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Depressive Symptoms Among Grandparents Raising Grandchildren: The Impact of Participation in Multiple Roles

Lindsey A. Baker, Ph.D. and Merrill Silverstein, Ph.D.

Davis School of Gerontology, University of Southern California

Abstract

Using the Health and Retirement Study, this research examines well-being among grandparents raising grandchildren during middle to late life, specifically looking at how other roles in which a grandparent is participating (such as worker, volunteer, parent or caregiver) may influence depressive symptoms among grandparent caregivers. Results indicate that grandparents who have recently begun raising a grandchild experience lower levels of well-being when compared to grandparents who are not raising a grandchild regardless of the grandparent's level of participation in roles beyond that of grandparent caregiver, while grandparents who have been raising a grandchild for longer periods of time seem to benefit from their participation in multiple roles. However, a higher level of participation in outside roles is associated with a decline in well-being among grandparents who stopped raising a grandchild, suggesting that, for these grandparents, participation in multiple roles acted mainly as a stressor, rather than as a resource.

Keywords

Grandparents as Caregivers; Depressive Symptoms; Social Integration; Role Strain

Introduction

Multigenerational family ties have long been considered an important source of support, both for older and younger generations (Bengtson, 2001). An example of this is the case of grandparents raising grandchildren, the growing importance of which is reflected in family-policy changes in the United States over the past 30 years. Grandparents have been identified as a preferable placement for children whose parents are not capable guardians (Smith & Beltran, 2003) and are allowed to receive welfare payments, even if the grandparent has not legally adopted the child (Mutchler, Gottlieb, Choi, & Bruce, 2002). The number of children living in grandparent-headed households in the United States has increased substantially—proportionately almost doubling—since these reforms have taken place (Bryson & Casper, 1999). Nearly two-thirds of grandparent caregivers are between the ages of 50 and 80 (Simmons & Lawler Dye, 2003), an age-group characterized by increasing diversity in both the type and number of roles in which adults participate. This group consists of both retirees and workers, volunteers and non-volunteers, “empty nesters” and parents of dependent children, those who are caregivers for their elderly parents and those who are not. However, little is known about how this role diversity may influence depression among grandparents raising grandchildren. This research focuses on whether the relationship between raising a grandchild and depression (specifically depressive symptoms) is influenced by other roles in which mature grandparents are participating, such as worker, volunteer, parent of dependent children, or caregiver of elderly parents.

Background

According to the life stress paradigm, the interplay of stressors and resources has a direct impact on psychological distress, specifically depressive symptoms (Ensel & Lin, 1991). In the case of grandparents raising grandchildren, stressors can be traced to the precipitating conditions that triggered entry into the role and the disruption caused by adopting the role, or *primary stressors*, and the daily hassles and sacrifices that come with managing the role, or *secondary stressors* (Giarrusso, Feng, Silverstein & Marenco, 2000). In order to balance these stressors, grandparents raising grandchildren may draw upon existing networks of social, psychological or financial resources; this research focuses on the resources provided specifically by the grandparent's participation in multiple roles.

Stressors among Grandparents Raising Grandchildren

While all primary caretakers are likely to experience stressors associated with the care of a child, grandparents seem to exhibit higher levels of stress than parents (Musil, Youngblut, Ahn & Curry, 2002). Stress may derive from the inopportune and untimely nature of the grandparent caregiving role, due to expectations about the proper timing and sequencing of life events and transitions (Bengtson & Allen, 1988). Raising a grandchild can also induce stress when the expectations of grandparenting and parenting come into conflict. Kivnick (1985) suggests that many grandparents expect to indulge and spoil, but not discipline their grandchildren. However, a caregiving grandparent may be conflicted by having to choose between being the indulgent grandparent and the disciplining parent. This is compounded by high levels of behavioral and emotional problems within the grandchild generation due to the often traumatic events leading up to the move into the grandparent's home, including economic crises, family conflict, and separation from one or both parent(s) (Billing, Ehrle, & Kortenkamp, 2002). Stress may also result from problems with the grandchild's parent – problems that precipitated the grandparent's entry into the caregiving role such as drug or alcohol abuse (Pillemer & Sutor, 1991). Finally, grandparents raising grandchildren are at particular risk for financial strain, are at elevated risk of living in inadequate housing conditions (Minkler & Fuller-Thomson, 2005) and are likely to experience poor health outcomes (Minkler & Fuller-Thomson, 1999). Within the context of the multiple jeopardy experienced by caregiving grandparents—in terms of the unexpected and ambiguous nature of the caregiving role, the strains associated with the tasks of caregiving, the social and emotional pathologies present in younger generations, and the challenges associated with poor socioeconomic and health status—it is not surprising that this group of grandparents has been shown to be at elevated risk of depression.

