Standing in the Breach: Psychosocial Challenges Facing Grandparents

Assuming the Care of Minor Grandchildren

A Literature Review from an Integrative Paper Presented to

The Faculty of the Adler Graduate School

In Partial Fulfillment of the Requirements for the Degree of Master of Arts in

Adlerian Counseling and Psychotherapy

By

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March 16, 2010
Dedication

I wish to dedicate this work to a number of individuals, named and anonymous. Robert Bartholow introduced me to Adlerian Psychology shortly before his untimely death. His enthusiasm and commitment to his students and clients will always inspire me. Herb Laube encouraged me to understand families as systems within multiple systems. Dan Haugen supported and strengthened my commitment to those individuals and families who struggle for access to mental health services. Finally, I thank the grandparents who ‘stand in the breach’ for their neglected grandchildren.
Abstract

During the past three decades, the number of children in the United States being raised by grandparents has increased dramatically. Parental drug addiction, child abuse and neglect, parental incarceration, and poverty are the primary precursors of grandparent-headed families. This literature review explores the psychosocial stressors encountered by grandparents who find themselves either the primary caregiver or de facto co-parent of young children. The studies reviewed range from qualitative projects with a small number of participants to longitudinal, quantitative studies with robust samples. The extant literature has delineated stressors such as depression, isolation, neglect of physical health, and increased poverty among grandparents serving as surrogate parents. Single, African American women living in poverty are disproportionally represented in the population of grandparent caregivers. Much of the research regarding grandparent caregivers has been conducted from a social services perspective. At present, little research has focused on psychotherapeutic treatment approaches for this population. Further research is needed to delineate individual and family psychotherapy models which would support grandparents parenting minor children.
**Introduction**

During the past three decades, families with minor children headed by grandparents have become increasingly common. The three generational household, consisting of grandparents, parents, and children is not a new phenomenon, and in some cultures is the norm. In the United States, economic challenges, including foreclosure, unemployment, and the high cost of child care may be causing an increase in three generation households. In the past, grandparents might assume total parenting responsibilities of their grandchildren in the rare event of the death or incapacity of both parents. This later type of family constellation, aptly termed “skipped generation family”, has increased significantly in recent years. The purpose of this discussion is to consider the psychosocial implications for grandparent caregivers and the challenges they face. It is the author’s belief that the Adler Graduate School of Minnesota is positioned to offer support to grandparent-headed families, and will conclude with further suggestions.

The 1990 United States Census revealed a 44% increase in the number of minor children living with grandparents or relatives other than their parents (Furukama, S., 1994). In response, Congress directed that the 2000 Census measure this trend as part of the Personal Responsibility and Work Opportunity Reconciliation Act (1996). Census 2000 found that 5.8 million citizens identified themselves as co-resident grandparents. Of this group, 2.4 million grandparents, or 42%, were the primary care providers for their co-resident grandchildren (Simmons, T., & Dye, J.L., 2003).

The later half of the 20th Century witnessed profound changes in American culture. Households headed by a single parent became increasingly common due to both high divorce rates and non-marital families. The children of such single parents are at greater risk of requiring
surrogate parenting should the primary parent be incapable of providing care. Grandparents are becoming surrogate parents due to child abuse and neglect by the parents, parental substance abuse, parental mental or medical illness, and parental incarceration. Substance abuse is frequently an underlying cause of neglect, abuse, illness, and incarceration.

The drug epidemic in the past two decades has been partially responsible for an unprecedented increase in the number of parents in prison. In the 1990s, over 75% of incarcerated women were mothers (Phillips & Bloom, 1998). As these mothers were usually the primary caregiver of their children, their children were often placed in foster care. Between 1986 and 1997, the percentage of children being cared for by grandparents due to parental incarceration rose from 5.8% to 12% (Johnson & Waldfogel, 2002). After serving their sentences, parents attempting to resume responsibility for their children face enormous barriers to obtaining employment and housing due to their criminal records. The Personal Responsibility and Work Opportunity Reconciliation Act (1996) created further barriers to family reunification. This legislation replaced the Aid to Families with Dependant Children program with the Temporary Assistance to Needy Families program, or TANF. Under this new legislation, former inmates who commit even minor parole violations, such as missing an appointment with a parole officer, are banned from receiving TANF benefits or food stamps. Furthermore, individuals who have been convicted of certain drug felonies are banned from these programs for life (Phillips and Bloom, 1998). These factors may force custodial grandparents to continue caring for their grandchildren until adulthood.

Who are these caregiving grandparents? Census 2000 found that 5,771,671 grandparents lived with their grandchildren. Of that figure, 42% were responsible for the care of their grandchildren. Grandmothers represented the majority, or 61% of these caregivers. There were
marked racial and ethnic differences in the care giving group. Only 2.5% of White citizens over the age of 30 lived with grandchildren. Of that number, 41.6% identified themselves as the primary care-givers. In the African American population, 8.2% of individuals over 30 lived with grandchildren, with 51.7% being the primary care-givers. Eight percent of Native American grandparents over 30 lived with grandchildren. Of that group, over 56% identified themselves as their grandchildren’s primary care-givers. Of Native Hawaiian Islanders and Other Pacific Islanders, 10% lived with grandchildren, 38.7% of whom were primary care-givers. Although 6.4% of citizens of Asian descent lived with grandchildren, only 20% of that group was primary care-givers. In the Hispanic population, 8.4% of individuals over 30 lived with their grandchildren, a figure similar to that of African Americans and Native Americans. However, only 39.7% of this group identified themselves as responsible for their co-resident grandchildren. The age span of grandparents serving as surrogate parents followed a curve, with the youngest group, ages 30-39, accounting for 6.7% of the total, followed by 29.2% of grandparents 40-49 years of age. Care-giving grandparents aged 50-59 were the largest group, accounting for 35.1% of the total. Grandparents aged 60 to 69 accounted for 21% of the care-giving group, while individuals aged 70 and above accounted for 8.1% of the total. Many of these care-giving grandparents had made a long-term commitment to their grandchildren. For example, 40% of the grandparents aged 50-59 had been caring for their grandchildren for over 5 years. In addition to assuming this challenging responsibility, 19% of the care-giving grandparents were doing so while living in poverty (Simmons, T., & Dye, J.L., 2003).

Skipped generation families are impacting multiple government and social systems. State and local social service agencies are usually in the front line, often being instrumental in removing children from abusive and neglectful parents. However, although state and local
child welfare agencies perform the work, funding for foster care and subsidized adoptions is provided by the federal government. In the past decade, there has been a significant change in philosophy at a federal level regarding permanent child placement. Rather than focusing on reunification of abused or neglected children with their parents, Congress has indicated that placing children in a safe and permanent home takes priority. If it is in the best interests of children to remain with kinship care providers, kin are given preference as adoptive parents even if those caregivers will need financial assistance (Kenney, 2009). Given the legal mandates for kinship care and permanent placement, social service agencies often make a concerted effort to recruit grandparents as foster, and ultimately, adoptive parents. Once children are placed with grandparents, local social services agencies are faced with the challenge of assisting these families in meeting their needs. Grandparents may require monetary assistance, health insurance for the children, and possibly public housing.

