Examination of Role Satisfaction and Mental Health of Caregiving Grandparents

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EXAMINATION OF ROLE SATISFACTION AND MENTAL HEALTH OF
CAREGIVING GRANDPARENTS

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By
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EXAMINATION OF ROLE SATISFACTION AND MENTAL HEALTH OF
CAREGIVING GRANDPARENTS

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Research has shown that the number of caregiving grandparents in America has steadily increased. If this trend continues there will be more of a need for society to recognize this population and the difficulties that they face due to the atypical structure of these households. Research has produced mixed results as to what effect raising grandchildren has on grandparent caregivers. Most research has found that raising a grandchild increases stress levels (Bowers & Myers, 1999; Musil 1998; Sands & Goldberg-Glen, 2000). Research has also shown that some caregiving grandparents possess other difficulties such as increased mental and physical health problems (Daly & Glenwick, 2000; Fuller-Thomson & Minkler, 2000; Minkler & Fuller-Thomson, 1999; Minkler, Fuller-Thomson, Miller, & Driver as described in Hayslip & Goldberg-Glen, 2000), decreased role satisfaction (Daly & Glenwick, 2000; Emick & Hayslip, 1999), difficulty managing grandchild behavior (Emick & Hayslip, 1999), and financial strain (Roe & Minkler, 1998/1999). However, not all caregiving grandparents experience significant negative effects. It is unclear to what extent mental and physical health problems, decreased role satisfaction, experiences with grandchild behavior problems, and financial strain specifically contribute to increased stress levels. Therefore, the purpose of this study was to examine how these factors influence caregiving grandparents.
Thirty-one custodial grandparents raising grandchildren between the ages of 6 and 18 participated in this study by completing a demographic questionnaire, the Beck Depression Inventory, Second Edition (BDI-II; Beck, Steer & Brown, 1996), the Beck Anxiety Inventory (BAI; Beck, Epstein, Brown & Steer, 1988), the Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2000, 2001), the Parent Satisfaction Scale (PSS; Guidubaldi & Cleminshaw, 1985), and the Parenting Stress Index (PSI-III; Abidin, 1995). It was found that the parenting stress level of grandparent caregivers is significantly influenced by child behavior problems and role satisfaction. Of all variables measured, externalizing child behavior problems were found to predict the largest portion of parenting stress. The combination of externalizing child behavior problems, satisfaction with spouse/ex-spouse’s parenting performance, and satisfaction with one’s own parenting performance produced the overall model of predictors of parenting stress.
Introduction

The population of grandparent caregivers has been steadily increasing in the United States. The United States (US) Census Report of 2000 indicated that 4.7 million grandparents lived in a home with their grandchildren. Of these grandparents, 79% were maintaining the household. This population of older adults is providing full-time care to their grandchildren for such reasons as parental substance abuse, abuse and neglect, teenage pregnancies, parental incarceration, and parental illness and death. This population of grandparents has been steadily increasing, permitting research to better understand the effects that this change in role has on grandparents.

The focus of research on grandparent caregivers has been with regard to their physical health, level of depression and anxiety, role satisfaction, grandchild behavior problems, and their stress levels. Previous researchers have found mixed results when investigating changes in physical health of grandparent caregivers. Some research has found an increase in physical health problems (Fuller-Thomson & Minkler, 2000; Minkler & Fuller-Thomson, 1999), while other research has found their physical health to stay the same (Bowers & Myers, 1999) or even improve (Minkler et al., 1992). With regard to depression and anxiety, research has shown levels to increase (Daly & Glenwick, 2000; Fuller-Thomson & Minkler, 2000; Minkler, Fuller-Thomson, Miller, & Driver as described in Hayslip & Goldberg-Glen, 2000). Caregiving grandparents have shown decreased satisfaction with their role as a parent (Daly & Glenwick, 2000), especially when raising grandchildren with problematic behavior (Emick & Hayslip, 1999) and in other areas of their lives such as in their marriages (Bowers & Myers, 1999; Minkler et
al., 1994). As a result of the aforementioned factors, stress levels of caregiving grandparents have been found to increase (Bowers and Myers, 1999; Musil, 1998).

Previous research has laid the groundwork for the present study, which explores various factors and their individual influences on the stress of grandparent caregivers. The following paper will cover literature pertaining to the previously mentioned factors that have been found to influence caregivers’ parenting stress levels. The remainder of this paper will focus on the current investigation of these numerous factors (level of depression and anxiety, severity of grandchild behavior problems, and level of reported role satisfaction) have been examined with influences on caregiver total stress. Further investigation of demographic characteristics (age, financial factors, and physical health) will also be discussed. It will then be discussed which of these factors have been found to significantly contribute to caregiver parenting stress levels.
Literature Review

The number of caregiving grandparents in America has been steadily increasing. In 1970, the United States (US) Census reported that 3.2% of children lived with a grandparent, including those homes that also included the mother, father, both parents, or neither parents. Of these children, 1.4% lived with a grandparent only. Since this time, this percentage has continued to grow. The US Census report of 1977 reported that 1.8% of children lived with a grandparent only, and 5.5% lived in the grandparent’s home, including those that included one, neither, or both parents (as reported by Bryson & Casper, 1999). In 2000, the US Census Bureau’s report documented that nearly 4.7 million of the nation’s grandparents lived in a home with their grandchildren, whether they only resided in the home or maintained the home. Of the 4.7 million, 79% of these grandparents maintained the household in which the grandchildren lived. In Kentucky alone, 69,504 grandparents were living with their grandchildren in the year 2000. This figure represents 3.0% of all households in Kentucky (US Census, 2000). These figures indicate that the number of grandchildren living in grandparents’ homes has steadily increased over time. If this trend continues, an increased need for recognition of this population is proposed.

Household Structure

Caregiving grandparents may be categorized according to the type of care that they provide to their grandchildren. Caregiving grandparents possess varying caregiving capacities based primarily on the physical care, financial responsibilities, and length of time in which they provide care to their grandchildren. Bowers and Myers (1999) classified caregiving grandmothers into two levels of contact: full-time and part-time
parenting responsibility. Full-time parenting responsibility required that the grandparents have full physical and financial responsibility for the grandchildren. Part-time caregiving required that the grandparents provide at least 15 hours of care per week to their grandchildren. For the purposes of the present study, full-time caregiving grandparents, those who have full-time physical and financial responsibility, were examined.

Demographic Characteristics of Caregiving Grandparents

Caregiving grandparents are a diverse population. They vary on characteristics such as age, gender, ethnicity, geographic location, and financial status. Demographic characteristics of grandparent caregivers will be discussed in the following paragraphs.

In the United States, it has been observed that many grandparents are caring for their grandchildren for a lengthy amount of time. The 2000 Census reports indicated that 42% of grandparents in the United States are grandparent caregivers, the majority of which had been caring for their grandchildren for 5 years or more. Further, it was reported that younger grandparents, those under the age of 60, were more likely than older grandparents to be responsible for their grandchildren; however, younger grandparents had not been caring for their grandchildren for as long of time (Simmons & Dye, 2003). Yet, the grandparents who were over the age of 60 were more likely than their younger counterparts to have cared for their grandchildren for more than 5 years: 55% compared to 3%, respectively (Simmons & Dye, 2003).

With respect to the age of caregiving grandparents, Hayslip and Goldberg-Glen (2000) reported that in 1990, the mean age of caregiving grandparents was 59.4 years compared to the non-caregiving grandparents age of 62.3 years. In 2000, the US Census Report stated that only 7% of caregiving grandparents were between the ages of 30 and 39, 29%
were between the ages of 40 and 49, 35% were between the ages of 50 to 59, and 29% were over the age of 60 (Simmons & Dye, 2003). With respect to the gender of the caregiving grandparent, Hayslip and Goldberg-Glen (2000) reported that during the 1990s, 77% of caregiving grandparents were female, and 23% were male. The US Census Report stated that in 2000, 61% to 66% of caregiving grandparents were female, and 35% to 38% were male, with little variation between males and females regarding the duration of time responsible (Simmons & Dye, 2003). Hayslip and Goldberg-Glen (2000) also reported that 54% of caregiving grandparents were married, while 68% of non-caregiving grandparents fell into this category. In summary, the majority of caregivers who have long-term care, or have cared for their grandchildren for longer than five years, are older females over the age of 60.

With regard to ethnicity, caregiving grandparents are prevalent across many ethnicities; however, the studies reviewed indicated that Caucasians have the largest population of caregiving grandparents, and African Americans have the second largest population of grandparent caregivers. The 1997 US Census Report indicated that Caucasians are the largest population of custodial grandparents, with 48% of grandparents caring for their grandchildren. The African American population has the second largest percentage of grandparents who are raising their grandchildren, with 31% of the grandparents having custody of their grandchildren (Bryson & Casper, 1999). Hayslip and Goldberg-Glen (2000) also reported that more Caucasian grandparents cared for their grandchildren than any other ethnicity during the 1990s. During the 1990’s, 62% of caregiving grandparents were Caucasian, while 27% were African American. While the Caucasian population does have higher percentages of grandparents caring for
their grandchildren, a larger percent of African American grandparents have been caring for their grandchildren for a longer period of time. In the African American population, 45.2% of caregiving grandparents have been caring for their grandchildren for 5 years or more, while 36.3% of Caucasian caregiving grandparents have had this responsibility (Bryson & Casper, 1999). In summary the Caucasian population is more likely to have grandparents caring for their grandchildren; however, the African American population is more likely to have grandparents who have cared for their grandchildren for a longer period of time.

The 2000 US Census Report contains the geographical and financial statistics of the caregiving grandparent population. Geographically, in the United States, the South has the highest reported percentage of caregiving grandparents, 48%, while the Northeast has the lowest percentage, 34% (Simmons & Dye, 2003). It was also reported by the 2000 US Census that Oklahoma and Wyoming have the highest percentages of caregiving grandparents, this being 55% to 59%, while Hawaii and Massachusetts were among states with the lowest percentages of caregiving grandparents with 28% to 31%. With regard to financial characteristics, the 2000 US Census Report noted that, on average, 19% of caregiving grandparents were below the poverty level in 1999. The largest percentage of these grandparents lived in the Southern United States (21%) with some Southern states having as high as 30% of caregiving grandparents at this financial level (Simmons & Dye, 2003). The March 2002 US Census Report indicated that the majority of grandparents caring for grandchildren received an income between $30,000 and $49,999, and the lowest proportion of caregiving grandparents were receiving under $15,000 (Fields, 2003). These statistics reveal that the majority of the United States’ grandparent
caregivers are receiving an adequate income; however, this significantly depends on geographical area.

