

GRANDPARENT FOSTER CAREGIVER CHARACTERISTICS, DIFFERENCES BETWEEN
FOSTER CAREGIVERS, AND
PREDICTORS OF SATISFACTION WITH SOCIAL SUPPORT

by

ALICIA SIMMONS

(Under the Direction of Alberta Ellett)

ABSTRACT

This study described grandparent foster caregivers in the National Survey on Child and Adolescent Well-Being (NSCAW) dataset of 727 long-term foster care children. It explored differences between foster caregivers in four groups (parents, grandparents, other relatives and non-relatives) on caregiver mental health, caregiver physical health, parenting behaviors, home environment and quality of caregiver-child relationship. It also explored the variables that explained social support satisfaction among caregivers. The purpose of this study was threefold. The first purpose of the study was to build on the current literature about grandparent caregivers and answer questions about grandparent caregivers in the specialized area of child welfare. The second purpose was to compare and contrast the differences between grandparent caregivers and other caregivers in the child welfare system using variables from the gerontological and kinship literature. The third purpose of the study was to determine which factors best predict social support satisfaction.

Major findings of the study showed that: a) although the number of social supports available was importantly related to social support satisfaction, total family annual income,

quality of the caregiver-child relationship, and caregiver mental health were also important factors in explaining caregivers' social support satisfaction; b) after a child has been in foster care for a year, grandparent and parent caregivers experience lower mental health scores than non-relatives and other relatives; and c) although there were no statistical differences in social support satisfaction, non-relatives reported significantly more social supports than kinship care providers..

INDEX WORDS: Foster caregivers, Grandparent caregivers, Social support, Mental health, Caregiver-child relationships

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DEDICATION

This dissertation is dedicated to my husband, Steve Simmons. Thank you for your steadfast devotion, constant faith, and abiding love.

This dissertation is also dedicated to the memory of Ruby Cole Simmons. She lived her life with faith, determination, and humor. More than anything, she delighted in her role as grandmother to our two beautiful nieces, Abby and Emma.

Finally, I dedicate this dissertation to the memory of my grandparents, William Claude and Nile Finley, and John William and Velma Smith. They gave me many fond memories of loving, proud, and nurturing grandparents. A special dedication is extended to my maternal grandmother, Nile Borden Finley, who inspired my career in social work and gerontology.

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CHAPTER 1

INTRODUCTION

Overview

The U.S. Department of Health and Human Services (2004) reported that on September 30, 2002 the number of children in foster care in the United States totaled 532,000. Of those, 124,036 (23 percent) were living in kinship foster family homes (U.S. Department of Health and Human Services). This total counted only those children who were also in the custody of the state (Ehrle, Geen, & Main, 2003). In contrast, the 2002 National Survey of America's Families (NSAF) estimated that 405,000 children were in kinship foster care in 2002 (Ehrle et al.). This estimate included all children for whom a court had made a relative responsible (Ehrle et al.). When the estimate included relative placements that were arranged without involving the court system, NSAF estimated that 542,000 children were in a relative's care in 2002 (Ehrle et al.).

Relatives began to be seen as optimal placements for children in child welfare during the 1980s (Geen, 2000). Beginning in 1983, the number of children in foster care doubled in a little more than a decade (Geen, 2000). In fact, during the four year period between 1986 and 1990 the proportion of children in state-supported kinship care in the United States increased from 18 to 31 percent, from 280,000 to 400,000 children (Kusserov, 1992). Also during that timeframe the number of non-kin foster parents decreased (Geen, 2000). The number of available foster families declined from 147,000 in 1985 to barely 130,000 in 1998 (Barbell, 1999; Casey Family Programs, 2000). Even with a recent climb in the number of non-relative foster homes, the Child

Welfare League of America (CWLA) reports that in 2001 542,000 children were in foster care with a total of 155,355 licensed non-kinship foster homes available (CWLA, 2005).

Federal policy requires that kinship care continue to be an integral placement option for children in child welfare (Adoption and Safe Families Act of 1997). The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, section 505, requires that state agencies give priority to relatives when making placement decisions (P.L. 104-193; US Government Accountability Office [GAO], 1999). This practice has been implemented by states. For example, by 1999 in California 51 percent of the children in foster care were in kinship care, while in Illinois, 55 percent resided with relatives (US GAO, 1999). The Adoption and Safe Families Act of 1997, section 475, states that if a child is placed with a relative the state is not required to file a petition to terminate the parent's legal rights (P.L. 105-89).

More than 50 percent of kinship care providers in the child welfare system are grandparents (Dubowitz et al, 1994; Geen, 2000; Harden, Clark, & Maguire, 1997; LeProhn, 1994; Scannepieco & Jackson, 1996; Thornton, 1991). Caring for grandchildren offers many rewards for grandparents (Burton, 1992; Fuller-Thomson & Minkler, 2000a; Minkler & Roe, 1993). Ultimately, grandparents care for their grandchildren so the family can stay intact, and they can provide security and continuity to the grandchild's life (Jendrek, 1994).

However, gerontological research reports that grandparent caregivers experience strains that impact their health, mental health and social support systems (Burton, 1992; Fuller-Thomson & Minkler, 2000a; Fuller-Thomson, Minkler & Driver, 1997; Kelley, 1993; Kelley, Yorker, Whitley, & Sipe, 2001; Minkler & Roe, 1993; Minkler, Roe & Price, 1992; Musil & Ahmad, 2002; Strawbridge, Wallhagen, Shema, & Kaplan, 1997; Whitley, Kelley & Sipe, 2001). Grandparent caregivers are older than other caregivers; the mean age for grandparent caregivers

is 59.4 years (Fuller-Thomson et al.). Grandparent caregivers are significantly more likely to be single than other grandparents (Fuller-Thomson et al.). Grandparent caregivers have a lower income than other grandparents and they are 60 percent more likely to report incomes below the poverty level (Fuller-Thomason et al.). With all of these factors known from the gerontological research, do we know if foster placements with grandparents are optimal? In other words, do we know enough about the impact of the placement on the grandparent and the grandchild to support the practice of grandparent placement in child welfare despite its assumed efficacy?

Individual and Microsystem Factors that Impact Grandparent Caregivers

We know that there were many similarities between the characteristics of grandparent caregivers in the general U.S. population and all kinship foster care providers in the child welfare system. (All kinship foster care providers included grandparents, other relatives such as aunts or siblings, and close friends of the family.) In both the general population and in kinship foster care, caregivers were primarily women. According to U.S. Census data, grandmothers outnumbered grandfather caregivers 5 to 3, primarily due to the fact that women live longer and were less likely to remarry after the death of a spouse (Bryson & Casper, 1999). Fuller-Thomson et al. (1997) found that 77 percent of caregiving grandparents in their national study were women. In a 2002 AARP Grandparent Survey of AARP members approximately 30 percent of the grandparent caregivers were male and 70 percent were female. In the child welfare system more than 50 percent of kinship foster caregivers were maternal grandmothers (Dubowitz et al, 1994; Gebel 1996; LeProhn, 1994). As with caregiving grandparents, relative foster caregivers tended to be single, older, and have lower incomes than non-kin foster parents (Barth, Courtney, Berrick & Albert, 1994; Berrick, Barth, & Needell, 1994; Chipungu, Everett, Verduik, & Jones

,1998; Dubowitz, 1994; Ehrle & Geen, 2002; Harden, Clark, & Maguire, 1997; LeProhn, 1994; Scannapieco, & Jackson, 1996).

Family functioning, including parenting behaviors, home environment and caregiver-child relationships were factors that impacted all family microsystems, including those in the child welfare system (National Research Council, U.S. Panel on Research on Child Abuse and Neglect, 1993). Parenting behaviors were widely believed to be passed on from generation to generation (Cicchetti & Aber, 1980; Kaufman & Zigler, 1987; Kempe & Kempe, 1978; National Research Council, U.S. Panel on Research on Child Abuse and Neglect, 1993; Weiss, Dodge, Bates, & Petit, 1992). Studies indicated that abusive parents were more likely to use punishment, threats and power, and were less likely to use reasoning and affection in disciplining their children (Lorber, Felton, & Reid, 1984; Trickett & Sussman, 1988). Gebel (1996) found that kinship caregivers had more favorable attitudes toward physical discipline than non-kinship caregivers.

Home environment was known to be an important factor in child safety and development, predicting success in school and emotional support for young children (Bradley, et. al, 1989; Caldwell & Bradley, 1984; Gottfried, 1984; Sugland et al, 1995). Orme and Buehler (2001) found nine studies that examined the physical environment of foster homes. Although one study found that 99 percent of foster homes were judged to be *comfortable and safe* (Lindholm & Touliatos, 1978), Berrick (1997) found that non-kinship foster care providers were more likely to provide a supportive home environment than kinship caregivers.

Another important factor of child well-being was a positive relationship between caregivers and children. Quality caregiver-child relationships supported the healthy neurophysiological, physical, and psychological development of a child (WHO, 2004). This was

especially important in foster care settings since inadequate, disrupted and negligent care had adverse consequences on child health and development (WHO). Family adjustments to change were dependent on a wide set of conditions, including the caregiver-child relationship (Poehlmann, 2003).

Study Variables

As the literature supported, the characteristics of caregivers (i.e., age, marital status, income), caregiver mental health, caregiver health, social support, parenting behaviors, home environment, and positive caregiver-child relationships were important variables in understanding grandparent caregiver households. They formed the primary dependent variables for this study. The type of caregiver (grandparent, parent, other relative caregiver, or non-relative caregiver) served as the primary independent variable in this study.

Exosystem and Macrosystem Impacts on Grandparent Caregivers

Although the study focused on individual and family level variables, this study recognized the importance of individual and family characteristics that function in context with social institutions and external forces that have an impact on children and families. This discussion included social issues that created the need for grandparent caregivers and the development of social policy in the United States that impacted the availability of services for grandparent caregivers and child welfare practice.

Social Issues and Need for Grandparent Caregivers

Grandparents increasingly care for their grandchildren for many reasons. Changes in child welfare policies have increased placements with grandparents (Berrick & Needell, 1999; Chalfie, 1994). Social factors, such as increases in drug and alcohol abuse among women 15 – 44 (Barth, 1991, Chalfie, 1994; Jendrek, 1993), mental health issues (Chalfie, 1994; Jendrek,

1993), divorce, and teen pregnancy contributed to grandparents providing care (Harden et al., 1997). AIDS and increased numbers of incarcerated mothers also contributed to children living with grandparents (Joslin & Harrison, 1998; U.S. Department of Justice, 1997). These factors, in addition to child maltreatment, combined to bring children into grandparents' custodial care.

Substance abuse was responsible for grandparents becoming caregivers to their grandchildren in a majority of cases (Kropf & Brunette, 2003, Jendrek, 1994; Kelley, 1993; Minkler & Roe, 1993; Burton, 1992). Specifically, the crack cocaine epidemic had a large impact on the increase of grandparent caregivers in the 1980s and 1990s (Minkler, Roe & Price, 1992). Substance abuse created many emotional, physical, social, and economic issues for kinship caregivers that included caring for children who were abused and/or neglected, or who had birth defects and learning disabilities (CWLA, 2004). The Child Welfare League of America reported that the impact of substance abuse on families impacted the roles of the substance abusing parent and child; changes in family structure; sense of uncertainty and instability; neglect; financial instability; feelings of separation and abandonment; negative interpersonal relationships; physical and emotional abuse; distrust of the world; poor problem solving skills; disregard for others' feelings; feelings of shame and guilt; and dangerous environments (CWLA, 2004). Children of a substance abusing parent were three times more likely to be abused and more than four times more likely to be neglected than children whose parents are not substance abusers (Jaudes & Voohis, 1999). Albert and Barth (1996) found a positive relationship between the number of arrests for narcotics and dangerous drugs to the number of child abuse and neglect reports in urban and rural counties. McNichol and Tash (2001) reported that children of parental substance abuse actually improved in cognitive functioning after placement in kinship foster care.

Another social issue that contributed to the need for grandparent caregivers is teen parenting. More than four out of ten girls in the United States got pregnant at least once before age 20 (Kirby, 2001). Although teen pregnancy rates among 15-19 year olds have declined by 30 percent nationally since 1991, the United States has the highest rate of adolescent births in the industrialized world (Georgia Campaign for Adolescent Pregnancy Prevention [GCAPP], 2005). The teen birth rate was at its highest in the United States in 1957, having increased 78 percent since 1940 (National Campaign to Prevent Teen Pregnancy [NCPTP], 2005). However, from 1991 through 2003 the teen birth rate decreased 32.5 percent to a record low of 41.7 per thousand girls age 15 - 19 in 2003 (NCPTP).

Although recent statistics were encouraging, teen mothers continued to be at higher risk for poor mental health, including depression, low self-efficacy and low self-esteem compared to women who delayed childbearing (Kalil, Spencer, Spieker, & Gilchrist, 1998; Kirby, 2001). These factors had an impact on poor parenting practices (Leadbeater & Bishop, 1994). Children of teen mothers were more than twice as likely to be abused or neglected and almost three times as likely to be placed in foster care (GCAPP, 2005). Supportive relationships with family members have been associated with better mental health (Caldwell, Antonucci, & Jackson, 1998; Kalil et al., 1998).

Acquired Immune Deficiency Syndrome (AIDS) also contributed to the increase of grandparent caregivers in the United States. By the year 2010, 11.2 million children were estimated to lose their mother to AIDS worldwide (Levine & Foster, 2000). Complex emotional and behavioral issues stressed the kinship foster caregivers of children with a parent infected with HIV/AIDS (Linsk & Mason, 2004). These issues included child behavior problems, HIV-related concerns, mental health issues, and sexual abuse. HIV-affected caregivers had more

concern about their health and multiple roles (Linsk & Mason). Non-affected caregivers were less likely to report severe parent stress and more likely to report financial stress (Linsk & Mason).

Yet another social phenomenon impacting the need for grandparent caregivers was the increased number of incarcerated women (Hungerford, 1996). It was estimated that 80 to 90 percent of incarcerated women were mothers with two or three children living with them prior to their arrest (Hungerford). Most children of imprisoned mothers lived with their grandparents during the incarceration period (Barnhill, 1996; Dressel & Barnhill, 1994; Enos, 1997). Research suggested that family relationships during incarceration predicted fewer child discipline problems, improved mental health and decreased recidivism rates for inmates, and increased probability of reunification following release (Hairston, 1991).

Policy Impacts on Grandparent Caregivers

Grandparent caregiving can include informal arrangements, custody, guardianship, foster care and adoption (Flint & Perez-Porter, 1997). Whatever arrangement is in place, caregivers must be able to care for the physical, emotional, and mental well-being of a grandchild in order to act in the child's best interest (Landry-Meyer, 1999). In order to address all of these issues, grandparents must assume full parental responsibilities, including legal, parental authority, and obtaining needed family resources (Landry-Meyer).

Policy supports grandparents in being able to acquire legal and economic necessities for their family. For example, federal support for kinship care was first evident through an amendment to the 1950 Social Security Act that offered assistance for children in the care of eligible relatives. This assistance was made available through Aid to Families with Dependent Children (AFDC) and through "child-only" grants (Geen, 2000). The following policies have

impacted the practice and supports available to grandparent caregivers, within and outside the child welfare system.

Table 1

Policy Timeline: Grandparent Caregiver and Kinship Foster Care

Year	Policy
1978	The Indian Child Welfare Act of 1978 stated that a child should be placed near their home and with a member of their extended family (Geen, 2000).
1979	U.S. Supreme Court decisions such as <i>Miller v. Youakim</i> in 1979 stated that kinship foster families had access to foster care benefits providing that the child was eligible and the family met licensing standards (Ingram, 1996).
1980	The Adoption Assistance and Child Welfare Act of 1980 required states to find the “least restrictive most family-like setting available located in close proximity to the parent’s home consistent with the best interests and special needs of the child” which translated to a preference for kinship placements (Geen, 2000).
1990s	Welfare reform required states to give preference to relative caregivers for foster care placement. Economic support for grandparent caregivers comes from Temporary Assistance to Needy Families (TANF) and food stamps, Social Security benefits, and Medicaid (Flint & Perez-Porter, 1997; Geen, 2000).
1992	Senate and House hearings focused on the causes for increases in grandparents as caregivers. The legislative focus became grandparent access to services and sources of support including cash assistance, health insurance, health care, education services, legal services, child care, and workplace policies affecting caregivers (Bryson & Casper, 1999).
1996	Congress included a provision in the Personal Responsibility and Work Opportunity Reconciliations Act (PRWORA) of 1996 to mandate the Census Bureau to ask adults over 30 whether they lived with their grandchildren, were financially responsible for them, and the duration of that responsibility.
1997	The Adoption and Safe Families Act (ASFA) relaxed the time period for termination of parental rights if a child was placed with a relative. (Geen, 2000).
2000	The National Family Caregiver Support Act was established through the reauthorization of the Older Americans Act. It provided grandparent caregivers the same services available to caregivers of older relatives: counseling training and respite care (Nelson & Lalich, 2003).
2000	48 states and the District of Columbia give preference to relative placement (Geen, 2000).
2002	Subsidized guardianship is now seen as a viable option for permanency when children remain in kinship foster care for longer than one year (Testa, 2002, 1996). Subsidized legal guardianship solves many of the issues that are inherent with kinship foster care including lack of independence and legal responsibility of children by family members, state worker liability, and administrative burdens on caseworkers. Subsidies similar to those provided for adoption were provided to 5000 family members in Illinois through a federal waiver (Testa, 1997). Subsidized guardianship was found to be successful leading to increased permanency for children placed in kinship care (Testa, 2002).
2003	The Living Equitably: Grandparents Aiding Children and Youth Act introduced affordable housing opportunities specifically for families headed by grandparents and other relatives of children (The Orator, 2003).