The legal system is attempting to meet the needs of both children and grandparent caregivers. At present, each state has its’ own specific statutes applicable to at risk children. In addition, the Indian Child Welfare Act supersedes state law in regards to Native American Children. This legislation, which was expanded in 2008 to provide financial compensation to kin caregivers, mandates that Native American children needing adoptive homes be must be placed with Native American families (National Indian Child Welfare Association, 2008). Despite the pressure to place children of all cultural backgrounds in kinship foster care, some states pay substantially less to kinship foster homes than traditional foster homes (Park, 2006). If a grandchild is formally adopted, financial assistance may be decreased further if not eliminated. Financial concerns aside, some grandparents fear that adopting their grandchild will drive a permanent wedge between them and the child’s parent. Fortunately, many states, including
Minnesota, allow some form of subsidized guardianship (Generations United, 2009). This allows grandparents to become legal guardians of their dependant grandchildren, while remaining eligible for some form of financial assistance. Guardianship could be transferred back to the child’s parent if the parent’s circumstances change.

Grandparent-headed families also impact employment, financial, and housing considerations. Employee policies do not necessarily extend the same consideration to kinship caregivers as they do birth or adoptive parents regarding use of sick time to care for an ill child or leave time for school conferences. Some grandparent caregivers have been forced to leave the work force to care for their grandchildren, placing the family in greater financial jeopardy. Other grandparents have been forced out of retirement to provide for their family. Grandparent caregivers also report needing to liquidate retirement funds to cover the expenses of their new family, an act with long-term consequences (Edelhoch, Liu, & Martin, 2002). Because children are not allowed to reside in senior housing developments, some grandparents have had to exchange subsidized senior housing for more expensive dwellings.

Grandparent caregivers must once again interact with school systems, which have likely changed since their own children were students. Different school systems will have differing levels of sensitivities to these new families. Grandparents may need to take an active role to secure special education or in-school mental health services for their grandchildren. Research has indicated that grandparents also struggle to cover the cost of school supplies and activity fees (Edelhoch, Liu, and Martin, 2002). Such costs to parents were rare a generation ago but are now common in public schools.

Health care systems are impacted by skipped generation families in multiple ways. Grandparents, who themselves may be facing health challenges, must attend to the needs of their
grandchildren. Children who endured fetal exposure to alcohol or illicit drugs may have congenital or neurological impairments. Any health problems the children had may have been compounded by parental neglect prior to placement with their grandparent. Health care providers must also tend to the medical needs of the grandparent, which may be exacerbated by the new stress of parenting. Grandparents may forgo their own appointments due to childcare demands or discontinue medications to save money for other family needs (Roe, Minkler, Saunders, & Thomson, 1996). Grandparents who are not yet eligible for Medicare may not have medical insurance. Finally, the mental health challenges of both grandparents and grandchildren are significant, and will be discussed in greater detail in the following literature review.

**Review of the Literature**

Care-giving grandparents are found throughout the United States, in various ethnic communities and social-economic groups. Grandparents may assume legal guardianship of their grandchildren, or provide part-time care. Grandparent caregivers may live with their grandchildren in a skipped generation household, or form a three generation household with the children’s parent. In the following discussion, we will consider the experiences of some of these populations.

**The Impact of Full-time Responsibility Compared to Part-time Care-giving**

As indicated earlier, grandparent householders with resident grandchildren may have primary or shared responsibility for these children. It is useful to compare the impact of different levels of responsibility to understand the grandparents’ needs. Two studies conducted in the late 1990s are instructive. Musil (1998) compared the emotional and physical stress, as well as supports, of grandmothers acting as a full-time parent surrogate and grandmothers who lived in three generational households and held partial responsibility for care-giving. Bowers and Meyers (1999) investigated the impact of full-time and part-time care-giving responsibilities on
Musil noted that at the time of her study, most research focused on grandmothers who had assumed full responsibility for their grandchildren. However, grandmothers in three generational households often provide many hours of child care, and may face different intergenerational challenges. Her subjects reported that shared residency was often triggered by stressors such as poverty, mental illness of the parent, parent still completing school, or divorce of the parents. Participants included African American and European American grandmothers of diverse educational and economic backgrounds from the greater Cleveland, Ohio, area. This convenience sample included 90 women recruited from a variety of sites. Participants answered queries regarding stressors, coping styles, social supports, and health status. As noted, Musil explored differences between the part-time and full-time caregivers. The author also explored the relationship between the ages of the grandmothers and that of the grandchildren, the number of children cared for, the duration of care giving, and racial background. Demographic data was obtained from interviews with the participants. Other measures included the Self-Assessed Health Questionnaire, the Center for Epidemiological Studies-Depression (CES-D) scale, the Symptom Checklist-90 (SCL-90), the Parenting Stress Index (PSI), and the Grandparent’s Strengths and Needs Inventory (GSNI), the Ways of Coping checklist, and the Duke Social Support Index. Grandmothers with full time responsibility for their grandchildren provided an average of 148 hours per week of care. Grandmothers who did not have primary responsibility for their grandchildren provided an average of 48 hours of care per week (Musil, 1998). It is not clear from the published report if hours of care included night-time hours during which grandmothers hopefully received some sleep. Even if this were the case, grandmothers with partial responsibility were still ‘on duty’ for more than a standard 40 hour work week.
In regards to self-reported health, 60 of Musil’s respondents rated themselves as in good or excellent health, 24 in fair health, and six in poor health. Anxiety scores were found to be higher than the normative sample, and 37 respondents had CES-D scores of 16 or above, indicating risk for clinical depression. Over one third of the respondents reported a clinically significant stress level on the PSI. On the parent/child dysfunctional interaction score, 14% scored at a level indicating increased potential for child abuse. Approximately 10% of the grandmothers had scores on the difficult child subscale indicating a high risk for parental loss of control or child abuse. Assessment of coping styles indicated that a variety of active, minimizing, and avoidant strategies were used by the participants. Differences were noted between grandmothers with full-time responsibility and those with partial responsibility in regards to parenting stress. Grandmothers with partial responsibility reported greater social and instrumental supports, which can be expected when two adults are sharing parenting responsibilities. No significant differences were noted between the two groups in regards to physical health, depression, anxiety or coping strategies. However, grandmothers caring for multiple grandchildren reported more health problems and higher stress than grandmothers caring for just one child. Musil noted no statistically significant differences between African American and European American participants in this study (Musil, 1998). Given that African American and European American grandmothers providing both full-time and part-time care scored above the normative sample in regards to stress, depression, and anxiety, these findings suggest that grandmothers with even partial responsibility for grandchildren are at risk for mental health problems.