Reasons for Placement

Many factors influence the reasons why grandparents are caring for their grandchildren. Studies have shown that the single greatest contributor to grandparental caregiving is parental substance abuse (Kropf & Burnette, 2003; Minkler, Roe, & Price, 1992; Sands & Goldberg-Glen, 2000). Parents who abuse substances often neglect their children. As a result, the children are removed from the home and often times placed in grandparent care. Another contributor to grandparental caregiving is parental illness or death. Parents with a chronic illness may not be able to physically or financially care for their children. Grandparents many times assume this responsibility. This responsibility often continues after parental death (Jendrek, 1994; Musil, 1998; Sands & Goldberg-Glen, 2000). The next contributor to grandparental caregiving is parental incarceration. It is estimated that, based on figures gathered from the 2001 US Census information, the percentages of grandchildren living with grandparents because of parental incarceration increased between 1986 and 1997, from 5.8% to 11.8% (Johnson & Waldfogel, 2002). The final contributor to grandparental caregiving is a feeling of responsibility to the family. Some grandparents report feeling like it is their responsibility to care for their grandchildren, especially if the grandchildren are to be placed in a foster care system (Jendrek, 1993). Thus, one can see that there are a variety of reasons why grandparents are placed in the caregiving role.
Effects on Grandparents

Older adults face many issues that accompany the aging process and may prove to interfere with their daily lifestyle. Physical and financial limitations present difficulties that produce strain on older individuals as well as caregiving grandparents. Discussed in the following paragraphs will be the physical and financial strains older adults face as a result of aging and as a result of caring for their grandchildren.

Physical issues.

Older adults often face physical limitations as a result of aging. These limitations include the possibility of visual and other sensory impairments (Shannon, 2001). For example, older adults may experience the inability to focus on near and far objects, experience declines in their sense of taste, declines in their ability to hear, declines in their sensitivity to touch, and declines in their physical strength (Papalia, Olds, & Feldman, 2004). In addition to visual and sensory impairments, older adults have shown an increase in health problems. Heart attacks, strokes, and hypertension have been shown to increase with age (National Center for Health Statistics, 2001) along with the risk of cancer (Frazer et al., 1996). As part of aging, older adults also can face an increase in mental health problems including dementia and other mental health concerns such as depression (Shannon, 2001). All of these impairments make various daily activities more difficult.

Because of the normal aging process, grandparent caregivers are faced with many of the age-related declines in functioning presented above; however, the severity of their issues may be exacerbated by their status as a caregiver. Because of the demands of caregiving, many caregiving grandparents fail to give their own health necessary
attention, placing their grandchildren’s needs ahead of their own. Whether due to self-neglect or financial constraints, caregiving grandparents have been shown to underreport the seriousness of their health problems (Minkler et al., 1992). Grandparent caregivers have reported to have increased physical health problems, as well as difficulties completing everyday tasks, such as moving about inside their homes (Fuller-Thomson & Minkler, 2000; Minkler et al., 1992; Minkler & Fuller-Thomson, 1999). Researchers have found that these older “parents” are at a greater risk for health problems due to the increase in daily activities and added energy need to care for a young child. Minkler and Fuller-Thomson (1999) compared the abilities of caregiving and non-caregiving grandparents to accomplish daily tasks, with health status, and satisfaction with personal health. By using the responses of 3,477 grandparents collected in the National Survey of Families and Households conducted in 1992, 1993, and 1994, the health status of caregiving and non-caregiving grandparents was compared. This study revealed that caregiving grandparents felt they had greater limitations in activities of daily living, such as moving about inside their home, completing household chores, climbing stairs, and having a paying job. These limitations make it difficult to physically and financially provide an adequate residence for a child.

Other research has further revealed that caregiving grandparents are at risk for increased health problems, more so than non-caregiving grandparents. Fuller-Thomson & Minkler (2000) hypothesized that African American caregiving grandparents are at a greater risk for health problems such as exacerbation of pre-existing conditions, comorbidity, and limitations in daily functioning. Their study compared health characteristics of 573 African American caregiving grandparents with African American
non-caregiving grandparents and found that African American caregiving grandparents are significantly more likely than their non-caregiving peers to have problems with daily functioning, including moving around inside their home, doing daily tasks, climbing a flight of stairs, and walking six blocks. These grandparent caregivers also reported higher levels of depressive features than non-caregivers; however, the majority of caregivers still reported to have “good” or “excellent” health. Nevertheless, caregiving grandparents of every ethnicity reportedly face more health problems and limitations in daily functioning as well as decreased satisfaction with their own health than they otherwise would (Minkler & Fuller-Thomson, 1999). In the study previously described regarding the health of caregiving grandparents, Minkler and Fuller-Thomson (1999) found that although both groups of caregivers and non-caregivers reported equal percentages of individuals with “good” or “excellent” health, there were statistically more caregivers than non-caregivers who reported their health to be “poor” or “very poor.” More caregivers were reported to be very dissatisfied with their health status than non-caregivers. Even if caregiving grandparents become aware of health problems, many will not seek healthcare services for themselves due to financial constraints. If they are able to afford health care for anyone in the family, these grandparents may not be obtaining the necessary health care for themselves because they want to put the children’s needs ahead of their own (Minkler et al., 1992). Therefore, these studies suggest that caregiving influences the physical health of grandparent caregivers.

Although some grandparents report failing health and limitations when caring for grandchildren, others have reported this experience to be positive with their reported health staying the same or improving while caring for the children. In their study of
caregiving and non-caregiving grandmothers, Bowers and Myers (1999) utilized multiple questionnaires to investigate characteristics, including questions about their general health, of a sample of 101 grandmothers. The grandmothers being studied were grouped into three categories: those providing full-time care, those providing part-time care, and those who were not caregivers. Results indicated that the majority of full-time caregiving grandmothers reported that their number of health problems had not changed since they began caring for their grandchildren. A small portion of the grandmothers reported their health problems increased, and a few reported their health improved. These results were similar for the part-time caregiving sample of grandmothers. Minkler, Roe, and Price (1992) examined the reported health of caregiving grandparents using a variety of measures and also found that close to half of the grandmothers in the sample reported their health had not changed from before they began caring for their grandchildren. However, half of the grandmothers also reported that they were currently concerned about their health, but 45% of the sample stated that their health never got in the way of things they needed or wanted to do. The researchers suggested that the tendency for grandmothers in this sample to not report health problems might be due to the traditional view of the strong African American grandmother. However, it is still yet to be determined which factors lead to positive health results and which factors do not.

Financial issues.

Besides physical and mental concerns, older adults may experience financial difficulties. The US Census Report of 2004, the mean income of those ages 55 to 64 was $50,400. The mean income for those ages 65 and over was $24,509 (US Census, 2005). Reasons for the drop in income include the inability to maintain a job because of health
issues, discontinuation work because extra income is no longer needed for the family, or the removal of working individuals from the household whether due to death or divorce. Overall, it can be concluded that typically as individuals age, their income declines.

Similar to non-caregiving grandparents, caregiving grandparents face similar financial difficulties at a level comparable, if not higher, than their counterparts. In their study, Roe and Minkler (1998/1999) found that grandparent headed households are more likely than others to have higher rates of poverty. Similarly, the US Census (2002) reports noted that 30% of children living in their grandparents' home without a parent present were below the poverty level (Fields, 2003). In order to assist grandparents, agencies provide public assistance or welfare benefits. The American Association of Retired Persons (AARP; Satterfield, n.d.) informs caregiving grandparents of financial options such as subsidized guardianship payments, which is comparable to foster care payments, adoption assistance, and Temporary Assistance for Needy Families. However, while there is financial assistance for caregiving grandparents, the programs are limited. Even if grandparents receive assistance, it may not be a substantial amount to offset the cost of raising a grandchild. For grandparents with careers, providing care for a grandchild may require a cutback of working hours or other job-related sacrifices. Roe and Minkler (1998/1999) observed in their study that grandparents who have already retired may have to go back to work or find other means of obtaining money such as selling possessions or redeeming insurance policies. For these reasons, many caregiving grandparents are faced with being at a poverty level or having general financial struggles, more so than that of non-caregiving grandparents.
Depression and Anxiety

Besides changes in physical health and financial stability, grandparents placed in the caregiving role often experience changes in their psychological functioning. Many grandparents report an increase in their level of anxiety, depression (Fuller-Thomson & Minkler, 2000), and stress which Poe (n.d.) attributed to their experience of a sense of failure, a sense of deprivation of a positive relationship with their children, deprivation of a normal relationship with their grandchildren. With these feelings often come other feelings of guilt, failure, anger, and embarrassment. Smith and Dannison (2001) also attribute changes in their psychological functioning due to a decline in social activities due to the responsibilities of providing care to their grandchildren. As noted in earlier sections, this change in lifestyle has reportedly resulted in increased symptoms of depression among caregiving grandparents. Studies have been conducted in order to determine whether or not these reports are upheld by research studies. Studies examining caregiving grandparent mental health will be reviewed.

Daly and Glenwick (2000) examined depression, parenting stress, parenting satisfaction, and the relationships between these variables and perceptions of children’s behavior in caregiving grandmothers who had and had not sought psychological services for their children and in mothers who had sought psychological services for their children. Participants were given a demographic questionnaire, the Parenting Stress Index (Abidin, 1990), the Beck Depression Inventory (Beck, Rush, Shaw, & Emery, 1979), the Cleminshaw-Guidubaldi Parent Satisfaction Scale (Guidubaldi & Cleminsaw, 1989), and the Eyberg Child Behavior Inventory (Eyberg & Ross, 1978). The results of this study showed that the grandmothers who had been seeking psychological services
reported significantly greater depression, parenting stress, and perceptions of grandchild maladjustment. They also reported significantly less parenting satisfaction than the grandmothers who had not been seeking psychological services. For all three groups of caregivers, there was a positive relationship between the levels of depression and stress and perceptions of child maladjustment in that increased stress and depression of the caregiver resulted in increased perceptions of maladjustment.

Similarly, Fuller-Thomson and Minkler (2000) compared caregiving and non-caregiving African American caregivers. They found that African American caregivers displayed more symptoms of depression than non-caregiving grandparents. More than one-third of caregivers in this study reported clinical levels of depression compared to only one-fifth of non-caregiving grandparents, further demonstrating that caregiving grandparents are experiencing higher levels of depression than non-caregiving grandparents.

Minkler, Fuller-Thomson, Miller, and Driver (as described in Hayslip & Goldberg-Glen, 2000) also examined grandparent caregivers and depression. Data were taken from the National Survey of Families and Households (NSFH). Depression levels were measured using a modified version of the Center for Epidemiological Studies Depression Scale, which is a 12-item, self-reporting measure. Analysis of data revealed that grandparent caregivers are twice as likely to have elevated levels of depressive symptoms than non-caregivers. However, the preliminary analysis was unable to reveal if the higher levels of depression were due to caregiving or other factors that may differ between caregivers and non-caregivers, such as the age and gender of the individual.
Further analysis controlled for these factors and suggested that caregiving, in fact, is associated with higher levels of depressive symptomatology.

The levels of depression and anxiety of caregiving grandparents has also been researched with regard to the ethnicity of the caregiver. Some have proposed that the levels of anxiety and depression of caregiving grandparents are consistent across ethnicities. Musil (1998) studied the mental health of African American and Caucasian caregiving grandmothers. This study examined the physical health, mental health, and coping abilities of 68 African American caregiving grandmothers and 22 Caucasian caregiving grandmothers. Overall, the researchers found that caregiving grandmothers report relatively high levels of depression and anxiety. There were no differences between the amount of depression and anxiety felt by those with full-time or part-time responsibility. There was also not discovered to be any ethnic differences regarding mental health.

