist (2005) reported on the demographic characteristics of a sample of 542 African-American grandmothers heading different family structures - skipped generation, three generation (with various levels of parenting responsibility) and not co-residing with grandchildren. They reported finding much heterogeneity within the different household structures. The grandmothers of three generation households were more likely to be living below the poverty line and also reported the highest rates for welfare and food stamp receipt. The household size differed significantly by grandmother type, with the three generation, high-parenting responsibility families reporting the highest mean number of household members (5.55) and the never primary caregiver grandparent households reporting the lowest mean number of household members (1.96). There was also a significant difference in the ages of co-resident grandchildren by family type, with grandparents in three generation households caring for children about 3 years younger than children in skipped generation households, who were more likely to be raising teenagers. Lee et al. also measured grandparents' reports

of stressful life events, such as serious illness, work difficulties, legal difficulties, substance abuse problems, death of parents and domestic violence. Grandmothers with higher levels of parenting responsibilities in the co-parenting households reported the highest average stressful event scores, while those grandmothers not co-residing and who had never had primary caregiving responsibility for grandchildren had the lowest rates of stressful life events (Lee et al., 2005). This study is one of many (for example, Goodman & Silverstein, 2002; Musil & Standing, 2005) which demonstrate the complexities and differences between the different structures of grandparent-headed households. It also suggests co-parenting may be more stressful for grandparents than those in skipped generation families, supporting Jendrek's (1994) work.

A somewhat different conclusion was reached by the following study. Musil and Standing (2005) researched differences between different family structures with a sample of grandmothers of varying caregiver status to grandchildren in their household. Data was coded from the 3-week diaries completed by 64 grandmothers who were either skipped generation caregivers to their grandchildren, were part of an intergenerational family and co-parenting with the grandchild's parents, or were non-caregiving grandmothers and living in a separate residence from their grandchildren. Both skipped generation caregiver grandmothers and co-parenting grandmothers reported more stresses related to their grandchildren's routines, transporting grandchildren, attending activities, and school progress. Skipped generation caregivers reported more time pressure, stress from financial issues, and difficult interactions with their grandchildren, while the co-parenting grandmothers identified stress from living with their adult children, such as disagreements over childrearing. Grandmothers who

did not provide care for their grandchildren reported more involvement with social contacts outside the family. Overall, more skipped generation caregiving grandmothers reported stress from general child care activities than the co-parenting or non-caregiver grandmothers.

Using a large (n=1,058) ethnically diverse Californian sample, Goodman and Silverstein (2002) considered the differences in well-being between grandmothers raising grandchildren in skipped generation and co-parenting households. Overall demographic findings were that the skipped generation grandmothers included a smaller proportion of married grandmothers, a higher educational level, lower annual family income, and higher per capita yearly income compared to co-parenting grandmothers. Grandchildren in the skipped generation families tended to be older, more likely to be supervised by child welfare agencies, and had greater reported behavioral problems than children in co-parenting households. Conflict between grandmother and a focal grandchild was higher in skipped generation households than co-parenting households across all ethnic groups. There were no differences between skipped generation and co-parenting households in terms of closeness between grandmother and the focal grandchild (Goodman & Silverstein, 2002).

A strength of Goodman and Silverstein's (2002) study was that the analyses were also conducted within the three ethnic groups, statistically controlling for demographic factors, reasons for assuming care, and stressful parent conditions, demonstrating the impact of the household structure itself on the various adaptations of the different cultural groups. African-American grandmothers showed no differences in well-being as a result of household structure until the stressful parental conditions and

reasons for assuming care were controlled. Following this, the African-American grandmothers in skipped generation households showed less negative affect, more positive affect, and better mental health than those in co-parenting families. Goodman and Silverstein suggested this indicated a greater acceptance of their surrogate role according to historical precedent. Initially, the Hispanic co-parenting grandmothers demonstrated greater well-being than their skipped generation peers. Without the stresses of the parent's problems, however, the Hispanic grandmothers of each household structure fared equally well. Within the Caucasian group, the skipped generation grandmothers reported higher levels of both positive and negative affect, which Goodman and Silverstein suggested may be indicative of an emotionally charged situation. With the statistical controls for parent's problems, the well-being of Caucasian grandmothers in the two family structures was roughly equal. In addition to the influence of family structure, Goodman and Silverstein's study underscores the importance of the role the adult child / parent plays in the well-being of the grandparent-headed household.

Intergenerational Relationships

As has been seen, while the nature of the structure of grandparent-headed families can be complex, it is also likely to be closely linked to the nature of the intergenerational relationships within the families. Dolbin-MacNab and Targ (2003) recommend that in order to understand the functioning of a grandparent-headed household, it is useful to consider the boundaries, interaction patterns and subsystems within the family. For example, families with rigid boundaries may experience more

difficulty in adjusting to stressors and life changes, whereas diffuse boundaries can be chaotic if there is insufficient generational hierarchy in the family. Healthier family functioning may be the result of having a firm and powerful grandparent subsystem at the helm of the family (Bartram, 1996; Dolbin-MacNab & Targ, 2003).

Goodman (2003) and Goodman and Silverstein (1997, 2001) have conducted much research into the area of intergenerational relationships with grandparent caregivers. First, Goodman and Silverstein (1997) studied intergenerational triads of grandparent caregiver families and reported that while close grandparent-grandchild and grandparent-parent relationships were beneficial to the caregivers, a close grandchild-parent relationship was more likely to increase grandparent-parent competition. Goodman (2003) then demonstrated patterns of family relationships based on closeness are related to the well-being of grandmother caregivers. She studied the intergenerational triads, or the affective bonds, between grandmother, parent and grandchild in an attempt to capture the complex alliances and coalitions that may exist in grandparent-headed families. For the study, a sample of ethnically diverse grandmothers from Los Angeles, CA, were surveyed, which included 512 skipped generation grandmothers and 475 co-parenting grandmothers. Goodman measured the well-being of the grandmothers using the CES-D (Radloff, 1977) and Satisfaction with Life Scale (Diener et al., 1985). To measure intergenerational closeness, she used the five-item Bengtson Scale of Intergenerational Solidarity (Mangen, Bengtson, & Landry, 1988), where the grandmother rated her relationships with the focal grandchild and parent as well as the relationship between the parent and the target grandchild. Overall, Goodman reported it is more depressing for grandmothers when one member of the

intergenerational triad is emotionally isolated than when one has a linking relationship. Triads wherein the parent is emotionally isolated results in poorer grandmother well-being in both skipped and co-parenting households. Goodman suggests emotional bonds with the parent are more salient and powerful than the physical proximity and interaction opportunities that distinguish the skipped generation and co-parenting households.

As was noted earlier, the reason for the grandparents' assumption of care of the grandchild is often due to the dysfunction of the middle generation, the child's parent (e.g. Goodman & Silverstein, 2002). This may have either been a result of, or possibly led up to, a difficult family context. Conway and Stricker (2003) emphasize one should not ignore the role played by the birth parent in considering the grandparent caregiving situation. The contributions of the birth parents, even merely their absence from the relationship, will greatly impact the grandparent-grandchild dyad (Conway & Stricker, 2003). They may or may not be isolated from the child, in poor physical or emotional health, incarcerated, abusing drugs or alcohol. Reappearances by the birth parent can be disruptive to caregiving for the grandchild (Kolomer et al., 2003). Goodman and Silverstein's (2002) study supported these views that the problems of the adult child / parent are a major source of relationship stress, since when they controlled statistically for parental stresses in their study of Californian custodial grandmothers there was an improvement in indicators of the grandmothers' well-being.

From the grandchild's perspective, Keller and Stricker (2003) explored the role of the caregiving relationship in the psychological adaptation of 60 preadolescent and adolescent children in kinship care, where the majority of caregivers were grandparents

and minorities. Most of the children had been in kinship care for several years (a mean of 9.8 years and a range of 4 to 15 years) and over half of the sample had little or no contact with the biological mother. Their hypothesis was perceptions of a supportive relationship with kinship caregivers would have a compensatory effect for earlier negative relationships. Based on the results of the Relatedness Questionnaire (Wellborn & Connell, 1987), Keller and Stricker reported more than 75 % of their sample reported non-optimal relationships with their mothers, while 50 % reported non-optimal relationships with kinship caregivers. The children who reported a non-optimal relationship with their mothers were more likely to report non-optimal relationships with their kinship caregivers. Children who reported optimal-adequate relationships, with either mothers or kin caregivers, were less likely (than children reporting non-optimal relationships) to experience emotional or behavioral difficulties, as measured by the Adolescent Depressive Experiences Questionnaire (DEQ-A; Blatt, Schaffer, Bers, & Quinlan, 1990), the Children's Depression Inventory (CDI; Kovacs, 1983), and the Self-Perception Profile for Children (SPPC; Harter, 1985). The greater the number of non-optimal relationships, the more likely a child was to report emotional or behavioral difficulties. The relationship with the kinship caregiver was more likely to predict depressive symptoms, low social acceptance and low self worth. The relationship with the mother predicted more behavioral conduct and school performance. Keller and Stricker (2003) concluded the relationship between grandparent caregivers and their grandchildren can indeed facilitate adaptation for the grandchildren and act as a buffer against developmental disturbances and experiences of loss and rejection.

In a further exploration of relationship factors, Hicks Patrick and Pickard (2003) studied 12 grandmother-grandchild dyads, 5 of which were co-residing (although no residence status interaction with any of the variables examined was observed). The dyads participated in a variety of interaction tasks (for example, drawing together on a single Etch-a-Sketch® board) which were videotaped and coded. The findings included a wide variation in levels of behavior displayed within the dyads. The grandchildren exhibited significantly more control behaviors (such as making critical or negative statements to the dyad partner or taking physical control of the materials), while grandmothers demonstrated a trend towards more guidance and affiliation behaviors. Higher levels of grandmother control were associated with better quality of task performance. The observation of two grandmothers with multiple grandchildren suggested grandmothers may be highly flexible when collaborating with different grandchildren. Hicks Patrick and Pickard (2003) concluded affectionate guidance might be a useful approach for grandparents to build a warm environment when faced with re-parenting and moderate levels of control by the grandparent may be useful in order to improve a child's performance.

Attachment theory has been proposed as providing a useful perspective in understanding the complex processes which take place in grandparent-headed households (Poehlmann, 2003). Attachment theory postulates early family relationships play an important role in the development of internal working models that will, in turn, influence the development of future relationships (Bowlby, 1988). A caregiver who is able to recognize and respond warmly to the emotional needs of a child will be more likely to assist the child in developing a secure internal working model. Those caregivers

unable to respond effectively to a child often have children who are insecurely attached (Brinkmeyer & Eyeberg, 2003). Due to the typical stresses and burdens faced by grandparent caregivers, many may find it difficult to interact with their grandchildren in a consistently empathic manner (see Kaminski & Hayslip, 2004).

Parental empathy has long been considered a crucial element for healthy psychological development and adjustment (Ginott, 1965; Landreth, 1991; Rogers, 1951). Children need attuned and responsive caregivers to feel securely attached, build positive self concepts, and develop affect regulation skills (Kaminski & Hayslip, 2004), yet in a recent comparison of child rearing beliefs of demographically matched groups of traditional parents and grandparent caregivers, Kaminski and Hayslip reported the grandparents were less likely to be aware of and empathically respond to children's emotional needs than traditional parents. Parental empathy is closely related to parenting skills and issues, which, as will be seen below, present several challenges for grandparent caregivers.

Parenting Challenges

Grandparents are often thrust unexpectedly into a re-parenting role for which they may be ill-prepared, leaving them feeling confused and unsure (Cox, 2000). The energy levels and physical demands of raising children, particularly young infants or rebellious teenagers, are taxing for grandparents. If, in addition, the grandparents are in poor health, their ability to effectively fulfill the demands of their role may be impeded (Cox, 2000).

Grandparent caregivers face several challenges in becoming active parents once more. One such unique challenge is having to act in both a parent and grandparent role (Kornhaber, 1996). As the role of the grandparent caregiver becomes closer to resuming a parenting role, the original grandparent-grandchild relationship, which may have been a highly valued role, is sometimes lost (Cox, 2000; Targ & Britnall-Peterson, 2001). Bratton, Ray and Moffit (1998) have suggested that while traditional grandparents are typically free enough of responsibility of their grandchildren to be accepting, fun and supporting, a sense of permissiveness is lost when they move into the role of custodian.

In a study comparing 90 grandmother caregivers with varying levels of responsibility for their grandchildren's care, Musil (2000) reported primary caregiver grandmothers reported significantly greater parenting stress than the partial caregivers. Grandparent caregivers may be dissatisfied with the original child-rearing outcomes that ultimately led them to having to assume care of their grandchild and now hope to improve their parenting (Gatti & Musatti, 1999). Existing parenting classes, however, typically do not fit the needs of grandparents rearing a second family (Woodworth, 1996) and several researchers have called attention to the need for custodial grandparent education (e.g., Chenoweth, 2000; Hayslip, 2003; Silverthorn & Durrant, 2000; Strom & Strom, 1990). Grandparent caregivers themselves have requested direction and information about parenting issues (Kennedy & Keeney, 1987). Grandparent caregivers who have participated in parent training have reported a decrease in negative affect scores related to their grandchild's behavior, in addition to

an increase in parental self-efficacy and the quality of relationship with their grandchild over time (Hayslip, 2003).

While parents themselves are being faced with unprecedented parenting stress related to recent cultural changes (Pipher, 1994), it is likely this may be exacerbated for custodial grandparents. The understanding of several disorders, especially Attention Deficit Hyperactivity Disorder (ADHD), have changed markedly over the past few decades, and it is likely grandparents may have little knowledge of current diagnostic and treatment procedures (Baker, 2000; Hayslip, 2003). Current knowledge of which grandparent caregivers may not be fully aware would include being familiar with STDs, drug use, school violence, or peer influences on their grandchildren (Silverthorne & Durrant, 2000). Since grandparent caregivers may be particularly susceptible to parenting children with disruptive behavior disorders (Baker, 2000; Silverthorn & Durrant, 2000), they are likely to benefit from education and information about such disorders. Further, there may be an intergenerational transmission of disorders, such as ADHD, across generations, and Baker suggests grandparents raising a grandchild with ADHD may incorrectly attribute behavioral problems to family traits, such as laziness or stubbornness.

Parenting for grandparent caregivers can also be complicated by their grandchild's temporary or permanent loss of a parent. The bereaved grandchild is likely to require more emotional resources than usual (Hayslip & Kaminski, 2005). Since grandparents may be mourning some sort of loss related to their adult child themselves, they may, thus, not be in a position to be as emotionally available as they might otherwise be. When an adult child is jailed or experiencing substance abuse problems,

grandparent caregivers may need to deal with their own feelings of sadness, frustration and disappointment (Chenoweth, 2000).

There are potential cohort differences between parents and grandparent caregivers. While few studies have explored these effects, some child rearing attitudes and behaviors of grandparent caregivers have been found to differ from parents, in some aspects being more problematic (Kaminski & Hayslip, 2004). Grandparent caregivers are more likely than parents to emphasize obedience and view a child's differing opinion as a sign of disrespect (Kaminski & Hayslip, 2004). Grandparent caregivers are also less likely to be aware of and respond to a child's psychoemotional needs. Hayslip and Kaminski (2005) have suggested one might explore potential cohort effects in parenting by studying non-caregiving grandparents.

Social Support

The availability of social support has been shown to have an impact on one's physical (e.g., Goode, Haley, Roth, & Ford, 1988; Kahn & Antonucci, 1980; Krause, 2001) and emotional health (e.g., Antonucci, 2001; Stroebe & Stroebe, 1996). The availability of adequate social support (or lack thereof) may, thus, be an important factor in contributing to the success (or difficulties) of grandparent-headed households. The extent of a grandparent's existing support networks could, thus, serve as an antecedent factor in the outcome of the household. Changes in social support are also likely to be one of the consequences of becoming a grandparent caregiver.

Giarrusso, Silverstein, and Feng (2000) found evidence that social support, in the number of confidants one has, buffers the negative effects of stress on grandparent

caregiver's psychological well-being, as measured by a short self-esteem scale. Grandparents who have more confidants appear to be better protected from the negative psychological effects of stress when compared to grandparents with fewer confidants (Giarrusso, Silverstein et al., 2000).

Grandparent caregivers express diverse needs for social support. Results of a recent qualitative survey of the need for formal and informal support among a small sample of 39 custodial grandparents differentiated between two distinct types of grandparent. One type appeared to be typically busy grandparents with adequate emotional supports who mainly required information and referrals that might assist in meeting the demands of everyday living, such as financial assistance or medical care information. The other group of grandparents appeared to be more overwhelmed and isolated, expressing the need for greater emotional support, such as support groups, mentoring, or counseling services (King, Hayslip, & Kaminski, 2006).

An important area of difficulty for grandparent caregivers involves changes in their social supports when they assume caregiving responsibilities. Their additional role, particularly if it is taken on suddenly, is likely to have an impact upon their social relationships and convoys of support. Many grandparent caregivers report feeling isolated (Woodworth, 1996; Kopera-Frye, Wiscott, & Begovic, 2003) and less satisfied with their social lives than before taking in their grandchildren (Fuller-Thomson & Minkler, 2000b; Hayslip et al., 1998). Wohl, Lahner, and Jooste (2003) noted the most prominent themes emerging from a group intervention program with custodial grandparents were difficulties involving relationships with others, relationships with the parents of the grandchildren, and difficulties in the relationships with the grandchildren

themselves. Since the grandparents' peers generally do not have caregiving responsibilities for children, grandparent caregivers commonly perceive themselves as "outcasts" whereby they neither belong with their former friends nor the younger parents of their grandchildren's friends (de Toledo & Edler Brown, 1995; Wohl et al., 2003). Grandparents report losing friends when they take on the caregiving role, mostly because the active parent role is no longer relevant to their friends' lives. In addition, finding support and friendship among active parents may be difficult if the age difference between grandparent caregivers and traditional parents creates barriers to relationships (Wohl et al., 2003; Woodworth, 1996). This puts grandparent caregivers at risk for social isolation (Cox, 2000).

Some grandparent caregivers report feeling alienated from social networks such as churches and other mediating structures that had previously acted as sources of support (Fuller-Thomson & Minkler, 2000a; Minkler & Roe, 1993). Family relationships also tend to change, which is likely to impact the grandparent's source of support. An adult child may have become an adversary. Caliandro and Hughes (1998), for example, conducted in-depth interviews of custodial grandmothers caring for HIV-infected grandchildren who described stressful relationships with some of the living biological mothers. Hayslip, Baird et al.'s (2006) qualitative study of grandparent caregivers also suggested adversarial relationships with their grandchildren's parents in their comments advising others to "hire a lawyer" and "get custody to keep the parents away from the grandchildren" (p. 176). Alternatively, the grandparent may have less support after experiencing the death of his or her own child (see Waldrop & Weber, 2001). Overall, custodial grandparents appear to experience decreased social support availability and

satisfaction, which potentially contributes to them being at risk for experiencing emotional distress and adverse health problems.

From a broader social context, the prejudices and perceptions of society are likely to have an impact on grandparent-headed households. Joslin (2000) points out that for grandparent caregivers who are taking care of grandchildren orphaned and affected by HIV / AIDS, there is an additional social stigma that can threaten self-esteem and social support. Miltenberger, Hayslip, Harris and Kaminski (2003-2004) explored the perceptions others have of losses experienced by grandparent caregivers. They reported the depth and intensity of sensitivity to the losses experienced by grandparent caregivers are influenced by both the feelings regarding the diverse circumstances surrounding reasons for role assumption and feelings evoked by the level of adjustment problems experienced by the grandchild. There appears to be a greater sensitivity to loss due to death, abandonment, child abuse, drug abuse, and incarceration than there is relative to loss due to divorce or job loss. This suggests others might underestimate grandparents' disappointments in their adult children's marriages or lack of career success. There was also a greater sensitivity to loss where there was knowledge the grandchild was experiencing problems relative to the grandchild not experiencing problems. Ethnicity of the grandparents also influenced participants' perceptions of losses experienced by the grandparent caregivers, with greater sensitivity for African American and Caucasian caregivers than Hispanic caregivers when the reasons for assuming care was due to death. The participants indicated a greater sensitivity to loss, however, for Caucasians when the reasons for assuming care were due to drug abuse. When incarceration was the reason given for

assuming care, participants were more empathic towards the African American caregivers.

Legal Issues

When a grandparent takes on the care of a grandchild, the legal system may act as an additional environmental stressor for some grandparent-headed households (Albert, 2000; Cox, 2003; Kopera-Frye, Wiscott & Begovic, 2003). The legal standing of grandparent caregivers is varied, ranging from informal arrangements with no court intervention, to formal custody and guardianship and even adoption in some cases (Woodworth, 1996). While many grandparents resume care for their grandchildren on an informal basis, some grandparents do initiate legal proceedings to gain custody of their grandchildren. A 5-year pilot program in Michigan, Project GUIDE, which developed educational resources for grandparent caregivers, identified a strong need among intergenerational families for legal assistance in gaining custody of their grandchildren, particularly since their custody issues are often complex and serious. Of the 110 grandparents participating in the Project Guide, 11 % received advocacy help with the Probate court in respect to legal guardianship and custody issues (Jones & Kennedy, 1996). A primary reason grandparents seek legal custody of their grandchildren is to stabilize their caregiving role with their grandchild, despite the potential for this being a costly outcome, particularly since parents may demand the return of their children (Cox, 2003; Woodworth, 1996). There is little research exploring whether grandparents with legal custody or who have formally adopted their grandchildren have different outcomes to those caregiving on a more informal basis.

Baird (2003) notes, however, even grandparents with legal custody tend to fear for the future in terms of how they may cope financially and emotionally if the child's parents petition to resume care again.

Benefits of Grandparent-Headed Households

As the above research demonstrates, grandparents usually assume care of their grandchildren under difficult and sometimes traumatic circumstances. These grandparents provide society with a vital service, since their care for their grandchildren prevents those children from entering the foster care system or becoming wards of the state (Pruchno & McKenney, 2002). Grandparent caregiving also offers many potential benefits to the grandchild. Kinship care may lessen the trauma of separation from the child's parents, offering continuity of care (Ingram, 1996; Kolomer, 2000), preserving family ties, and tending to be culturally sensitive (Ingram, 1996; Scannapieco & Hegar, 1996), particularly since grandchildren are biologically, historically and usually culturally matched with their grandparents (Connealy & DeRoos, 2000). Children are likely to be already attached to grandparents they know, compared to non-kin foster care options (Scannapieco & Hegar, 1996). Grandparents can offer their grandchildren valuable life experience (Hayslip & Kaminski, 2006) in addition to the continued transmission of family history, values and traditions (Hirshorn, 1998; Kopera-Frye & Wiscott, 2000). Solomon and Marx (1995) reported children raised solely by their grandparents fared better in terms of health and school adjustment than children in families with just one biological parent present. Grandchildren may experience the love, security and structure

with their grandparents they might not otherwise gain in a foster care environment (Hayslip & Kaminski, 2005).

Raising a grandchild may also offer benefits for grandparents. Grandchildren themselves may become a source of social support and happiness. Minkler and Roe (1993) cited grandparents as describing a renewed sense of purpose and fun from having children in their household again. Parenting can be a very positive and satisfying experience (Meredith, Stinnett, & Cacioppo, 1985). When a sample of 162 grandparent caregivers were asked to respond to how rewarding it was to raise a grandchild (with a 5 point scale ranging from “not at all rewarding” to “extremely rewarding”), 81 % responded it was “extremely rewarding”, while only 2 % responded it was “not at all rewarding” to raise a grandchild (Giarrusso, Silverstein & Feng, 2000). Grandparents may also gain a sense of substantial satisfaction and pride in watching their grandchildren grow and develop. Cherlin and Furstenberg (1986, p.196) describe the importance of the “symbolic rewards” of grandparenthood, whereby grandparents tend to bask in the special accomplishments of grandchildren in addition to valuing the love, affection, and emotional satisfaction of the relationship with their grandchildren. Custodial grandparents are also likely to experience these symbolic rewards. Many grandparents report they would still take on the caregiver role for their grandchildren if they had to make the choice again (Shore & Hayslip, 1994).

Several studies of grandparent caregivers have pointed out the benefits of re-parenting. Merriweather-de Vries, Burton, and Eggleton (1996) describe rewards expressed by grandparent caregivers as: another opportunity to “do it right” ; parenting more effectively due to earlier parenting experiences; the receipt of unconditional love,

companionship and the support of one's grandchild; and the ability to nurture family traditions and legacies via one's grandchild. Minkler and Roe (1993) report that after worrying about adult children's substance abuse, grandparent caregivers were grateful for the opportunity to do something positive for the family. In a study by Baird, John and Hayslip (2000), several grandparents noted that keeping "up with the times" was an advantage of raising grandchildren (p.131). Other benefits of re-parenting reported by grandparent caregivers included feeling closer to the grandchild, experiencing more purpose in life, having fun with the grandchild, and feeling younger (Jendrek, 1993; Pruchno, 1999).

The Well-Being of Grandparent Caregivers

For grandparents, the physical and psychological consequences of transitioning back into a caregiver role may be substantial, given the often stressful reasons for assuming care, including grief and loss issues, the caregiver burden involved, and the role conflicts which are likely to arise. Concerns with regards to the physical and emotional well-being of grandparent caregivers have been well documented in the research literature (for example, Burnette, 1999a; Burton, 1992; Musil & Ahmad, 2002; Strawbridge, Wallhagen, Shema, & Kaplan, 1997). While health status could function either as a stressor or an outcome of caregiving demands, there is no doubt that custodial grandparents appear to have particular challenges in the physical and mental health arena.

