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Impact of Coping Resources on the Well-Being of Custodial Grandmothers and Grandchildren

Gregory C. Smith*, Kelly E. Cichy*, and Julian Montoro-Rodriguez*

Gregory C. Smith: gsmith2@kent.edu

Human Development Center, 144 Nixson Hall, Kent State University, Kent, OH 44242

*School of Lifespan Development and Educational Sciences, 405 P White Hall, Kent State University, Kent, OH 44242

**Social Work, CHHS, 499C, 9201 University City Blvd., The University of North Carolina, Charlotte, NC 28223

Abstract

The authors blended elements from the Stress Process Model and the Family Stress Model to investigate the direct and indirect effects of custodial grandmothers' (CGMs') coping resources (i.e., active strategies, passive strategies, and social support) on their psychological distress, their parenting practices, and their grandchild's internalizing and externalizing symptoms. Participants included African American and White CGMs ($N = 733$, $M_{\text{age}} = 56$) who provided full-time care to a grandchild ($M_{\text{age}} = 9.8$). Structural equation modeling revealed that social support and active coping were related to lower CGM distress and less ineffective parenting, whereas passive coping was associated with increased distress and more ineffective parenting. Ineffective parenting had direct effects on grandchildren's outcomes, whereas CGM coping resources had direct effects on ineffective parenting and indirect effects (through ineffective parenting) on grandchildren's externalizing and internalizing difficulties. The authors conclude that CGM coping resources affect the psychological well-being of both generations.

Keywords

caregiving; coping; mental health; race

Approximately 937,784 grandparent householders provide care to a grandchild/grandchildren (GC) under age 18 without birth parents present (U.S. Census Bureau, 2011). Families of this household structure are known as either *custodial* or *skipped generation* families. Primary carers in these households are mostly custodial grandmothers (CGM), who tend to be older, single, and have lower incomes and less education than non-kin (foster) carers (Dolan, Casanueva, Smith, & Bradley, 2009). There is also growing evidence that custodial GC face greater risk for psychological difficulties than do children in the general population (Kelley, Whitley, & Campos, 2011; Smith & Palmieri, 2007).

Recently, there has been a call for research on how challenges facing CGM are linked to their parenting practices and to the well-being of their GC (Dunifon, 2013). Investigating the coping resources of CGM is an important step in this direction given that they face diverse stressors (e.g., financial strain, lack of formal and informal support, lifestyle disruption, conflict with GC parents, and health changes) that may increase their distress and thus hinder their ability to provide a supportive home environment (Hayslip & Kaminsky, 2005; Kelley et al., 2011). The importance of such research is further suggested by C. C. Goodman's (2012) longitudinal findings, which show that the mental health of CGM can have a long-term impact on GC behavior. She found that GC behavioral problems were reduced over time when CGM enjoyed better mental health early on. In addition, improvements in both CGM mental health and in GC–CGM relationship closeness were associated with positive changes in GC behavior.

Our study is the first to examine simultaneously the role of carers' coping resources, psychological distress, and parenting practices on children's outcomes within the context of custodial grandfamilies. We blend key elements from the Stress Process Model (SPM; family caregiving literature) with those from the Family Stress Model (FSM; parenting literature) to derive the conceptual model shown in Figure 1. This model is innovative in that it depicts how the coping resources of CGM influence both their own psychological adjustment and that of their GC.

Our model builds on earlier research showing that the coping strategies and resources used by CGM are related significantly to their physical and mental health (Gerard, Landry-Meyer, & Roe, 2006; Muliira & Musil, 2010; Musil & Ahmad, 2002; Ross & Aday, 2006). Our model is also based on findings in the parenting literature indicating that (a) a carer's distress is linked to poor parenting, (b) poor parenting is related to problems in child adjustment (Elgar, Mills, McGrath, Waschbusch, & Brownridge, 2007; Papp, Cummings, & Goeke-Morey, 2005; Rubin & Burgess, 2002), and (c) parenting mediates the link between carer distress and child adjustment (Deater-Deckard, 1998; Shelton & Gordon, 2008). The parenting literature further reveals that carers use coping resources to prevent their emotional distress from adversely affecting the parental role (Elgar et al., 2007) and that children of psychologically distressed carers are at risk for diverse adjustment difficulties, including both internalizing and externalizing problems (Rubin & Burgess, 2002). This risk is present even when carer stress is limited to normal daily hassles (Elgar et al., 2007; Papp et al., 2005).

How CGM Coping Resources Are Linked to CGM Distress

Stress and resilience models such as the SPM maintain that stressors can cause, sustain, or amplify family members' mental health difficulties (e.g., Kwok et al., 2005; Pearlin, Mullan, Semple, & Skaff, 1990). Yet stressors alone do not explain the intensity of one's psychological distress. According to the SPM, coping resources mediate between life stress and negative outcomes (Pearlin et al., 1990). *Coping* refers to any strategy used to support the management of stress, which includes regulating emotional distress (emotion focused), dealing with the cause of the distress (problem focused), and having social support (Folkman & Lazarus, 1986).