*Grandparent Caregiver Stress*

In addition to increases in anxiety and depression, caregiving grandparents also experience increases in their level of reported stress. Many factors can influence caregiving grandparent stress levels. Factors such as gender, age, and the severity of the children’s behavior can influence the amount of stress felt by the grandparents.

Some have suggested that grandmothers and grandfathers are affected differently by the stress of their parenting role which they attribute to the fact that grandmothers and grandfathers reportedly engage in different relationships with their grandchildren with grandmothers being more involved in the child rearing experience. The 2002 US Census Report indicate that in grandmother headed households, 591,000 of grandmothers are
responsible for caring for their grandchildren, while 69,000 of grandfathers are individually responsible (Fields, 2003). Musil (1998) studied the stress of caregiving grandmothers, specifically those with partial care and those with primary care, and found that grandmothers who were primary caregivers reported greater levels of overall parenting stress and greater difficulty in parent/child interactions. It was also concluded that the more children are in the care of the grandmothers, the more stress felt relating to the parenting aspect of their role. Primary caregiving grandmothers reported feeling trapped and restricted in their daily lives, possibly as a result of the changes made in their lifestyles since they became caregivers. Bowers and Myers (1999) also reported that full-time caregiving grandmothers reported significantly higher levels of parenting stress than part-time caregiving grandmothers. Therefore, it can be concluded that grandmothers spend more time in the caregiving role, and as a result, they experience greater stress than grandfathers.

The age of caregiving grandparents has also been reported to be a factor determining the levels of stress. Sands and Goldberg-Glen (2000) studied the factors associated with the stress of caregiving grandparents. Results concluded that younger caregiving grandparents, ages 50 to 59, experienced more stress than their older counterparts, who were between the ages of 60 and 90. The researchers suggested that this finding could be attributed to the added stressors the younger caregivers were receiving from the workplace as well as from older and younger family members.

It has also been noted that grandparents also experience higher levels of stress when raising children with problematic behaviors. Because children are often removed from their parents’ care due to neglect, parental substance abuse, and parental incarceration
and placed with their grandparents, it can be assumed these children are at risk for developing similar behaviors (Bowers & Myers, 1999).

In summary, caregiving grandparents are influenced by multiple factors that can increase the levels of stress they experience. The levels of stress can differ by the whether or not the grandparent is providing the primary care, whether or not the grandparent is older, and whether or not their grandchild is demonstrating problematic behaviors.

*Grandparents' Role*

Typically, grandparents are seen as the “spoiler” of the family’s grandchildren and as a historian for the family. They often engage in some of the same activities as the parents with the children, such as entertaining, listening to problems, and giving gifts; however, they must also fill the parental role. Some have proposed that this role confusion can elicit various feelings in addition to conflict and stress.

As traditional grandparents, grandmothers have found a biological fulfillment in grandparenting, by being a “part-time” caregiver to grandchildren (Thomas, Sperry, & Yarbrough, 2000). Grandmothers may receive a sense of still being needed when they are able to practice their parenting skills on their grandchildren. Grandfathers receive more of an emotional fulfillment when having contact with grandchildren. They are able to provide advice and be a mentor to their grandchildren (Thomas, Sperry, & Yarbrough, 2000). Roberto and Stroes (1992) examined the relationships between grandchildren and grandparents. One hundred and forty-two college students were recruited to complete a questionnaire with questions pertaining to frequency of activities, value development, relationship solidarity, and role conception. The grandchildren were found to spend more
time with their grandmothers than grandfathers. An examination of activities indicated that grandchildren engage in brief visits, family gatherings, important conversations, and chores with their grandmothers more often than with their grandfathers, though there were no significant differences between maternal and paternal grandparents or granddaughters and grandsons. This study also revealed that grandmothers were perceived as having a greater influence on the development of the grandchildren’s values and grandchildren perceived their relationships with their grandmothers as stronger than those with their grandfathers.

While grandmothers may have stronger relationships with their grandchildren, Hayslip et al. (1998) found an interaction of grandparent group and grandparent gender in their study of caregiving and traditional grandparents. From a sample of 193 custodial and traditional grandparents, results suggested that grandfathers have a less difficult time coping with their new roles. The researchers hypothesized that perhaps the men in their sample might have been more involved in the raising of their own children than some fathers, and as a result are more involved in raising their grandchildren. They also speculated that perhaps the men who volunteered to participate in their study had a more positive view of their role and as a result were more eager to participate.

*Role Satisfaction*

Because caregiving grandparents are being placed in a role that they previously had not expected to be in, the levels of satisfaction that they have with their new role may be lower than that of traditional grandparents. Factors such as gender, the amount of support given to caregivers, and children’s behavior problems have been found to have an effect
on the amount of satisfaction caregiving grandparents have with their role. These factors will be discussed in the following section.

It has been reported that gender differences can be found when examining the amount of satisfaction that traditional grandparents receive from their role. Thomas (1986) studied the gender differences in perceptions of grandparenting by comparing age and gender differences with the satisfaction of grandparenting, perceived responsibility for grandchildren’s discipline, perceived responsibility for giving childrearing advice, perceived responsibility for helping grandchildren, and perceived responsibility for grandchildren’s care. Two hundred and seventy-seven grandparents who were members of church and civic organizations participated by completing questionnaires describing grandparenting experiences. Researchers found that grandmothers expressed higher levels of satisfaction with grandparenting than grandfathers. However, this finding, together with the finding that grandmothers did not endorse caretaking responsibilities as much as grandfathers, suggested that grandmothers are not eager to take on a caregiving role with their grandchildren. Contrary to what was expected, grandfathers in this study did reveal a greater responsibility for caregiving and offering advice on childrearing. This finding may not be surprising considering that previous research has indicated that traditional grandfathers enjoy giving advice and being mentors to their grandchildren (Thomas, Sperry, & Yarbrough, 2000).

Caregiving grandparents experience lower levels of satisfaction in many areas of their lives compared to non-caregiving grandparents, not just satisfaction with their role. Their marriages and social lives are among the areas to be affected by the parental role. Minkler et al. (1994) reported that many married grandmothers did not feel like their
marriage had improved since taking on the responsibility of their grandchildren. More than one-third of the sample reported that there had been a negative change in their marriage and some husbands had even left the relationship. Those that remained married reported less time spent together and fewer opportunities to get away together. Bowers and Myers (1999) examined the differences in the satisfaction of full-time and part-time caregiving and non-caregiving grandmothers with regard to their marriages and stress. Multiple measures were utilized in questionnaire form to compare demographics, stress, and satisfaction. It was found that full-time caregiving grandmothers reported a negative change in their marital relationships. This change is possibly due to jealousy of the grandfather, less privacy, having less sex, less time for her to devote to her husband, and more tension and arguments. One grandmother even responded that her husband believed the grandchild to be her responsibility only. Part-time caregiving grandmothers reported significantly higher levels of grandparent satisfaction than either full-time caregivers or non-caregivers. Full-time caregiving grandmothers reported lower levels of life satisfaction than part-time or non-caregiving grandmothers. There were no significant findings regarding social support between the three groups. Grandmothers in this study reportedly had increased feelings of burden and parenting stress and decreased grandparenting satisfaction. The full-time caregiving grandmothers reported more burden and child behavior problems than the part-time caregivers showing that there are differences between full and part-time caregivers (Bowers & Myers, 1999).

Grandparents who care for children with severe behavior problems also experience lower levels of satisfaction. Children with behavioral problems require added attention from caregiving grandparents. The behaviors of these children can negatively affect the
satisfaction that caregivers have with their relationships with their grandchildren as well as the fulfillment they gain as a parent. Emick and Hayslip (1999) compared the satisfaction of custodial grandparents with their non-caregiving peers with regard to their roles as well as the relationships the grandparents have with problematic and non-problematic grandchildren. Differences were found between the two groups in that the grandparents raising the problematic children reported less satisfaction with their grandparent role than the traditional grandparents. As was to be expected, the grandparents raising problematic grandchildren reported more parental role strain than those raising grandchildren without problems.

While many caregiving grandparents report the negatives involved with their surrogate role, it was also discovered that these grandparents have some rewards in their role. Burton (1992) found that they reported having a reason to live and a feeling of being needed and loved. Those who previously found satisfaction as parents are able to play this role one more time. In a study regarding the role satisfaction and role meaning of caregiving grandparents, Hayslip et al. (1998) discovered that many grandfathers in the caregiving role found greater meaning in their role than traditional grandfathers. This finding suggests that despite child behavior problems and the circumstances surrounding placement, some grandparents receive a sense of personal meaning in their role as parents. This study also found that many of its participants believed that they would reassume the caregiving role if they were to do it all over; however, almost half of the participants reported that if another acceptable individual were found to care for the children, they would have no problem allowing this other person to assume
responsibility. These results contribute to other findings that conflict with regard to the satisfaction that caregiving grandparents have with their role and lifestyle.

*Disruption of Role*

Because of the time and attention required to care for a child, grandparents are unable to enjoy leisurely activities they have become accustomed to as well as plans that had been anticipated for retirement. Grandparents are looking forward to settling into retirement and a disruption in their plans will have an effect on the satisfaction with variety of areas of their lives. Emick and Hayslip (1999) reported that traditional grandparents reported less life disruption than caregiving grandparents and that grandparents raising children with problematic behaviors reported more life disruption than caregiving grandparents raising non-problematic grandchildren. This finding shows that not only can raising a child be disruptive for these grandparents, but also those who are caring for a child with behavior problems face increased difficulties. The age of these grandparents also played a role in determining sources of stress. Because of the options that are more readily available to younger grandparents, they may have higher satisfaction with a parenting role than older adults. Older grandparents may not be financially able to support a child considering that they have been without children in the home for many years. Raising children with problematic behavior can also cause more financial strain than children without problems (Emick & Hayslip, 1999). Unlike younger grandparents, older grandparents may not have been recently employed and may not be physically able to go back to work to support a family. Because of their age, it may be more difficult for them to acquire a new job and because of this unplanned re-entrance into the workforce; their job satisfaction may not be as high as younger
grandparents who may still have a career. Younger grandparents may still be working or are able to go back to work without difficulty because of the more desired qualities associated with a younger age. Some have better health and higher energy levels than older grandparents and because of this their role satisfaction may be higher.

In summary, it is known that caregiving grandparents are at risk of having increased mental and physical health problems, decreased role satisfaction, increased difficulty with grandchild behavior problems, and increased financial strain. Some research has shown that the increases in levels of anxiety, increased levels of depression, decreased levels of parenting satisfaction, and increased child behavioral problems contribute to increased stress levels. However, it is unclear as to which demographic variables impact their stress level nor is it clear as to what extent factors such as age, level of financial strain, and characteristics of grandparent physical health play a role in the stress levels. Therefore, the purpose of this study was to examine these select factors to see how they influence the parenting stress levels of caregiving grandparents. In particular, the level of anxiety, level of depression, severity of grandchildren’s behavior, amount of parenting satisfaction, demographic variables, and parenting stress levels were measured.

