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## **Grandparents Raising Grandchildren: Challenges and Opportunities for Mental Health Practitioners**

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The composition of American families has changed radically in the last 10 years in that a far greater number of children are living in grandparent headed households. The reasons for these changes are complex and compounded by both psycho-social and socio-economic factors. It is imperative that counselors and human services providers in all sectors recognize the changing composition of the family. This study offers specific strategies designed to support the increasing grandparent headed family in the United States. Data from the U.S. Census Bureau's 2005-2009 American Community Survey (2011), show that there are 20,738 grandparents responsible for their own grandchildren in Miami Dade County, Florida.

Demographic studies indicate that this new structure, the grandfamily, is created because of parental substance abuse, incarceration, illness and death, and financial crises. U.S. military policy allowing multiple deployments has gravely affected many families—sometimes leaving children without the presence of either parent. Almost 7.8 million children under age 18 live in homes where the householders are grandparents or other relatives, representing 10.5% of all children under 18 (U.S. 2010 Census, as cited in AARP Grandfacts, 2011). These significant numbers have been impacted by the challenges in our economy over the past five years, including the housing and foreclosure

crisis, the loss of jobs and general economic woes. Clearly, grandparents are increasingly providing the stability and security of home for their families.

It is normative in many minority families for grandparents to take a major role in the raising of their grandchildren. Foster care is avoided through kinship care which is a cultural strength that may be, at best, unsupported and at worst, is sometimes exploited (Boyd-Franklin, 2003). Grandparents are sometimes expected to provide parenting without resources.

A Pew Research Center study (Livingston & Parker, 2010) that found one in ten children in the U.S. now lives with a grandparent. The trend was most noticeable among whites, according to the Pew study's analysis of census data. Caucasian grandparents who were primary caregivers for their grandchildren rose 9% from 2007 to 2008, compared with only a 2% increase among black grandparents and no change among Hispanics (Livingston & Parker, 2010).

In the state of Florida, 476,474 children under age 18 live in homes where the householders are grandparents or other relatives. That number represents 12% of all the children in the state (U.S. 2010 Census, as cited in AARP Grandfacts Florida, 2011). Of these, 354,716 live with grandparents who are the householders (8.9% of the children in the state) and 121,758 live with other relatives who are the householders (3.1% of the children in the state; U.S. 2010 Census, as cited in AARP Grandfacts Florida, 2011).

The authors hypothesized that disparities in both mental and physical health services for African Americans and other minorities increase with age. It appears that grandparents residing in violent, urban communities are confronted with multiple stressors that are often ignored by mainstream sources of quality health care. Based on the authors' many years of working with minority children and families, it seems that minority grandparents, who are primary caregivers for a skipped generation of grandchildren with absent parents, are more vulnerable to health disparities. These grandparents endure often overwhelming financial, emotional, and physical stress and health issues based on the many demands associated with raising grandchildren attending urban schools that lack the resources needed to meet their educational and affective developmental needs. African American grandparents raising grandchildren in high-risk, urban, minority communities, are likely to encounter significant stressors and difficulties with health care access (Miranda, McGuire, Williams, & Wang, 2008; National Alliance on Mental Illness, n.d.; National Alliance on Mental Illness, 2004). It is important to research the health and stress of grandparent caregivers of young children to inform the development of support and intervention services for this population.

### **The Study**

This NIH funded study examined health and stress indicators among minority grandparents raising grandchildren whose parents are incarcerated or absent for other reasons. Additionally, mapping of target community resources was conducted to identify health care and mental health support services, as well as gaps and barriers resulting in racial/ethnic differences in access and utilization of these services.

Measures of minority grandparent caregivers' health status and mental health/stress indicators provided a baseline assessment of needs that assisted in the process of development of community-based, culturally appropriate interventions to

overcome racial/ethnic health disparities. Concurrent measures of family cultural, linguistic and economic variables provided insight into factors that support and buffer, or add to cumulative risk, with regard to grandparents who find themselves raising children in the context of minority communities with crime, high-risk schools and challenging neighborhoods.