Bowers and Meyers (1999) investigated the impact of both full-time and part-time care provided by grandmothers using the Child Behavior Checklist, Zarit Burden Interview,
Satisfaction with Grandparenting Scale, Parenting Stress Index, Interpersonal Support Evaluation List, and Life Satisfaction Index. Although part-time participants were obtained through random survey, the researchers were required to recruit full-time care givers through support groups, word of mouth, and notices in church bulletins. The participants in this study resided in Virginia, Pennsylvania, and Minnesota. Grandparents who had full physical and financial responsibility were defined as full-time care givers, those who provided at least 15 hours of care a week were defined as part-time caregivers, and those with only intermittent contact were defined as non-caregivers. Both full-time and part-time respondents noted that any changes in their relationship with the grandchild’s parent tended to be negative. The grandmothers frequently reported that their own adult child’s inability to function as a parent was very difficult to accept. Full-time caregivers reported a greater perception of burden and higher levels of parenting stress than part-time grandmothers. Full-time grandmothers attributed the increased parenting stress to the challenging behaviors of their grandchildren, who became their responsibility due to parental neglect, substance abuse, or divorce. Full-time grandmothers also reported a lesser degree of life satisfaction than part-time grandmothers. Half of the married full-time grandmothers reported that their relationship with their spouse had deteriorated since assuming care of the grandchildren. Of the full-time grandmothers, 96% stated they did not regret assuming care of their grandchildren, but 45% stated they would relinquish care if a suitable surrogate could be found. One interesting note was that although full-time grandparents reported the lowest levels of grandparent satisfaction, part-time caregivers reported a higher level of satisfaction than the grandmothers who provided minimal care (Bowers & Meyers, 1999). This finding would seem to support developmental theory which endorses the importance of elders caring for and mentoring children (Armstrong, 2007). Bowers and Meyers (1999) did not specify if the part-time grandmothers were living in a three-generation household, or resided
separately from their grandchildren. Further demographic study to track the status of multigenerational households in the United States would be helpful.

Further Consideration of the Impact of Full-time Responsibility

Most of the research regarding the phenomenon of grandparents assuming care of grandchildren involves grandparents in a full parental surrogacy role. Fuller-Thompson, Minkler, and Driver (1997) examined data from the National Survey of Families and Households, or NSFH, conducted in 1992, 1993, and 1994. The authors determined that 173 grandparents in the sample of 3,477 grandparents had held full responsibility for at least one grandchild for at least six months. Of this sample, 44% had assumed childcare responsibilities when the child was an infant, and 72% did so before the child was five years old. Over half of the respondents reported they were their grandchild’s primary caregiver for over three years. By applying bivariate techniques and logistic regression, the authors obtained a breakdown of demographic data regarding care-giving grandparents in the United States during the 1990s. Racial and geographic data were consistent with that obtained in the 1990 Census. However, the NSFH data also included information regarding the recent death of a grandchild’s parent. The authors’ research indicated that women, particularly African American women and recently bereaved parents, had the highest odds of becoming full-time, care-giving grandparents. The authors further note that two thirds of the grandparents were caring for their daughters’ children (Fuller-Thomson, Minkler, & Driver, 1997).

An early study regarding grandmother caregivers, conducted in 1990 at three pediatric health clinics in poverty-stricken regions of New York City, supports the above findings (Joslin & Brouard, 1995). Noting a marked increase in pediatric patients being cared for by grandparents, the New York City Department of Health and New York City Department of Aging conducted a study of the prevalence of grandmother primary care givers at three selected
clinics. Ethnic composition of the clinic neighborhoods, Central Harlem and East Harlem, was predominantly African American and Hispanic. Although the authors did not include specific reasons for a parent’s absence, they note that the neighborhoods represented were significantly impacted by the crack cocaine epidemic and AIDS mortality. The authors obtained a 50% random sample of families by selecting every other family record in the alphabetical files. These records were then reviewed to determine which families were headed by a grandmother or great grandmother. Results indicated that 7.8% of the pediatric patients were in the custody of a grandparent. Nursing staff interviewed families at the beginning of clinic visits, attempting to solicit the caregiver’s age. Based on ages disclosed, 47% of the grandmothers were at least 55 years of age. 25% were over 60 years of age, and 8% were over the age of 70 years. Over half of the grandmother caregivers were caring for more than 2 children aged 12 years or younger.

Information regarding the grandmothers’ emotional and physical health was not obtained in this study. However, the authors note that older African American and Hispanic adults living in poor neighborhoods have a higher incidence of chronic health problems and disability. The authors raised concern that the stress of care-giving might both exacerbate chronic health problems and cause grandmothers to neglect their own health (Joslin & Brouard, 1995).

Gibson (2002) used inner city Denver as the stage of a small qualitative study to explore beliefs and values which motivated African American grandmothers to assume responsibility for grandchildren. Twelve African American grandmothers were recruited to participate. Although the participants shared racial background, they represented a range of educational backgrounds and employment status. Six themes emerged from this study. The first involved the tradition of kinkeeping. Respondents noted that they had been raised in multigenerational households in which the elder members cared for children. The respondents reported positive experiences growing up in such families, and were motivated to continue this tradition. A similar theme
involved maintaining and enriching a close relationship with their grandchildren. Respondents also reported an underlying distrust of the formal foster care system, and a desire to prevent the children from being cared for by strangers. Following this theme was the conviction that they were their grandchildren’s only resource. Spiritual belief and a strong conviction that God would provide the strength needed to be caregivers was another theme that emerged from the interviews. The final theme delineated respondents’ frustration that their grandchild’s other grandmother offered little help. The author noted that the circumstances which led this group of African American grandmothers to assume care of their grandchildren are quite different than those of previous generations. In the earlier part of the twentieth century, grandparents played a significant care-giving role to allow their grandchildren’s parents to work or finish school. However, the parents remained part of their children’s lives. Gibson urges service providers to allow grandparent caregivers to express their feelings about such changes. The author concludes that culturally sensitive services for African American grandmothers should recognize and support the role of their client’s spiritual faith (Gibson, 2002).