Although policy related to grandparent caregivers has been patch worked together to minimally support the financial and legal burdens of caring for grandchildren, the emotional and social support needs of grandparents continue to be unaddressed through policy. Through their own efforts, grandparent support groups, rallies, web sites, chat rooms, and programs have filled a need for grandparents who are primary caregivers. However, the need for coherent policies that support intergenerational families can not be overstated. One of the areas that policy has largely ignored is the need for high quality, public child care services for all families. High quality child care would support grandparent caregivers and all parents to ensure that the early developmental needs of children from birth to age three, including optimal brain development, attachment and definition of self, are met (Berrick, 1991).

The child welfare system has three goals for children in foster care: permanency, safety and child well-being. Studies on kinship care primarily focus on permanency and safety of children (Altshuler & Gleeson, 1999). Well-being of children with related child outcomes has been a lower priority due to data collection procedures of local child welfare agencies (Altshuler & Gleeson, 1999). Shlonsky and Berrick (2001) define quality in kinship care as being made up of the following domains: child safety, educational support, mental health and behavioral support, developmental support, the furtherance of attachment, caregiver characteristics, and foster children's quality of life. The foster care experiences across these domains vary widely for children in kinship foster care; however, quality of care is substandard in a high proportion of cases (Courtney, 2001).

The future of child welfare policy must also consider the cultural lens through which families experience kinship foster care. Since most kinship foster families are African American (Berrick, Barth, & Needell, 1994), policies that recognize the strengths of intergenerational

caregiving as a natural response to ensure family preservation and to empower grandparents to build on their strengths must be developed and proliferated (Cox, 2002, Danzy & Jackson, 1997; Scannapieco & Jackson, 1996).

In addition to culturally competent practice, Gleeson and O'Donnell (1997) suggest that caseworkers are mired in the child welfare system bureaucracy and this prevents them from seeing the opportunities available to them in working with extended families to create long-term plans for the child and from discussing private guardianship as a permanency option. Although caseworkers are typically required to provide the same supervision for all foster parents, research shows that caseworkers tend to provide less supervision to kinship foster families (Geen, 2000, Berrick, Barth & Needell, 1994; Brooks & Barth, 1998; Dubowitz, 1990).

Policy in the United States has been slow to develop, a fact attributed to societal values that do not support the caregiving role (Minkler, 1999). One result of lack of policy translates to grandparents not having the legal authority to obtain financial, medical, or educational services for their grandchildren (Karp, 1996; Pew Commission, 2004). With a written, notarized note from the parent, many grandparents are enrolling grandchildren in school, and accessing medical care, but they are not free to fully provide for the grandchild's needs without custody (Glass & Honeycutt, 2002). Ultimately, societal values have not provided adequate support to children needing protection. Gleeson states,

Our society is increasingly unwilling to financially support the care of children, and particularly the care of economically disadvantaged children, by the family members. It is not clear whether efforts to reduce support of impoverished and otherwise vulnerable children and families are occurring because of public perceptions that the need is not great- or because of

awareness that the needs are so great that considerable more resources will have to be shared to respond adequately to the needs (Gleeson, 1996, p. 425).

Statement of the Problem

Although grandparent caregiving has increased within the child welfare system and in the general public, we still have gaps in knowledge about the strengths, needs and impact of intergenerational caregiving on grandparents and their grandchildren. The societal, legal, policy and child welfare system issues that surround grandparent caregiving obscure the clarity of the picture of grandparent caregiving in the child welfare system. Grandparent caregivers themselves have largely filled a gap in service delivery by providing their homes to care for their grandchildren. In a family environment that is largely wrought with angst over their own child's inability to continue the role as parent, there is added role ambiguity, role conflict, and overload of caring for grandchildren 24 hours a day. With limited resources available to caregivers in this role, there is little wonder that grandparent caregivers experience decreased health, mental health and social supports.

The National Commission on Family Foster Care (1991, p. 103) stated: "The use of kinship care has expanded so rapidly that child welfare agencies are making policy, program, and practice decisions that lack uniformity and/or a substantive knowledge base... Kinship care provides an opportunity to affirm the value of families. But the assessment process and support should include unique family strengths and needs, cultural and ethnic identification, necessary financial and service supports, continuity of care and permanency goals."

This study adds to the current literature on grandparent caregivers, and specifically to the literature on kinship care providers in the child welfare system by identifying whether all kinship caregivers have the same needs and strengths, or whether grandparent kinship foster care

providers have specialized needs. There are many reasons to think that the needs of grandparents are different. However, it is possible that the impacts of the caregiving role, child's experience, and the similarity in role sets across caregivers will determine that they are not significantly different.

Purpose of Study

The first purpose of the study is to build on the current literature about grandparent caregivers and answer questions about grandparent caregivers in the specialized area of child welfare. The second purpose is to compare and contrast the differences between grandparent caregivers and other caregivers in the child welfare system using variables from the gerontological and kinship literature. We know that most kinship caregivers are grandparents, but are grandparents similar to other foster caregivers? Do they have specialized needs and strengths? The answers have practice implications related to effective training, support, and retention of foster care providers. The third purpose of the study is to determine which factors best predict social support satisfaction. In the community, social work practice can make an impact on the social support that grandparent caregivers receive. It is important to understand more about how caregivers interpret social support and their need for it. It is important to note that the definition for grandparents in this study does not include great-grandparents, who have different characteristics and issues related to caregiving.

Conceptual Framework

In discussing the purpose of the study it is important to clearly state the conceptual framework on which the study is based. The conceptual model, figure 1, of the study takes into account the context in which grandparent caregivers and their grandchildren reside. The ecological perspective accounts for systems that impact grandparents and children, such as the

school system, religious organizations, the child welfare system, and the family itself. Feminist theory focuses on the political and societal factors that impact women as caregivers. Finally, role theory explains the challenges of grandparent caregivers changing roles and experiencing ambiguity, role conflict and other potentially detrimental stresses related to role changes. The context includes the major variables that will be used in the study that are supported in gerontological, child welfare and child development literature. Ultimately, the findings have implications for child welfare practice with kinship foster caregivers with recommendations for services and supports that meet the needs of grandparent caregivers in the child welfare system.

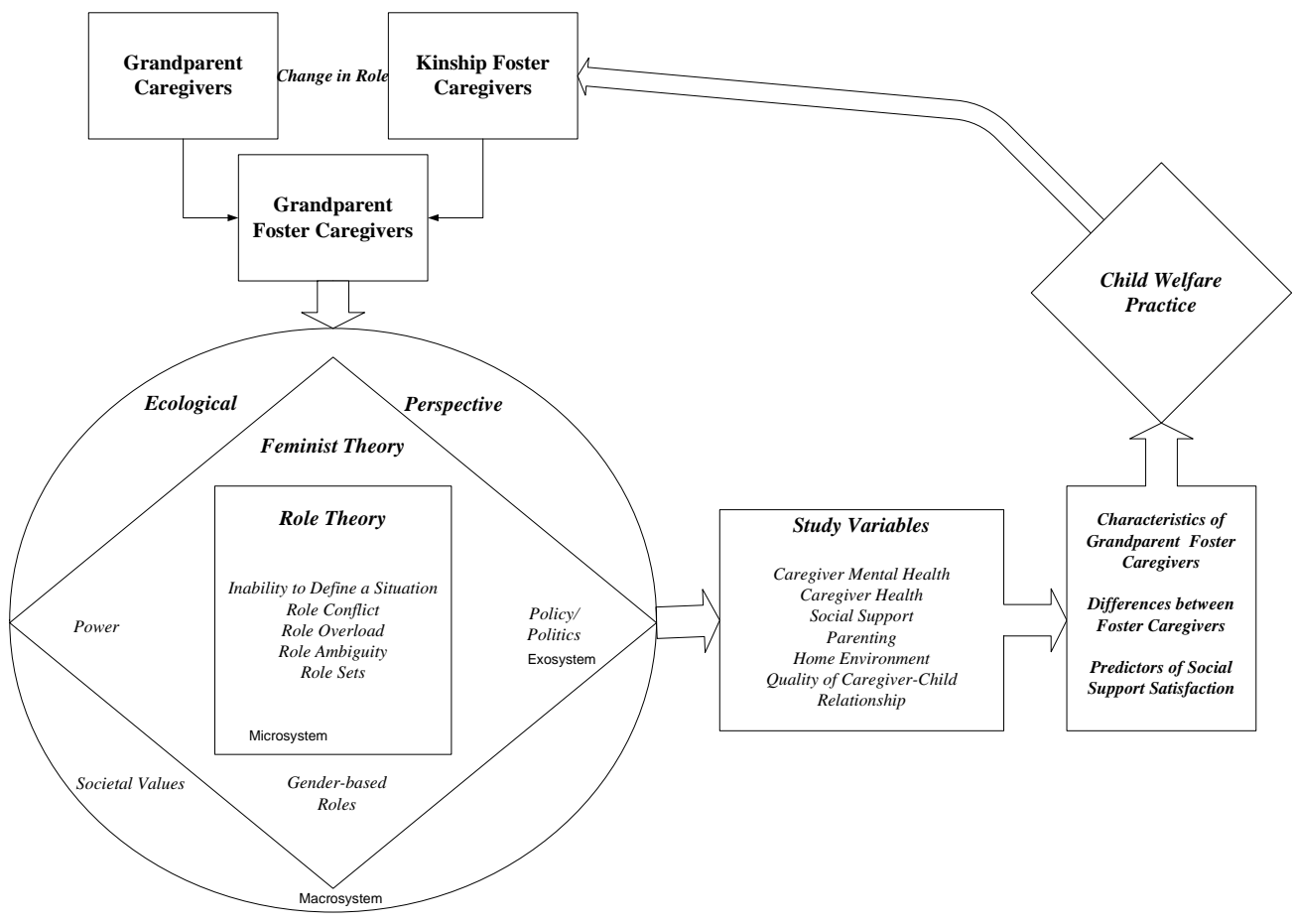


Figure 1. Conceptual Model of the Study

Significance of the Study to the Profession of Social Work

The study will add the dimension of understanding characteristics of grandparent caregivers in the child welfare system as compared with other caregivers in the system. In addition, the context will expand to include relationships between caregivers and grandchildren, providing some initial insights into specialized needs of intergenerational caregivers. This study attempts to bridge gerontology and child welfare. The findings will be of interest to local child welfare agencies as they strive to develop innovative, supportive social work practice methods that are focused on the needs, and promote the strengths of grandparents raising their grandchildren in the child welfare system.

Because grandparent caregivers are a marginalized group, individual and specific family needs and experiences can become lost (Waldrop & Weber, 2000). As the numbers of grandparents raising grandchildren continue to increase, professionals have begun to recognize the need for information, skill, and resources that can aid this population (Brintnall-Peterson & Targ, 2001). Although more programs are being developed with the needs of intergenerational families in mind, more work is needed to provide security and stability to these families that promote role definition, support systems and knowledge about parenting practices.

The findings of this study may also appeal to policy makers on state and federal levels. Policies that fund programs that differentiate between the needs of grandparent foster caregivers and other foster caregivers may help lead to change the current child welfare practices of providing fewer services to kinship care providers than non-kinship foster caregivers. The findings may also inform the need for support services for grandparents providing care to grandchildren outside the child welfare system. Despite policies that support grandparents circumventing child welfare, services may still be vital to support grandparents and their

grandchildren in dealing with the multiple-levels of trauma, anxiety and stress that these non-traditional families face.

Definition of Terms

Below are definitions of terms relevant to the literature and this study.

Caregiving- Baber and Allen define caregiving as the “work involved in meeting the physical and emotional needs of others and being responsible for nurturing their growth and development” (1992, p. 143).

Grandparent Caregivers- The U.S. Census Bureau defines grandparent caregivers based on whether a grandchild lives in the household and whether the grandparent has responsibility for the basic needs of the grandchild. According to the Census Bureau (2004), a grandparent caregiver has a grandchild under the age of 18 living with a grandparent over the age of 30; the grandparent is responsible financially for food, shelter, clothing, day care, and other basic needs for the grandchild. Lastly, duration of responsibility, which ranges from “less than 6 months” to “5 years or more” is important in defining the grandparent caregiver. Grandparent caregiving may be provided informally or formally (i.e., foster care or legal guardianship).

Kinship care- Kinship care encompasses the informal arrangements that families make for the shared care of children in a range of circumstances (Geen, 2000). Often, however, kinship care is a term referring to foster care placement. Scarnapiego, Hagar, & McAlpine (1997) define kinship care as “out-of-home-placement with relatives of children who are in the custody of state and local child welfare agencies.” Although the lack of distinction between the terms kinship care and kinship foster care is pervasive in the literature, this document will use the term kinship foster care to avoid confusion of intent.

Kinship foster care- Kinship foster care is the situation where relatives or others who have a kin relationship with a child or young person are caring for a child in partnership with the state, and where social workers therefore play a key role (Geen, 2000). Grandparent caregivers may provide kinship foster care.

Hypotheses and Research Questions

The review of the literature presents the characteristics of grandparent caregivers in the United States. Based on this information, the accompanying hypotheses and research questions used in the study are as follows:

- 1) Hypothesis: Grandparent foster caregivers are more likely than other caregivers in the child welfare system to be older women of color with lower incomes and a greater number of grandchildren.

Rationale for hypothesis 1: This hypothesis is supported by research in the general grandparent caregiver literature and in the kinship foster care literature that grandparent caregivers tend to be older, African American, single and with lower incomes and greater numbers of grandchildren (Barth, Courtney, Berrick & Albert, 1994; Berrick, Barth, & Needell, 1994; Chipungu, Everett, Verduik, & Jones, 1998; Dubowitz et al., 1994; Ehrle & Geen, 2002; Harden, et al., 1997; LeProhn, 1994; Scannapieco et al., 1996). These characteristics of grandparent caregivers in the study will determine if this sample is similar to samples in other national studies.

- 2) Hypothesis: Grandparent foster caregivers are more likely than other caregivers in the child welfare system to have significantly poorer mental health.

Rationale for hypothesis 2: Gerontological research asserts that grandparent caregivers are more likely to have mental health issues related to stress and burden of the caregiving role and to describe their health as poorer than non-caregiving grandparents (Burton, 1992; Fuller-

Thompson & Minkler, 2000a; Fuller-Thomson et al, 1997; Kelley, 1993; Kelley, Yorker, Whitley, & Sipe; 2001; Musil & Ahmad, 2002; Strawbridge et al., 1997). Studies found that grandparents raising their grandchildren were more likely to be clinically depressed compared to grandparents who are not primary caregivers (Fuller-Thomson & Minkler, 2000a; Minkler et al., 1997).

3) Hypothesis: Grandparent foster caregivers are more likely than other caregivers in the child welfare system to have significantly poorer health.

Rationale for hypothesis 3: Gerontological research asserts that the stresses on grandparent caregivers have a negative impact on their physical health. Research supports that grandparent caregivers are more likely to have decreased ability to take care of daily personal activities, more chronic health conditions, and have a lower self-rated physical health than other grandparents (Fuller-Thomson, & Minkler, 2000b; Marx & Solomon, 2000).

4) Hypothesis: Grandparent foster caregivers are significantly less likely than other caregivers in the child welfare system to have social support.

Rationale for hypothesis 4: Several studies addressed grandparent caregivers' tendencies to delay or fail to gain needed support for themselves and their grandchildren (Burnette, 1999; Minkler & Roe, 1993; Shore & Hayslip, 1994). Social isolation of grandparent caregivers is often a result of shame and guilt of the reasons their children are no longer parenting (Minkler & Roe, 1993).

5) Research Question: Are grandparent foster caregivers more likely than other caregivers in the child welfare system to have positive parenting behaviors?

Rationale for research question 5: Parenting behaviors are widely believed to be passed on from generation to generation (Cicchetti & Aber, 1980; Kaufman & Zigler, 1987; Kempe & Kempe, 1978; National Research Council, U.S. Panel on Research on Child Abuse and Neglect, 1993;

Weiss et al., 1992). Gebel (1996) found that kinship caregivers have more favorable attitudes toward physical discipline than non-kinship caregivers. Physical discipline and parenting behaviors remains a highly charged topic of interest in child welfare. This question allows inquiry that does not assume that grandparents will use physical discipline in parenting.

6) Research Question: Are grandparent foster caregivers more likely than other caregivers in the child welfare system to have more nurturing home environments?

Rationale for research question 6: Home environment is known to be an important factor in child development, predicting success in school and emotional support for young children (Bradley, et al, 1989; Caldwell & Bradley, 1984; Gottfried, 1984; Sugland et al, 1995). Although one study found that 99 percent of foster homes were judged to be *comfortable and safe* (Lindholm & Touliatos, 1978; Orme and Buehler (2001)), Berrick (1997) found that non-kinship foster care providers are more likely to provide a supportive home environment than kinship caregivers. This question will allow investigation of grandparent caregivers apart from other relatives to inform whether grandparent caregivers have a more supportive home environment than other caregivers.