### **Phase I**

In August 2010, Phase I of this project centered on the task of mapping the community resources gaps in services for grandparents raising grandchildren in the targeted high-risk communities of Miami Gardens, Opa Locka, and North Dade County Florida. These included faith organizations, community centers, health centers, mental health centers, and schools among other community institutions. The community mapping resulted in the compilation of a Resource Guide that will be shared with community partners who assisted with the study. Phase I also consisted of researching demographic information (race, ethnicity, poverty level, and crime level) related to the population of North Miami-Dade County.

The identification of grandparent participants was begun utilizing a snowball sampling method. Our first focus group was conducted in December of 2010 and was attended by Antioch Baptist Church leaders and an interdisciplinary cadre of interested St. Thomas University faculty and administrators. The research question focused on the perceived health disparities as well as factors that would support a healthy community, specifically, “What characteristics must a community include to ensure that the dignity and strength of grandparents raising grandchildren are supported and nurtured?” This information was gathered using a nominal needs technique and the energy of the focus group was directed toward the exploration of this question.

Participants identified the desire for a healthy, nurturing community in which all members would thrive. They spoke of their concerns about the risks faced by their grandchildren and their frustrations regarding limited community resources. Family and relationship stressors were discussed within the context of their family life cycle stages. The nominal needs assessment produced a salient portrait of a supportive community in which businesses, faith groups, government, and social service organizations work together to achieve a healthy community. A positive narrative for the future would include supportive institutions, educational and health resources, and financial assistance for kinship care.

### **Phase II**

Phase II of the study was initiated by establishing relationships with community partners and identifying potential participants. Faculty, staff, students, teachers, and religious and human service leaders in the community were contacted for information regarding potential participants. Senior groups and Bible study classes at local churches were visited in order to invite participation. Various social service organizations that focus on seniors were contacted. Additional methods of locating participants included meeting grandparents at local community centers and health institutions in order to engage potential participants. Through these efforts, 50 grandparents were interviewed.

Participants were interviewed individually using structured questionnaires. The following instruments were utilized:

- 1) The Health Screening Survey (Health E-Technologies Initiative, 2007)—Health Initiative Brigham Women's Hospital, which inquires about general health issues, existing medical conditions, accidents, mobility, and doctor visits.
- 2) The Health Access Interview (Statistics Canada, 2007)—Canadian Health Study, Statistics Canada, which measures access to health care, and barriers/issues associated with accessing health care.
- 3) The Parenting Stress Index (PSI Short Form; Abidin, 1995)—adapted for grandparents, widely used with African American & low-SES families. This measure assesses adult and child factors in the caregiver-child relationship including Parenting Stress, Difficult Child, and Adult-Child Interaction subscales.

The data collected from the structured interviews were entered into the Statistical Package for Social Sciences (SPSS) for quantitative analysis of the demographic and Likert items. The software package SPSS was used to check reliability and frequencies were calculated for each of the Likert items.

Phase II also included a focus group for the purpose of gathering qualitative data about the experiences of grandparent kinship caregivers and to seek rich descriptions of culturally competent support and service provisions as articulated by these grandparent kinship caregivers. This group was conducted in June of 2011 with eight participants. The focus group session was videotaped for the purpose of data collection. In addition, our initial research findings were shared with the focus group and the members were asked for their responses to the information.

The focus group discussions allowed us to go beyond the limits of our instruments and gain a deeper understanding of the experience of grandparenting. We heard of the strength and resiliency of our participants. They felt they played an important role in the lives of these children. They spoke of the authority that grandparents possess, and the respect they receive from their grandchildren. They felt that they were more consistent, due to their years of experience as parents. They believed that grandparents are the best teachers of cultural history, and that at their stage in the family life cycle, they can now relax and enjoy parenting more. Our focus group participants strongly emphasized that they were able to impart family values to the children they were raising. These grandparents did mention that economic strain was frequent, making it difficult to afford sports and artistic activities for the children. The study data analysis indicated that 55% of the participants earned \$30,000 or less in annual income.

### **Phase III**

In Phase III, the third and final phase in the grant, the data were analyzed and interpretation of the findings was begun. In collaboration with local partners, the study began to develop culturally appropriate community-based interventions, using three counseling models: filial therapy, structural family therapy, and narrative therapy. Additional goals include increasing grandparent caregiver access to support services.

