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The Utility of the Family Empowerment Scale With Custodial Grandmothers

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Abstract

The Family Empowerment Scale (FES) was developed specifically to assess empowerment in families with emotional disorders. Its relevance to custodial grandfamilies is reflected in the difficulties in grandchildren's social, emotional, and behavioral functioning, wherein such difficulties may be explained via either reactions to changes in their family structure or in their responses to the newly formed family unit. Utilizing 27 items derived from the 34-item version of the FES, which had represented differential levels of empowerment (family, service system, community) as indexed by one's attitudes, knowledge, and behavior, we explored the factor structure, internal consistency, construct, and convergent validity of the FES with grandparent caregivers. Three-hundred forty-three (M age = 58.45, SD = 8.22, n Caucasian = 152, n African American = 149, n Hispanic = 38) custodial grandmothers caring for grandchildren between ages 4 and 12 years completed the 27 FES items and various measures of their psychological well-being, grandchild psychological difficulties, emotional support, and parenting practices. Factor analysis revealed three factors that differed slightly from the originally proposed FES subscales: Parental Self-Efficacy/Self-Confidence, Service Activism, and Service Knowledge. Each of the factors was internally consistent, and derived factor scores were moderately interrelated, speaking to the question of convergent validity. The construct validity of these three factors was evidenced by meaningful patterns of statistically significant correlations with grandmothers' psychological well-being, grandchild psychological difficulties, emotional support, and parenting practices. These factor scores were independent of grandmother age, health, and education. These findings suggest the newly identified FES factors to be valuable in understanding empowerment among grandmother caregivers.

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Keywords

family empowerment; grandmothers; caregiving

Introduction

Empowerment as an Adaptive Characteristic

Empowerment as a construct can be understood as being derived from a *strengths perspective* on families, wherein a key goal of interventions with families reflects “creating opportunities for competencies to be learned or displayed, environmental modification, and advocacy” (Early & GlenMaye, 2000, p. 119). In the context of empowerment-based clinical work with families, professionals and families participate jointly in the process of goal setting, identifying problems to be solved and strategies by which these problems can be solved. They also jointly identify outcomes that will benefit the family associated with such problem solving (Early, 2001). Indeed, a strengths perspective reflects the identification of the family's strengths, that is, survival skills, and knowledge, resources, and skills that will enhance family functioning (Early, 2001). Although empowerment and such constructs as self-efficacy (Bandura, 1977), resilience (Rutter, 2007), or resourcefulness (e.g., Zauszniewski & Musil, 2013) are not interchangeable, these ideas may be precursors or outcomes associated with empowerment, consistent with a view that various characteristics or processes are protective regarding susceptibility to negative outcomes in individuals (Smith & Hayslip, 2012). This article explores the measurement of empowerment in a sample of grandparent caregivers, for whom being empowered is most important to their mental and physical health as well as to their ability not only to parent a grandchild but also to access needed services crucial to their own well-being as well as that of the grandchildren they are raising.

The Challenges of Grandparent Caregiving

Grandparents who raise their grandchildren face multiple challenges in doing so, wherein grandparent caregiving is usually linked to the divorce, drug use, incarceration, job loss, teenage pregnancy, or death of the adult child, as well as to the abandonment or abuse of the grandchild (Cox, 2000). These circumstances often stigmatize and isolate grandparents from needed social and emotional support, making it difficult for them to be treated equitably by social service providers (see Hayslip & Kaminski, 2005). In this respect, social policy often puts them at a disadvantage, in that they are not treated equally relative to foster parents. In addition, they may have difficulty in enrolling their grandchildren in school and in getting both medical treatment and insurance coverage for them, due to their lack of legal standing in not having legal custody or not having formerly adopted their grandchild.

Complementing the difficulties grandparent caregivers experience in accessing needed social and medical services (see Park & Greenberg, 2007; Roberto, Dolbin-MacNab, & Finney, 2008) is the role confusion and role stress many experience (see Landry-Meyer & Newman, 2004) linked to their parenting skills, where the impact of grandmothers' distress on grandchildren's adjustment is mediated by dysfunctional parenting (Smith, Palmieri, Hancock, & Richardson, 2008), significant in that many grandchildren raised by

grandparents express many emotional, behavioral, and interpersonal difficulties. Such difficulties are likely a response to changes in the structure of their families and the subsequent placement with a grandparent (see Hayslip & Kaminski, 2006; Hayslip, Shore, Henderson, & Lambert, 1998; Park & Greenberg, 2007).

Difficulties in child rearing may also pose challenges to grandparents whose parenting skills are less than adequate and/or who have not raised children for many years (Campbell & Miles, 2008; Kaminski & Murrell, 2008; Smith & Richardson, 2008). As Cox (2000) has noted, these challenges can easily overwhelm some grandparents who are ill prepared to deal with them, who have few resources, and who are largely unaccustomed to acting in a proactive manner to solve problems arising from their newly acquired parental responsibilities. Indeed, the isolation that often accompanies grandparent caregiving can easily be accompanied by a sense of powerlessness (see Cox, 2000). The stigma attached to others' views about them as either poor parents or as necessarily in need of professional assistance (see Hayslip & Glover, 2008; Hayslip et al., 2009; Hayslip, Glover, & Pollard, 2015) may also be impediments in grandparents' coping with their parental responsibilities.