Multiple studies have shown that grandparents raising grandchildren exhibit high levels of depression when compared with grandparents who are not raising grandchildren (Blustein, Chan & Guanais, 2004; Burton, 1992; Fuller-Thomson & Minkler, 2000; Minkler & Roe, 1993). However, the mechanisms behind these low levels of well-being are unclear. Grandparent caregivers seem to be predisposed to high levels of depression even before a grandchild enters the household (Hughes, Waite, LaPierre, & Luo, 2007). This already high level seems to increase during the transition into care (and for some the transition out of care); however, there is evidence that grandparents who have been caring for a longer period may adapt to their new role over time and return to prior levels of well-being (Minkler, Fuller-Thomson, Miller & Driver, 1997; Szinovacz, DeViney, & Atkinson, 1999). In adapting to the caregiving role, grandparents may be affected by other roles in which they are simultaneously participating, such as worker, volunteer, parent of dependent children or caregiver of elderly parents. However, little is known about how roles external to the caregiving situation may enhance or harm the well-being of grandparent caregivers. These external roles may be thought of both as resources and stressors which moderate the stress process among grandparents raising grandchildren.

Participation in Multiple Roles – Resources and Stressors

Participation in multiple roles can enhance well-being indirectly through greater social integration and accumulated social capital in the form of willing helpers (Pillemer, Moen, Wethington & Glasgow, 2000). To date, no studies have examined the impact of participation in multiple roles on well-being among grandparents raising grandchildren; however, there is evidence that participation in multiple roles has a beneficial impact on depression among parental and spousal caregivers (Moen, Robison & Dempster-McClain, 1995). There is some evidence that participation in individual roles may benefit grandparent caregivers. For example, employment seems to lessen the impact of both raising a grandchild (Sands & Goldberg-Glen, 1998) and providing extensive care to a grandchild from outside the home (Szinovacz & Davey, 2006) on depression. It is unclear why this may be the case; a possible explanation is that grandparent caregivers who are working, in addition to gaining access to a wider social network of coworkers, receive income needed to support a grandchild, as well as ancillary benefits such as health insurance. Other roles, such as volunteer, parent to dependent children and caregiver of elderly parents may also provide resources to grandparents raising grandchildren. Volunteer work has been shown to have a beneficial effect on depression among older adults, partially through increased social integration (Musick & Wilson, 2003). It is likely that these positive influences would also be experienced by grandparent caregivers. The benefits of parenting and caregiving on grandparents raising grandchildren have not been shown empirically; nevertheless, each of these roles has possible benefits for this group. Those grandparent caregivers raising a child of their own may be more likely to have peers who are also raising children with whom they could exchange assistance; additionally, they may directly benefit from the assistance that a child, particularly an adolescent, might provide. As for the role of caregiver, it is possible that care provided to a parent may indeed be part of a larger system of mutual help. For example, a grandparent caregiver may run errands for an aging parent; in return, the elderly parent may watch the grandchildren while the grandparent caregiver is running those errands. This could give the grandparent caregiver a needed respite, as well as time to run errands of his/her own.