In several within-group studies, grandparent caregivers have reported suffering from a variety of health-related problems (e.g., Dowdell, 1995; Joslin, 2000; Kopera-

Frye, Wiscott & Begovic; 2003; Minkler, Roe & Price, 1992). From a sample of grandmother caregivers raising their grandchildren as a result of substance abuse of the adult parent, Minkler et al. (1992) reported declines in physical health following the assumption of caregiving in one-third of the sample. Over half of the sample (51 %) suffered from joint swelling and stiffness, 41 % reported severe back problems, and 25 % reported cardiac problems. Similarly, in an ethnically diverse sample of 154 grandmothers who provided primary care to their grandchildren, Dowdell (1995) found 45 % of the grandmothers reported physical problems or illness that seriously affected their health, including hypertension, heart disease, diabetes, asthma, arthritis, and cancer. The grandmothers who reported poor health were also more likely to have a lower score for self esteem, a perception of having a poor financial status, to perceive themselves as lacking of family support, and to perceive that caregiving had a greater negative impact on their schedules (Dowdell), indicating the multilevel antecedents and consequences of caregiving well-being and the necessity for an ecological conceptualization of this population.

Joslin (2000) described an exploratory study conducted in New Jersey with 16 grandmothers raising grandchildren affected and orphaned by AIDS which highlighted the participants' vulnerability to physical health problems, many of these being chronic. In the sample, 55 % reported their health had declined in the last year, while even those in good health reported their physical stamina was being taxed by parenting responsibilities. Burton (1992) studied qualitative data gained from two research samples from predominantly black urban communities. Participants included 60 African-American grandmothers, grandfathers and great-grandparents raising grandchildren as

a result of parental drug addiction. Burton (p.749) noted that 86 % of these caregivers reported feeling depressed or anxious most of the time; 61 % reported smoking more than they ever had in their lives; 36 % said they were drinking “quite heavily”; 35 % complained of arthritis and diabetes; 8 % had recently suffered a stroke; and 5 % had experienced a heart attack within the past year.

These difficulties do not appear to be limited to African-American grandparent caregivers. Kopera-Frye et al. (2003) found a small sample of mainly Caucasian grandmother caregivers also reported a variety of health problems, including arthritis, diabetes, asthma, and heart conditions. The majority of the caregivers reported these health problems interfered to a moderate degree with their ability to provide care for their grandchildren. Further, 11 of the 14 grandmothers reported experiencing emotional problems since assuming care for their grandchildren, including depression, anxiety and stress, many expressing the belief that their emotional difficulties interfered with their ability to provide adequate care to grandchildren to at least a moderate degree. Most of the grandmothers, however, had not sought professional help, due to either insufficient time or a lack of financial resources. Not only does this study help illustrate the interconnectedness of physical and mental well-being, but it suggests some of the health-related difficulties of grandparent caregivers may go untreated.

Kelley (1993) found that in a sample of 41 white grandparents, 44 % had clinically significant scores of psychological distress. Many grandparent caregivers described feeling anxious they would not live long enough to continue to provide for their grandchildren (Kelley, 1993; Joslin, 2000). According to Cox (2003), anxiety can be a difficulty for grandparents who sense their own child cannot parent and undermines

their sense of competency. Anxiety may also be a particular problem for some grandparent caregivers who live in communities under threat of gangs, drugs and violence (Cox, 2003).

Consistent with the findings of other studies, Kelley, Whitley, Sipe, and Yorker (2000) and Kelley and Whitley (2003) reported compromised physical and mental health amongst grandparent caregivers. They collected data from 102 African American grandparent caregivers in skipped generation households, and from the Brief Symptom Inventory (BSI: Derogatis, 1983) reported significantly greater psychological distress than national normative data, with 28.4 % of respondents scoring in the clinical range. These grandparent caregivers also reported significant physical health difficulties, as compared to the general population on the Short Health Form-36 (SF-36: Ware & Sherbourne, 1992), which specifically highlighted their difficulties in general health, bodily pain, physical role functioning and social functioning (Kelley & Whitley, 2003). Further, grandparents who reported fewer family resources (including financial support, nutrition, physical shelter, employment, child care, and intra-family support), less social support, and poorer physical health tended to experience higher levels of psychological distress.

Silverstein and Vehvilainen (2000) interviewed 134 grandparent caregivers and reported that more than a third of the grandparents had identified chronic health problems that limited their activities, the most common of which included arthritis, hearing problems, and mobility impairments. A quarter of the same sample of grandparents reported the perception that they were experiencing worse health than before they had assumed responsibility for their grandchildren. These findings are

supported by Whitley, Kelley and Sipe (2001), who suggested the overall moderate levels of physical difficulties they found in a sample of 100 grandmother caregivers could restrict their routine activities of daily living, hamper their involvement in social and recreational activities, and potentially affect the relationship between grandmother and grandchild.

To implicate the caregiving role as an antecedent factor in well-being, it important to consider cross-sectional studies which compare the well-being of grandparent caregivers to their non-caregiver peers. Using a national sample, Marx and Solomon (2000) compared the self-reported health of 123 grandparent caregivers to 1,152 non-caregiving grandparents. They reported grandparent caregivers were more likely to report fair to poor physical health than non-caregiver grandparents. This finding is supported by studies by Minker et al. (1997), who also reported grandparent caregivers had worse self-rated health than the non-caregivers, and Shore and Hayslip (1994), who reported that a sample of custodial grandparents scored lower than non-custodial grandparents on 3 of 4 domains of psychological functioning, including overall psychological well-being. Marx and Solomon further noted that 21.2 % of their sample of grandparent caregivers reported a decline in physical health over the last year, compared to 13.9 % of the non-caregivers. However, 20.3 % of grandparent caregivers actually reported an improvement in health over the last year, compared to 17.5 % of non-caregivers, leading Marx and Solomon to conclude health influences for grandparent caregivers should be studied in more detail.

Using a national data set to explore differences between African American grandparents raising grandchildren and non-caregiving African American grandparents,

Fuller-Thomson and Minkler (2000c) reported caregiving grandparents were significantly more likely than their peers to have limitations in 4 of 5 activities of daily living (ADL), which included difficulties in moving about inside the house, in completing day-to-day tasks, in climbing a flight of stairs, and in walking six blocks. The caregivers also had more symptoms of depression, as measured by a shortened version of the Center for Epidemiological Studies Depression Scale (CES-D) (Radloff, 1977). It should also be noted, however, that compared to the non-caregivers, these African American grandparent caregivers were more likely to be single (75 % compared to 50%), female (77 % compared to 55 %) and to live below the poverty line (47 % compared to 24%).

Musil and Ahmad (2002) compared the health of 283 grandmothers by caregiver status, which included primary caregivers (from both skipped generation and co-parenting households), partial caregivers and non-caregivers. As expected, the non-caregiver grandmothers reported less stress than the caregiver grandmothers, as indicated by a single item measure “How much stress do you have in your role as grandmother?” There was no significant difference in reported stress between the primary and partial caregiver groups. Primary caregiver grandmothers reported significantly worse self-assessed health than non-caregivers, whereas the partial caregiver grandmothers showed a tendency towards more depressive symptoms than the non-caregivers. Further analysis showed women who were more likely to show more depressive symptoms were younger, less educated, Caucasian, unmarried, had been caregiving for less time, unemployed, and cared for older grandchildren.

Longitudinal research is also a valuable tool in understanding how much of the negative effect on the well-being of caregivers may have occurred before caregiving

actually begins. Strawbridge et al. (1997) followed a longitudinal study of the health of almost 7,000 persons chosen in 1964 to represent the adult non-institutionalized population of a Californian county. Participants were interviewed again in 1974, 1983, and 1994. In 1994, 42 participants indicated they were raising a grandchild, great grandchild, grandniece or grandnephew, under the age of 18, on a full-time basis. Measures of the physical health, mental health, and physical functioning of these grandparent caregivers from both 1974 and 1994 were compared to the same measures in groups of peers caring for a spouse (n=34), an adult child (n=130), or those who were non-caregivers (n=1,669). Strawbridge et al. reported that unlike the spouse and adult child caregivers, even in 1974 and prior to caregiving experiences, the sample of custodial grandparents had significantly poorer health on all measures compared to non-caregivers. After 20-years, Strawbridge et al. found the custodial grandparents were more likely to experience declines in both physical and mental health than the other groups, suggesting something about grandchild caregiving is particularly challenging. The custodial grandparents had more depressive symptoms, worse health, and experienced more chronic conditions than the non-caregivers, even after adjusting for age and education.

Minkler, Fuller-Thomson, Miller and Driver (1997, 2000) used a large national data set, the National Survey of Families and Households, to examine the phenomenon of depression in grandparent caregivers. Their sample included grandparents who had been parenting their grandchildren for a minimum of 6 months in the 5 year period leading up to the study. As they collected their data in multiple waves, they were able to re-interview many of the grandparents and compare baseline data. Grandparent

caregivers were more than twice as likely, compared to non-caregiving peers, to score at a clinically significant level for depression on a modified version of the Center for Epidemiological Depression Scale (CES-D; Radloff, 1977). Further, caregiving grandparents were more likely to have had higher rates of precaregiving depression. After controlling statistically for pre-caregiving depression and other demographic differences, the caregivers still scored an average 2 points higher on the CES-D than non-caregivers, suggesting grandparent caregiving itself is directly associated with higher levels of depression which supports the earlier findings of Strawbridge et al. (1997).

Not all studies have linked grandparent caregiving to poorer well-being (Crowther & Rodriguez, 2003; Giarrusso, Feng et al., 2000). Giarrusso, Feng et al. (2000) compared 146 grandparent caregivers to 774 non-caregiving grandparents on several measures of psychological well-being. These measures included the Bradburn Affect Balance Scale (measuring positive and negative affect) (Bradburn, 1969), the Rosenberg Self- Esteem Scale (Rosenberg, 1979), and three single-item indicators (giving a rating for the best possible life; their perceptions of how well they perform in the grandparent role; and level of caregiver stress). The grandparents only differed on self-rated performance of the grandparent role, with caregivers rating their performance of the grandparent role significantly higher than non-caregiving grandparents. Crowther and Rodriguez (2003) compared 55 African-American grandparent caregivers to 37 of their non-caregiver peers, and reported no significant variation in health and well-being, as measured by the SF-38, SCL-90, and three single-item measures of life satisfaction, happiness and goal attainment. Overall, the grandparents reported high levels of health

and well-being. While not statistically significant, 32 % of participants stated they had developed new health problems since they had begun their caregiving. Crowther and Rodriguez suggested explanations that included a possible selection bias, wherein grandparents in poor health are less likely to assume responsibility for a grandchild. Also, grandparents may have not wanted to admit health problems for fear of losing custody of their grandchildren. Grandparents may also deemphasize their health concerns if they are faced with what they consider to be more troubling concerns. This tendency to downplay the severity of health problems was also noted by Minkler (1994), where grandmothers reported inadequate time for doctor's visits for themselves or wished to convey the message they were up to the task of caregiving.

Other different findings, for example, Giarrusso, Feng et al., (2000) compared to Strawbridge et al. (1997), may be due to samples of differing populations, such as varied racial and ethnic groups. Some grandparent caregivers may have greater resources than others that act as moderators on the effects of caregiving stress, e.g., better coping skills, parenting skills, greater financial resources or more social support networks. They may also have assumed caregiving under different circumstances (e.g., caregiving due to parental drug abuse may be experienced as more stressful than caregiving due to a grandchild wanting to attend a better school).

Several researchers have explored various antecedents which may be related to some of the well-being outcomes for grandparent caregivers. Crowther and Rodriguez (2003), for example, reported that a discrepancy in role expectation was an independent predictor of subjective well-being in their study of grandparent caregivers, with higher levels of role discrepancy associated with lower levels of subjective well-being. Many

grandparents, for example, stated they had expected to be doing other things with their lives than primary caregiving (Crowther & Rodriguez, 2003), a finding supported by the work of Baird (2003), Cox (2000, 2003) and Jendrek (1993).

The link between reasons for caregiving and caregiver well-being have also been explored (Crowther & Rodriguez, 2003; Giarrusso, Feng et al., 2000) Giarrusso, Feng et al. (2000) found grandparents who cited addictive, illegal or lethal activities of the parent as reasons for assuming caregiving reported higher levels of caregiver stress and negative affect than grandparents who cited other reasons for the assumption of caregiving. This same study also coded an open-ended question about what grandparents found stressful about raising a grandchild. While 30 % of grandparent caregivers reported caregiving was not at all stressful, 25 % mentioned characteristics of the grandchild (such as discipline or emotional problems), 44 % mentioned aspects of the caregiving situation (physically demanding, emotionally demanding, required a change in lifestyle, involved added responsibilities and / or financial burdens), and 5 % reported negative interactions with the parent as stressors. Grandparents who cited addictive, illegal or lethal activities as reasons for assuming care of their grandchildren were also more likely to cite difficulties of the grandchild as a further stressor (Giarrusso, Feng et al., 2000). Crowther and Rodriguez (2003), on the other hand, reported no significant differences in health between grandparent caregivers based on reasons for assumption of caregiving. However, given their relatively small sample size, the reasons for caregiving were divided into just two groups: substance abuse related reasons for assumption of caregiving, and non-substance abuse reasons for the assumption of caregiving. It is possible non-substance abuse reasons (such as the

divorce or death of an adult child) are perceived by grandparents to be just as stressful as substance abuse.

Given that elevated levels of depression tend to occur in grandparent caregivers, the potential of loss as a psychosocial factor that increases one's vulnerability to depression has been discussed in the research literature. An unexpected re-parenting role involves the loss of personal time and community (Baird et al., 2000), interferes with grandparents needs to achieve their own developmental tasks (Baird, 2003), affects retirement plans, work, friendships and daily activities (Cox, 2000; Jendrek, 1993). Many grandparent caregivers experience grief over the various losses that placed them in their caregiving role (Pinson-Millburn et al., 1996), such as the loss of their own child, or over losses experienced since taking on the role (Baird, 2003). Baird, a custodial grandmother herself, has described a long and protracted grief period that often takes place for grandparent caregivers. These losses could play a role in the higher rates of depression grandparent caregivers experience in comparison to their peers (Minkler et al., 1997).

Also in terms of psychological health, Wohl et al. (2003) have suggested coming to terms with the losses inherent in raising a grandchild resembles a grief process, and as such may involve different phases. They described three separate dynamics and themes that emerged in a series of parental training / psychosocial skills groups held in North Texas for 36 grandparent caregivers. Some expressed feelings of frustration and being overwhelmed by the responsibility of raising their grandchildren. Others denied experiencing any difficulties in raising their grandchildren, instead focusing on their unresolved feelings of anger towards the parent of the grandchild. A third theme was

that of acceptance, where grandparents appeared to have come to terms with their circumstances despite their multiple losses, seemed to have better coping strategies in place, and were able to express their anger and sadness appropriately. These phases are not likely to be linear but, as in the course of grieving, may emerge and reemerge throughout the re-parenting process (Wohl et al.) and may, thus, account for some of the conflicting reports of the psychological well-being of grandparent caregivers. Miltenberger et al. (2003-2004) have suggested that grandparent caregivers' grief may be somewhat disenfranchised (that is, not well validated by society) and heightened according to the grandparents' ethnicity and the reasons for assuming grandchild care. This may also account for some of the differences found in the psychological well-being of grandparents.

Other aspects of the context of caregiving that may influence the health of caregivers included the length of time of caregiving, the number and ages of grandchildren cared for, and resources such as available social support and the use of active coping efforts (Musil & Ahmad, 2002; Solomon & Marx, 1999). Solomon and Marx (1999), for example, reported single grandmother caregivers had the poorest physical health compared to married grandmother caregivers, women living alone, or women living with only a spouse. In comparison to the other groups of women, more single grandmother caregivers viewed themselves as being in poor health, reported more health conditions, and reported a recent restriction in daily activities due to health problems. Marx and Solomon (2000) suggest that given married grandmother caregivers have better health than single grandmothers, other factors besides the presence of or absence of grandchildren in the household are associated with

grandparent well-being. The characteristics of the grandchild, however, are also likely to be influential, given that women living alone have better health than single women living with grandchildren (Marx & Solomon, 2000). A study by Dowdell (1995), who found grandmother caregivers who reported not being married were more likely to perceive they had poorer health than those who were married, supports the findings of Marx and Solomon. Additionally, Dowdell reported grandmothers who were not married were less likely to perceive they had family support. Hayslip et al. (1998) and Emick and Hayslip (1999) compared the psychological well-being of custodial grandparents and non-caregiving grandparents and reported that those custodial grandparents raising children with special needs exhibited the most personal distress. All of these studies further strengthen the importance of considering the phenomenon of grandparent-headed households from a contextual perspective.

According to the contextual perspective, development will proceed in multiple directions, leading to diverse outcomes for grandparents and their grandchildren. Thus, at a particular point in time, some grandparent caregivers and their grandchildren may demonstrate better well-being than others. This may also account for some of the mixed findings of the research reviewed here. With regards to the experience of poorer well-being overall, however, it seems grandparent caregivers are not alone in their suffering. As will be seen in the following discussion, the children of grandparent headed households may be expected to experience difficulties as well.

The Well Being of Children in Grandparent-Headed Households

Given the transition to a grandparent-headed household is often a sudden one

and, as discussed, generally related to stressful circumstances, one may expect to find a greater proportion of children experiencing difficulties in well-being than in traditionally-structured families. Glass and Huneycutt (2002) suggest most grandchildren being cared for by grandparents could use some sort of professional counseling, even as a preventive measure, in order to assist them to adjust to the changes in their family structure. Increasing numbers of grandparent caregivers do appear to be seeking psychological help for their grandchildren (Emick & Hayslip, 1996). Shore and Hayslip (1994) for example, have reported more children being raised by grandparents were receiving counseling than a control group of children. At the same time, however, some grandparents may also minimize the need for intervention (Emick & Hayslip, 1996), perhaps reluctant to reveal the extent of their grandchild's difficulties for fear the grandchild might be taken away from them (Jones & Kennedy, 1996). Additionally, grandparents may not be aware their grandchildren require professional help. Jones and Kennedy (1996) reported staff members of their social service agency often saw children with problems not recognized as such by grandparents, such as reading below age or grade expectations. A study by Solomon and Marx (1995) supports these findings, reporting caregivers would often fail to recognize a child needed professional counseling to cope with significant distress and maladjustment.

When grandparent caregivers do attempt to seek professional help and services for their grandchildren, there is some research which suggests available social services can be inconsistent and sporadic (Kolomer, 2000). Interviews with a small sample of caregiving grandmothers who were caring for a grandchild with a developmental disability revealed these grandparents felt overwhelmed and discouraged at the lack of

support they received from social services, including the limited services and interventions they could access for their grandchildren, such as psychological assessments and counseling (Kolomer, 2000).

A review of the literature reveals there has been little direct research on the difficulties, experiences and needs of custodial grandchildren as compared to their grandparent caregivers (Edwards, 1998). Thus, it may be valuable to consider some of the research related to children with similar life experiences, such as bereaved children, abused or neglected children, drug exposed children, and children from families undergoing transitions such as divorce or remarriage, including the available research on the well-being of children in kinship care, which in many cases, includes a substantial number of grandparent-headed households (for example, Billing, Ehrle, & Kortenkamp, 2002; Dubowitz, Feigleman, Harrington, Starr, Zuravin, & Sawyer, 1994; Sun, 2003).

It would be reasonable to assume the reasons for the grandchild's living in a grandparent-headed household may have a direct influence on a grandchild's well-being, or at the very least, leave him or her vulnerable to future difficulties. Kolomer (2000) suggests risk factors for children in kinship foster care include, but are not limited to, abuse, neglect, prenatal exposure to drugs and alcohol, poverty, and lack of prenatal care. She also suggests many families who have resorted to kinship foster care are less likely to have identified and addressed any developmental disabilities experienced by the children. Children who have been abused or neglected by their parents prior to being raised by their grandparents may manifest symptoms of depression, behavioral disorders, inadequate coping skills, developmental delays, anxiety disorders, and

posttraumatic stress disorder, while children whose parents have died will be dealing with loss and bereavement issues (Pinson-Millburn et al., 1996). Silverthorn and Durrant (2000) have suggested that given the stressors usually present for children prior to grandparents assuming responsibility for them, it is probable many of these children may suffer from behavioral disorders such as Oppositional Defiant Disorder (ODD) or Conduct Disorder (CD). Indeed, children living with their grandparents do appear to experience a high prevalence of physical, emotional and behavioral problems and are difficult to parent (Jones & Kennedy, 1996). Simply being raised by a grandparent might affect children in that they may feel different from their age peers (Hayslip & Kaminski, 2006).

More specifically, drug-exposed grandchildren can be a challenge, with those born to substance-abusing mothers at substantial risk for developmental and behavioral problems (de Toledo & Brown, 1995; Pinson-Milburn, Fabian et al., 1996). Several grandmothers interviewed by Kolomer (2000) became caregivers when contacted by the hospital requesting they take home a newborn grandchild because the infant had been drug-addicted at birth. Potential difficulties of grandchildren exposed to parental drug abuse include being born with birth defects and Fetal Alcohol Syndrome, which, in turn, may lead to learning disabilities, mental retardation, and disabilities such as cerebral palsy; a higher incidence of attention deficit disorders; or they may come to abuse drugs and alcohol themselves (Pinson-Millburn et al., 1996). Further, the soothing techniques that might have worked for the grandparents' own babies may not be effective in calming drug-exposed infants, leaving the grandparents feeling like failures (de Toledo & Brown, 1995).

In a somewhat related manner, children in the care of their grandparents as a result of parental incarceration are also at risk for emotional and behavioral problems (Pinson-Millburn et al., 1996). Further, the stigma related to incarceration may result in experiences of shame and social isolation, or the grandchild may experience posttraumatic stress following seeing their parents arrested, shot or taking drugs (Pinson-Millburn et al., 1996). There is also a social stigma related to having a sick parent or being orphaned due to HIV / AIDS (Joslin, 2000). Adding to the complexity of HIV caregiving, Joslin notes that if the grandchild him or herself is infected with HIV, he or she may have special nutritional or medical needs.

Studies which have reported on grandparent caregiver experiences, or have suggested interventions for use with grandparent headed-households have sometimes commented on the well-being of grandchildren in the demographic description of their participants. For example, a focus group study by Baird et al. (2000) reported a high number of physical handicaps in children being cared for by 21 African-American grandparents, including 3 children with severe asthma, several with mild to moderate asthma, one with a severe hearing loss, one with a clubfoot, one with a congenital heart defect, and a child with multiple complications following premature birth. In addition to physical difficulties, two grandparents reported experiencing difficulties related to the sexual abuse of their granddaughters, and one child had expressed suicidal ideation. Further, gang membership was a concern for several of the families. Of the 134 grandparent caregivers interviewed by Silverstein and Vehvilainen (2000), more than a third reported at least one of the grandchildren in their care had health problems. The most common problems were asthma and chronic ear infections. More than a quarter of

the grandparents stated they had taken their grandchildren to the emergency room within the previous 6 months. Kopera-Frye et al. (2003) interviewed a small sample of 14 grandparent caregivers who reported common mental health problems experienced by their grandchildren including depression, feelings of worthlessness and rejection, and anxiety over missing parents. Five grandchildren were identified by their grandparents as suffering from ADHD. Other health complaints included irritable bowel syndrome, asthma, and side effects from a mother's crack cocaine usage.

The health of custodial grandchildren also appears to be closely linked to the health of the grandparents who care for them. For example, Dowdell (1995), from a sample of 154 grandmother caregivers, reported grandmothers who reported their own health had suffered as a result of caregiving were also more likely to have rated their grandchild's health as lower and reported more doctor visits for grandchildren.

School Related Difficulties

Grandchildren raised by grandparents may also manifest emotional, behavioral and academic difficulties in their school environment (Edwards, 1998). Edwards reports a lack of communication between teachers and grandparent caregivers which might exacerbate the difficulties of children in grandparent-headed households. Some grandparents are caring for their own elderly parents or an ill or disabled spouse in addition to their grandchildren (Crowther & Rodriguez, 2003; Silverstein & Vehvilainen, 2000), which, as Reynolds, Wright and Beale (2003) suggest, leaves less time and energy for assisting school-age grandchildren with schoolwork. Silverstein and Vehvilainen (2000) note schools have changed a great deal since grandparents' own

children were in school and they may not be aware of many of the resources available to their grandchildren.

Edwards (2006) compared teacher ratings on the Child Behavior Checklist - Teacher Report Form (TRF: Achenbach, 1991) of a group of 54 African American children raised by grandparents with 54 peers being raised by their parents. The students all attended eight urban schools in low socioeconomic communities in the Southeastern United States. Participating teachers, who were unaware of the exact purpose of the study, perceived significantly more children raised by grandparents than children raised by parents as demonstrating overall psychopathology. The teachers also perceived grandchildren as exhibiting more internalizing and externalizing problems than both the comparison group of peers and the normative population used for the TRF standardization.