Empowerment and Grandparent Caregiving

In light of the above challenges to grandparent caregivers, it is vitally important that they find a way to maintain their relationships with others as well as tend to their own physical and emotional health. In this respect, feeling *empowered* to cope with the many demands of caregiving has been demonstrated to be vital to grandparents' physical and mental health (Cox, 2000; Cox & Parsons, 1994). Indeed, the antithesis of powerlessness is empowerment, which reflects one's attitudes, values, and beliefs regarding (a) confidence in oneself and one's self-worth, (b) the ability to understand that one's experiences are not unique—that they can be shared with others, (c) knowledge and skills for critical thinking about problems to be solved and the factors contributing to them, and (d) translating these into action and decision making—developing action strategies to influence others and work toward goals important to oneself (Cox, 2000; Cox & Parsons, 1994). As pointed out by Singh et al. (1995), “empowerment has come to imply a process whereby individuals gain control over their own lives by influencing their interpersonal and social environments” (p. 85). Empowering grandparent caregivers has several advantages: It can (a) enable them to competently and compassionately parent their grandchildren, (b) help them cope with the psychosocial demands of caregiving, and (c) assist them in being able to access needed social and medical services. Rather than seeing themselves as victims, empowered grandparents are proactive in making decisions that affect them and their grandchildren and are advocates for their needs in terms of acting upon others and the community, rather than having their needs determined by external forces, for example, service providers, policy makers, and child protective services staff. In light of the demands they face as caregivers, and to the extent that empowerment reflects a *strength* that many grandparent caregivers possess in actively solving problems and accessing needed services, its assessment is important (see Early, 2001; Koren, DeChillo, & Friesen, 1992; Singh et al., 1995). Indeed, empowerment can be an effective means of overcoming barriers to accessing social and medical services for grandparent caregivers and for their grandchildren (see Carr, Gray, & Hayslip, 2012; Cox, 2000; Fruhauf & Bundy-Fazioli, 2013; Roberto et al., 2008),

consequently improving the mental health and overall functioning of such grandfamilies. In this context, it is clear that assessing empowerment is an important goal in understanding the strengths of grandparent caregivers.

Collectively, these factors not only argue for a focus on identifying the particular challenges that grandparents face but also underscore the importance of attending to what *resources* and *strengths* grandparent caregivers possess to help them cope with the demands of raising a grandchild. In these respects, Cox (2000) has highlighted the importance of developing strategies to empower grandparent caregivers, emphasizing their strengths with the intention of making them more self-reliant and proactive, and Olds (2002) identified empowerment as a salient dimension of caregiving based upon interviews with grandparents raising emotionally disturbed grandchildren. Other resources that caregiving grandparents might possess that complement empowerment include the instrumental and emotional support of others (see MacNab, Roberto, & Finney, 2013) as well as grandparents' sense of personal resilience (Hayslip & Smith, 2013) and resourcefulness (Zauszniewski & Musil, 2013) in overcoming isolation from others.

The Family Empowerment Scale (FES) and Grandparent Caregiving

As the FES (Koren et al., 1992) reflects a *strengths* perspective (Early, 2001), in the context of empowerment, it was developed specifically to assess empowerment in families with children with emotional disorders. This is relevant to custodial grandfamilies, as among them, difficulties in grandchildren's social, emotional, and behavioral functioning are not uncommon, either in reaction to the changes in their family structure or in response to the newly formed family unit (see Castillo, Henderson, & North, 2013; Fuller-Thomson & Minkler, 2000; Hayslip & Kaminski, 2006).

Despite its potential in helping to assess the strengths of grandparent caregivers, a limited amount of work with such persons has been conducted with the FES. In this respect, Whitley, Kelley, and Campos (2011, 2013) found that increased levels of empowerment (family, services, community/political) and its expression (knowledge, advocacy, and self-sufficiency) characterized participants in a community-based intervention program. However, these authors also found that FES scores (with the exception of knowledge) were not correlated with perceived family support and community resources among grandparent caregivers. Yet, McCallion, Janicki, and Kolomer (2004) found increased FES empowerment scores among grandparent caregivers participating in a support group for such persons who were raising grandchildren with developmental disabilities. These latter findings might suggest that although self-reported empowerment may be, for example, a stable personal characteristic residing within the individual, it is nevertheless amenable to influence by experience. Given the comparative lack of research dealing with the measurement of empowerment via the FES with grandparent caregivers, it is clear that there is a need for more empirical work exploring the utility of the FES with grandparents raising grandchildren.

The Development and Psychometric Adequacy of the FES

Koren et al. (1992) first reported on the psychometric adequacy of the FES. Based upon a sample of 440 birth parents whose children had emotional, behavioral, or mental disorders, these authors framed the original 34-item FES in terms of a two-dimensional framework through which empowerment can be understood reflecting *how empowerment is expressed*, that is, *knowledge* (what a parent knows and can potentially do), *attitudes* (the parent's feelings and beliefs), and *behaviors* (what parents actually do) regarding empowerment. In addition, as originally conceived, the FES was designed to reflect the multiple *levels* at which such knowledge, attitudes, and behaviors are expressed, that is, the *family* (i.e., one's immediate situation at home), the *service system* (those that provide services to one's child), and the *community/political system* (policy makers, community members, and agencies who influence the existence and delivery of services to one's child). Results published by Koren et al. (1992) suggested that the FES was both reliable (its internal consistency, test-retest reliability) and validated via high agreement between independent raters regarding the classification of items in light of the above two-dimensional framework.

Koren et al. (1992) also report that both exploratory and confirmatory factor analyses yielded a matrix of items loading on four derived factors: (1) parents' efforts to advocate for and improve services for their children, (2) parents' knowledge of and self-confidence in working with service providers and agencies, (3) self-confidence in one's parenting and ability to handle problems at home, and (4) parents' attitudes and behaviors reflecting parents' right to make decisions about their children. According to Koren et al. (1992), this factor structure paralleled the above distinctions regarding *levels* of empowerment, which were intercorrelated positively, wherein Factor 1 reflected parental empowerment via the community/political level, Factors 2 and 4 reflected family empowerment via the service system, and Factor 3 reflected empowerment via the family (confidence in one's parenting skills and in handling problems when they arise; see Koren et al., 1992). This factor structure regarding levels of empowerment was independently confirmed by Singh et al. (1995) in a sample of 228 families raising children with emotional, behavioral, or mental disorders, where congruence coefficients across the four factors in the Koren et al. (1992) and Singh et al. (1995) studies ranged from .88 to .98. In the Singh et al. (1995) study, the split-half reliability of the FES was .93.

Additional evidence for what the FES's authors label as the construct validity of the FES was obtained regarding comparisons across levels of activity regarding community, advisory, political, legal, organizational, and participatory activities as reported by the parents in the Koren et al. (1992) sample. Each of the level dimensional scores (family, community, service) differentiated parents along each of these six aspects of empowerment-related activities.