Conversely, it is possible that participation in multiple roles may act not only as a resource to grandparents raising grandchildren, but also as a stressor in and of itself. Experiencing a new stressor (such as beginning care for a grandchild) may aggravate prior stressors (or roles) which a grandparent is already experiencing (McCubbin & Patterson, 1983). It is likely that the costs and benefits of participation in multiple roles work simultaneously on grandparent caregivers. Given that prior research has found the transition into raising a grandchild to be most highly associated with elevated levels of depression (Minkler et al., 1997; Szinovacz et al., 1999), it may be that during the transition into care grandparents are so overwhelmed by this new role that taking on the care of a grandchild will decrease well-being regardless of external factors. In contrast, grandparents who have been raising grandchildren for a longer period of time will have more time to adjust to the negative consequences of participation in multiple roles and to capitalize on the benefits of this participation. Finally, grandparents who have recently relinquished the caregiving role will again be thrust into a period of adaptation and adjustment, particularly if the cessation of care was involuntary. During this period, the balance between the benefits and costs of participation may once again shift, so that multiple role occupancy acts mostly as a stressor rather than as a resource.

Based on the previous discussion concerning the sequential process of disruption and adaptation related to caregiving, and the possibility that alternative involvements may be either adaptive or maladaptive for caregivers, we advance the following hypotheses: (1) Grandparents who have recently begun raising a grandchild will experience greater levels of depressive symptoms when compared to grandparents who have performed the role for a longer time, as well as those who are not raising a grandchild. (2) Participation in roles beyond that of caregiver

will moderate the relationship between caregiving status and depressive symptoms such that (a) grandparents who recently adopted the caregiving role will experience high levels of depression regardless of their involvement in additional roles, (b) grandparents who have been raising a grandchild for a longer period of time will be most favorably affected by their involvement in additional roles, and (c) grandparents who recently relinquished the caregiving role will be most adversely affected by their involvement in additional roles.

Methods

Data

Data for this research is taken from Waves 2000 and 2002 of the Health and Retirement Study (HRS), a nationally representative dataset collected by the University of Michigan and funded by the National Institute on Aging. The HRS provides extensive information on many aspects of the grandparent's life, including health information, financial information, and living arrangements. The current sample is limited only to non-Hispanic white, non-Hispanic black, and Hispanic respondents, who reported having at least one grandchild, did not reside in a nursing home, did not have a proxy, had complete information on depression in 2000 and 2002, and were between the ages of 52 and 74 ($N=8,468$). Respondents who were younger than 52 years and those older than 74 years were excluded from our analyses because of their relatively infrequent participation as grandparent caregivers within this sample.

Measures

Depressive Symptoms—The dependent variable in this analysis is depression, specifically depressive symptoms. The measure of depressive symptoms in this analysis is taken from the revised 8-item Center for Epidemiological Studies-Depression Scale (CES-D) and is a shortened version of the 20-item CES-D. The scale has been found to be similar to the full CES-D in both internal consistency (Cronbach's alpha, $r = .78$) and factor structure (Turvey, Wallace & Herzog, 1999). Respondents are directed to, “think about the past week and the feelings you have experienced. Please tell me if each of the following was true for you much of the time during the past week. Much of the time during the past week: 1) you felt depressed; 2) you felt that everything you did was an effort; 3) your sleep was restless; 4) you were happy; 5) you felt lonely; 6) you enjoyed life; 7) you felt sad; 8) you could not get going.” One point is assigned to each affirmative response (items 4 and 6 are reverse coded) to create a scale from 0-8. Depression is measured as a dichotomous variable indicating a score of 4 or more symptoms on the CES-D, a cutoff recommended by the HRS as comparable to the cutoff score of 16 on the full version of the CES-D (Wallace et al., 2000). Because of the relatively small number of grandparents raising grandchildren in this sample, it was determined that a higher cut-off point would yield too few grandparent caregivers above the cut-off score, making comparative analysis unwise. This does raise the possibility of, “false positives,” in the data; that is, grandparents who score above the cut-off, but are not actually depressed. However, it is important to keep in mind that this score does not necessarily imply a diagnosis of clinical depression; rather, it is a generalized measure of psychological distress, and it is used as such in this research.