## **Participants**

Of the 50 participants who were interviewed, 45 (90%) were female and 5 (10%) were male. The ethnicities represented in the sample included Black, non-Hispanic (58%); White Hispanic (28%); White, non-Hispanic (8%); and, Black, Hispanic (6%). In terms of marital status, the largest group of participants (46%) was married, followed by 36% who were divorced. Eight participants (16%) were widowed.

Income level for the sample was low, with 34% of participants falling in the income range of \$20,001 to \$30,000. Twenty percent earned less than \$20,000 in annual income. Therefore, 54% of the sample earned under \$30,000 yearly.

Many religious denominations were represented in the sample, with the largest groups of participants noting that they were Catholic (30%), Baptist (28%), and “Christian” (12%).

This sample of grandparents ranged in age from 45 to 81 years of age. The number of grandchildren they were raising ranged from one to ten, with 34% raising two grandchildren and 26% of the participants raising three.

## **Descriptive and Statistical Results**

The grandparent participants reported that they were in generally good health, that they were not overly stressed, and that they were able to obtain health care services when needed. SPSS analysis of the interview data indicated that 86% of these grandparents considered themselves to be in good, very good or excellent health.

The reasons for raising their grandchildren varied and included the parents’ lack of maturity, lack of capability, and lack of resources. Some concerns regarding legal custody of grandchildren were raised.

## **Qualitative Findings**

Creswell (1998) and Patton (2002) recommend that qualitative inquiry begins with bracketing preconceived notions or assumptions about the phenomena or specific focus of study. Nwokeji (2009) further explains that this helps prevent bias in the researchers’ data collection and data analysis. Efforts were made to identify knowledge and assumptions about our multiethnic population and to insure cultural competence. The research team met weekly to identify and review cultural barriers that might inhibit culturally competent communication and understanding.

The data collected from the two open ended questions were subjected to a coding process to discern systemic categories. To begin the analysis, each question was analyzed to examine the unit of meaning. The meaning extrapolated from the sentences or phrases were compiled together with similar units and clustered into categories. The units of data were used as the basis of the analysis of emergent themes. The method utilized in this process was the constant comparison technique (Lincoln & Guba, 1985, as cited in Correa-Torres & Durando, 2011). This procedure provided a contextual lens with which to understand the reasons for the assumption of the “grandparent as caregiver” role, and to provide much needed information about the grandparents’ main concerns and challenges faced in raising their grandchildren.

**Becoming a Parent Again.** The themes that emerged revealed that the grandparents were caring for their grandchildren for myriad reasons that are listed in order of frequency. All of the categories pertain to their description of the parent of the child or children being raised. Mental illness and substance abuse, was followed by emotional immaturity, financial instability, parental death, deployment, parent not available because of work and school demands on time and energy, parental behaviors that threatened foster care, and parental divorce or separation from partner. These factors are consistent with national characteristics (Dolbin-MacNab & Traylor, 2008).

The second open-ended focus of inquiry sought to explore the grandparents' concerns with regard to their actual lived experiences. Provisional categories included worries, challenges, and resource needs. Themes that emerged revealed specific concerns about themselves in their roles as grandparents and parents. Data indicated that the good health, well-being, and education of their grandchildren were tantamount to fulfilling their hopes and dreams for their grandchildren's futures. These grandparents are concerned that their ability to parent will be restricted by the aging process, increasingly limited income, and poor health in the future. One grandparent declared, "How will my advancing age impact my ability to raise two special needs children, one of whom remains on a waiting list for services?" Another posits, "Will I have the finances I need to raise them?" A compelling question was asked, "Will my grandchildren make responsible choices and decisions or will they become addicted to drugs like my daughter?" They worry that their lack of legal custody status may jeopardize their grandchildren's health and safety and that removal from their homes would lead to dire futures.

### **Application of Counseling Models for Effectiveness with Resilient Grandfamilies**

This research indicated both the need and the call for culturally competent counseling interventions that would strengthen these cherished family relationships. The following three counseling models are relevant for grandfamilies who are willing to validate their commitment to their grandchildren.

The following models provide a strength-based approach that honors the cultural values of each individual family.

