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Grandparents Raising Grandchildren

Stressors, Social Support, and Health Outcomes

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The major purpose of this study was to identify predictors of grandparent caregiver health status. Additional purposes were to describe the physical and emotional health of grandparent caregivers and the perceived benefits of support group attendance. A convenience sample of 42 grandparents was recruited from support groups. Data were collected through telephone interviews. Grandparents who had higher parenting stress reported lower levels of physical, social, and mental health. Inverse correlations were present between life stress and mental health. Positive correlations were found between social support and physical health. No pattern emerged in a comparison of the health of caregiving grandparents and a normative sample. Emotional support was the primary benefit derived from support group attendance. There were modest inverse associations between the length of time the child had lived with the grandparent and six of the eight indicators of grandparent health.

Keywords: *grandparent health; grandchildren; grandparent caregiver; social support; stressor*

An increasing number of grandparents are raising their grandchildren in the United States. According to Census 2000, 5.8 million grandparents live with grandchildren under the age of 18, and 42% of these grandparents have primary responsibility for their grandchildren (Simmons & Dye, 2003). Grandparents have been pressed into the primary caregiving role because of reasons such as parent incarceration, death, mental illness,

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substance abuse, and neglect and abuse of children (Gibson, 2002; Grant, 2000; Haglund, 2000; Janicki, McCallion, Grant-Griffin, & Kolomer, 2000; Kelley, Whitley, Sipe, & Yorker, 2000; Minkler, Roe, & Price, 1992; Musil, 1998; Pruchno, 1999; Ross & Aday, 2006; Sands, Goldberg-Glen, & Thornton, 2005).

Stressors associated with caregiving place grandparents at risk for the development of health problems. Caring for grandchildren who come from abusive and neglectful backgrounds might be expected to present even more challenges for grandparents. If grandparents are to meet the new parenting responsibilities that have been thrust on them, they need the energy and motivation that is associated with positive physical and mental health. To develop interventions that support the health of grandparents, nurses need to conduct studies that identify predictors of health in this population. Therefore, the major purpose of this study was to identify factors that contribute to change in the physical, mental, and social health of grandparents who are raising grandchildren.

Conceptual Framework

The conceptual framework for this study was derived from the caregiver stress model of Pearlin, Mullan, Semple, and Skaff (1990). According to this model, life stressors associated with the caregiving experience negatively affect the health and well-being of caregivers. In this study health was measured by the Short Form-36 (SF-36) Health Survey, which includes indicators of physical and mental health. Stressors were conceptualized as primary and secondary. Primary stressors include those that are related directly to demands of caregiving. In this study primary stressors were measured by the Parental Distress subscale and the Child Behavior Checklist (CBCL). Secondary stressors are an outgrowth of the primary caregiving stressors and involve changes in role relationships, which were measured by components of the Life Stress subscale.

As one explanation for people's dissimilar responses to stresses, this model includes several concepts of coping and social support, which are referred to as mediators of stress. The mediating concept in this study is social support, which was measured by the Family Support Scale (FSS). According to Pearlin et al. (1990), mediators can have direct and indirect effects on outcomes. Mediators indirectly affect outcomes by blocking the outgrowth of secondary stressors from primary stressors. In the present

study, only the direct effects of social support on the outcomes of grandparents' mental and physical health were analyzed.

Review of Research

Grandparents who have assumed the caregiving role for their grandchildren have reported experiencing a variety of stressors. One of the major stressors described in the literature is the presence of chronic conflict between the grandparents and their adult children (Butler & Zakari, 2005; Ehrle & Day, 1994; Leder, Grinstead, Jensen, & Bond, 2003; Musil & Standing, 2005; Orb & Davey, 2005; Weber & Waldrop, 2000). In providing for the grandchildren's needs, grandparents encounter another significant source of stress. Having an additional child in the home can strain family resources and place unusual demands on grandparents' time (Burnette, 1999b; Dowdell, 1993; Kelley & Damato, 1995; Pruchno, 1999; Weber & Waldrop, 2000). The burden of raising the grandchildren was increased when the child had physical and behavioral problems (Bowers & Myers, 1999; Emick & Hayslip, 1999; Janicki et al., 2000; Orb & Davey, 2005; Sands & Goldberg-Glen, 2000).