In a descriptive study of 134 Massachusetts grandparent caregivers conducted by Silverstein and Vehvilainen (2000), a high level of interaction and involvement with schools was actually noted. This may not be typical since this sample had a large proportion of grandparents with higher education. A third of the grandparents reported their grandchildren needed to change schools when they moved in with their grandparents, suggesting relocation may be a contributing factor to the well-being of children living with grandparents. As an indicator of the difficulties experienced by the grandchildren, 42 % of the grandparents reported their grandchildren had special needs, including learning disabilities, ADHD, depression, or developmental delays.

In a study related to the implementation of an intervention program for addressing school performance problems, Rogers and Henkin (2000) described the

need to address substance abuse prevention in children in kinship care. They described the application of such a program, named “Grandma’s Kids” run in Philadelphia, which aimed to increase the academic performance and knowledge of the harmful effects of substance abuse, while decreasing negative behaviors and mental health problems among children in kinship care. A fairly frequent difficulty which they noted was that children in kinship care were often mobile, tending to travel to other kin or their biological parents on weekends, resulting in high absenteeism rates on Fridays and Mondays.

Dubowitz and Sawyer (1994) looked at school behavior among children in kinship foster care and reported 53 % were rated by their teachers as having poor study habits, while 47 % were rated as having poor attention and concentration skills. Billing et al. (2002) found that 29 % of their sample of children living with kin, compared to 20 % of the participants living with parents, were rated by their caregivers as showing low levels of school engagement (which included the caregiver rating if the child completed homework, cared about doing well in school, only did schoolwork when forced to, or did just enough schoolwork to get by). Billing et al. (2002) also reported that a higher percentage of teenagers (26%) living in relative care were suspended or expelled from school, compared to those living with parents (13 %t). Using data from the 1988 National Health Interview Survey, Solomon and Marx (1995) reported children living with grandparent caregivers in skipped generation households were at greater risk of experiencing problems at school compared to their peers living with two biological parents. However, children living with just one biological parent were more likely to experience school problems than the children living with their grandparents.

Using data from the 1988 National Survey of Families and Households, Aquilino (1996) investigated the impact of family structure on the educational achievements of children born to unmarried mothers. Children being raised by grandparents in a skipped generation household differed significantly from those raised with co-resident grandparents with a parent present, in that the children in the co-resident household were significantly more likely to both finish high school and obtain postsecondary training. Perhaps these children have the benefit of greater family resources in terms of both economic resources and attention, with more adults present than in the skipped generation households. The transition to grandparent care with no parent present was also associated with poorer educational outcomes (lower chances of high school completion and postsecondary education enrollment), compared to children remaining in single-parent families. If these results are considered together with those from the Solomon and Marx (1995) study, it would seem that in terms of fewer school problems, children in traditional families may fare best, followed by children in co-parenting household with grandparents. It is uncertain whether skipped generation households or single parent families may have children who experience the most school difficulties, since Aquilino and Solomon and Marx used different outcome measures, with Solomon and Marx looking at shorter term effects on current school performance versus the longer term effects considered by Aquilino.

Kinship Studies and Child Well-being

Kennedy and Keeney (1988) report children in kinship care tended to experience feelings of loss, anger and rejection, which may pose a problem in them forming trusting

relationships with others. It is possible grandchildren in skipped-generation households may attempt to emotionally distance their grandparent caregiver, given they have already lost a primary caregiver. There may be an anticipation of further loss and change in guardian for the child, particularly given some custodial grandparents may be older adults (Kennedy & Keeney, 1988).

When Dubowitz et al. (1994) compared a sample of children in kinship families to both their peers in parent-present families and national norms, they found the children in kinship care appeared to show poorer physical health, a greater level of behavioral problems and poorer school achievement. On the Child Behavior Checklist (Achenbach, 1991), 26 % of the children from kinship families demonstrated clinically significant levels of emotional and behavioral problems compared to an expected 10 % usually found in the general population. The children in kinship care were also found to have many medical concerns, suffering from anemia, asthma, dental problems, and lacking immunizations (Dubowitz et al., 1994). A similar trend was reported by Billing et al. (2002), who reported 13 % of children in relative care exhibited high levels of behavioral and emotional problems, compared to 7 % of children living with their parents.

The findings of Dubowitz et al. (1994) and Billing et al. (2002) have been supported by the more recent study by Sun (2003), who investigated the well-being of 354 adolescents in households with no biological parents present. This sample included 265 participants living with their grandparents or relatives, and Sun reported no significant variation in outcome between the children in kinship and foster care. She compared different aspects of their well-being (academic performance, educational aspirations, locus of control, self esteem, behavioral problems, and the number of

cigarettes smoked per day) with peers from five family types, which included families with two biological parents, single mothers, mother and stepfather / male partner, single father, and father and stepmother / female partner. Her results suggested a moderate disadvantage of living in non-biological parent families, with an overall lower level of well-being among adolescents living with neither parent. Investigation of the interaction effects of gender and family structure suggested that in non-biological-parent households, boys and girls have approximately the same levels of well-being. Sun further reported family resources (including annual household income, guardian's educational attainment, cultural activities, and guardian's social resources and investments) acted as effective mediators, accounting for almost 84 % of the group differences between non-biological parent and other types of families in the well-being outcome measures. Family resources, thus, appear to play an essential role in mediating the differences in child well-being between different types of family structure.

Benedict and Zuravin (1996) conducted interviews with 214 adults, aged 19 to 31 years, who had been in foster care, either with kin or non-kin, as children. While it was not known how many of the kin-foster parents were grandparents it would be reasonable to assume many grandparent caregivers would have been included. Social service records revealed that, as children, there were significant differences in functioning between kin and non-kin placements, with those children placed with kin less likely to have developmental or behavioral problems. While Benedict and Zuvarin hypothesized children placed with kin should be doing better as adults than those placed with non-relatives, there were no differences between the samples in terms of adult functioning. The authors suggested poorer economic resources and health of

kinship foster parents, together with fewer services and less support offered to kinship foster parents compared to non-relative foster parents might have accounted for their findings (Benedict & Zuravin, 1996).

Overall, it seems children in grandparent-headed households, like those in kinship families, do exhibit some difficulties in physical and psychological well-being. However, given the absence of data that considers their pre-grandparent caregiving arrangements, it is difficult to determine whether their difficulties might originate in their family of origin, the circumstances surrounding their transition to grandparent caregiving, or from actually residing with their grandparents. Some behavior problems in grandchildren, for example, may be related to the family sociodemographic factors (Hayslip, Silverthorn, Shore & Henderson, 2000). Given this population of children has been noted to be at risk, Pinson-Millburn et al. (1996) suggest that perhaps grandparent caregivers will provide the type of nurturance to offset some of the risk, albeit at a cost to their own well-being. Hayslip et al. (2000) found several significant antecedents to a sample of grandparent caregivers reporting on grandchild problem behaviors that included alcohol and drug use, oppositional behavior, mental retardation, hyperactivity, sexual identity, learning difficulties, depression, and altercations with the law. Having sought professional help for the grandchild was related to the overall problem severity. Greater perceived overall problem severity was also associated with poorer grandparent health, as well as the grandparent's desire to be a better parent and feeling a personal obligation to raise the grandchild.

Conclusions and Recommendations

Grandparent-headed families are extremely diverse in nature. Overall, it does appear both grandparent caregivers and the grandchildren who reside with them experience more than their fair share of physical and psychological difficulties. Their lessened sense of well-being however, is not simply a manifestation of the structure of their household, but rather a complex interaction of intrapersonal, interpersonal, historical, social, economic and cultural factors. This research review has explored a range of the diverse antecedent and consequent factors which play a role in the well-being of grandparent-headed households, including the circumstances leading up to the formation of the grandparent-headed household, in addition to other risk factors present in the household and environment.

The reasons for assuming caregiving can make a difference to the type and amount of stress under which a grandparent-headed family is placed. For example, the loss of an adult parent may affect the family differently in a family headed by a grandparent due to an unplanned teen pregnancy. Ethnicity exerts a considerable influence in how families may adjust to being headed by a grandparent, being a more normative experience for African-American and Hispanic families as compared to Caucasian families. The well-being of African-American and Hispanic families, however, is also more likely to be at risk for other influences, such as lower income and education. Younger grandmothers appear to have poorer psychological well-being outcomes such as depression, while older grandparents tend to struggle more with their physical health. Concerning gender, grandmothers appear to be more at risk for depression than grandfathers, though very little is known about the experiences of

grandfather caregivers. Poverty, particularly in the southern U.S., is an antecedent of many grandparent-headed households and, in turn, is exacerbated by the expenses related to caring for a grandchild. On the whole, welfare reform does not appear to have assisted grandparent caregivers.

Family structure tends to influence the types of difficulties experienced by grandparent-headed households. Co-parenting households appear to have more household members, younger children, and experience greater difficulty with role ambivalence and poverty. Skipped generation households have fewer family members, may experience more time pressure in caregiving activities, and have greater conflicts between grandparent and grandchild. In terms of overall well-being, African American skipped generation households appear to fare better co-parenting households, whereas there is little difference in well-being for skipped generation and co-parenting families within Hispanic and Caucasian cultures. The quality of the intergenerational relationships within grandparent-headed households, particularly the role played by an adult parent (even in their absence) be a powerful influence on the well-being of both grandparents and grandchildren. Grandparent caregivers may be less empathic than traditional parents are towards their children. They may also have less current parenting knowledge of disruptive behavior disorders and difficulties such as drug use or school violence.

Social supports, an important resource for grandparent caregivers, may be more likely to change and become less available as a result of caregiving. The legal system may act as an additional environmental stressor for grandparent caregivers, should they or their adult child seek court intervention. Despite the hardships of grandparent

caregiving, grandparents are a resource in family preservation, offering their grandchildren benefits they may not gain in a foster care environment. Overall, however, research points towards greater difficulties in the physical and psychological health of grandparent caregivers, as compared to their non-caregiving peers. Although there has been less direct research concerning the children of grandparent-headed households, attachment theory and the presence of risk factors related to the reasons for grandparent caregiving suggest the children are likely to experience developmental, behavioral and emotional problems. Further, reports from the grandparent caregivers themselves and schools seem to indicate several difficulties in well-being.

The Advantages and Disadvantages of National Data Sets

From a methodological perspective, the review of the grandparent caregiving research literature reveals much of the data that has been collected is typically based on the subjective self-report of grandparents (for example, Pruchno & McKenney, 2002) and anecdotal evidence. Participants may either positively or negatively accentuate the difficulties they may be experiencing. As such, care should be taken when interpreting these findings. Few studies rely on any participation by the grandchildren themselves. Consequently, it would be important to incorporate grandchildren's experiences in future studies. Many studies are cross-sectional, with few longitudinal studies being available (e.g., Strawbridge et al., 1997). Studies also tend to use small samples, which are often of a convenience nature (for example, Musil & Ahmad, 2002; Crowther & Rodriguez, 2003). Even when samples of grandparent caregivers are large and diverse, they tend to be composed of volunteers (for example, Pruchno & McKenney, 2002) and, thus,

may not represent grandparent caregivers as a whole. It would, moreover, be important to determine if there are any differences between these volunteers and grandparent caregivers who do not come forward to participate in studies.

Research on grandparent-headed households based on national studies or nationally representative samples is not common. Some national data sets which have been used include the National Health Interview Survey (NHIS) (Solomon & Marx, 1995), the National Survey of Families and Households (NSFH) (Fuller-Thomson, Minkler, & Driver, 1997; Fuller-Thomson & Minkler, 2000), and the National Survey of America's Families (NSAF) (Brown, 2004; Scarcella, Ehrle & Geen, 2003). National samples offer large enough numbers of participants to investigate a greater number of interactions than one is typically able to investigate in a smaller sample. Typically, however, studies using national data sets have considered factors in isolation and have not placed enough focus on interactions in order to better understand which antecedents of grandparent-headed households may negatively influence well-being. For example, in their analysis of data from the NSAF, Scarcella, Ehrle, and Geen (2003) studied the well-being of children in the care of a single grandparent in comparison to other relative caregivers but did not compare these families to more traditionally structured families, or consider the potential influences of ethnicity or gender. Similarly, with respect to the NSAF data, Billing, Ehrle and Kortenkamp (2002) have compared the well-being of children living with kin versus with parents, but did not consider the potential influence of ethnicity, gender, and caregiver age and physical health.

There are still, however, some disadvantages to the NSAF data set, which may limit some aspects of a study. This would include the consideration that the NSAF does

not provide for the measurement of duration of various family types or the number of transitions that children may have experienced (Brown, 2004). It will not provide any understanding of the reasons for grandparents assuming care of their grandchildren, which as the literature points out can be an important variable related to the subsequent well-being of both child and grandparent. In addition, imputation of missing data has already taken place and, thus, an analysis will necessarily incorporate such values. In considering income, the NSAF does not collect data on assets such as savings, real estate, stocks and bonds, which may have a significant effect on grandparents' financial resources (Scarcella, Ehrle & Geen, 2003). However, given the large number of households surveyed and the detailed information collected about various household members, the NSAF data remains a valuable source of relatively untapped information on the well-being of grandparent-headed households.

Statement of the Problem

Due to the diversity of grandparent caregivers and their grandchildren, one needs to be able to identify values and norms about what is desirable with respect to interventions. It is important to understand which groups of grandparents and grandchildren are more likely to experience which problems, so that in future, interventions may be developed and tailored to be most helpful for specific custodial grandparent and grandchild groups, particularly in order to avoid making logical typing errors described by Danish (1981) and Watzlawick, Weakland and Fisch (1974). For example, King, Hayslip and Kaminski (2006) found evidence to suggest that when it comes to social support needs, distinct subgroups of custodial grandparents exist.

Some have adequate emotional support and are seeking instrumental support in the form of information and referrals for services such as financial assistance or medical care. Others are seeking more emotional support for themselves or their grandchildren. An unnecessary type of intervention offered is, thus, likely to be unsuccessful and may even result in alienating the subpopulation it had intended to serve.

The present study, using a large national sample and a focus on various measures of well-being, seeks to identify vulnerable subgroups of custodial grandchildren and their grandparent caregivers and the extent of their difficulties in order to better inform agencies and social policy makers as to which groups are more likely to require which types of resources and interventions. This study uses an existing large national database, the National Survey of America's Families (NSAF), to describe the characteristics of grandparent-headed households in the context of comparing the differences in well-being of children and grandparent caregivers across several independent variables, including family type, ethnicity, gender and age. While there have been studies to address the well-being of custodial and co-parenting grandparents in culturally diverse families (Goodman & Silverstein, 2002), to date there has been little focus on the well-being of children raised in differently structured and ethnically diverse grandparent-headed households or which considers a variety of antecedents to the well-being of both grandparent caregivers and their grandchildren. This study aims to address this void.

Research Hypotheses

The following hypotheses are proposed:

Main Effects

1. Members of traditional two-parent families will demonstrate greater evidence of well-being than those in co-parenting families, who, in turn, will demonstrate greater evidence of well-being than skipped generation families, who, in turn, will demonstrate greater evidence of well-being than single parent families.

Interactions

2. For ethnicity and family type, evidence of well-being for both caregiver and child may be expected to vary as follows:

Table 1

Hypothesis 2

Family Type	Ethnicity		
	Caucasian	African American	Hispanic
Traditional	Higher	Higher	Higher
Co-parenting	Lower	Higher	Higher
Skipped Generation	Higher	Higher	Lower
Single Parents	Lower	Lower	Lower

3. For child gender (Hypothesis 3A) and caregiver gender (Hypothesis 3B) and family type, evidence of well-being for both caregiver and child may be expected to vary as follows:

Table 2

Hypothesis 3

Family Type	Gender	
	Male	Female
Traditional	Higher	Higher
Co-parenting	Lower	Lower
Skipped Generation	Lower	Higher
Single Parents	Lower	Lower

4. For child's age and family type, evidence of well-being for caregivers may be expected to vary as follows:

Table 3

Hypothesis 4

Family Type	Child's Age		
	0 to 5 years	6 to 11 years	12 to 17 years
Traditional	Higher	Higher	Higher
Co-parenting	Lower	Higher	Lower
Skipped Generation	Lower	Higher	Lower
Single Parents	Lower	Lower	Lower

5. For caregiver's age and family type, evidence of well-being for caregivers may be expected to vary as follows:

Table 4

Hypothesis 5

Family Type	Caregiver Age		
	Under 49 years	50 to 64 years	+65 years
Traditional	Higher	Higher	(Lower)*
Co-parenting	Lower	Higher	Lower
Skipped Generation	Lower	Higher	Lower
Single Parents	Lower	Lower	(Lower)*

Note. Not expected to find a significant number of traditional / single parents in this age category

6. In a three way interaction between ethnicity, family type and caregiver gender, evidence of well-being for both caregiver and child may be expected to vary as follows:

Table 5

Hypothesis 6

Family Type	Ethnicity					
	Caucasian		African American		Hispanic	
	Male	Female	Male	Female	Male	Female
Traditional	H	H	H	H	H	H
Co-parenting	H	L	H	H	L	H
Skipped Generation	H	H	L	H	H	L
Single Parents	L	L	L	L	L	L

Note. H = higher; L = lower.

CHAPTER 2 METHODS

The purpose of this study was to compare the well-being of caregivers and children in differently structured and ethnically diverse families, with a particular interest in grandparent-headed households. The study is based on data collected by Westat for the National Survey of America's Families (NSAF), part of an Urban Institute project. The NSAF is a major household survey, focusing on the economic, health, and social characteristics of children and their families (Brick, Ferraro, Strickler & Liu, 2002). The Urban Institute was established in 1968 as a non-profit, non-partisan economic and social policy research organization, which often uses its research to evaluate and inform education, health care and social welfare programs. The original goal for producing the NSAF's estimates of child and family well-being was to monitor the policy changes in social program responsibilities (particularly as these related to lower income families) from the federal government level to state and local government levels.

Sample and Procedure

This study used 2 of 3 waves of data collected by the NSAF in 1997 and 2002, which were independent samples. Given potential history effects, they were analyzed separately. The 1999 NSAF data was not used, since it could not be considered independent of the 1997 sample. The study selected 13 states from which to draw the majority of the samples in order to represent a broad range of fiscal capacity, child well-being, and approaches to government programs. These states included Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin (Abi-Habib, Safir, Triplett, &

Cunningham, 2002). The oversized state samples were supplemented with a balance of the United States sample, in order for estimates to be made at both the state and national levels. The states sampled by the NSAF include several states (Alabama, California, Florida, Mississippi, New Jersey, New York, and Texas) that have been reported to having high percentages of co-resident grandparents (U.S. Census Bureau, 2003) and, thus, the NSAF samples fit in well with the interest that this study has in grand-parent headed households.

The 1997 and 2002 NSAF rounds each included telephone interviews with over 40,000 families and yielded information on over 100, 000 people. Both the 1997 and 2002 samples used a “dual-frame” approach, which consisted of two components to the survey - randomly dialed telephone samples, supplemented by area probability samples of households without telephones (Brick et al., 2002; Kenney, Scheuren & Wang, 1997). The latter was included because the Urban Institute was interested in the experiences of low income families and it was estimated that about 20 % of households in poverty had no telephone (Judkins et al., 1997).

For the first component to the survey, in 1997 a total of 179,000 potential participants were screened via a list-assisted, random-digit dialing (RDD) sample of 483,260 telephone numbers (Judkins et al., 1997). A short screening interview was used to determine household eligibility and any households where all members were aged 65 or older were dropped from the study. The sample was stratified due to a primary goal to gather information from children in lower income households, with a secondary goal to gain information about children in higher income households. If children were present and the household had an income below 200 % of the poverty

threshold, the household was retained for the study. Higher income households with children were sub-sampled according to rates ranging from 25 to 40 % and calculated for each state according to estimates for income misclassifications and to fix the total number of interviews to a predetermined limit per state. A total of 42,973 households completed the extended interview for the 1997 study.

The first component for the 2002 sample was conducted in a similar manner, resulting in a total of 43,157 completed extended interviews (Abi-Habib, Safir & Triplett, 2002). However, some differences between the 1997 RDD sample and the 2002 RDD sampling methods were noted. A lower response rate in 2002 ultimately resulted in more phone numbers being released than originally had been planned. Two conversion attempts were made to refusing households by interviewers in 2002. A further difference for the 2002 study was that the sample size allocated to the Milwaukee area was reduced and sample sizes for California, Michigan and the balance of the nation were increased accordingly (Abi-Habib, Safir & Triplett, 2002).

The second component to the survey supplemented the RDD sample with an area probability sample of non-telephone households. For the 1997 sample, information from the 1990 census was used to select 114 primary sampling units made up of metropolitan areas or counties, which were further subdivided into 1,388 area segments such that each area segment contained an average of 30 dwelling units (Judkins et al., 1997). Some area segments with a high percentage of households with telephones were eliminated. From the remaining 37,000 households that were contacted by fieldworkers in person, 1,488 non-phone households completed the NSAF questionnaire. Once a fieldworker pre-screened a household that was willing to

participate in the study, the participant was connected to a Westat interviewer using a cell phone provided by the fieldworker. An area probability sample of households without telephones was also carried out in the 2002 study. However, in 2002, the area sample was reduced substantially due to factors such as cost, new research on statistical adjustment methods, and lower estimates of the percentages of households without telephones (Abi-Habib, Safir & Triplett, 2002). The 2002 area probability sample thus screened 730 households and yielded 578 completed interviews.

Overall, the 1997 and 2002 samples can be considered biased in favor of lower income households. This is a disadvantage in that the sample cannot be considered truly representative of all households. However, the advantage of targeting lower income households is that these are typically the households most at risk in terms of well-being and would, thus, be the households more likely to benefit from suggested interventions arising out of the conclusions and recommendations of a study such as this.

Families included in the study were reported to be living in “regular” housing, which included apartments, houses, and mobile homes. Military personnel living with their families were included. The population excluded from the study by the Urban Institute were those living in any dwelling unit with 9 or more unrelated persons, group homes, communes, halfway houses, dormitories, military barracks or ships, the homeless, the institutionalized population (those in jails, juvenile detention, residential treatment centers, psychiatric hospitals, and nursing homes), and people in transient or temporary arrangements, such as living in tents, vehicles, hotels or motels.

The interviews themselves were conducted over the phone by more than 650 interviewers based in three central interviewing facilities (in Frederick, MD, Rockville, MD, and Lebanon, VA), using computer assisted phone interviewing technology. Each interviewer was given 60 hours of training initially. At least 10 % of each interviewer's work was silently monitored for quality control purposes (Brick et al., 2002; Kenney, Scheuren & Wang, 1997). Confidentiality of participants was protected by the elimination of any direct identifiers, such as phone numbers, names, addresses, and geographic details (other than state identifiers) (Kenney et al., 1997).

Measures

The full 1997 and 2002 NSAF questionnaires, each of which is several hundred pages in length, may be downloaded from the Urban Institute's web site at <http://anf.urban.org.nsaf>. The data used for this study was part of a public database, accessible to anyone, conditional to registration with the Urban Foundation. The NSAF data and codebooks may be downloaded from the web site <http://anfdata.urban.org/drsurvey/login.cfm>. Several versions of the data are available in public use files with varying emphases. This study makes use of the "focalchl" public use files for the 1997 and 2002 samples. Several of the independent and dependent variables for this study were generated from combinations of the NSAF variables, the description of which follows.

Independent Variables

Family Type

The NSAF used a broad definition of family, based on relationships, and included unmarried partners, unlike surveys such as the Current Population survey (Abi-Habib, Safir, Triplett & Cunningham, 2002). During each interview, a household roster was set up to establish the relationships between all persons living in the family and the name, age and gender of each. Sample families with children were given different interview options (Option A) to households without children. This study used the data set that collected information from participants using the Option A interview.

The Focal Child

In sampled households completing interview Option A, up to two children were selected as focal children for the study, depending on their ages. One child under the age of 6 and one child between ages 6 and 17 were selected. The child under the age of 6 was referred to as Focal Child 1, and the child between the age of 6 and 17 was referred to as Focal Child 2.

Most Knowledgeable Adult

Once children in each household were selected, interviewers asked for the name of the caregiver most knowledgeable about the selected child's health and education. This caregiver was known as the Most Knowledgeable Adult (MKA) and answered questions related to the sample child, family and household. The MKA was usually the parent of the selected child. Where there were two focal children in the household, the

MKA was often the same person for both children, but this was not always the case. The MKA who answered questions related to a child under the age of 6 was known as the MKA1. Similarly, the MKA who answered questions related to a 6-to 17-year-old focal child was known as the MKA2. For households with two children and a different MKA for each child, an order rule was established, whereby MKA2 was interviewed first.

Four family structures were identified in this study. These included traditional two-parent intact families, skipped generation families with no parent present, co-parented families, and single parent families. These family types were determined by a consideration of various combinations of the UFAMSTR, UMKA1REL and UMKA2REL variables, coded by the NSAF from responses to the family roster in Section D of the NSAF questionnaire. While the majority of respondents belonged to either traditional two-parent families or single parent families, there were also respondents from both skipped generation and co-parenting grandparent-headed households.

The UFAMSTR variable provided information about the living arrangements of children with respect to their caregivers. According to the NSAF data, a value of 1 meant a child lived in a family without a biological or adoptive parent ($N_{1997} = 1,363$; $N_{2002} = 1,348$). A value of 2 was given to families where the child lived with a single biological or adoptive parent and may or may not have included that parent's unmarried partner ($N_{1997} = 10,678$; $N_{2002} = 9,044$). A value of 3 meant the child lived in a blended family, where parents were married and included one biological or adoptive parent and one stepparent ($N_{1997} = 2,451$; $N_{2002} = 2,583$). A value of 4 was given to families in which the child lived with two married or unmarried biological or adoptive parents ($N_{1997} = 19,862$; $N_{2002} = 21,336$).