Despite Koren et al.'s (1992) contention that an important dimension of empowerment is how it is expressed (via knowledge, attitudes, and behaviors), it is important to note that the data by Koren et al. (1992) and Singh et al. (1995) failed to clearly reflect these purported distinctions between knowledge, attitudes, and behaviors. Indeed, Koren et al. (1992) state that "empirical distinctions between attitudes, knowledge, and behaviors were overshadowed by stronger differences among the levels of empowerment" (p. 314), and Singh et al. (1995)

did not explore the factor structure of attitudes, knowledge, and behaviors, only focusing on the four-factor structure obtained in their exploratory factor analysis pertaining to levels of empowerment.

The FES and Programmatic Work With Parents Raising Problematic Children

In the context of assessing parental empowerment, the FES has been used with much success in work dealing with interventions targeting parents raising a child with a variety of difficulties. Its use reflects family social work practice that emphasizes a strengths perspective (see Early, 2001; Koren et al., 1992; Singh et al., 1995, for discussions), where family competence and coping skills are assumed and promoted. From a strengths perspective, families and practitioners co-define problems to be solved and work together to develop solutions to those problems (Cleek, Wofsy, Boyd-Franklin, Mundy, & Howell, 2012; Early, 2001; Herbert, Gagnon, Rennick, & O'Loughlin, 2009; Simon, Murphy, & Smith, 2005; Smock, 2012).

In a meta-analysis of 17 intervention studies dealing with the effects of individualized education programs for culturally and linguistically diverse students, the FES was often utilized as a barometer of such participation (Griffin, 2011). Utilizing the FES as a criterion of treatment success, positive gains in FES scores were found by Lucksted et al. (2013) in a 12-session Family to Family peer support and education program for persons who had a family member with a serious mental illness. Myers, Vander, and Lobdell (2013) successfully utilized the FES to demonstrate the feasibility of a telemental health/videoconferencing to provide care usually delivered in person, targeting families raising children with attention deficit disorder. Farber and Maharaj (2005) found the FES to be sensitive to the effects of a parent education program designed for African American families raising developmentally delayed children. In parallel fashion, Weiss, Vieceili, Sloman, and Lunksy (2013) found the FES to reflect the gains for parents whose children with autism participated in social skills training, and Resendez, Quist, and Matshazi (2000) found FES knowledge scores to increase among parents over time who had participated in the Vanderbilt Family Empowerment Project. Minjaris, Mercier, Williams, and Harden (2013) found positive pre-post changes in a group therapy program for parents with autistic children. However, participation in a social worker intervention program was not associated with greater FES scores (Walsh & Lord, 2004), and FES scores failed to change over 1 year among participants in a home-based intervention program for children with autism and developmental delays (Rickards et al., 2009). In a novel use of the FES, Fischer, Sherman, Han, and Owen (2013) found positive changes in family empowerment among veterans suffering from posttraumatic stress disorder (PTSD) who participated in program REACH (Reaching Out to Educate and Assist Caring, Healthy Families).

Using the FES as a predictor of treatment efficacy, Graves and Shelton (2007) found the FES to predict positive change in children's problem behavior over a 1-year time frame in 79 families exposed to a family-system model of care, wherein family empowerment also mediated the relationship between family-centered care and children's problem behaviors. Scheel and Rieckmann (1998) utilized the FES in predicting parental self-efficacy among parents raising emotionally disturbed children, finding multiple indices of family

functioning, parental stress, employment, and education to predict FES scores. Data collected by Jivanjee, Kruzich, Friesen, and Robinson (2007) suggest that FES scores and perceptions of participation in an educational planning program for children with disabilities are interrelated; similar findings have been obtained by MacMullin, Viecili, Cappadocia, and Weiss (2010).

Using the FES to Understand the Parenting of Problematic Children

In addition to its use as a barometer of program efficacy and as a predictor/correlate of related constructs such as parental self-efficacy, the FES has also been successfully utilized as a mediating variable to understand the potential link between children's emotional and behavioral problems and parent functioning. In this respect, FES-measured empowerment mediated the relationship between child problem behaviors and parents' mental health (Weiss, Cappadocia, MacMullin, Viecili, & Lunskey, 2012; Weiss, Robinson et al., 2013), and empowerment mediated the effects of trauma on survival for women enrolled in family-based services for their emotionally disturbed children (Jager, 2003). Gerkensmeyer, Perkins, Scott, and Wu (2008) found the FES to mediate the relationship between internalizing child behaviors and parental depression, and Gerkensmeyer et al. (2011) found empowerment (as one of several indicators of secondary appraisal) to predict depression among such persons. FES scores assessing parental empowerment also predicted parents' perceptions of their autistic children's educational experiences (MacMullin et al., 2010), and Benson and Hersh (2011) found marital quality to predict parental empowerment among those raising children with autism.

Rationale for and Purpose of the Present Study

Although the above literature suggests that the FES has been extensively utilized to both understand families' ability to cope with the demands of raising a difficult child and as a criterion to assess interventions to help families cope with such challenges, its use with other groups of caregivers has been scant. Indeed, its utility with custodial grandfamilies has received little attention, whether it is used to study the impact of interventions on them, or as a mediator of the parenting practices of grandparents on their grandchildren's functioning. The importance attached to these questions is underscored by the fact that the FES reflects a strengths perspective, which frames the present article's purpose in exploring the psychometric characteristics of the FES with grandparent caregivers, for whom empowerment is a critical resource they can call upon.

Empowerment is a valuable construct enabling one to understand grandparent caregivers' efforts to cope with the many challenges of raising a grandchild. Yet, an evaluation of the FES's reliability and validity with such persons has yet to be carried out. In this context, evidence speaking to its psychometric adequacy is critical to its continued use with grandparent caregivers. In this light, the purpose of the present study was to present the psychometric characteristics (i.e., reliability and validity) of the FES in a sample of grandmother caregivers who were raising their grandchildren on a full-time basis.