Researchers have reported a variety of physical health problems in grandparent caregivers (Haglund, 2000; Leder et al., 2003; Strawbridge, Wallhagen, Shema, & Kaplan, 1997). Almost half of the grandmothers in Dowdell's (1995) study reported a serious physical problem or illness. More than two-thirds of grandparents in Butler and Zakari's (2005) and Grant's (2000) studies were found to have multiple chronic conditions. Among 74 Latino grandmothers, 70% rated their health status as fair or poor (Burnette, 1999b). Using data from a national survey of families, Minkler and Fuller-Thomson (1999) found that custodial grandparents had more limits in carrying out their activities of daily living than noncustodial grandparents.

The stress of caregiving also has been associated with a decline in the grandparents' emotional well-being (Burnette, 1999b; Szinovacz, DeViney, & Atkinson, 1999; Waldrop, 2004). Anxiety and depression were frequently addressed mental health concerns of grandparent caregivers (Burton, 1992; Musil, 1998; Odulana, Camblin, & White, 1996; Roe, Minkler, Saunders, & Thomson, 1996). When compared with noncustodial grandparents, custodial grandparents were more likely to have high depression levels (Janicki et al., 2000; Minkler, Fuller-Thomson, Miller, & Driver, 1997; Strawbridge et al., 1997).

Findings related to grandparents' health were inconsistent across studies; some grandparents reported no decline in health after assuming care of grandchildren (Bowers & Myers, 1999; Minkler et al., 1992). Among this group of grandparents were those who viewed themselves as physically healthier because of a more active lifestyle with their grandchildren (Waldrop & Weber, 2001). Many of the 717 caregiving grandmothers in Pruchno's (1999) study indicated their self-esteem improved as a result of caring for their grandchildren. Other grandparents felt that caregiving provided them with an increased purpose for living (Burton, 1992; Jendrek, 1993). Grandparents tended to worry less about their grandchildren after they were removed from neglectful homes (Haglund, 2000).

Researchers have examined social support as an important element in coping with the stressors faced by grandparents in the caregiving role (Bowers & Myers, 1999; Burnette, 1999c). Grandparents have described having large formal and informal support networks (Burnette, 1999b; 1999c). However, grandparents in other studies have focused on inadequacies in their support systems. These inadequacies included raising the children without an adult partner (Minkler, Roe, & Robertson-Beckley, 1994), receiving little or no help from the grandchildren's biological parents (Pruchno, 1999), and receiving insufficient formal support services (Henderson & Cook, 2005; Kelley & Damato, 1995; Orb & Davey, 2005). The few studies that examined the relationship between social support and health of grandparents primarily focused on their psychological well-being. In general, supportive social networks have been associated with improved mental health (Kelley, 1993; Kelley et al., 2000; Sands & Goldberg-Glen, 2000; Shore & Hayslip, 1994). Musil and Ahmad (2002) found that subjective support, but not instrumental support, was associated with lower levels of depression. In one of the rare studies focusing on grandfathers raising grandchildren, Bullock (2005) reported that grandfathers attributed their sense of empowerment to their social support network.

Grandparent caregivers have reported that support groups help them deal with the day-to-day stressors of raising their grandchildren (Minkler, Driver, Roe, & Bedeian, 1993). However, Sands and Goldberg-Glen (2000) found that attendance at support groups did not lower levels of anxiety in the grandparent participants. Overall, there have been few systematic attempts to evaluate the effects of support group attendance on caregiver stress and on the physical and emotional health of the grandparent caregivers.

This study aims to advance grandparent caregiving research by addressing some of the substantive gaps. Although multiple studies have described

various stressors associated with raising grandchildren, few have specifically tested the relationship between stressors and the health of grandparents. The literature indicates that grandparents have large support networks and access to a variety of social services. However, there are gaps in the support received by grandparents to deal with the challenges of raising grandchildren. This study examined various modalities of support available to grandparents and their effect on health. There was a specific focus on the perceived helpfulness of support group attendance.