The UMKA1REL and UMKA2REL variables were generated by the NSAF from each household roster and provided information on the relationship of the focal child to the MKA. The UMKA1REL variable related to families where the focal child was between the ages of 0 to 6 years, while the UMKA2REL variable related to families where the sampled child was aged from 6 to 17 years. From a wide range of options, the two labels that were of interest for this variable were biological child (value = 20; UMKA1REL $N_{1997} = 17,585$; $N_{2002} = 16,752$ and UMKA2REL $N_{1997} = 25,666$; $N_{2002} = 25,298$) and grandchild (value = 32; UMKA1REL $N_{1997} = 503$; $N_{2002} = 470$ and UMKA2REL $N_{1997} = 1,077$; $N_{2002} = 1,078$).

In order to identify the four family types used in this study, the UFAMSTR, UMKA1REL and UMKA2REL variables were combined, using SPSS 14.0, as follows. Participants were categorized as belonging to traditional families if UFAMSTR = 4 (child lived with two parents) and UMKA1REL or UMKA2REL = 20 (child was a biological child). Single parent families were identified if UFAMSTR = 2 (child lived with single parent) and UMKA1REL or UMKA2REL = 20 (child was a biological child). Skipped generation families were defined by {UFAMSTR = 1 (child lived with no parent) or UFAMSTR = 4 (two biological *or adoptive* parents)} and {UMKA1REL or UMKA2REL = 32 (was a grandchild)}. Co-parenting families were identified as {UFAMSTR = 2 (lived with a single parent) or UFAMSTR = 3 (lived in a blended family)} and {UMKA1REL or UMKA2REL = 32 (was a grandchild)}.

A disadvantage of the above description of family types is that it may not have strictly captured the distinction between skipped generation and co-parenting families. For example, a family where the child lived in a co-parenting household with both

parents and a grandparent (who was the MKA) could possibly end up in the skipped generation group instead of the co-parenting group. This was, however, likely to have been a rare occurrence. When UFAMSTR = 4 was omitted from the skipped generation equation, the sample size decreased considerably, despite the indicated higher number of grandparents identified as MKAs. It seemed many married grandparent caregivers in the NSAF survey identified themselves as their grandchild's adoptive parents and it was, thus, decided to include UFAMSTR = 4 as part of the descriptor in the skipped generation family equation.

For the 34,439 completed interviews for the NSAF 1997 study, 19,412 families were identified as "traditional", 450 as "co-parenting", 802 as "skipped generation" and 9,990 as "single-parent" families. Similarly, of the 34,332 completed interviews for the NSAF 2002 study, 20,776 families were identified as "traditional", 446 as "co-parenting", 806 as "skipped generation" and 8,294 as "single-parent" families. Since these figures demonstrated the presence of vastly unequal sample sizes, both the traditional and single parent families from 1997 and 2002 samples were equated to the smaller co-parenting and skipped generation families by means of random sampling from the larger cells. The final pool, whose data upon which the statistical analyses were performed for this study, is presented in Table 6.

Table 6

Family Type Sample Sizes for 1997 and 2002 NSAF Participants

Family Type	1997 Samples		2002 Samples	
	Original	Random	Original	Random
Traditional	19,412	610	20,776	604
Co-parenting	450	450	446	446
Skipped Generation	802	802	806	806
Single Parent	9,990	587	8,294	591
Total	29,932	2,449	30,322	2,447

Ethnicity

The responses of participants of three different ethnicities were studied: Caucasian, African- American and Hispanic. Ethnicity was defined in the data set by questions which asked the MKA to identify whether they were of Spanish or Hispanic origin, in addition to asking them their race. This was further prompted by providing the categories of white, black, American Indian (or Aleutian or Eskimo), Asian / Pacific Islander, or "Other". These were coded by the NSAF as the variables URACETH and UBFACE4. For the purpose of this study, Hispanic participants were determined by URACETH = 1. African American participants by the variable URACETH = 2. Caucasian participants were found by eliminating the Hispanic participants (UBFACE4 = 1) from the UBFACE4 = W (white) variable. Asian Americans, Native American Indians and Pacific Islanders made up less than 4% of the total sample and were thus excluded from further analysis.

Age of the Focal Child

The age of the focal child was considered as categorical data. Focal children fell into one of three age categories: 0 to 5 years, 6 to 11 years, or 12 to 17 years. Different well-being related questions were asked for differing age categories of child and depended in part on school-related factors that applied in different ways to the two older groups of children. Thus, this study also divided the focal children into three age groups (0 to 5 years; 6 to 11 years; 12 to 17 years) and separate analyses were run for each age group.

Caregiver Age

Age of the caregivers was accounted for by dividing the caregivers into three age groups (under 49 years; 50 to 64 years; 65 years and older). The main focus of interest was potential differences between skipped generation and co-parenting households, as it was unlikely there would be many grandparents under the age of 35 years, or traditional / single parents over the age of 65, in order to do a comparison across all four family types.

Gender of Caregiver and Focal Child

The gender of both focal child and the MKA was established.

Covariates

Family Income

Sections I and J of the NSAF questionnaire asked about the amount of money

income received in the preceding calendar year by each person in the sampled family. Included sources of family income were: money wages or salary; net income from self-employment; social security; supplemental security income; public assistance or welfare payments; interest on savings or bonds; dividends, income from estates of trusts, or net rental income; veterans payment or unemployment and worker's compensation; private pensions or government employee pensions; alimony or child support; regular contributions from persons not living in the household; and other periodic income. Food stamps and vouchers or coupons from the welfare office to pay for special expenses were excluded from the calculation of family income. These various income sources were summed, family size was taken into consideration and income was compared to the relevant year of the Census Bureau's Federal poverty thresholds (U.S. Census Bureau, 2006). The resulting variable, U_SOCPOV, which was used in this study, expressed family income as a percentage of poverty. A value of .05 was given to family incomes which were less than 50% of the poverty level (determined by the relevant year of the Census Bureau's Federal Poverty threshold - 1996 for 1997 sample). Correspondingly, a value of 1 was given to families with incomes greater than 50% but less than 100% of the relevant poverty level, 1.5 to those with incomes between 100% and 150% of the poverty level, 2 to incomes between 150% and 200%, 3 to incomes between 200% and 300%, and a 4 for families with incomes above 300% of the poverty level.

Table 7

Social Family Income Sample Sizes for the 1997 and 2002 NSAF Participants

Social Income	Value	1997 N	2002 N
Family income < 50% poverty line	0.5	308	195
50% < family income < 100% poverty	1	464	358
100% < family income < 150% poverty	1.5	408	356
150% < family income < 200% poverty	2	357	276
200% < family income < 300% poverty	3	386	495
Family income above 300% poverty	4	526	767
Total		2449	2447

It should be noted that, while overall item non-response rates for the NSAF questionnaires were generally low (often less than 1%), the item non-response rates for income questions were much higher (between 20 to 30%) and the missing data was imputed by Westat, using a “hot deck” method (Brick et al., 1999). This involved giving a value of income reported by a respondent who was similar to the person who failed to respond to the income question

Caregiver Education

The caregiver’s highest level of education was assessed by Section L of the NSAF questionnaire. Caregivers were asked about the highest grade of regular school completed, whether or not a GED or high school diploma had ever been earned, if any type of postsecondary education was pursued, and if any specific degrees had been

attained. This study used the UMEDULEV variable, the most detailed educational variable of the NSAF. Values ranging from 1 to 12 were given to caregivers, depending on their highest reported level of education, where higher values indicated higher levels of education. Unlike the social family income level, missing values were not imputed and were recoded as “missing system” in SPSS 14.0.

Table 8

Caregiver Education Sample Sizes for 1997 and 2002 NSAF Participants

Education Level	Value	1997 N	2002 N
Completed 8 th grade	1	167	143
Completed 9 th , 10 th or 11 th grade	2	357	293
Completed 12 th grade, no GED/diploma	3	32	35
Completed 12 th grade, GED	4	109	153
Completed 12 th grade, high school diploma	5	699	664
Some voc/tech classes, no certificate	6	16	5
Vocational or technical certificates	7	168	156
Completed some college classes	8	345	359
Associates degree	9	170	156
Bachelor's degree	10	206	245
Completed some graduate classes	11	33	29
Completed graduate of professional degree	12	120	146
Missing System		27	23
Total		2449	2447

Dependent Variables

Several indicators of well-being for both caregivers and children were used for this study. Indicators of well-being for the caregivers include self-report measures of

mental health and parental aggravation. The original intention of the study was to include a measure of the caregiver's physical health, but the health-related questions on the NSAF questionnaires were inexplicably skipped and not asked of the majority of caregivers. Indicators of well-being for focal children included a subjective report of current health status, behavior problems reported by the caregiver, school engagement, and caregiver involvement with younger children (in terms of the number of outings per month on which the child was taken and the number of days per week a family member read to the child). Each of these measures will be discussed in more detail below. Alpha values were run for all of the indicators of well-being. It was the original intention of the study to analyze only those measures (for the 1997 and 2002 sub-samples used for this study) with a reliability of at least .70, as per Hair, Anderson, Tatham and Black's (1995) recommendations for acceptable reliability. An exception was made, however, for the measure of caregiver aggravation, which had slightly lower Cronbach's alpha values of .67 for the 1997 sub-sample and .65 for the 2002 sub-sample.

Caregiver Mental Health

The NSAF questionnaire assesses caregiver mental health by means of a 5-item mental health scale, the Mental Health Inventory (MHI-5), which originated from a 38-item Mental Health Inventory (Urban Institute, 1999). Studies of the performance of the MHI-5 support its use as an effective instrument to detect mood and anxiety disorders (Berwick et al., 1991; Rumpf, Meyer, Hapke & John, 2001). The five items on the MHI-5 asked caregivers how often in the past month had they a) been a very nervous person, b) felt calm and peaceful, c) felt downhearted and blue, d) been a happy person, and e)

felt so down in the dumps nothing could cheer them up. For each item, the caregiver was asked to indicate whether he or she felt this way all of the time (scored 1), most of the time (scored 2), some of the time (scored 3), or none of the time (scored 4). For the purposes of this study, two of the MHI-5 items (b and d) were reverse scored and then scores for all 5 items were summed to give a final score to represent caregiver mental health (CGMNTLHT). The possible range for final scores was between 5 and 20, with higher scores indicative of better mental health. The reliability coefficient (alpha) for the 1997 sub-sample on this measure was .81, while the alpha for the 2002 sub-sample was .83.

Caregiver Aggravation

The NSAF questionnaire incorporated a 4-item parental aggravation scale, addressing the negative impact of the child's behavior on the caregiver and which was adapted from a component of the National Evaluation of Welfare-to-Work Strategies (NEWWS: Urban Institute, 1999). The 4 items asked caregivers how often in the past month they felt their child was much harder to care for than most, felt their child did things that really bothered them a lot, felt they were giving up more of their lives to meet their child's needs than ever expected, and felt angry with their child. For each item, the caregiver was asked to indicate whether they felt this way all of the time, most of the time, some of the time, or none of the time. Respondents' scores were summed to create a scaled score ranging from 4 to 16, labeled CGIMPACT, with lower scores indicative of a greater negative impact. The reliability for the 1997 sub-sample was .67, while the alpha value for the 2002 sub-sample was .65.

Child's Current Health Status

One indicator of well-being for focal children included a single item measure of the caregiver's subjective report of the child's current health status. The NSAF questionnaire item asked, "Now I'd like to talk about (CHILD's) health status. In general, would you say (CHILD's) health is excellent (scored 1), very good (scored 2), good (scored 3), fair (scored 4), or poor (scored 5)". A lower score is, thus, indicative of a better subjective perception of child's health. The reliability and validity of this single item measure is unknown and may be questionable. However, a lack of an alternative multi-item health measure may be deemed to warrant its cautious use in this study.

Child's Behavior Problems

The items on the NSAF questionnaire which addressed the behavioral and emotional problems of children were developed for the National Health Interview Survey (NHIS; Urban Institute, 1999). The caregiver of each child aged 6 and older was asked to indicate the extent to which, during the past month, the child did not get along with other kids, could not concentrate or pay attention for long, and had been unhappy, sad or depressed. These items were scored as often true (score of 1), sometimes true (score of 2) or never true (score of 3). In addition to these questions, the caregivers of children aged 6 to 11 years were asked to indicate whether the child felt worthless or inferior, had been nervous, high strung or tense, or acted too young for his or her age. The MKA's for children aged 12 to 17 years were asked whether the child had trouble sleeping, lied or cheated or did poorly at schoolwork. All the responses were summed for each child, to create a score ranging from 6 to 18, with a lower score indicating

greater behavioral and emotional problems. Alpha values for the measure for children aged 6 to 11 years were .75 for the 1997 sub-sample and .76 for the 2002 sub-sample. Alpha values for the measure for children aged 12 to 17 years were .77 for the 1997 sub-sample and .73 for the 2002 sub-sample.

Extent of Caregiver Involvement with a Younger Child

Two single item measures, the NSAF variables NREAD and NOUTING, were included to reflect measures of the caregiver's active involvement with a younger child (families with a focal child aged 5 or under). The items themselves did not demonstrate sufficient reliability to combine them as an overall measure of caregiver involvement (alpha for the 1997 sub-sample was .17 and .20 for the 2002 sub-sample). The variable, NREAD, was determined by asking the caregiver, "How many days in the past week did you or any family member read stories or tell stories to (CHILD 1)?" A family member was defined as any relative, whether or not they lived with the child (for example, grandparents, brothers, sisters, parents, aunts and uncles). Responses were coded from 0 to 7 (days in the past week). The NSAF variable, NOUTING, was determined by asking the caregiver, "How often in the past month have you or any family member taken (CHILD 1) on any kind of outing, such as to the park, grocery store, a church, or a playground?" Outings were included if they were with family members or relatives who did not live with the child. They could also include outings such as a trip to the zoo or going out for ice cream, but interviewers were instructed not to include going to the doctor, dentist or traveling to and from a day care site. Responses were coded as either 1 (Once a month or less), 2 (About 2 or 3 times a month), 3 (Several times a

week), or 4 (About once a day). The caregiver's active involvement with a younger child in the form of reading and outings were considered to be measures of psychological well-being for the younger child, since there appears to be substantial research to support the positive effects of these resources on children (for example, Coplon & Worth, 1985; Fielding-Barnsley & Purdie, 2003; Jacobs, 2004; Sharif, Ozuah, Dinkevich & Mulvihill, 2003).

Child's School Engagement

Four items on the NSAF questionnaire addressed the focal child's school engagement and were selected from the parent report version of the Rochester Assessment Package for Schools (RAPS-P; Wellborn & Connell, 1987). Respondents of children aged from 6 to 17 years were asked to describe whether the child cared about doing well in school, only worked on schoolwork when forced to, did just enough schoolwork to get by, and always did homework, using the response categories "all of the time," "most of the time," "some of the time," or "none of the time." Responses were summed to create scale scores that ranged from 4 to 16, where higher scores indicated greater school engagement (Urban Institute, 1999). The reliability coefficient for this measure was .74 for the 1997 sub-sample and .71 for the 2002 sub-sample.

Table 9

Summary of Descriptive Statistics for Dependent Variables for 1997 Sample

Dependent Variable		Traditional Family	Co-parenting Family	Skipped Generation	Single Parent Family	Sample Total
Caregiver mental health	<i>M</i>	16.34	15.24	15.21	15.04	15.46
	<i>SD</i>	2.46	2.86	3.02	2.98	2.89
	Range	5-20	5-20	5-20	5-20	5-20
Caregiver aggravation	<i>M</i>	14.14	13.52	13.23	13.48	13.57
	<i>SD</i>	1.65	2.37	2.36	2.12	2.17
	Range	6-16	4-16	4-16	4-16	4-16
Child health status	<i>M</i>	1.64	1.9	2.07	1.81	1.87
	<i>SD</i>	0.83	0.98	1.0	0.93	0.96
	Range	1-5	1-5	1-5	1-5	1-5
Behavior problems, 6-11 years	<i>M</i>	16.21	15.59	15.08	15.56	15.57
	<i>SD</i>	1.95	2.26	2.44	2.34	2.31
	Range	9-18	9-18	7-18	9-18	7-18
Behavior problems, 12-17 years	<i>M</i>	16.31	14.82	15.34	15.33	15.57
	<i>SD</i>	2.07	2.60	2.42	2.59	2.43
	Range	6-18	10-18	7-18	7-18	6-18
Outings with child	<i>M</i>	3.07	2.98	2.98	2.91	2.99
	<i>SD</i>	0.66	0.76	0.74	0.68	0.72
	Range	1-4	1-4	1-4	1-4	1-4
Reads to child	<i>M</i>	4.97	4.44	4.67	4.49	4.63
	<i>SD</i>	2.23	2.42	2.43	2.33	2.37
	Range	0-7	0-7	0-7	0-7	0-7
School engagement	<i>M</i>	13.05	12.54	12.22	12.54	12.56
	<i>SD</i>	2.71	2.70	2.94	3.00	2.90
	Range	4-16	6-16	4-16	4-16	4-16
Income	<i>M</i>	2.86	1.96	1.91	1.77	2.13
	<i>SD</i>	1.13	1.18	1.17	1.14	1.23
	Range	0.5-4	0.5-4	0.5-4	0.5-4	0.5-4
Education	<i>M</i>	7.13	5.26	5.13	6.24	5.92
	<i>SD</i>	3.10	2.81	3.11	2.68	3.07
	Range	1-12	1-12	1-12	1-12	1-12

Table 10

Summary of Descriptive Statistics for Dependent Variables for 2002 Sample

Dependent Variable		Traditional Family	Co-parenting Family	Skipped Generation	Single Parent Family	Sample Total
Caregiver mental health	<i>M</i>	16.39	15.59	15.51	14.92	15.60
	<i>SD</i>	2.32	2.82	3.07	3.07	2.90
	Range	5-20	5-20	5-20	5-20	5-20
Caregiver aggravation	<i>M</i>	14.08	13.76	13.29	13.60	13.64
	<i>SD</i>	1.84	2.08	2.32	2.12	2.14
	Range	4-16	4-16	4-16	4-16	4-16
Child health status	<i>M</i>	1.56	1.82	2.09	1.81	1.84
	<i>SD</i>	0.83	0.90	1.04	0.94	0.96
	Range	1-5	1-5	1-5	1-5	1-5
Behavior problems, 6-11 years	<i>M</i>	15.96	15.65	15.23	15.39	15.51
	<i>SD</i>	2.19	2.34	2.51	2.36	2.38
	Range	6-18	6-18	6-18	6-18	6-18
Behavior problems, 12-17 years	<i>M</i>	16.18	16.06	15.14	15.34	15.47
	<i>SD</i>	2.16	2.06	2.37	2.19	2.29
	Range	7-18	7-18	7-18	7-18	7-18
Outings with child	<i>M</i>	3.08	2.94	2.92	2.98	2.98
	<i>SD</i>	0.61	0.75	0.76	0.67	0.71
	Range	1-4	1-4	1-4	1-4	1-4
Reads to child	<i>M</i>	5.54	4.99	4.83	4.63	5.02
	<i>SD</i>	2.07	2.27	2.31	2.19	2.24
	Range	0-7	0-7	0-7	0-7	0-7
School engagement	<i>M</i>	13.13	12.69	12.24	12.41	12.54
	<i>SD</i>	2.62	2.89	2.82	2.84	2.81
	Range	4-16	4-16	4-16	4-16	4-16
Income	<i>M</i>	3.16	2.42	2.30	2.11	2.49
	<i>SD</i>	1.07	1.21	1.23	1.23	1.26
	Range	0.5-4	0.5-4	0.5-4	0.5-4	0.5-4
Education	<i>M</i>	7.75	5.56	5.45	6.16	6.21
	<i>SD</i>	2.98	2.82	3.10	2.76	3.08
	Range	1-12	1-12	1-12	1-12	1-12

CHAPTER 3

RESULTS

The focus of this study was to compare differences in well-being of both caregivers and children in differently structured and ethnically diverse families, with a particular interest in grandparent-headed households. The original overall plan was to run a MANCOVA for each hypothesis. However, due to the exclusive nature of the dependent variables (Caregiver Mental Health and Caregiver Aggravation, Child's Health Status, Behavior Problems specifically related to 6- to 11-year-olds, Behavior Problems related to 12- to 17-year-olds, Caregiver Involvement with younger children aged from 0 to 5 years, and School Engagement applicable to 6- to 17- year-olds), an analysis of covariance (ANCOVA), using education and family income as covariates, was performed for each measure of well-being. Where the null hypothesis was rejected, a post hoc pairwise comparison of means, the Least Significant Difference, was used to determine which groups were significantly different from each other.

Caregiver Mental Health

Main Effect for Family Type on Caregiver Mental Health

The first hypothesis in this study proposed caregivers of traditional two-parent families would demonstrate better perceived mental health than those in co-parenting families, who, in turn, would demonstrate better perceived mental health than caregivers of skipped generation families, who, in turn, would demonstrate better perceived mental health than caregivers in single parent families. A higher score for caregiver mental health was indicative of better mental health.

A one-way analysis of covariance (ANCOVA) with family income and caregiver education as covariates was carried out for the 1997 sample. There was a significant main effect for family type on caregiver mental health, $F(3, 2356) = 6.91, p < .05$. The power was .98, with an effect size of .009. Based upon pairwise comparisons, traditional families ($M_{adj} = 15.92; SD = 2.46$) were found to have significantly better mental health scores than those of co-parenting families ($M_{adj} = 15.38; SD = 2.86$), skipped generation families ($M_{adj} = 15.36; SD = 3.02$) and single parent families ($M_{adj} = 15.17; SD = 2.90$). The three remaining family types did not differ from one another.

A similar main effect for family type on caregiver mental health was found for the 2002 sample, $F(3, 2375) = 12.27, p < .05$. The power was 1.00, with an effect size of .02. For this sample, traditional families ($M_{adj} = 16.09; SD = 2.33$) were found to have significantly better mental health scores than those of co-parenting families ($M_{adj} = 15.65; SD = 2.82$), skipped generation families ($M_{adj} = 15.61; SD = 3.07$) and single parent families ($M_{adj} = 15.04; SD = 3.07$). Further, co-parenting and skipped generation family caregivers (while not significantly different from each other) reported better mental health scores than the single parents. Partial support for Hypothesis 1 with respect to caregiver mental health was thus found for both the 1997 and 2002 samples.

Interaction of Family Type and Ethnicity on Caregiver Mental Health

The second hypothesis in this study proposed there would be an interaction between family type and ethnicity and that, in this respect, caregiver mental health would be expected to vary as follows:

Table 11

Review of Hypothesis 2

Family Type	Ethnicity		
	Caucasian	African American	Hispanic
Traditional	Higher	Higher	Higher
Co-parenting	Lower	Higher	Higher
Skipped Generation	Higher	Higher	Lower
Single Parents	Lower	Lower	Lower

There was an interaction in the 1997 sample for family type and ethnicity on caregiver mental health, $F(6, 2271) = 2.45, p < .05$. The sample sizes, adjusted means and standard deviations are displayed in the table below. The power was .83, with an effect size of .006.

Table 12

Statistics for 1997 Family Type X Ethnicity on Caregiver Mental Health

Family Type		Ethnicity		
		Caucasian	African American	Hispanic
Traditional	<i>n</i>	437	43	94
	<i>M</i>	15.67	15.98	16.73
	<i>SD</i>	2.43	2.56	2.66
Co-parenting	<i>n</i>	163	181	76
	<i>M</i>	15.23	15.56	15.33
	<i>SD</i>	2.84	2.96	2.69
Skipped Generation	<i>n</i>	305	317	112
	<i>M</i>	15.50	15.46	14.96
	<i>SD</i>	2.94	3.04	3.21
Single Parents	<i>n</i>	285	185	87
	<i>M</i>	14.97	15.54	15.21
	<i>SD</i>	2.88	3.20	2.96

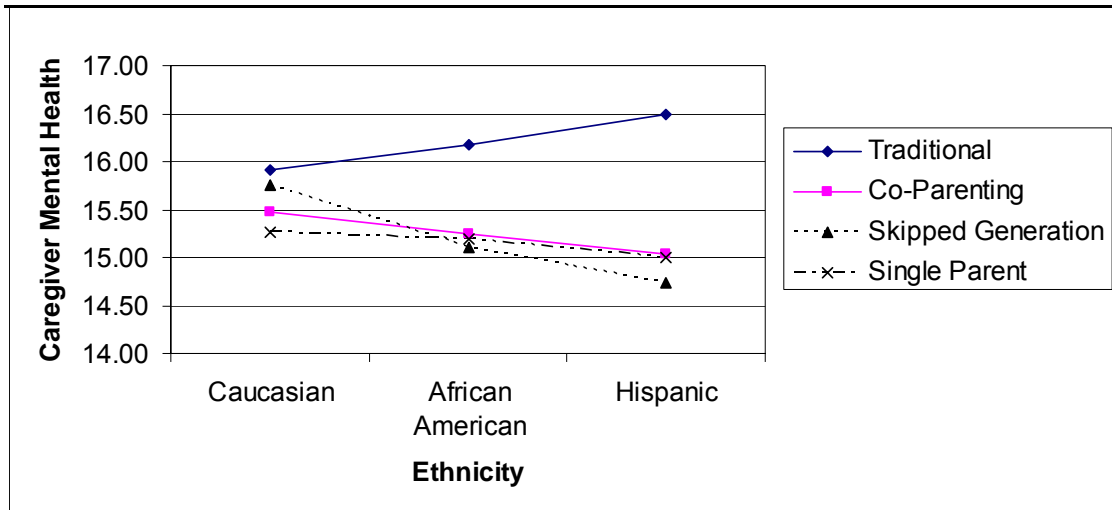


Figure 1. 1997 interaction of family and ethnicity on caregiver mental health.