Utilizing a modified 27-item version of the FES (vs. the original 34-item version, see Koren et al., 1992), we explored the internal consistency, the convergent validity, and the construct

validity of the FES with grandparent caregivers. We also explored the factor structure of the FES in this sample, wherein in studying parents of disturbed children, Koren et al. (1992) obtained four factors, which were *interpreted* as reflecting *three* levels of empowerment.

Although we had no formal hypotheses regarding the factor structure of the FES in this sample, it *might* be that the factor structure of the FES in a sample of grandparent caregivers could differ from that of Koren et al. (1992), largely due to the fact that the context in which grandparents assume their caregiving responsibilities is very different from that of parents, wherein the former take on the caregiving role in the context of largely negative events (e.g., the divorce, imprisonment, or drug use of a parent; parental abandonment; or incompetence), which are superimposed upon them. Under such circumstances, grandparent caregiving can be understood as a *countertransition* (see Hagestad, 1985).

The primary research questions here are pertinent to construct validity, where construct validity reflects

the extent to which the test may be said to measure a theoretical construct or trait . . . Each construct is developed to explain and organize observed response consistencies . . . Any data throwing light on the nature of the trait under consideration and the conditions affecting its development and manifestations represent appropriate evidence for this validation.

(Anastasi & Urbina, 1997, p. 126)

In this context we argue that, for example, to the extent that grandparental functioning, grandchild difficulties, grandchild relationship quality, or grandparent parenting skills might affect empowerment is evidence for the construct validity of the FES in this sample of grandparent caregivers. Such factors influence the *manifestation* of empowerment, that is, that some grandmothers might be more empowered than others as a function of their level of functioning, grandchild relationship quality, parenting skills, or measured grandchild difficulties.

This operational definition of construct validity is consistent with our choice of measures here (see below), and focused upon ascertaining whether FES levels scores related to either grandparent functioning (where one might expect higher FES scores to relate to more positive such functioning) as well as to both parental skill-related and grandchild-related variables. In such cases, greater empowerment might be expected to reflect greater skill in parenting grandchildren, less grandchild problem behaviors, and more positive grandchild relationship quality.

The convergent validity (a subcategory of construct validity, see Anastasi & Urbina, 1997) of the FES in this sample was explored via examining correlations among the factor scores so derived via a factor analysis of the FES data collected here. Evidence for convergent validity would reflect the existence of at least moderate relationships among such factor scores, on the assumption that each represents a dimension of empowerment.

We also explored the relationship between FES factor scores and the demographic factors of age, health, and level of education. These factors were chosen as being poorly educated,

older and/or in poorer health could easily weaken the coping skills and resources of a grandparent, underscoring the need for such grandparents to become empowered (see Cox, 2000).

Method

Sample and Procedure

The participants were 343 custodial grandmothers (CGMs) enrolled in a randomized clinical trial (RCT) designed to compare two evidence-based interventions (behavioral parent training and cognitive behavioral skills training) with each other and to a theoretically inert control condition. These interventions were designed to positively affect them personally as well as the functioning of the grandchild they were raising.

Inclusion criteria were (a) that CGMs had provided care to a custodial grandchild (CG) between the ages of 4 and 12 for at least 3 months at her home in the complete absence of the CG's birth parents, (b) that CGMs were fluent in the English language, (c) that CGMs were willing and able to attend 10 two-hour-long group sessions at a community site, and (d) that CGMs self-identified as being of either of White, Black, or Hispanic origin. The ethnically diverse nature of our sample is in contrast to that of Koren et al. (1992), whose participants were predominantly Caucasian. For demographic variables, complete data were available for between 336 and 343 CGMs (Table 1).

Sample recruitment occurred across four states (California, Maryland, Ohio, and Texas) and included diverse methods (e.g., mass media announcements; contacts through schools, social service and health agencies, courts, libraries, faith communities, and support groups; appearances at community events; brochures; and letters mailed to randomly selected households). The RCT was described to potential participants as providing "information that can help grandmothers get through the difficult job of caring for grandchildren in changing times." If a CGM was caring for multiple grandchildren who met study eligibility criteria, then a target CG was selected based on asking the CGM which child was the most difficult to provide care to. This target CG was then used as the reference for all measures described here.

Key sociodemographic and background characteristics for the CGMs and their target CGs in this study are presented in Table 1. The mean age of the grandmothers was 58.45 years ($SD = 8.22$ years) and 7.8 years ($SD = 2.6$ years) for the CGs. The age range for CGMs was 40 to 89 years. Most CGMs were either Caucasian (44%) or African American (43%), followed by Hispanic/Latino (11%), and then "Other" (1%). Only 38% of CGMs were married, with 51% being divorced or widowed. Many (44%) of the CGMs had completed some college, 19% earned their GED or high school diploma, 13% did not complete high school, 13% received bachelor's degrees, and 6% had graduate or professional degrees. Forty-four percent of CGMs were working part time, 19% were retired, 13% were unemployed/looking for work, and 13% were working full time. Each site's institutional review board (IRB) committee approved the project. In the context of interviews by graduate-level interviewers trained by the authors to competently administer the measures described below, each grandmother completed either over the phone or in person a variety of measures assessing

aspects of her psychosocial functioning and the mental health of both herself and that of the grandchild she was raising. All measures were completed by grandparent caregivers *prior to* their enrollment in one of the above evidence-based interventions or in an inert control condition.

Measures

FES—In the present study, complete data for the original 34-item FES were not available, where 12 items, based upon an a priori developed conceptual framework (see Koren et al., 1992, Figure 1) had defined Service, 12 items had defined Family, and 10 items had defined Community/Political. In the present study, we used the 12 original items defining Family, 9 of the original 12 items defining Service, and 6 of the original 10 items defining Community/Political. Pertinent to the Service and Community subscales, items that were deleted from the original FES (Table 2) were those that were felt to be least likely to realistically apply to the lives of CGMs, who are often isolated and either lack knowledge about or have difficulty accessing existing services (see Carr et al., 2012; for example, “Professionals should ask me what services I want for my child,” “I get in touch with legislators when important bills or issues concerning children are pending,” “I help other families get the services they need,” “I have a good understanding of the service system that my child is involved in”). In addition, items from the Services and Community subscales were deleted based upon their redundancy with other items that were retained here (e.g., retained items “I tell professionals what I think about services being provided to my child,” “I understand how the service system for children is organized”). To make the response options for the FES similar to those of other measures that were utilized here, all items were changed to a 4-point Likert-type scale, (vs. the original 5-point Likert-type scale) ranging from *never* to *very often* and all items were changed as appropriate to reflect “grandchild (ren)” rather than “child (ren).” Items defining empowerment were summed, and higher scores indexed greater empowerment. Although the alpha coefficient for the total FES score was .918 in the present study, in light of the comments by Koren et al. (1992) and Singh et al. (1995) placing primary importance on FES *levels scores*, such scores were our focus here.