7) Research Question: Are grandparent foster caregivers more likely to have emotionally secure relationships with their grandchildren compared with the relationships between other foster caregivers and the children they care for?

Rationale for research question 7: Berrick's (1997) comparison of kin and non-kinship households found that although kinship foster care homes indicated a greater degree of fondness between family members, the differences were not statistically different from non-kinship foster families. This question allows for analysis that separates grandparents and other relatives to

identify whether grandparents have a more positive nurturing relationship with grandchildren than other foster caregivers.

8) Research Question: What factors combine to best predict satisfaction with social support among all caregivers in the child welfare system?

Rationale for research question 8: Social support is a factor that social work practice can impact through casework, support group facilitation, and linkages with community resources. However, although caseworkers are typically required to provide the same supervision for all foster parents, research shows that caseworkers tend to provide less supervision to kinship foster families (Geen, 2000, Berrick, Barth & Needell, 1994; Brooks & Barth, 1998; Dubowitz, 1990). Given that grandparent caregivers tend to have less social support and are more likely to become socially isolated (Burnette, 1999; Minkler & Roe, 1993; Shore & Hayslip, 1994), it is important to understand which factors predict social support satisfaction so social workers can design and develop programs that meet the needs of all caregivers.

Chapter Summary

Chapter one provided the context considered relevant for the study, which included an overview of the issue of grandparents raising their grandchildren in the United States. Next, the individual, microsystem, exosystem and macrosystem factors that impact grandparent caregivers were presented. The purpose of the study was discussed and the conceptual framework was detailed. The dependent and independent variables used in the study were presented and the relevant terms related to the study were defined. Finally, the research hypotheses and research questions were stated with rationales presented for each.

In Chapter two the theoretical context of the study will be presented. This context is based in role theory with feminist theory and the ecological perspective supporting the societal

implications that affect grandparent foster caregivers. Next, a thorough literature review will detail current findings related to the study variables and grandparent caregivers.

CHAPTER 2

FRAMEWORK FOR UNDERSTANDING GRANDPARENT CAREGIVERS

Theoretical Context

In this section, Role Theory is first described as the primary theoretical context for the study of grandparent caregivers. Role Theory offers the opportunity to discuss grandparents in a context that acknowledges not only the individuals in the system, but also the dynamics that impact well-being in the family (Giarrusso & Silverstein, 1996). Relationship anxiety and the symptoms that can result from it are significant in families for which one family member has been unable to serve, for whatever reason, in their role as parent. The fact that they are not performing the parenting role has an impact on the grandparent and the grandchild as individuals and also on their relationship. Next, feminist theory and the ecological perspective will be used to expand the context of grandparents as caregivers beyond the individual and family into the community and society.

Role Theory

Role theory is beneficial in exploring grandparent caregivers because it allows for both a physiological and social view of the experience of being a grandparent caregiver. Role theory evolved out of the work of several disciplines beginning in the late 1920s and early 1930s (Biddle, 1979). Theorists included G. H. Mead, Merton, Parsons, Moreno, Linton, Biddle, Thomas, Strean, Davis and Perlman (Biddle, 1979; Payne, 1997). Role theory represents thought from social psychology, structural-functional theory, symbolic interactionism, psychodrama, anthropology, and many other disciplines and theoretical frameworks (Biddle, 1979). Although

the authors' contributions to this theory are diverse, they are consistent in focusing on individual interactions with others and positions in social structures (Payne, 1997).

The major concepts used in role theory will be discussed in the section to follow. Based on the concept that roles are sets of expectations or behaviors associated with positions in social structures (Biddle, 1986), this study will focus on the roles that grandparents assume as caregivers and the impact of the change in roles. Since roles may be either ascribed or attained (Biddle, 1986), it will be important to look at the grandparent caregiver and how the way in which they became caregivers impacts their understanding of the role. Role conflict, role overload, and role ambiguity are discussed within the context of caregiver mental health and physical health. Role sets, collections of roles that go with a particular social position, are discussed related to grandparent caregivers and social support.

Role Theory and Caregiver Mental and Physical Health

Stress related to role has an impact on both mental and physical health. Stress related to mental health has been reported in several studies of grandparent caregivers (Burton, 1992; Kelly, 1993; Robinson, Kropf & Myers, 2000). Kelly (1993) found that more than half of the caregiving grandparents had scores in the clinical range on parenting stress and psychological distress.

Physically, the grandparent who is responsible for the caregiving role of a grandchild suffers more physical issues in comparison to grandparents who have only part-time responsibilities in a grandchild's life (Bowers & Myers, 1999; Fuller-Thomson, & Minkler, 2000b; Jendrek, 1993; Musil, 1998). When compared to non-caregiving grandparents, grandparent caregivers are more likely to have decreased ability to take care of daily personal activities, more chronic health conditions, and have a lower self-rated physical health (Fuller-

Thomson, & Minkler, 2000b; Marx & Solomon, 2000). Pre-existing caregiving grandparent conditions, such as diabetes or high blood pressure are made worse by stress (Waldrop & Weber, 2000).

In the sections that follow, mental health and physical health functioning will be discussed through the context of role theory concepts. Heiss (1981) defined five types of role-based interaction issues that have an impact on mental and physical health: 1) inability to define a situation; 2) inability to choose a role; 3) lack of agreement between self and others; 4) role conflict; and 5) role overload (Burnette, 1999, Heiss, 1981). For the purposes of this study, Heiss' first three issues will be combined as one, inability to define a situation. Each of these issues involves loss of control in the process of resolving a change in role. In addition, the role theory concept of role ambiguity will be discussed related to mental health and physical health functioning.

Inability to Define a Situation

After grandparents take responsibility for grandchildren it can be confusing for the entire family because it is believed that the parent will resume their role. The original role of grandparent is lost to the necessity of becoming a parental figure for the grandchild being raised. In addition, the role of grandparent continues with non-custodial grandchildren, who may feel jealous of the relationship that the grandparent has with the custodial grandchild (Brintnall-Peterson, & Targ, 2001).

The grandparent caregiver role has a lack of structure concerning role expectations and low societal awareness about role norms (Landry-Meyer, 1999; Rosow, 1985). In other words, full-time caregiving of a grandchild by a grandparent is a non-normative stressor because it prolongs time spent in parenting (Landry-Meyer, 1999; Bowers & Meyers, 1999). Due to the

lack of social understanding, grandparents report that that they feel alone in the caregiving role (Woodworth, 1996) often finding that their previous social network has deteriorated (Burnette, 1999; Jendrek, 1993; Minkler, Roe, & Robertson-Beckley, 1994). It is more stressful than a normative life event, such as caring for a grandchild part-time or for a definitive time.

Rosow (1985) describes five “temporal connotations” (p. 77) related to role change. They are 1) simple movement between positions that may be held simultaneously, such as the roles of parent and employee; 2) social change related to normative expectations caused by historical events and evolution of culture, such as the expectation for women to work outside the home; 3) changes within roles that take place at different life-stages, such as retirement; 4) the loss of old roles or acquisition of new roles by joining or leaving a group, usually a voluntary choice, such as joining a church; and 5) status passage, which involves moving from one role into a mutually exclusive new role in a sequential manner, such as moving from employed person to retired person. Although Rosow (1985) states that additional role changes are possible, it is interesting to note that transitioning from grandparent to grandparent caregiver is not a role change defined by these categories, emphasizing the non-normative nature of this role.

Role changes that occur out of time sequence due to events cause stress (Hagestad, & Neugarten, 1985). Age-related expectations are used to determine if an individual is on-course with their life. “Major stresses often arise when events upset the expected sequence and rhythm” (p. 41). An example of an out of sequence event is the death of a child. Parents expect their children to live beyond them and therefore, do not anticipate that they will experience the death of their child in their lifetime. Individuals anticipate age-related events in their lives and have expectations about their life in that role. When life events occur in sequence it is anticipated that

peers will experience role transitions together and provide each other social support (Hagestad, & Neugarten).

Grandparents do not usually take over the parenting of a grandchild by choice (Bowers & Meyers, 1999; Hayslip, Shore, Henderson, & Lambert, 1998; Jendrek, 1994). In fact, the role of full-time caregiver is not the preferable one for most grandparents; instead the role is accepted based on obligation (Bowers & Meyers, 1999; Hayslip et al.). As represented by the families in this study, child welfare authorities and/or the courts may have recommended that a child be placed in housing outside of the parental home (Bowers, & Meyers, 1999). Therefore, the lack of choice that grandparents experience has an impact on their psychological well-being.

Family problems that precipitated the change in grandparent role from grandparent to caregiver, such as an adult child's unpredictable behavior, concern for the grandchild's well being, or marital strife, contribute to the levels of grandparent stress (Waldrop & Weber, 2000). Grandparents who provide full-time care for grandchildren are often providing this level of care because their own children (grandchildren's parents) are no longer capable of providing the necessary parenting (Bowers, & Meyers, 1999). The reasons that grandparents may feel that their own children are not capable of giving appropriate care to the grandchildren may include alcohol and/or drug abuse, mental or emotional problems, neglect or abuse of children, divorce, job loss, incarceration, hospitalization, or death (Bowers, & Meyers, 1999; Hayslip et al., 1998). The fact that the grandparent/grandchild family structure often emerges out of dysfunction in the middle generation (Landry-Meyer, 1999), is one of the main influences on grandparent caregiver's mental health (Hayslip et al., 1998).

The relationship between grandparents and their adult children becomes an issue for concern in the family. Grandparents stated that one of the hardest parts of taking full-time care of

a grandchild was accepting the lack of responsibility and life problems of their own child (Hayslip et al., 1998). In turn, grandparents were forced to question their own parenting skills (Bowers & Meyers, 1999). If a grandparent chooses to seek adoption of a grandchild, they must often come to terms with the fact that their own child is an unfit parent (Hertzog, Kleiner, & Targ, 1998).

Role Conflict

Role conflict is the incompatibility of one person playing two or more different roles at the same time (Biddle, 1979). Role conflict can be of short duration, tied to a certain situation, or long-lived (Biddle, 1979). Accordingly, the traditional role of grandparents in the family, without major responsibilities for child care, has primarily had a positive connection to grandparents' well-being (Dellmann-Jenkins, Blankemeyer, & Olesh, 2002; Pruchno & Johnson 1996). Grandparents in the traditional role can *spoil* grandchildren; they are often called on in times of crisis; and they act as fun playmates for children, role models, and mentors who help establish self-esteem and security for children (Cox, 2003). In contrast, grandparents as caregivers become the enforcers of rules, the disciplinarians, and the ones who have to say no. They can not play both roles at the same time. As a result of role conflict, grandparent caregivers are likely to have less life satisfaction and more depression than grandparents with part-time caregiving responsibilities (Marx & Solomon, 2000).

Grandchild needs and concerns have an impact on stress and poor mental health among grandparent caregivers (Hayslip et al., 1998). For example, if grandchildren have been exposed to drugs prenatally or if they have suffered from abuse or neglect, the resulting physical and/or emotional problems may follow when they are transferred into the grandparent's care causing role conflict (Hertzog et al., 1998). As a result grandparents may be pulled into the conflicting

roles of concern and care for the grandchild and also for the parent who was responsible for the grandchild's suffering.

Grandchildren bring previously established behavioral problems with them from the parents' home to the grandparents' home (Bowers & Meyers, 1999). The more problems the child has, the more caregiving is required. Therefore, the greater the perception of burden and stress reported by the caregiver (Bowers & Meyers) and the greater the amounts of stress on the family as a whole.

Role Overload

Role overload exists when an individual is confronted with excessive demands to carry out assigned role obligations (Biddle, 1979). Feelings of burden and obligation are commonly experienced among grandparents who have assumed a parenting role (Cox, 2003). Predictors of burden perceived by the full-time caregiving grandparent included higher levels of child behavior problems, lower energy and vitality of the grandparent, and a lower family income (Bowers & Meyers, 1999). The burden of raising a grandchild may be lessened if the grandparent takes satisfaction in the opportunity to give their grandchild a better life (Korhaber, 1996).

One of the most common contributors of the feeling of burden is financial strain. Two causes of financial burden include the strain of providing for an extra person(s) in the household, the cost of legal intervention, difficulty applying for governmental assistance, poverty, and under-employment (Waldrop & Weber, 2000). Work and family strain is another predictor of increased levels of stress in the family of the caregiving grandparent (Waldrop & Weber).

Contributors of work and family strain may include balancing demands of job with the needs of

the grandchild, concerns about child care, and previous retirement plans that are delayed with the advent of caring for the grandchild (Waldrop & Weber).

The role overload related to the child's needs is exacerbated when the grandparent has health concerns as well (Cox, 2003). African-American grandmothers raising their grandchildren report feeling overwhelmed, unable to keep up with grandchildren's activities, suffering from financial burdens, and lacking the time to take care of their own needs (Bowers & Meyers, 1999).

Role Ambiguity

Role ambiguity exists when we are uncertain about what a role entails (Biddle, 1979; Payne, 1997; Merton, 1957). Research indicates that there are many ways to describe a grandparent role, making definition of a clear role more difficult (Silverstien & Marengo, 2001). Role ambiguity has been shown to increase stress and tension, resulting in poor performance and lack of satisfaction with the role (Rizzo, House, & Lirtzman, 1970; Singh, 1998; Van Sell, Brief, & Schuler, 1981).

It is also important to reduce role ambiguity and increase family stability (Landry-Meyer, 1999). When grandparents are raising children without the benefits of custody, they may experience role ambiguity (Landry-Meyer & Newman, 2004). Grandparents may experience the revolving door syndrome in which parents can reclaim their child at any time and then abandon them again to the grandparent when it is inconvenient (Korhaber, 1996). Obtaining legal custody of a grandchild may seem like the best option to protect the grandparent's rights and meet their grandchild's needs. However, obtaining full custody of a grandchild may create ill will between the parent and the grandparent. Receiving permanent custody has not been shown to diminish the overall amount of stress experienced by grandparent caregivers (Waldrop & Weber, 2000).

Role clarification through clear goals, on-going training, and social support may decrease stress among kinship foster families, while ensuring that grandparent caregivers understand what is expected of them as parents of young children in the 21st Century (Bauer & Simmons, 2005).

Role Theory and Social Support

Social support is defined as “help available to an individual in difficult or stress-arousing situations” (Sarason & Sarason, 1982, p. 332). High levels of perceived social support were correlated with positive self-concept and belief in the ability to control aspects of one’s environment (Veroff, Douvan & Kulka, 1981). Social support also eases the burden of multiple-role performance (Kissman, 1990).

Merton (1966) describes social support by others with a similar role and social status as a mechanism for defining a role set. It assumes that people in the same social status have similar problems in their roles (Merton, 1966). When pressures from the role set are encountered, the lack of social support from peers causes instability in role performance (Merton, 1966).

Grandparents may experience social isolation from cohort groups because their peers are not also parents (Burnette, 1999; Jendrek, 1993; Landry-Meyer, 1999; Minkler, 1999; Waldrop & Weber, 2000). Grandparent caregivers do not often have community social support because they are too young for senior services and too old for parent support services. Therefore role-based, not age-based supports are needed (Landry-Meyer, 1999). Landry-Meyer (1999) states, “The perception of a grandparent being a parent upsets a grandparent’s personal support network as same age peers are not enacting a parental role and age acts as a barrier to the interaction of younger parents whose life cycle issues and experiences differ from a grandparent’s life cycle stage parenting experience” (p. 384). Grandparents with legal custody of their grandchild are likely to suffer socially because they have fewer people to rely on for child care assistance or in

case of emergency and they are less likely to have others they can confide in or have other sources of social support (Marx & Solomon, 2000).

The legal status of the caregiving grandparent affects the availability of social supports. Once grandparents begin raising their grandchildren, they face a new set of needs and challenges (Waldrop & Weber, 2000, p. 462). Grandparents may have difficulty obtaining social supports such as health insurance, social services, housing, and enrolling grandchildren in a school, especially if they do not have full custody of their grandchildren (Korhaber, 1996).

Role Theory and Parenting Behaviors

Parenting behaviors related to discipline and the use of spanking are explained by role theory. Role theory views discipline as a factor in parenting that shapes behavior in two ways: “when an aversive stimulus is presented following a response” or “by the withdrawal of a positive reinforcer following a response” (Thomas & Biddle, 1966, p. 56). An example of an aversive stimulus is spanking a child after an undesired behavior. An example of withdrawing a positive reinforcer is taking away television privileges after an undesired behavior.

Larzelere and Kuhn (2005) describe two major perspectives on the effects of physical punishment. The first, unconditional anti-spanking, does not condone physical punishment in any situation (Gershoff, 2002; Straus, 2001). As a result, at least 13 countries have outlawed physical punishment by parents (EPOCH-Worldwide, 2004). The second perspective, conditional-spanking, identifies situations for which “spanking may be beneficial or at least not detrimental to children” (Larzelere & Kuhn, p. 1). The child welfare system typically supports, through policy, the anti-spanking perspective; while many grandparents and other foster caregivers may support a conditional-spanking perspective. Clearly, this is a role issue that

raises questions for grandparents who are parenting again, especially those who are involved in the child welfare system, where role identity and policy may conflict.

Role Theory and Home Environment

Thomas and Biddle (1966) incorporated the concept of environmental constraint into role theory. “The physical environment, including its human and nonhuman components, may exercise immense control over behavior” (Thomas & Biddle, 1966, p. 55). They describe three ways in which environment affects behavior: 1) it prohibits behavior; 2) it permits, but doesn’t fully govern behavior, and 3) it forces behavior (Thomas & Biddle, 1966).