Purposes and Research Questions

The primary purpose of this cross-sectional correlational study was to address the following research questions:

1. Is there a relationship between parenting stress, as measured by the Parental Distress subscale of the Parenting Stress Index Short Form, and grandparent caregivers' health, as measured by the SF-36 Health Survey?
2. Is there a relationship between the stress of children's problem behavior, as measured by the CBCL, and grandparent caregivers' health?
3. Is there a relationship between general life stress, as measured by the Life Stress Scale, and grandparent caregivers' health?
4. Is there a relationship between social support, as measured by the FSS, and grandparent caregivers' health?

Other purposes of the study were to (a) compare the physical and emotional health of grandparent caregivers with a normative sample, (b) describe the perceived benefits of support group attendance, and (c) examine the relationship between selected demographic variables (age of grandparent, number of grandchildren residing with the grandparent, length of time the grandchild was in the grandparent's home) and grandparent health.

Methods

Sample/Setting

A convenience sample was recruited from grandparents who were the custodial caregivers for at least one grandchild. These grandparents had attended a minimum of one session of a grandparent caregiver support

group within the past 6 months. The support groups that were accessed included 11 groups in nine midwestern urban and rural communities. These groups were identified through a resource manual of services for kinship care families. The support groups selected were those whose leaders were willing to provide the researchers access to the group and that were within a 100-mile radius of the researchers' university campus. The support groups were supported by a variety of agencies, including county departments on aging, human service agencies, school districts, and religious and other private organizations. In all cases the groups were led by professionals, primarily social workers. Most groups met monthly; several met weekly.

If two grandparents resided in a household, the primary caregiver was asked to participate in the study. In families with multiple grandchildren, questions about the children's behavior were asked in regard to only the oldest grandchildren to avoid overburdening these grandparents with lengthy interviews.

The final sample consisted of 42 grandparents, including 39 grandmothers and 3 grandfathers. Ages ranged from 37 to 73 with a mean of 58 years. Grandparents were predominantly Caucasian (71%) and African American (19%). Most of the grandparents were married or living with a significant other (67%), and 33% were widowed, divorced, or separated. All but three were high school graduates, and 55% had some college. Two-thirds of the participants were not employed.

Grandparents cared for a maximum of four grandchildren. One grandchild was being raised in 55% of the households and more than one in the remainder of the homes. Only four grandparents had other minor children living in the home. Children ranged in age from 1 month to 18 years. Grandparents had been caring for their grandchildren for 1 month to 15 years. Most of the grandparents (93%) had some type of legal custody of the children, and 24% actually adopted the children. The two primary reasons for grandparents raising their grandchildren included neglect of children (62%) and drug use by parents (57%), followed by parent illness (26.2%), parent unemployment (19%), parent abuse (14.3%), death of parent (7.1%), and minor status of parent (2.4%).

Instruments

The Parental Distress scale is a 12-item subscale of the Parenting Stress Index Short Form used to assess stress associated with parenting. Each item is rated on a 5-point scale from *strongly agree* to *strongly disagree*. An example of an item is, "Since having this child I have been unable to do new

and different things." Test-retest reliability with 800 participants was .85, and Cronbach's alpha was .87. Validity testing for the short form was not performed by the tool developers. However, they expected the extensive construct and predictive validity for the full length form to be applicable to the short form (Abidin, 1995). For the present sample, a Cronbach's alpha was calculated to be .87.

The CBCL measures children's behavioral problems as reported by parents or parent surrogates. The forms for 6- to 18-year-olds and 1.5- to 5-year-olds contain 113 and 100 items respectively. Grandparents with the oldest child less than 18 months of age did not complete the questionnaire. Study participants responded to each item on a three-point scale: 0 = *not true*, 1 = *somewhat true or sometimes true*, and 2 = *very true or often true*. The CBCL has two general subscales labeled internalizing and externalizing. Internalizing items include problems within the self, such as depression and withdrawal. Externalizing items reflect interpersonal conflicts and conduct problems. Examples of externalizing items include "argues a lot," "cruel to animals," and "disobedient at school." Testing from multiple large samples has demonstrated substantial reliability and validity for the tool. Reliability testing for this tool has included interparent reliability (.52-.87), one week test-retest reliability (.70-.93), one year test-retest reliability (.41-.87), and internal consistencies of subscales (.42-.96). Validity has been supported by correlations between the CBCL scales and a variety of tools that measure children's behavior. The tool has demonstrated ability to discriminate between children with and without mental health problems (Achenbach & Rescorla, 2000, 2001). Cronbach's alphas for the CBCL in the present study were .90 for the internalizing behaviors subscale and .92 for the externalizing subscale.