Coping constructs in our model include the use of active and passive coping by CGM and perceived emotional support. Passive (or avoidant) strategies remove the person from the source of stress, whereas active coping strategies cognitively or behaviorally affect the stressor (McKelvey, Fitzgerald, Schiffman, & von Eye, 2002). In their research on caregiving grandparents, Musil and Ahmad (2002) found that active coping reduced the effects of stress on CGM mental and physical health, whereas avoidant coping was associated with increased depression. Avoidant coping has similarly been linked to psychological distress in diverse community samples (Folkman & Lazarus, 1986; Holahan, Moos, Holahan, Brennan, & Schutte, 2005). Thus, we hypothesized that greater use of active coping by CGM will lead to lower psychological distress, whereas greater use of passive coping will yield heightened distress.

On the basis of earlier studies of CGM coping we further hypothesized that greater perceived social support is related to lower psychological distress for CGM. For example, Gerard et al. (2006) found that both perceived informal support and perceived formal support provided general benefits to caregiving grandparents in the form of reduced caregiving stress, regardless of stressor level. Similarly, Musil and Ahmad (2002) found in a hierarchical regression analysis that perceived subjective (but not instrumental) social support reduced depression among their sample of 171 caregiving grandmothers. The general social support literature likewise points to the benefits of perceived social support for general health and well-being (Uchino, 2004).

How CGM Coping Resources Are Linked to Parenting Practices

The parenting literature indicates that how birth parents cope with stressors affects their parenting behavior (McKelvey et al., 2002). For example, social support appears to buffer the effects of parenting stress on discipline, parental warmth, and sensitivity (Martin, Gardner, & Brooks-Gunn, 2012; McKelvey et al., 2002). Active/problem-focused coping has been similarly linked to positive parenting practices (Smith Bynum & Brody, 2005; Tein, Sandler, & Zautra, 2000). Although heretofore untested with caregiving grandparents, we hypothesized that the coping resources of CGM will similarly have direct effects on their parenting behavior. On the basis of the studies with birth parents described above, we specifically predicted that social support and active coping yield less ineffective parenting by CGM. We expected passive coping to have the opposite effect given past findings in which avoidant coping was related to increased depression in CGM (Musil, Warner, Zauszniewski, Wykle, & Standing, 2009) and general community samples (Folkman & Lazarus, 1986; Holahan et al., 2005) alike.

How CGM Distress and Parenting Practices Are Linked to Grandchild Outcomes

The basic tenet of the FSM is that increased psychological distress reduces the quality of parenting, which then leads to increased psychological difficulty for the child (Conger, Rueter, & Conger, 2000). Thus, consistent with the FSM, we hypothesized that the impact of CGM psychological distress (anxiety and depression) on GC psychological difficulties (externalizing and internalizing symptoms) is indirect in that it increases ineffective

parenting (low nurturance and ineffective discipline) rendered by CGM. This hypothesis is consistent with repeated cross-sectional and longitudinal findings in the parenting literature (for a review, see Elgar et al., 2007) and by previous work specifically involving custodial grandfamilies (Smith & Hancock, 2010; Smith, Palmieri, Hancock, & Richardson, 2008). In addition, Rodgers-Farmer (1999) found that parenting stress among CGM was significantly related to their depression, which in turn was associated with inconsistent discipline. However, no past studies involving the FSM have considered the potential influence of coping resources on parenting behavior as we do here.

Hypothesized Indirect Effects and Key Covariates

Another novel aspect of our model (see Figure 1) is the hypothesis that the effects of CGM social support, active coping, and passive coping on GC outcomes are indirect through their prior influence on CGM psychological distress and CGM ineffective parenting. In the parenting literature, mothers' active coping is often associated with better mental health outcomes for children (McLoyd & Wilson, 1990; Smith Bynum & Brody, 2005). In contrast, avoidant coping is linked to poorer mental health outcomes for both parents and children (Timko, Cronkite, & Moos, 2010). However, our model is the first to consider simultaneously linkages between the coping resources, distress, and parenting behaviors of CGM in relation to GC outcomes. Having a better understanding of these linkages is essential to designing appropriate interventions for custodial grandfamilies.

Our model also considers the potential influence of CGM education and physical health. We specifically expect higher levels of CGM education and CGM health to be associated with greater support, more active coping, and less passive coping. Research on coping reveals that individuals with more education report greater social support (Adler, Epel, Castellazzo, & Ickovics, 2000) and are more likely to use active coping and less likely to use passive strategies (Adler et al., 2000; Smith Bynum & Brody, 2005). Similarly, better physical health is typically associated with more effective coping and greater social support (Leder, Grinstead, & Torres, 2007). As is commonly observed in studies of aging and depression (see Blazer, 2003), we also hypothesized covariance between CGM health status and depressive symptoms.