To decompose the interaction, 3 one-way ANCOVAs were run by family type for caregiver mental health for each ethnic group separately. These analyses indicated an effect was found for the Caucasian families, $F(3, 1184) = 3.55, p < .05$, with post hoc tests indicating caregiver mental health was better in Caucasian traditional families ($M_{adj} = 15.91; SD = 2.43$) than Caucasian single parent families ($M_{adj} = 15.27; SD = 2.88$). Caucasian skipped generation families ($M_{adj} = 15.76; SD = 2.94$) also reported better caregiver mental health than the Caucasian single parent families ($M_{adj} = 15.27; SD = 2.88$). No differences between Caucasian co-parenting families ($M_{adj} = 15.48; SD = 2.84$) and other family types emerged, and no other differences between the Caucasian family types were found. For African American families, all caregiver mental health scores were similar across family type. For Hispanic families, $F(3, 363) = 7.25, p < .05$, post hoc tests indicated Hispanic traditional families ($M_{adj} = 16.50; SD = 2.66$) had higher well being than Hispanic co-parenting families ($M_{adj} = 15.04; SD = 2.69$), Hispanic skipped generation families ($M_{adj} = 14.74; SD = 3.21$) and Hispanic single

parent families ($M_{adj} = 14.99$; $SD = 2.96$). The latter three groups were similar in this respect.

There was no interaction in the 2002 sample for family type and ethnicity on caregiver mental health. Hypothesis 2 was, thus, partially supported by the 1997 sample but rejected with respect to the 2002 sample.

Interaction of Family Type and Child’s Gender on Caregiver Mental Health

The third hypothesis in this study proposed there would be an interaction between family type and gender (of child and caregiver separately), wherein the mental health for caregivers would be expected to vary as follows:

Table 13

Review of Hypothesis 3

Family Type	Gender	
	Male	Female
Traditional	Higher	Higher
Co-parenting	Lower	Lower
Skipped Generation	Lower	Higher
Single Parents	Lower	Lower

There were, however, no interactions for either the 1997 or 2002 samples for child’s gender and family type on caregiver mental health. Hypothesis 3A, with respect to child gender, was, thus, rejected.

Interaction of Family Type and Caregiver Gender on Caregiver Mental Health

There was an interaction for the 1997 sample for caregiver gender and family

type on caregiver mental health, $F(3, 2352) = 4.05, p < .05$. The power was .84, with an effect size of .005. The adjusted means for each group appear below.

Table 14

Statistics for 1997 Family Type X Caregiver Gender on Caregiver Mental Health

Family Type	Caregiver Gender		
	Male	Female	
Traditional	<i>n</i>	125	470
	<i>M</i>	16.08	15.92
	<i>SD</i>	2.23	2.52
Co-parenting	<i>n</i>	25	407
	<i>M</i>	16.96	15.27
	<i>SD</i>	2.60	2.83
Skipped Generation	<i>n</i>	93	674
	<i>M</i>	16.16	15.24
	<i>SD</i>	3.06	2.98
Single Parents	<i>n</i>	50	518
	<i>M</i>	16.66	15.01
	<i>SD</i>	2.29	2.98

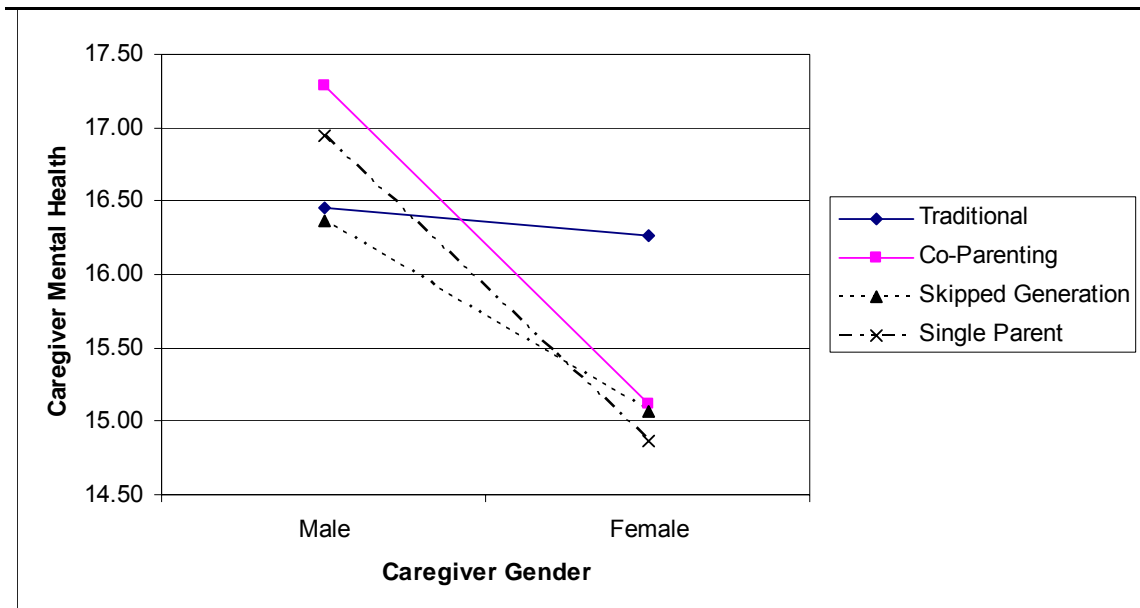


Figure 2. 1997 interaction of family type and caregiver gender on caregiver mental health.

To decompose the interaction, a one way ANCOVA was run by family type for caregiver mental health for each caregiver gender. An effect for family type was found for female caregivers, $F(3, 2063) = 7.57, p < .05$, but not for male caregivers. Post hoc testing indicated caregiver mental health was better for the female caregivers in traditional families ($M_{adj} = 15.54; SD = 2.52$) as compared to female caregivers in co-parenting families ($M_{adj} = 15.23; SD = 2.83$), skipped generation families ($M_{adj} = 15.20; SD = 2.99$), or single parent families ($M_{adj} = 14.99; SD = 2.98$). No other differences in caregiver mental health between family types emerged.

There was also an interaction for the 2002 sample for family type and caregiver gender on caregiver mental health, $F(3, 2371) = 3.46, p < .05$. The power was .78, with an effect size of .004. The adjusted means for each group appear below.

Table 15

Statistics for 2002 Family Type X Caregiver Gender on Caregiver Mental Health

Family Type		Caregiver Gender	
		Male	Female
Traditional	<i>n</i>	129	458
	<i>M</i>	16.23	16.07
	<i>SD</i>	2.28	2.34
Co-parenting	<i>n</i>	32	404
	<i>M</i>	17.38	15.51
	<i>SD</i>	1.85	2.83
Skipped Generation	<i>n</i>	87	695
	<i>M</i>	16.57	15.48
	<i>SD</i>	2.89	3.07
Single Parents	<i>n</i>	78	498
	<i>M</i>	15.73	14.93
	<i>SD</i>	3.11	3.04

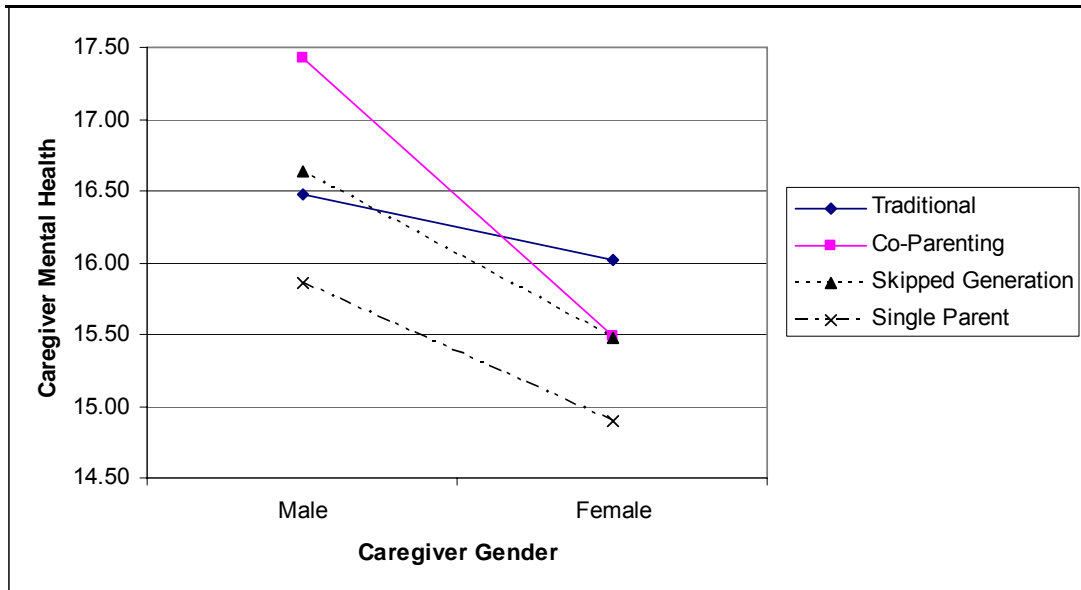


Figure 3. 2002 interaction of family type and caregiver gender on caregiver mental health.

As for the 1997 sample, a one way ANCOVA was run by family type for caregiver mental health for each caregiver gender in the 2002 sample to decompose the interaction. An effect for family type was found for both female caregivers, $F(3, 2049) = 11.33, p < .05$, and male caregivers, $F(3, 320) = 2.926, p < .05$. Post hoc testing indicated caregiver mental health was better for the 2002 female caregivers in traditional families ($M_{adj} = 16.02; SD = 2.34$) as compared to female caregivers in co-parenting families ($M_{adj} = 15.49; SD = 2.83$), skipped generation families ($M_{adj} = 15.47; SD = 3.07$), or single parent families ($M_{adj} = 14.90; SD = 3.04$). In addition, female caregivers of co-parenting and skipped generation families reported better mental health than female single parents. No differences in caregiver mental health between female caregivers in the co-parenting and skipped generation families were found. For the 2002 male caregivers, caregiver mental health was better for the male caregivers in co-parenting families ($M_{adj} = 17.43; SD = 1.85$) as compared to male caregivers in

single parent families ($M_{adj} = 15.86$; $SD = 3.12$). No other differences between caregiver mental health of family types for male caregivers was found, including male caregivers in traditional families ($M_{adj} = 16.48$; $SD = 2.28$) and male caregivers in skipped generation families ($M_{adj} = 16.63$; $SD = 2.89$).

Partial support was thus found for Hypothesis 3B (caregiver gender) in both the 1997 and 2002 samples.

Interaction of Family Type and Child’s Age on Caregiver Mental Health

The fourth hypothesis in this study proposed there would be an interaction between family type and child’s age on caregiver mental health. However, no interactions were found for either the 1997 or 2002 samples in this regard. Hypothesis 4 was thus rejected.

Interaction of Family Type and Caregiver Age on Caregiver Mental Health

The fifth hypothesis of this study proposed there would be an interaction between family type and caregiver’s age on caregiver mental health as described below:

Table 16

Review of Hypothesis 5

Family Type	Caregiver Age		
	Under 49 years	50 to 64 years	+65 years
Traditional	Higher	Higher	(Lower)*
Co-parenting	Lower	Higher	Lower
Skipped Generation	Lower	Higher	Lower
Single Parents	Lower	Lower	(Lower)*

Note. * Not expected to find a significant number of traditional / single parents in this age category

There were no interactions for either the 1997 or 2002 samples for family type and caregiver age on caregiver mental health. With respect to caregiver mental health, Hypothesis 5 was, therefore, rejected.

*Interaction of Family Type, Ethnicity and Caregiver Gender
on Caregiver Mental Health*

The final hypothesis in this study proposed there would be an interaction between family type, ethnicity and caregiver gender on caregiver mental health. An interaction was found for the 1997 sample, but this was not interpreted due to some very small cell sizes, mainly due to the low number of male caregivers in the African American co-parenting group ($N = 3$), the African American single parent group ($N = 5$), and the Hispanic co-parenting group ($N = 5$). No interaction was found for the 2002 sample. Hypothesis 6 was thus rejected.

Caregiver Aggravation

Main Effect for Family Type on Caregiver Aggravation

The first hypothesis in this study proposed caregivers in traditional two-parent families would demonstrate higher scores for caregiver aggravation (indicating less aggravation and, thus, better well-being) than those in co-parenting families, who, in turn, would demonstrate higher aggravation scores than caregivers in skipped generation families, who, in turn, would demonstrate higher aggravation scores than caregivers in single parent families.

For the 1997 sample, there was a significant main effect for family type on caregiver aggravation, $F(3, 2355) = 8.98, p < .05$. The power of this analysis was .996,

with an effect size of .01. Looking at pair wise comparisons, traditional families ($M_{adj} = 13.94$; $SD = 1.65$) were found to have higher scores, indicating less negative impact of caregiver aggravation, than those of co-parenting families ($M_{adj} = 13.58$; $SD = 2.37$), skipped generation families ($M_{adj} = 13.30$; $SD = 2.36$) and single parent families ($M_{adj} = 13.55$; $SD = 2.12$). In addition, there was a difference between the caregiver aggravation scores of co-parenting families and skipped generation families, and between skipped generation families and single parent families, with the skipped generation caregivers reporting greater caregiver aggravation than both the co-parenting and single parent caregivers. There was no difference in reported caregiver aggravation between co-parenting and single parent caregivers.

For the 2002 sample, there was also a main effect for family type on caregiver aggravation, $F(3, 2366) = 9.92$, $p < .05$. The power of this analysis was .998, with an effect size of .012. From pair wise comparisons, traditional families ($M_{adj} = 13.96$; $SD = 1.84$) were found to have higher scores, indicating less negative impact of caregiver aggravation, than those of skipped generation families ($M_{adj} = 13.33$; $SD = 2.33$) and single parent families ($M_{adj} = 13.65$; $SD = 2.12$). In addition, co-parenting families ($M_{adj} = 13.78$; $SD = 2.08$) demonstrated less negative impact of caregiver aggravation than the skipped generation families. The skipped generation caregivers also reported greater caregiver aggravation than the single parent caregivers. There was no difference in reported caregiver aggravation between traditional families and co-parenting families.

With respect to caregiver aggravation, Hypothesis 1 was partially supported for both the 1997 and 2002 samples.

Interaction of Family Type and Ethnicity on Caregiver Aggravation

The second hypothesis in this study proposed there would be an interaction between family type and ethnicity and that, in this respect, caregiver aggravation (with a higher score indicating less aggravation) would be expected to vary as follows:

Table 17

Review of Hypothesis 2

Family Type	Ethnicity		
	Caucasian	African American	Hispanic
Traditional	Higher	Higher	Higher
Co-parenting	Lower	Higher	Higher
Skipped Generation	Higher	Higher	Lower
Single Parents	Lower	Lower	Lower

There was no interaction for either the 1997 or the 2002 sample for ethnicity and family type on caregiver aggravation. Hypothesis 2 was thus rejected.

Interaction of Family Type and Child's Gender on Caregiver Aggravation

The third hypothesis in this study proposed there would be an interaction between family type and gender (of child and caregiver), wherein the mental health for caregivers would be expected to vary as follows:

Table 18

Review of Hypothesis 3

Family Type	Gender	
	Male	Female
Traditional	Higher	Higher
Co-parenting	Lower	Lower
Skipped Generation	Lower	Higher
Single Parents	Lower	Lower

There were, however, no interactions for either the 1997 or 2002 samples for family type and child’s gender on caregiver aggravation. Hypothesis 3A was thus rejected.

Interaction of Family Type and Caregiver Gender on Caregiver Aggravation

Testing the second part of Hypothesis 3, there was no interaction for either the 1997 or the 2002 sample for family type and caregiver gender on caregiver aggravation. Hypothesis 3B was thus rejected.

Interaction of Family Type and Child’s Age on Caregiver Aggravation

The fourth hypothesis in this study proposed there would be an interaction between family type and child’s age on caregiver aggravation. However, no significant interactions were found for either the 1997 or 2002 samples in this regard. Hypothesis 4 was rejected.

Interaction of Family Type and Caregiver Age on Caregiver Aggravation

The fifth hypothesis of this study proposed there would be an interaction between family type and caregiver’s age on caregiver aggravation as described below:

Table 19
Review of Hypothesis 5

Family Type	Caregiver Age		
	Under 49 years	50 to 64 years	+65 years
Traditional	Higher	Higher	(Lower)*
Co-parenting	Lower	Higher	Lower
Skipped Generation	Lower	Higher	Lower
Single Parents	Lower	Lower	(Lower)*

Note. * Not expected to find a significant number of traditional / single parents in this age category

There was, however, no interaction in either the 1997 or 2002 samples for caregiver age and family type on caregiver aggravation, and Hypothesis 5 was rejected.

Interaction of Family Type, Ethnicity and Caregiver Gender on Caregiver Aggravation

The final hypothesis in this study proposed there would be an interaction between family type, ethnicity and caregiver gender on caregiver aggravation. No interaction was found for either the 1997 or 2002 samples. Again, several small cell sizes were noted for the male African American and Hispanic caregivers. Hypothesis 6 was rejected.

Child's Current Health Status

Main Effect for Family Type on Child's Current Health Status

The first hypothesis in this study proposed children of traditional two-parent families would be rated by their caregivers as having better perceived current health than those in co-parenting families, who, in turn, would be rated as having better perceived current health than children of skipped generation families. Similarly, the children of skipped generation families would be rated by their caregivers as having better perceived current health than those in single parent families. A lower score was indicative of a better subjective perception of child's health.

For the 1997 sample, there was a significant main effect for family type on the caregiver's rated health status of the child, $F(3, 2416) = 11.02, p < .05$. The power of this analysis was .999, with an effect size of .013. From the pair wise comparisons,

caregivers in skipped generation families ($M_{adj} = 2.02$; $SD = 1.01$) were found to report higher scores, indicating poorer rated health of the focal child, than those of traditional families ($M_{adj} = 1.77$; $SD = .83$), co-parenting families ($M_{adj} = 1.86$; $SD = .98$), and single parent families ($M_{adj} = 1.77$; $SD = .93$). There were no differences in the caregiver's rated health status of the child between traditional, co-parenting and single parent families.

For the 2002 sample, there was a significant main effect for family type on the caregiver's rated health of the child $F(3, 2418) = 21.29$, $p < .05$. The power of this analysis was 1.0, with an effect size of .03. As in the 1997 sample, caregivers in skipped generation families ($M_{adj} = 2.05$; $SD = 1.04$) were found to report higher scores, indicating poorer perceived health of the focal child, than those of traditional families ($M_{adj} = 1.66$; $SD = .83$) co-parenting families ($M_{adj} = 1.80$; $SD = .90$), and single parent families ($M_{adj} = 1.78$; $SD = .95$). There were also differences in the caregiver's rating of current health status of the child between traditional and co-parenting families (with children of traditional families having better rated health), and between traditional and single parent families (again with children of traditional families having better rated health). Hypothesis 1 was partially supported in both the 1997 and 2002 samples.

Interaction of Family Type and Ethnicity on Child's Current Health Status

With respect to the second hypothesis of this study, for both the 1997 and 2002 samples, there was no significant interaction between family type and ethnicity on the focal child's health. Hypothesis 2 was, therefore, rejected.

*Interaction of Family Type and Child's Gender or Caregiver Gender
on Child's Current Health Status*

There was no support for the third hypothesis of this study for this dependent variable. For both the 1997 and 2002 samples, there was no significant interaction between family type and gender (for either the focal child or caregiver) on the focal child's health. Both hypotheses 3A and 3B were, therefore, rejected.

Interaction of Family Type and Child's Age on Child's Current Health Status

With respect to Hypothesis 4, an interaction of family type and child's age on the child's health was found. For the 1997 sample, there was an interaction between family type and focal child's age on the child's health, $F(6, 2408) = 4.41, p < .05$. The power of this analysis was .985, with an effect size of .011.

Table 20

Statistics for 1997 Family Type X Child Age on Child Health Status

Family Type		Age of Focal Child		
		0 to 5 Years	6 to 11 Years	12 to 17 Years
Traditional	<i>n</i>	246	200	160
	<i>M</i>	1.68	1.72	2.00
	<i>SD</i>	0.78	0.79	0.94
Co-parenting	<i>n</i>	357	56	30
	<i>M</i>	1.77	2.27	2.14
	<i>SD</i>	0.94	1.13	1.03
Skipped Generation	<i>n</i>	272	264	207
	<i>M</i>	1.90	2.16	2.01
	<i>SD</i>	0.98	1.02	1.01
Single Parents	<i>n</i>	198	207	176
	<i>M</i>	1.67	1.67	1.99
	<i>SD</i>	0.94	0.89	0.96

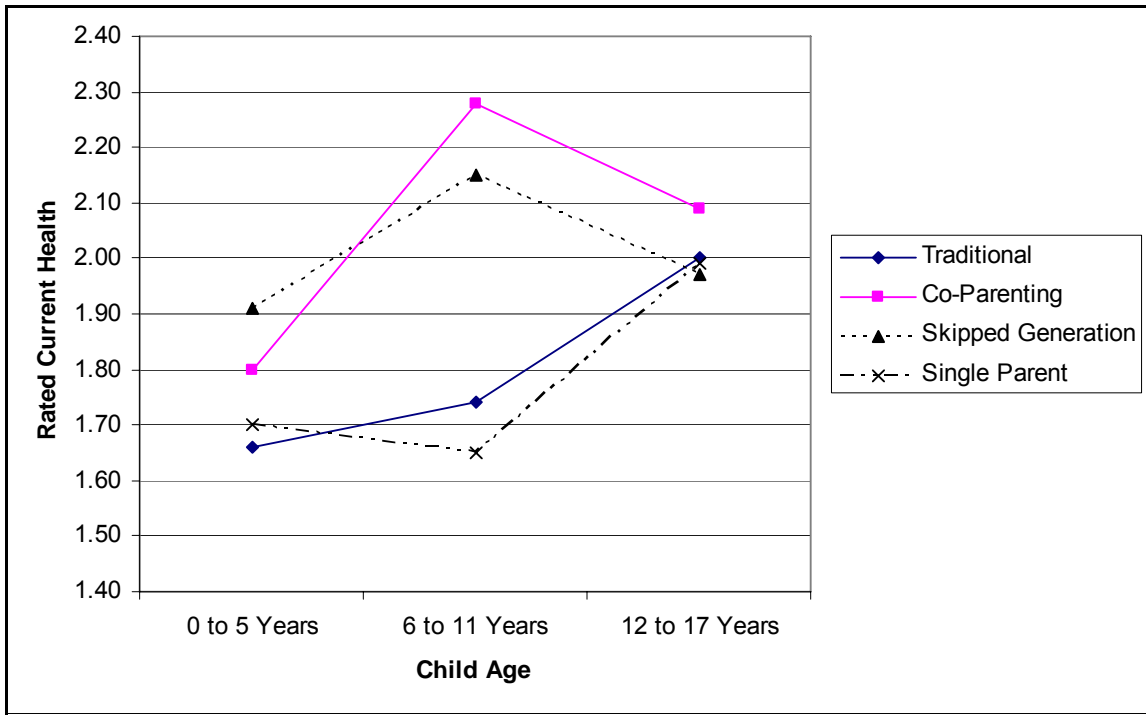


Figure 4. 1997 interaction of family type and child age on child health.

A one way ANCOVA for each age group was run by family type on child's health.

Significant effects were found for family type on child health for focal children in the 0- to 5-year-old age group, $F(3, 1067) = 3.79, p < .05$ and the 6- to 11-year-old age group, $F(3, 721) = 17.11, p < .05$. No differences in health were found for the 12- to 17-year-old age group. For the 0- to 5-year-olds, health was reported to be worse for children in skipped generation families ($M_{adj} = 1.91; SD = .98$) than compared to children in traditional families ($M_{adj} = 1.67; SD = .77$) and single parent families ($M_{adj} = 1.70; SD = .94$). There were no differences in reported health for children aged 0 to 5 years in co-parenting families ($M_{adj} = 1.80; SD = .94$). For the 6- to 11- year-olds, health was also reported to be worse for children in skipped generation families ($M_{adj} = 2.15; SD = 1.02$) than children in traditional families ($M_{adj} = 1.74; SD = .79$) and single parent families ($M_{adj} = 1.65; SD = .89$). In addition, the reported health of 6- to 11-year-olds was also

worse for children in co-parenting families ($M_{adj} = 2.28$; $SD = 1.13$) than their peers in the traditional and single parent families. There were no differences, however, between the reported health of 6- to 11-year-olds in co-parenting and skipped generation families.

Further testing of Hypothesis 4 for the 2002 sample did not find an interaction between family type and focal child's age on the child's health. Hypothesis 4 was, thus, partially supported in the 1997 sample, but not in the 2002 sample.

