Grandmothers Count: The Silent Contributions of Grandmothers in Promoting Child Development

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ABSTRACT

Grandmothers are in a unique position to promote grandchildren’s nutrition, health, development and safety—indirectly by emotional and instrumental support of the grandchild’s parent, and directly by raising the grandchild. Ten percent of the child population in the U.S. live with a grandparent. In a survey design with a sample of convenience, this study described 155 diverse grandmothers in three grandmother family profiles: multigenerational families (10.5%); grandmother caregivers (16.2%); and involved non-residential grandmothers (73.3%). To access these grandmothers, we reached out to churches in central North Carolina. More than three out of four grandmothers saw their children at least weekly, 43.4% daily. The survey identified both the challenges e.g. food insecurity (11.5%), housing insecurity (17.4%), and the opportunities e.g. providing childcare (70.8%) to promote positive health and development of their grandchildren. The study described the roles grandmothers play in the lives of families—activities, advice offered, skills taught, and efforts grandmothers made to keep their grand-children safe. The survey also explored grandmothers’ worries and needs e.g. food and housing insecurity, respite care, and wanted information e.g. parent trainings. Grandmothers were asked about their social supports, informal e.g. family, friends, neighbors, formal supports e.g. church, community groups, and instrumental social support e.g. help with food, clothing, housing, transportation, child care, sick care. We compared the experiences of African American, Black (26.7%) and European American, White (69.3%) grandmothers.
I. ABSTRACT

Grandmothers are in a unique position to promote grandchildren’s nutrition, health, development and safety—indirectly by emotional and instrumental support of the grandchild’s parent, and directly by raising the grandchild. Ten percent of the child population in the U.S. live with a grandparent. In a survey design with a sample of convenience, this study described 155 diverse grandmothers in three grandmother family profiles: multigenerational families (10.5%); grandmother caregivers (16.2%); and involved non-residential grandmothers (73.3%). To access these grandmothers, we reached out to churches in central North Carolina. More than three out of four grandmothers saw their children at least weekly, 43.4% daily. The survey identified both the challenges e.g. food insecurity (11.5%), housing insecurity (17.4%), and the opportunities e.g. providing childcare (70.8%) to promote positive health and development of their grandchildren. The study described the roles grandmothers play in the lives of families—activities, advice offered, skills taught, and efforts grandmothers made to keep their grandchildren safe. The survey also explored grandmothers’ worries and needs e.g. food and housing insecurity, respite care, and wanted information e.g. parent trainings. Grandmothers were asked about their social supports, informal e.g. family, friends, neighbors, formal supports e.g. church, community groups, and instrumental social support e.g. help with food, clothing, housing, transportation, child care, sick care. We compared the experiences of African American, Black (26.7%) and European American, White (69.3%) grandmothers. Black grandmothers were more likely to be single, not have the child’s parent living in the home, have a child in the child welfare system, and were twice as likely to be a primary caregiver, yet, they did not report higher levels of stress or poor health, than the White grandmothers. Even though all of the grandmothers actively provided for the needs of the family, they did so at a cost. Although within one standard deviation of the comparison sample, all five health indicators—physical, social, self-esteem, general and perceived health of the grandmothers trended towards poorer health when compared to her community peers. This pattern also held true of all four indicators of dysfunction—anxiety, depression, anxiety-depression, and pain.

II. INTRODUCTION

The Grandmother Hypothesis argues that it is the contribution of grandmothers to the survival of children, and thus the species, that allows humans to enjoy a long life (Herndon, 2009). Although it is recognized that “grandmothers play a critical role in family and community life in societies all around the world, especially in caring for young children and advising and educating younger women on all aspects of family well-being” (Aubel, 2014, p. 7), the contribution of grandmothers in American society is mostly silent. The PEW Research Center (Livingston, 2013) reports that “in 2011, 7.7 million children in the U.S.—one-in-ten—were living with a grandparent, and approximately 3 million of these children were also being cared for primarily by that

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grandparent” (p. 1). These numbers increased sharply from 2007 through 2009 during the financial crisis, and, yet, did not decrease during the recovery. Moreover, 71% of the 7.7 million grandchildren, are living in the grandparents’ home (Livingston). Young mothers moved home with their children and they stayed.