Multigroup Comparisons

Another key goal of this study was to explore whether both the measurement and structural aspects of our blended model are invariant by CGM race and age and by GC age and gender. Determining whether the measurement model is the same for these groups is important because if factor loadings for model constructs differ by group, then their inferred meanings may also differ. Even if the measurement model is equivalent between groups it is possible that groups differ in the structural paths connecting latent constructs in a given model (Byrne, 2006).

Although a prior study of the FSM revealed measurement and structural invariance across all of the groupings mentioned in the preceding paragraph (Smith et al., 2008), the present model differs by the inclusion of coping constructs that could influence invariance. Moreover, in the parenting literature the role of child and parent individual-difference

factors (e.g., age, gender, race) as potential moderators of the relation between particular parenting behaviors and child outcomes is largely inconclusive (see, e.g., McKee, Colletti, Rakow, Jones, & Forehand, 2008). Therefore, we explored multigroup comparisons without testing specific hypotheses while considering the need for multigroup comparisons supported by findings from prior research.

Consistent with earlier studies of children in kinship care (Dubowitz et al., 1994; Dunn, Deater-Deckard, Pickering, O'Connor, & Golding, 1998), Smith and Palmieri (2007) found more behavioral problems and less prosocial behavior in male custodial grandchildren than in females. Prior research also emphasizes the unique parenting stressors and necessary resources for CGM parenting younger children (Kelley & Whitley, 2003) versus adolescents (Brown et al., 2000). For these reasons, we explored whether the proposed model operates similarly for CGM parenting grandsons and granddaughters and for younger versus older grandchildren.

With respect to race, studies of the FSM in the parenting literature provide support for racial similarities in the pathways among parental distress, parenting behaviors, and child outcomes (Conger et al., 2002; Gutman, McLoyd, & Tokoyawa, 2005), suggesting that the proposed pathways in our blended model may characterize the experiences of both African American and White CGM and GC. Also, few studies have examined associations between African Americans' parenting practices and parents' active or passive coping behaviors (Gaylord-Harden, Campbell, & Kesseling, 2010).

As for caregiving grandparents per se, Hayslip and Kaminski (2005) cited ethnicity/race as among the most important factors differentiating the experiences of CGM. For example, African Americans are more likely to have peers living with them and to come from multigenerational families (Hayslip & Kaminski, 2005), which may serve as important sources of social support that are less available to White CGM. Yet no published studies to date have specifically compared coping resources and corresponding outcomes between White and African American CGM. This, along with the absence of any prior research or theory on how GC age and gender and CGM age may be related to CGM coping, prevented us from formulating specific hypotheses regarding the group invariance analyses in the present study.

Method

Participants

The participants were 733 CGM (M age = 56 years, SD = 8.1) providing full-time care to a GC in absence of his or her parents for at least 3 months (M = 6.4 years, SD = 4.0, range: 3 months–16 years). Recruitment was done across the 48 contiguous states for an National Institute of Mental Health–funded study of stress and coping among custodial grandparents through a combination of convenience and population-based methods. Population-based sampling involved letters to randomly generated mailing lists of the approximately 38 million households containing children under age 18. The sample was diverse in terms of marital status, education, residential locale, work status, and income. A CGM was excluded if she provided care because of the death of her own child. If a CGM was caring for multiple

GC, then a target grandchild (TGC) was selected using the most-recent-birthday technique. The TGC were 391 girls and 342 boys (M age = 9.8 years, SD = 3.7, range: 4–17). The majority of CGM (65.8%) provided care to a TGC born to a daughter. Most reported multiple reasons for giving full-time care (e.g., parent substance abuse, incarceration). Demographic information, including reasons for providing care, is presented in Table 1.

Measures

The following self-report measures were completed by CGM as part of a comprehensive telephone interview conducted by trained interviewers at a public research university in Ohio.

TGC adjustment—Four subscales from the parent-informant version of the Strengths and Difficulties Questionnaire (R. Goodman, 2001) were used. The Strengths and Difficulties Questionnaire shows good psychometric properties in diverse populations and correlates highly with other indices of childhood maladjustment (Goodman, 2001). Externalizing problems were assessed by the Hyperactivity–Inattention (α = .82; M = 4.43, SD = 3.02) and Conduct Problems (α = .74; M = 2.59, SD = 2.37) subscales, whereas internalizing problems were assessed by the Emotional Symptoms (α = .73; M = 2.60, SD = 2.45) and Peer Problems (α = .62; M = 2.41, SD = 2.11) subscales. Each scale had five items rated by CGM regarding TGC behavior on a 3-point scale that ranged from 0 (*not true*) to 2 (*certainly true*). Items were summed on each scale for a potential range of 0–10. High scores reflect more of each behavior.