Center for Epidemiologic Studies Depression Scale (CES-D)—The CES-D Scale is a 20-item measure originally designed to report the participant's level of depression (Radloff, 1977). In the initial report of this measure, a four-factor model was suggested, which included the subscales of well-being (reverse scored), interpersonal problems, somatic symptoms, and depression. Initial reliability estimates for the CES-D were excellent when tested on a general population sample, $\alpha = .85$, and even higher with a clinical patient sample, $\alpha = .90$. In the present sample, the CES-D yielded a reliability estimate of $\alpha = .90$. Higher total scores on the CES-D indexed greater depression/lessened well-being.

Overall Anxiety Severity and Impairment Scale (OASIS)—The OASIS (Campbell-Sills et al., 2009) was developed as a short form anxiety measure that could be used to diagnose across anxiety disorders as well as in the presence of multiple other disorders (see also Norman, Hami, Means-Christian, & Stein, 2006). Questions are asked on a 5-point Likert-type scale with low values indicating no anxiety and high values indicating constant

anxiety. The original five-item OASIS was utilized here. In the development of the OASIS, it produced a coefficient alpha of .80. In the present administration, alpha was equal to .84. Higher scores indexed greater overall anxiety.

Parent Behavior Inventory (PBI) Nurturance—The PBI (Lovejoy, Weis, O'Hare, & Rubin, 1999) is a measure composed of 10 Likert-type questions indicating the frequency with which various parenting behaviors occur. These items indicate the latent factor of Nurturance behavior and include statements such as “I hold or touch my child in an affectionate way,” “I laugh with my child about things that we both find funny,” and “I try and teach my child new things.” Higher scores on individual questions indicate greater overall nurturance behaviors. When this measure was created, it produced a coefficient alpha value of .83. When it was tested with the present sample, that value increased to .88. Higher scores indexed greater parental nurturance.

Parenting Practices Inventory (PPI)—The PPI (Lochman & Conduct Problem Prevention Research Group, 1995) is a measure consisting of 17 Likert-type items designed to assess various disciplinary styles, and originally, this included the latent factors of Consistent, Effective, and Punitive discipline. Original coefficient alphas for these subscales were .71, .70, and .69, respectively. An exploratory factor analysis was conducted on these items with the present sample of grandmothers to indicate if any alternative factor structures appeared. Three factors appeared to be the best fitting structure, but the arrangement of items appeared to group in a slightly different order than originally proposed. This new factor structure produced higher alphas overall and included the factors of Effective ($\alpha = .85$), Inconsistent ($\alpha = .76$), and Harsh ($\alpha = .71$) discipline. For purposes of the present study, higher scores indexed *more* consistent (C), *less* harsh (P), and *more* effective (E) discipline (see also Smith et al., in press).

Positive Affect Scale (PAFF)—The PAFF was derived from the Bengtson Affective Solidarity scale (Bengtson & Schrader, 1982); the PAFF assesses the perceived quality of the relationship with one's grandchild, that is, the degree to which grandparents feel trust, fairness, respect, affection, and understanding between themselves and their grandchild. The coefficient alpha for the PAFF in this sample was .87. Higher total scores index greater positive affect.

Strengths and Difficulties Questionnaire (SDQ)—The SDQ (Goodman, 2001) is a collection of items used to indicate child behavior, for the case of this analysis, as it occurs across the subscales of emotional difficulties, peer problems, hyperactivity, and conduct problems. These subscales were used to measure child behavior outcomes as they are affected by grandmother parenting style. The SDQ consisted of 25 statements speaking to the grandmother's perceptions of the positive (prosocial behavior) and problematic (hyperactivity-inattention, emotional symptoms, peer problems) attributes of the child she was raising, and in the case of grandmothers raising multiple grandchildren, the grandchild identified as the most problematic to raise. SDQ items reflect attributes generally identified as strengths (e.g., thoughtful of the feelings of others) and difficulties (e.g., fidgets, tearful) and one neutral item (e.g., relates better to adults). Items are rated along a 3-point scale from

not true (0) to *certainly true* (2), where five items are reverse scored. Total SDQ difficulty scores were utilized here, with higher scores indexing greater overall difficulty. In the present sample, the alpha for the SDQ was .73.

Short Form Survey of Health Quality of Life (SF-12)—The SF-12 (Ware, Kosinski, & Keller, 1996) is a multidimensional measure designed to assess the health-related quality of life of participants. Items in the SF-12 reflect overall ratings of health and the extent to which emotional and physical problems affect daily life and activities, including mobility and social functioning. Higher scores reflected better perceived health quality of life.

Positive and Negative Affect Scale (PANAS)—The PANAS (Watson, Clark, & Tellegen 1988) was developed to measure both the positive and negative emotions exhibited by an individual. For the purposes of this study, only the positive emotion portion of the measure was used. Examples of affective states assessed were proud, strong, active, and alert. The alpha in the present sample was .91.