Hypotheses

It was hypothesized that the level of reported anxiety, level of reported depression, severity of grandchild behavior problems, and reported level of parenting satisfaction would significantly predict the level of reported parenting stress. First, it was expected that higher scores on the Beck Anxiety Inventory (BAI) would significantly predict higher scores on the Parenting Stress Index- Third Edition (PSI-III). Second, it was expected that higher scores on the Beck Depression Inventory-II (BDI-II) would
significantly predict higher scores on the PSI-III. Third, it was expected that higher scores on the Child Behavior Checklist (CBCL), specifically higher externalizing child behavior problem T-scores and higher internalizing child behavior problem T-scores, would significantly predict higher scores on the PSI-III. Fourth, it was expected that lower scores on the Parenting Satisfaction Scale (PSS), specifically decreased satisfaction with spouse’s parenting, decreased satisfaction with parenting performance, and decreased satisfaction with the grandparent-grandchild relationship, would significantly predict higher scores on the PSI-III.

Even though individual hypotheses were not made regarding specific demographic variables (e.g., age), characteristics of grandparent physical health, and the level of grandparent financial strain, these variables were explored to see whether or not they significantly contributed to higher levels of reported stress.
Method

Participants

Thirty-six custodial grandparents agreed to participate in the study. Thirty-one packets were returned, resulting in a return rate of 89%. Of these participants, 4 were males and 27 were females, ranging in age from 45 to 74 years with a mean age of 59. Eighty-four percent of participants described themselves as Caucasian, 10% described themselves as African American, 3% described themselves as Asian American, and 3% described themselves as Multiracial. With regard to marital status, 64.5% reported being married, 3.2% reported being single, 22.6% reported being widowed, and 6.5% reported being divorced. With regard to financial status, 12.9% reported a monthly income between $800 and $1,000, 22.6% reported a monthly income between $1,001 and $1,500, 9.7% reported a monthly income between $1,501 and $2,000, 19.4% reported a monthly income between $2,001 and $2,500, and 32.3% reported a monthly income of over $2,500. With regard to employment status, 29.0% of participants reported being currently employed, while 38.7% of spouses were currently employed. The ages of grandchildren being raised by grandparents ranged from 5 to 18 years with a mean age of 12. Of these grandchildren, 22 were male and 18 were female. The average number of grandchildren per household was 1.4. Descriptive characteristics of the sample can be seen in Table 1.
Table 1

*Descriptive Characteristics of the Sample*

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<tr>
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<td>22.6</td>
<td>7</td>
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<td>over $2,500</td>
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Participant Employment

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<tr>
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<tr>
<td>Unemployed</td>
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Grandchild Gender

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<tr>
<td>Female</td>
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</tr>
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</table>
Measures

Demographic questionnaire.

Each participant completed a demographic questionnaire to provide demographic information such as gender, age, ethnicity, monthly income, career history, health history, and characteristics of the children in his or her care (Appendix A). Participant monthly income was reported by indicating an average range of one’s monthly income. Participant total physical health was determined by taking the sum of physical health problems reported by each participant. For the purposes of this study, reported participant age will be noted as AGE, reported participant monthly income will be noted as INC, and the total number of participant reported health problems will be noted as HEA.

Beck Anxiety Inventory.

The Beck Anxiety Inventory (BAI; Beck, Epstein, Brown & Steer, 1988) was used to assess levels of anxiety symptomatology. The BAI is comprised of 21 items, with each item being answered on a 4-point Likert Scale from 0 to 3, with 0 being not at all and 3 being severely, I could barely stand it. The summation of items can range from 0 to 63. Scores above 36 are considered to be at the level of extreme anxiety. The BAI obtained high internal consistency and item-total correlations ranging from .30 to .71. Test-retest reliability was .75 (Beck et al., 1988). Osman et al. (1997) examined the factor structure and psychometric properties of the BAI by having 350 participants complete a brief background information questionnaire, the BAI, and the following three self-report questionnaires: State-Trait Anxiety Inventory (Spielberger, 1983), Cognition Checklist (Beck, Brown, Steer, Eidelson, & Riskind, 1987), and the Brief Symptom Inventory
Researchers found that analysis of internal consistency reliability indicated that the BAI had adequate item-total score correlations and a Cronbach alpha value of .90. Zero-order correlational analysis indicated convergent validity. The BAI total and subscale scores were significantly correlated with self-report anxiety scales, with correlations ranging from .24 to .69 (Osman et al., 1997). For the purposes of this study, the BAI total score will be used and noted as BAI Raw Score.

*Beck Depression Inventory, Second Edition.*

The Beck Depression Inventory, Second Edition (BDI-II; Beck, Steer & Brown, 1996) was used to determine the level of depressive symptomatology. The BDI is comprised of 21 items that are summed to give a single score. Each item contains a scale ranging from 0 to 3, with items 16 and 18 giving seven options to indicate an increase or decrease in sleep and appetite. Total scores range from 0 to 63, with 0 to 13 indicating *Minimal* depression, 14 to 19 indicating *Mild* depression, 20 to 28 indicating *Moderate* depression, and 29 to 63 indicating *Severe* depression. When correlated with the BDI-IA, the correlation coefficient was .93. Item analysis revealed a coefficient alpha of .91 for the BDI-II and high internal consistency. Item correlations ranged from .39 to .68 (Beck, Steer, Ball, & Ranieri, 1996). Adequate reliability has been demonstrated for this scale, with a test-retest reliability of .93 (Beck, Steer, & Brown, 1996). For the purposes of this study, the total BDI score will be used and reported as BDI-II Raw Score.

*Child Behavior Checklist.*

The Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2000, 2001) was completed by caregivers. It is a standardized questionnaire that uses a three-point rating to assess emotional and behavioral characteristics of children between the ages of 1 ½
and 18. The CBCL is a 100-item scale and uses a three-point rating. A Total Problem T-score is produced in addition to a T-score for Externalizing and Internalizing behaviors. Externalizing behaviors that are measured include delinquent behaviors and aggressive behaviors. Internalizing behaviors that are measured include depressive and anxious features, somatic complaints, and withdrawn behaviors. A T-score of 67 or above indicates that the child is functioning in the clinical range. Reliability was tested for the CBCL ages 6-18 using test-retest reliability method. Test-retest item reliabilities were computed by a single interviewer at one week intervals. The intraclass correlation coefficient was 1.00 for the 20 competence items and .95 for the 118 specific problem items. This indicates high test-retest reliability for item scores (Achenbach & Rescorla, 2001). Validity of this scale has been proven using several kinds of evidence. Content validity has been supported by numerous significant findings between demographically matched, such as matching by race of SES, children. Construct validity has been proven with significant associations with other instruments. For the purposes of this study, Externalizing and Internalizing T-scores will be used in this study in order to determine which types of child behaviors are influencing caregiver stress levels. Externalizing child behavior problems will be abbreviated EXT and Internalizing child behavior problems will be abbreviated INT.

*Parenting Satisfaction Scale.*

The Parenting Satisfaction Scale (PSS; Guidubaldi & Cleminshaw, 1985) was given to determine one’s satisfaction with his or her own parenting styles, satisfaction with the parent-child relationship, the degree of satisfaction with a spouse’s parenting performance, and overall parenting satisfaction. Forty-five items were answered using a
4-point Likert Scale, ranging from strongly agree to strongly disagree. The scale yields a Total Standard Score for Parenting Satisfaction, as well as standard scores for three subscales: Satisfaction with Spouse/Ex-Spouse’s Parenting Performance, Satisfaction with the Parent-Child Relationship, and Satisfaction with Parenting Performance. T-scores have a mean of 50 and a standard deviation of 10. Reliability was tested during standardization of the scale. Six hundred, forty-four parents of school-aged children participated. Internal consistency reliabilities on the subscales were found to show high reliability during Trial 1: Satisfaction with Spouse/Ex-Spouse Parenting Performance (PSS1), r = .96, Satisfaction with the Parent-Child Relationship (PSS2), r = .86, and Satisfaction with Parenting Performance (PSS3), r = .82. Trial 2 occurred two years after Trial 1. It involved the participants who could be reached from the first trial. Scores revealed internal reliability to be PSS1, r = .95, PSS2, r = .89, PSS3, r = .82. Test-retest reliability for these two trials revealed moderate stability across the 2 years between trials: PSS1, r = .81, PSS2, r = .59, and PSS3, r = .64. The PSS has been used in multiple studies, ensuring adequate validity. Examples of such studies include an examination of the relationship between PSS scores, stress, and ecological conditions for a sample of 1,081 women. Another study explored the relationship between PSS scores and academic and social adjustment of 1,746 elementary school children. The author reports that both studies yielded data that support the validity of the PSS. For the purposes of this study, the three subscale standard scores will be used in place of the Total Standard Score for Parenting Satisfaction. Satisfaction with spouse’s parenting will be abbreviated PSS, satisfaction with grandparent-grandchild relationship will be abbreviated SPC, and participant parenting satisfaction will be abbreviated PPS.

The Parenting Stress Index-Third Edition (PSI-III; Abidin, 1995) was administered to determine the level of parenting stress experienced by participants. The PSI-III contains 120 items, yielding a Total Stress Score and scaled scores in the Child and Parent Domains. Participants who receive scores at or above 260 for the Total Stress Score are considered to be experiencing high levels of parenting stress. Coefficient alpha reliability coefficients ranged from .70 to .83 for the subscales of the Child Domain, and .70 to .84 for the subscales of the Parent Domain. Reliability coefficients for both domains and the Total Stress scale were .90 or greater. Test-retest reliability was obtained after a one-year interval and reliability coefficients of .55 for the Child Domain, .70 for the Parent Domain, and .65 for the Total Stress score were obtained (Hamilton, 1980). Kruecheberg and Kapp-Simon (1993) found parenting stress to be a predictor of levels of social skills in preschool children with craniofacial anomalies. The PSI-III Total Stress score was also a predictive factor of the parent’s rating of the child’s level of social skill in the control group, indicating adequate validity for the PSI-III (Abidin, 1995). For the purposes of this study, the Total Stress Score will be abbreviated STR.
Procedure

Participants for this study were recruited through newspaper advertisements and fliers in the community. Participants were also solicited from support groups at local agencies. Participants contacted the experimenter to receive a packet of questionnaires through the mail or to schedule an appointment to complete the questionnaires at a specified time. For participants who scheduled appointments, greetings and introductions (Appendix B, Script 1) were made. Informed consent was also obtained (Appendix C). Participants completed a series of questionnaires, including a demographics questionnaire (Appendix A), Beck Anxiety Inventory (Beck, Epstein, Brown & Steer, 1988), Beck Depression Inventory-II (Beck et al., 1996), Child Behavior Checklist (Achenbach & Rescorla, 2000, 2001), Parenting Satisfaction Scale (Guidubaldi & Cleminshaw, 1985), and the Parenting Stress Index–III (Abidin, 1995). Questionnaires were counterbalanced to prevent possible order effects. Completion took approximately 45 minutes to one hour. For those who had difficulty reading the questionnaires, the experimenter was present to provide assistance. Once the questionnaires had been completed, participants were debriefed (Appendix B, Script 2) and given the opportunity to receive results.