CGM psychological distress—This construct encompassed self-reported indicators of depression and anxiety. Depression was assessed by the 20-item Center for Epidemiologic Studies Depression Scale (Radloff, 1977). For each item, CGM endorsed the response best describing how often they had felt a particular way in the past week on a 4-point scale that ranged from 0 (*rarely or none of the time—less than 1 day*) to 3 (*most or all of the time—5 to 7 days*). Potential scores range from 0 to 60 (α = .90; M = 10.74, SD = 9.75), and higher scores indicate more frequent symptoms. Anxiety was assessed by the three-item Anxiety subscale from the Mental Health Inventory II (Stewart, Ware, Sherbourne, & Wells, 1992). The CGM rated how often during the past month they had been very nervous, tense, or restless on a scale that ranged from 1 (*all of the time*) to 6 (*none of the time*). The summed total score across the three items ranged from 1 to 6 (α = .84; M = 2.06, SD = 1.07); higher scores indicate greater anxiety.

Low nurturance—Two subscales from the Parenting Stress Index (Abidin, 1995) were used to measure this construct. The six-item Reinforces Parent subscale (e.g., “Most times I feel that my grandchild likes me and wants to be close to me”) measures the extent to which a carer projects negative responses onto the child (range: 6–29; α = .69; M = 11.92, SD = 3.92). The seven-item Attachment subscale (e.g., “I expected to have closer and warmer feelings for my grandchild than I do and this bothers me”) assesses the carer’s emotional closeness to the child and the real or perceived inability to observe and understand the child’s needs and feelings (range: 7–35; α = .60; M = 13.83, SD = 3.92). Items on both

scales are rated from 1 (*strongly agree*) to 5 (*strongly disagree*) with several items reverse scored so that the higher scores reflected a more problematic CGM–TGC relationship.

Ineffective discipline—Scales measuring CGM use of harsh and inconsistent discipline, respectively, served as indicators of this construct. Each scale contained three items adapted from the Parenting Practices Interview derived from the Oregon Social Learning Center’s discipline questionnaire (Webster-Stratton, Reid, & Hammond, 2001). The CGM rated each item (e.g., “Raise your voice, scold, or yell,” “Threaten to punish your grandchild but not really punish him/her”) on a 5-point scale ranging from 1 (*never*) to 5 (*very often*) in response to the query “In general, how often do you do each of the following when your grandchild misbehaves?” Items were summed to yield scores for each type of discipline (possible range: 3–15), with higher scores indicating greater use ($\alpha = .66$; $M = 7.63$, $SD = 2.51$, for harsh discipline, and $\alpha = .54$; $M = 7.04$, $SD = 2.47$, for inconsistent discipline).

Social support—This was measured in terms of both perceived availability of and satisfaction with support from friends and family. Availability was assessed with the eight-item Expressive Support Scale (Pearlin et al., 1990). All items were rated on a scale that ranged from 1 (*strongly disagree*) to 5 (*strongly agree*), with scores ranging from 8 to 40 ($\alpha = .89$; $M = 26.10$, $SD = 3.80$). Satisfaction was measured with one item: “Overall, how satisfied are you with the emotional support and understanding that you receive from your friends and neighbors?”, rated from 0 (*not at all*) to 5 (*extremely*; $M = 3.27$, $SD = 1.10$).

Active and passive coping strategies—Both types of coping were measured by items from the Ways of Coping Checklist (WCCL; Vitaliano, Russo, Carr, Maiuro, & Becker, 1985), which contains three emotion-focused subscales: (a) Wishful Thinking (five items; e.g., “Had fantasies or wishes about how things might turn out”; $\alpha = .72$; $M = 10.55$, $SD = 3.87$), (b) Avoidance (five items; e.g., “Tried to make myself feel better by eating, drinking, smoking, taking medications”; $\alpha = .55$; $M = 6.00$, $SD = 2.31$), and (c) Blame Self (three items; e.g., “Realized you brought the problem on yourself”; $\alpha = .60$; $M = 5.32$, $SD = 2.13$). We used each of these three subscales as indicators of the latent construct “passive coping.” The latent construct “active coping” was measured with six items ($\alpha = .56$; $M = 19.80$, $SD = 2.98$) from the WCCL Problem-Focused subscale (e.g., “I make a plan of action and follow it”). To assess coping regarding the stress of raising the TGC specifically, the following instructions preceded the items used to measure both active and passive coping:

Please indicate how often you do the following things when you experience stressful events in providing care to your grandchild. Think about what you usually do when you are under a lot of stress in providing care to [grandchild name].

All WCCL items were rated by CGM on a scale that ranged from 1 (*I usually don’t do this at all*) to 4 (*I usually do this a lot*).

Demographic variables—Education was self-reported by CGM with response alternatives ranging from 1 (*less than five years of school*) to 7 (*graduate/professional training*). Health status was assessed through a single item that was self-rated by CGM from 1 (*poor*) to 5 (*excellent*).