Caregiving Status—Grandparents in this study are grouped into four categories indicating duration of care for grandchildren: those who recently began raising a grandchild, those who recently stopped raising a grandchild, those who were raising a grandchild continuously, and those who were not raising a grandchild at all (See Figure 1 for a detailed explanation of the identification of grandparents raising grandchildren in the HRS). Those who recently began raising a grandchild are defined as grandparents who reported raising a grandchild in 2002, but did not report raising a grandchild in 2000. Grandparents who recently stopped raising a grandchild are defined as grandparents who reported raising a grandchild in 2000, but not in

2002. Grandparents who were raising a grandchild continuously are defined as grandparents who reported raising a grandchild in 2000 and 2002. Grandparents who were not raising a grandchild are defined as grandparents who did not report raising a grandchild in 2000 or 2002. This variable is measured as a series of dichotomous variables: began care, stopped care, and continuous care, with no care as the reference category.

A potential source of error in the identification of grandparents raising grandchildren is that the question refers to the couple as a unit rather than to the individual spouse. It is possible that one grandparent may be providing less direct care to the grandchild than the other grandparent. Unfortunately, there is no way to distinguish the respondent who is actually primary caregiver, except in cases where the grandparent caregiver is not married/cohabiting. However, prior research shows that in the vast majority of grandparent caregiver households, both grandparents claim primary responsibility for the grandchild (Mutchler, Lee, & Baker, 2006). In addition, secondary grandparent caregivers have been shown to experience similar levels of stress, anxiety, well-being and life satisfaction as compared to primary grandparent caregivers (Goldberg-Glen & Sands, 2000). Even if a grandparent is not providing direct care to the grandchild, his/her well-being may still be affected by the disruption in the grandparent/grandchild roles that may occur in these households. In order to address these issues, preliminary analyses were run separately by marital status. Results for unmarried and married respondents were similar in both direction and magnitude, lessening the possibility of potential bias.

Participation in Multiple Roles—Participation in multiple roles is measured as the count of roles a grandparent is currently participating in, beyond care for a grandchild (range 0-4). Roles included in this measure are worker, volunteer, parent of dependent children and parental caregiver. A respondent is considered to be a worker if he/she is currently working at both Time 1 and Time 2. Those whose employment status changed between waves are coded as not employed. While this categorization is less than perfect, it applies only to a small number of respondents, most of whom reported retiring between waves. It was determined that the experience of those who retired would be most similar to those who were not working at either wave. A respondent is considered to be a volunteer if he/she reports providing volunteer work at any time during the two years prior to the survey. A respondent is identified as a parent of dependent children if the respondent had at least one of his/her own children in the household under 18 years old at either Time 1 or Time 2. It is possible that a parent may have children in the household over the age of 18; however, the relationship between parents and adult children is much more ambiguous than the relationship between parents and dependent children. This ambiguity makes the effect of parenting an adult child on the relationship between raising a grandchild and depression unclear. For that reason, the role of parent is limited only to parents with dependent children. Finally, a respondent is identified as a parent caregiver if the respondent provided 100 hours of care or more for a parent during the two years prior to the survey. This care could encompass running errands, transportation, help with household chores and/or personal care.

Control Variables—A measure of depressive symptoms in 2000 is included in this analysis in order to control for the respondent's baseline level of depression. This variable is measured in the same way as the dependent variable; that is, a dichotomous variable indicating a score of 4 or more symptoms on the 8-item CES-D. In addition, two types of health status are controlled for in this analysis: physical health and functional health. Physical health is measured as a count of the number of chronic conditions a person reports at Time 1, including hypertension, diabetes, cancer, pulmonary disease, heart disease, stroke, and arthritis (range 0-7). Functional health is measured as a count of the number of activities of daily living (ADLs) with which a person reports difficulty at Time 1, including walking, dressing, bathing, eating, getting in/out of bed and using the toilet (range 0-6).