For those participants who wished to have packets mailed to them, written instructions regarding completion of the questionnaires was included with the packet. An informed consent document was also included with the packet as well as the form to enter the gift-certificate drawing. As an incentive, all participants were given the opportunity to submit their name on a slip of paper for the chance to win gift certificates (Appendix D). At the completion of data collection, five names were drawn and those individuals received a twenty-dollar gift certificate. Winners were contacted by telephone, and the gift
certificate was mailed to them. In order to receive the results, participants submitted a slip of paper with their address on it and results were mailed to them. Participants were also provided with a copy of the consent statement should they have any questions in the future and a referral list if it was requested. All methods and procedures were reviewed and approved to comply with the Human Subjects Review Board of Western Kentucky University (Appendix E).
Results

Descriptive Statistics

Participants completed a number of questionnaires in regard to physical health, mental health, role satisfaction, and grandchild behavior problems. The Total Health Raw Score was determined by taking the sum of physical health problems reported by each participant. Other scores were obtained from the BDI-II, BAI, PSI-III, PSS, and CBCL. The mean scores for the BDI-II and BAI indicate that participants are experiencing minimal levels of depression and anxiety. The mean score for the PSI-III indicates that participants are, on average, experiencing high levels of parenting stress. The mean scores for the subscales of the Parenting Satisfaction Scale indicate that participants are experiencing average levels of satisfaction with regard to their spouse’s parenting performance, the grandparent-grandchild relationship, and their own parenting performance. The mean scores for Externalizing and Internalizing Child Behavior Problems indicate that the grandchildren of the participants are not functioning in the clinical range. Mean participant scores for each questionnaire can be viewed in Table 2.

Preliminary Analyses

Correlation coefficients for all major variables are presented in Table 3. Several significant moderate to strong correlations emerged between variables. In regard to specific grandparent variables, a significant negative correlation was found between income and age in that as a participant’s age increased, their monthly income decreased ($r = -.47, p < .01$). A significant positive correlation emerged between levels of reported anxiety and the participant’s total health in that as higher levels of anxiety were reported,
Table 2

*Mean Participant Scores (N = 31)*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean Score (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Health Raw Score</td>
<td>3.48 (2.34)</td>
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<tr>
<td>BDI-II Raw Score</td>
<td>14.17 (12.29)</td>
</tr>
<tr>
<td>BAI Raw Score</td>
<td>13.67 (12.92)</td>
</tr>
<tr>
<td>PSI-III Total Stress Raw Score</td>
<td>265.55 (46.40)</td>
</tr>
<tr>
<td>Parenting Satisfaction Scale</td>
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</tr>
<tr>
<td>Spouse’s Parenting Performance</td>
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<tr>
<td>Standard Score</td>
<td>48.61 (6.91)</td>
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<td>Parent-Child Relationship</td>
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<tr>
<td>Standard Score</td>
<td>40.60 (11.24)</td>
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<td>Parenting Performance</td>
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<td>Standard Score</td>
<td>48.97 (9.42)</td>
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<td>Child Behavior Checklist ¹</td>
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<tr>
<td>Externalizing T-score</td>
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</tr>
<tr>
<td>Internalizing T-score</td>
<td>59.23 (11.55)</td>
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*Note.¹ Child Behavior Checklist (Achenbach & Rescorla, 2000, 2001). Total Health Raw Score represents the number of physical health problems reported. BDI-II = Beck Depression Inventory-II raw score, BAI = Beck Anxiety Inventory raw score, PSI-III = Parenting Stress Index-III Total Stress raw score.
Table 3

*Intercorrelations Between Demographic Variables and Measures Associated with Parenting Stress (N = 31)*

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<td>-.19</td>
<td>-.26</td>
<td>-.18</td>
<td>-.50**</td>
<td>-.55**</td>
<td>-.67**</td>
<td>.31</td>
<td>.47*</td>
<td></td>
</tr>
</tbody>
</table>

*Note.* AGE = Participant Age, INC = Monthly Income (determined by an indicated range of monthly income by participant), HEA = Participant Total Health (determined by taking the sum of physical health problems reported by each participant), BAI = Beck Anxiety Inventory raw score, BDI = Beck Depression Inventory-II raw score, INT = Child Behavior Checklist, Internalizing T-score, EXT = Child Behavior Checklist, Externalizing T-score, STR = Parenting Stress Index-III, Total Stress raw score, SSP =
Parenting Satisfaction Scale, Spouse’s Parenting Performance subscale standard score,
SPC = Parenting Satisfaction Scale, Parent-Child Relationship subscale standard score,
PPS = Parenting Satisfaction Scale, Parenting Performance subscale standard score.
* = $p < .05$, ** = $p < .01$
more health problems were reported \((r = .48, p < .01)\). A significant negative correlation was found between levels of reported depression and participant age in that as a participant’s age increased, reported depressive features decreased \((r = -.43, p < .05)\). A significant positive correlation was found between levels of reported depression and levels of reported anxiety in that as higher levels of depression were reported, higher levels of anxiety were reported \((r = .67, p < .01)\).

In regard to grandchild behavior, a significant positive correlation was found between internalizing child behavior problems and levels of reported anxiety in that as more internalizing child behavior problems were reported, levels of reported anxiety increased \((r = .54, p < .05)\). A significant negative correlation was found between externalizing child behavior problems and monthly income in that as monthly income became less, more externalizing behavior problems were reported \((r = .42, p < .05)\). Two significant positive correlations were found for externalizing child behavior problems in that as more externalizing behavior problems were reported, more participant health problems were reported \((r = .37, p < .05)\) and more internalizing child behavior problems were reported \((r = .72, p < .01)\). Two significant positive correlations were found for total parenting stress in that as higher stress levels were reported, more internalizing child behavior problems were reported \((r = .76, p < .01)\) and more externalizing child behavior problems were reported \((r = .77, p < .01)\).

In regard to role satisfaction, a significant negative correlation was found between satisfaction with spouse’s parenting and total parenting stress in that as satisfaction with spouse’s parenting decreased, total parenting stress increased \((r = -.63, p < .01)\). Two significant negative correlations were found for grandparent-grandchild relationship in
that as satisfaction with the grandparent-grandchild relationship decreased, more
externalizing child behavior problems were reported ($r = -.44, p < .05$) and higher levels
of total parenting stress were reported ($r = -.43, p < .01$). Two positive correlations were
found for participant parenting satisfaction in that as parenting satisfaction increased,
monthly income increased ($r = .37, p < .05$) and satisfaction with the grandparent-
grandchild relationship increased ($r = .47, p < .05$). Finally, three negative correlations
were found for participant parenting satisfaction in that as parenting satisfaction
decreased, more internalizing child behavior problems were reported ($r = -.50, p < .01$),
more externalizing child behavior problems were reported ($r = -.55, p < .01$), and more
total parenting stress was reported ($r = -.67, p < .01$).

Main Analyses

A stepwise multiple regression was conducted to determine which independent
variable(s) (level of satisfaction with spouse parenting performance, level of satisfaction
with parent-child relationship, level of satisfaction with participant parenting
performance; level of reported anxiety; level of reported depression; level of grandchild
internalizing behavioral problems; level of grandchild externalizing behavioral problems)
were the predictors of total reported stress levels. Regression results indicate an overall
model of three predictors (level of grandchild externalizing behavioral problems; level of satisfaction with spouse/ex-spouse parenting performance; level of satisfaction with
participant parenting performance) that significantly predict total stress, $R^2 = .72$, $R^2_{adj} = .67$, $F (3, 19) = 15.98, p < .001$. This model accounted for 71.6% of the variance in total
reported parenting stress. A summary of the regression model is presented in Table 4. In
addition, bivariate and partial correlation coefficients between each predictor and the
dependent variable are presented in Table 5.

*Exploratory Analyses*

Exploratory analyses were conducted using the enter method of multiple regression
analysis to determine if demographic variables, specifically age, family income, and
physical health, accounted for a significant amount of variance in total parenting stress
when added to variables used in the previous regression analysis. Analyses revealed that
these three variables did not account for a significant amount of variance of reported
parenting stress. A summary of the model can be seen in Table 6. In addition, bivariate
and partial correlation coefficients between each variable and the dependent variable are
presented in Table 7.
Table 4

Regression Model for the Predictors of Parenting Stress (N = 31)

<table>
<thead>
<tr>
<th>Step</th>
<th>$R$</th>
<th>$R^2$</th>
<th>$R^2_{adj}$</th>
<th>$\Delta R^2$</th>
<th>$F_{chg}$</th>
<th>$p$</th>
<th>df1</th>
<th>df2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Externalizing T-score</td>
<td>.72</td>
<td>.51</td>
<td>.49</td>
<td>.51</td>
<td>21.95</td>
<td>.00</td>
<td>1</td>
<td>21</td>
</tr>
<tr>
<td>2. Satisfaction with</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spouse’s Parenting</td>
<td>.81</td>
<td>.65</td>
<td>.62</td>
<td>.14</td>
<td>7.96</td>
<td>.01</td>
<td>1</td>
<td>20</td>
</tr>
<tr>
<td>3. Satisfaction with</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parenting Performance</td>
<td>.85</td>
<td>.72</td>
<td>.67</td>
<td>.07</td>
<td>4.41</td>
<td>.05</td>
<td>1</td>
<td>19</td>
</tr>
</tbody>
</table>

Note. Externalizing T-score = Child Behavior Checklist, Externalizing T-score.

Satisfaction with Spouse’s Parenting = Parenting Satisfaction Scale, Satisfaction with Spouse’s Parenting subscale standard score. Satisfaction with Parenting Performance = Parenting Satisfaction Scale, Satisfaction with Parenting Performance subscale standard score.
Table 5

_Bivariate and Partial Correlations for the Predictors of Parenting Stress (N = 31)_

<table>
<thead>
<tr>
<th></th>
<th>B</th>
<th>β</th>
<th>t</th>
<th>Bivariate r</th>
<th>Partial r</th>
</tr>
</thead>
<tbody>
<tr>
<td>Externalizing T-score</td>
<td>1.80</td>
<td>.43</td>
<td>2.90**</td>
<td>.72</td>
<td>.56</td>
</tr>
<tr>
<td>Satisfaction with</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spouse’s Parenting</td>
<td>-2.29</td>
<td>.84</td>
<td>-2.72**</td>
<td>-.63</td>
<td>-.53</td>
</tr>
<tr>
<td>Satisfaction with</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parenting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performance</td>
<td>-1.30</td>
<td>.62</td>
<td>-2.10*</td>
<td>-.62</td>
<td>-.43</td>
</tr>
</tbody>
</table>

_Note._ Externalizing T-score = Child Behavior Checklist, Externalizing T-score.

Satisfaction with Spouse’s Parenting = Parenting Satisfaction Scale, Satisfaction with Spouse’s Parenting subscale standard score. Satisfaction with Parenting Performance = Parenting Satisfaction Scale, Satisfaction with Parenting Performance subscale standard score.