Although some measures had low alphas, all had reliability estimates exceeding .50, which is acceptable for correlational analyses (Stewart et al., 1992). Furthermore, all standardized factor loadings from the latent variables were above .40. Coping scales often show lower internal consistency because the use of one coping response may reduce the need to use other responses from the same category—in particular when response frequencies are low, as with avoidant coping (Moos & Holahan, 2003). Also, our use of structural equation modeling (SEM) corrected for measurement error (Byrne, 2006).

Data Analytic Plan

We used SEM to test the proposed model (Amos, Version 20). To reduce the number of parameters estimated, we used a parceling technique to model the latent construct “active coping.” Three parcels (representing composite indexes) were used as indicators instead of using six separate items from the WCCL. Despite its potential problems (e.g., masked multidimensionality and loss of information), such parceling is appropriate when the primary goal is to examine the nature of a set of constructs rather than to understand the exact relations among the items comprising the measured construct (Little, Cunningham, Shahar, & Widaman, 2002). Also, instead of conceptualizing Ineffective Parenting as a first-order latent construct assessed by multiple indicators, we modeled it as a higher order factor encompassing two first-order factors labeled *Ineffective Discipline* and *Low Nurturance*. This is consistent with the view that ineffective discipline and low nurturance are distinct yet highly correlated constructs that affect the development of adjustment problems in children (see Locke & Prinz, 2002).

Exogenous variables (CGM health and education) were allowed to correlate among each other, and covariances between coping factors and between the two dimensions of the TGC adjustment were freely estimated. One parameter for each latent variable was constrained to 1.0 for scaling purposes. No data were missing, and variables displayed univariate and multivariate normality.

We followed Byrne’s (2006) recommendations for examining multigroup invariance by CGM race, TGC age, and TGC gender. After determining the baseline model separately for each group, we then tested for group invariance in a logically ordered and increasingly restrictive sequence. We first tested for configural invariance across each grouping under investigation. In these tests, the same parameters estimated in the baseline model for each group separately were estimated again within a multigroup representation of the baseline model. The fit of the resulting configural models provided baseline values against which subsequently specified invariance models were compared.

Next, we tested group invariance of the measurement model by computing model fit for a pooled sample of groups (e.g., Whites and African Americans) with the hypothesized factor loadings for all latent constructs constrained to be equal across groups. Fit indices from the fully constrained measurement model were then compared to those of the configural model, and a nonsignificant difference in the Satorra–Bentler (SB) chi-square values (χ^2_{SB}) indicated invariance.

To test for structural invariance, we used a procedure that was analogous to that used to examine measurement invariance. With all of the same constraints that were imposed in the final model of the test for measurement invariance left in place, all hypothesized causal paths (see Figure 2) were then constrained to be equal across groups. A χ^2_{SB} difference test was then computed and interpreted in the same manner as for the tests of measurement invariance (Byrne, 2006).

Results

Indices of model fit suggested that data from all groups under investigation fit the baseline model well. The range of values for the indices across all groups were the following: comparative fit index (CFI) = .945–.962; root-mean-square error of approximation (RMSEA) = .044–.046; $\chi^2(294-441) = 438.25-652.69$, $p < .001$. No alterations to the baseline model were indicated for any groups under investigation. Moreover, for each grouping, none of the CFI tests between the constrained (measurement and structural models) and nonconstrained models exceeded a value of .01, suggesting that both the baseline and structural models were invariant with respect to CGM race and age and GC age and gender.

In light of the above invariance findings, we report more detailed SEM results for the entire sample of 733 CGM rather than separately by group. There was evidence of good fit between the observed data and the proposed model: $\chi^2(147) = 319.98$, $p > .001$; Tucker–Lewis Index = .943; CFI = .956; RMSEA = .040, 90% confidence interval [.034, .046]. Figure 2 shows the standardized factor loadings for the indicators associated with each latent construct in our model.

Direct Effects

Figure 2 also shows the standardized regression path coefficients observed for each of the hypothesized pathways and covariances among the total sample of 733 CGM. All pathways were statistically significant except for the following: CGM distress to TGC Externalizing Behaviors, CGM Distress to Ineffective Parenting, CGM Health to Active Coping, and CGM Education to Social Support. After controlling for CGM Education and CGM Health, as expected, higher levels of Social Support were associated with lower levels of both CGM Distress and Ineffective Parenting. In contrast, consistent with our hypothesis, higher levels of Passive Coping were related to greater levels of both CGM Distress and Ineffective Parenting. Greater Active Coping was related to less CGM Distress and Ineffective Parenting. Contrary to the FSM, CGM Distress was not significantly related to Ineffective Parenting. In line with the FSM, however, more Ineffective Parenting was associated with greater TGC Internalizing and Externalizing symptoms. On the other hand, greater CGM Distress was related significantly to increased TGC Internalizing symptoms, but not to Externalizing symptoms.