Developmental Psychopathology (Cicchetti & Rogosch, 1996) theorizes that children raised with multiple adversities, are at risk for mental illness, substance abuse and other poor outcomes; whereas, protective factors can alter a negative trajectory to one of health and wellbeing. Children need ‘expected’ inputs such as secure attachments, language, affection, comforting, and continuity (Sroufe, Egeland, Carlson & Collins, 2009), and protection from toxicity e.g. abandonment, maltreatment, coercive parenting. Barnett, Scaramella, Neppl, Ontai & Conger (2010) in a study of grandmothers as a protective factor, concluded that the more grandmothers of preschool children were involved, the better emotional regulation and social competence of the grandchildren. Emotion regulation is salient to mental health (Jones, Greenberg, & Crowley, 2015). Musil, Warner, Zauszniewski, Wykle and Standing’s 2009’s longitudinal study of U.S. grandmothers, found that self-regulatory efficacy and social support were important for the health and well being of grandchildren and also their grandmothers. Luthar (2006), in a synthesis of the resilience research over five decades, states that: “grandparents often provide substantial support directly to their grandchildren: in fact, they are sometimes more willing to offer support to their grandchildren than their own children, such as when the latter have drug problems” (p. 757). Grandmothers are in a unique position to effect grandchildren’s nutrition, health, development and safety—indirectly by emotional and instrumental support of the grandchild’s parent, and directly by raising the grandchild. Moreover, Hayslip, Blumenthal & Garner (2014) in a longitudinal study of grandparent caregivers, found that child emotional, social and behavioral difficulties predicted elevated grandparents’ distress—but not the reverse. This offers an argument for teaching grandparents parenting and family management skills. In the pioneer World Vision international report, The Grandmother Project of non-Western societies, Aubel (2014) argues that grandmothers can be empowered to play positive roles in the family through purposeful building of social-support, knowledge and practical skills.

III. BACKGROUND

3.1 Grandmother families

The PEW Research Center (Livingston, 2013) described three profiles of grandparent families, as: 1) grandparent co-resider (a grandparent residing with her grandchildren and the grandchild’s parent—in the grandparents’ home or the home of the parent); 2) grandparent caregiver (children living with a grandparent that is responsible for most of a minor grandchild’s basic needs—the grandchild’s parent may or may not be dependent, also, on the grandparent) and 3) non-residential grandparent (families where the grandparent is involved but does not live in the same home). An alternative organization of grandmother family profiles divides grandparent co-residers into two groups: (1) multigenerational families—where the grandparent lives with both the grandchild and the child’s parent—but not responsible for basic needs; and (2) grandparent caregiver—where she is responsible.

3.2 Multigenerational families

Grandparent family profiles are not similar across ethnic and economic groups in the U.S. The majority of grandparent co-residers are non-White families: 15% Black, 15% Asian, 13% Latinos, and only 7% White (Livingston). Grandparent co-residers families have become more prevalent over the last decade (Hayslip & Kaminski, 2005) during the financial crisis. Young families where the adult children grandchildren moved back home—and stayed (Livingston, 2013) where described by the US Census Bureau (October 2014):
Grandparents who lived with a grandchild in 2012 were younger, had lower levels of education and were more likely to be in poverty than those who did not live with a grandchild.

Two percent of grandparents who lived with a grandchild were age 30 to 39, while the highest percentage was for those age 50 to 59 (34 percent). Those age 80 and over made up only 4 percent.

Women comprised 64.2 percent of grandparents who lived with their grandchildren.

Forty-nine percent of children in grandparent-maintained households lived with both grandparents compared with only 19 percent of children in parent-maintained households.

Since 2007, about one-third of children who lived with a grandparent also had two parents present.

The percentages of children who were uninsured were not statistically different when looking at whether or not the child lived with a grandparent. However, those who did live with a grandparent were more likely to have public insurance.

3.3 Grandparent caregivers

Grandparent caregivers and their grandchildren (approximately three of the 7.7 million children living with a grandparent), have multiple risks—in 52% of these families, the child’s parent is also dependent on the grandmother, they are poorer (28% Vs 17% live below the poverty line), less educated (grandmothers lack a high-school education in 26% of the families), younger (68% of grandparents are under the age of 60 and, of the grandchildren, 14% are under six years-old compared to grandparent co-resider families. Saxena and Brotherson (2013) identified that the most common reasons that grandparents become primary parents of their grandchildren include parent substance abuse, parental mental illness, child maltreatment, parent incarceration, teenage parent, parent poor physical health or death, unstable home life, homelessness, poverty, lack of general ability, domestic violence, divorce, and military deployment. Generations United (Lent, 2016) argues that the five percent increase of grandparent caregivers from 2008 to 2014, occurred in response to the opioid epidemic in the U.S. Moreover, the federal government financially incentivizes public child welfare systems, when removing unsafe children, to place them with a relative. “Grandmothers and grandfathers often are the first — and best — choice when state and local caseworkers have to take a child out of a home and find someone else to take custody” (Wiltz, 2016, n.p.). However, according to Lent (2016), deputy executive director of Generations United, a Washington, D.C.-based family research and advocacy group: “for every child in foster care who has been placed with a relative, another 20 children are being raised by relatives outside the system” (p.2).

Furthermore according to PEW’s 2013 report (Livingston, 2013), the likelihood that a grandparent co-resider (multigenerational family) will also be the primary caregiver, varies notably by race and ethnicity. Grandmother caregivers, those responsible for the primary needs of their grandchildren, are twice as likely to be Black (8%) compared to White (3%) (Livingston). About half (49%) of Black co-resident grandparents are also the grandparent caregiver. The share is also quite high—42%—among White grandparents. Among Latino co-resident grandparents, the share drops to 31%, and just 15% of Asian co-resident grandparents are the primary caregiver for their grandchild. Moreover in Black families, there is a lower rate of the grandchild’s parent also living in the grandmother’s home (51%) compared to Whites (61%), Hispanics (66%), and Asians (84%). Black grandmothers are the most likely to be parenting alone.