Kelley (1993) used a different demographic group to explore the reasons grandparents became full-time caregivers and their subsequent experiences. For this study, 41 participants were recruited from organizations supporting grandparents in the northeastern United States. The majority of the participants were European-Americans in the middle upper class to upper class socio-economic status. As 40 of her 41 participants were female, Kelley’s research essentially involved grandmothers. Ninety percent of these grandparents assumed care of their grandchildren due to neglect, abuse or abandonment. Parental use of alcohol and other drugs played a large role in the maltreatment of the children, with 78% of the mothers and 63.5% of the fathers identified as substance abusers. Kelley employed the Parenting Stress Index (PSI) to compare the grandparents’ degree of parenting stress to normative values. The PSI measures
characteristics in the child domain and parent domain. The child domain considers such characteristics as the child’s adaptability, demanding behavior, and mood. The parenting domain considers factors such as social isolation, relationship with spouse, and life stress. Participants in this study displayed scores higher than the norm in regards to role restriction, deteriorating spousal relationship, and social isolation. A disturbing 40% of the participants had clinically significant scores on the total score of the PSI. The author used qualitative measures to assess the level of financial stress this group of grandparents experienced. Although not living in poverty, 56% of this group reported financial stress due to fixed incomes, needing to leave the work-force to care for young children, and being forced to move to more expensive housing to accommodate a larger family. Utilizing the Symptom Checklist 90-Revised to assess psychological distress, 44% of the participants scored above the clinically significant 90th percentile. Specifically, the subscales pertaining to depression, interpersonal sensitivity, hostility, paranoia, obsessive-compulsive traits, and somatization were elevated (Kelley, 1993). Although this study focused on the well-being of the grandparent care-givers, the findings raise questions regarding the ability of some to effectively parent the children in their care.

Seeking to gain understanding of a specific community, Roe, Minkler, Saunders, and Thomson (1996) explored the physical and emotional health of 71 African-American grandmothers, great grandmothers, and great aunts caring for children whose parents were casualties of the crack-cocaine epidemic. Participants were limited to African American women in Oakland, CA, who had assumed care for at least one child under the age of five years whose parent(s) were incapacitated due to crack cocaine abuse. The subjects participated in two interviews which explored physical and emotional health status using self-rated health scales. The ages of the participants ranged from 41 to 79 years of age, with 57% being under the age of 55, and 88% under the age of 65. Financially, 62 of the 71 rated themselves as either ‘not doing
very well’, or ‘doing poorly’. The age group and financial standing of these women has obvious implications for grandmothers who may be trying to balance employment with their new care-giving role. Close to 40% of the participants rated their health as fair, 43% as good, and 10% as excellent. However, the authors noted that these figures were lower than the National Health Interview Survey of African American women. Thus, the Oakland sample rated themselves as less healthy than the national average of their peers. In regards to mental health symptoms experienced during the previous week, 78% affirmed feelings of exhaustion early in the day, 72% reported feeling depressed, 70% reported difficulty ‘getting going’, 58% stated they ‘would go crazy’ if they did not have a break from their responsibilities, and 47% stated they were lonely. Of particular concern is the finding that the employed women of this study reported that both their physical and emotional health had deteriorated since care-giving responsibilities started (Roe, Minkler, Saunders, & Thomson, 1996).

**Grandfathers as Surrogate Parents**

Research discussed thus far has focused on the experience of grandmothers. Okagbue-Reaves (2005) compared the health and wellbeing of grandfathers to grandmothers raising grandchildren. The grandparent respondents were recruited from caregiver support groups in four counties in the central part of Michigan, with families living in small to medium sized urban communities. Of the 19 male respondents, 15 were European American, two were Hispanic, one was African American, and one was Native American. Over half of the grandfathers were employed. The author used the Grandparent Assessment Tool and the Medical Outcomes Trust SF-36 TM Health Survey to assess both grandmother and grandfather perceptions of health and role satisfaction. When compared to grandmothers, the grandfathers scored lower on life satisfaction, emotional health, and physical health. The discrepancy between the two groups may be partially attributed to the older age of the male sample. Only 23% of the grandmothers
in the study were over 55 years of age, compared to 47% of the grandfathers. Nevertheless, this study indicates that the well-being of both grandmothers and grandfathers is challenged by the stress of caring for minor children (Okagbue-Reaves, 2005).

**Latino and Native American Grandparent Caregivers**

Much of the literature regarding custodial grandparents has focused on African American families living in urban settings. This is understandable in that this group has the highest proportion of skipped generation families. Attention has turned to the experience of Latino and Native American custodial grandparents, as well as grandparent-headed families in rural areas. Kopera-Frye (2009) compared the needs and perceptions of Latino and Native American custodial grandparents from Nevada in a small qualitative study. The author noted that traditionally, both Latino and Native American cultures value strong family commitment. In addition, Native Americans view a child as being the responsibility of both the family and the tribe. In this study, the author found that Latino grandparents reported poorer health as compared to Native American grandparents. However, the Latino grandparents were, on average, ten years older than the Native American participants. In regards to pressing needs, the Latino grandparents reported difficulty in accessing health care services for their grandchildren. The Native American grandparents cited access to legal services regarding custody issues as their greatest concern (Kopera-Frye, 2009).

Letiecq, Bailey, and Kurtz (2008) specifically compared the prevalence of depression in Native American and European American custodial grandparents living in rural Montana. Participants were recruited via newsletters, an e-mail list-server, child care programs, senior citizen groups and grandparent support groups. Respondents included 19 Native American grandparents and 36 European American grandparents. Depressive symptoms, perceived supports, and parental stress were measured. Native-American grandparents had the highest
level of depressive symptoms, with 58% reporting CES-D scores that were clinically significant. In both groups, custodial grandparents who had cared for their grandchildren for less than 5 years were at higher risk of depressive symptoms. A high level of parental stress was a predictor of depressive symptoms in both groups. Those grandparents with higher incomes had lower rates of depression (Letiecq, Bailey, & Kurtz, 2008).

Goodman and Silverstein (2006) compared the impact of custodial grandparenting or co-parenting on European American, Latino, and African American grandmothers in Los Angeles County. Recruiting participants through schools, media, and community organizations, the authors amassed a large sample of 1,051 respondents. Of note is the particular care given to ensure accurate Spanish translations of measures used, and the practice of using trained interviewers fluent in the respondent’s version of Spanish. In addition to a structured interview, measures used to assess well-being included the Positive and Negative Effect Scale, Life Satisfaction Scale, the SF-36 Health Survey, and the Center for Epidemiologic Studies Depression Scale. In regards to family stress, the majority of African American and Latino custodial grandmothers in this sample noted they assumed care of the grandchildren to assist parents economically. The majority of European American custodial grandmothers indicated they assumed care due to parental substance abuse. Approximately 10% of both custodial and co-parenting grandmothers in all three ethnic groups endorsed the presence of clinically significant depressive symptoms. However, European American grandmothers reported higher negative affect than either African American or Latino grandmothers. European American grandmothers also reported more distressed relationships with their grandchild’s parents than the other two groups. These findings, consistent with higher levels of parental substance abuse, suggest that the European American grandmothers experienced a higher degree of family conflict. It is interesting to note that the higher economic status of the European American
grandmothers did not appear to alleviate their distress, which conflicts with the findings of Letiecq, Bailey, and Kurtz (2008). The authors speculate that the increased levels of family stress in the European American families may be attributed to the fact that these grandmothers assumed care in response to acute crisis (Goodman & Silverstein, 2006).