Indirect Effects

Using the bootstrapping procedure (Amos, Version 20) both exogenous and mediating coping variables had significant indirect standardized effects in the model. Bias-corrected

and accelerated 95% confidence intervals (CIs) were computed using 1,000 bootstrapped resamples for each indirect point estimate. CIs that do not contain a zero value indicate a significant effect. In particular, CGM Health indirectly affected CGM Distress ($-.196, p < .004$) and Ineffective Parenting ($-.201, p < .005$) through Social Support and Passive Coping. It also affected the TGC Internalizing ($-.175, p < .010$) and Externalizing Difficulties ($-.160, p < .005$) through CGM Distress and Ineffective Parenting. Statistically significant indirect effects were also found for CGM education level on CGM Distress ($-.109, p < .016$) and Ineffective Parenting ($-.127, p < .007$) through Active and Passive Coping mechanisms. Lower but statistically significant indirect impacts were also noted for CGM education and the TGC Internalizing ($-.071, p < .009$) and Externalizing Difficulties ($-.081, p < .007$) through CGM Distress and Ineffective Parenting. As expected, coping factors showed standardized significant indirect effects associated with the psychological difficulties of the TGC. Specifically, indirect effects were associated with the TGC Internalizing Difficulties from social support ($-.129, p < .044$), Active Coping ($-.091, p < .027$) and Passive Coping ($-.347, p < .005$), and with the TGC Externalizing Difficulties from Social Support ($-.140, p < .007$), Active Coping ($-.091, p < .009$), and Passive Coping ($-.401, p < .007$), both through the CGM level of Distress and Ineffective Parenting.

Discussion

We tested a blended model that includes elements of the SPM of the family caregiving literature (Pearlin et al., 1990) with elements of the FSM model from the parenting literature (Conger et al., 2000) to investigate how the coping resources of CGM influence the psychological adjustment of both them and their GC. Unlike past studies, our use of SEM allowed us to examine the direct and indirect effects of CGM coping resources on their psychological distress, their parenting behaviors, and the psychological difficulties of GC.

Key Influences on Grandchildren's Outcomes

The most important and innovative feature of our model is that it considers simultaneously the direct and indirect effects of CGM psychological distress, CGM parenting behaviors, and CGM coping resources on GC psychological outcomes. No other studies involving either parents or custodial grandparents have tested these specific associations to date.

Consistent with the FSM (Conger et al., 2000), and with prior findings involving custodial grandfamilies (Smith et al., 2008; Smith & Hancock, 2010), ineffective parenting was found here to have significant direct effects on GC externalizing and internalizing difficulties. However, in contrast to the FSM and our prior findings with custodial grandfamilies, CGM psychological distress had no significant direct effect on ineffective parenting within the context of our new blended model. Instead, all three coping resources had statistically significant direct effects on CGM ineffective parenting. Our findings reveal for the first time that a CGM's coping resources may have a greater impact than her levels of psychological distress on both her parenting behaviors and the consequent adjustment outcomes for her child.

We also found that the standardized path coefficient between passive coping and ineffective parenting was of greater magnitude than those involving either active coping or perceived

social support. These findings with CGM are consistent with those of Tein et al. (2000), who observed in a longitudinal study with divorced custodial mothers that active coping facilitated positive parenting behaviors (i.e., acceptance, consistent discipline) and reduced negative parenting behaviors (i.e., rejection), whereas avoidant coping hampered positive parenting and increased negative parenting. Along these lines, it is noteworthy that custodial divorced mothers and CGM face many comparable stressors, including a significant life readjustment, passing from one identity to another, financial hardships, social isolation, and conflicted family relationships. In both the present study and that conducted longitudinally by Tein et al. with divorced mothers, coping behaviors ultimately had a greater impact on parenting behaviors than did the carer's psychological distress. Although these findings are inconsistent with the basic FSM tenet that a carer's distress has a direct effect on parenting behaviors, it is important to note that no prior studies of the FSM have ever considered the potential influence of caregivers' coping resources. We should also note that Tien et al. did not go the further step of examining the impact of carer coping and distress on child outcomes as we have done here. Thus, our findings are unique in that they show that all three coping resources can have significant indirect effects (through ineffective parenting) on children's externalizing and internalizing difficulties.

That all three coping resources had such pronounced effects on CGM parenting is understandable given that effective parenting requires planning, patience, and resistance to the disruptive influence of stressors (Tein et al., 2000). It may be that distressed carers respond to life stressors with ineffective coping strategies. In turn, the children in their care may adopt these same behaviors through modeling.

It is also noteworthy that we found both CGM health and education to be important risk factors, with both showing statistically significant indirect effects on GC psychological difficulties within the context of our blended model. Those CGM with better health and more education tend to possess superior coping resources, which in turn lead to better parenting and more favorable GC outcomes.