* = p < .05, ** = p < .01
Table 6

Regression Analysis for Predictors of Parenting Stress, Incorporating Demographic Variables (N = 31)

<table>
<thead>
<tr>
<th>Model</th>
<th>$R$</th>
<th>$R^2$</th>
<th>$R^2_{adj}$</th>
<th>$\Delta R^2$</th>
<th>$F_{chg}$</th>
<th>$p$</th>
<th>df1</th>
<th>df2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>.92</td>
<td>.84</td>
<td>.71</td>
<td>.84</td>
<td>6.38</td>
<td>.00</td>
<td>10</td>
<td>12</td>
</tr>
</tbody>
</table>
Table 7

_Bivariate and Partial Correlations for Predictors of Parenting Stress, Incorporating Demographic Variables (N = 31)_

<table>
<thead>
<tr>
<th></th>
<th>B</th>
<th>β</th>
<th>t</th>
<th>Bivariate r</th>
<th>Partial r</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant Age</td>
<td>-1.13</td>
<td>-.15</td>
<td>-1.00</td>
<td>-.08</td>
<td>-.28</td>
</tr>
<tr>
<td>Total Health Score</td>
<td>.01</td>
<td>.00</td>
<td>.01</td>
<td>.21</td>
<td>.00</td>
</tr>
<tr>
<td>Monthly Income</td>
<td>-5.38</td>
<td>-.16</td>
<td>-.96</td>
<td>-.40</td>
<td>-.27</td>
</tr>
<tr>
<td>BAI Score</td>
<td>-.74</td>
<td>-.22</td>
<td>-1.10</td>
<td>.17</td>
<td>-.30</td>
</tr>
<tr>
<td>BDI-II Score</td>
<td>.57</td>
<td>.17</td>
<td>.78</td>
<td>.35</td>
<td>.22</td>
</tr>
<tr>
<td>Internalizing T-score</td>
<td>1.93</td>
<td>.45</td>
<td>2.22</td>
<td>.68</td>
<td>.54</td>
</tr>
<tr>
<td>Externalizing T-score</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>.72</td>
<td>.00</td>
</tr>
<tr>
<td>Satisfaction with</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spouse’s Parenting</td>
<td>-2.57</td>
<td>-.41</td>
<td>-2.93</td>
<td>-.63</td>
<td>-.65</td>
</tr>
<tr>
<td>Satisfaction with</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grandparent-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grandchild Relationship</td>
<td>-.70</td>
<td>-.19</td>
<td>-1.01</td>
<td>-.47</td>
<td>-.28</td>
</tr>
<tr>
<td>Satisfaction with</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parenting Performance</td>
<td>-.62</td>
<td>-.14</td>
<td>-.95</td>
<td>.62</td>
<td>-.26</td>
</tr>
</tbody>
</table>
Note. Participant Age = reported age in demographic questionnaire. Total Health Score = mean number of reported physical health problems reported in demographic questionnaire. Monthly Income = range of reported monthly income reported in demographic questionnaire. BAI Score = Beck Anxiety Inventory raw score. BDI = Beck Depression Inventory-II raw score. Internalizing T-score = Child Behavior Checklist, Internalizing T-score. Externalizing T-scores = Child Behavior Checklist, Externalizing T-score. Satisfaction with Spouse’s Parenting = Parenting Satisfaction Scale, Satisfaction with Spouse’s Parenting subscale standard score. Satisfaction with Grandparent-Grandchild Relationship = Parenting Satisfaction Scale, Satisfaction with Grandparent-Grandchild Relationship subscale standard score. Satisfaction with Parenting Performance = Parenting Satisfaction Scale, Satisfaction with Parenting Performance subscale standard score.
Discussion

The purpose of the present study was to examine factors that influence the parenting stress levels of caregiving grandparents. More specifically, participant age, participant monthly income, participant total physical health score, level of reported anxiety, level of reported depression, externalizing child behavior problems, internalizing child behavior problems, satisfaction with spouse’s parenting performance, satisfaction with one’s own parenting performance, and satisfaction with the grandparent-grandchild relationship were examined in order to see how each influences the parenting stress levels of caregiving grandparents.

The first hypothesis stated that higher levels of reported anxiety, as measured by the BAI, would significantly predict higher scores of parenting stress, as measured by the PSI-III. Results did not support this hypothesis. A mean participant raw score of 13.67 on the BAI indicates that, on average, participants are not experiencing clinically significant levels of anxiety. As a result, anxiety was not shown to be a predictor of parenting stress. These results differ from previous research that showed caregiving grandparents to have increased levels of anxiety (Musil, 1998).

The second hypothesis stated that higher scores on the BDI-II would significantly predict higher scores on the PSI-III. Results did not support this hypothesis. The mean participant raw score of 14.17 on the BDI-II indicates that participants are, on average, to be experiencing minimal to mild levels of depression. As a result, depression was not found to be a significant predictor of parenting stress. These results differ from previous research that has found caregiving grandparents to have higher levels of depression. Fuller-Thomson and Minkler (2000) found depression to increase as a result of
caregiving and social deprivation. Daly and Glenwick (2000) also found depression levels and stress to increase as a result of caregiving. Minkler, Fuller-Thomson, Miller, and Driver (as described in Hayslip & Goldberg-Glen, 2000) found levels of depression to increase as a result of caregiving. Participants of the present study reported low levels of depression. As a result, these findings of previous research are not supported.

The third hypothesis stated that higher T-scores on externalizing child behavior problems and internalizing child behavior problems, as measured by the CBCL, would significantly predict higher scores on the PSI-III. Internalizing child behavior problems were not found to significantly predict higher levels of parenting stress; however, externalizing child behavior problems were found to predict higher levels of parenting stress. This finding supports previous research that has shown grandchild behavior problems to be a significant predictor of caregiver stress. Emick and Hayslip (1999) found grandchild behavior problems to result in increased parenting stress among grandparent caregivers.

The fourth hypothesis stated that lower scores reported on parenting satisfaction, as measured by the PSS, would significantly predict higher scores on the PSI-III. The three subscales: Satisfaction with Spouse’s Parenting Performance, Satisfaction with Parenting Performance, and Satisfaction with the Grandparent-Grandchild Relationship, were examined to determine the influences on parenting stress by each aspect of parenting satisfaction. Results revealed that of the three, Satisfaction with Spouse’s Parenting Performance and Satisfaction with Parenting Performance significantly predicted the parenting stress levels of caregiving grandparents. These findings support previous research that has found satisfaction to decrease among grandparent caregivers. Daly and
Glenwick (2000) found that caregiving grandmothers report more parenting stress and less satisfaction with parenting. Emick and Hayslip (1999) also found caregivers to report decreased satisfaction and greater parenting strain.

Finally, exploratory analyses were conducted on the demographic variables participant age, monthly income, and participant total health to see whether or not they significantly contributed to higher levels of reported parenting stress. Results showed that none of these variables are significantly influencing caregiver stress levels. These findings conflict with previous research involving these demographic variables.

Unlike with previous research, financial strain was not found to be a significant source of stress with this sample of caregiving grandparents. Roe and Minkler (1998/1999) noted that caregiving grandparents were more likely to experience higher rates of poverty and financial strain as a result of caregiving. This finding did not exist due to the financial characteristics of the sample. The majority of participants in this study were found to describe their monthly income as being over $2,500. Approximately half of the participants felt they were experiencing financial difficulties, while the other half said they were not. Twenty-nine percent of participants reported that they are employed, while 38% of spouses were employed. These findings regarding financial difficulties are not consistent with what most caregivers have reported in previous studies. Reasons why these findings are not consistent with those of previous research may include such explanations as those pertaining to the geographical location of participants, previous or current employment, and outside supplements. The cost of living in Kentucky is not as high as inner-city areas or cities with larger populations that have been used to draw participants from in previous research. Participants in this study may also have been
previously or are still currently employed and have financial support associated with their careers. Participants also may be receiving supplements that assist in financial responsibilities, such as social security and retirement benefits.

Inconsistent results regarding the physical health of grandparent caregivers have formerly been found. The results of this study did not support previous research that has shown health problems to increase with caregiving (Minkler and Fuller-Thomson, 1999); however, the results of this study do support those previous studies showing physical health to stay the same (Bowers and Myers, 1999; Minkler, Roe and Price, 1992). Reasons for this finding regarding physical health may include characteristics of the samples surveyed. The study conducted by Minkler and Fuller-Thomson (1999) finding health problems to increase utilized data from a national survey of 173 caregiving grandparents, while the current study and other research have utilized a smaller sample size with participants living in individual states and cities. The age of the grandparent caregivers may also influence their physical health status. The average age of the participants in this study was 59 years old. Previous research studies that have found the physical health of caregiving grandparents to stay the same also have had participants with an average age in the fifties. The studies previously mentioned conducted by Bowers and Myers (1999) and Minkler, Roe, and Price (1992) utilized a sample of caregiving grandmothers with the average age of 54 and 53, respectively. More specifically, findings of the current study can be contributed to characteristics of the participants. The majority of participants in this research study did not support a large number of health problems, with the average number of problems reported being three. Of the health problems reported, most were considered to be minor, such as allergies,
arthritis, and colitis. Few reported having serious illnesses, such as cancer, diabetes, and heart disease. Finally, another factor that may have influenced the number of health problems reported by participants may be their financial status. Because the average number of participants in this study had a monthly income of more than $2,500, their financial status might allow them to have better and more consistent healthcare than those who are not able to afford reliable healthcare. For these various reasons, health issues were not found to be significant predictors of caregiver stress.

In summary, of the variables explored, three (externalizing child behavior problems, satisfaction with spouse’s parenting performance, and satisfaction with parenting performance) were found to contribute to the largest portion of grandparent caregivers’ total parenting stress. These findings support the hypothesis that child behavior problems, specifically externalizing behavior problems, and role satisfaction, specifically satisfaction with spouse’s parenting and satisfaction with parenting performance, would significantly predict the levels of caregiver stress. As previously mentioned, results from the present study further support previous research regarding child behavior problems, role satisfaction, and stress. Emick and Hayslip (1999) found that grandparents raising children with problematic behaviors have less satisfaction with their role than traditional grandparents. They also had more parental role strain than grandparent caregivers who did not have grandchildren with problematic behavior. Findings from the present study show that externalizing child behavior problems are the main source of stress among grandparent caregivers. Daly and Glenwick (2000) also found that caregiving grandmothers report more parenting stress and less satisfaction with parenting. Results of the present study determined that parenting satisfaction and child behavior problems
combined with decreased satisfaction with a spouse or ex-spouse’s parenting
performance create the largest percentage of stress in a grandparent caregiver’s life.