Goodman and Silverstein’s (2006) study is significant in that it involved a large sample of the groups found in urban settings. Their data suggest structural differences in families of different ethnic backgrounds, which are salient to therapists. The European American respondents in this study attributed parental substance abuse as the catalyst to becoming the grandchildren’s caregivers. However, European American grandparents traditionally take a more distant role in the lives of their adult children and grandchildren than African American or Latino grandparents. This may account for the increased level of distress in the European-American grandmothers. Also, the Latino and European American co-parenting grandmothers reported higher life satisfaction than their custodial counterparts. Conversely, custodial African American grandmothers reported higher life satisfaction than co-parenting African American grandmothers (Goodman & Silverstein, 2006). Although therapeutic approaches must be tailored to specific family needs, these findings are useful in understanding cultural differences.

**Long-term Implications for Grandparent Caregivers**

The studies reviewed to this point have been cross-sectional in design. In contrast, Blustein, Chan, and Guanais (2004) utilized data from the Health and Retirement Study to assess depressive symptoms of grandparent caregivers in a large, longitudinal study. The Health and Retirement Study, or HRS, is a large study conducted by Michigan State University examining the status of middle-aged and older adults. The respondents were interviewed every two years, starting in 1992 and ending in 2000. Blustein and colleagues focused on the data obtained in the waves between 1994 and 2000, as information collected in 1992 did not consistently address
The study was somewhat limited in that participants were identified ethnically only as ‘white’ or non-white.’ Depressive symptoms were measured using the abbreviated form of the Center for Epidemiologic Studies-Depression (CES-D) instrument. This data yielded a robust sample, starting with 8,409 grandparents in the 1994 wave, 6419 of which were still participating in 2000. The HRS was structured to ascertain the number of respondents who were grandparents, if they had grandchildren living in the home, if they were married or partnered, and if they had an adult child living in the home. Blustein determined that 16% of the sample had a grandchild living in their home during at least one wave of data collection. However, grandchildren move in and out of their grandparents’ care. Only approximately one third of the grandparents had co-resident grandchildren in all four waves, the rest were termed ‘switchers.’ Changes in CES-D responses of the switcher group allowed the authors to assess the correlation between having a grandchild move in and subsequent depressive symptoms. Twelve percent of the grandparents who never had co-resident grandchildren reported clinically significant CES-D scores. Eighteen percent of the switchers had CES-D scores indicative of clinical depression. Twenty two percent of grandparents who had grandchildren with them through all four waves reported clinically significant CES-D scores. The presence of a partner for European American grandmothers appeared to offset depressive symptoms. However, grandmothers of color experienced an increase in depressive symptoms despite the presence of a spouse or partner. Having an adult child in the home mitigated depressive symptoms in European American women and women of color. Grandfathers of color, on the other hand, experienced an increase in depressive symptoms despite the presence of an adult child in the home (Blustein, Chan, Guanais, 2004).
Financial Challenges

When considering the psychological well-being of grandparents who are raising grandchildren, it is difficult to ignore family financial concerns. Poverty exacerbates all other social and emotional stressors. In initial data collection for the purpose of developing a support group model, Smith and Monahan (2007) found that 43% of their respondents acknowledged feeling overwhelmed by financial stress frequently, if not constantly. It is therefore pertinent to consider the economic status of grandparent-headed households. Park (2006) analyzed data obtained from the 1997 and 1999 National Survey of American Families, or NSAF, to assess the financial status of grandmother-headed families. The NSAF is a large study of the U.S. population under the age of 65, excluding those residing in institutions or serving in the military. Using the NSAF data, Park studied a pooled sample of 1,363 grandmothers who identified themselves as the primary caregivers of their grandchildren. The sample was further divided by four types of family structure: single grandmother and grandchildren, partnered grandmother and grandchildren, single grandmother living with grandchildren and children’s parent, and partnered grandmother living with grandchildren and grandchildren’s parent (Park, 2006). Although the NSAF did not collect data on citizens over the age of 65, the resulting sample is consistent with U.S. Census data indicating that the majority of custodial grandparents are age 40 to 65. In Park’s study, the data revealed that single grandmothers in both skipped generation households and three generation households experienced poverty, despite the fact that over half of this group worked at least part-time. This group also reported more health problems than the partnered grandmothers. Grandmothers in skipped generation households were older, were providing care for older children, were less likely to have finished high school, and were more likely to have incomes under $10,000 annually. Grandmothers in three generation households were more likely to be supporting teenage daughters with young children. Grandmothers heading skipped
generation households often received little support from welfare agencies. Park noted that all states have different policies in administering TANF funds and foster care payments. Indeed, some states pay grandparents much smaller foster care stipends than payments to non-kin foster parents. The plight of grandparents in skipped generation households was further hampered if the care arrangements were informal, with custody still in the hands of absent parents. In order to receive government aid, grandparents must either have legal custody of the children, or the children must be wards of the state, with grandparents serving as foster parents. Some grandmothers are unwilling to engage with local child welfare entities for fear of irrevocably breaking ties with the child’s parent. Park further noted that even if the grandparents had legal custody of their grandchildren, they were often unaware of financial and other types of assistance available. The NSAF data scrutinized by Park revealed that even with income from TANF or foster care subsidies, one half of the single grandmothers from both types of families remained in poverty. One fifth of the families had household incomes of less than 50% of the poverty level (Park, 2006).

Casper and Bryson (1998) considered the impact of family structure on the financial well-being of families maintained by grandparents using data from the 1997 Current Population Study conducted by the U.S. Census Bureau. These data allowed the authors to examine the economic characteristics of a variety of family constellations of grandparent headed households. The results indicated that children living with their grandparents are more likely to live in poverty than those living with their parents. Those children living with a single grandmother and no parent were the most likely to live in poverty. A somewhat unexpected finding was that households with both grandparents and a parent present had rates of poverty that were similar to that of skipped generation households consisting of two grandparents and grandchildren (Carson and Bryson, 1998). Perhaps this reflects grandparents providing support for an unemployed or
disabled adult child as well as grandchildren. If so, this would suggest additional sources of psychosocial distress.

**Discussion**

In studies reviewed thus far, evidence has been presented that custodial grand parenting adversely affects the physical and emotional well being of the care-giving grandparents (e.g. Blustein et al., 2005; Goodman & Silverstein, 2006; Kelley, Kopa-Frye, 2009; Letiecq et al., 2008; Musil, 1998; Okagbue-Reaves, 2005; Roe et al., 1996). The negative impact is somewhat ameliorated for Latino grandmothers in three generation household, whereas African American grandmothers fared better when the adult parent did not live with the family unit (Goodman & Silverstein, 2006). Because the majority of grandparent-headed households consist of single grandmothers, the bulk of the research has focused on grandmothers. More research is needed concerning the effect that serving as a surrogate parent has on grandfathers.