#### **Filial Family Therapy**

Filial Family Therapy (FFT), also known as Child Relationship Enhancement Family Therapy, represents an extension of the principles of the Child-Centered Play Therapy Model to the entire family unit. FFT, developed by Drs. Bernard and Louise Guerney, was designed for instances where children between ages 2 and 12 present with problems where inclusion of their parent(s) would be advantageous (VanFleet, 2011a). Essentially, parents are systematically trained to conduct therapeutic play sessions with their children and receive on-going supervision and support from the FFT-trained professional to reach four goals: 1) to reduce or eliminate the child's maladaptive behaviors and presenting problems; 2) to enhance the parent-child relationship; 3) to improve child competence and self-esteem; and, 4) to improve parenting skills, including communication, coping, and problem-solving skills (VanFleet, 2005, p. 4).

Typically, filial therapy takes place in a support group format that meets for 2 hours each week over a 10-12 week period. During this time, six to eight parents learn basic child-centered play therapy principles to use with their children in special half-hour weekly play sessions. The combination of didactic instruction and supervision in a supportive atmosphere provides a dynamic process that sets filial therapy apart from other parent training and psychotherapy programs that are exclusively educational in nature (Andronico, Fidler, Guernsey, & Guernsey, 1967 as cited in Reynolds & Schwartz, 2003). As in child-centered play therapy, filial therapy is structured to enhance and strengthen the relationship. However, in filial therapy the focus is the relationship between parent and child, rather than the relationship between therapist and child. As in family therapy, the “client” is this relationship of child and parent (VanFleet, 2011b). Through viewing play sessions (videotaped or live), receiving supportive feedback from the therapist and the group, doing role plays, and participating in a variety of didactic experiences, parents learn to convey acceptance, empathy, and encouragement to their children, as well as to master the skills of effective limit-setting. This new creative dynamic of empathic responding by parents becomes the creative process through which change occurs both within the parent and child and between the parent and child (VanFleet, 2005; Reynolds & Schwartz, 2003).

**Application to Grandfamilies.** Grandchildren living apart from their parents who have left them due to incarceration may feel vulnerable and distrustful of adults. If these children have spent time living with parents with addiction problems, or have experienced prior abuse, they can benefit from filial therapy. The methods of FFT give them the opportunity to process their feelings in a supportive environment, as well as provide them a model of healthy family relationships (VanFleet, 2005, pp. 58-61).

VanFleet (2005) advocated individual parent sessions over a shorter period of time. A condensed 5-week filial therapy model (10 sessions, twice a week) has shown positive results, although some aspects of the intervention (e.g., supervision and follow-through) may be reduced. According to VanFleet (2005), “... these very brief formats provide a viable alternative when resources are limited” (p. 58). Perhaps this shortened model in a home-based application would be most accessible to these grandparents who often experience transportation and scheduling difficulties. FFT is a truly collaborative model, in that it welcomes and encourages parental input at every step of the way (VanFleet, 2011b, p. 10). This is particularly important for effective work with these resilient grandparents.

### **Narrative Therapy**

Narrative Therapy is an approach that sees people as the experts in their own lives and views problems as separate from people. According to White and Epston (1990), people's lives are organized by their life narratives, and these stories don't mirror life, they shape it. There are multiple ways to tell one's life story. Society provides dominant narratives that influence the way family members may interpret everyday lived experiences, such as what it means to be a “mother,” a “grandparent,” or a “success.” When a person's life differs from these “dominant social discourses,” one may experience the sense of family difficulties (White & Epston, 1990; Gehart & Tuttle, 2003). Narrative approaches assume that people have many skills, beliefs, values, commitments, and abilities that will assist them to reduce the influence of problems in

their lives. Their “local knowledges” (the often subjugated stories that families know about themselves) are valued and explored by the therapist to assist clients in reauthoring a preferred narrative (Gehart & Tuttle, 2003).

**Application to Grandfamilies.** Narrative practices help to conceptualize the stories that grandfamilies tell. The focus groups demonstrated that their narratives are not problem-saturated, but instead emphasized resiliency, values, and commitment. Their “local knowledges” tell stories of families who reflect great love, support, and strength. In addition, this therapeutic approach closely attends to sociopolitical issues such as culture, gender, race, disability, social class, social status, and other marginalizing practices (Gehart & Tuttle, 2003, p. 215). Exploring unique outcomes and externalizing problems (concerns or challenges) are two interventions that would be appropriate for use with grandfamilies.