Home environment is the result of children interacting with the learning opportunities provided by caregivers (Votruba-Drzal, 2003). Combined with biological and genetic aptitudes, home environment influences a child’s developmental course (Bronfenbrenner & Ceci, 1994; Bronfenbrenner & Morris, 1998). Primary caregivers are central in shaping young children’s environments since they guide early learning activities (Votruba-Drzal, 2003). These developmental opportunities are correlated to cognition and literacy skills at school entry (Brooks-Gunn, Klebanov & Duncan, 1996). Home environment is known to be an important factor in child development predicting success in school and emotional support for young children (Bradley, et. al, 1989; Caldwell & Bradley, 1984; Gottfried, 1984; Sugland et al, 1995).

Role Theory and the Quality of Caregiver-Child Relationships

The grandparent’s relationship with the live-in grandchild and other grandchildren in the family can be altered as a result of the grandparent’s change in role. Grandparents who are full-time caregivers must be concerned with discipline, homework, and healthcare. Because of these demands, the full-time grandparent cannot be as generous as part-time caregiving grandparents can (Bowers & Meyers, 1999). The grandparent can not be both a parent and a traditional

grandparent, who spoils and gives the extra attention that a parent cannot (Landry-Meyer, 1999). However, experience and perspective may assist grandparents in providing stability and predictability to the lives of the grandchildren they are raising (American Academy of Child and Adolescence Psychiatry, 2000).

Research indicates that the middle generation has an impact on the grandparent relationship with the child (Burnette, 1999a; Weber & Waldrop, 2000). Despite potential dilemmas with their own children, 52 percent of grandparents overall reported good to excellent relationships with the grandchild's parent (Bowers & Meyers, 1999). Only 48 percent reported fair to poor relationships with the parent of the grandchild (Bowers & Meyers). Negative changes were caused by the grandparent not having time to work on the relationship with their own child, or the grandparent and their adult child not communicating well, or the grandparent losing respect for their adult child (Bowers & Meyers). When positive changes were reported between the grandparent and their adult child, reasons included the extra support that the grandparent attempted to give their adult child and the concern that the grandparent had for the grandchild's parent (Bowers & Meyers).

Role theory acknowledges the psychological and physical strains that changes in role can have on grandparent caregivers. These strains are believed to impact mental health, physical health, social support, parenting behaviors, home environment, and relationships between grandparents and their grandchildren.

Feminist Theory

Childrearing has long been prescribed as a woman's responsibility (Baber & Allen, 1992). Feminist theory describes caregiving as a social relationship that is impacted by politics and social structures (Baber & Allen). Before the 1960s American families primarily consisted of

two-parent households, for which the father worked and the mother raised children in the home. In the 21st Century, American households are more often comprised of two working parents, single parents, or other family systems with women providing multiple roles including those outside the home. As women determine they also want or need fulfilling careers outside the home, caregiving has increasingly become the responsibility of family caregivers, such as grandparents (Giarrusso & Silverstein, 1996, Reynolds, Wright & Beale, 2003). For postmodern feminists, the issue is whether caregiving is chosen, rewarding and a valuable activity as opposed to *women's work* that is conducted because women are subordinate to men (Baber & Allen).

Feminist theory uses philosophical, cultural, and political views to explain the oppression of women, rooted in the social structures of a patriarchal society (Collins, 1986). Feminist theory shares many values with the profession of social work, including the worth of all individuals, the appreciation of diversity, the importance of considering the person in their environment, the need for personal empowerment, and the call for active participation that brings about social change (Barretti, 2001).

Feminist theory supports that the role of caregiving is devalued because it is socially considered the role of women (Baber & Allen, 1992). One aspect that demonstrates value for caregiving is recognizing the economic value of caregivers; for example, by developing legal and social recognition of caregivers that ensures they have equal entitlement to all household funds (Okin, 1989). Another important aspect to valuing caregiving emphasizes the degree of choice in caregiving as an important variable that impacts whether caregiving is enjoyable or burdensome (Baber & Allen). Feminist theory is useful in the theoretical context to ensure that dimensions of power and politics are included in the understanding of grandparent caregivers raising their grandchildren, most of whom are women.

Feminist theory reminds us that: (a) women have been socialized to be emotional caretakers (Gilligan, 1993) and therefore, women-headed households reflect the commitment and strength of women (Abramovitz, 1991); (b) understanding of the history of female socialization is one way to look at the politics of gender, including the oppression of women (Colucci-Coritt, 1999); (c) traditional family structures are not always appropriate for all families (Featherstone, 1996); (d) there should be a respect for alternative family structures and an understanding that these alternative structures necessitate different family strategies for survival (Kissman, 1991); and (e) there should be a link between the personal and the political or, the individual experience and the broader social structure, such as social, economic, political and cultural conditions (Dankoski, Penn, Carlson, & Hecker, 1998). This point is emphasized because power realities in a patriarchal society may contribute to problems encountered by grandparent-headed families (Becvar & Becvar, 1996).

Ecological Perspective

The ecological perspective is also important to contextualizing grandparent-headed families in broader terms (Robinson, Kropf, & Myers, 2000). The ecological perspective focuses on the interchange between family and environment (Hartman & Laird, 1987) with the assumption that the individual and environment are inseparable and must be considered together (Bronfenbrenner, 1989). It fits well with role theory, embedding concepts such as role conflict, role overload and role performance, which can greatly impact interactions and well-being (Cox, 2003). It also supports the feminist view emphasizing interconnectedness and interdependencies (Germain & Gitterman, 1996). Family problems are linked with politics and culture reflecting power relations in society, while recognizing the multiple relationships and systems that impact the grandparent and family's well-being (Robinson et al.).

The family is the closest, most intense, most durable, and influential part of the mesosystem in Bronfenbrenner's (1979) ecological perspective. The influences of the family extend to all aspects of a child's development; language, nutrition, security, health, and beliefs are all developed through the input and behavior related feedback within the family (Bronfenbrenner, 1979). Non-traditional families, such as grandparent headed households are more common today than the traditional family. The loss of the parent of the child can have a profound effect on the family and the development of the child, but it is often a product of society, decided by a judge, enforced by social services. In turn, the family affects the community and society through its social attitudes and perceptions. The school is also affected by the changes in a grandparent headed family. Where does the report card go and who comes to parent-teacher conferences? A number of other systems: community, religion, school, society, and cultural forces from within the mesosystem and the exosystem directly affect the family. Society and the culture of both the family and the neighborhood have influence on the child's perception of the family's place in the community. The family can affect the community through its need for services and its contribution as taxpayers and voters. These relationships are multi-directional and interrelated. It is a dynamic, complex and ever changing matrix.

Therefore, this study will assume a "multidimensional view" (Kissman, 1995, p. 152) of families incorporating role theory, feminist theory, and the ecological perspective. It takes into account the external environment and therefore, results in a wider view of family interaction (Kissman, 1995).

Literature Review

This review of literature encompasses three areas of research: 1) the broader context of grandparents caring for their grandchildren from the gerontological literature; 2) the literature on

kinship foster care; and 3) the literature related to intergenerational relationships. The literature is organized by the major study variables: characteristics of grandparent households, grandparent caregiver mental health, grandparent caregiver physical health, social support, parenting behaviors, home environment, and quality of the caregiver-child relationship.

Nationwide, almost 4 percent of the population 30 and over live with their grandchildren. Fifteen percent of individuals 30 and older are responsible for their grandchildren's basic needs, including food, shelter, clothing and day care (Nelson & Lalich, 2003). The following discussion investigates the characteristics of grandparent caregivers and kinship foster parents, identifying the major variables in the study.

Characteristics of Grandparent Caregivers and Kinship Foster Parents

As presented in Chapter 1, grandparent caregivers are more likely to be grandmothers. Grandmothers outnumber grandfather caregivers 5 to 3, primarily due to the fact that women live longer and are less likely to remarry after the death of a spouse (Bryson & Casper, 1999). Fuller-Thomson et al. (1997) found that 77 percent of caregiving grandparents in their national study were women. In the American Association of Retired Persons (AARP) Grandparent Survey of AARP members (2002) approximately 30 percent of the grandparent caregivers were male and 70 percent female.

Most kinship foster care parents are grandparents (Geen, 2000, Harden et al., 1997). Due to this fact, kinship foster caregivers tend to be female, older, single, have less education, and lower incomes than non-kinship foster parents (Barth et al., 1994; Berrick et al, 1994; Chipungu et al., 1998; Ehrle & Geen, 2002; Harden et al.). About half of kinship caregivers are employed out of the home (Berrick, Barth, & Needell, 1994; Dubowitz et al., 1994). Compared with traditional foster care parents, kinship foster care parents describe themselves as poorer in health

(Berrick et al, 1994), having lower incomes, and being less likely to own their homes (Berrick et al, 1994).

Single grandmothers living with their families are more likely to be poor than co-resident grandfathers. Twenty-five percent of grandmother caregivers with a parent or spouse in the home are poor, compared with 60 percent if no parent or spouse lives in the home (Bryson & Casper, 1999). Fuller-Thomson et al. (1997) concur with this finding. In their study, caregiving grandparents were 60 percent more likely to have incomes below poverty-level than non-caregiving grandparents. Casper & Bryson (1998) found that 27 percent of grandchildren living in grandparent headed households live in poverty. Two-thirds of grandmother-only homes are in poverty contrasted with 19 percent of children living in homes headed by their parents. They found that marital status of grandparents, their gender, and the presence or absence of parent in the home is related to economic well-being (Casper & Bryson, 1998).

Landry-Meyer (1999) recently found that 90 percent of grandparent caregivers do not receive social security and 85 percent do not receive any public assistance. Of these, only a small percentage are receiving foster care stipends, precluding them from child care assistance and other support services for the grandchild (Landry-Meyer, 1999).

According to 2000 Census data, of all grandparents over 30, 3.6 percent live with their grandchildren. Of white, non-Hispanic grandparents, only 2 percent live with grandchildren, while 10 percent of Pacific Islanders, 8 percent of Black, Hispanic and American Indian, and 6 percent of Asian grandparents live with their grandchildren (Simmons & Dye, 2003). However, in Fuller-Thomson's et al. (1997) national study, 62 percent of caregiving grandparents were non-Hispanic white, 27 percent were Black, and 10 percent were Hispanic. However, when compared with non-caregiving grandparents, caregiving grandparents were significantly less

likely to be non-Hispanic White. In fact, African Americans had an 83 percent greater chance of being a grandparent caregiver than grandparents of other races (Fuller-Thomson et al.). The 2002 AARP Grandparent Survey found that five percent of white grandparents and 17 percent of African American grandparents had grandchildren living with them.

Differences in race have an impact on the grandparent caregiver experience. Pruchno (1999) found that African American grandmothers were more likely to have friends who cared for their grandchildren, receive formal support services, and come from multigenerational households than White grandmother caregivers. As a result, White grandmothers experienced more burden from caregiving than African American grandmothers (Pruchno, 1999).

Hispanic grandmother caregivers who are monolingual (Spanish speaking) are not likely to receive needed services, even when they are connected to formal service systems due to lack of knowledge about available resources (Burnette, 1999). Grandmothers with low levels of education, poor health, high levels of life stress, and lack of reliable assistance with child care were most susceptible to having unmet needs (Burnette).

Grandparent caregivers tend to be older than non-caregiving grandparents (Fuller-Thomson & Minkler, 2000). In 2000, Census data reported fifty percent of co-resident grandparents under age 60 were caregivers of their grandchildren. Thirty-one percent of co-resident grandparents over age 60 were caregivers (Simmons & Dye, 2003). In another national study, the mean age for grandparent caregivers was 59.4 years (Fuller-Thomson et al., 1997). This study also revealed that the older a grandparent is, the less likely they will become a grandparent caregiver (Fuller-Thomson et al.).

Grandparents providing caregiving tend to have more grandchildren than non-caregiving grandparents (Fuller-Thomson & Minkler, 2000). Fuller-Thomson and Minkler (2000) found

that among African-American grandparents, caregiving grandparents had an average of 8.2 grandchildren, while non-caregiving grandparents had an average of 5.3 grandchildren.

The West is the region with the highest percentage of co-resident grandparents, at 4.3 percent, compared with only 2.7 percent in the northwest (Simmons & Dye, 2003). Simmons and Dye (2003) noted that the South had the highest percentage of grandparent caregivers at 48 percent compared with 34 percent in the Northeast. According to Census data (U.S. Census Bureau, 1999), the highest percentage of grandchildren living with their grandparents is found in the District of Columbia and in Hawaii. However, the next five states with the greatest percentages of children living with grandparents are in the deep South: Mississippi, South Carolina, Louisiana, Alabama, and Georgia. The grandchildren living with their grandparents in these five states account for 14 percent of all grandchildren in the U.S. who live with their grandparents. Grandchildren in North Carolina, Tennessee, Florida and Arkansas are included in the top 15 states based on percentage of grandchildren living with their grandparents.

Fuller-Thomson et al. (1997) found that 42.5 percent of the caregiving grandparents in their study were from the South. However, this variable was not a predictor of grandparent caregiving in multivariate regression analysis. Harden and associates (1997) also found that kinship care is more prevalent in the South.

Grandparent caregiving is a commitment that impacts the lives of grandparents for long durations of time. One study found that more than half (56 percent) of the grandparent caregivers were caregivers for at least three years (Fuller-Thomson et al., 1997). On the average, grandparent caregivers provide care to two grandchildren, most less than six years old, for six years, without legal custody (Landry-Meyer, 1999).

Characteristics of Children in Kinship Foster Care

Children in foster care experience traumatic experiences that influence their health, behavior and well-being. Chipman, Wells and Johnson (2002) found in their qualitative study of 24 focus groups that kinship foster care providers were more concerned with providing love, moral and spiritual guidance than caseworkers, who are more focused on safety and permanency. In addition, kinship caregivers were more concerned with school performance, child behavior, and happiness as outcomes more important than permanency.

Children in kinship foster care had fewer placement moves than those in traditional placements (Webster, Barth & Needell, 2000, Sawyer & Dubowitz, 1994). Youth with fewer placements have been shown to have increased positive school performance (Zimmerman, 1982). In fact, Shin (2003) found that kinship care placement was the factor that predicted educational success across all youth in foster care. However, Leslie, Gordon, Ganger, & Gist, (2002) found that young children initially placed in kinship care were as likely to be developmentally delayed as children placed in traditional foster care. Likewise, long-term differences in functioning between children in kinship versus non-kinship foster care were not found (Benedict & Zuravin, 1996).

Other findings include that youth in kinship care are less likely to have mental health issues (Iglehart, 1994) and fewer reported behavior problems (Shore et al., 2002) than non-kinship youth. More specifically, placement with a relative has psychological advantages for a child in knowing family members and having a family identity (American Academy of Pediatrics, 2000). However, concerns about circuitous returns to parents raise questions about whether kinship care is a superior home environment (American Academy of Pediatrics, 2000).

Research indicates that children in kinship foster care remain in foster care significantly longer than children in other foster care placements (Benedict, Zuravin, & Stallings, 1996). In addition, they are not more likely to be reunified with parents (Geen, 2003a; Berrick, Needell, & Barth, 1998; Testa, 1997) and less likely to be adopted (Berrick & Needell, 1999; Berrick et al., 1998). Gleeson (1999) found that kinship foster parents are less interested or willing to adopt. Testa (2001) found that if informed, kin are willing to adopt. One trend is to provide alternatives to adoption through subsidized guardianship programs (Testa, 2004). The Urban Institute reports that 35 states have implemented such programs (Geen, 2003a).

Geen (2003a) found that the result of kinship care placements is often longer-term than other permanency options, such as adoption and guardianship. In addition, birth parent compliance with case plans decreases when children are placed with family. Finally, relative caregivers are not motivated to adopt due to the perceived impact it will have on family relationships, including the parent of the child, and because financial support programs and services are not available to families after adoption (Geen, 2003a). A study of Baltimore kinship foster caregivers found that few of the children were expected to return to their parents or be adopted. There was little discussion about permanency planning, and kinship foster caregivers were unsure of the long-term plan for the child in their care (Dubowitz & Feigelman, 1993).

The probability that reunification will occur is highest early in the placement process and decreases as the child remains in care over time (Courtney, 1994, Goerge, 1990). Frame, Berrick & Brodowski (2000) found that children placed with kin prior to reunification were 80 percent less likely to re-enter care than those whose last placement was with non-kin. Other factors most closely associated with reunification for infants are maternal criminal history and substance abuse, child age, and the presence of housing problems at the time of reunification (Frame et al.).

However, Courtney (1994) found that children placed in kinship care were less likely to be reunified in the first few months than children placed in non-kin placements. Testa (1997) confirmed that in Illinois children in kinship care were less likely to return to their parents. Some suggest that paying family caregivers to raise children and not offering the same support to the parent is a disincentive for reunification (Takas, 1992; Hegar & Scannapieco, 1995). Hornby and Zeller (1996), however, suggest that kinship foster care providers should receive more money than welfare recipients, but less than licensed foster parents. This arrangement would require less supervision and no requirement for licensing, assuming the child had never been taken into state custody.

The following sections will outline the literature related to the major study variables chosen for this study. They are caregiver mental health, caregiver physical health, social support, parenting behaviors, home environment, and caregiver-child relationship.