Two forms of socioeconomic status are controlled for in this analysis: income and education. Income is measured as the log of the total annual household income of the respondent at Time 1. The log of income will be used in this analysis to account for the skewness of income distribution, which can often produce inconsistent results. Education is measured as the highest year of education completed by the respondent as of Time 1. Demographic characteristics controlled for in this analysis include age in years, gender and marital status (1=married; 0=divorced, separated, widowed, never married). Race/ethnicity is measured as a series of dichotomous variables: non-Hispanic black and Hispanic with non-Hispanic white as the reference category. All demographic characteristics are measured at Time 1. Finally, the number of adults twenty-five years or older living in the household (beyond the respondent and the respondent's spouse) is controlled for as a proxy for the amount of potential support within the household (or, conversely, the amount of potential conflict).

Results

Characteristics of Grandparent Caregivers

Chi-square analyses (for categorical variables) and one-way ANOVAs (for continuous variables) are performed to determine significant differences by caregiver status. All calculations use centered weights. As shown in Table 1, all three groups of grandparents raising grandchildren are more likely than non-caregivers to be non-Hispanic black or Hispanic. In fact, over half of grandparents who provided continuous care were of a minority group, compared to only 15% of grandparents who did not provide care in either wave. As expected, all three groups of grandparents raising grandchildren have lower household incomes and lower levels of education than grandparents not raising grandchildren. In addition, grandparents raising grandchildren have a higher average number of other adults in the household, likely driven in many cases by the presence of one or more of the grandchild's parents.

Table 1 also shows the bivariate association between caregiving status and depressive symptoms in 2000 and 2002. Results show that the percentage of respondents who are depressed varies significantly by caregiving status in both 2000 ($p < .001$) and 2002 ($p < .001$). All groups of grandparent caregivers exhibit high levels of depressive symptoms when compared to non-caregivers. Notably, grandparents who began raising a grandchild have higher levels of depressive symptoms than non-caregivers even before the care began; this suggests that, to some extent, this group is predisposed to depression. Grandparents who began raising a grandchild and grandparents who stopped raising a grandchild show an increase in levels of depression between waves, while levels of depression among those raising a grandchild in both waves and those not raising a grandchild remain relatively stable. This supports our proposition that it is really the transition in or out of care, rather than the day-to-day care, that is particularly stressful for grandparents raising grandchildren.

Depressive Symptoms and Grandparent Caregivers

In order to assess the impact of caregiving on depressive symptoms, we used a lagged design where the outcome variable is the binary indicator of depression in 2002 and a comparable indicator of depression in 2000 is a control variable. This prospective design reduces the possibility of endogeneity by estimating risk of depression with baseline risk controlled, producing a type of change analysis. Where possible, imputed variables are taken directly from the HRS imputation file; for the remaining variables, missing data are imputed as the mean for continuous variables and the mode for categorical variables. Due to oversampling, sample weights provided by the HRS are used in analysis of the data; weights are centered for analysis. Because the HRS is collected using a multi-stage probability sampling design, the SVYLOGIT command in STATA is used in this analysis to yield standard errors that more accurately reflect

the results of the analysis, thereby avoiding inflated statistical significance caused by the clustering of the sample selection.

As shown in Table 2, the effects of three caregiving statuses (relative to not caregiving) on depressive symptoms are evaluated with logistic regression, controlling for participation in multiple roles, health status, socioeconomic status, demographic characteristics, number of additional adults in household and depressive symptoms at Time 1. Model 1 assumes only direct relationships between raising a grandchild and depressive symptoms, while Model 2 assumes that the relationship between raising a grandchild and depressive symptoms is moderated by the number of roles in which a grandparent is participating. The results of Model 1 show that grandparents who began raising a grandchild between 2000 and 2002 were significantly more likely to be depressed than non-caregivers; specifically, the odds of being depressed in 2002 were over 60% higher for those who began raising a grandchild, as compared to those who were not raising a grandchild at either wave ($p < .05$). In contrast, neither providing continuous care for a grandchild nor stopping care for a grandchild have significant direct effects on depressive symptoms. Grandparents who had a higher level of participation in outside roles tended to have lower risk of depressive symptoms in 2002, compared to those with fewer roles. For each additional role in which a grandparent participated, the odds of being depressed in 2002 decrease by approximately 22% ($p < .01$). In addition, grandparents who were younger, female, unmarried, less educated, and more functionally impaired, as well as those who had more chronic conditions and were characterized as depressed in 2000 experienced significantly greater risk of depression in 2002 compared to their counterparts.