3.4 Child development and grandmothers

Children exposed to maltreatment, poverty, and other risks can be set on a negative developmental trajectory toward poor emotional, social, behavioral ( Cicchetti & Valentino), and health outcomes (Felitti et al., 1998). It is the...
accumulation of risks that can overwhelm the developing child (Sroufe, Egeland, Carlson & Collins, 2009). The children who are raised by grandparent caregivers have multiple risks for poor development outcomes (Livingston, 2013): 44% of the parents gave birth as a teen, compared to 18%; 31% of the parents are under the age of 25.9, compared to only 5%; 77% of parents in households with grandparent caregivers were unmarried, compared to just 31%; and 29% of parents living in a household with a grandparent caregiver lack a high school diploma, compared with 18% of children raised in other family profiles. Moreover, one-fifth (21%) of parents living with a grandparent caregiver are unemployed, compared to 10%; and 12% of parents in households that include a grandparent caregiver report that they have a serious disability, compared to only 8% among parents of households with minor children and no grandparent caregiver.

Grandmothers are in a pivotal role to provide safe, stable and nurturing relationships for high-risk children. Grandmothers as a protective factor has been supported in numerous longitudinal studies (Barnett, et al., 2010; Werner, 2000; Furber & Egeland, 1987; Furstenberg, Brooks-Gunn, & Morgan, 1987). Grandmothers can potentially modify a grandchild’s life trajectory (Rutter, 2006; Afifi et al., 2008), including health (Felitti, et al., 1998), and brain development (Luby et al., 2013)—improving children’s lifelong health and wellbeing.

### 3.5 Grandmother’s needs

Hayslip and Kaminski (2005) argue that social support is the most salient need of custodial grandmothers. The reality of having adult children move back home, or choosing to take primary responsibility for grandchildren, sets a grandmother on a different path than her peer group. Most senior women have the time and resources to socialize, and participate in church or other community groups; whereas, a sole provider of young children are focused on parental tasks. Social support is critical to positive coping—both emotionally (caring friends and family), and instrumentally e.g. respite care (Minkler, Fuller-Thomson, Miller & Driver, 1997). The negative effects of isolation can be exacerbated when caring for grandchildren with emotional, behavioral or learning problems (Hayslip, et al., 2014). Rural grandmothers are at an additional risk for poor social support. Outside of social support, grandmothers taking on parental responsibilities may need more financial resources. Additionally, they may need specialized parent training when caring for grandchildren with disabilities, behavior problems, learning difficulties or mental illness. According to Musil and colleagues (2009), successful grandmothers are resourceful:

We found that resourcefulness was a significant predictor of mental health in all three groups of grandmothers and in the total sample. Grandmothers who were more resourceful in performing daily activities despite disruption or adversity (redressive self control), in adopting new and more effective methods for managing daily activities or coping with adversity (reformative self control), and in maintaining a belief in their coping effectiveness (perceived self efficacy) reported fewer depressive symptoms. Given this, interventions to bolster resourcefulness may be beneficial. (Musil, et al, 2009, p. 404).

### 3.6 Augmenting self-efficacy

Boosting self-efficacy in grandparenting and family management requires competent knowledge, skills, and support. Not all parents and grandparents are educated, or have been lucky enough to have had modeled effective parenting as a child. Moreover, children who have experienced the loss of a parent due to death, incarceration, child maltreatment or other risks to their development, may need grandparents skilled in parenting children with emotional and behavioral problems. Interventions are currently being scientifically tested in Australia to support grandmother caregivers (Kirby, 2015). An example of one emerging program, is...
Grandparent Triple P Positive Parenting. GPTP focus on grandmother caregivers—a six two-hour weekly group sessions and three individualized phone calls (Leung, Sanders, Fung & Kirby, 2014). The evidence-based parenting program, GPTP, provides a refresher course in parenting, improves relationships between grandparents and parents, and teaches coping strategies to manage stress that can arise from the grandparent role. GPTP is in the suite of Triple P Positive Parenting Programs. TP is the most extensively researched parenting program in the world; effective at improving parent self-efficacy, child emotional and behavioral problems and family management (TripleP.net).

3.7 Non-Western Grandmothers

Aubel (2014), with the Christian NGO, World Vision International, explored the roles of grandmothers in non-Western societies and noted that “Grandmothers are highly respected within most non-Western cultures” (p. 6); a perspective that Western societies could learn from. Aubel identifies seven core roles of grandmothers in non-Western cultures that include: Advising and guiding parents, transmitting religious values, supporting young mothers in child care and upbringing, promoting family health (including home treatments for illnesses of children), advising male family members on the wellbeing of women and children, advising pregnant and postpartum women, and providing support to women and children within the family and the neighborhood. Based on the core grandmother roles, Aubel’s project created a toolkit to improve child nutrition, health and development (CNHD) in communities of poverty throughout Africa, Asia, India, Latin America and the Pacific.