CGM Psychological Distress and Coping Resources

Consistent with the SPM and prior studies of coping among CGM (Gerard et al., 2006), we found that perceived social support was related to significantly lower levels of CGM psychological distress, whereas the use of passive coping was significantly associated with increased CGM distress. Active coping was inversely related to CGM distress, as hypothesized. The fact that the present findings were based on a large national sample of CGM and involved SEM latent constructs with measurement error controlled extends and reinforces the generalizability of the earlier studies reporting similar findings.

Of the three coping resources we examined, the standardized path coefficient between Passive Coping and CGM Distress was of greater magnitude than those between either Active Coping or perceived social support with CGM Distress after controlling for education and health status. This suggests that the use of passive coping by CGM is especially detrimental to their psychological well-being, which reinforces the belief that ineffective coping strategies exacerbate stress (Tein et al., 2000; Timko et al., 2010). Although passive coping behaviors, such as avoidance, might help by providing time to

garner resources during the initial stages of coping, their prolonged use may prevent carers from dealing with a crisis or its consequences directly, which then results in increased psychological dysfunction (Tein et al., 2000). In contrast, individuals who use more effective coping strategies may integrate their thoughts and actions into a more stable and adaptive framework that ultimately lowers their psychological distress.

Our findings also suggest that CGM health and education may affect their coping resources directly. Higher use of passive coping was associated with both poorer health and less education, whereas greater use of active coping was related only to more education. Perceived social support was associated with better CGM health but was not significantly related to education. Health status and education were also found to have statistically significant indirect effects on CGM psychological distress through their direct effects on coping. These findings, coupled with the observed direct effect of CGM health on CGM psychological distress, point to CGM education and health as important contributors to CGM well-being.

Multigroup Comparisons: Model Invariance

Finally, our multigroup analyses revealed that both the measurement and structural models were invariant by CGM race and age as well as by GC age and gender. We were unable to formulate specific hypotheses about these specific invariance comparisons because past research has been either equivocal along these lines or not conducted at all. That we found measurement invariance across all of the comparisons made suggests that the constructs within our model hold similar meanings across these particular groupings (Locke & Prinz, 2002). That we also found strong evidence regarding invariance for the structural paths in our model instills confidence in the generalizability of our results. The overall generalizability of the present findings is further supported by our large national sample of CGM, half of which was obtained by means of diverse sampling approaches.

Implications for Policy and Practice

Our findings have important implications for the development of programs and policies to improve psychological well-being within custodial grandfamilies. First, researchers and practitioners should view CGM psychological distress and coping resources from a family perspective as opposed to the singular focus on CGM well-being that has predominated to date. Indeed, there is increased recognition that parenting is the central responsibility of CGM and that insufficiently managed stressors related to their overall family situation may compromise their ability to parent competently (Dolbin-MacNab, 2006; C. C. Goodman, 2012; Kelley et al., 2011).

Second, when assisting caregiving grandparents, practitioners should be attuned to both their parenting practices and coping resources. In order to prevent and treat externalizing and internalizing problems for GC it is important that practitioners provide helpful coping strategies. Although elements of stress and anxiety might subside after focusing solely on positive parenting strategies, to help with long-term implementation and provide buffering from future obstacles attention to effective coping resources would also be beneficial for CGM. By not doing so, CGM could potentially relapse when faced with future external

stressors and may require further support to effectively cope. This then places additional burden on the health care system and does not assist in providing a cost-effective model of assistance for CGM. Alternatively, grandparent programs that include both parent training and an emphasis on coping resources (e.g., Hayslip, 2003; Kirby & Sanders, 2014) could decrease the possibility of relapse and prevent future problems from occurring. However, this needs to be empirically tested.

Third, our findings suggest that CGM are likely to vary in their coping resources, and these individual differences influence important outcomes, as illustrated by the fact that CGM with less education and in poorer health appeared to be at higher risk for ineffective coping and lower quality parenting. Thus, assessing both the parenting practices and coping resources of caregiving grandparents is a critical first step in the intervention process. Such assessments would uncover those areas for which caregiving grandparents have a higher need for support so that these needs would be addressed first. This initial assessment could also be used to determine whether a “light touch” intervention (e.g., that focuses on only one target problem, such as parenting or coping resources) or a more intense program that includes both parenting strategies and coping strategies is required. Such an approach appreciates the heterogeneity of families with caregiving grandparents and enables a more cost-effective implementation of services for them.

Finally, our findings further suggest that not only should interventions be designed to promote active coping strategies and to increase levels of social support among CGMs, but also they must attend simultaneously to the reduction of their passive coping strategies. This is indicated by the fact that the magnitude of both the indirect and direct effects for passive coping on CGM distress, parenting behaviors, and GC outcomes were greater than those found for either active coping or social support. Specific attempts to instruct CGM on how passive coping strategies may adversely affect both them and their GC may be especially worthwhile.