The Life Stress Scale, a 19-item optional component of the Parenting Stress Index, measures general life stress. Study participants indicate whether each event occurred during the past year. Examples include "divorce," "went deeply into debt," and "legal problems." Studies have provided evidence for the construct and predictive validity of this tool by reporting associations between life stress and measures of social support, child functioning, and family functioning (Abidin, 1995).

The FSS has 18 items on a five-point Likert-type scale. The FSS measures helpfulness of formal and informal support services for families raising children. It has a coefficient alpha of .77 and test-retest reliability of .75. In a number of studies, the score on the FSS was related to parent and family well-being (Dunst, Trivette, & Deal, 1988). A Cronbach's alpha based on the sample in the present study was .65.

The SF-36 Health Survey is a 36-item questionnaire that assesses a wide range of physical and mental health problems. The tool includes four indicators of physical health (physical functioning, role-physical, bodily pain, and general health) and four indicators of emotional health (vitality, social functioning, role-emotional, and mental health). Role-physical and role-emotional refer to the extent to which physical or emotional health affects role functioning. Higher scores on the subscales indicate a better level of health. Across multiple studies the eight scales have displayed internal consistency reliabilities of .63-.96 and test-retest reliabilities of .60-.90. This tool has support for criterion validity as a number of studies have demonstrated good correlations with other health-related instruments (Ware, Snow, & Kosinski, 2000). Cronbach's alphas for the SF-36 in the present study ranged from .71 (role-emotional) to .96 (social functioning).

All of the above tools were selected because they have been used in previous studies of grandparents raising grandchildren (Bachman & Chase-Lansdale, 2005; Bowers & Myers, 1999; Kelley, Yorker, Whitley, & Sipe, 2001; Musil, 2000; Robinson, Kropf, & Myers, 2000; Ross & Aday, 2006).

Demographic information included grandparent age, ethnicity, education, employment and marital status, number of grandchildren and other minor children, age and gender of grandchildren, reasons for grandparent caregiving, finances, length of time with grandchildren in the home, and legal authority. In addition, there was a 6-item scale developed by the researchers for rating the benefits of support group attendance. Participants were asked to rate on a 4-point scale the extent to which the support group helped them with emotional support, child rearing, and access to support services.

Procedure for Data Collection

Permission was obtained from the support group leaders to attend a meeting for the purpose of introducing the study. Grandparents attending the meeting were given the demographic data form, a consent form that also served as an information letter, and a self-addressed stamped envelope for returning the forms. Additional copies of the forms were left with the group leader to distribute to grandparents on the group's roster but not in attendance at the meeting.

A trained researcher contacted grandparents willing to participate to schedule a telephone interview. The decision was made to collect data by telephone interview for the following reasons: (a) individuals who had any difficulty with reading would not be excluded, (b) response rate is generally higher with interviews than mailed questionnaires, and (c) it is less

likely that items will be omitted inadvertently by the participants. Prior to the interviews, participants received questionnaire materials, which they used to follow along during the telephone interview. Interviews lasted approximately 45 minutes. Grandparents were given the option to participate in two shorter interviews in place of one longer interview. Approval of the study was obtained from a university human research review committee.

Data Analysis Methods

Descriptive statistics, which included frequencies, percentages, and means, depicted characteristics of the sample and benefits of support group attendance. Pearson's correlations were used to test the relationship between grandparent's health and stress, social support, and demographic variables. The differences in physical and emotional health between grandparent caregivers and a normative sample were analyzed using *t* tests.

Findings

Predictors of Grandparent Health Status

Stressors. Significant inverse relationships were found between grandparent scores on the Parental Distress Scale and all eight scales of the SF-36 Health Survey. The Life Stress Scale was significantly related only to the social functioning, role-emotional, and mental health scales (see Table 1).

A third measure of stress, the CBCL, was related to a number of the SF-36 scales. Whereas CBCL externalizing behaviors were negatively correlated with general health and the four social/emotional scales, internalizing behaviors were negatively correlated with all eight scales (see Table 2). The results reported in this table included children older than 5 years. There were too few younger children to perform a separate analysis.