3.8 Aims and Objectives

Using a survey design and a sample of convenience, this study described 155 diverse grandmothers in three grandmother family profiles. Our aim was to identify the challenges and opportunities of grandmothers in their efforts to promote positive health and development of their grandchildren. The first priority was to learn more about the roles grandmothers play in the lives of families—what activities they participated in, what advice they offered, what skills they taught and what efforts they made to keep their grandchildren safe. The second objective was to explore the grandmothers’ worries and needs e.g. food and housing insecurity, respite care, and wanted information. Thirdly, we asked grandmothers about their social supports, informal e.g. family, friends, neighbors, formal supports e.g. church, community groups, and instrumental social support e.g. help with food, clothing, housing, transportation, child care, sick care. A fourth objective was to compare the experiences of African American (Black) and European American (White) grandmothers. To access these grandmothers, we reached out to churches in North Carolina. We also posted the survey online in an effort to reach non-residential grandparents. Lastly, using standardized scales, we explored the relationships of diverse grandmothers and their perceived health, social support, and child behavior problems.

IV. METHODS

4.1 Grandmothers

The 155 grandmothers represented three family profiles: multigenerational families (a grandparent living with her grandchildren and the grandchild’s parent, 10.5%; 2) grandparent caregiver (children living with a grandparent that is responsible for most of a minor grandchild’s basic needs—the grandchild’s parent may also be dependent on the grandparent), 16.2%; and 3) non-residential grandparent (families where the grandparent is involved but does not live in the same home), 73%.
The grandmothers reported their race/ethnicity as: African American 26.7%; Caucasian American 69.3%; Hispanic American 1%; and Asian American 3%. Thirty-four percent of the respondents did not report their ethnicity. The sample was drawn from two sources: in-person (n=98); and online (n=57). The in-person sample were Christian church attendees. We reached out to 17 Christian churches—a cross-section of North Carolina; 14 churches allowed us access to the grandmothers. In eight of the churches, we invited grandmothers to complete the survey directly after the service. Two of the churches invited us to a church sponsored social event. At the request of the grandmothers, about 10% of the surveys were read out loud. Additionally, three mega Christian churches, in predominantly White neighborhoods, distributed the survey electronically in their monthly newsletter. We also sent out a survey-link to a small Christian college in Buffalo NY, inviting undergraduate students to forward the link to their grandmothers.

4.2 Measures

The questionnaire was written by the researchers based on published literature. An initial version of the survey was focus-grouped with 18 Black grandmothers. The grandmothers suggested that: (1) we cut the length of the survey in half; (2) we eliminate two standardized scales that the focus group members found confusing, and (3) we change the wording of a few items to be more sensitive to the Black population. Based on this input, we modified the survey, accordingly. The final survey included four types of questions. First, demographic questions were used to gather information about the age and sex of grandchildren, family profile, status of grandchild in child welfare system, if the grandchild’s mother was a teenager, grandmothers’ marital status, food and housing insecurity. The second set of questions covered the grandmothers’ roles in the family e.g. advice given, skills taught, activities done, strategies to keep the children safe. The third section was standardized scales: Duke-UNC Functional Social Support Questionnaire (FSSQ);
Duke Health Profile (The DUKE); Perceived Stress Scale; and Child Adjustment and Parent Efficacy Scale (CAPES). A fourth section of non-standardized items were included to assess the grandmothers’ management of her and her grandchild’s health conditions. There was no variability in the health management responses, and thus it was not included in the results section of this paper.

Duke-UNC Functional Social Support Questionnaire (FSSQ). Duke-UNC FSSQ was used to assess the grandmothers perceived social support, in general, and available help from friends and family. The FSSQ is an eight-item, self-administered, multidimensional, functional social support questionnaire developed by Broadhead, Gehlbach, De Gruy & Kaplan (1988). Construct validity, concurrent validity, and discriminant validity were demonstrated for the two scales: Confidant support—five items that measure “primarily a confidant relationship where important matters in life are discussed and shared” (p. 715) and Affective support—three items that measure emotional forms of support or caring. The Pearson’s product moment correlations for Confidant Support and Affective Support are 0.62 and 0.64, respectively. Unfortunately, the FSSQ was assessed on a Caucasian population and be interpreted with caution. Based on the suggestions of López and Cooper (2011), we added an additional three items to reflect the instrumental needs of grandmothers: Assistance with transportation; Assistance with cooking or household tasks; and Help caring for a child. Higher scores on the FSSQ mean more perceived social support. We do not have a community sample to compare our scores against.

Duke Health Profile (The DUKE). The DUKE was used in this study to assess the grandmothers’ perceived physical, mental, social and overall health. The DUKE is a brief 17 item, self-administered multi-dimensional questionnaire of six health measures (physical, mental, social, general, perceived health, and self-esteem), and four dysfunction measures (anxiety, depression, pain, and disability). Parkerson, Broadhead & Tse (1990) report that the DUKE has “Cronbach's alphas (0.55 to 0.78) and test-retest correlations (0.30 to 0.78). Convergent and discriminant validity were demonstrated by score correlations between the DUKE and the Sickness Impact Profile, the Tennessee Self-Concept Scale, and the Zung Self-Rating Depression Scale” (p. 1056). The subscales of health are calculated so that scores range from 0 to 100; the higher the score the better the perceived health.