Caregiver Mental Health

The loss of the parent, for whatever reason and whatever length of time, is a crisis for both grandparents and the grandchildren in their care. From a family systems perspective, a family crisis may indicate that family members are operating in a highly anxious system. The impact of this anxiety leads to emotional distress for grandparents; while depression is the characteristic most associated with caregiving (Walker & Pomeroy, 1996).

Compared with other caregivers, grandparents experience more stressful life events and more burdens related to caregiving (Burton, 1992; Fuller-Thompson & Minkler, 2000; Fuller-Thomson et al, 1997; Kelley, 1993; Kelley, Yorker, Whitley, & Sipe; 2001; Musil & Ahmad, 2002; Strawbridge et al., 1997). Studies found that grandparents raising their grandchildren were

more likely to be clinically depressed compared to grandparents who are not primary caregivers (Fuller-Thomson & Minkler, 2000; Minkler et al., 1997).

A national study of African American grandparents indicated that one-third of grandparents caring for their grandchildren had symptoms of depression, compared with one-fifth of the grandparents not caring for their grandchildren (Fuller-Thomson & Minkler, 2000). Kelley, Whitley, Sipe, and Yorker (1999) found that psychological distress was predicted by family resources, participants' physical health, and to a lesser extent, social support. In addition, grandchildren who are raised by grandparents are experiencing the anxiety of family dynamics as well. Grandchildren often suffer from emotional and behavioral problems due to prior abuse, neglect, and abandonment (Kelley, Yorker, & Whitley; 1997). The needs of grandchildren surely have an impact on the grandparents' feelings of emotional distress.

Waldrup & Weber (2001) found that family relationships most often contribute to long-term stress for grandparent caregivers. The well-being of their traumatized grandchildren was also cited as reason for psychological stress (Waldrup & Weber, 2001). Sands and Goldberg-Glen (1998) found that grandmothers raising their grandchildren were at risk for psychological anxiety if they had a life-threatening physical condition, were younger and white.

Bowers and Myers (1999) compared grandmothers providing different levels of caregiving to their grandchildren. They found that full-time grandparent caregivers experienced less life-satisfaction, more parenting stress, and decreased grandparent satisfaction. They also found that grandchild behavior was the most important determinant of negative grandmother perceptions.

Caregiver Physical Health

Several studies (Minker & Roe, 1993; Minkler, Roe & Price, 1992; Musil & Ahmad, 2002; Strawbridge, Wallhagen, Shema, & Kaplan, 1997; Whitley, Kelly & Sipe, 2001) have supported the concept that grandparent caregivers report decreased health status compared to other grandparents. Minkler and Fuller-Thomson (1999, 2000) found that grandparent caregivers had a 50 percent greater chance of having difficulties with activities of daily living (i.e., bathing, climbing stairs, etc.). In addition, caregivers were more likely to have a lower self-rating on their health and report lower satisfaction with their health (Minkler & Fuller-Thomson, 1999). Strawbridge and associates (1997) determined that grandparent caregivers had poorer physical health than other caregivers. There is also evidence that grandparent caregivers tend to downplay their health concerns (Minkler, Roe & Price, 1992; Whitley, Kelly & Sipe, 2002).

Social Support

Several studies addressed grandparent caregivers' tendencies to delay or fail to gain needed support for themselves and their grandchildren (Burnette, 1999; Minkler & Roe, 1993; Shore & Hayslip, 1994). Burnette (1999) studied Latino families that historically have a rich informal social support system. However, when grandmothers are raising their grandchildren, there is a skipped-generational effect that greatly reduces the reliable support that grandmothers receive for raising children. Burton (1992) found that only 3 percent of African American grandparent caregivers were receiving consistent, reliable family support. Minkler and Roe (1993) report that social isolation of grandparent caregivers is often a result of shame and guilt of the reasons their children are no longer parenting. Isolation ensures they do not have to discuss their child's substance abuse problem. Social support also decreases when grandparent peers are uninterested in the tasks of parenting (Minkler & Roe, 1993).

In Burton's qualitative study of 60 grandparent caregivers, the services needed by grandparents include economic assistance, respite services, emotional support, mental health counseling and grandparent support groups (Burton, 1992). A comparative study of family caregivers reports that caregivers involved in individual and group interventions experience significant improvements with coping with caregiver stress (Toseland, Rossiter, Peak, & Smith, 1990). However, individual interventions worked best with psychological issues, while group interventions worked best with social support issues (Toseland et al.).

Parenting Behaviors

Although parenting behaviors encompass a wide array of interactions with children, this study focused on parenting behaviors related to discipline. Discipline practices, ranging from non-physical to corporal punishment, are important topics in child welfare. Foster parents, as representatives of the state, are not allowed to use physical punishment, i.e. spanking, with foster children.

This policy, as part of an unconditional anti-spanking perspective upheld in social science literature (Gershoff, 2002; Straus, 2001), may become an issue for relative caregivers, who may discipline their own children physically. In a 1994-1995 study of American parents, 94 percent reported using physical punishment at least occasionally (Larzelere, 2005; Straus & Stewart, 1999). To support the unconditional anti-spanking perspective a recent meta-analysis reported that physical punishment was positively correlated with immediate compliance, but negatively correlated with 10 other outcomes in children and families (Gershoff, 2002). On the other hand, Larzelere (2000) concluded in his qualitative review, that nonabusive spanking of 2 to 6 year olds produced more benefits than detriments to child outcomes when it supported other forms of discipline, such as reasoning or time-out.

Despite research on the outcomes of physical discipline, parenting behaviors are widely believed to be passed on from generation to generation (Cicchetti & Aber, 1980; Kaufman & Zigler, 1987; Kempe & Kempe, 1978; National Research Council, U.S. Panel on Research on Child Abuse and Neglect, 1993; Weiss et al., 1992). Studies indicate that abusive parents are more likely to use punishment, threats and power and are less likely to use reasoning and affection in disciplining their children (Lorber et al., 1984; Trickett and Sussman, 1988). Gebel (1996) found that kinship caregivers have more favorable attitudes toward physical discipline than non-kinship caregivers. Physical discipline and parenting behaviors remains a highly charged topic of interest in child welfare.

Home Environment

Safety issues are the primary reasons that children are removed from their homes. The goal of child protective services is to remove children from dangerous environments and place them in safe ones. Child safety involves treatment of child, safety of home, safety of neighborhood, and availability of medical and dental care (Geen, 2000). Meyer and Link (1990) found that kinship caregivers provide a much safer home environment than biological parents. However, Berrick (1997) found that non-kinship foster homes were significantly in better order, more spacious, less threatening and in better repair than kinship foster care homes. Non-kinship foster homes were also more likely to own first aid kits, know CPR, and own a fire extinguisher than kinship foster homes (Berrick, 1997).

Home environment is known to be an important factor in child development predicting success in school and emotional support for young children (Bradley, et. al, 1989; Caldwell & Bradley, 1984; Gottfried, 1984; Sugland et al, 1995). Orme and Buehler (2001) document nine studies that examined the physical environment of foster homes. Although one study found that

99 percent of foster homes were judged to be *comfortable and safe* (Lindholm & Touliatos, 1978), Berrick (1997) found that non-kinship foster care providers are more likely to provide a supportive home environment than kinship caregivers.

Over the last three decades home environment has been considered a reliable indicator of a young child's future cognitive and socio-emotional development (Caldwell, 1998). The overall quality of the home environment has been measured through eight factors that affect children's healthy growth, including: a high frequency of adult contact with a small number of loving adults, the provision of a social learning environment that is both stimulating and responsive, an optimal level of need gratification, a positive emotional climate in which the child learns to trust others and himself or herself, an environment containing a minimum number of restrictions on exploration (other than experiential feedback), the provision of rich and varied cultural experiences, a physical environment containing modulated amounts and varieties of sensory input, and access to appropriate toys and play materials (Caldwell, 1998). In a recent national study on early child care, home environment and child care quality were found to have a greater impact on children's cognitive development than whether their mother worked outside the home (Brooks-Gunn, Wan, & Waldfogel, 2002).

In a synthesis of research using the HOME Inventory, Caldwell (1998) reported that more than 300 studies on home environment over 35 years found that HOME scores tend to correlate significantly with measures of developmental competence during the first three years of life and to predict later functioning with reasonable accuracy. In addition, prediction of children's functioning level on cognitive and language measures using the HOME Inventory at age three is more accurate than predicting success using the children's early development test scores. Of equal importance is the fact that the studies indicate that responses to parent-oriented

intervention programs indicate that the behavior called for by some HOME items can be learned and can change following intervention (Caldwell, 1998).

Quality of Caregiver-Child Relationship

In African-American and Hispanic cultures, intergenerational caregiving is a norm and considered a healthy alternative to raising children in isolation of other family members. Relationships provide social support, which is a factor long believed to positively influence longevity and well-being. When grandparents become parents due to the middle generation's failure to parent, there are three themes that emerge from the literature: individual and family stress, family structure, and role change.

Children in high conflict families have lower well-being, whether or not there are differences in family structure as a result of the conflict (Vanderwater & Landsford, 1998). Parental warmth is seen as a mediator between conflict and child well-being (Vanderwater & Landsford). Conflict and stress precipitating grandparents becoming the primary caregiver to grandchildren are often due to parent mental health, substance abuse, or incarceration. These stressors strain family relationships and increase anxiety, leading to lower levels of cohesion in the family (Sands & Goldberg-Glen, 2000). In fact, the reasons for parent loss have an impact on child coping and behavior (Pinson-Milburn, Fabian, Schlossberg, and Pyle, 2001). Children who lose parents due to death or divorce are more likely to be consolable and less likely to be withdrawn or to act out than children who perceive their parent as neglectful, cruel, absent without explanation, incarcerated or involved with drugs (Pinson-Milburn et al.).

As presented earlier, grandparents' stress is also increased by the circumstances that cause their children to no longer care for the grandchildren. Kluger and Aprea (1999) found that although grandparents felt their child had done their best to raise their grandchildren, they felt

anger towards their child. Minkler et al., (1994) reported that a majority of grandmother caregivers, for which 70 percent were providing care to children prenatally exposed to crack, were angry and resentful toward their own child, but were very happy to support their grandchild. Goodman and Silverstein (2002) compared grandmothers coparenting grandchildren with those parenting with full custody. They found that African American custodial and coparenting grandmothers experienced equal well-being; but when stresses related to their child's dilemma were factored in, they preferred custodial caregiving over coparenting (Goodman & Silverstein).

When families experience stress, the middle generation governs the structure and dynamics of intergenerational relations, even when they are absent (Burnette, 1999). In fact, Umberson (1992) found that the quality of intergenerational relationships are based on two factors: the structural circumstances of parents and adult children, influenced by marital status, gender and age; and that negative aspects of relationships are more strongly associated with psychological distress than are the positive aspects. Overall, the effect of intergenerational relationships on distress depends on the structure of the relationships (Umberson).

Several authors describe intergenerational relationships as triads (Goodman, 2003; Scannapieco & Jackson, 1996). In identifying different triad structures, Goodman found that poor grandmother well-being was related to parent emotional isolation. Scannapieco and Jackson recommend that a system of services be developed that focuses on all three generations to ensure permanency. In this context, social workers would include all family members, including extended family, in planning; recognize that grandparent caregivers, particularly African American grandmothers, see themselves as meeting a need in the family, not serving a traditional foster parent role; ensure that social work practice takes into account the cultural traditions of

kinship care families; and recognize that kinship care is a natural system for raising children that existed before child welfare embraced the concept (Scannapeico & Jackson).

Research on role changes in grandparent-parent-grandchild networks following separation or divorce highlight the mediating role of parents, especially daughters, on the grandparent-grandchild relationship (Burnette, 1999). Even when the parent is absent, the parent remains an important emotional factor in the family (Weber & Waldrop, 2000). Although families have ways of coping with the changes, the traumatic nature of the events that lead up to change permanently change the family roles and dynamics (Weber & Waldrop, 2000).

When the middle generation is not seen as able to make good decisions about the care of the child, the grandparent may take responsibility for decision-making for their grandchild, but will experience role conflict due to the perceived natural order of parent determination for the grandchild. Poehlmann (2003) found that when grandparents raise grandchildren, three relationship processes develop. First, disruption in parental relationship occurs; second, attachment relationships between grandparent and grandchild develop; and third, the internal working models that parents and grandparents have for what attachment relationships should look like are challenged.

Berrick's (1997) comparison of kinship and non-kinship households found that although kinship foster care homes indicated a greater degree of fondness between family members, that the differences were not statistically different from non-kinship foster families. McFadden (1996) states that all kinship foster parents experience stresses, whether they are grandparents, other relatives, or unrelated foster parents. She identifies issues such as maintaining boundaries, creating a cohesive family structure, issues with child welfare agencies, child needs, and working with the child's parents as major stressors for all foster families (McFadden, 1996).

Chapter Summary

In conclusion, Chapter 2 described the theoretical context of this study, explaining grandparent caregiving through the primary theory, Role Theory. Next, the theoretical context was expanded to represent the larger systems that impact individual and family functioning through Feminist Theory and the Ecological Perspective. The literature review presented current literature relevant to the study variables, caregiver mental health, caregiver physical health, social support, parenting behaviors, home environment, and the quality of the caregiver-child relationship.

CHAPTER 3

METHODOLOGY

Chapter 3 presents the methods used in this study for selection of the participants, the variables used in each phase of analysis, the measures used for each variable, the data collection procedures, and data analyses plan. The data analyses included methods for pre-analysis, the descriptive phase, the comparative phase, and the predictive phase.

One of the past criticisms of kinship care research was the lack of research infrastructure from a national funding source (Barth, 2001). The National Survey of Child and Adolescent Well-Being (NSCAW) is a national survey of children, caregivers, case workers and teachers of children receiving child welfare services (Barth, 2001). It provided critical information using data collected from more than 6,200 children from 92 localities in the United States (Administration on Children, Youth and Families, 2003).

While this data set is a rich source for secondary data analysis, it is important to note that the original design is not an experimental design, making generalizations and explanatory hypotheses of cause and effect impossible (Rubin & Babbie, 2001; D'Onofrio, 2003). Although an experimental design would potentially provide more useful knowledge it would seem unrealistic and costly to implement a more rigorous design (Nackerud, 2001). Therefore, this study drew on as much useful knowledge as possible, given the limitations of the design, available measures, and completed data collection.

Much of the methodology of this secondary analysis of a cross-sectional study was predetermined by the National Survey of Child and Adolescent Well-Being (NSCAW) work

group. The methods for selecting participants and data collection procedures were drawn entirely from the Administration on Children, Youth and Families' *National Survey of Child and Adolescent Well-Being (NSCAW): Combined Waves 1-3 Data File User's Manual General Release Version* (2003).

Selection of Participants

The NSCAW team of experts and data collectors collected data for 6,200 children. Of these, 727 children were in foster care for at least one year and were included in the Long Term Foster Care (LTFC) sample (Administration on Children, Youth and Families, 2003). The target population for the LTFC sample was all children in the United States (excluding four states that had laws requiring study participants to receive their first contact from CPS (instead of NSCAW study representatives) who had been in out-of-home care for approximately one year, and whose placement in out-of-home care was preceded by an investigation of child abuse or neglect or by a period of in-home services (Administration on Children, Youth and Families, 2003). This study focused on the LTFC sample of children and their caregivers.

NSCAW was based on a complex sample; “a sample that may be multi-stage, stratified, unequally weighted, and/or clustered” (Research Triangle Institute, 2004, p. 2). The NSCAW used a weighted, two-stage stratified sample design. In complex surveys, stratification may be used in the selection of subjects for a study (Administration on Children, Youth and Families, 2003). This process involved dividing the population members into “non-overlapping subgroups, called strata for the purpose of improving the [statistical] efficiency of the sample design” (Kalsbeek & Heiss, 2000, p. 12). The process is described in the following paragraphs and is depicted in Figure 2.

Sampling error is the error caused by what we don't know about those not sampled. It creates a statistical uncertainty that only a skillfully crafted sampling design can minimize (Kalsbeek & Heiss, 2000). The statistical efficiency is improved by reducing variance of total population estimates "by assuring adequate representation of all strata in the sample" (Kalsbeek & Heiss, p. 12). Stratification can also improve efficiency by oversampling strata that contain large percentages of population subgroups (Kalsbeek & Heiss).