In Model 2, interaction terms are added to the equation in order to determine whether caregiving status moderates the relationship between participation in multiple roles and depressive symptoms. The second equation in Table 2 shows that the strength of this relationship varies with respect to two groups of caregivers as compared to the reference group consisting of those who did not care for a grandchild at either wave. Among grandparents who provided continuous care to grandchildren, a higher number of additional roles is associated with *lower* risk of depressive symptoms ($p < .05$). In contrast, among grandparents who stopped providing care to grandchildren, a higher number of additional roles is associated with *higher* risk of depressive symptoms ($p < .01$). The relationship between number of roles and depressive symptoms is the same for grandparents who began raising a grandchild between waves as it is for those who did not provide any care.

To aid in the interpretation of these interaction terms, predicted values based on the coefficients in Model 2 are plotted in Figure 2. The predicted probability of depression for grandparents who provided continuous care precipitously declines as the number of roles increases. In this caregiving group, 23% of those with no outside roles were considered depressed, declining to 1% of those who participated in three outside roles. On the other hand, the predicted probability of depression for those who stopped care rises dramatically as the number of roles increases, moving from 8% of those with no roles to nearly 50% of those with three roles. Notably, while grandparents who began care are consistently more likely to be depressed than those who did not provide care, their patterns of decline look similar (though both groups do not change significantly as a function of outside roles).

Discussion

This research examines how the relationship between raising a grandchild and well-being is influenced by the grandparent's participation in multiple roles. Using the Health and Retirement Study, we find that grandparents who have begun raising a grandchild within the past two years experience lower levels of well-being when compared to grandparents who are not raising a grandchild. This relationship holds regardless of the grandparent's level of participation in roles

beyond that of grandparent caregiver, suggesting that any positive influence of social integration provided by those roles is outweighed by the high level of stress experienced during the transition into care or balanced by the stress induced by the roles themselves. In support of our hypotheses, the results also suggest that among grandparents who have been raising a grandchild for a longer period of time, external roles may serve as adaptive resources that allow a return to homeostasis in terms of psychological well-being. However, for grandparents who relinquished their role as caregiver, the function of external roles seems to shift from a primarily adaptive resource to an additional source of stress. If we imagine groups of grandparent caregivers in our model as synthetic, "caregiving cohorts," we can extrapolate developmental dynamics from the pattern of interaction terms. Early caregivers are plunged into a new and challenging role that induces distress regardless of external roles. Over time, caregiving grandparents use the resources provided by external roles to help them return to equilibrium over time. Upon cessation of care, grandparents are again thrust into a transitional phase, during which the balance between the costs and benefits of multiple role occupancy is again shifted so that external roles are functioning primarily as an added source of stress. Unfortunately, this research is not able to illuminate what factors may determine the balance between these forces among grandparents raising grandchildren.

As such, this research has limitations that bear discussion. The HRS does not allow for examination of several of the mechanisms that potentially link grandparent caregiving to distress outcomes. These include the cluster of stressors that are often associated with the caregiving role, such as the reason for care, the presence of behavior problems in the grandchild generation, the grandparent's feelings about raising a grandchild or the grandparent's level of control over the situation. Further, specific benefits and strains produced by external roles that may bear on well-being cannot be directly ascertained (e.g., social integration, overload) nor is it possible to gauge satisfaction with these roles. It is possible that these mechanisms could help explain why some grandparents raising grandchildren experience benefits associated with participation in multiple roles, while other grandparents are overwhelmed by these same roles. Future research should focus on the possible influence of these variables on the relationship between stress, depression and participation in multiple roles among grandparents raising grandchildren.