*Interaction of Family Type and Caregiver Age
on Child's Current Health Status*

No interaction was found for family type and caregiver age on the child's health for either the 1997 or the 2002 samples. Hypothesis 5 was rejected.

*Interaction of Family Type, Ethnicity and Caregiver Gender
on Child's Current Health Status*

Hypothesis 6 proposed there would be an interaction between family type, ethnicity and caregiver gender on child's health. There was, however, no interaction in either the 1997 or 2002 samples for family type and caregiver age on the focal child's health status, and Hypothesis 6 was rejected once again.

Behavior Problems in 6- to 11-Year-Olds

To reflect the nature of these data, behavior problems were examined specific to younger (6 to 11 years) and older (12 to 17 years) children. Results for the younger age group will be reported first.

Main Effect for Family Type on Behavior Problems in 6- to 11-Year-Olds

As per the first hypothesis of study, there was a main effect in the 1997 sample for family type on behavior problems in the 6- to 11-year-old age category, $F(3,694) = 5.17$, $p < .05$. The observed power for the analysis was .94, with an effect size of .023. Pairwise comparisons indicated traditional families ($M_{adj} = 16.02$; $SD = 1.95$) experienced significantly fewer behavioral problems regarding 6- to 11-year-olds as compared to skipped generation families ($M_{adj} = 15.15$; $SD = 2.44$). Further, skipped generation families raising 6- to 11-year-olds reported more behavioral problems than did single parent families ($M_{adj} = 15.67$; $SD = 2.34$). Co-parenting families ($M_{adj} = 15.53$; $SD = 2.26$) did not differ from the other family types in terms of behavioral problems reported for 6- to 11-year-olds. No other differences between family types were found for the 1997 sample.

In the 2002 sample, family type was also found to have a significant main effect on behavioral problems in 6- to 11-year-olds, $F(3, 679) = 2.60$, $p = .05$. The observed power was .64, and the effect size was .011. Post hoc pairwise comparisons indicated caregivers in traditional families reported fewer behavioral difficulties in the 6- to 11-year-olds that they parented ($M_{adj} = 15.91$; $SD = 2.19$) than those in skipped generation families ($M_{adj} = 15.25$; $SD = 2.50$) and single parent families ($M_{adj} = 15.40$; $SD = 2.36$), but not when compared to co-parenting families ($M_{adj} = 15.66$; $SD = 2.34$). No other differences between family types were evident for the 2002 sample.

For behavior problems in 6- to 11-year-olds, Hypothesis 1 was partially supported by the findings for both the 1997 and 2002 samples.

*Interaction of Family Type and Ethnicity on
Behavior Problems in 6- to 11-Year-Olds*

There was no interaction in the 1997 sample for family type and ethnicity on behavior problems reported by caregivers for the 6- to 11-year-old age group. In this respect, it should be noted some of the samples sizes for these groups were much smaller than for other groups, which would affect the degree of variability observed (for example, $N = 7$ for the Hispanic co-parenting group and $N = 10$ for the African American traditional family group, compared to much larger sample sizes such as $N = 143$ for the Caucasian traditional family group, or $N = 122$ for the African American skipped generation family type). Similarly, there was no interaction in the 2002 sample for ethnicity and family type on behavior problems as reported by caregivers for the 6- to 11-year-old age group. Hypothesis 2 was thus rejected.

*Interaction of Family Type and Child's Gender on
Behavior Problems in 6- to 11-Year-Olds*

There were no interactions for either the 1997 or 2002 samples for child gender and family type on behavior problems in 6- to 11-year-olds and, therefore, Hypothesis 3A was rejected.

*Interaction of Family Type and Caregiver Gender on
Behavior Problems in 6- to 11-Year-Olds*

There were no interactions for either the 1997 or the 2002 samples for family type and caregiver gender on behavior problems reported by caregivers for the 6- to 11-year-old age group. Again, it should be noted some of the samples sizes for these

groups were much smaller than for other groups, which would affect the degree of variability observed. Hypothesis 3B was rejected.

*Interaction of Family Type and Caregiver Age on
Behavior Problems in 6- to 11-Year-Olds*

Hypothesis 5 was rejected as there were no interactions for either the 1997 or the 2002 samples for family type and caregiver age on behavior problems reported by caregivers for the 6- to 11-year-old age group.

*Interaction of Family Type, Ethnicity and Caregiver Gender on
Behavior Problems in 6- to 11-Year-Olds*

Hypothesis 6 proposed there would be an interaction between family type, ethnicity and caregiver gender on reported behavior problems in 6- to 11-year-olds. There was, however, no interaction in either the 1997 or 2002 samples for family type, ethnicity and caregiver gender on the behavior problems for this younger age group of children, and Hypothesis 6 was rejected.

Behavior Problems in 12- to 17-Year-Olds

*Main Effect for Family Type on Behavior Problems
in 12 to 17-Year-Olds*

For the first hypothesis, there was a main effect in the 1997 sample for family type on behavior problems in the 12- to 17-year-old age category, $F(3, 574) = 4.50, p < .05$. The observed power was .88, and the effect size was .023. Pairwise comparisons indicated traditional families ($M_{adj} = 16.21; SD = 2.07$) reported fewer behavioral problems in the 12- to 17-year-old age category as compared to either co-parenting

families ($M_{adj} = 14.92$; $SD = 2.60$), skipped generation families ($M_{adj} = 15.41$; $SD = 2.43$), or single parent families ($M_{adj} = 15.32$; $SD = 2.59$).

In the 2002 sample, family type was also found to be related to behavioral problems in 12- to 17-year-olds, $F(3, 655) = 3.917$, $p < .05$. The observed power was .83, and the effect size was .018. Post hoc pairwise comparisons indicate caregivers in traditional families reported significantly fewer behavioral difficulties in the 12- to 17-year-olds they parented ($M_{adj} = 15.95$; $SD = 2.16$) than those of skipped generation families ($M_{adj} = 15.23$; $SD = 2.37$) and single parent families ($M_{adj} = 15.36$; $SD = 2.19$), but not when compared to co-parenting families ($M_{adj} = 16.10$; $SD = 2.06$). Also, co-parenting families reported fewer behavioral problems in 12- to 17-year-olds than did skipped generation families.

Once again, the results for the 1997 and 2002 samples lend partial support for Hypothesis 1.

Interaction of Family Type and Ethnicity on Behavior Problems in 12- to 17-Year-Olds

With respect to the second hypothesis, there was an interaction in the 1997 sample for ethnicity and family type on behavior problems reported by caregivers for the 12- to 17-year-old age group, $F(6, 556) = 3.25$, $p < .05$. The observed power was .93, and the effect size was .03. The sample sizes, adjusted means and standard deviations are displayed in the table below.

Table 21

Statistics for 1997 Family Type X Ethnicity on Behavior Problems in 12- to 17-Year-Olds

Family Type	Ethnicity			
	Caucasian	African American	Hispanic	
Traditional	<i>n</i>	123	11	19
	<i>M</i>	16.22	13.81	17.57
	<i>SD</i>	1.94	3.18	0.90
Co-parenting	<i>n</i>	10	15	3
	<i>M</i>	14.63	15.52	13.05
	<i>SD</i>	3.16	2.23	1.53
Skipped Generation	<i>n</i>	102	93	31
	<i>M</i>	15.50	15.31	15.36
	<i>SD</i>	2.15	2.57	2.84
Single Parents	<i>n</i>	94	46	25
	<i>M</i>	15.17	15.44	15.64
	<i>SD</i>	2.76	2.40	2.35

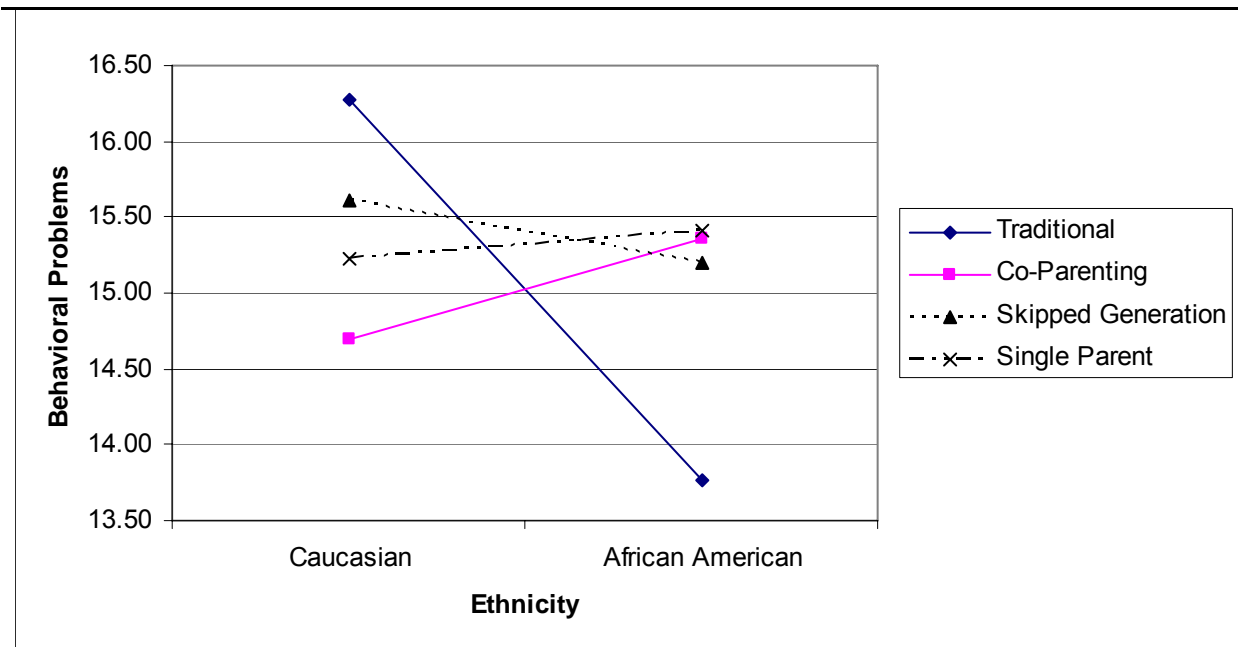


Figure 5. 1997 interaction of family type and ethnicity on behavioral problems in 12- to 17-year-olds.

One way ANCOVAs analyzing the effect of family type on behavioral problems (12- to 17-year-olds) were run for each ethnic group in order to decompose the

interaction. An effect was found for ethnicity, $F(3, 321) = 4.14, p < .05$, with post hoc tests indicating fewer behavioral problems were reported in Caucasian traditional families for children aged 12 to 17 years ($M_{adj} = 16.27; SD = 1.94$) than in Caucasian co-parenting families ($M_{adj} = 14.69; SD = 3.16$), Caucasian skipped generation families ($M_{adj} = 15.61; SD = 2.15$) or Caucasian single parent families ($M_{adj} = 15.22; SD = 2.76$). No differences were found between the latter three groups. No effect was found for the 1997 African American families. The one way ANCOVA was not run for the Hispanic traditional families given the low cell size ($N = 3$) for the Hispanic co-parenting group.

There was no interaction in the 2002 sample for ethnicity and family type on behavior problems reported by caregivers for the 12- to 17-year-old age group.

There was thus partial support for Hypothesis 2 with respect to the 1997 sample, but not according to the 2002 sample.

Interaction of Family Type and Child's Gender on Behavior Problems in 12- to 17-Year-Olds

There were no interactions for either the 1997 or 2002 samples for family type and child's gender on behavior problems in 12- to 17-year-olds, and Hypothesis 3A was thus rejected.

Interaction of Family Type and Caregiver Gender on Behavior Problems in 12- to 17-Year-Olds

There was no interaction in the 1997 sample for family type and caregiver gender on behavior problems reported by caregivers for the 12- to 17-year-old age group.

There was an interaction in the 2002 sample for family type and caregiver gender on behavior problems reported by caregivers for the 12- to 17-year-old age group, $F(3, 651) = 3.62, p < .05$. The power was .80, and effect size .016.

Table 22

Statistics for 2002 Family Type X Caregiver Gender on Behavioral Problems in 12- to 17-Year-Olds

Family Type	Caregiver Gender		
	Male	Female	
Traditional	<i>n</i>	37	107
	<i>M</i>	16.08	15.67
	<i>SD</i>	2.34	2.10
Co-parenting	<i>n</i>	5	31
	<i>M</i>	17.23	15.92
	<i>SD</i>	0.84	2.14
Skipped Generation	<i>n</i>	35	240
	<i>M</i>	16.16	15.09
	<i>SD</i>	2.03	2.38
Single Parents	<i>n</i>	36	170
	<i>M</i>	14.92	15.46
	<i>SD</i>	2.32	2.15

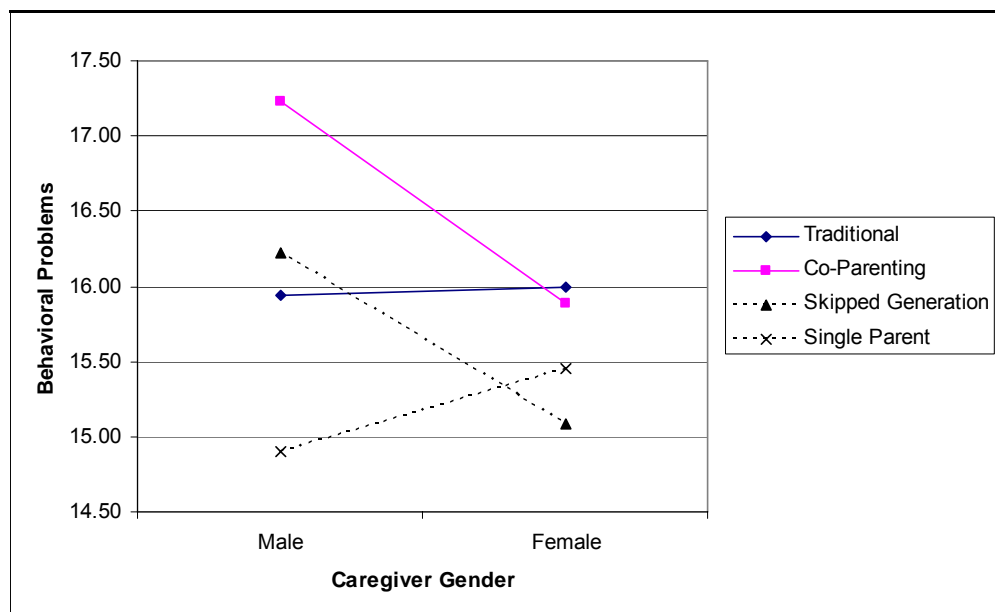


Figure 6. 2002 interaction of family type and caregiver gender on behavior problems in 12- to 17-year-olds.

To decompose the interaction, a one way ANCOVA for each gender was run by family type for behavioral problems reported for 12- to 17-year-olds. An effect for family type was found for female caregivers, $F(3, 542) = 4.15, p < .05$. Post hoc testing indicated behavioral problems (in 12- to 17-year-olds) were reported to be less serious by female caregivers in traditional families ($M_{adj} = 16.00; SD = 2.10$) as compared to female caregivers in skipped generation families ($M_{adj} = 15.08; SD = 2.38$). No differences were found between any of the other family types, including those of female caregivers in co-parenting families ($M_{adj} = 15.89; SD = 2.14$) and females caregivers in single parent families ($M_{adj} = 15.45; SD = 2.15$).

An effect was also found for male caregivers, $F(3, 107) = 3.12, p < .05$. However, this interaction was not interpreted further, due to a small cell size ($N=5$) for the male co-parenting group.

In conclusion, there was some partial support for Hypothesis 3B, but only with respect to the 2002 sample.

Interaction of Family Type and Caregiver Age on Behavior Problems in 12- to 17-Year-Olds

Hypothesis 5 was rejected as there were no interactions for either the 1997 or the 2002 samples for family type and caregiver age on behavior problems reported by caregivers for the 12- to 17-year-old age group.

Interaction of Family Type, Ethnicity and Caregiver Gender on Behavior Problems in 12- to 17-Year-Olds

Hypothesis 6 proposed there would be an interaction between family type, ethnicity

and caregiver gender on reported behavior problems in 12- to 17-year-olds. There was, however, no interaction in either the 1997 or 2002 samples for family type, ethnicity and caregiver gender on the behavior problems for this older age group of children, and Hypothesis 6 was rejected.

Extent of Caregiver Involvement with a Younger Child

There were no main effects or interactions on the extent of caregiver involvement, as measured by the number of days the focal child (aged 0 to 5 years) was read to by a family member, for either the 1997 or 2002 samples. For this dependent variable, all the hypotheses for the study were rejected.

Main Effect for Family Type on Caregiver Outings with 0- to 5-Year-Olds

There was no main effect for family type on the number of outings a caregiver reported with a younger child (aged 0 to 5 years) for either the 1997 or 2002 samples. Hypothesis 1 was, therefore, rejected.

Interaction of Family Type and Ethnicity on Caregiver Outings with 0- to 5-Year-Olds

There was no interaction for either the 1997 or the 2002 sample for family type and ethnicity on the number of outings a caregiver reported with a younger child, and Hypothesis 2 was rejected.

*Interaction of Family Type and Child's Gender on
Caregiver Outings with 0- to 5-Year-Olds*

For the 1997 sample, there was an interaction for family type and child gender on the number of outings reported by caregivers, $F(3, 1050) = 2.60, p = .05$. The sample sizes, adjusted means and standard deviations are displayed in the table below. The power was .64, with an effect size of .007.

Table 23

Statistics for 1997 Family Type X Child Gender on Outings with Caregiver

Family Type		Child Gender	
		Male	Female
Traditional	<i>n</i>	118	127
	<i>M</i>	3.09	2.96
	<i>SD</i>	0.68	0.64
Co-parenting	<i>n</i>	185	167
	<i>M</i>	2.98	3.02
	<i>SD</i>	0.77	0.76
Skipped Generation	<i>n</i>	134	134
	<i>M</i>	3.04	2.96
	<i>SD</i>	0.74	0.75
Single Parents	<i>n</i>	112	83
	<i>M</i>	2.82	3.05
	<i>SD</i>	0.61	0.76

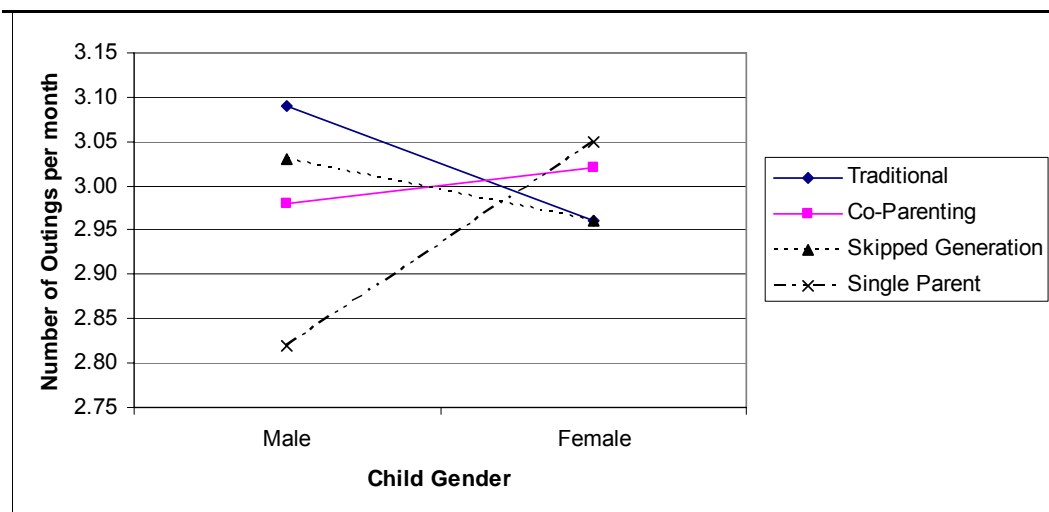


Figure 7. 1997 interaction of family type and child gender on outings with caregiver.

When a one way ANCOVA for each gender was run to decompose the interaction, an effect for family type was found for male focal children, $F(3, 543) = 2.83$, $p < .05$. Post hoc testing indicated caregivers of single parent families take their male children on outings less frequently ($M_{adj} = 2.82$; $SD = .61$) than caregivers in traditional families ($M_{adj} = 3.09$; $SD = .68$), co-parenting families ($M_{adj} = 2.98$; $SD = .76$), or skipped generation families ($M_{adj} = 3.03$; $SD = .74$). There were no differences between traditional, co-parenting and skipped generation families in how often male children were taken on outings by their caregivers. No effects were found for family type and female children on the number of outings with caregivers. There was no similar interaction of family type and child gender on the number of outings for the 2002 sample.

From the 1997 sample, there was, thus, some limited support for Hypothesis 3A, but this support was not confirmed by the 2002 sample.

*Interaction of Family Type and Caregiver Gender on
Caregiver Outings with 0- to 5- Year-Olds*

There was no interaction of family type and caregiver gender on caregiver outings with 0- to 5 years-olds for either the 1997 or the 2002 samples, and Hypothesis 3B was, thus, rejected.

*Interaction of Family Type and Caregiver Age on
Caregiver Outings with 0- to 5-Year-Olds*

Hypothesis 5 was rejected as there was no interaction of family type and

caregiver age on caregiver outings with 0- to 5-year-olds for either the 1997 or the 2002 samples.

*Interaction of Family Type, Ethnicity and Caregiver Gender on
Caregiver Outings with 0- to 5-Year-Olds*

Hypothesis 6 proposed there would be an interaction between family type, ethnicity and caregiver gender on caregiver outings with 0- to 5-year-olds. There was, however, no interaction in either the 1997 or 2002 samples for family type, ethnicity and caregiver gender on the frequency of caregiver outings with young children, and Hypothesis 6 was rejected.

School Engagement

Main Effect for Family Type on School Engagement

With respect to the first hypothesis in this study, there was no main effect for the 1997 sample for family type on school engagement. In the 2002 sample, however, family type was found to be related to school engagement, $F(3, 1331) = 3.02, p < .05$. The observed power was .713, and the effect size was .007. Post hoc pairwise comparisons indicate caregivers in traditional families reported greater school engagement ($M_{adj} = 12.92; SD = 2.62$) than did those in skipped generation families ($M_{adj} = 12.34; SD = 2.82$) and single parent families ($M_{adj} = 12.43; SD = 2.84$), but were not different in this respect from co-parenting families ($M_{adj} = 12.74; SD = 2.89$). There were no other differences between family types for school engagement. There was, thus, some limited support for Hypothesis 1, but only from the finding of the 2002 sample.

Interaction of Family Type and Ethnicity on School Engagement

Hypothesis 2 was rejected as there was no interaction for either the 1997 or the 2002 sample for family type and ethnicity on the reported school engagement of the focal child.

Interaction of Family Type and Child's Gender on School Engagement

There was no interaction for either the 1997 or 2002 sample for child's gender and family type on school engagement, and Hypothesis 3A was, therefore, rejected.

Interaction of Family Type and Caregiver Gender on School Engagement

There was no interaction for either the 1997 or the 2002 sample for caregiver gender and family type on the child's reported school engagement. Hypothesis 3B was rejected.

Interaction of Family Type and Caregiver Age on School Engagement

Hypothesis 5 was rejected as there was no interaction for either the 1997 or the 2002 sample for caregiver age and family type on the child's reported school engagement.

*Interaction of Family Type, Ethnicity and Caregiver Gender
on School Engagement*

Hypothesis 6 proposed there would be an interaction between family type, ethnicity and caregiver gender on the child's reported school engagement. There was, however, no interaction in either the 1997 or 2002 samples for family type, ethnicity and

caregiver gender on the child's reported school engagement, and Hypothesis 6 was, thus, rejected.

Summary

The above interactions and results of hypothesis testing are summarized in the following tables:

Table 24

Summary of Hypotheses by Dependent Variable for 1997 Sample

	H1	H2	H3A	H3B	H4	H5	H6
Caregiver Mental Health	Partial Support	Partial Support	Reject	Partial Support	Reject	Reject	Partial Support
Caregiver Aggravation	Partial Support	Reject	Reject	Reject	Reject	Reject	Reject
Child Health	Partial Support	Reject	Reject	Reject	Partial Support	Reject	Reject
Behavior Problems Age 6 to 11	Partial Support	Reject	Reject	Reject	Not Applicable	Reject	Reject
Behavior Problems Age 12 to 17	Partial Support	Partial Support	Reject	Reject	Not Applicable	Reject	Reject
Outings with Child	Reject	Reject	Partial Support	Reject	Not Applicable	Reject	Reject
Reads to child	Reject	Reject	Reject	Reject	Not Applicable	Reject	Reject
School Engagement	Reject	Reject	Reject	Reject	Not Applicable	Reject	Reject

Table 25

Summary of Hypotheses by Dependent Variable for 2002 Sample

	H1	H2	H3A	H3B	H4	H5	H6
Caregiver Mental Health	Partial Support	Reject	Reject	Partial Support	Reject	Reject	Reject
Caregiver Aggravation	Partial Support	Reject	Reject	Reject	Reject	Reject	Reject
Child Health	Partial Support	Reject	Reject	Reject	Reject	Reject	Reject
Behavior Problems Age 6 to 11	Partial Support	Reject	Reject	Reject	Not Applicable	Reject	Reject
Behavior Problems Age 12 to 17	Partial Support	Reject	Reject	Partial Support	Not Applicable	Reject	Reject
Outings with Child	Reject	Reject	Reject	Reject	Not Applicable	Reject	Reject
Reads to child	Reject	Reject	Reject	Reject	Not Applicable	Reject	Reject
School Engagement	Partial Support	Reject	Reject	Reject	Not Applicable	Reject	Reject

Table 26

Overall Summary of Results for 1997 and 2002 Samples

	H1: Family Type Main Effect		H2: Family Type X Ethnicity		H3A: Family Type X Child Gender		H3B: Family Type X MKA Gender		H4: Family Type X Child Age		H5: Family Type X MKA Age		H6: Family Type X Ethnicity X Gender	
	1997	2002	1997	2002	1997	2002	1997	2002	1997	2002	1997	2002	1997	2002
Caregiver/ MKA Mental Health (High score = better mental health)	Sig. T >	Sig. T >	Sig. CaT >				Sig. ♀T >	Sig. ♀T >						Sig. (*Small cell size) *
	CP	CP	>				♀CP	♀CP						
	T >	T >					♀CP	♀CP						
	SG	SG	CaSP				♀SG	♀SG						
	T >	T >	CaSG				♀SG	♀SG						
	SP	SP	>				♀SP	♀SP						
		CP >					♀SP	♀SP						
		SP	CaSP					♀CP						
		SG >	HiT >					>						
		SP												
			HiCP					♀SP						
								♀SG						
			HiSG					>						
			HiSP					♀SP						
								♂CP						
								>						
								♂SP						

(table continues)

Table 26 (continued).