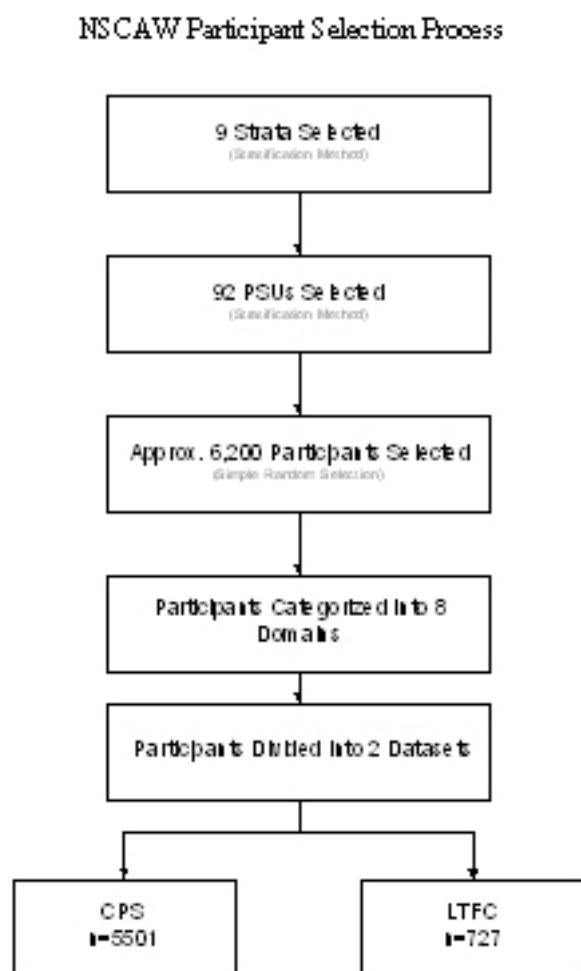


Figure 2. NSCAW Participant Selection Process

The NSCAW workgroup defined nine sampling strata. Eight of the strata included the eight states with the highest child welfare caseloads and the ninth stratum consists of the remaining 38 states and the District of Columbia. This is an example of an optimum allocation method for choosing the strata; a method that "applies the largest sampling rates in the strata with the greatest diversity in the measurements of relevance and the lowest cost of adding members to the sample" (Kalsbeek & Heiss, 2000, p. 25). This method can be risky with a potential for the stratum data to produce less efficiency in total population estimate than if the population were not stratified (Kalsbeek & Heiss).

NSCAW team members then divided each of the strata into primary sampling units (PSUs) that are made up of child welfare offices and their service area, which in most cases is a

county (Administration on Children, Youth and Families, 2003). The PSUs were selected using a probability-proportionate-to-size (PPS) procedure that gave a higher chance of selection to PSUs having larger caseloads (Administration on Children, Youth and Families, 2003). “Size” refers to the number of subjects in each cluster, which is usually not known. In this case, estimates are used to measure the size of each cluster.

“PPS sampling is generally used to select clusters in all but the last stage of multi-stage samples, particularly when the number of population members varies considerably among clusters at all levels. One uses PPS sampling mainly to offset reductions in estimate efficiency that can result from applying SRS devices to clusters of unequal size. Common by products of PPS sampling in a multi-stage design are equal selection probabilities for all chosen population members (as statistical advantage), and roughly equal sample sizes in each sample cluster (a practical advantage)” (Kalsbeek & Heiss, 2000, p. 26).

Of the PSUs chosen, six refused and were replaced with PSUs approximately the same size (Administration on Children, Youth and Families, 2003). Eight were determined to be in states requiring first contact by CPS staff (Administration on Children, Youth and Families, 2003). Therefore, the sample consisted of 92 PSUs.

The subjects for NSCAW were selected using a balanced allocation, with the same sample size for each PSU, even though the strata were unequal in size (Administration on Children, Youth and Families, 2003). Eight mutually-exclusive and exhaustive domains defined the categories for children of interest to the study (see Table 2). This approach creates a disproportion that limits the efficiency of the estimate for the populations. Sample weights are

used to offset this loss in precision (Kalsbeek & Heiss, 2000). Since this study focuses only on those children in out-of-home placement for a year, some of the domains with children less than 1 year old or with children not placed in out of home care do not apply to this study. Therefore, the domains relevant to this study are domains number 7 and 8 in Table 2.

Table 2

Domains in NSCAW Dataset

Domain	Description
1	Infants (age < 1 year old) who were not receiving CPS agency funded services.
2	Children age 1 to 14 years old who were not receiving CPS agency funded services.
3	Infants (age < 1 year old) who were receiving CPS agency funded services and were not in out of home care.
4	Children age 1 to 14 years old who were receiving CPS agency funded services and were not in out of home care and were investigated for allegations of sexual abuse.
5	Children age 1 to 14 years old who were receiving CPS agency funded services and were not in out of home care and were investigated for allegations of other abuse or neglect.
6	Infants (age < 1 year old) who were receiving CPS agency funded services and were in out of home care.
7	Children age 1 to 14 years old who were receiving CPS agency funded services were in out of home care and were investigated for allegations of sexual abuse.

Table 2 (continued)

Domain	Description
8	Children age 1 to 14 years old who were receiving CPS agency funded services, were in out of home care and were investigated for allegations of other abuse or neglect.

Sample weights were used in the analysis to increase statistical accuracy and interpretation of results. Sample weights are “numbers tied to a member of a sample that is intended to reflect the inverse of the member’s selection probability, which is calculable in any probability sample” (Kalsbeek & Heiss, 2000, p. 18). A sample weight can also be thought of as a representation of the population members that each subject chosen represents (Kalsbeek & Heiss, 2000).

The sample frame for the LTFC sample was made up of the PSU’s lists or files of children who were in CPS for one year. Eligible children were those meeting the following criteria:

- Placed into out-of-home care approximately one year before the sample selection period,
- Placed into out-of-home care preceded by an investigation of child abuse or neglect or by a period of in-home services, and
- Were in out-of-home care at the time that the sampling frame was produced.

Only one child per household was included in the frame (Administration on Children, Youth and Families, 2003). The LTFC sample selection period was during December 1999 through February 2000 (Administration on Children, Youth and Families). In some PSU’s the

number of children eligible was too small and the window for selection was increased to include July 1998 through February 1999(Administration on Children, Youth and Families).

Variables

This three part study with a correlational design, first described grandparent caregiver households. The second phase of the study compared grandparent caregivers to parents, other relative caregivers, and non-relative caregivers in the sample using critical concepts from the grandparent and kinship care literature. These concepts include mental health, health, social support, parenting behaviors, home environment, and grandparent-grandchild relationships. The third phase of the study generated a Multiple Linear Regression model that predicts positive grandparent-grandchild relationships.

As Table 3 shows, demographic variables that described grandparent households were used in Phase I. They included gender, income, age, race, number of children in care, and other variables available and useful to describing grandparent households. Phase II used type of caregiver as the independent variable and compared differences across caregiver mental health, caregiver health, social support, parenting behaviors, home environment and grandchild relationship with caregiver. Phase III used the variables in phases I and II as predictors of social support satisfaction.

Measures

The measures available in the NSCAW dataset were chosen by a national panel of experts in child welfare and complex survey methodology. The measures for this study are listed in Table 4 with the corresponding variable, author of the instrument and a summary of the type of data collected.

Table 3

Phases of Study and Corresponding Hypotheses and Research Questions

Phase	Hypotheses and Research Questions
<i>I-Descriptive</i>	1. Grandparent foster caregivers are more likely than other caregivers in the child welfare system to be older women of color with lower incomes and a greater number of grandchildren.
<i>II- Comparative</i>	<p>2. Grandparent foster caregivers are more likely than other caregivers in the child welfare system to have significantly poorer mental health.</p> <p>3. Grandparent foster caregivers are more likely than other caregivers in the child welfare system to have significantly poorer physical health.</p> <p>4. Grandparent foster caregivers are significantly less likely than other caregivers in the child welfare system to have social support.</p> <p>5. Are grandparent foster caregivers more likely than other caregivers in the child welfare system to have positive parenting behaviors?</p> <p>6. Are grandparent caregivers more likely than other caregivers in the child welfare system to have nurturing home environments?</p> <p>7. Are grandparent foster caregivers more likely to have emotionally secure relationships with their grandchildren compared with the relationships between other foster caregivers and the children they care for?</p>
<i>III- Predictive</i>	8. What factors combine to best predict satisfaction with social support among all caregivers in the child welfare system?

Table 4

Cross Classification of Study by Measures, Authors and Information Gathered

Variable	Measure	Author	Info Gathered
Caregiver Type:	1. Parent		Originally gathered through
Relationship to Child	2. Non-Relative 3. Other Relative 4. Grandparent		16 types of caregivers, recoded into 4 types
Caregiver Mental Health	Composite International Diagnostic Interview Short-Form (CIDI-SF) <ul style="list-style-type: none">• Alcohol• Drug Dependence	Kessler, Andres, Mroczek, Ustun & Wittchen (1998)	Permanent caregiver experiences that indicate symptoms of poor mental health
Caregiver Physical Health	Short-Form Health Survey (SF-12)	Ware, Kosinski & Keller (1996)	Caregiver's physical health status
Social Support	Social Support Questionnaire Duke-UNC Functional Social Support Scale	Sarason, Levine, Basham & Sarason (1983); Sarason & Pierce (1987) Broadhead, Gehback, deGruy & Kaplan (1988)	Perceived social support for child and family includes Satisfaction with Social Support and # of social supports available.
Parenting Behavior	Parent-Child Conflict Tactics Scale (CTSPC)	Straus, Hamby, Finkelhor, Moor & Runyon (1998)	Methods and frequency of discipline measures used in the last 12 months
Caregiver's Home Environment	Home Observation for Measurement of the Environment-Short Form	Caldwell & Bradley (1984)	Scripted items about the child's home environment w/ children ≤ 11
Quality of Caregiver-Child Relationship	Rochester Assessment Package for Schools (RAPS)	Connell (1990); Lynch & Cicchetti (1991); Carolina Population Center, UNC-CH (2002)	Degree of supportive relationship between child ≥ 11 and adult

Description, Scoring and Psychometric Properties of Measures

The following sections describe each measure. Reliability estimates, considered a characteristic of the data and not the measure itself (American Educational Research Association, 1999), are also reported for the NSCAW/LTFC sample. Overall, Cronbach alpha coefficients are considered within acceptable limits given the purpose of the instruments (Cronbach, 1951).

Short-Form Health Survey (SF-12)

The Short-Form Health Survey (SF-12), administered to caregivers, is a shorter form of the Short-Form-36 Health Survey that originated from the National Survey of Functional Health Status (NSFHS) (Ware, Kosinski & Keller, 1996). It is a self-report measure with 12 items that have two to six choice responses that are either nominal (yes/no) or ordinal (all of the time/most of the time/a good bit of the time/some of the time/a little of the time/none of the time). The twelve items were chosen based on the SF-36. The SF-12 included two scales, one for physical health and one for mental health, and eight health concepts: physical functioning, role limitation due to physical health problems, bodily pain, general health, vitality (energy/fatigue); social functioning, role limitation due to emotional problems, and mental health (psychological distress and psychological well-being) (Ware et al.). The SF-12 is best suited for large samples of 500 or more (Marosszky, Granger, & Marosszky, 1995). Two standardized scores were used in this study, physical health and mental health. Both have a range of possible scores from 1 to 100 with 50 as the national average.

Test-retest correlations for the physical component ($r = .89$) and the mental component ($r = .76$) have been reported by Ware et al. (1996). The SF-12 was correlated with the SF-36. As a result, the correlation for the physical health scale was .95 and the correlation for the mental

health scale was .96 (Ware et al.). The NSCAW internal consistency reliability overall was $\alpha = .90$. For the physical health scale, $\alpha = .59$ and for mental health $\alpha = .79$ (Administration on Children, Youth and Families, 2003). For this study using the Long Term Foster Care (LTFC) sample of 727, the internal consistency reliability for physical health was, $\alpha = .98$ and for mental health $\alpha = .97$.

The SF-12 was developed using the normative data for the SF-36 (Marosszeky, et al., 1995). Scores are based on norm-based scoring (NBS) and are standardized, with a score of 50 being the average. The possible range for the respective SF-12 component scores is 1 to 100 (mean=50, SD=10 in the 1998 National Survey of Functional Health Status), with higher scores representing better physical (PCS) or mental (MCS) health.

Social Support Questionnaire (SSQ3)

The NSCAW work group combined the Social Support Questionnaire (SSQ3) and the Duke-UNC Functional Social Support Questionnaire (FSSQ) to create a measure of social support with seven two-part questions. The odd number questions pertained to the number of people providing support to the caregiver. These seven responses are then averaged to create the mean number of social supports available. The even number questions contained the level of satisfaction the caregiver felt for that support using four options, 1=very dissatisfied, 2=dissatisfied, 3=satisfied and 4=very satisfied (Administration on Children, Youth and Families, 2003). Social support satisfaction scores were computed by averaging the responses to the seven even numbered questions. The overall internal consistency reliability coefficients for the NSCAW/LTFC sample were $\alpha = .99$, while the reliability coefficients for the number of people was $\alpha = .98$ and for satisfaction, $\alpha = .98$. The following discussion presents psychometric properties of the original measures.

The SSQ3 is a three-item measure derived from the original SSQ of 27 items, each with 2 parts for the purpose of providing a shorter and more convenient measure of social support (Sarason, Levine, Basham & Sarason, 1983; Sarason & Pierce, 1987). The first part of each item uses Likert-type items (i.e., 1=very dissatisfied, 2=dissatisfied, 3=satisfied, 4=very satisfied) and constitutes the social support satisfaction score. Therefore, the mean score of the three items measuring social support satisfaction can range from 1 to 4. The second part of each item asks for the number of individuals who provide social support. The three scores are averaged to create a mean score of the number of individuals who provide social support. This mean number of people providing social support in this sample ranged from 0 to 10.

The measure was initially administered to a sample of 182 undergraduate students. A sample of 106 men and women was used to provide test-retest data 3 – 4 weeks after the initial administration (Sarason et al., 1983; Sarason & Pierce, 1987). The test-retest correlations of SSQ3 were $r=.84$ for number and $r=.85$ for satisfaction (Sarason et al.) The correlation with the adjusted original SSQ were $r = .80$ for number of social supports and $r = .84$ for social support satisfaction (Sarason et al, 1983).

Internal consistency reliability coefficients were computed for the number of social supports and the satisfaction with social supports. For the number of supports, $\alpha = .75$, for social support satisfaction $\alpha = .79$, and the combined $\alpha = .97$. The SSQ3 was correlated with the SSQ for the number of social supports, $r = .81$ ($p < .001$), and satisfaction, $r = .85$. Significant negative correlations were found with measures of emotional discomfort, including The Multiple Adjective Affect Check List Scales measuring anxiety, depression and hostility, and the Lack of Protection Scale (Sarason et al., 1983; Sarason & Pierce, 1987).

Duke-UNC Functional Social Support Questionnaire (FSSQ)

The second measure combines to create the NSCAW social support measure is the Duke-UNC Functional Social Support Questionnaire (FSSQ). This questionnaire is short and simple with four items that consist of two parts: one for satisfaction (i.e., 1=very dissatisfied, 2=dissatisfied, 3=satisfied, 4=very satisfied), and one for the number of people that provide support. The test-retest reliability was conducted two weeks after the original test with only 14 of the 401 participants. The test-retest reliability was $r = .66$ (Broadhead, Gehback, deGruy & Kaplan, 1998). The internal consistency reliability coefficients for the social support measure with the NSCAW LTFC sample used in this study was $\alpha = .99$.

Parent-Child Conflict Tactics Scale (CTSPC)

This measure was developed from the Conflict Tactics Scale (Straus & Gelles, 1990) that measures physical violence between adults. The 22 items were rated with a Likert scale. The scale was revised to consist of six scales: nonviolent discipline, psychological aggression, physical assault, supplemental questions on discipline in the previous week, neglect and sexual abuse. The measure was standardized using a nationally representative sample of 1,000 U.S. children (Straus, Hamby, Finkelhor, Moor & Runyon, 1998).

The measure was scored by adding the midpoints for the response categories chosen by the participant (Straus et al., 1998). The response categories were 1 = 1 time, 2 = 2 times, 3 = 3-5 times, 4 = 6-10 times, 5 = 11-20 times, 6 = more than 20 times, 7 = not in the past 12 months but it happened before and 8 = this has never happened (scored as zero). The midpoints were the same as the response category numbers for categories 1, and 2 and category 8 = 0 (Straus et al.). For category 3 (3-5 times) the midpoint is 4, for category 4 (6-10 times) it is 8 and so on (Straus et al.). Category 7 was scored as its own item and was not used in this study (Straus et

al.). Category 6 (more than 20 times) was scored as 25 making the range of scores for each item 0 to 25 (Straus et al.). Items within the same scale were added together to compute the score for each scale. For example, in this study the range of scores for the non-violent discipline scale was 0 to 100 with a mean score of 31.66. The child neglect scale scores ranged from 0 to 48 with a mean of 2.71.

The internal consistency reliability coefficients of the measure for the Total Score using the NSCAW caregiver reports, $\alpha = .92$ with subscales ranging from .66 for Psychological Aggression to .95 for Very Severe Physical Assault (Administration on Children, Youth and Families, 2004). The test-retest reliability has not been reported for this measure (Straus et al., 1998). The internal consistency reliability coefficient for the measure used in this study was $\alpha = .90$.

The Home Observation for Measurement of the Environment (HOME)

The Home Observation for Measurement of the Environment (HOME) assesses the quality of the home environment for providing stimulation and support for young children (Bradley, Burchinal, & Casey, 2001). This study uses three versions of the HOME: Infant/Toddler for ages 2 years and younger, Preschool for ages 3 – 5 years, and School age for 6 – 10 years olds. Each version consists of 18 to 26 items, some of which are nominal yes/no items and some of which are categorical items, i.e. 1= None, 2= 1 or 2 books, 3= 3 to 9 books, 4= 10 or more books. Each item is scored as either 0 or 1. For nominal items “no” is scored with 0 and “yes” items are scored with 1. Categorical items are also score 0 or 1. In the example above, if the response is 1=“none” or 2=“1 or 2 books” the item is scored 0, and if the response was 3=“2 to 9 books” or 4=“10 or more books” the item is scored 1. As a result, the possible

range of scores is dependant on the number of items in each measure, 0 to 18 for infants or 0 to 26 for toddlers and school-age versions of HOME.