In addition, while there are substantial advantages to a prospective empirical design, the history of living arrangements and depression within multigenerational households is difficult to trace with only two panels of data. In order to more definitively identify the causal sequencing of multiple dynamic factors in the lives of caregiving grandparents (entry into and exit from caregiving, fluctuations in depression levels, and the addition/subtraction of roles) longer term data collected over more panels of measurement will be required. As further waves of data become available, it will become possible to trace the trajectory of depression among grandparent caregivers over multiple waves; allowing for examination of levels of depression in one cohort of grandparent caregivers as they transition from non-caregivers, to recent caregivers, to long-term caregivers, to former caregivers. Until more waves become available, the direction of causality and length of depression will remain unclear.

Policy Implications

Nevertheless, in spite of these limitations, this research provides a basis for making policy recommendations. This research suggests that the supportive needs of grandparent caregivers may become more diverse as the length of care provided increases. During the initial transition into care, grandparent caregivers seem to experience high levels of depressive symptoms regardless of the number of outside roles in which they participate, suggesting that depression is a more universal outcome within this group. Many of these grandparents are grappling with similar dilemmas regardless of participation in outside roles, socioeconomic status, or

demographic characteristics. This may include adjustment to conflicts with the grandchild's parent over care/custody, as well as behavioral and emotional problems of the grandchild. These grandparents may benefit from support groups designed to provide emotional support for grandparents who are dealing with these difficult issues.

However, it is important to remember that during the transition into raising a grandchild, many grandparents are experiencing financial strain and issues of housing adequacy either due to or exacerbated by the assumption of care for a grandchild (Fuller-Thomson & Minkler, 2003; Minkler & Fuller-Thomson, 2005). These problems may contribute to the high levels of depression observed among grandparents who have recently begun care for a grandchild as much as the emotional strain experienced by these grandparents. While policy initiatives that help to create and maintain support groups are an important part of ensuring high levels of well-being among grandparents raising grandchildren, programs which help grandparents obtain adequate housing and maintain financial stability may also indirectly help to improve the psychological well-being of grandparents who recently began raising a grandchild(ren).

This research also suggests that as duration of care increases, grandparents sort themselves into different caregiving trajectories with dramatically different needs. Some grandparents have the resources to deal with and adapt to these universal stressors, while other grandparents do not. Longer-term grandparent caregivers, who have moved beyond the initial transition into the role, may benefit from an intervention that encourages continued participation in roles beyond that of grandparent caregiver. For example, a grandparent who is feeling socially isolated may benefit from providing respite care to other grandparents on a volunteer basis. This research also provides evidence that the emotional impact of raising a grandchild extends beyond the duration of care itself. Depending on their level of participation in external roles, grandparents who have recently relinquished care for a grandchild may actually be at higher risk of depressive symptoms than grandparents who are currently raising a grandchild. Efforts should be made to ensure that at-risk grandparents who relinquish care for a grandchild do not subsequently sever ties with support groups and community organizations as their need for the services provided may actually increase. Local support groups may want to focus on these issues in their meetings, in order to address the unique needs of recent vs. long-term vs. former grandparent caregivers.

Finally, longer-term grandparent caregivers could benefit from federal, state, or local policy initiatives aimed at minimizing the stressors and maximizing the resources provided by multiple role occupancy. Currently, various agencies within the United States provide respite care for grandparents raising grandchildren (Generations United, 2004). This respite care can provide much needed flexibility, allowing a grandparent to run errands, schedule medical appointments, or simply take a break from the care of a grandchild. These programs can be quite effective in the management of stressors introduced by multiple role occupancy; however, it is important for new policies to be implemented that not only help grandparents manage multiple role conflicts, but actually reduce the amount of conflict experienced in the first place. Given the large number of grandparent caregivers who are employed outside the home, it is important to encourage employers to provide child-care benefits for grandparents raising grandchildren. Recent years have seen a rise in the number of companies within the United States who offer family friendly benefits (such as free/subsidized daycare, extended family leave, etc.) to parents; however, many grandparents raising grandchildren are not eligible for these programs, particularly if they are not the legal guardian of that child. Providing monetary incentives to employers who recognize these informal relationships could go far to minimize work/family conflict for grandparent caregivers.