Social support. Scores from the FSS were positively related to physical functioning, role-physical, bodily pain, and social functioning (see Table 3).

Physical and Emotional Health of Grandparent Caregivers

The physical and emotional health of grandparent caregivers can best be described by comparing their scores on the SF-36 Health Survey with the scores of a normative sample within their approximate age range (Ware

Table 1
SF-36 Health Survey and Measures of Stress (N = 42)

SF-36 Scales	Parental Distress Scale		Life Stress Scale	
	<i>r</i>	<i>p</i>	<i>r</i>	<i>p</i>
Physical functioning	-.436	.002	-.061	.701
Role-physical	-.424	.003	-.246	.117
Bodily pain	-.523	.000	-.248	.114
General health	-.426	.002	-.225	.152
Vitality	-.629	.000	-.171	.279
Social functioning	-.531	.000	-.404	.008
Role-emotional	-.491	.000	-.422	.005
Mental health	-.776	.000	-.378	.014

Note: Level of significance = $p < .05$.

Table 2
SF-36 Health Survey and Child Behavior Checklist (N = 35)

SF-36 Scales	Internalizing Behaviors		Externalizing Behaviors	
	<i>r</i>	<i>p</i>	<i>r</i>	<i>p</i>
Physical functioning	-.359	.017	-.198	.127
Role-physical	-.300	.040	-.193	.133
Bodily pain	-.362	.016	-.205	.118
General health	-.543	.000	-.396	.009
Vitality	-.438	.004	-.286	.048
Social functioning	-.551	.000	-.367	.015
Role-emotional	-.534	.000	-.367	.015
Mental health	-.432	.005	-.359	.017

Note: Level of significance = $p < .05$.

et al., 2000). As delineated in Table 4 the normative sample had more positive scores on all scales than the grandparent caregivers. However, only the *t* values for the scales of physical functioning, bodily pain, vitality, and role-emotional were statistically significant.

Benefits of Support Group Attendance

Most of the grandparents reported considerable benefit from the emotional support they received from support groups (88%) and the sense that

Table 3
Family Support Scale and SF-36 Health Survey ($N = 42$)

SF-36 Scales	<i>r</i>	<i>p</i>
Physical functioning	.290	.031
Role-physical	.351	.011
Bodily pain	.288	.032
General health	.075	.319
Vitality	.257	.050
Social functioning	.277	.038
Role-emotional	.209	.092
Mental health	.255	.051

Note: Level of significance = $p < .05$.

Table 4
**Physical and Emotional Health of Grandparent
 Caregivers ($N = 42$)**

SF-36 Scales	Normative Mean	Study Mean	<i>t</i>	Significance
Physical functioning	73.09	62.26	2.32	*
Role-physical	71.61	62.50	1.24	<i>ns</i>
Bodily pain	66.64	55.19	2.63	*
General health	62.87	58.74	1.00	<i>ns</i>
Vitality	58.08	42.86	3.83	*
Social functioning	79.43	74.11	0.97	<i>ns</i>
Role-emotional	79.51	65.87	2.12	*
Mental health	73.40	70.29	1.03	<i>ns</i>

Note: The normative mean is based on females ages 55-64.

* $p < .05$.

there were others who were in the same situation (86%). Fewer reported assistance with child rearing (55%), the legal system (41%), finances (29%), and the social service system (29%).

Demographics and Grandparents' Health

There was no relationship between the age of the grandparents and their scores on the eight SF-36 Health Survey scales. The number of grandchildren in the home was related significantly only to the vitality scale ($r = -.276$, $p = .038$). Significant inverse relationships were found between the length of time the grandchild was in the grandparents' home and six of the SF-36 Health Survey scales (see Table 5).

Table 5
Time in Home and Grandparents' Health (N = 41)

SF-36 Scales	<i>r</i>	<i>p</i>
Physical functioning	-.341	.014
Role-physical	-.334	.016
Bodily pain	-.331	.017
General health	-.349	.013
Vitality	-.089	.290
Social functioning	-.393	.006
Role-emotional	-.341	.015
Mental health	-.236	.069

Note: Level of significance = $p < .05$.