The HOME includes 6 to 7 scales: Emotional & Verbal Responsivity, Acceptance of Child's Behavior, Organization of the Environment, Provision of Play Materials, Parental Involvement with Child & Opportunities of Variety (infant/Toddler), Learning Simulations, Language Stimulation, Physical Environment, Warmth & affection, Academic Stimulation, and Modeling (Preschool). Total and subscale scores are derived with separate means and standard deviations for seven different periods in a child's development. It is used with children less than 11 years of age (Caldwell & Bradley, 1984).

The internal consistency reliability coefficients for the NSCAW/LTFC data set for total scores were .96 for infant/toddler, .97 for toddler and .99 for school age. The infant/toddler measure was normed using 174 infants and the preschool measure was normed using 117 preschool age children (Administration on Children, Youth and Families, 2004). The internal consistency reliability coefficients for the NSCAW LTFC sample used in this study was $\alpha = .84$. Research Assessment Package for Schools (RAPS)

The RAPS self-report measure completed by children 11 years old and older in NSCAW was based on the relatedness measure of RAPS that focuses on feelings of being respected, connected and cared for by others (Institute for Research and Reform in Education, Inc., 1998). Each RAPS item had the following ordinal responses: 4 = very true, 3 = sort of, 2 = not very true, and 1 = not at all true (IRRE). The perceived relatedness subdomain was originally comprised of six composites, from which NSCAW chose three: parental emotional security (scored as the mean of 3 items), peer emotional security (scored as the mean of 4 items), and perceived parental support (scored as the mean of 2 items). The measure was tested using 2,429

male and female subjects, stratified by gender and ethnicity, from three middle schools in an urban school district and one from an adjacent suburban district (ACYF, 2004). The range of scores was 1 to 4 on each scale.

Internal consistency reliability coefficients were: parental emotional security $\alpha = .74$; peer emotional security, $\alpha = .73$; perceived parental support $\alpha = .86$ (Connell, 1990). The NSCAW/LTFC reliability coefficient for the total score was $\alpha = .99$. The internal consistency reliability coefficients for the NSCAW LTFC sample used in this study was $\alpha = .99$.

Data Collection Procedures

This section describes data collection procedures for NSCAW Wave 1. Data were collected from children, current caregivers, former caregivers, investigative caseworkers, state and local agency representatives and teachers (ACYF, 2004). Most of the data collection involved baseline interviews and interim interviews at 2 to 6 months after the close of investigation (ACYF). The NSCAW study was designed from multiple perspectives that represent the many factors impacting child and family well-being.

This study focuses primarily on data collected during the child interview and the current caregiver interview. Once a subject was identified as a participant in the study, field representatives, who were trained by the NSCAW workgroup, contacted the child and family, mailed introductory materials and consent forms and administered the interview according to NSCAW protocol (ACYF, 2004). A description of the contact protocol, informed consent procedures, policies for mandatory reporting, and samples of letters, brochures and training procedures are detailed in the *NSCAW Combined Waves 1-4 Data File User's Manual: General Release Version* (ACYF, 2004).

Child and current caregivers were interviewed, often during the same home visit, but at the convenience of the respondent (ACYF, 2004). A computerized interview protocol, CAPI, was followed for each interview that included assessment materials and prompts for certain activities (ACYF). The field representative or respondent entered data directly into the computer program and scores were generated automatically (ACYF). A showcard booklet that listed response choices for specific questions was used as well (ACYF). Cash incentives of \$25 to \$50 were provided to caregiver respondents and gift certificates of \$10 to \$20 were provided to children respondents (ACYF).

Data Analyses Plan

The data analysis plan is detailed in the following sections, beginning with a pre-analysis plan that describes data inspection, data recoding and missing data issues. The next section describes the first phase of analysis, the descriptive phase, in which descriptive characteristics of caregivers were analyzed. Next, the second phase of analysis involved comparing grandparent caregivers with other caregivers in the study. This analysis involved comparing means across six dependent variables and identifying differences between groups. The final phase of the analysis involved identifying predictors of social support satisfaction. This phase included the procedures for conducting Standard Multiple Regression Analysis.

Pre-Analysis

Data inspection was completed to ensure that data were available for the chosen variables and that planned analyses could be performed given the assumptions of the statistical procedures and the sample size requirements. The distributions of the variables were examined to ensure normality. No variables were deleted as a result of inspection of the data. The studentized deleted residual was used to identify potential outliers with values greater than $|2|$ that might

influence the data. Two potential outliers were identified. The analysis was run without the outliers and no significant change was seen in the interpretation of the results. Therefore, results presented included the potential outliers. Collinearity was tested using the variance inflation factor (VIF) to determine if the precision of the weight estimates was affected. The VIF for each predictor variable was less than 10, indicating that the predictor variables are not too highly correlated so as to affect the precision of the weight estimates (Huberty, 2003). Cook's D was examined to measure the change in the parameter estimates caused by deleting each observation. In all cases Cook's D was less than 1 signifying the absence of observations that would over-influence the result (Pedhazur, 1997).

The variable, *relationship to the child*, was recoded. Using *SPSS, 11.0* the 16 categories for *relationship to the child* were recoded into 4 categories: *parents* included biological mothers, biological fathers, step-mothers and step-fathers; *other relatives* included aunts, uncles, brothers, sisters, and other relatives; *non-relatives* included foster parents and adoptive parents; and *grandparents* included grandmothers and grandfathers. Table 5 indicates the original coding of the variables.

Table 5

Original Categories for Caregiver Relationship to Child

Caregiver	Frequency	Percentage
Biological Mother	63	8.7
Step Mother	1	.1
Adoptive Mother	25	3.4
Foster Mother	368	50.6

Table 5 (continued)

Caregiver	Frequency	Percentage
Sister	0	.0
Aunt	60	8.3
Grandmother	85	11.7
Biological Father	9	1.2
Step Father	2	.3
Adoptive Father	3	.4
Foster Father	11	1.5
Brother	1	.1
Uncle	5	.7
Grandfather	7	1.0
Other Relative	16	2.2
Other Non-Relative	71	9.8
Total	727	100.0

Table 6 shows the recoded caregiver variable and its distribution. Grandparent caregivers made up 12.7% of the sample. Parents (biological and step-parents) made up 10.3% of the sample. While other relatives and non-relatives made up 11.3% and 65.7% of the sample respectively.

Table 6

Caregiver Variable Recoded

Caregiver	Frequency	Percentage
Parent	75	10.3
Other Relative	82	11.3
Non-Relative	478	65.7
Grandparents	92	12.7
Total	727	100.0

Phase 1- Descriptive Analyses

In Phase 1, SPSS, 11.0 was used to conduct a descriptive analysis of continuous and categorical variables in the study. DESCRIPTIVES was used to compute means, totals, percentages, and standard errors for continuous variables. CROSSTABS were used for categorical variables to identify percentages of the population across the independent variable *caregiver relationship to child*. This analysis was useful in identifying the characteristics of the sample.

A weight variable was used in the analysis. The weight variable is needed to obtain unbiased estimates of population parameters since the sample members were chosen with unequal probabilities (Administration on Children, Youth and Families, 2004). Each child selected for the study has a sample weight associated with their data. The weight variable is the inverse of that child's selection probability (Research Triangle Institute, 1997). It represents the

number of individuals in the target population that the sampled child represents (Administration on Children, Youth and Families, 2004).

As a result, the weighted standard deviations, sum of squares and any statistic connected with estimated population variance will be based on the estimated population size instead of the actual sample size. In other words, weighted standard deviations and sums of squares displayed in output tables will be based on population estimates instead of sample size.

Variables used during this phase were:

- Caregiver gender
- Caregiver marital status
- Caregiver race
- Caregiver age
- Caregiver's highest grade completed
- Caregiver employment status
- Household income
- # of children in HH
- Child gender
- Child age
- Child depression
- Child health
- Child behavior

Phase 2- Comparative Analyses

Phase 2 of the analysis plan involved testing the means for several dependent variables across *caregiver type/relationship to child* to identify differences between grandparent caregivers

and other caregivers (parents, other relatives, and non-relatives). The NSCAW documentation suggested that SUDAAN, a statistical package designed to correctly account for complex survey designs using stratification techniques and weighted data, be used with NSCAW data. SUDAAN adjusts for the intracluster correlation using Generalized Estimating Equations (*GEE*). In complex survey analysis assuming independence, variance tends to be underestimated, thus inflating Type I errors (Williams, 2000). In SUDAAN, robust variance estimators ensure consistent variance estimates and valid inferences even when the correlation structure was stratified, and therefore, wasn't a simple random sample design (Bieler & Williams, 1995). This study computed statistics using Taylor series linearization, a form of GEE that estimates the variance of beta (β), the variance of the estimates of the regression coefficients (RTI, 2004). Taylor linearization is a popular method of variance estimation for complex statistics such as ratio and regression estimators and logistic regression coefficient estimators. It is generally applicable to any sampling design that permits unbiased variance estimation for linear estimators, and it is computationally simpler than a re-sampling method such as the jackknife procedure (Demnati & Rao, 2001). With this method there were no assumptions about the structure of the covariance matrix and no strict assumptions about distribution of the response variables (RTI, 2004). SUDAAN allowed the user to weight each observation to ensure errors in design, (i.e., unequal probability selection, clustering, stratification, and nonresponse) and did not underestimate variance and thus bias results used in interpretation (Brogan, 2004).

Phase 2 included running the SUDAAN, 9.01 *Regress* program to perform overall tests and conduct multiple comparisons for the hypotheses and research questions. The independent variable for this study was the categorical variable *caregiver type/relationship to child*. Dependent variables for each one-way ANOVA were caregiver mental health, caregiver physical

health, social support, home environment, and quality of relationship to the child. Typically, designs with categorical variables were analyzed using analysis of variance (ANOVA).

ANOVA, “a method to test differences among more than two means” (Pedhazur, 1997, p. 347), was a special case of Multiple Regression Analysis (MRA), for which the independent variables may be categorical (Pedhazur, 1997). For this study, multiple linear regression (MLR) in SUDAAN was run to test each hypothesis by examining differences between caregiver groups.

SUDAAN was developed under that assumption that multiple regression analysis (MRA) is comparable to analysis of variance (ANOVA) when comparing the means between groups. Therefore, MRA was the only available option to compare group differences in SUDAAN.

This approach is preferred by some researchers and strongly opposed by others. Pedhazur said, “when the independent variable is categorical, multiple regression analysis (MRA) and the analysis of variance (ANOVA) are equivalent” (1991, p. 405). Pedhazur goes on to argue that MRA is a superior option to ANOVA because “it is a more comprehensive and general approach on the conceptual as well as the analytic level. On the conceptual level, all variables, be they categorical or continuous, are viewed from the same frame of reference: information available when attempting to explain or predict a dependent variable. On the analytic level, too, different types of variables (i.e., categorical and continuous) can be dealt with in MRA. On the other hand, ANOVA is limited to categorical independent variables (except for manipulated continuous variables, p. 406). Whether MRA was preferred in the context of this study, it was the analysis option available in SUDAAN and remained a legitimate choice endorsed by respected statisticians.

SUDAAN provided the option to use the Wald F-Test in place of a t-test or other F-test. The Wald F-Test test was applicable to data collected through complex sample surveys and was

analogous to F-tests in standard regression analysis (Research Triangle Institute, 1997). The Wald F-statistic is based on Wald chi-square (Research Triangle Institute). It tests the null hypothesis that none of the variables added to the model are significant (Research Triangle Institute). “This test statistic has an approximate F distribution with d and e degrees of freedom under the null hypothesis. If C is the matrix of coefficients for the null hypothesis, then d is the rank of C and e equals the degrees of freedom used to estimate the variance of the betas” (Research Triangle Institute, SUDAAN program index).

The MULTILOG program in SUDAAN, which extends logistic modeling to categorical variables with two or more categories, was used to conduct preliminary analyses for the variable *parenting behavior* because it was operationalized by multiple scales. The MULTILOG program “estimates model parameters using generalized estimating equations (GEE)” (Research Triangle Institute, 1997, p.628) and was used to determine which scales additional analyses would be completed. Additional analyses were conducted in SUDAAN as explained above.

Phase 3- Prediction Analyses

Phase 3 of the study used SUDAAN, v.9.0.1 Multiple Linear Regression program to determine predictors of satisfaction with social support for all foster caregivers in the sample. SUDAAN was used for this multiple regression analysis for the same reasons explained in Phase 2. Linear Regression estimates the coefficients of the linear equation, involving one or more independent variables that best predict the value of the dependent variable. The criterion (dependent) variable was the social support satisfaction score, as measured by the even questions on the combined SSQ3 and the Duke-UNC FFSSQ.

Power Analysis

Missing data in the NSCAW dataset prevented multivariate analysis procedures across many of the variables chosen. In fact, although the sample of 727 is large, power analysis was necessary to ensure that the available sample was of acceptable size. Cohen (1988) developed a table for determining appropriate sample size based on the number of predictor variables, degrees of freedom error (dfe), R^2 , and a value of effect size that he called f^2 (Cohen, 1988).

Cohen's (1988) effect size index was calculated by dividing the effect size, f^2 , by the standard deviation of the measure. Cohen's table (1988) indicated that for 4 predictor variables and $dfe = 27$, the $\Lambda = 15$. The f^2 was calculated by dividing R^2 by $1 - R^2$ resulting in an $f^2 = 2.33$. The Λ value, 15, was divided by f^2 , 2.33, resulting in a sample size requirement of 6.0. Therefore, the n of 29 ensures that power was at least .80, indicating that 80 times out of 100, when there is an effect, it will be identified (Keppel, 1991).

The predictor variables, chosen were:

- Caregiver mental health
- Mean Number of Social Supports
- Total family income
- Quality of Caregiver-Child Relationship

These variables were chosen based on the literature review and also keeping in mind the need to limit the number of categories since the degrees of freedom are limited based on the sample size of 29.

Chapter Summary

This chapter described the methods for implementing the study. The National Study on Child and Adolescent Well-Being, General Release, Long Term Foster Care sample, Wave 1

provided the data set used in the secondary analyses completed. Issues related to the two-stage, stratified study had an impact on the measures available, the statistical software used for analysis and the statistical procedures implemented.

CHAPTER 4

RESULTS

Major Findings

This chapter presents the results of the analysis for each of the three phases of the study. First, the results of the descriptive analysis is presented, which provides evidence related to the first hypothesis. Second, the comparative analysis is presented, which details the findings for the second through seventh hypotheses/research questions. Finally, the predictive analysis of social support satisfaction is presented, responding to the eight research question.

Phase 1- Descriptive Analysis

As evident in Table 7, of the 727 subjects in the study, 92 (12.7%) were grandparents. Grandparent caregivers in this study tended to be older (see Table 7). The highest percentage (45%) were 55 years old or older; while 40% were 46 to 55 year old, and 14% were 36 to 45 years old. The table shows that 85% of grandparents were 46 years old or older. Only 17% of non-relatives and 11% of other relatives were more than 55 years old. None of the parents were older than 55.

Table 7 also shows that 52.0% of parents were 26-35 years old. A majority of other relatives were age 26-45, with 48.8% between 36-45 years of age. Non-relatives consisted of 37.4% between the ages of 36 and 45. This table indicates clearly that grandparents tended to be older than the other caregivers in the study.

In Table 8 the results presented show that of all grandparent caregivers, 85 (92%) were female and 7 (8%) were male. Of these grandparents, 44.6% were married, 53.3% were single

Table 7

Descriptive Summary Statistics on Caregiver Characteristics

Caregiver	Parents		Other Relatives		Non-Relatives		Grand-parents	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
	75	10.3	82	11.3	478	65.7	92	12.7
<u>Age</u>								
< 25	9	12.0	2	2.4	12	2.5	0	0.0
26-35	39	52.0	23	28.0	88	18.4	0	0.0
36-45	22	29.3	40	48.8	179	37.4	13	14.1
46-55	4	5.3	7	8.5	115	24.1	37	40.2
>55	0	0.0	9	11.0	80	16.7	41	44.6
Unknown	1	1.3	1	1.2	4	.8	1	1.1

(widowed, divorced, separated, never married). Two percent didn't know their marital status or were not interviewed. The highest percentage of grandparents in the study were black (46.7%), followed by white (35.9%), and other (17.4%). As the previous literature suggests, this sample is similar in that grandparent caregivers tend to be women, older, single, and black.

Only 9.7% of grandparent caregivers continued college or technical school, while 26.1% completed twelfth grade or their GED. Of all grandparent caregivers in the study, 20.7% completed their education sometime during ninth through eleventh grade; while 15.2% completed their educations in eighth grade or less. Grandparents in this study tended to be split regarding their employment status with 47.8 not working and 35.9% working 35 or more hours a week. Others worked less than 35 hours a week (6.5%) or worked when work was available

(2.2%). Total family income varied with 28% making \$40,000 a year or more, 20.7% earning \$10,000 to \$19,999, 17.4% earning \$20,000 to \$29,999, 13% earning \$30,000 to \$39,999, and 9.8% earning less than \$10,000.