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Figure 1.
Identification of Grandparents Raising Grandchildren in the Health and Retirement Study

Figure 2.
Predicted Probability of Depression by Caregiving Status and Participation in Multiple Roles
Note: Control variables set equal to sample mean for calculation of predicted probabilities.

Table 1

Descriptive Statistics by Caregiving Status (N=8,468)

Independent Variables				
	Began Care (N=115)	Stopped Care (N=133)	Continuous Care (N=171)	No Care (N=8,049)
	<u>Percentage</u>			
Female	67.6%	67.0%	65.3%	60.4%
Married	69.6%	67.5%	66.9%	70.1%
Non-Hispanic Black *	27.0%	24.3%	39.3%	9.1%
Hispanic *	11.7%	24.3%	16.8%	6.1%
Depression (2000) *	24.3%	20.2%	23.1%	14.1%
Depression (2002) *	28.6%	24.3%	22.1%	15.0%
	<u>Mean</u>			
Age *	60	61	59	63
Years of Education *	11	11	11	12
Activities of Daily Living	.28	.18	.35	.23
Chronic Conditions	1.67	1.66	1.58	1.55
Number of Other Adults in Household *	.49	.58	.55	.21
Number of Additional Roles	.84	.85	.80	.81
Household Income *	\$47,248	\$45,070	\$37,374	\$59,797

* p<.05; comparisons for categorical variables evaluated with chi-square, comparisons for continuous variables evaluated with ANOVA; centered weights are used for analysis.

Table 2

Logistic Regression Results of Effect of Raising a Grandchild on Depressive Symptoms in 2002 (N=8,468)

	<i>Model 1</i>		<i>Model 2</i>	
	B	Odds Ratio	B	Odds Ratio
Main Effects				
Depressed in 2000	1.945***	6.993	1.962***	7.117
(<i>Not depressed in 2000</i>)	----	(1.000)	----	(1.000)
Age	-0.030***	0.970	-0.030***	0.971
Female	0.371**	1.449	0.387**	1.473
(<i>Male</i>)	----	(1.000)	----	(1.000)
Married	-0.364**	0.695	-0.366**	0.694
(<i>Divorced, separated, widowed, never married</i>)	----	(1.000)	----	(1.000)
Non-Hispanic black	0.009	1.009	0.013	1.013
Hispanic	0.103	1.108	0.115	1.122
(<i>Non-Hispanic white</i>)	----	(1.000)	----	(1.000)
Household income (logged)	-0.028	0.972	-0.027	0.974
Education	-0.081***	0.922	-0.082***	0.921
Activities of daily living	0.245***	1.278	0.242***	1.274
Chronic conditions	0.088**	1.092	0.090**	1.094
Number of other adults in household	0.061	1.062	0.057	1.059
Number of additional roles	-0.248**	0.780	-0.252**	0.777
Began grandchild care	0.483*	1.621	0.417	1.518
Stopped grandchild care	0.283	1.328	-0.580	0.560
Continuous grandchild care	0.023	1.023	0.709	2.031
(<i>No grandchild care</i>)	----	(1.000)	----	(1.000)
Interaction Terms				
Began grandchild care × number of roles			0.088	1.092
Stopped grandchild care × number of roles			1.059**	2.882
Continuous grandchild care × number of roles			-1.350*	0.259
F		61.99***		51.03***
D.F.		(15,38)		(18,35)

*
p< .05;**
p< .01;***
p< .001.