Perceived Stress Scale. The PSS (Cohen, Kamarck & Mermelstein, 1983) was used to measure both perceived stress (cognitively mediated events) and self-efficacy—belief in one’s efficacy to face stress (Bandura, 1977). The PSS is the “most widely used psychological instrument for measuring the perception of stress” and the “unpredictable, uncontrollable and overloaded respondents find their lives” (Cohen, 1994, p. 4). The brief PSS, has four questions, each starting with the prompt “in the last month, have you felt: (1) You were unable to control the important things in your life? (2) Confident about your ability to handle your personal problems? (3) That things were going your way? And (4) Difficulties were piling up so high that you could not overcome them? Questions were presented on a 5-point Likert scale from 0 to 4. Higher scores represent, higher stress and lower sense of efficacy. The 4-item brief screen has acceptable internal consistency, Cronbach’s alpha coefficient = .79 (Karam et al., 2012) and stability with the 10-item well validated 10-item scale (r = .63; p < .001).

Child Adjustment and Parent Efficacy Scale. The CAPES (Morawska, Sanders, Haslam, Filus, & Fletcher, 2014) was used to assess the grandchild behaviors. The CAPES is a 27-item survey of parents’ reports of their child’s internalizing, externalizing, and positive behaviors on a 4-point scale. The scale consists of an Intensity scale with two subscales measuring children’s behavior problems and emotional problems. The scales have good internal consistency (r = .74, .90 and
.96 respectively) and construct validity (Morawska et al., 2014). Higher scores indicate greater levels of child emotional or behavioral problems. Whereas, parents’ self-efficacy in managing child emotional and behavioral problems was measured with the CAPES Confidence scale (Morawska et al., 2014). Parents rated their confidence in being able to successfully deal with 19 different child misbehaviors, on a 10-point scale, ranging from (1) certain I can’t do it, to (10) certain I can do it. This scale shows good internal consistency (r = .79). Higher scores reflect greater confidence.

4.3 Procedures

The study was approved by California State University, Northridge’s Human Subjects Committee. The principal investigator flew to Charlotte, North Carolina (Southern USA) to conduct the study. She first approached public mental health and early childhood education organizations to get their support and advice on reaching diverse grandmothers. An early childhood education program organized a group of 18 Black grandmothers that they believed represented the Black community. We conducted a focus group on an initial draft of the survey; a valuable step in the process. The principal investigator (who is White) also had long discussions with individual Black grandmothers and ministers of Black churches to better understand issues unique to Black grandmothers in the South, and also to gain access to the grandmothers. We were initially told that to have access, one needed to invite the key person to one’s home and “serve fresh cucumber sandwiches and sweet tea”. Although, this was more a myth, it did take three independent introductions to be invited to an in-person meeting with a minister of a Black congregation. It was with the homemade chocolate chip cookies that ultimately gave us access. We set up a table with the surveys in the vestibules of the invited churches. The cookies attracted the children who brought their grandmothers in tow. About 10% of the sample, requested that we read the survey to them. The online survey was first suggested by the education director of a mega-Christian church; she offered to post a link to an electronic copy of the survey, hosted by Qualtrics software, in their monthly newsletter. This led to other mega-churches joining in the effort. We expanded the online by blasting an email to undergraduates at a small Christian college in Buffalo NY. The undergraduates were invited to forward the link to their grandmothers. The entire data collection took approximately three months in early winter, 2015.

V. RESULTS

5.1 Demographics

The 155 grandmothers represented three family profiles: multigenerational families (a grandparent living with her grandchildren and the grandchild’s parent, 10.5%; 2) grandparent caregiver (children living with a grandparent that is responsible for most of a minor grandchild’s basic needs—the grandchild’s parent may also be dependent on the grandparent), 16.2%; and 3) non-residential grandparent (families where the grandparent is involved but does not live in the same home), 73%. Regardless of the family profile, grandmothers saw their grandchildren often (43.4% daily, 33.1% weekly, 17.6% monthly); less than 6% of the grandmother participants rarely saw their grandchildren.

The grandmothers reported their race (ethnicity) as: Black 26.7%; White 69.3%; Hispanic 1%; Asian 3%; and no response, 34.8%. A Chi-square test for independence (with Yates Continuity Correction) indicated a significant association between Black race and being a primary caregiver, X² (1, n= 92) = 4.719, p = .03. Although, the majority of grandmothers lived with a spouse (56.6%), White grandmothers were four times more likely to be doing so. A Chi-square test for independence (with Yates Continuity Correction) indicated a significant association between race and living with a spouse, X² (1, n= 99) = 4.772, p = .030. Of all the grandmothers, 15.8% had lived with their own grandmothers more than six months of their childhood.
Majority of grandchildren were girls (58.4%); grandchildren ages ranged from newborn infants to 19, with an average age of 7.8 (s = 4.92). Grandchildren had chronic health conditions (29.2%), though there was no relationship between grandmothers’ race and grandchildren’s chronic health condition, $X^2 (1, n= 99) = 0000, p = .988$. Grandchildren in the child welfare system were 14.3%; the majority of these children being raised by an African American grandmother. A Chi-square test for independence (with Yates Continuity Correction) indicated a significant association between race and grandchild in the child welfare system, $X^2 (1, n= 92) = 7.980, p = .005$. Of the grandchildren’s parents, 7% were teen moms, though being a teenage Mom was not related to race, $X^2 (1, n= 93) = .226, p = .634$.