Different studies conducted in various U.S. locations reveal different reasons grandparents are taking on the care of their grandchildren. Nevertheless, a picture has emerged of families challenged and often fragmented by parental drug abuse, poverty, mental illness and incarceration. In some cases, absent parents seem incapable of parenting due to immaturity or lack of responsibility. Additionally, contemporary society is more aware and less tolerant of child abuse and neglect than it was several generations ago. As a result, more children are being removed from their parents’ care.

The paradigm of placing abused and neglected children with paid foster parents has been replaced by the preference for kinship care. Although remaining with their extended family can provide some continuity for foster children, more research is needed to understand the experiences and outcomes of these children. This review of the literature focused on the well-being of grandparent caregivers. The authors of the studies discussed invariably expressed
concern about the negative impact the assumption of child-rearing may have on the grandparents. However, there is little challenge to the practice of kin foster placements in the U.S. literature. Kinship care will likely remain the preferred policy unless longitudinal research proves it is harmful to children. With this as a given, mental health providers, medical practitioners, and social service providers need to find ways to strengthen and support these families.

The experience of grandparents in three generation households may prove to be less stressful than that of custodial grandparents. Several studies indicated that three generation households are developing in response to financial challenges (e.g., Casper & Bryson, 1998; Kelley, 1993; Park, 2006; Smith & Monohan, 2007). This may be increasing in the United States due to the recent economic downturn. In many cultures the world over, three generation households are the norm. Although less common in the United States, this type of family structure may be both adaptive and enriching. During times of transition, however, mental health providers can assist in helping such families form effective roles and structure.

**Clinical Implications**

At the end of the 20th century, Thomas, Sperry, and Yarbrough (2000) advocated that psychological research focus on two areas. First of all, therapy interventions need to be linked with theory to articulate why these interventions work. Secondly, research samples need to be larger in size to test the efficacy of interventions in diverse populations. Despite such enjoinders, such efforts remain sparse. The few works which address these issues will be discussed below.

Brattan, Ray, and Moffett (1998) discussed the advantage of using Filial Play Therapy with custodial grandparents and their children. This technique involves teaching grandparents the basic skills of play therapy, which would allow the grandparents to be the therapeutic agents of change in their grandchild’s life. Grandparents participated in 2 hour small group sessions for 10 weeks. Participants were assigned to video tape a 30 minute practice session at home, and the
tapes were discussed by group participants. The weekly sessions also provided participants with a form of supportive group therapy. The authors did not offer a quantitative review of therapeutic outcomes. However, they noted that participants learned relational and parenting skills which would, in turn, strengthen family bonds and improve family functioning (Brattan, Ray and Moffet, 1998).

Goodman (2008) analyzed the impact of familial triangulation on the well-being of grandmothers raising grandchildren. Although this work did not directly address therapy approaches, the results have implications for family therapists. Goodman’s participants included 512 custodial grandmothers and 475 co-parenting grandmothers in the Los Angeles region. Based on interview data, subjects were classified as belonging to connected, linked, isolated, or disconnected family triads. The connected grandmother family may be symbolized by an equilateral triangle in which there were equal connections between grandmother, parent, and child. Linked families were represented by family structures in which the grandmother was linked to the parent, child, or both. Unlinked families had a linkage gap, representing an absent connecting line of the triangle. This linkage gap could be between grandmother and parent, grandmother and child, or parent and child. Isolated family structures were those in which connections existed between only two of the generations, and disconnected family structures had no meaningful connection between any of the generations. The author analyzed the impact that the various family structures had on the grandmother participants’ reported well-being. No difference in well-being was noted between custodial and co-parenting grandmothers in parent-linked triads. However, custodial grandmothers in child-linked triads reported high levels of well-being, while co-parenting grandmothers in child-linked triads reported low levels of life-satisfaction. Both custodial and co-parenting grandmothers reported low levels of well-being when they were isolated from the parents. These findings suggest that child-linked triads in
custodial grandparent headed families may reinforce the grandparent’s authority, leading to improved life and role satisfaction. In co-parenting families, grandparents in child-linked triads may be finding themselves at odds with the child’s parent, resulting in a decreased sense of well-being. Goodman (2008) demonstrated that the well-being of both custodial and co-parenting grandmothers benefits from a positive connection with the grandchild’s parent. Likewise, both custodial and co-parenting grandmothers’ well-being suffered when the grandchild’s parent was isolated from both child and grandparent. Although isolated-parent configurations were rare in the co-parenting families studies, Goodman (2008) noted they can occur when the co-resident parent is too immature or otherwise impaired to take a meaningful adult role. This finding has implications for family therapists. Interventions aimed at strengthening bonds between grandparents and parents appear salient to both custodial and co-parenting families. However, to increase a custodial grandmother’s sense of well-being and, therefore, their ability to parent, it is pertinent to maximize the bonds between grandmother and grandchild. The likelihood of therapy repairing bonds in families with isolated parents is dependant on the parent’s willingness and functional capacity to change. Referral to appropriate resources to assist such parents, such as mental health or chemical dependency treatment, is warranted. If the dysfunctional parent is unable or unwilling to change, family therapy interventions should address issues of abandonment and grief circumstances.

**The Role of Formal Support Groups**

Other researchers have focused on the role of support groups and parent education for grandparents in conjunction with other forms of social services. Whitley, White, Kelley, and Yorke (1999) advocated the use of strength-based case management combined with support groups and educational classes. These services were offered to grandparents of skipped generation households in Atlanta, Georgia. Noting that the strength-based approach underscored
the structure of the support groups, participants reported feeling less isolated and more confident. These findings were based on qualitative responses from participants, and the authors noted that more research is needed to assess the effectiveness of this model.

Several projects reported in the literature focus primarily on the development of support groups and educational programs tailored for grandparents. Although these projects were not guided by specific theoretical approaches, they embraced the philosophy of strength-based services. Grant and colleagues stressed the importance of gaining trust and building relationships with grandparent caregivers before the initiation of formal services (Grant et al, 1997). McAllion, Janicki, Grant-Griffen, and Kolomer (2000) noted that barriers to support group participants had to be addressed to facilitate participation. In their project, most support group meetings were scheduled during the school day, when grandparents had more time. For preschool children, childcare was provided. One support group was held in the evening, to accommodate working grandparents, also with childcare. In addition, transportation to the meeting site was provided for the participants.

Analysis regarding a thirteen site demonstration project titled KinNET primarily focused on the demographics of the grandparent participants. However, authors Smith and Monohan (2007) included practical suggestions garnered from experience with the project. The authors found that successful groups had to be flexible to meet needs of participants. Logistical challenges made it difficult for many support group participants to attend regularly. To offset these challenges, the KinNET project also provided childcare and transportation services. In addition, the KinNET project offered onsite information and referral services for support group participants.