### **Structural Family Therapy**

Structural family therapy is a model of treatment primarily characterized by its emphasis on structural change and on the therapist as an active agent of change. Salvador Minuchin developed the model to be “... a body of theory and techniques that approaches the individual in his social context. Therapy based on this framework is directed toward changing the organization of the family. When the structure of the family group is transformed, the positions of members in that group are altered accordingly. As a result, “... each individual’s experiences change” (Minuchin, 1974, p. 2).

The model conceptualizes the family as a living open system whose members are interdependent and which undergoes transformation over time. Family process is regulated by the multilevel interplay of homeostasis and change. Structural Family Therapy defines family structure as the rules that govern family relationships and interactions. Special attention is given to the family hierarchy, considering who may be in charge and making important decisions. Minuchin was clear in advocating for a hierarchical structure in which the parents are clearly in charge. As the children mature, a healthy family structure would allow for more input from adolescents. This requires a change in boundary structures (Minuchin & Fishman, 1981).

Minuchin (1974) described interpersonal boundaries as invisible lines between individuals and/or subsystems that regulate the amount of emotional contact, privacy, autonomy, and dependency. A rigid boundary indicates little emotional connection and high independence between two individuals or subsystems. Rigid boundaries lead to disengaged relationships (Gehart & Tuttle, 2003; Minuchin, 1974). In contrast, a diffuse boundary allows a great amount of emotional contact, with very little privacy and autonomy for each person or subsystem. This type of boundary leads to enmeshed relationships, with confused authority lines. Clear boundaries are firm yet flexible, permitting appropriate emotional connection, freedom to develop an identity and make decisions. This type of boundary allows for maximum adaptation to change (Gehart & Tuttle, 2003; Minuchin, 1974).

**Application to Grandfamilies.** Structural Family Therapy may be helpful in conceptualizing some of the challenges that grandfamilies may experience. Which parental subsystem—parents or grandparents—is in charge? Had boundaries changed over time between the grandparents and parents? How does this influence the hierarchy in these multigenerational families? One assessment tool is to map the family structure in

order to identify patterns, conflicts and coalitions (Gehart & Tuttle, 2003, p. 27). The technique of “shaping competence” is particularly appropriate for this sample of grandparents as it highlights their strengths and progress.

### **Conclusion**

Incidental to the acknowledged focus of inquiry of this study were the identified findings that resonated throughout the oral individual interviews with the grandparents. Speaking for themselves, the grandparents challenged researchers’ assumptions about the effects of stress and the scarcity of resources on their grandparenting roles. Individually unique, together they wove a clear and united pattern that contradicts some current gerontological thought. They are what Bonnie Barnard (1994) refers to as the “in spite of” population. In spite of the physical limitations imposed on their bodies by the aging process, the economic struggles they endure, and the crime and violence in the community, they reveal a deep emotional connection that is life-giving. Buoyed by a profound and unfathomable love for these children, a professed spirituality, or a combination of both factors, they are strong, resilient caregivers willingly situated in loving grandfamilies.

In their work with these families, counselors need to demonstrate cultural competence that honors familism and the strengths of kinship networks that are culturally based. Grandfamilies are entitled to therapists who advocate for social justice and empower them to challenge policies and practices that affect their health, wellbeing, and their full and equal participation as families. Counselors must be acutely aware of the interdependence of these factors in the context of their community environment and must be vigilant in empowering these families to develop their full capacities as self-determining members of society. Specifically, as Dolbin-MacNab and Traylor (2008) suggest, “...therapists should be prepared to assist grandparents in locating public benefits, accessing medical care, and finding legal representation. Therapists also need to coordinate with school personnel, child welfare professionals and physicians” (p. 43).

Merriam & Clark (1991) advise that, “In a sense, any research study has three phases: It begins in the world we live in, asking questions and gathering data about that world; then it moves beyond everyday life in the process of analysis, getting the larger picture of what is going on in that world; and finally it returns to the everyday world to situate what it has learned in that context and to ask what difference the new understandings make to real life” (p. 218). In this research, the learning about the current needs of these resilient grandparents presents a clarion call for counselors, policy makers and human service providers. Grandfamilies are increasing in number every day and are entitled, indeed deserve, culturally competent and expanded counseling interventions addressing their complex realities.

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