5.2 Grandmothers’ roles

Grandmothers in the study reported that they gave advice to parents on a multitude of subjects, (most common and in descending order) including: child education (61.1%); child health (59.8%); child nutrition (56.1%); child safety (49%); religion (45.5); child discipline (45%); parent employment (33.6%); Money (33.8%), and parent birth control (11.7%). Grandmother responses indicated that they are very active with their grandchildren (most common and in descending order); they, talked with grandchild about the child’s friends (76.9%); provided child care (70.8%); read stories (69.4%); took to the park (66.4%); took care of grandchildren when sick (57.3%); took to church (56.7%); took to sporting events (53.8%); provided after school care (48.9%); helped with homework (46.6%); took to sports practices (36.4%); and took to the doctor when grandchild was sick (35.6%). Grandparents also taught skills to their grandchildren (most common and in descending order) including family history and values (85.9%); help with reading and writing (78.2%); played music (64.1%); bake (57.1%); built and fixed things (52.3%); cared for animals and pets (47%); sewed and did arts and crafts (43.6%); gardened (43.4%); planned and prepared meals (35.9%) and did laundry (35.3%). Grandmothers also took actions to keep their grandchildren safe, they: gave safety information directly to the child (79.9%), the parent (65.4%); supervised social situations (40.5%); and walked children to and from school (16.5%).
Table 1: Grandmothers’ Roles in the Family

<table>
<thead>
<tr>
<th>Activities Done with Grandchild</th>
<th>% of Grandmothers’ Participation (N=155)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Talk to about friends</td>
<td>76.9</td>
</tr>
<tr>
<td>Child care or babysitting</td>
<td>70.8</td>
</tr>
<tr>
<td>Read stories</td>
<td>69.4</td>
</tr>
<tr>
<td>Take to the park</td>
<td>66.4</td>
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<tr>
<td>Take care of when sick</td>
<td>57.3</td>
</tr>
<tr>
<td>Go to church/church events</td>
<td>56.7</td>
</tr>
<tr>
<td>Attend sporting events</td>
<td>53.8</td>
</tr>
<tr>
<td>Before and after-school care</td>
<td>48.9</td>
</tr>
<tr>
<td>Homework or help with school</td>
<td>46.6</td>
</tr>
<tr>
<td>Get to and from sports practice</td>
<td>36.4</td>
</tr>
<tr>
<td>Take to doctors</td>
<td>35.6</td>
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</tbody>
</table>

Skills taught to grandchild

<table>
<thead>
<tr>
<th>Skills taught to grandchild</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family history and values</td>
<td>85.9</td>
</tr>
<tr>
<td>Read and write</td>
<td>78.2</td>
</tr>
<tr>
<td>Play music or sing</td>
<td>64.1</td>
</tr>
<tr>
<td>Make candy, bake cookies or cakes</td>
<td>57.1</td>
</tr>
<tr>
<td>Build and fix things</td>
<td>52.3</td>
</tr>
<tr>
<td>Care for animals and pets</td>
<td>47.0</td>
</tr>
<tr>
<td>Sew, knit or do arts and crafts</td>
<td>43.6</td>
</tr>
<tr>
<td>Garden</td>
<td>43.4</td>
</tr>
<tr>
<td>Plan and prepare meals</td>
<td>35.9</td>
</tr>
<tr>
<td>Do laundry and care for clothes</td>
<td>35.3</td>
</tr>
</tbody>
</table>

Keep grandchild safe

<table>
<thead>
<tr>
<th>Keep grandchild safe</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Give safety information to grandchild</td>
<td>79.9</td>
</tr>
<tr>
<td>Give safety information to parent</td>
<td>65.4</td>
</tr>
<tr>
<td>Supervise friends and social activities</td>
<td>40.5</td>
</tr>
<tr>
<td>Walk grandchild to and from school</td>
<td>16.5</td>
</tr>
</tbody>
</table>

Grandmothers have challenges and needs. Grandmothers reported food insecurity at 11.5% and rent insecurity at 17.4%—these indicators of poverty were not significantly associated with race. When asked directly about their needs, grandmothers reported needing more financial resources, 47%; more time with friends, 38.2; respite care, 29.8%; and more time for church activities, 30.8%. Grandmothers also reported that it would be useful to have more information on: child health behaviors, 55.6%; child behavior and moods, 60%; strategies for co-parenting, 47%; and marital communication, 27.2%. They also rated how they would prefer to get this information (percentage of grandmothers that rated each of the following as useful or very useful) in descending order from most preferred to least: computer, 49.7%; church group, 29.2%; TV, 21.6; social media, 17.6; agency group, 15%; agency therapist, 13.5%; radio, 12.9; and lastly, home therapist, 12.7%. The majority of grandmothers, 67.3%, have a Facebook account and on average check it daily.