Strengths

To begin, this study is different from previous research studies investigating the stress
of caregiving grandparents in that it gathers information from numerous sources of
possible stress in their lives. It then determines which of the factors and combination of
factors has the largest influence on caregiver’s parenting stress levels. Previous research
studies have only focused on one factor per study. It has never been previously
determined the degree to which factors influence stress levels when examined together.
Next, unlike previous research that only examined overall parenting satisfaction, this
study incorporates multiple areas that can contribute to one’s satisfaction. There are
various aspects of the caregiving role that can provide a caregiving grandparent with
increased or decreased satisfaction, thus it is important to delineate the types of
satisfaction grandparent caregivers can experience. Therefore, this study incorporated the
satisfaction one has with the relationship between grandparent and grandchild, the
satisfaction one has with his or her own parenting performance, and the satisfaction one
has with the parenting performance of his or her spouse. These areas of satisfaction have
been found by this research to be very influential on the parenting stress levels of
grandparent caregivers. Results of this study show that caregivers can experience
decreased satisfaction with their spouse’s parenting as well as with their own parenting
performance; however, they were not experiencing decreased satisfaction with the
relationship they have with their grandchild. Another strength of this study is that it
specifies child behavior problems into internalizing and externalizing problems. Most
research has only examined overall behavior problems. The stresses created by types of behavior problems differ according to different behavioral issues. Externalizing problems, such as acting out and fighting, has been shown by this study to be more influential on caregiver parenting stress rather than internalizing problems, such as anxiety felt by the child. Lastly, a strength of this study is that an attempt was made to gather information from caregiving grandmothers and grandfathers. The majority of previous research has focused on the issues caregiving grandmothers face and have failed to examine the influences caregiving has had on grandfathers.

Limitations

The current study has its limitations. The first limitation is in regard to sample size. A small sample size makes applying the findings of this study to other caregiving grandparents difficult. A larger sample allows for more diversity among the participants and allows results to be representative of the entire population of caregiving grandparents. The second limitation is in regard to generalizeability. The representativeness of a sample is a concern when making generalizations. Demographic characteristics of the sample also make applying the findings to the entire population of caregiving grandparents difficult. The majority of grandparents who participated in this study were caregiving grandmothers and, therefore, findings of this study cannot be generalized to caregiving grandfathers. Also, the participants of this study were primarily Caucasian and, as a result, findings of this study then cannot be generalized to caregiving grandparents of other ethnicities. Grandparent caregivers of other ethnicities may face different sources of increased stress that are related to cultural differences. Another issue with generalizeability refers to geographical location of participants. The population
sample for this study was drawn from areas of rural Kentucky. Finally, the majority of
grandparent caregivers were financially stable, which has not been shown to be true for
grandparent caregivers throughout the United States, as noted by Fields (2003) and Roe
and Minkler (1998/1999). The third limitation is in regard to the use of self-reporting
inventory. By using self-reporting questionnaires, the researcher assumes participants
answer questions honestly. However, the responses of participants may be influenced by
the day’s events, other individuals at the location, or the ideal image one has of oneself.
In other words, participants may answer questions in a way they would like to believe
applies to them or their grandchildren, when in fact this may not be the case. The fourth
limitation of the present study is that it only focused on a limited number of grandchild
behavior characteristics and grandparent characteristics. There are a variety of grandchild
characteristics that may influence the stress levels of caregivers differently, such as a
child’s physical limitations, mental limitations, and temperament. The grandchildren
may possess illnesses, diseases, or psychological disorders that would make parenting
more difficult. Grandparent characteristics, such as parenting strategies, also may
influence stress levels. These issues and characteristics, combined with the various other
factors that influence stress levels, may be influencing grandparent caregiver stress levels
in ways that have yet to be explored.

Future research

Much research still needs to be conducted in regard to grandparent caregivers and
their stress levels. To begin, future studies should incorporate a larger sample in order to
gather results more representative of all caregiving grandparents. Secondly, because
generalizeability issues are of concern in the present study, future research should allow
for diverse demographic characteristics to be incorporated in order to allow results to be applicable to all grandparent caregivers and not just those similar to the sample. Both grandmothers’ and grandfathers’ physical health, mental health, and financial strain should continue to be explored to determine adequate results that are representative of both genders. Also, cultural differences may exist that influence stress levels differently, such as geographical location, employment and financial status, spousal relationships, and parenting styles. Thirdly, specific grandchild mental, physical, and behavioral problems should also be incorporated into research to determine how different grandchild issues may influence caregiver parenting stress. Next, there are still numerous variables associated with the parenting role that need to be explored in order to determine characteristics of parenting that are elevating stress levels. Parenting strategies, role confusion, and grandparent-grandchild relationship issues are just a few of these variables that may influence caregiver stress. Finally, future research should incorporate findings into the development of treatment programs to alleviate caregiver stress and assist with their specific needs. Results of this study only reinforce the fact that there is much more to be learned about this special population of older adults because they are so different from traditional parents and grandparents, and an urgency exists to provide them with the means of sustaining a stable lifestyle.
References


Appendix A

Demographic Questionnaire
Demographics Questionnaire

Participant Number ______

Please complete this confidential questionnaire. An answer to every question is requested.

**Basic Demographic Information**

1. Your age ______

2. Your sex: ______ Male _____ Female

3. Your race/ethnicity:
   - a. Caucasian/European American
   - b. African/African-American
   - c. Asian/Asian-American
   - d. Hispanic/Hispanic-American
   - e. Pacific Islander
   - f. Middle Eastern
   - g. Native American/Indigenous/Aboriginal
   - h. Multiracial (please indicate) __________________________

4. Your religion:
   - a. Atheist
   - b. Catholic
   - c. Protestant
   - d. Muslim
   - e. Buddhist
   - f. Jewish
   - g. Hindu
   - h. Other

5. Do you attend church? ___Yes ______No
   - a. If so, please circle how often you attend.
     - Weekly
     - 1-2 times a month
     - Once every couple of months
     - Less than once a year

6. Highest level of education *completed*:
   - a. Grade School 1 2 3 4 5 6 7 8
   - b. High School 9 10 11 12
c. College/University  13  14  15  16

d. Graduate School  17+ up

7. Marital Status:
   a. Single
   b. Married
   c. Divorce
   d. Living with another
   e. Widowed
   f. Separated
   g. Other

8. If married, please provide the following information about your spouse:
   a. His/her age
   b. His/her race or ethnicity
   c. His/her highest level of education completed

Financial Resources
Please answer the following questions regarding your and/or your spouse’s employment and financial resources.

9. Are you currently employed? _____Yes _____No
   If yes, please answer the following:
   Occupation
   How many hours a week do you work?
   Did you have to become employed, change jobs, or take on another job since you began caring for your grandchild(ren)?
   _____Yes _____No

10. Are you retired? _____Yes _____No
    If so, how long have you been retired?

11. Is your spouse employed? _____Yes _____No
    If yes, please answer the following:
    Spouse’s occupation
    How many hours a week does he/she work?
    Did he/she have to become employed, change jobs, or take on another job since you began caring for your grandchild(ren)?
    _____Yes _____No

12. Is your spouse retired? _____Yes _____No
    If so, how long has your spouse been retired?
13. Total family income per month:
   a. Less than $800  
   b. $800-1000  
   c. $1000-1500  
   d. $1501-$2000  
   e. $2001-2500  
   f. over $2500

14. Are you currently receiving any financial assistance with caring for your grandchild(ren)?
   ____ Yes  ____ No
   If so, please describe: __________________________________________________________
   If so, how much do you receive? ___________________  

15. Are you currently experiencing any financial difficulties, strain, or hardship in caring for your grandchild(ren)?
   ____ Yes  ____ No
   If yes, please describe? _____________________________________________________________

Grandchild Characteristics

16. Number of grandchild(ren) that currently reside with you?
   Length of time residing in your home:
   Sex: _____  Age: _____  ___________
   Sex: _____  Age: _____  ___________
   Sex: _____  Age: _____  ___________
   Sex: _____  Age: _____  ___________

17. Describe the reason for the grandchild(ren) being placed with you?

18. Do you have full custody of your grandchild(ren)?
   ____ Yes  ____ No  

19. Do any of your grandchild(ren) have a disability or mental disorder?
   a. Not known
   b. No
   a. Yes  If yes, please state ____________________________

20. If your grandchild has a known disability or psychological disorder, has the child ever received services for the disability?
   ____ Yes  ____ No
   If so, describe what type of services the child has received? __________________________
How long did the child receive the services?

21. Is your grandchild currently receiving services due to a known disability or psychological disorder?  ___Yes  ___No
If so, please describe the nature of the services.

22. Do you feel services have been effective?  ___Yes  ___No

23. Do you feel your grandchild needs these services?  ___Yes  ___No

24. Is there another type of service you would like your grandchild to receive or feel would be more effective?  ___Yes  ___No
If so, please specify.

Parenting
25. Does your grandchild currently have contact with his/her biological parent(s)?  
___Yes  ___No
a. If you answered “Yes”, how often does your grandchild see his/her biological parent(s)?

i. If your grandchild does have contact, do you want your child to be having contact with his/her biological parent(s)?  
___Yes  ___No

b. If your grandchild does not have contact, would you like for your grandchild to have contact with his/her biological parent(s)?  
___Yes  ___No
i. If you answered “Yes” on letter b., how often would you like for your grandchild to have contact with his/her biological parent(s)?

26. Who is primarily responsible for caring for your grandchild (i.e. feeding, helping with homework, etc)
a. You 
b. Spouse 
c. Other (please specify)

27. Who is primarily responsible for punishing your grandchild when they have been bad?
a. You 
b. Spouse 
c. Other (please specify)

28. How does the “punisher” normally react to the child’s bad behaviors? (please circle all that apply)
a. Give time-out 
b. Spank 
c. Yell
d. Take away items (i.e. toys, games, money, etc)
e. Ignore child
f. Ground
g. Reason with child about behavior

29. Who is primarily responsible for rewarding your grandchild when they have done well?
   a. You
   b. Spouse
   c. Other (please specify) __________________________

30. How is the child rewarded?
   a. Given items (i.e. toys, games, money, candy, etc)
   b. Verbal praise (i.e. good job!, good!, well done!, etc)
   c. Visits with friends
   d. Other (please specify) __________________________

**Social Activities**

31. On average, how much contact do you have with other adults outside your home during the week?
   a. 0-3 hours
   b. 4-7 hours
   c. 8-11 hours
   d. 12 hours or more

32. List activities/hobbies that you regularly participate in (at least once a week).

33. Who do you participate in these activities with?
   a. Spouse
   b. Grandchild
   c. Friend
   d. Other __________________________

34. Have you experienced a change in your social activity level as a result of caring for your grandchild?
   ____ Yes   ____ No

35. Have you had to drop social activities that you previously participated in order to accommodate your grandchild’s social activities?
   ____ Yes   ____ No
Grandparent Physical Health/Mental Health

36. Do you currently experience any of these physical health problems? (Please check all that apply)

- Allergies
- Arthritis
- Asthma
- Bleeding Disorder
- Cancer
- Colitis
- Diabetes
- Epilepsy/Seizures/Blackouts
- Menstrual Difficulties
- Heart Disease
- Hernia
- High Blood Pressure
- Joint Injury/Surgery
- Kidney Disease
- Mental/Emotional Problems
- Neck/Back Pain/Injury
- Osteoporosis
- Respiratory Problems
- Tuberculosis
- Ulcer

37. If you checked Mental/Emotional Problems above, please be specific:

38. Have you been diagnosed by a professional with this mental/emotional disorder?
   ___Yes    ___No

39. Have you, in the past, received any services for physical/mental health problems (i.e. physical therapy, counseling, support groups, etc). Please specify type of services received and for how long you received these services.