Results

Data Analytic Plan

Missing data were less than 10% for all variables included in these analyses and multiple imputations were thus performed using Mplus (v. 7.11, Muthen & Muthen, 1998-2012) for all analyses, yielding a working analytic sample of 343. To explore the factor structure of the 27 FES items, we conducted an exploratory factor analysis SPSS v.21 (IBM Corp, 2012) with a forced four-factor structure and varimax rotation based on the prior findings of Koren et al. (1992). To explore the internal consistency of the FES, we computed Cronbach's alpha coefficients for each factor so derived. To explore the convergent validity of the FES here, we intercorrelated the factor scores derived from the above-mentioned exploratory factor analysis. To explore the construct validity of the FES levels scores, measures of grandparent functional/affective status (CES-D-depression, OASIS-anxiety, PANAS-positive affect, SF-12-health-related quality of life), grandchild problem behaviors (SDQ), grandparent parenting practices (PPI), parental nurturance (PBI), and grandchild relationship quality (PAFF) were each intercorrelated with FES scores. These measures used here to explore the construct validity of the FES reflect the above-cited literature utilizing the FES as a criterion of program effectiveness and that exploring the mediational role that empowerment might play in understanding the relationship between child problem behaviors and parenting practices.

Factor Structure and Internal Consistency of the FES

Because the initial exploratory factor analysis (utilizing varimax rotation having forced the extraction of four factors; paralleling the work of Koren et al., 1992) resulted in seven items that loaded across multiple factors, we then tested a three-factor model that reduced the number of cross loading items to three. The results of this analysis are summarized in Table 2, which shows how each of the 27 items loaded uniquely onto the three newly identified factors. Inspection of the nine items that loaded significantly on to Factor 1 reveals that each (e.g., "I feel I am a good parent") reflects the construct of *Parental Self-Efficacy/Self-*

Confidence as parallel to that obtained by Koren et al. (1992) In the present sample, its internal consistency was quite adequate ($\alpha = .840$).

Inspection of the items that loaded highly onto Factor 2 reveals that they are reflective of specific actions that respondents make with regard to the service system, and they are worded as such (e.g., “I make sure . . .”; “I tell . . .”; “I am able to work . . .”; “I look for . . .”). Thus, we label this factor *Service Activism* ($\alpha = .830$).

Inspection of the items that loaded highly onto Factor 3 reveals that they are reflective of knowledge or understanding of the service system (e.g., “I know the steps . . .”; “I understand how . . .”; “I know what services . . .”). Thus, we label this factor *Service Knowledge* ($\alpha = .810$). It is of note that the item “I know what to do when problems arise with my child” also loaded (.47) on Parental Self-Efficacy/Self-Confidence, though its loading on Factor 2 was substantially greater (.66).

Only three of the 27 FES items did not fit well into this factor structure. One item (“I feel that I can have a part in improving services . . .”) did not load highly onto any factor, though its loadings for two factors did exceed .30 (a criterion of .40 was utilized in this respect). The remaining two items (“I am able to get information to help me better understand my child” and “When dealing with my child I focus on the good things as well as the problems”) loaded highly onto two factors simultaneously. Thus, to an extent, though they did not load *uniquely* on any factor, for the most part, they nevertheless did map onto the three factors we obtained here, that is, they were not independent of such factors. In light of this pattern of loadings for these three items, they were retained in computing factor scores that were utilized in exploring the convergent and construct validity of the FES with grandparent caregivers.

Convergent Validity of the FES

To examine the convergent validity of these three factors, we performed zero-order correlational analyses of the factor scores (Table 3). As expected, the three FES factors correlated at least moderately, yet positively with each other, accounting for at best 34% of the shared variance among them, based upon the fact that correlations between the factors defined by our set of 27 of items ranged from .53 to .58 (Table 3). Thus, higher Parental Self-Efficacy/Self-Confidence (Factor 1—a belief in one's adequacy as a parent, having the requisite skills to be an effective parent) is accompanied by both greater Service Activism (Factor 2—being proactive in accessing services and working with service providers) and greater Service Knowledge (Factor 3—being knowledgeable about available services for a grandchild and how to access such services).

Construct Validity of the FES

As hypothesized, and relevant to the construct validity of the FES (Table 3), each factor was also inversely related to indices of grandmothers psychological distress, the use of dysfunctional parenting, and grandchildren's psychological difficulties. All these relationships were statistically significant, except that the activism factor was not related significantly to grandmothers' depression and anxiety or to grandchildren's psychological difficulties. Also as hypothesized, and again relevant to the construct validity of the FES, we

found that all three factors were related positively and significantly to grandmothers' positive affect and their perceived emotional support.

Contrary to our expectations, grandmothers' age, self-rated health, or education were not related significantly to any of the three factors. Although we did not predict this pattern of relationships, it might constitute evidence for the discriminant validity of the FES (see Anastasi & Urbina, 1997).

At a descriptive level (Table 3), mean scores (scaled from 0 to 4) for our Parental Self-Efficacy/Self-Confidence ($M = 3.2$) and Service Activism ($M = 3.4$) factors were considerably higher than the mean Service Knowledge score ($M = 2.6$).

Discussion

The Factor Structure of the FES With Grandparent Caregivers

We derived three internally consistent factors from the data, where such factors were defined as Parental Self-Efficacy/Self-Confidence, Service Activism, and Service Knowledge. While Parental Self-Efficacy/Self-Confidence most closely parallels the family empowerment factor found by Koren et al. (1992) in their study of parents, the Service Activism and Service Knowledge factors obtained here are unique to this sample of grandparent caregivers, especially so regarding the empowerment via the community/political level and, to an extent, via what parents know and do regarding the service system. Parental Self-Efficacy/Self-Confidence (Factor 1) reflects a belief in one's adequacy as a parent, and in having the requisite skills to be an effective parent. Service Activism (Factor 2) reflects being proactive in accessing services and working with service providers, Service Knowledge (Factor 3) reflects being knowledgeable about available services for a grandchild and how to access such services.

That Parental Self-Efficacy/Self-Confidence transcends work with both parents and grandparent caregivers reflects the universality of beliefs about one's effectiveness as a parent figure (see, for example, Etaugh & Folger, 1998; Gettinger & Guetschow, 1998; Holden & Buck, 2002; Smith & Richardson, 2008). Similarly, the service factor obtained by Koren et al. (1992) that reflects what parents believe, know, and do regarding effecting the service system bears some similarity to the Service Knowledge and Service Activism factors found here. This is especially salient given grandparent caregivers' reliance on formal and informal social and medical services for themselves and their grandchildren as well as their needs for social support (Dolbin-MacNab, Roberto, & Finney, 2013; Kolomer, Himmelheber, & Murray, 2013; Park & Greenberg, 2007; Roberto et al., 2008).