5.3 Grandmothers’ social supports

Grandmothers in our sample enjoyed social support. Using the Duke-UNC Functional Social Support Questionnaire (FSSQ), 11 items from 1-5...
with higher scores representing more support, our grandmothers had a mean of $= 52.2$ (SD $= 12.62$). We were unable to secure community norms to compare these numbers with. There was no significant differences between African and White grandmothers’ perceptions of support.

**Grandmothers perceived stress and self-efficacy.**

On the PSS, where higher scores represent more stress and lower self-efficacy, the grandmothers in this study were more stressed, mean $= 4.726$, $s = 2.968$, than a community sample of young pregnant mothers ($n = 217$), mean $= 2.88$, SD $= 2.93$ (Karam et al., 2012). In an Independent Samples T-Test, comparing the average levels of stress between Black and European grandmothers, this study found no significant differences between African ($x= 5.62$, SD $= 2.99$) and European ($x= 4.64$, SD $= 3.06$) grandmothers, $t(56), 1.20, p = .232$. Both groups of grandmothers perceive their circumstances as equally stressful.

### 5.4 Grandmother’s health

The DUKE Health Profile was used to assess the grandmothers’ perceived six health measures (physical, mental, social, general, perceived health and self-esteem), and four dysfunction measures (anxiety, depression, pain and disability). On the Duke Health Scales, the higher the health measures the better perceived health; whereas higher scores on the health dysfunction indicated more dysfunction. We compared our grandmothers to a community sample of females, ages 66 to 96 years of age, who were policy holders of a health insurance company (Parkerson, 2002). Other than similar Physical Health scores, 57.36, SD $= 27.3$ (compared to 57.6, SD $= 21.7$), our grandmothers scored more poorly on multiple scales including: mental Health, 74.04, SD $= 20.16$ (compared to 81, SD $= 19.1$); social health, 65.89, SD $= 17.96$ (compared to 80, SD $= 17.9$); self-esteem, 73.44, SD $= 17.51$ (compared to 82.9, SD $= 17.6$); and general health, 65.76 (compared to 72.9). Our grandmothers’ overall perceived health was 78.94, SD $= 32.10$, compared to the insurance enrollees at 84.2, SD $= 27.4$. On The DUKE Health Profile, our grandmothers also reported more dysfunction (higher scores represent more dysfunction) compared to the insurance enrollees, on measures related to anxiety, 32.75 SD$=16.92$ (compared to 24.4, SD$=17.9$); depression, 34.84, SD$= 21.62$ (compared to 25.2, SD$= 19.8$); anxiety-depression, 32.08, SD$= 19.05$ (compared to 22.9, SD$= 17.8$); and pain, 48.14, 37.36 (compared to 44.1, SD$= 32.9$). In independent-samples t-tests used to examine the mean differences between Black and White American grandmothers reported health, there were no significant differences on any of the Duke health scales.

Although within one standard deviation of the comparison sample, all five health indicators—physical, social, self-esteem, general and perceived health—of the grandmothers indicated trends toward poorer health when compared to her community peers. This pattern also held true of all four indicators of dysfunction—anxiety, depression, anxiety-depression, and pain.
Table 2: Grandmothers’ Health

<table>
<thead>
<tr>
<th>Health Measures*</th>
<th>Grandmothers’ Sample (N=155)</th>
<th>Community Comparison Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mean</strong></td>
<td><strong>Standard Deviation</strong></td>
<td><strong>Mean</strong></td>
</tr>
<tr>
<td>Physical health</td>
<td>57.36</td>
<td>27.3</td>
</tr>
<tr>
<td>Mental health</td>
<td>74.04</td>
<td>20.2</td>
</tr>
<tr>
<td>Social health</td>
<td>65.89</td>
<td>17.9</td>
</tr>
<tr>
<td>General health</td>
<td>65.76</td>
<td>72.90</td>
</tr>
<tr>
<td>Perceived health</td>
<td>78.94</td>
<td>32.1</td>
</tr>
<tr>
<td>Self-esteem</td>
<td>73.44</td>
<td>17.5</td>
</tr>
<tr>
<td><strong>Health Dysfunction Measures</strong></td>
<td><strong>Mean</strong></td>
<td><strong>Standard Deviation</strong></td>
</tr>
<tr>
<td>Anxiety</td>
<td>32.75</td>
<td>16.9</td>
</tr>
<tr>
<td>Depression</td>
<td>34.84</td>
<td>21.6</td>
</tr>
<tr>
<td>Pain</td>
<td>48.14</td>
<td>37.4</td>
</tr>
<tr>
<td>Anxiety-Depression</td>
<td>32.08</td>
<td>19.1</td>
</tr>
</tbody>
</table>

*On the Duke Health Scales, the higher the Health Measures, the better the perceived health. Whereas, higher scores on the Health Dysfunction Measures indicated more dysfunction.