Study Limitations and Future Directions

The current study is not without limitations. The cross-sectional design limits our ability to determine conclusively the direction of effects. One could argue that GC who exhibit more behavior problems may also elicit more negative responses by CGM. However, the rare longitudinal studies with custodial grandfamilies to date reinforce the causal direction hypothesized in our model (C. C. Goodman, 2012; C. C. Goodman & Hayslip, 2008). C. C. Goodman (2012) found that behavior problems were reduced over time for GC whose CGM had better mental health early on, and that improvements in both CGM mental health and in CGM–GC relationship closeness were related to positive shifts in GC behavior over time. Most likely, a transactional process exists whereby CGM parenting and GC problems reciprocally influence each other (McKee et al., 2008).

We also relied exclusively on self-reports from a single informant, the CGM herself, whereas the parenting literature illustrates the importance of also including the perspective of the child and outside observers (Martin et al., 2012). Studies are needed that incorporate observations of interactions between CGM–GC dyads in order to explore behaviors of which CGM may be unaware or are reluctant to endorse in questionnaires. Also, although

we assessed three primary forms of coping, other potentially important coping strategies (e.g., religious coping) were unexplored here (Myers, Taylor, Alvy, Arrington, & Richardson, 1992).

There are also limitations with our study sample. For example, the sample did not include custodial grandfathers, and its racial composition was limited to White and African American CGM only. Also, because we did not record whether participants were caring for the first time as a CGM or not, we were unable to examine the potential influence of custodial grandparenting for two or more times in one's lifetime on the constructs within our model.

Finally, we did not assess stressor exposure separately from coping strategies. Prior research has revealed that everyday stressors have the greatest effects on psychological distress and parenting behaviors and highlights how different styles of coping may be effective for different domains of stressors (Tein et al., 2000). Future studies are needed to explore how various types of stressors encountered by CGM are associated with particular styles of coping.

Despite these limitations, our findings underscore how programs to improve CGM coping resources have the potential to improve outcomes for both generations. As so eloquently stated by C. C. Goodman (2012), "Grandmothers who maintain their own mental health and create a loving, close relationship with their grandchild over time may better assist struggling or deprived grandchildren to control difficult behaviors and successfully develop social skills" (p. 653).

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Figure 1.

Model of Custodial Grandmothers' (CGMS') Coping and Parenting Outcomes.

Note. TGC = target grandchild.

Figure 2.
Structural and Measurement Model of Custodial Grandmothers' Coping and Parenting Outcomes.

Note. GM = grandmother.

Table 1Descriptive Statistics for Key Background Variables ($N = 733$)

Variables	African Americans ($n = 366$)	Whites ($n = 367$)
Marital status		
Married		
Divorced	33.6	62.4
Widowed	23.5	19.9
Single, never married	16.1	11.7
Separated	15.6	2.5
Living with partner	10.7	2.7
Education	0.5	0.8
Less than 5 years		
5–8 years	0.8	0.5
Some high school	2.2	3.0
High school graduate	16.7	10.4
Some college	25.1	30.8
Graduate/professional training	12.8	34.1
Residential locale	5.5	8.2
Urban		
Rural	60.9	34.6
Suburban	8.5	22.1
Other	29.5	43.3
Work status	1.1	0.0
Not working		
Retired	27.8	27.2
Working full or part time	19.9	19.3
Full-time homemaker	44.0	45.9
Seeking employment	4.9	6.3
Income	3.3	1.4
< \$15,000		
\$16,000–\$25,000	42.3	21.0
\$26,000–\$50,000	24.9	22.9
\$51,000–\$75,000	21.8	35.7
\$76,000–\$125,000	4.4	11.7
Target grandchild (TGC) age	2.5	3.8
4–7 years	29.5	34.6
8–10 years	27.0	25.9
11–14 years	29.5	26.7
15–17 years	13.9	12.8

Variables	African Americans (<i>n</i> = 366)	Whites (<i>n</i> = 367)
Formal legal arrangements		
Formal custody	30.9	43.1
Foster parent	1.9	2.5
Adoption	8.5	16.1
Guardianship	33.6	25.1
Seeking legal custody	12.6	6.3
None	12.6	7.1
Relationship TGC's parent to grandmother ^a		
Son	30.3	31.6
Stepson	1.1	0.8
Daughter	66.4	65.1
Stepdaughter	1.9	2.5
Reasons for care ^b		
Abandonment	27.3	28.6
Physical or emotional abuse	21.0	33.8
Removed from parent	31.7	29.7
Parent mental health problems	21.3	38.1
Teen pregnancy	17.8	18.5
Parent substance abuse	48.9	61.9
Parent incarceration	39.9	45.2
Parent HIV/AIDS	2.2	0.8
Other health problems (not AIDS)	16.9	16.9
Parent death	7.7	5.2

Note. All table values are percentages.

^a Missing data were for family income only and was less than 10%. Mean substitution was used for imputation of family income only.

^b Respondents were asked to report any and all reasons for assuming care of the target grandchild that applied to their situation. Parental death was reported only when it was in reference to the death of the birth parent who was not biologically related to the CGM.