That a community factor was absent in the present analysis could reflect the omission of items from the original 34-item version of the FES that would have defined a community factor, as obtained by Koren et al. (1992). The absence of a community factor here could also however reflect many grandparent caregivers' isolation from others via the felt stigma attached to their effectiveness as parents (Hayslip & Glover, 2008) and their lack of involvement in the community at large; many are consumed with simply raising their

grandchildren and meeting their own and their grandchildren's medical and nutritional needs on a daily basis (Hayslip, 2010).

Thus, in this sample of grandparent caregivers, we were able to in part, replicate the factor structure of the FES based upon work with parents raising problematic children. That such parallels in the factor structure of the FES would exist across independent and diverse samples of caregivers in work separated by nearly three decades attests to the salience of family empowerment as an adaptive construct in understanding the challenges in raising children with medical, social, and behavioral difficulties.

The correlations among the above-derived factors suggest that the three factors that we identified, each reflecting a distinct dimension of empowerment, are indeed interrelated. This constitutes evidence for the convergent validity (see Anastasi & Urbina, 1997) of the FES in this sample of grandparent caregivers. Nevertheless, as noted above (Table 3), they only accounted for, at best, 34% of the shared variance in one another, based upon the intercorrelations among the derived factors. In this respect, Koren et al. (1992) reached a similar conclusion regarding the extent to which each of the FES scales was assessing something unique regarding empowerment.

Construct Validity of the FES With Grandparent Caregivers

We found ample evidence for the construct validity (see Anastasi & Urbina, 1997) of the three factors that we identified, based upon the factor scores derived from a factor analysis of the 27 items that we administered to our sample of grandmother caregivers. Several noteworthy trends were observed along these lines. For instance, the findings presented in Table 3 reveal that magnitude of the correlations between the three factors and the other variables examined were consistently the highest for the Parental Self-Efficacy/Self-Confidence factor. This is consistent with the widespread belief within the stress and coping literature that perceived self-efficacy is a major coping resource for dealing with life stressors (Thoits, 2010). It is also worth noting that grandmothers' positive affect was more strongly correlated with the three FES factors than were the indices of grandmothers' psychological distress. This reinforces the belief that positive affect and coping act reciprocally such that positive affect might beneficially influence coping and stress reactions and conversely and that good coping can generate positive affect (Lazarus, 2000; Pearlin, Mullan, Semple, & Skaff, 1990). Grandparents who are more empowered may therefore be more effective in parenting their grandchildren, indeed feel more confident in doing so, and such confident and efficacious parenting may result in greater personal well-being and improved relationships with one's grandchild.

A similar argument could be made with respect to the positive relationships that we observed in the present study between grandmothers' perceived emotional support and all three FES factors, given the prominent role of social support in promoting the well-being of CGMs and their grandchildren (Dolbin-MacNab et al., 2013; Ramaswamy, Bhavnagri, & Barton, 2008). The statistically significant inverse relationships that we observed for dysfunctional parenting and grandchildren's psychological difficulty with all three of our identified FES factors can also be understood from a stress and coping perspective. For instance, Smith, Cichy, and Montoro-Rodriguez (2015) recently reported evidence that the use of positive

quantifiable criterion of program success/treatment outcome variable (see Cox, 2000) is in order. Reflecting the above-cited literature with the FES, it may be that empowerment moderates the impact of such interventions, with the likelihood of more positive outcomes varying by whether grandparents report greater or lesser degrees of personal empowerment.

In light of the correlational nature of the present data, it may be that more adequate personal functioning, as well as both more effective parenting practices and more adequate rated grandchild functioning *stem from* more empowerment at both the family, service system, or community levels. Alternatively, greater empowerment may *result from* enhanced personal functioning or more effective parenting. Thus, future research might evaluate the potentially causal nature of these relationships utilizing longitudinally based structural equation modeling techniques.

Given the face validity of the FES items regarding their similarity to those indexing self-efficacy, it may also be that interventions that enhance empowerment may also positively affect grandmothers' sense of personal and parental self-efficacy (see Cox, 2000). This enhanced self-efficacy is important in that their age peers may in fact perceive them to be less efficacious in these respects (see Hayslip & Glover, 2008; Hayslip et al., 2015). Alternatively, interventions targeting grandparents' parenting skills per se (see Campbell & Miles, 2008; Smith & Richardson, 2008) may enhance their sense of personal empowerment.

Based upon these findings, there are many directions for research and practice of an interventive nature for which the FES might be quite useful, either as a predictor of which grandparent caregivers are likely to benefit from participating in formal interventions to aid in their adjustment to caregiving demands, or even as a predictor of the effects of participation in support groups. In this respect, based upon the FES, those who are the least empowered might be considered at risk of (a) experiencing the most negative personal, social, and health-related impact of parenting difficult grandchildren; (b) having the most difficulty in accessing needed services for themselves and their grandchildren; or (c) responding with depression to the challenges of raising a grandchild. In addition, and consistent with the above literature, the FES would likely be valuable as an outcome variable in studying many types of interventions with grandparent caregivers.

Overall, these findings suggest our adaptation of the FES to be valuable in understanding empowerment among grandmother caregivers in the face of the many personal and parental challenges they face in raising a grandchild. When working with grandparent caregivers, we recommend utilizing the present 27-item version of the FES, to include those items that cross-loaded on more than one factor. In assessing such persons with the FES, important information can be gained regarding how a given grandparent approaches the task of parenting as well as the extent to which a grandparent is likely to be both knowledgeable and proactive in accessing needed social, medical, or legal services.

Although the present findings in many respects parallel much of the above-cited work based upon parents raising emotionally disturbed children, they are especially salient with regard to empowerment's relationship to grandparent caregiver mental health and parenting

practices. As being empowered is a strength that grandparent caregivers can call upon in the face of the caregiving challenges that confront them, being able (a) to understand the nature of measured empowerment, (b) to understand its relationship with key grandparent caregiving characteristics, and (c) to measure empowerment reliably are of utmost importance.