When examining the level of parenting difficulty, we used the two subscales of the CAPES: Intensity of child problems and the confidence that the grandmother perceives in coping with the problems. Higher scores on the intensity scale, indicates more child problems, whereas higher scores on the Confidence subscale is an indicator of more self-efficacy in coping with the problems. Our grandmothers reported Intensity (problems) scores with a mean of 26.88, SD= 8.94 (compared to a community sample, N = 370 mothers, M = 25.57, SD 13.03) and a Confidence (in dealing with child problems) scores with a mean of 172.75 SD= 26.29 (compared to the community sample, M= 157.62 (34.20). Interestingly, our grandmothers reported slightly (within one standard deviation) more problems, but also reported (within one standard deviation) more self-efficacy than community mothers to cope with these problems. In independent-samples t-test, there were no significant differences between Black (M=28, SD= 8.55) and White (M=27.42, SD=7.74) grandmothers on Intensity, t(40)=.169, p=.867. Furthermore, there was no significant differences between Black (M=175.6, SD= 14.9) and White (M=170.49, SD=29.7) grandmothers on Confidence, t(43)=.521, p=.605.

VI. DISCUSSION

Young mothers moved home with their babies during the financial crisis of the last decade, and they stayed. In the U.S. 10% of children live with a grandmother, 7.7 million children of which three million children are dependent on grandmother. This number is believed to have increased during the recent opioid epidemic (Lent, 2016). In our study, 26.7% of the grandmothers lived with a grandchild of which 10.5% were multigenerational families and 16.2% were primary caregivers.
Regardless of the grandparent family profile, in our sample grandmothers saw their children frequently. More than three quarters of children saw their grandmothers at least weekly. Seventy percent provided childcare. Importantly, the majority of our sample were caring for young children—a pattern in the Western world of which about a quarter of preschool children receive child care from a grandparent (Leung et al., 2014). The preschool years of accelerated development lay the emotional, social and cognitive floor of child development. High-risk children—absent, disabled, incarcerated or abusive parents—are on an adverse trajectory. For a grandchild, the number of days or hours spent with a grandmother can be the protective factor that alters the path to one of health and wellbeing.

The grandmothers in our study, provided instrumental support to the children’s parents some provided housing and food, while others provided childcare and care when children were sick so that parents could go to work, almost half of our grandmothers provided after school care. Grandmothers advised the parents on a multitude of important issues. Grandmothers read stories and talked to their grandchildren. They took the children to the park, sports practices, church and to the doctors when a child was ill. Grandmothers read to the children and helped with their homework. Moreover, grandmothers supplemented busy or absent parents by providing safety—such as walking children home from school or supervising social activities.

All this loving support, though, has come with a price for the grandmother. She demonstrates a consistent and worrisome trend toward perceived poor mental, social, and general health, high levels of stress, anxiety, depression and pain compared to community peers. Black grandmothers, in particular, were isolated: they were more likely to be single, less likely to have the child’s parent in the home, and twice as likely to be the child’s primary caregiver; and a grandchild in the child welfare system. Black grandmothers, though, did not report higher levels of stress and health dysfunctions than their White counterparts. Although they face more severe challenges, Black grandmothers may share a large social community of support, especially through Church association. “Similarly, for both African-Americans and Latina, the family group often may include not only extended family members (including those who may reside in the household), but also a broader network of fictive kin who may provide important sources of support to family members” (López & Cooper, 2011, p. 12).

Both Black and White grandmothers reported child problems within normal range, although grandmothers as a group trended toward more confidence in their parenting compared to a community sample of mothers. The majority of the grandmothers reported that they would like more information on child behaviors and moods. Grandmothers prefer to get information via a computer program, or a church group—not home-based services. One program, Grandparents Triple P, is currently in development and testing (Kirby, 2014), is showing promise. Grandmothers also identified practical needs for financial resources, time with friends and church activities, and respite care.

6.1 Limitations of the study

Future studies should use probability sampling to be more representative of the grandmothers—including non-church attendees, and a wider range of geographical locations e.g. Western states. It would also be interesting to inquire on how the grandmothers activate and secure social needs. Furthermore although we were able to assess perceived health trends, we were unsuccessful in measuring how grandmothers managed their health and the health of their grandchildren—especially chronic conditions. Information on health management could contribute to developing effective resources designed for grandmothers.
Grandmothers were a salient factor in helping families, especially young families, during the financial crisis of the last decade and most recently, the opioids’ epidemic. They, though, are silent heroes. Grandmothers contribution to the development of the next generation is immeasurable. We as a society need to recognize their work and develop programs and policies to support them. Young children need secure attachment, emotion regulation, conversation, language, and protection to reach their full human potential. Grandmothers are emotionally attached, committed to their grandchildren’s survival, and possess the wisdom of longevity. Who could be more ideal?

REFERENCES