40. Are you currently receiving any assistance for physical/mental health problems (i.e. physical therapy, counseling, support groups, etc). Please specify type of services receiving and when you began these services.

41. Do you feel that the services you received in the past or are currently receiving were/are effective? ___Yes ___No

42. Do you feel that you need(ed) the services you receive(d)?
   ___Yes     ___No

43. Is there another type of service you would like to receive?
   ___Yes     ___No
   If yes, please describe the services you would like to receive

43. Do you take medication on a regular basis? ___Yes ___No
If yes, please list medications currently taking


**Spouse’s Physical Health/Mental Health (If you do not have a spouse, skip to next section)**

44. Does your spouse currently experience any of these physical health problems? (Please check all that apply)

- Allergies
- Arthritis
- Asthma
- Bleeding Disorder
- Cancer
- Colitis
- Diabetes
- Epilepsy/Seizures/Blackouts
- Menstrual Difficulties
- Heart Disease
- Hernia
- High Blood Pressure
- Joint Injury/Surgery
- Kidney Disease
- Mental/Emotional Problems
- Neck/Back Pain/Injury
- Osteoporosis
- Respiratory Problems
- Tuberculosis
- Ulcer

45. If you checked Mental/Emotional Problems, please be specific:

46. Has your spouse been diagnosed by a professional with this mental/emotional disorder?

- Yes
- No

47. Has your spouse, in the past, received any services for physical/mental health problems (i.e. physical therapy, counseling, support groups, etc). Please specify type of services received and for how long he/she received these services.

48. Is your spouse currently receiving any assistance for physical/mental health problems (i.e. physical therapy, counseling, support groups, etc). Please specify type of services receiving and when he/she began these services.

49. Do you feel that the services your spouse received in the past or is currently receiving were/are effective? Yes No

50. Do you feel that your spouse need(ed) the services he/she receive(d)? Yes No
51. Is there another type of service you would like your spouse to receive?
   ____Yes  ____No
   If yes, please describe the services you would like him/her to receive

52. Does your spouse take medication on a regular basis?  ____Yes  ____No
   If yes, please list medications currently taking

53. Please circle the stressor(s) which you are currently facing or have faced while caring for your grandchild(ren)?
   a. Financial
   b. Personal physical health
   c. Grandchild(ren)'s physical health
   d. Personal mental health
   e. Grandchild(ren)'s mental health
   f. Parenting
   g. Marital Stress
   h. Employment
   i. Grandchild academic performance (school)

54. Given the stressors circled above, do you feel you have access to the resource that you need?  ____Yes  ____No
   a. If no, what other resources do you feel you need?
Appendix B, Script 1

Introduction Script
Introduction Script

For this study, you will be completing a series of questionnaires that will take about one hour. In the questionnaires, you will be asked about your children’s behaviors, your typical mood, feelings you have about caring for a young child, and basic information about your household. Your participation is completely voluntary and if at any time you feel uncomfortable, you may stop without penalty. The information you provide is confidential. Your name will not be associated with the data or answers given on the questionnaires. Results will be presented in group format. All information gathered here will be kept in a secure place in the laboratory.
Appendix B, Script 2

Debriefing Script
Debriefing Script

Thank you for participating in this study. You have just completed a variety of questionnaires pertaining to depression, anxiety, stress, your children’s behaviors, and parenting satisfaction. The information obtained from these questionnaires was gathered in order to provide information on the influences on stress in your life. In particular, the levels of anxiety and depression, mental health, severity of children’s behavior, stress, and parenting satisfaction will be measured and compared to see how caregivers are affected by the parenting role. Results of this study will allow individuals to be informed of the difficulties involved with being a caregiving grandparent, specifically the factors influencing stress in your life. While you were completing these questionnaires you may have discovered some things about yourself or children that you have not thought about before. If you would like, you may receive information on parenting, anxiety, or depression.
Appendix C

Informed Consent Statement
INFORMED CONSENT STATEMENT
Grandparent Form

Project Title: Examination of role satisfaction and mental health of caregiving grandparents

Investigators: Jennifer L. Copen, B.S. & Melissa Hakman, Ph.D.
Department of Psychology
(270) 745-5435

You are being asked to participate in a project conducted through Western Kentucky University. The University requires that you give your signed agreement to participate in this project.

The investigator will explain to you the purpose of the project, what you will be doing, and the potential benefits and possible risks of participation. You may ask him/her any questions you have to help you understand the project. A basic explanation of the project is written below. Please read this explanation and discuss with the researcher any questions you may have.

A. Purpose: This study will examine what it is like to be a grandparent raising your grandchildren. Specifically, your role as a nontraditional parent, your typical mood, factors influencing your stress level, and questions about your grandchild(ren)'s behavior will be looked at.

B. Procedures: This study will involve the following procedures:
   1. Completion of five questionnaires. One questionnaire will ask for basic information about you and your grandchild(ren). One questionnaire will ask questions about what your typical mood is like. Yet another questionnaire will ask questions about your grandchild(ren)'s typical behaviors. Another questionnaire will ask about your feelings about raising your grandchild(ren), and another will ask about the stress you experience.

C. Duration of Participation: Your participation is completely voluntary and may be ended at any point. This study is designed to last approximately 1 hour.

D. Confidentiality: All information about you will be kept confidential and will not be released. Questionnaires will have participant numbers, rather than names on them. All information will be kept in a secure place that is open only to the researcher and her assistants. This information will be saved as long as it is scientifically useful; typically such information is kept for five years after publication of the results. Results from this study may be presented at professional meetings or in publications. You will not be identified individually; we will be looking at the group as a whole.
E. Benefits of participation: For participating in this study, your name will be entered into a drawing for several cash certificates. In addition, if you are interested, we will send you a copy of the results of the study when it is finished.

F. Risks of participation: The risks to you are minimal. Some individuals may become uncomfortable with the situation. If you become uncomfortable or upset, you will be given an opportunity to stop the procedure at that point with absolutely no penalty including any future services you may be entitled from the University. You may also choose to stop at any time, even without our asking you. In completing the questionnaires, some caregivers may become aware that their grandchild’s behavior is not typical for his or her age. You will be offered several names and phone numbers of agencies that work with parents and children should you desire psychological services to assess or treat developmental or behavioral problems.

I have been fully informed about the procedures listed here. I am aware of what I will be asked to do and of the benefits of my participation. I also understand also that it is not possible to identify all potential risks in an experimental procedure, and I believe that reasonable safeguards have been taken to minimize both the known and potential but unknown risks to me. I also understand the following statements (please check next to each to note that you agree):

___ I affirm that I am 18 years of age or older.
___ I agree to complete the questionnaires.

I understand that I may contact the researcher at the following address and phone number, should I desire to discuss my participation in the study and/or request information about the results of the study: Jennifer L. Copen, B.S. 256 Tate Page Hall, Dept. of Psychology, Western Kentucky University, Bowling Green, KY 42101, (270) 745-5435. I may also contact Dr. Melissa Hakman at (270) 745-5435. I have read and fully understand this consent form. I sign it freely and voluntarily. A copy of this form will be given to me. I hereby give permission for my child’s and my participation in this study.

_________________________             _______________________
Signature of Participant                    Date

_________________________             _______________________
Witness                                Date

THE DATED APPROVAL ON THIS CONSENT FORM INDICATES THAT THIS PROJECT HAS BEEN REVIEWED AND APPROVED BY THE WESTERN KENTUCKY UNIVERSITY HUMAN SUBJECTS REVIEW BOARD
Dr. Phillip E. Myers, Human Protections Administrator
TELEPHONE: (270) 745-4652
Appendix D

Results and Gift Certificate Drawing Form
Results and Gift Certificate Drawing Form

Name: __________________________________________

Address: _______________________________________

___________________________________________

Phone Number: (    )______________

Please check all that apply:

_____ I would like to receive results.

_____ I would like to be entered in the gift certificate drawing
Appendix E

HSRB Approval Form
Jennifer Copen
TPH
Psychology Department

Dear Jennifer:

Your revision to your research project, “Differences in role satisfaction and mental health of traditional caregivers and non-traditional caregiving grandparents,” was reviewed by the HSRB and it has been determined that risks to subjects are: (1) minimized and reasonable; and that (2) research procedures are consistent with a sound research design and do not expose the subjects to unnecessary risk. Reviewers determined that: (1) benefits to subjects are considered along with the importance of the topic and that outcomes are reasonable; (2) selection of subjects is equitable; and (3) the purposes of the research and the research setting is amenable to subjects’ welfare and producing desired outcomes; that indications of coercion or prejudice are absent, and that participation is clearly voluntary.

1. In addition, the IRB found that you need to orient participants as follows: (1) signed informed consent is required; (2) Provision is made for collecting, using and storing data in a manner that protects the safety and privacy of the subjects and the confidentiality of the data. (3) Appropriate safeguards are included to protect the rights and welfare of the subjects.

This project is therefore approved at the Expedited Review level until January 12, 2006.

2. Please note that the institution is not responsible for any actions regarding this protocol before approval. If you expand the project at a later date to use other instruments please re-apply. Copies of your request for human subjects review, your application, and this approval, are maintained in the Office of Sponsored Programs at the above address. Please report any changes to this approved protocol to this office. A Continuing Review protocol will be sent to you on May 15, 2005 to determine the status of the project.

Sincerely,

Scan Rubino, M.P.A.
Compliance Manager
Office of Sponsored Programs
Western Kentucky University

cc: Dr. Melissa Hakman
cc: HS file number Copen HS05-068
In future correspondence please refer to HS05-068, March 31, 2005

Jennifer Copen
TPH
Psychology Department

Dear Jennifer:

The amendment to your research project, "Differences in role satisfaction and mental health of traditional caregivers and non-traditional caregiving grandparents," was reviewed by the HSRB and it has been determined that risks to subjects are: (1) minimized and reasonable; and that (2) research procedures are consistent with a sound research design and do not expose the subjects to unnecessary risk. Reviewers determined that: (1) benefits to subjects are considered along with the importance of the topic and that outcomes are reasonable; (2) selection of subjects is equitable; and (3) the purposes of the research and the research setting is amenable to subjects' welfare and producing desired outcomes; that indications of coercion or prejudice are absent, and that participation is clearly voluntary.

1. In addition, the IRB found that you need to orient participants as follows: (1) signed informed consent is required; (2) provision is made for collecting, using and storing data in a manner that protects the safety and privacy of the subjects and the confidentiality of the data; (3) appropriate safeguards are included to protect the rights and welfare of the subjects.

Your research amendments therefore meet the criteria of Expedited Review and are approved until May 15, 2005.

2. Please note that the institution is not responsible for any actions regarding this protocol before approval. If you expand the project at a later date to use other instruments please re-apply. Copies of your request for human subjects review, your application, and this approval, are maintained in the Office of Sponsored Programs at the above address. Please report any changes to this approved protocol to this office. A Continuing Review protocol will be sent to you on May 15, 2005 to determine the status of the project.

Sincerely,

Sean Rubino, M.P.A.
Compliance Manager
Office of Sponsored Programs
Western Kentucky University

cc: Dr. Melissa Hakman
cc: HS file number Copen HS05-068