	H1: Family Type Main Effect		H2: Family Type X Ethnicity		H3A: Family Type X Child Gender		H3B: Family Type X MKA Gender		H4: Family Type X Child Age		H5: Family Type X MKA Age		H6: Family Type X Ethnicity X Gender	
	1997	2002	1997	2002	1997	2002	1997	2002	1997	2002	1997	2002	1997	2002
Caregiver/ MKA	Sig.	Sig.												
Aggravation (High score = less negative impact)	T > CP T > SG T > SP CP > SG SP > SG	T > SG T > SP CP > SP > SG												
Child's Health (High score = poorer health)	Sig. SG > TF SG > CP SG > SP	Sig. SG > TF SG > CP SG > SP CP > TF SP > TF							Sig. 0- 5yrs SG > TF SG > SP 6- 11yrs SG > TF SG > SP CP > TF CP > SP			*	*	

(table continues)

Table 26 (continued).

	H1: Family Type Main Effect		H2: Family Type X Ethnicity		H3A: Family Type X Child Gender		H3B: Family Type X MKA Gender		H4: Family Type X Child Age		H5: Family Type X MKA Age		H6: Family Type X Ethnicity X Gender	
	1997	2002	1997	2002	1997	2002	1997	2002	1997	2002	1997	2002	1997	2002
Behavior Problems 6-11 (High score = fewer problems)	Sig. TF > SG SP > SG	Sig. TF > SG TF > SP											*	*
Behavior Problems 12-17 (High score = fewer behavior problems)	Sig. TF > CP TF > SG TF > SP	Sig. TF > SG TF > SP CP > SG	Sig. CaTF > CaCP CaSG CaSP				Sig. ♀T > ♀SG						*	*
Outings with Child 0-5					Sig. SP♂<								*	*
					TF♂ CP♂ SG♂									
Reads to Child 0-5													*	*
School Engagement 6-17		Sig. TF > SG TF > SP											*	*

Note. TF = Traditional Family; CP = Co-parenting family; SG = Skipped Generation Family; SP = Single Parent Family; Ca = Caucasian; Hi = Hispanic; * = cell sizes less than 10

CHAPTER 4

DISCUSSION

The results of this study for each dependent variable will be discussed in terms of the original hypotheses, starting with caregiver well-being (mental health and aggravation) and progressing with the measures of child well-being (health status, behavior problems, caregiver involvement, and school engagement). Following this, some implications of this study will be addressed, particularly in respect to how the study may inform counseling and intervention with grandparent caregivers and custodial grandchildren. The strengths and weaknesses of the study will be addressed. Finally, some recommendations for future research in the area of custodial grandparenting will be made.

Caregiver Mental Health

Hypothesis 1

Based on some initial findings in the research literature (for example, Brown, 2004; Solomon & Marx, 1995), the first hypothesis for this study suggested members of traditional two-parent families would demonstrate greater well-being than those in co-parenting families. Co-parenting families, in turn, would demonstrate greater well-being than skipped generation families, who, in turn, would demonstrate greater evidence of well-being than single parent families. With respect to caregiver mental health for the 1997 and 2002 NSAF samples, this hypothesis was partially supported, as the apparent advantage of mental health reported by the caregivers of traditional families over the other three family types was in the direction anticipated by the study hypothesis. For

both the 1997 and 2002 samples, caregivers in traditional families reported better mental health than did caregivers from the co-parenting, skipped generation and single families. For the 1997 sample, no differences were noted between these three latter types of families. In the 2002 sample, however, there were additional differences in that both the co-parenting and skipped generation caregivers (while not significantly different from each other) reported better mental health than the single parent caregivers.

This study controlled for both caregiver education and family income. There are still, however, elements of family structure that appear to favor the mental health of caregivers in traditional families over the other family types and, for the 2002 sample, particularly disadvantage the single parents. One likely explanation may lie in the availability of social support received by the caregivers, which, as discussed in the earlier literature review, tends to have an impact on one's emotional health (for example, Antonucci, 2001; Stroebe & Stroebe, 1996). While a measure of social support was not included in the NSAF questionnaires and could, thus, not be directly explored by this study, it was suspected that the two parents of a traditional family are likely to have a greater convoy of support than would a single parent. Parents in a traditional family would likely also have each other as a source of support, which would not be the case for single parents. The support could be viewed in terms of both emotional availability, as well as instrumental support, such as having an extra person to run errands or help out with household responsibilities. Married co-parenting and skipped generation caregivers would likely have some of the same advantages of social support as the traditional family caregivers. It is estimated that approximately half of the grandparent caregivers (that is, both the co-parenting and skipped generation families)

in the 1997 and 2002 samples were married, given that Scarcella, Ehrle and Geen (2003) reported 48% of the grandparent caregivers in the 1999 NSAF sample were married. The co-parenting and skipped generation households, however, may also have lost some of their support networks during the process of becoming caregivers again, as reported by the literature findings (for example, Cox, 2000; de Toledo & Edler Brown, 1995; Wohl et al., 2003; Woodworth, 1996), which could explain some of the mental health advantage of traditional parents over the co-parenting and skipped generation caregivers.

It was noted that differences in caregiver mental health emerged for the 2002 sample that were not evident in the 1997 sample, that is, in 2002, co-parenting and skipped generation caregivers reported better mental health than single parents. The fact that 1997 and 2002 family type comparisons were not parallel suggests an historical shift that has magnified the family type differences between single parents and co-parenting or skipped generation caregivers. It is possible changes in the environment (for example, welfare, political and economic changes) may have differentially impacted caregivers of single parent families, as compared to grandparent caregivers. Caregivers in co-parenting and skipped generation families, for example, may have become increasingly aware of or more able to tap into community resources, such as support groups or access to parenting information. Perhaps the custodial grandparent is viewed more normatively. Single parents, on the other hand, may simply not have had the time to explore potential resources in a similar manner to their peers in other family types. In recent years, an increasing number of supports appear to have been developed and directed towards assisting custodial grandparents. In November, 2000, for example, the

National Family Caregiver Support Program (NFCSP) was enacted into law. The NFCSP was designed to provide support to family caregivers of individuals aged 60 and older, as well as to grandparents and older relatives aged 60 and older who raise children (Generations United, 2003a). As a further example, in 2001, the National Center on Grandparents Raising Grandchildren was established in order to support grandparent-headed families and inform service professionals, policy makers and the general public on the social and health service issues confronted by grandparents (Whitely, n.d.).

Hypothesis 2

The second hypothesis predicted there would be an interaction between family type and ethnicity on caregiver and child well-being. Based on the research reviewed, it was suspected, that due to a greater emphasis on the values of individualism and independence, it may be more non-normative for Caucasian families to co-parent than it would be for African American or Hispanic families. Given a tradition of surrogate parenting (Brown & Mars, 2000), African American co-parenting and skipped generation families were anticipated to report little difference in well being over traditionally structured African American households. The Hispanic tradition of *familismo* was expected to mitigate some of the stress for Hispanic co-parenting families (Goodman & Silverstein, 2006; Toledo et al., 2000).

The results of this study partially supported this hypothesis for caregiver mental health, finding an interaction between family type and ethnicity for the 1997 sample. When the interaction was examined in more detail, it emerged that for Caucasian

families, parents in traditional families reported better mental health than single parents. Caucasian grandparent caregivers in skipped generation families also reported better mental health than Caucasian single parents. As discussed in the earlier literature review, Caucasians tend not to view their family of origin as a child-rearing resource. The 1997 Caucasian single parents may, thus, have experienced less support and guidance, which led to their reports of poorer mental health than the Caucasian skipped generation grandparent caregivers, who had demonstrated their ability to extend their traditional family boundaries by raising their grandchildren. No similar interaction was found for the 2002 sample, suggesting that perhaps Caucasian families have experienced a shift in their culturally defined family values, leading to fewer differences in mental health between traditional and non-traditional family types.

For African American families, there were no reported differences in caregiver mental health between different family types for either the 1997 or 2002 samples. As expected, these African American families may have adjusted to the more normative role of surrogate parenting (Brown & Mars, 2000). Recent research by Stevenson, Henderson and Baugh (2007) appears to support this suggestion of adjustment, as they reported African American grandmothers parenting grandchildren demonstrated resiliency and used a wide range of formal and informal social support resources to address family needs.

For the 1997 sample, Hispanic parents in traditional families reported better mental health than either Hispanic grandparent caregivers (of co-parenting or skipped generation households) or Hispanic single parent families. It would appear that *familismo* could have applied mainly to traditionally-structured Hispanic families to assist

in maintaining better caregiver mental health. Accordingly, Hispanic caregivers who were not embedded in a traditional family structure may have experienced more stigma or stress in regards to their family differences and, thus, reported poorer mental health than the caregivers in traditional families. Again, for Hispanic caregivers, these results were not replicated in the 2002 sample where no interactions between family type and ethnicity on caregivers' mental health were found. A potential historical shift in this respect may suggest culturally defined family values such as *familismo* may not always act as a protective factor in the maintenance of mental health for Hispanic families.

Hypothesis 3A

The third hypothesis predicted there would be an interaction between family type and child's gender on caregiver and child well-being, since many disruptive behavioral disorders (such as Attention Deficit Hyperactivity Disorder, Conduct Disorder and Oppositional Defiant Disorder) occur more frequently in males than females and may have challenged susceptible grandparent caregivers (Baker, 2002; Silverthorne & Durrant, 2000) or single parents. No interaction, however, was found between family type and child gender on caregiver mental health, for either the 1997 or 2002 samples, lending no support to the research hypothesis.

Hypothesis 3B

Caregiver gender was also hypothesized to play an important role, given the literature findings that coping with activities for daily parenting may be more non-normative for grandfathers (Bullock, 2005) and grandfathers are less likely to feel in

control of the caregiver situation (Kolomer & McCallion, 2005). In the 1997 sample for this study, an interaction of family type and caregiver gender on caregiver mental health was found in that there were differences for female caregivers, supporting the findings of Burnette (1999a) that being female is a risk factor for the health of caregivers. The 1997 female caregivers in traditional families reported better mental health than their counterparts in the co-parenting, skipped generation and single parent families. No differences in reported mental health were noted between the latter three family types, or between male caregivers for all four family types. While the null hypothesis was, thus, rejected for the 1997 sample, the interaction did not result in findings in the direction originally expected, that is, the grandfather caregivers would demonstrate poorer mental health than male caregivers in other family structures. Since rearing children has historically been regarded as a female role which occurs in the context of a traditionally structured family, the 1997 female caregivers in the non- traditional families may have generally felt less overall support, less competent and more pressure from assuming a less normative role than mothers in traditionally structured families.

These findings were partly replicated for the 2002 sample in that the female caregivers of traditional families reported better mental health than female caregivers of co-parenting, skipped generation and single parent families.. It seems that the above suggestion, that social support mitigates some stress for traditional caregivers and to a lesser extent the grandparent caregivers (in both the co-parenting and skipped generation families) as compared to single parents, would also apply to female caregivers. Similar to the pattern noted for Hypothesis 1, female caregivers of both co-parenting and skipped generation families reported better mental health than female

single parents, lending support to the above suggestion that some sort of historical shift may have occurred in respect to caregiver mental health. Female single parents may, thus, not have as much access to community resources and interventions, or not perceived as much support, compared to female caregivers in the other family types.

A further difference emerged for the 2002 sample with respect to the interaction of family type and caregiver gender on caregiver mental health. Male caregivers in co-parenting families reported better mental health than caregivers in skipped generation families. It may be easier for males to accept their caregiving role in a co-parenting situation, where they have the presence of at least one of the child's parents in the family, as opposed to male caregivers in a skipped generation household, where they may experience a compounded effect of the non-normative roles of grandparent caregiver and male caregiver, without the presence of the child's parent.

Hypothesis 4

The fourth hypothesis suggested there would be an interaction between family type and the age of the child on well-being for the caregivers, particularly since it was suspected the grandparent caregivers in both the co-parenting and skipped generation households may be more challenged when it came to parenting either a very young child or a teenager. However, no differences emerged in either the 1997 or 2002 samples, which did not support the research hypothesis. It would, thus, appear that a child's age does not have a significant influence on caregiver's mental health. However, it is also possible that the division of the child's age into the three categories for this study (that is, 0 to 5 years, 6 to 11 years, and 12 to 17 years) may have been too broad

to capture any differences brought about by different developmental challenges. For example, a small infant would require more intensive caregiving than a 5-year-old child, yet both were included in the same group, as defined by the dataset, for this study.

Hypothesis 5

The fifth hypothesis predicted there would be an interaction between family type and the caregiver's age on caregiver mental health. Age was suspected to be an important influence on psychological well-being if grandparenthood and re-parenting occurred at an early age, given the earlier reported findings of Burnette (1999a) and Lee et al. (1998). For the both the 1997 and 2002 samples, as expected, few traditional ($N=1$) or single parents ($N=0$) were found in the older age group of 65-year-olds and older. No interaction between family type and caregiver age on caregiver mental health was found, however, for the 1997 or 2002 samples.

Hypothesis 6

The final hypothesis predicted there would be an interaction between family type, ethnicity, and the caregiver's gender on well-being. Unfortunately, this hypothesis could not be tested due to the small sub-sample sizes which ultimately emerged for both the 1997 and 2002 samples, particularly as male caregivers were uncommon among the minority co-parenting and single parent groups. Despite the initial large pool of participants for this study, once a sub-sample had been selected based on the number of grandparent caregivers, there were few minority male caregivers relative to the females. This difficulty reflects the tendency of the grandparent caregiver literature (for

example, Fuller-Thomson & Minkler, 2000a; Goodman & Silverstein, 2002; Musil & Ahmad, 2002) to focus primarily on samples of grandmothers, since many more grandparent caregivers appear to be women.

Conclusions

For caregiver mental health, this study partly supported the original research hypotheses and demonstrated differences in mental health between caregivers of various family types were present in both the 1997 and 2002 samples. There was also an interaction between caregiver gender and family type on mental health for both the 1997 and 2002 samples. In 1997, for both the main effect of family type and its interaction with caregiver gender, traditional parents (and traditional female parents) reported better mental health than co-parenting, skipped generation and single parent caregivers. In the 2002 sample, in addition to the differences noted in 1997, grandparent caregivers in the co-parenting and skipped generation families reported better mental health than single parents. In 2002, grandmothers in the co-parenting and skipped generation families reported better mental health than single mothers. An interaction between ethnicity and family type on caregiver mental health was found for only the 1997 samples. Provided these differences are not due to differences in sample composition and / or data collection, a historical shift has possibly taken place, in that increased community supports, resources and / or interventions are more available for more families, with the exception of single parent families.

Caregiver Aggravation

Hypothesis 1

Caregiver aggravation, which was defined as a measure of the negative impact of the child's behavior on the caregiver, was found, for both the 1997 and 2002 samples, to be worse for caregivers in skipped generation families as compared to caregivers in the traditional, co-parenting or single parent families. This finding lends support to earlier studies, which suggested that overall, skipped generation caregivers reported more difficult interactions with their grandchildren than co-parenting caregivers (Musil & Standing, 2005) and that conflict between skipped generation caregivers and their focal grandchildren was higher than in co-parenting households (Goodman & Silverstein, 2002). Goodman and Silverstein (2002) reported some differences in reasons for assuming caregiving between grandparents in skipped generation and co-parenting households. These differences may play a role in grandparent caregivers' experience of parental aggravation. According to Goodman and Silverstein's research, co-parenting grandparents more often assume care to assist their adult children financially, assist working parents, or as a result of divorce, while skipped generation grandparents more often assume care due to a parent's drug use, mental or emotional problems, child abuse or neglect, or a grandchild's medical problems. The children of skipped generation households may thus be harder to care for than most and have difficulties that result in their caregivers feeling they are giving up more of their lives to meet their child's needs than they ever expected. Baird (2003) has also reported on the anger and frustrations experienced by skipped generation caregivers.

Further, caregivers in the traditional families were at an advantage, in that they reported less caregiver aggravation than single parents, for both the 1997 and 2002 samples. Traditional caregivers have the advantage of a partner (the child's other parent) on hand with whom they can share day-to-day parenting challenges and aggravations, unlike many single parents, who may feel more challenged and isolated in their parenting. Some single parents may hold negative feelings towards or have an adversarial relationship with their child's other parent, which could spill over into their relationship with their child, particularly if that child reminds them of a former partner. For the 1997 sample, traditional parents also reported less caregiver aggravation than co-parenting families. This effect was not repeated for the 2002 sample. Perhaps there has been a shift over time in such a manner that co-parenting caregivers in particular feel less aggravated by the children for whom they care. It is possible ecological factors in general (such as educational, political, economic and societal changes) have leveled the playing field in such a manner that traditional parents and co-parenting grandparents are equally impacted negatively by their children's behaviors. It may have become, for example, more normative over time for traditional families to encourage grandparents to come and live with them to assist with parenting duties. These grandparents, in turn, may view their caregiving duties (and grandchildren) in a more positive light than their skipped generation peers, who (as discussed above) have come into the role for different and often more adverse reasons. Given that proportionately more children in the skipped generation households have come into their grandparents' care due to parental difficulties with substance abuse (Goodman & Silverstein, 2002),

they may have experienced prenatal conditions that subsequently leads them to be more challenging to parent.

Hypotheses 2, 3A, 3B, 4, and 5

No differences emerged for these interactions on caregiver aggravation for either the 1997 or 2002 samples.

Hypothesis 6

As for caregiver mental health, the final hypothesis, predicting an interaction between family type, ethnicity, and the caregiver's gender on caregiver aggravation, could not be tested due to the small sub-sample sizes (for minority male caregivers in particular) for the 1997 and 2002 samples.

Conclusions

For caregiver aggravation, only the first research hypothesis was supported in that there was a main effect for family type, with less aggravation for traditional parents. Skipped generation caregivers, in both the 1997 and 2002 samples, experienced worse caregiver aggravation than even the single parents. Given the often adverse reasons for skipped generation grandparents assuming care of their grandchildren, it is understandable that, more than most caregivers, they have endorsed the statements that make up the aggravation scale, such as feeling their child was much harder to care for than most and that they were giving up more of their lives to meet their child's needs than ever expected. A historical shift was suggested in that the 2002 co-parenting

caregivers may be less aggravated than their 1997 peers. It may be that it has become more normative for grandparents to co-reside to assist their adult children with parenting duties and that these co-parenting caregivers view the children they care for in a more positive light than their skipped generation peers, who often assume caregiving under more adverse circumstances. The remaining research hypotheses were not supported, in that no interactions of family type with ethnicity, age or gender were found.

Child's Current Health Status

Hypothesis 1

The first hypothesis of this study, in respect to child's health, proposed that children of traditional two-parent families would demonstrate greater health than those in co-parenting families. In turn, children in co-parenting families would demonstrate greater health than children in skipped generation families, who themselves would demonstrate better health than children of single parent families. This hypothesis was partially supported for both the 1997 and 2002 NSAF samples.

Although Kenney, Haley and Tebay (2003a; 2003b), using the NSAF 1999 and 2002 samples reported the number and percentage of children without health insurance declined dramatically between 1999 and 2002 and that caregiver familiarity with public health insurance increased markedly in this time, the findings of the present study suggest these improvements may not have affected all family types equally. For the 1997 sample, skipped generation grandparent caregivers reported poorer child's health than caregivers in traditional families, co-parenting families, and single parent families. No differences were noted between these three latter types of families. This finding was

replicated for the 2002 sample. In addition, for the 2002 sample, caregivers in co-parenting families and single parent families reported poorer child's health than caregivers in traditional families.

Overall, these results appear to support anecdotal reports in the grandparent caregiver literature (for example, Baird et al., 2000; Kopera-Frye et al., 2003; Silverstein & Vehvilainen, 2000) that suggested children raised by grandparents experience many health problems. It seems children being raised in skipped generation households may experience greater health difficulties than their peers being raised in traditional families, which could possibly be a reflection of the stressful circumstances related to the necessity of being raised by one's grandparents. The health of children in skipped generation households may also fare worse than their peers being raised in co-parenting households and single parent households. In this respect, having at least one parent present in the household may act partially as a protective factor for the health of co-parented or single-parented children. A parent's presence may be more reassuring for a child. It may even be the presence of a parent (to sign consent for medical treatment or to legitimize access to health insurance) increases the likelihood of a child being seen by a health professional. In general, however, children of traditional families may fare better in terms of health if they have had less exposure to the traumatic events and risk factors (for example, divorce, illness or loss of a parent) that may have been implicated in the reasons for a non-traditional family structure.

Hypothesis 2

While the second hypothesis predicted there would be an interaction between

family type and ethnicity on child well-being, this was not supported with respect to child health, and there were no interactions for the 1997 and 2002 samples on caregiver reported child health.

Hypothesis 3A and 3B

The third hypothesis predicted there would be an interaction between family type and child gender (Hypothesis 3A) or caregiver gender (Hypothesis 3B) on child well-being. No interaction was found between family type and child or caregiver gender on the child's health, as perceived by the caregiver, for either the 1997 or 2002 samples, lending no support to the research hypothesis.

Hypothesis 4

The fourth hypothesis, which predicted an interaction would occur between family type and age of the child on reported child health, was partially supported by differences which emerged for the 1997 sample. With respect to the youngest group of children, aged 0 to 5 years, grandparent caregivers of skipped generation families reported poorer child health than traditional families and single parent families. There were no other differences in reported child health between family types for this age group. In 1997, it is possible that, given these were younger children and, thus, were more likely to have been in their grandparent's care for less time, some of these skipped generation caregivers may have been less knowledgeable about advances in health care options, such as wellness exams or availability of healthcare insurance and newer welfare programs that emerged since they had parented their own children. This explanation

may also apply to the further interaction found for the group of children aged 6 to 11 years (also in the 1997 sample). Here, the health of skipped generation family children was reported to be poorer than that of children in traditional families and single parent families. In addition, the health of children aged 6 to 11 years in co-parenting families was reported to be poorer than that of children in traditional and single parent families. The interactions found for the 1997 sample were not replicated for the 2002 sample. By this point in time, it is possible the overall trend for increasing familiarity with Medicaid and State Children's Health Insurance Programs (reported by Kenney et al., 2003b) had filtered down to grandparent caregivers with younger children in skipped generation and co-parenting families, in addition to the traditional and single parent families.

Hypothesis 5

The fifth hypothesis, which predicted there would be an interaction between family type and the caregiver's age on caregiver well-being, did not apply to child well-being.

Hypothesis 6

The final hypothesis predicted there would be an interaction between family type, ethnicity, and the caregiver's gender on child well-being. While no significant interaction was found for child health for the 1997 and 2002 samples, once again it should be cautioned that there were small sub-sample sizes (among the male caregivers).

Conclusions

For child health, this study partially supported the original research hypotheses by finding differences in reported health, generally suggesting children being raised in skipped generation households are reported to have worse health than their peers in other family types, particularly traditional families. While overall health insurance coverage and service use for children has improved (Kenney et al., 2003a), it may be that grandparents in skipped generation households are not gaining access to services as quickly as other family types, a suggestion which appears to be supported by the literature (Baird, 2003; Scarcella et al., 2003). In particular, with respect to the 1999 NSAF sample, Scarcella et al. (2003) reported that, despite health coverage, 26 % of younger children (ages 0 to 5) and 38 % of older children (ages 6 to 17) living with their grandparents did not have a well-child care visit in the survey year. This finding and those of the present study appear to suggest greater emphasis needs to be placed on educating grandparent caregivers about the benefits and availability of healthcare services for their grandchildren.

Behavior Problems in Ages 6 to 11 Years

Hypothesis 1

Hypothesis 1 was partially supported in regard to reported differences in behavioral and emotional difficulties of children aged 6 to 11 years, for both the 1997 and 2002 samples.