Discussion

Of the three measures of stress, the Parental Distress Scale scores were more consistently and more strongly related to health measures ($r = -.424$ to $-.776$) than were the other two measures of stress. The negative relationships indicated that increased parenting stress was associated with lower levels of physical, social, and mental health. The unexpected reentry into parenthood created upheaval in the lives of these grandparents. Because most of the grandchildren came from dysfunctional families, they were likely to present more behavioral and emotional problems, magnifying the stress of parenting.

Grandparents' health appeared to be negatively affected by the grandchildren's behavior problems. The stress resulting from the children's behavior had a more consistent impact on the grandparents' emotional health than on their physical health. Overall, the children's internalizing behaviors were more strongly correlated with grandparents' health than were the externalizing behaviors. The internalizing behaviors appeared to have a negative impact on all eight domains of grandparent health, whereas externalizing behaviors were primarily related to emotional and social health. The reason for the greater impact of the internalizing behaviors on health is unclear. Grandparents might experience a greater sense of helplessness in dealing with internalizing behaviors, which are defined as mainly within the self, than with the acting out problems that are characteristic of the externalizing behaviors.

As a measure of generalized stress, the Life Stress Scale was more weakly related to grandparents' health than were other measures of stress.

Life stress appeared to have an impact on mental health and social functioning but was not significantly related to physical health. The items on this scale dealt with broad areas of stress and might not have concerned these grandparents as much as the immediate stressor of raising the grandchildren.

Overall, relationships between stressors and grandparents' health were consistent, and in a number of cases, relatively strong. As in the case of any correlational research, interpretation of these relationships needs to be approached with caution. Rather than stressors having a negative effect on health, the direction of the relationship could have been reversed. Grandparents with poor health might have a tendency to perceive life from a more negative perspective and therefore report more life stress.

Significant relationships were found between physical health scales and social support. However, social support was not related to any of the mental health scales. The scoring of the FSS could partially account for the low correlation between support and grandparent health. For example, participants could receive a score of one on an item if that source of support was rated "not at all helpful," whereas they received a zero if the source was not available. It could be questioned whether a source that is not at all helpful contributes more to overall support than an unavailable source. Another explanation of the low correlation could be the relatively low reliability of the FSS including a .65 alpha coefficient and a .75 test-retest reliability (Dunst et al., 1988). Moreover, Underwood (2000) summarized the lack of clarity that exists in understanding the precise effects of social support on health measures.

No clear patterns emerged when the health of caregiving grandparents and a normative sample were compared. It was expected that the additional stress of child rearing would have a detrimental effect on grandparents' health. However, caregiving grandparents did not differ significantly from the normative sample in four of the subscales. One explanation might relate to the issue of sample bias. Perhaps grandparents who had positive functional health were more likely to participate in the study than those who were less healthy. Caregiving grandparents had lower scores on three indicators of physical functioning and one indicator of emotional functioning. Although the mean ages of the normative sample and the current sample were approximately the same, the age range of the current sample was greater. The inclusion of women up to the age of 73 could account for the lower scores on some of the SF-36 scales.

Grandparents reported support groups to be of some use in the work of raising their grandchildren. The primary benefit was the emotional support they received to cope with child rearing. Support groups provided less help

with finances and the legal and social systems, which have been described in the literature as needed by caregiving grandparents (Burnette, 1999a; Scarcella, Ehrle, & Geen, 2003). Because the scale for rating the benefits of support group attendance had no psychometric testing, the decision was made not to relate the scores from this scale to grandparents' physical and emotional health.

Although it might be expected that older grandparents would have poorer physical health, the age of the grandparents in this study was not related to any aspect of health. This is contrary to the norms of the SF-36 that were recorded in Ware et al. (2000), in which the mean scores of the physical health scales gradually decreased across the age groups. Another unexpected finding was the failure to find a relationship between the number of grandchildren in the home and the grandparent's health. It would seem that the burden on the grandparents would increase with additional children in the home. This failure to find a significant relationship may have been because most of the families ($n = 23$) were raising only one grandchild.