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Table 1

Sample Demographic Information.

Characteristic	<i>M</i> or <i>n</i>	<i>SD</i> or %
Age (grandmother, <i>n</i> = 336)	58.45	8.22
Age (grandchild, <i>n</i> = 343)	7.81	2.56
Years caring for child (<i>n</i> = 343)	5.21	3.21
Number of children in care (<i>n</i> = 343)	1.78	1.03
Child gender (<i>n</i> = 343)		
Male	175	51
Female	168	49
Ethnicity (grandmother, <i>n</i> = 343)		
Caucasian	152	44.3
African American	149	43.4
Hispanic/Latino	38	11.1
Other	4	1.2
Education (<i>n</i> = 343)		
Less than high school	46	13.4
High school graduate or GED	64	18.7
Some college	152	44.3
Bachelor's degree	44	12.8
Graduate or professional degree	21	6.1
Missing	16	4.7
Family income (<i>n</i> = 343)		
Below US\$15,000	64	18.7
US\$15,000 to US\$30,000	73	21.3
US\$30,000 to US\$45,000	52	15.2
US\$45,000 to US\$60,000	38	11.1
US\$60,000 to US\$75,000	17	5
US\$75,000 or more	42	12.2
Missing	57	16.6
Relation to grandchild (<i>n</i> = 343)		
Child of son	107	31.1
Child of daughter	184	53.4
Child of step son	5	1.5
Child of step daughter	10	2.9
Child of grandchild	13	3.8
Offspring of non-biological child	9	2.6
Caring for grandchild but no relationship specification	15	4.4
Reason for care (<i>n</i> = 343)		
Drug abuse	162	47.2
Parent in jail	132	38.5
Parent mental illness	97	28.3

Characteristic	<i>M</i> or <i>n</i>	<i>SD</i> or %
Parent physical illness	14	4.1
Death of parent	35	10.2
Teenage pregnancy	26	7.6
Divorce	10	2.9
Parent unwilling to care for child	80	23.3
Other	43	12.5

Note. GED = General Equivalency Diploma.

Table 2

Results of the Exploratory Factor Analysis of the FES.

FES items ^a	Factors		
	1 ^b	2 ^c	3 ^d
When problems arise with my child, I handle them pretty well	.68	.16	.09
I feel confident in my ability to help my child	.67	.12	.14
I know what to do when problems arise with my child	.66	.04	.47
I feel my family life is under control	.61	.06	.33
I believe I can solve problems with my child when they happen	.62	.23	.25
When faced with a problem involving my child, I decide what to do and then do it	.46	.31	.24
I have a good understanding of my child's behavior	.67	.21	.23
I feel I am a good parent	.63	.26	.01
I am able to make good decisions about what services my child needs	.43	.31	.38
I feel that I have a right to be informed of all services available and approve of all services my child receives	.01	.51	-.02
I make sure that professionals understand my opinions about my child's needs	.31	.44	.26
I am able to work with agencies and professionals to decide what services my child needs	.18	.64	.24
I make sure I stay in regular contact with professionals who are providing services to my child	.15	.70	.21
I believe that parents and I can have an influence on services for children	.21	.61	.05
I tell professionals what I think about services for being provided to my child	.00	.63	.38
I feel that my knowledge and experience as a parent can be used to improve services for children and families	.34	.49	.22
I make efforts to learn new ways to help my child grow and develop	.36	.55	.15
When necessary I look for services for my child and family	.21	.62	.23
I know the steps to take when I am concerned my child is receiving poor services	.24	.17	.61
I understand how the intervention system is organized	.22	.03	.69
I know what services my child needs	.35	.19	.59
I know what the rights of parents and children are under special education laws	.08	.10	.75
When I need help with problems in my family, I am to ask for help from others	.19	.28	.51
I understand how to access community services for my child	.07	.23	.77
I feel that I can have a part in improving services for children in my community ^e	.31	.38	.11
I am able to get information to help me better understand my child ^e	.25	.49	.52
When dealing with my child I focus on the good things as well as the problems ^e	.53	.51	-.03

Note. "Professionals should ask me what services I want for my child," "I get in touch with legislators when important bills or issues concerning children are pending," "I help other families get the services they need," "I have a good understanding of the service system that my child is involved in," "I tell professionals what I think about services being provided to my child," "I understand how the service system for children is organized," "My opinion is just as important as professionals' opinions in deciding what my child needs." FES = Family Empowerment Scale.

^aOriginal FES items (7) not utilized here. Boldface loadings define (.40 or above) each factor.

^bSelf-Efficacy.

^cService Activism.

^dService Knowledge.

^eItems not loading *uniquely* on any factor.

Table 3Zero-Order Correlations and Descriptive Data ($Ns = 343$).

Variable	Factor 1	Factor 2	Factor 3	<i>M</i>	<i>SD</i>
F1: FES self-efficacy	—	—	—	3.2	0.6
F2: FES activism	.58**	—	—	3.4	0.5
F3: FES knowledge	.56**	.53**	—	2.6	0.9
GM anxiety	-.24**	-.03	-.12*	4.3	4.2
GM depression	-.27**	-.05	-.18**	14.2	12.0
GM positive affect	.45**	.26**	.31**	32.5	7.7
CG psychological difficulties	-.44**	-.04	-.18**	14.2	7.6
Inconsistent parenting	-.28**	-.26**	-.11*	8.1	4.0
Harsh parenting	-.49**	-.22**	-.21**	7.0	3.1
Ineffective parenting	-.44**	-.23**	-.19**	4.1	3.6
Emotional support	.33**	.24**	.28**	18.1	4.3
GM age ^a	-.06	-.08	.04	58.5	8.2
GM health	.06	-.04	-.01	2.0	1.0
GM education	.04	.05	.08	1.8	1.1

Note. FES = Family Empowerment Scale; CG = custodial grandchild; GM = grandmother.

*
 $p < .05$.

**
 $p < .001$.

^a
 $N = 336$.