For the 1997 sample, grandparent caregivers in skipped generation families reported greater behavioral and emotional difficulties in their 6- to 11-year-old focal

children as compared to those reported by parents in traditional families or those in single-parent families. No differences between the other family types were found. The findings for the 2002 sample were similar in that the grandparent caregivers in skipped generation families reported greater behavioral and emotional difficulties for their 6- to 11-year-old group of children as compared to those reported by parents in traditional families. Since there has been little direct research on the extent of difficulties of custodial grandchildren (Edwards, 1998; Jones & Kennedy, 1996), the findings from these two samples lend important support to the position taken by researchers such as Kolomer (2000), Pinson-Millburn et al. (1996), Silverthorn and Durrant (2000) and de Toledo and Brown (1995) who have suggested custodial grandchildren are at risk for increased behavioral and emotional problems. When one considers grandparent caregivers may have a tendency to minimize the extent of their grandchildren's difficulties (Emick & Hayslip, 1996; Jones & Kennedy, 1996), this finding underscores the need to identify custodial grandchildren from skipped generation households as a group of children particularly vulnerable to behavioral and emotional difficulties and to offer professional support and services to these skipped generation families.

In the 2002 sample, single parents also reported greater behavioral and emotional difficulties for their 6- to 11-year-old children than were reported by parents in traditional families. This particular finding supports that of Carlson and Corcoran (2001), who considered the influence of family structure on the behavioral outcomes for a similarly aged sample of children (of 7 to 10 years), and reported the children reared in single parent homes were at higher risk for poor outcomes.

Hypotheses 2 to 6

No significant interactions were found (in either the 1997 or 2002 sample) between family type and the other independent variables for this study on the behavioral and emotional difficulties of children aged 6 to 11 years. Many of the analyses had low power and the sub sample sizes were very small, leaving this as a potential area for further investigation in future research.

Conclusions

The research hypothesis suggesting a main effect for family type on behavioral difficulties of children aged 6 to 11 years was partly supported in that children in traditional families appear to fare better than those in skipped generation or single parent households. These results suggest it is a protective factor for children aged 6 to 11 years to have two parents present in their family.

Behavior Problems in Ages 12 to 17 Years

Hypothesis 1

In the 1997 sample, overall, the parents in the traditional families reported the fewest behavioral and emotional difficulties amongst 12- to 17-year-olds, as compared to all three of the other family types. It is possible the traditional family structure, particularly since it has likely been long-standing for families with this older group of children, offers greater stability, leading to the lower reported behavioral difficulties in children by their caregivers. For the 1997 sample, there were no other differences in

behavioral and emotional difficulties amongst 12- to 17-year-olds between the other family types.

In the 2002 sample, 12- to 17-year-olds were once again reported to have fewer behavioral and emotional difficulties in traditional families as compared to skipped generation and single parent families. The co-parenting families in 2002, however, appeared to report less difficulty than the co-parenting families of 1997, such that in the 2002 sample, co-parenting families reported fewer behavioral difficulties than the skipped generation families. This supports the findings of the earlier reported study by Goodman and Silverstein (2002), where grandmothers of skipped generation families reported greater behavioral problems than children in co-parenting households, and conflict between grandmother and grandchild was higher in skipped generation households than co-parenting households. With respect to the historical shift in the difference between co-parenting and skipped generation households, the presence of one or more additional adult in the house, such as is the case in the co-parenting families, may be becoming more normative or accepted (as society becomes more sensitive to multiple generations living in one household). In turn, this might have led to a better outcome among the behavioral issues of 12- to 17-year-olds who could perceive their co-parenting grandparents as more legitimate. There is also the possibility of increased actual or perceived supports for the co-parenting grandparent caregivers, as compared to those in the skipped generation household, which filters down to the well-being of the children for whom they care.

The finding of both the 1997 and 2002 samples, that grandparent caregivers in skipped generation families reported greater behavioral difficulties for older children

than traditional families, highlights the greater vulnerability of the custodial grandchild in skipped generation families.

Hypothesis 2

In the 1997 sample, Caucasian parents in traditional families reported fewer behavioral and emotional difficulties (for the 12- to 17-year-old focal children) than Caucasian grandparent caregivers (of either co-parenting or skipped generation families) or single parents. This finding is somewhat similar to a study by Duniform and Kowaleski-Jones (2002), who, although they limited their family structure comparisons to single, married, and co-habiting Caucasian and African American parents, reported single parenthood was associated with reduced well-being among Caucasian children from single parent families, but not for African American children of single parent families.

These results were not confirmed for the 2002 sample, where there were no interactions of ethnicity and family type on behavioral difficulties. This could be due to differences in sample composition and / or data collection or represent some sort of historical shift whereby children from Caucasian co-parenting, skipped generation and single parent families are gaining more resources and support from their communities and schools. Society may gradually be gaining a greater awareness of the needs of non-traditional families.

Hypothesis 3A

No interactions were found for the 1997 or 2002 sample for family type and child

gender on the behavioral and emotional difficulties of children aged 12 to 17 years.

Hypothesis 3B

No interaction was found for the 1997 sample for family type and caregiver gender on the behavioral and emotional difficulties of children aged 12 to 17 years. For the 2002 sample, however, female caregivers in traditional families reported fewer behavioral and emotional difficulties in their 12- to 17-year-old children, than did grandmothers caring for the same age group of children in skipped generation households. No other differences between family types were found. Teens being raised by their grandmothers in skipped generation households may have experienced greater losses (in terms of their parental figures) than those in traditional families and, thus, are more susceptible to behavioral and emotional difficulties.

Given the differences found in the 2002 sample were not found in the 1997 sample, if this is not attributable to sampling / methodological (data collection) differences, it is possible grandmothers in skipped generation households have come to feel more challenged by the behaviors of the teenagers they are raising than do mothers in traditional families.

Hypotheses 5 and 6

No significant interactions were found for the 1997 or 2002 sample between family type and caregiver age or family type, ethnicity and caregiver gender on the behavioral and emotional difficulties of children aged 12 to 17 years.

Conclusions

Family type appears to be an important influence on this age group as far as behavioral and emotional difficulties are concerned. It would appear teenagers living in skipped generation and co-parenting households experience greater behavioral difficulties than those in traditional families and are more similar in this regard to teens from single parent families. Overall, the results support the findings of kinship studies (Billing et. al., 2002; Dubowitz et al., 1994; Kennedy & Keeney, 1988; Sun, 2003) in the earlier literature review.

Extent of Caregiver Involvement with a Younger Child

For the most part, family structure, ethnicity, child and caregiver gender, and caregiver age did not influence how often a family member read to a child or how many outings a child was taken on by a caregiver. The only significant finding was for the 1997 sample with respect to Hypothesis 3A, where an interaction occurred between family type and child gender on the number of monthly outings that children were taken on by caregivers. Here, it was found that single parents took their male children on significantly fewer outings than traditional parents, co-parenting caregivers, or skipped generation caregivers. No other differences were found, and the results were not replicated for the 2002 study.

School Engagement

Hypothesis 1

The only reported differences between families for school engagement emerged

in the 2002 sample for traditional families, whose caregivers reported greater school engagement than did either the grandparent caregivers in skipped generation families or single parents. It is possible traditional families, who may have the advantage of greater stability, may have greater supports, time and knowledge to support their children in their school-related endeavors. It is also possible the school environments themselves have been more favorable for children from traditionally structured families than children and caregivers of more non-traditional families who may feel more stigmatized.

Conclusions

Hypothesis 1: A Main Effect for Family Type

Overall, the first hypothesis for this study, proposing a main effect for family type, has some partial support in that there appeared to be differences between family types for many of the well-being measures (1997 and 2002 caregiver mental health, 1997 and 2002 caregiver aggravation, 1997 and 2002 child health, 1997 and 2002 behavior problems of 6- to 11-year-olds, 1997 and 2002 behavior problems of 12- to 17-year-olds, and 2002 school engagement), with the traditional family demonstrating better well-being than one or more of the other family types. Between the co-parenting, skipped generation, and single parent families, skipped generation families often experienced the poorer well-being.

Differences in the mental health and parental aggravation of caregivers favored traditional families in both the 1997 and 2002 samples. For the 1997 sample, there were no differences in mental health between the co-parenting, skipped generation and

single parents. For the 2002 sample, single parents demonstrated lower mental health than the co-parenting and skipped generation caregivers, leading to the suggestion that single parents may not have benefited from increased resources and services as have grandparent caregivers. In both the 1997 and 2002 samples, skipped generation grandparents reported the most parental aggravation. It was suggested the adverse circumstances under which many skipped generation caregivers assume care (see Goodman & Silverstein, 2002) may result in these caregivers feeling more negatively impacted by their children.

In relation to the child's well being (both health and reported behavioral and emotional difficulties for both the 6- to 11-year-old and the 12- to 17-year-old age groups), differences which favored traditional families and disadvantaged skipped generation families were also found across both the 1997 and 2002 samples. Given very little research has been directed towards the well-being of or interventions with custodial grandchildren, correspondingly, less effort to provide support services and interventions directly to this group of grandchildren may have led to the consistent difficulties both sample years (1997 and 2002) suggest.

Hypotheses 2 to 6: Interaction

While these hypotheses were not well supported as a whole, where differences in well-being did emerge, these tended to do so in the directions predicted by the research hypotheses. Although the study started with large samples, the sub-grouping of participants to investigate the effects of ethnicity, gender and age led to much smaller cell sizes and often a decrease in power. In particular, there were few male caregivers.

With respect to ethnicity, the results of this study suggest Caucasian single parents suffer from worse mental health than Caucasian traditional and skipped generation caregivers. Hispanic traditional caregivers fared better than co-parenting, skipped generation, and single parent families in terms of mental health. No significant effects were found for mental health for African American grandparent caregiver families for whom it may be more normative to have a non-traditional family structure. No other interactions with ethnicity were found for caregiver well-being. As far as the children themselves were concerned, there appeared to be some indication Caucasian 12- to 17-year-olds in co-parenting, skipped generation and single parent families may experience more difficulties than their peers in traditional Caucasian families.

With respect to gender, the results of this study suggest female caregivers who are not in traditionally structured families, that is, grandmother caregivers or single mothers, may be at greater risk for poorer mental health. Also, older children (aged 12 to 17 years) being raised by grandmothers in skipped generation households may also be at risk for greater behavioral and emotional difficulties than peers in traditional families. Some differences arose in the 2002 sample with respect to the mental health of male caregivers, in that male co-parenting caregivers experienced better mental health than single parent fathers. However, the small sub-sample sizes for males in this study limited the interpretation of this finding. It is possible grandfather caregivers may be vulnerable in different aspects of mental health than were tapped by the NSAF measures, such as feeling less in control, as suggested by Kolomer and McCallion (2005) or less efficacious as parents, as suggested by Hayslip, Kaminski and Earnheart (2006). Future studies with grandfather caregivers may, thus, wish to focus on different

aspects of effective functioning salient for male caregivers, such as more specific training in aspects of childcare. They may also feel they have more in common with a gender specific “networking” group of other grandfathers, as opposed to a more traditional support group consisting mainly of grandmothers.

Finally, the only significant findings with respect to age suggested that in the 1997 sample younger children (aged 0 to 5 years) in skipped generation families were disadvantaged by poorer health, as were children (aged 6 to 11 years) of both skipped generation and co-parenting families.

CHAPTER 5

CONCLUSIONS

Overall, the findings of this study are not surprising in that they do appear to provide some evidence for a need for greater support for the challenges faced by co-parenting and skipped generation caregiving grandparents. These non-traditional families are disadvantaged in terms of well-being, and efforts to address this may be directed towards greater education and awareness of service providers and the public, in addition to targeting the custodial grandparents themselves. The social stigma and challenges of low income and ageism will need to be addressed.

Implications for Counseling and Intervention

Since family structure appears to play a role in determining the well-being of co-parenting and skipped generation households, it would make sense for counseling psychologists to direct some efforts towards family focused interventions for these families that might present as struggling. This could take the form of family therapy, with a focus on identifying significant issues and areas of stress salient for that particular family, and encouraging grandparent-headed households to think about how they function and explore ways of resolving their difficulties. Specifically, Goodman (2007) recommends the use of triad analysis (that is, examining representatives from all three family generations and their interactions) to address intergenerational issues for both co-parenting and skipped generation families. Family therapy may then address any negative histories, blurred boundaries and conflicts that have arisen within the grandparent-headed household.

A further effective intervention may be to offer parent education to grandparent caregivers. Dolbin-MacNab (2006) reported grandparent caregivers tend to perceive second time around parenting as more difficult due to some contemporary societal challenges such as the media, drugs and alcohol, peer pressure, more liberal attitudes towards sex, crime and violence, and a lack of prosocial peers. As a cautionary note, however, Baird (2003) and Dolbin-MacNab (2006) have suggested care should be taken to avoid offending grandparents by suggesting they lack parenting skills. Making parent education more “grandparent-friendly” could involve framing it in terms of re-education, or “updating” one’s parenting skills with current research-based knowledge on issues pertinent to child-rearing. Similarly, the University of Wisconsin-Madison offers (via the website <http://www.uwex.edu/relationships/>) parenting information specifically tailored towards the context of custodial grandparenting (Poehlmann, Britnall-Peterson, Schlafer & Morgan, 2003). For grandparents caring for a younger aged child, filial therapy, which involves training the grandparent how to use play as a means of communication with their grandchild, may be effective.

Individual counseling for may also assist grandparents to better cope with the demands of caregiving. For example, Ross and Aday (2006) reported African American grandparent caregivers who used professional counseling as a resource reported lower levels of stress compared to those grandparent caregivers who did not. Given many grandparent-headed households are financially challenged, they may benefit from free or sliding-scale professional counseling services.

This study also suggests family type plays a role in determining the well-being of the children who are raised in co-parenting and skipped generation households who

tend to fare worse than children in traditional families. As with caregiver well-being, these effects for children were evident across sample years. There has been, however, a lesser emphasis in the custodial grandparent literature on the well-being of the child (versus caregiver). There is now a need for more interventions and resources for this vulnerable group of children and the field of counseling may, thus, wish to offer increased support directly towards custodial grandchildren themselves.

From a preventive perspective, schools could be encouraged to increase support towards custodial grandchildren. While some states are changing their educational enrollment requirements (Generations United, 2002), local school districts which require caregivers to show documentation of legal custody or guardianship in order to enroll children should be made aware that grandparent caregivers often raise their grandchildren informally and should, therefore, not unjustly prevent grandchildren from attending school or accessing special education services. Edwards (2006) has suggested children being raised by grandparents may experience greater stability if school officials can work towards placing them with the same teachers and classmates in consecutive years. Grandchildren who are perceived to be struggling, for example, in terms of poor grades or social skills, should be closely monitored and offered opportunities to join support groups or have access to increased tutoring, mentoring, or counseling services as necessary within the school environment. An example of a school-based program which incorporates a combination of tutoring, mentoring, counseling, advocacy, and resource procurement for children being raised by kin is the Kinship Care Connection, which has been demonstrated to improve caregivers' sense

of self efficacy in addition to benefiting children's self-esteem (Strozier, McGrew, Krisman & Smith; 2005).

Ross and Aday (2006) found custodial grandchildren's use of school programs such as tutoring and special education provided a protective effect against the stress perceived by their grandparent caregivers, in addition to helping the grandchildren themselves. Administrators may, thus, have to make a greater effort to educate custodial grandparents as to the services available to their grandchildren, given the school environment may have changed significantly since the grandparents last negotiated the system (or may even have not made the most of the available services the first time around).

Grandparents may be less aware of the services available to them or their grandchildren than both traditional and single parents. Grandparents may benefit from referrals to a wide variety of resources such as support groups (in person, on-line or telephone groups), respite care (for example, before or after school care or summer camp information for their grandchildren), resources for legal aid, legislative advocacy, parent training, information about any disabilities their grandchild may be experiencing, transportation assistance, housing assistance, and health insurance information. Many more resources targeting grandparent caregivers have appeared in recent years. For grandparent caregivers over the age of 60, the National Family Caregiver Support Program was established in 2000, and in partnership with Area Agencies on Aging, offers caregivers information and assistance to gain access to relevant services. Younger grandparent caregivers may be able to access aging network services through other funding sources (Generations United, 2003b). Some of the national resources that

may be helpful for grandparent-headed households include: Generations United, a national non-profit organization which assists and trains service providers in addition to identifying state-specific caregiver resources; the American Association for Retired Persons Grandparent Information Center, which offers a National Database of Grandparent Support Groups; the Brookdale Foundation Relatives as Parents Program, a national network of support groups for relatives raising children informally; the Children's Defense Fund, which provides information on health insurance for children and information on the child welfare system; Eldercare Locator, providing 24-hour access to community assistance resources for seniors; the National Association of Child Care Resource and Referral Agencies, offering information on community based childcare resources; and the National Council on the Aging Benefits Check Up, an internet based service to help identify state and federal assistance programs (Generations United, 2003b). Practitioners may thus wish to educate themselves on these as well as the availability of support services for grandparent headed households specific to their geographical areas and then pass on any relevant information to their clients. For example, in the Denton County area, a comprehensive social services agencies directory is available at <http://dentoncounty.com/socialservices.asp>.

Strengths and Limitations of this Study

Traditionally, studies of grandparent caregivers have tended to compare the well-being of these grandparents with their non-caregiving peers, neglecting to consider how these caregivers may fare in comparison to more traditionally-structured or single parent families. This study used the existing national data bases of the NSAF to explore, in

combination, the potential influence of family structure, ethnicity, gender, and age in relation to the well-being of grandparent caregivers and their grandchildren.

A further strength of this study was that instead of the grandparent caregiver households being viewed as a single group, the families were analyzed as two distinct groups of skipped generation and co-parenting grandparents, given previous research (for example, Goodman & Silverstein, 2002) has suggested differences between these family types exist. The larger sample size of this study allowed for greater statistical power to explore the effects of family structure. As was noted in the review of the literature, studies of grandparent caregivers tend to use small samples, many of a convenience nature or composed of volunteers. Interestingly, the large sample size permitted by this national data set also demonstrated some findings that paralleled many of those based on smaller samples of convenience.

Although the original NSAF questionnaire was not designed to specifically investigate the well-being of grandparent-headed households, many of the measures used (e.g., caregiver mental health, caregiver aggravation, and child behavior problems) have parallels in custodial grandparenting research and are, thus, applicable to custodial grandparents.

While the power for the analyses in this study was generally high because of the large sample sizes, counter to this, the effect sizes of the analyses in this study were small, indicating the findings may not have been substantial. A lack of specificity in some of the measures used (for example, the child health question and the questions relating to parental involvement), which could have been better tailored, may have underestimated the true effect sizes. Despite starting with fairly large sub-samples, by

the time several of the interactions (particularly in regards to family type, ethnicity and caregiver gender) were run, the cell sizes were too small to interpret further.

A further limitation was that as a result of using a secondary source of data, this study had to rely on the post hoc creation of the independent and dependent variables of interest. In particular, a disadvantage of having to combine different NSAF variables in order to establish the co-parenting and skipped generation family groups may have led to the misidentification of some families, as suggested by the higher numbers of skipped generation families compared to co-parenting families (which is somewhat contradictory to previous research). It was possible that some co-parenting families (where both parents, in addition to a caregiving grandparent, were present) may have ended up in the skipped generation group. This is likely, however, to have been a rare occurrence, with the more likely explanation for the presence of greater numbers of skipped generation families being related to the nature of the predominantly low income sample. While an analysis of income differences (where co-parenting and skipped generation families did not differ) does not explain this, it may be that the greater likelihood of skipped generation families having experienced incarceration, death, substance abuse, and abandonment might explain their greater numbers in this study. However, lacking information regarding the circumstances leading to caregiving, this remains speculative.

Another disadvantage of using a secondary data source was that it was difficult to control for many of the antecedent factors which are also likely to have had an impact on caregiver well-being, such as the marital status of the grandparent caregivers, the reasons why the grandparents had assumed a caregiving role, the duration of

caregiving, the number of children being cared for in the family (which may in itself have increased caregiver burden), available social supports, or even the quality of the relationship between the caregiver and child. Some of the difficulties in considering these factors resulted from the incomplete collection of data, a further artifact of using secondary data, which had been collected for different purposes than a primary focus on grandparent caregivers. For example, the 1997 NSAF questionnaire was set up to ask respondent caregivers whether they were married, divorced, or had never married (Question D9A). In the 1997 data collection, however, only 53 respondents (out of a total of 34,539 respondents) were actually asked about their marital status. In setting up the groups for family structure, it was, therefore, not known whether the co-parenting and skipped generation grandparent caregivers were married or not. This might have been an important factor to explore, considering the literature which suggests ones social supports play a role in helping caregivers cope better with the burdens of caregiving.

Further, while the NSAF questionnaire initially appeared promising in terms of offering several potential dependent variables, particularly in terms of posing questions related to the physical health of caregivers, once again, limited data were actually collected by the interviewers in this respect. In the 2002 data collection, for example, it appeared only 28 interviewees were asked to respond to two physical health-related questions, and over 34,000 respondents were coded on as these same questions being “inapplicable.” These specific questions about the physical health status of the caregiver were not included as part of the 1997 data, so no conclusions could be drawn about the physical health of those respondents either. Some exploration of potential questions

which may have served as indicators for physical health was undertaken, but it was decided against using a single item, such as the number of health professional visits made in the past year, as a proxy for caregiver health. Similarly, it was difficult to justify using the questions related to the focal child's physical health. For some of the physical health related-type questions, it was not possible to distinguish whether the response applied to the caregiver, the focal child, or an additional member of the family (for example, "During the past 12 months, were you, a spouse, a partner, or your child a patient in a hospital overnight?"). In conclusion, this study was limited to the dependent variables which existed and had reasonable alpha values.

It should be noted the selection criteria for the NSAF samples biases the findings of this study towards a lower income group and, thus, excludes the generalizability of the findings, particularly towards those families in higher income groups. On the other hand, low income groups are less amenable to study and are more vulnerable, which helps to justify the use of the NSAF samples to explore the antecedents of well-being in grandparent-headed families.

A further disadvantage of this study is that like so many other studies of grandparent caregivers, it relies upon the self-report of the participants. Not only were the caregivers reporting on their perceptions of their own well-being, but were also reporting on their perceptions of the well-being of the children for whom they were caring. Even the indicator for child's current health status was based upon the subjective perceptions of the caregiver. Thus, common method variance may influence perceptions of both caregiver and child in this study. Future studies may, thus, wish to include other sources of information, such as measures directed towards teachers or

health care providers. The grandparent caregiving literature in particular has noted grandparent caregivers may have a tendency to underestimate difficulties experienced by the children for whom they care, as well as their own difficulties (Hayslip et al., 2000).

Directions for Future Research

It is evident from both the literature review and the results of this study that grandparent-headed families are diverse in nature, particularly in terms of family type, gender, and ethnicity. With regards to family type, it would appear there are indeed some differences between grandparent caregivers who are raising grandchildren in a household where one or more of the child's parents are also present and those who live in skipped generation households. Future custodial grandparenting research should be clear about the type of family structure being investigated, since this may lead to a greater understanding of the antecedents and consequences for this vulnerable population. It would also be important to distinguish between married and unmarried or cohabiting grandparent caregivers as this is likely to make a difference in the social and emotional supports available to the grandparent caregivers. Within the co-parenting households, it may be valuable to explore the extent of involvement or support of the child's parent/s. If gender is to be thoroughly explored in the context of grandparent-headed households, future efforts will need to be directed towards finding larger samples of male caregivers.

As suggested by the above literature, since families are embedded in complex environmental systems, many factors other than family type, ethnicity, gender and age are likely to have influenced caregiver and child well-being. While this analysis may

have controlled for income and education, it did not take into account varying influences such as the stability and duration of the family structure, available social supports and coping resources of the families, household size, parenting skills, and the physical health of all family members. Future research may wish to address more of these factors.

Ideally, longitudinal studies may shed more light on some of the historical trends noted in this study. Will the growing phenomenon of custodial grandparenting become more normative in society and, thus, continue to even out any differences in caregiver well-being between family types?

Of the dependent variables considered in this study, findings suggest an area of difficulty for grandparent caregivers tends to lie in the reported behavioral and emotional difficulties of the grandchildren, particularly relative to children being raised in traditional families. There was no similar measure available for this study to investigate the behavioral and emotional difficulties of children under the age of 6, so it may be important for future research to include measures to assess difficulties experienced by younger children. Of the two age groups where reported behavior was evaluated, since significant differences were found more often for the well-being of the older group of children (12 to 17 years), this may be another important focal area for future grandparent caregiver research. Do older custodial grandchildren, for example, find it more difficult to adapt to changes in their caregiving situation than younger grandchildren, and, if so, might this manifest more in terms of internalizing (such as depression or anxiety) or externalizing (more disruptive behavioral) difficulties? Future

research directed towards the well-being of children being raised by their grandparents should include the development of interventions for this vulnerable group of children.

Finally, future research in the field of custodial grandparenting may wish to consider some of the more positive aspects of grandparent caregiving. Ruiz (2004) and Gibson (2005), for example, have noted several strengths of African-American grandmothers, which included working with the vulnerabilities of their grandchildren, involving extended family for additional support, maintaining effective communication, and taking a strong role in the education of their grandchildren. In addition to preserving family ties and offering many benefits to the grandchildren for which they care, grandparent caregivers are a valuable resource to society in that they prevent many children from entering an already over-burdened foster care system. Highlighting the strengths and resilience of grandparent-headed households, with a de-emphasis on problems, may ultimately assist these families to focus upon building their protective factors and experiencing greater success.

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