Six indicators of grandparent health were related to the length of time the child had lived with the grandparent. Although there is no clear explanation for these relationships, caring for children with behavior problems could have a gradual eroding effect on grandparent health. There is documentation that children who are living with grandparents have an unusually high incidence of emotional and behavioral problems (Billing, Ehrle, & Kortenkamp, 2002; Dubowitz, Zuravin, Starr, Feigelman, & Harrington, 1993; Shore, Sim, Le Prohn, & Keller, 2002).

A major limitation of the study was the size of the sample. A sample size of 42 did not allow the use of a multivariate procedure such as regression analysis in which multiple predictors of grandparent health could have been analyzed simultaneously. The original intent was to obtain 75-100 participants from three to five support groups because of the size of the groups as estimated by the group leaders. However, the level of participation was much less than expected and was somewhat dependent on the degree of enthusiasm about the study expressed by the group leader. It was not clear how many grandparents were approached about participating. Many were not in attendance at the support group meetings when the investigators presented the study, and invitations to participate were left with the group leaders to distribute. There was no way to determine how many were actually distributed. Participants continued to be sought from additional support groups until a decision was made to stop data collection after one year.

In this study it was requested that the primary caregiver provide the interview data, resulting in the inclusion of only three grandfathers in the

sample. Most prior studies have included only grandmothers (Grinstead, Leder, Jensen, & Bond, 2003). Although they may not view themselves as primary caregivers, grandfathers are often involved in caregiving. The perspective of grandfathers in the caregiving experience is needed and should be the focus of future studies.

Future research should explore the differential effects of externalizing and internalizing behaviors on grandparent health. It would also be useful to examine the unique needs that grandparents have when caring for children with externalizing as opposed to internalizing behavioral problems. More studies are needed that address supportive interventions for these grandparents. Potential studies could examine the effects of child-rearing classes and grandparent support groups as means to mediate the stress of caregiving. Of particular relevance for grandparents with limited access to face-to-face support groups are online support groups. At the present time there is a blossoming of literature on support groups, but there are no studies evaluating the effects of such support groups on the well-being of grandparent caregivers.

For adequate evaluation of support groups, reliable and valid measures of effectiveness are needed. In the present study, data analysis was limited because of the unavailability of a well-developed tool. Although the originators of the FSS reported adequate reliability, the reliability coefficient for our present sample was lower than usually viewed as acceptable. Further study is needed to determine whether this tool can be modified to be acceptable with grandparent caregivers.

As with most past studies of grandparents raising grandchildren, this study had a cross-sectional design. Longitudinal studies present financial and methodological challenges. However, they are essential in order to draw conclusions about causal relationships between grandparent health and contributing factors.

Implications for Family Nursing Practice

Nurses encounter grandparents raising grandchildren in a variety of health care settings and need to be prepared to meet the unique challenges confronting this family constellation. These grandparents are caring for children who tend to come from dysfunctional families, which is likely to increase the stress of parenting. Nurses providing care for grandparent-headed families should consistently assess for potential sources of stress related to child rearing. To cope with the stress of child rearing, grandparents might benefit from

receiving information about available support groups, particularly if they need emotional support, feel alone in their task of raising their grandchildren, or need assistance with child rearing. Grandparents with children who have emotional or behavioral problems may require specialized parenting guidance from qualified mental health professionals. Other referrals that can be used to buffer the stress of parenting include respite care or special programs for the child that give the grandparents time away from the demands of caregiving.

As caregivers, grandparents are older than the typical parents of young children and are more likely to have health problems, particularly of a physical nature. Grandparents need to attend to their physical and mental health needs to meet the challenges of raising young children. Nurses should encourage grandparents to seek regular care for any existing health problems and to engage in healthy lifestyle activities such as regular exercise and a healthy diet.

Conclusion

Studies of grandparent-headed families have appeared in the literature primarily over the last decade. Most of the research has been descriptive in nature, which has provided a better understanding of this family structure. The present study sought to examine the relationships among stress, social support, and grandparent health. Various aspects of stress were consistently related to grandparents' physical and mental health. Although the nature of the relationships was not clear, the concept of stress has promise for future research in grandparent caregiving. The descriptive data in this study revealed some benefits from support group attendance. Future research could build on these preliminary data by examining the benefits of support groups in more controlled evaluation studies.

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