Support groups may be a logical first step in providing a group service to grandparents who are once again filling a parental role. If paired with an educational component addressing
issues pertinent to the audience, a support group may provide a safe entry for participants wary of anything resembling psychotherapy. This is particularly true when targeting a population which prides itself on self-sufficiency and resists seeking help. It would be prudent to include a core group of consultants from the community of child-rearing grandparents to serve as advisors on the design, focus, and implementation of such a group. Facilitators, either lay or professional, must be sensitive to group participants’ cultural influences. It would be helpful if transportation could be facilitated. The provision of childcare during the meeting times appears critical. Once established, the group itself could take a role in choosing topics of interest.

**Implications for Psychotherapy**

If services such as support groups and parent education classes are not sufficient, grandparent-headed families may benefit from some form of psychotherapy. This may take the form of individual, couples, or family therapy. As this brief literature review has revealed, grandparents assuming responsibility for minor grandchildren are at risk for depression (e.g. Blustein et al., 2004; Goodman & Silverstein, 2006; Kelley, 1993; Letiecq et al. 2008; Okagbue-Reaves, 2005; and Roe et al., 1996). Chase-Goodman (2008) and Kelley (1993) note that isolation from other adults was a consequence of parenting grandchildren. Grandparents may neglect their own medical needs due to limited finances and lack of child care (e.g. Kopera-Frye, 2009; Musil, 1998; Okagbue-Reaves, 2005; and Roe et al., 1996). Working grandparents struggle to balance career and childcare, but without the protections and benefits accorded working parents. In addition to these issues, grandparents are often faced with a new family configuration at times of crisis. Psychotherapy may help grandparents address the issues of grief regarding the loss of the lifestyle they had planned for later adulthood. Therapy may also help grandparents cope with the stigma often assigned to the behavior of their own children who failed, for whatever reason, the critical life task of parenting. Grandparents also may need
assistance dealing with guilt regarding their own real or perceived errors as parents. Grandparents may need assistance in coping with conflicted or ambiguous relationships with their adult child. A therapist may assist grandparents in considering the step of adopting or seeking permanent custody of the grandchildren in their care. Finally, managing anxiety over the future may be a focus of therapy.

In this literature review, there seemed to be a passive acceptance that kinship foster placements will continue to be the norm. Little attention is given to the multigenerational role families may have in the development and passive maintenance of substance abuse in skipped generation families. One exception found was raised by Kroll (2007) of Great Britain. Kroll poses two concerns regarding children who are placed with kin due to parental substance abuse. First of all, she notes that substance abuse is frequently a family disease. Are social service agencies carefully investigating and considering if the grandparents are either abusing substances themselves or supporting the disease through enabling behavior? Secondly, she notes that birth parents failure to nurture their children may result in complex attachment issues. Do the grandparents have the ability to cope with the resultant challenges? Kroll does not reject kinship placements per se, but challenges child welfare agencies and social policy makers to be aware of potential pitfalls.

Kinship placements are likely to remain the norm. In such situations, family therapy may be helpful in molding a new, cohesive family structure. It is crucial that a therapist treating grandparent-headed families be comfortable working with complicated relationships and situations. Family therapy could help the new family unit define roles and responsibilities. Particularly in families including preteens and teenagers, a therapist may help bridge the cultural gap between a grandparent’s generation and that of their grandchildren. Healthy communication
skills and conflict resolution skills could be addressed. Perhaps most crucially, family members could process feelings of grief and loss in a safe setting.

Assuming full-time responsibility for grandchildren has been shown, in some cases, to have an adverse effect on partnered relationships (e.g. Bowers & Meyers, 1999; Kelley, 1993). The situation could be further complicated if the couple represents a blended family, and the grandchildren are blood relations to only one partner. Conflict over childrearing responsibilities, time spent as a couple, and finances may challenge care-giving grandparents. Radical changes to life plans could prove to be extremely divisive. These stressors, as well as many others, may be mitigated through couples counseling.

Although this paper has focused on the psychosocial concerns of care-giving grandparents, it is pertinent to briefly discuss mental health challenges facing the grandchildren. Children who have been raised by chemically dependant or mentally ill parents may suffer from attachment disorders because they had no nurturing adult figure to bond with. Children from violent families may be victims of personal or witnessed trauma. Abused children are often loyal to parents despite maltreatment, as this is the only family they have known. Consequently, they may feel torn between parent and grandparent. On the other hand, they may fear that the abusive, neglectful parent may return to remove them from the stability of their grandparents’ home. Children in the care of their grandparents may feel stigmatized by such factors as parental mental illness or incarceration. Finally, children of chemically dependant parents may present with a range of neurological impairments due to in vitro exposure to drugs or alcohol. In short, the developmental, psychological, and educational challenges of their grandchildren may erode the grandparents’ emotional and psychological reserves.
Applications of Adlerian Therapy with Grandparent-Headed Families

It would be presumptuous to assume all grandparent-headed families need psychotherapeutic intervention. For those who do seek such services, treatment rooted in Adlerian theory could be beneficial. Adlerian psychology incorporates Alfred Adler’s concept of Gemeinschaftsgefühl, translated by Adler as community feeling or social interest. In brief, this concept reflects Adler’s belief that an individual’s psychological well-being is reflected in that person’s connectedness with the larger society. Embedded in the larger cultural community, a person begins to learn and demonstrate social interest in their family of origin. Children hopefully learn to demonstrate caring and respect for family members as well as sharing household responsibilities. Children who master these tasks will likely grow into citizens who value the well-being of community members (Adler, 1964). Adlerian therapists can honor the high degree of Gemeinschaftsgefühl displayed by care-giving grandparents. These grandparents often make great sacrifices to ensure that their grandchildren have a stable childhood.

Adlerian therapy is also genuinely optimistic. Grandparents who assume the care and responsibility for neglected, possibly abused, grandchildren need a therapist who can offer positive, yet realistic, encouragement. In contrast to authoritarian stance often taken by governmental services, Adlerian theory stresses an egalitarian relationship with clients. This approach can facilitate collaborative problem solving. Holistic in philosophy and approach, Adlerian therapists will consider all aspects of a person in formulating a treatment plan. This is critical in that the therapist must continually encourage self-care of the body, mind and spirit with this population.

Adlerian therapists realize that clients, either as individuals or families, cannot be isolated from their cultural milieu. Thus, the Adlerian therapist will strive to understand and honor the
client’s cultural and ethnic background. Adlerian therapy in the United States is usually short term, with a focus on solutions. However, Adlerian therapists do not attempt to understand a client’s present circumstances without a basic understanding of the client’s past. Adlerian therapists seek to challenge the client’s erroneous beliefs, usually acquired in childhood, so they can adopt cognitive constructs which will facilitate change. Adlerians also recognize that core assumptions and styles of interpersonal relationships are learned in one’s family of origin and carried into adult relationships. These considerations may be critical in assisting older adults who once again find themselves in the role of a parent to minor children. If custodial or co-parenting grandparents made errors raising their own children, a sensitive therapist could help redirect guilt and challenge self-defeating beliefs which undermine their new roles. Adlerians stress that children and adults are of equal worth as human beings.

However, Adlerians do not pretend that a family with children is a democracy. As such, the therapist could help grandparent caregivers create a healthy family structure while fostering open communication between members. Adlerian therapists are trained to pay attention to the influence of ordinal position, which could help care-giving grandparents understand the behavior of their grandchildren. This may be particularly critical if grandparents have assumed the care of cousins as well as sibling groups. In such situations they may need to understand the behavior of a ten year old first-born from one family who has been demoted in position by a twelve year old first born cousin. Adlerian therapists function as educators, able to offer information regarding child development and positive discipline techniques. Finally, Adlerian therapists are comfortable being directive. This can be helpful to grandparents who are looking for concrete guidance (Carlson, Watts, & Manniacci, 2006).

Traditionally, Adlerian therapists identify three realms in life which individuals must
master to sustain psychological health. These realms, or life tasks, are intimacy, work, and friendship (Carlson, 2006, p. 13). The level of functioning in each area is often a starting point which guides therapy. Although there are specific therapeutic interventions unique to Adlerian therapy, Adlerian therapists tend to be eclectic in their choice of techniques (Carlson et al., 2006). In other words, the therapist selects techniques and approaches which best serve the client. However, Adlerians utilize a unique personality appraisal technique known as the Life Style Assessment (Shulman & Mosak, 1995, chap. 1). This assessment, as used in individual therapy, could be very informative in regards to the family history, values, and possibly misguided beliefs of grandparents and grandchildren. The Life Style Assessment has also been adapted for use in family therapy (Oberst & Stewart, 2003, chap. 4). Use of the Life Style Assessment when counseling grandparent-headed families would serve to illustrate both shared and discordant values of various family members. This understanding could function as the foundation for the family treatment plan.

**Other Theoretical Applications**

In addition to Adlerian approaches, it would seem that techniques developed by Narrative therapists could be useful. Specifically, therapists could assist individual clients and families discover their positive, affirming story in the face of stigmatizing messages received from the larger society (Morgan, 2000). Therapists providing family therapy would benefit from competency in addressing attachment issues, as the children involved are often at high risk for attachment disorders (Kroll, 2007). Finally, helping family members cope with the unresolved loss of relationships and uncertain futures may be critical to the stability of these new families.
Suggested Roles for the Adler Graduate School

The Adler Graduate School of Minnesota may be in a unique position to serve
grandparent-headed families. The Hennepin County Department of Social Services has
expressed interest in leasing office space from the school. This space would be utilized as a
satellite office to serve clients in the southern part of the county (D. Haugen, personal
communication, February 9, 2009). With room available for group meetings, the school could
host grandparent support groups. The location would be convenient in that participants could
combine group attendance with appointments with case managers and other county social service
staff. To ensure that the direction and content of a support group is pertinent to prospective
members, a core group of grandparents could serve as advisees. This advisory group could help
determine the content of the support group. Such an advisory group would also foster sensitivity
to specific cultural concerns and dynamics of potential participants. Should individuals in the
group request psychotherapy services, referrals could be made. Such services could be offered
onsite, either by licensed practitioners or advanced graduate students under the supervision of the
Adler Graduate School faculty. The literature has shown that provision of child care for
participants is an important factor (e.g. McAllion, Janicki, Grant-Griggen, & Kolomer, 2000;
Smith & Monohan, 2007; Whitley, White, Kelley, & Yorke, 1999). A play-centered, yet
supportive format for the children who attend could be developed and provided onsite, staffed by
Adler graduate students interested in child development.

Recommendations for Future Research

As this discussion has illustrated, there have been research projects involving small and
large samples of grandparents ‘standing in the breach’ as surrogate parents for their
grandchildren. These studies have illustrated the emotional, social, financial, and medical
stressors faced by grandparent caregivers. Although these challenges have been identified, more research is needed regarding effective ways to manage these stressors. The bulk of the research to date has been conducted from a social work perspective. This research is salient to therapists. However, it behooves the psychotherapy profession to perform research to identify effective clinical strategies and approaches. Longitudinal studies regarding the efficacy of specific psychotherapeutic strategies are lacking, and would be very useful. The existing literature has focused largely on African American participants, and to a lesser degree on Hispanic, American Indian, and European American participants. Little research has been published about the prevalence and experience of grandparent caregivers in growing immigrant communities, such as those of East African and West African origin. In order for psychotherapy to be beneficial, techniques and strategies must resonate in the cultural context of the individuals and families served.

A new group of grandparent caregivers is emerging in response to U.S military engagement in two concurrent theaters of war. Some circumstances may involve serving as caregivers while a parent is deployed overseas. Other circumstances involve the formation of three generation households so that grandparents can assist not only with the care of grandchildren, but also a wounded veteran parent left with severe disabilities. Families of both active military members and veterans face unique challenges. Commitment to these families by society will hopefully be greater than that provided in the past. Although much research is being conducted regarding psychiatric conditions specific to soldiers and veterans, a greater understanding is needed to address the complex challenges of the families of these soldiers and veterans.
Conclusion

Although social workers have historically integrated social advocacy into their professional work, this is less true of psychotherapists in general. However, Individual Psychology incorporates Alfred Adler’s concept of Gemeinschaftsgefühl, translated by Adler as community feeling or social interest (Adler, 1998). Psychotherapists can demonstrate social interest by educating the public and advocating appropriate legislative initiatives. On a state and national level, policies need to be formulated to support grandparent-headed families. Such policies must address not only financial concerns, but also the legal challenges grandparent caregivers face. However, unless the conditions which prevent parents from responsibly parenting are addressed, grandparents will continue to serve as default surrogates. Alleviating substance abuse, poverty, and HIV infection will require political will, social commitment and financial capital. Therapists could serve as agents of larger social change by advocating legislation and policy which will address on these issues.

Other issues involve changing cultural norms in the United States. Single parent families, predominantly headed by mothers, have become common. In some communities, teenage girls expect to raise a family without an active partner. At the same time, society has not held fathers socially or financially responsible for their children. It is not sufficient to advocate legislation to hold absent fathers accountable. Social entities, from families to schools and religious organizations, must take an active role in teaching young men how to be engaged and effective fathers.

In the past quarter century, a more insidious change seems to have occurred. Historically, cultures have made the care and socialization of children a priority. However, single or partnered, an unprecedented number of American parents have abdicated their
responsibility in recent years. All professions providing services to children should question this trend. Are the parents who surrender their children to the care of others too self-absorbed to do the hard work involved in addiction recovery? Have young Americans come of age with the assumption that someone will take over if the task becomes too difficult? If the answers to these questions are yes, how do we reverse this trend? Ultimately, parents who relinquish responsibility for their offspring fail not only their children but society as well.
References