Table 8

Descriptive Summary Statistics on Grandparent Characteristics

	Frequency	Percentage
<u>Gender</u>		
Female	85	92.0
Male	7	8.0
<u>Marital Status</u>		
Married	41	44.6
Single	49	53.3
Don't Know	2	2.1
<u>Race</u>		
Black	43	46.7
White	33	35.9
Other	16	17.4
<u>Education</u>		
Continued college/technical school	9	9.7
Completed twelfth grade or GED	24	26.1
Completed ninth – eleventh grade	19	20.7
Completed eighth grade or less	14	15.2

Table 8 (continued)

	Frequency	Percentage
<u>Education</u>		
Missing/Unknown	26	28.3
<u>Employment Status</u>		
Work 35 hours or more per week	33	35.9
Work less than 35 hours per week	6	6.5
Work when work available	2	2.2
Not working	44	47.8
Missing/Unknown	7	7.6
<u>Total Annual Family Income</u>		
\$40,000 or more	26	28.0
\$30,000 to \$39,999	12	13.0
\$20,000 to \$29,999	16	17.4
\$10,000 to \$19,999	19	20.7
Less than \$10,000	9	9.8
Unknown or missing	10	10.8

The mean child age was 6.61 and the mean child age for grandparent caregivers was 7.18. There were no significant differences between caregivers in the age of the child ($F_{(3, 723)} = 1.386$, $p = .24$). Table 9 shows that of all grandparent caregivers in this study, 28.3% of their grandchildren had chronic health problems a similar percentage to those of parents (24%), other

relatives (28%), and non-relatives (31%). Grandparent caregivers had the lowest percentage of children with depression at 2.2%. However, there was little difference for other relatives, for which 2.4% of the caregivers care for children with clinically significant depression, while 2.5% of non-relatives and 6.7% of parents cared for children with depression. Grandparent caregivers cared for children with the lowest percentage of behavior problems considered borderline or in the clinical range at 25%. Of the children that other relatives cared for, 26.8% had behavior issues rated at the borderline or clinical range, while 34.6% of children in parent care and 36% of children in non-relative care had behavior problems considered borderline or in the clinical range.

Table 9

Child Characteristics by Type of Caregiver

Caregiver	Parents		Other Relatives		Non-Relatives		Grandparents	
	n	%	n	%	n	%	n	%
<u>Child Chronic Health Problems</u>								
Yes	18	24.0	23	28.0	148	31.0	26	28.3
No	55	73.3	57	69.5	324	67.8	65	70.7
Missing/Unknown	2	2.6	1	2.4	6	1.2	1	1.1
<u>Child Depression</u>								
Yes	5	23.8	2	2.4	12	2.5	2	2.2
No	33	44.0	33	40.2	199	41.6	42	45.7
Missing/NA	37	49.3	47	57.3	267	55.9	48	52.2
<u>Child Behavior Problems</u>								
Yes	22	29.3	17	20.7	154	32.2	15	16.3

Table 9 (continued)

Caregiver	Parents		Other Relatives		Non-Relatives		Grandparents	
	n	%	n	%	n	%	n	%
<u>Child Behavior Problems</u>								
Borderline	4	5.3	5	6.1	18	3.8	8	8.7
No	28	37.3	30	36.6	115	24.1	49	53.3
Missing/NA	21	28.1	30	36.6	191	39.9	20	21.8
<u>Number of Children in Household</u>								
1 Child	18	24.0	24	29.3	142	29.7	30	32.6
2 Children	18	24.0	12	14.6	69	14.4	24	26.1
3 Children	11	14.7	18	22.0	66	13.8	13	14.1
4 Children	19	25.3	12	14.6	57	11.9	13	14.1
5 or more Children	9	12.0	16	19.5	144	30.1	12	13.0

Grandparents in this study were more likely to have one child in the household (32.6%), than two children (26.1%), three children (14.1%), four children (14.1%) and five or more children (13.0%). Interestingly, non-relatives in this study were more likely to have five or more children in the household (30%), which equaled the percentage of non-relative households with one child in the home (30%).

Phase 2- Comparative Analysis

The comparative phase of this study consisted of hypotheses and research questions designed to examine whether the four groups of caregivers (e.g., parents, other relatives, non-relatives and grandparents) differed significantly on the dependent variables (e.g., mental health, physical health, social support, parenting and home environment). Means and standard deviations for all measures were computed for each caregiver group. These descriptive statistics

were examined to determine whether significance tests would be fruitful. The initial inspections of these results showed that mean differences did exist between at least some groups for each variable. Subsequently, statistical tests were used to determine if there were differences between the means of groups in a sample, implying that there were differences between groups in the population (Keppel, 1991).

SUDAAN's simple linear regression was the statistical procedure for this phase. In response to the recommendations of the NSCAW statistical team, weights were used with the general release version of the data. A limitation of using the general release version was that the weighted variable alone does not correct for the bias caused by the multi-stratified design (Christ, 2004). Effect size was measured by computing the r^2 , a measure of the strength of relationship between the independent and dependent variable (Cohen, 1973). The r^2 was interpreted to indicate the percentage of variance in the dependent variable that is accounted for by the independent variable (Keppel, 1991). Cohen (1977) suggests that effect size is interpreted using guidelines that a *small* effect size is .01, a *medium* effect size is .06 and a *large* effect size is .15 or greater. Post hoc comparisons of group means were computed when statistical significance was found in the overall test.

Pearson's correlation coefficients were computed with the study variables to determine bivariate correlations. Variables with linear associations at the .05 level (2 tailed test) were mean number of social supports and social support satisfaction, and mental health and parent behavior. Variables with linear associations at the .01 level (2 tailed test) were the mean number of social supports and the HOME for 3-6 year olds; social support satisfaction and mental health; and physical health and the HOME for children over the age of 6. Bivariate correlations for the study variables are displayed in Table 10.

Table 10

Bivariate Correlations for Study Variables

Variable	Emotion Support	Mean # Soc Sup	Soc Sup Sat	Phys Health	Mntl Health	Parent Behav	Home <3	Home 3-6	Home >6
Em Support	1	-.314	.274	.038	.098	-.154	.	.	.
Mean # SS	-.314	1	.176*	.054	.047	.009	.090	.511**	.114
SS Satisf.	.274	.176*	1	.152	.298**	-.020	.117	.207	.138
Phys Hlth	.038	.054	.152	1	.023	.035	.074	.097	.293**
Mental Hlth	.098	.047	.298**	.023	1	-.199*	.032	.017	-.078
Parent Behav	-.154	.009	-.020	.035	-.199*	1	.058	-.209	-.142
Home <3	-	.090	.117	.074	.032	.058	1	-	-
Home 3-6	-	.511**	.207	.097	.017	-.209	-	1	-
Home >6	-	.114	.138	.293**	-.078	-.142	-	-	1

*Correlation is significant at the .05 level (2 tailed).

** Correlation is significant at the .01 level (2 tailed).

- Cannot be computed because at least one of the variables is constant.

Tests for normal distributions were conducted by plotting the data for each dependent variable in SPSS. Visual inspection of the normal distribution curve supported the assumption of normality. The random sample assumption, although violated by the stratified design, was supported by using the weighted variable to correct for the selection bias. The overall design of the study ensured that all scores were independent of each other by ensuring that a child's family was only chosen once. The minimum scores, maximum scores, sample sizes, means and standard deviations are reported for all of the analyses in Table 11.

Caregiver Mental Health

Simple Linear Regression (SLR) with a weighted variable was computed to test for statistical differences between the types of caregivers and the caregiver's mental health. The independent variable, the type of caregiver, included four categories: parents, other relatives, non-relatives and grandparents. The dependent variable was the caregiver's mental health, a continuous

Table 11

Minimums, Maximums, Sample Sizes, Means and Standard Deviations for the Study Variables

Variable	Caregiver	Min	Max	n	Mean	SD	Est. N*	Mean**
Mental Health	Parents	23	66	73	49.04	11.14	7016	48.97
	Other Relatives	18	66	81	54.37	7.37	5612	55.31
	Non-Relatives	25	69	469	55.02	6.26	25616	55.18
	Grandparents	20	63	89	52.36	8.88	8007	52.08
	Total	18	69	712	54.00	7.60	46,251	53.72
Physical Health	Parents	21	66	73	47.85	11.68	7016	51.23
	Other Relatives	20	66	81	50.06	9.58	5612	50.66
	Non-Relatives	14	64	469	50.06	9.19	25,616	50.86
	Grandparents	16	63	89	45.82	11.81	8007	46.26
	Total	14	66	712	49.30	9.96	46,251	50.08
Social Support Satisf. Score	Parents	2	4	73	3.51	.56	6998	3.46
	Other Relatives	3	4	8	3.62	.52	793	3.50
	Non-Relatives	3	4	38	3.58	.50	1850	3.59
	Grandparents	1	4	19	3.42	.77	2168	3.49
	Total	1	4	138	3.52	.57	11809	3.49
Mean # of People Providing Soc. Sup.	Parents	0	6	73	2.44	1.46	6998	2.31
	Other Relatives	0	3	8	2.38	1.06	793	2.79
	Non-Relatives	1	10	38	4.61	2.45	1850	4.68
	Grandparents	0	7	19	2.79	1.99	2168	3.16
	Total	0	10	138	3.08	2.05	11809	2.87

Table 11 (continued)

Variable	Caregiver	Min	Max	n	Mean	SD	Est. N*	Mean**
Non-Violent Discipline	Parents	0	100	73	36.07	28.34	6998	29.56
	Other	5	63	8	31.13	23.12	793	34.78
	Relatives							
	Non-Relatives	0	100	39	44.05	31.10	1863	42.33
	Grandparents	0	90	19	30.26	23.73	2168	28.11
	Total	0	100	139	37.23	28.44	11822	31.66
Psych Aggress	Parents	0	79	73	14.38	18.81	6998	11.83
	Other	1	75	8	13.13	25.26	793	24.44
	Relatives							
	Non-Relatives	0	73	39	9.74	15.91	1863	14.24
	Grandparents	0	40	19	14.58	15.20	2168	12.55
	Total	0	79	139	13.04	17.92	11822	13.19
Minor Physical Assault	Parents	0	75	73	6.63	14.05	6998	4.07
	Other	0	19	8	2.63	6.65	793	5.69
	Relatives							
	Non-Relatives	0	27	39	2.54	5.43	1863	3.59
	Grandparents	0	16	19	1.79	3.74	2168	4.44
	Total	0	75	139	4.59	10.95	11822	3.74
Severe Physical Assault	Parents	0	8	73	.30	1.43	6998	.22
	Other	0	16	8	2.00	5.66	793	4.76
	Relatives							
	Non-Relatives	0	0	39	.00	.00	1863	.00
	Grandparents	0	2	19	.11	.46	2168	.01
	Total	0	16	139	.29	1.708	11822	.45

Table 11 (continued)

Variable	Caregiver	Min	Max	n	Mean	SD	Est. N*	Mean**
Very Severe Physical Assault	Parents	0	4	73	.05	.47	6998	.02
	Other Relatives	0	0	8	.00	.00	793	.00
	Non-Relatives	0	0	39	.00	.00	1863	.00
	Grandparents	0	0	19	.00	.00	2168	.00
	Total	0	4	139	.03	.34	11822	.01
Total Physical Assault	Parents	0	75	73	6.99	14.57	6998	4.32
	Other Relatives	0	35	8	4.62	12.29	793	10.45
	Non-Relatives	0	27		2.54	5.43	1863	4.44
	Grandparents	0	16		1.89	3.74	2168	1.38
	Total	0	75	139	4.91	11.56	11822	4.21
Child Neglect	Parents	0	46	73	3.82	8.82	6998	4.12
	Other Relatives	0	48	8	6.50	16.83	793	14.34
	Non-Relatives	0	23	39	.72	3.69	1863	1.66
	Grandparents	0	15	19	.89	3.43	2168	.34
	Total	0	48	139	2.71	7.96	11822	3.72
Home Environment <3 years old	Parents	13	17	13	15.08	1.44	689	14.66
	Other Relatives	8	17	23	13.70	2.34	1694	13.12
	Non-Relatives	5	18	157	15.18	2.25	7848	15.45
	Grandparents	10	17	16	14.44	2.00	1190	14.30
	Total	5	18	209	14.95	2.24	11421	14.93
Home Environment 3 to <6 year old	Parents	15	25	18	19.78	3.10	689	19.76
	Other Relatives	16	23	14	20.29	2.20	1694	19.26
	Non-Relatives	13	26	79	21.20	3.27	7848	20.95

Table 11 (continued)

Variable	Caregiver	Min	Max	n	Mean	SD	Est. N*	Mean**
Home Environment 3 to <6 year old	Grandparents	9	25	19	19.79	3.66	1190	20.59
	Total	9	26	130	20.70	3.25	11421	20.47
Home Environment 6 to <10 years old	Parents	12	23	19	17.89	3.11	689	18.54
	Other Relatives	11	24	21	18.52	3.52	1694	19.97
	Non-Relatives	8	25	98	18.76	3.53	7848	18.23
	Grandparents	11	25	29	17.86	3.75	1190	17.48
	Total	8	25	167	18.47	3.51	11421	18.30
Quality of Caregiver-Child Relationship	Parents	1	4	20	3.45	.76	2133	3.49
	Other Relatives	2	4	19	3.47	.70	1021	3.64
	Non-Relatives	1	4	122	3.19	.82	7563	3.15
	Grandparents	2	4	24	3.50	.66	2030	3.48
	Total	1	4	185	3.29	.79	12747	3.30

* Weighted by National Analysis Weight **Weighted standard deviations are not available though SUDAAN since there is no one estimate of standard deviation in a complex sample because homogeneity of variance is not assumed. For example, there would be a different standard deviation for observations in each cluster (Christ, 2005).

variable measured by the Short-Form Health Survey (SF-12) (Ware, Kosinski & Keller, 1998).

With a sample size of 712, the differences among groups were statistically significant, $F(3, 708)$

$= 5.85$, $p < .001$. The strength of the relationship between the type of

caregiver and mental health score, as assessed by r^2 was .085, interpreted as 8.5% of the variance associated with the type of caregiver accounting for the variance in mental health scores.

Since there was a statistically significant difference among the four groups, further analysis was needed to determine which groups differed on this variable. Post hoc pairwise comparison tests were computed to evaluate differences among the group means using the Wald F-test. This analysis showed statistically significant differences between parents (mean = 48.97) and other relatives (mean = 55.31); parents (mean = 48.97) and non-relatives (mean = 55.18); and grandparents (mean = 52.08) and non-relatives (mean = 55.18). Table 12 provides the F-Test values for the overall test, the post hoc tests and a supplemental comparison.

After these differences were examined a supplemental analysis grouped parents with grandparents and compared them with non-relatives and other relatives. This supplemental analysis is consistent with the theoretical framework presented on Role Theory and the discussion related to the importance of the intergenerational triad (grandparent, parent, and child). This analysis led to the greatest statistically significant difference $F(3, 708) = 15.28$, $p < .001$.

Table 12

Overall and Post Hoc F-Tests for Mental Health

	Wald F-Test
Overall	5.85**
Parents vs. Other Relatives	12.13**
Parents vs. Non-Relatives	14.17**
Non-Relatives vs. Grandparents	3.81*
Supplemental: Grandparents & Parents vs. Other Relatives & Non-Relatives	15.28**

* $p < .05$, ** $p < .001$

Physical Health

Weighted SLR was computed to test for group differences between the type of caregiver and their scores on caregiver's physical health. The independent variable, the type of caregiver, included four categories: parents, other relatives, non-relatives and grandparents. The dependent variable was the caregiver's physical health, as measured by the Short-Form Health Survey (SF-12) (Ware et al., 1998). With an $n = 712$, the differences were not statistically significant, $F(3, 708) = 2.399, p < .0667$.

Since health issues are typically related to age, a supplemental analysis was run on all caregivers to examine whether that age was a contributing factor to lower physical health scores, since type of caregiver was not. A weighted SLR was computed in SUDAAN, 9.01 using a weighted variable that was statistically significant among caregiver age groups, $F(3, 708) = 6.85, p < .001$. Although this is not a surprising finding, post hoc pairwise comparison tests were computed to evaluate differences among the physical health group means using the Wald F-test. The results are shown in Table 13.

Statistically significant differences ($p < .05$) were found between 26-35 (mean = 53.04) and 36-45 year olds (mean = 50.87), 26-35 (mean = 53.04) and 46-55 (mean = 49.96), and between 46-55 (mean = 49.96) and >55 year olds (mean = 44.85). Statistically significant differences were found at or below the .001 level between <25 (mean = 52.33) and >55 year olds (mean = 44.85), 26-35 (mean = 53.04) and >55 year olds (mean = 44.85), and between 36-45 (mean = 50.87) and those older than 55 (mean = 44.85).

Social Support

To test for differences between type of caregiver by social support a weighted SLR was computed using the caregiver's social support satisfaction score as measured by the Social

Table 13

Overall and Post Hoc F-Tests for Physical Health and Age

	Wald F-Test
Overall	6.85**
<25 vs 26-35	.15
<25 vs. 36-45	.63
<25 vs 46-55	1.51
<25 vs >55	11.53**
26-35 vs 36-45	3.95*
26-35 vs 46-55	6.30*
26-35 vs >55	25.31**
36-45 vs 46-55	.50
36-45 vs >55	13.01**
46-55 vs >55	8.45*

*p < .05, ** p < .001

Support Questionnaire (SSQ3) (Sarason, Levine, Basham & Sarason, 1983; Sarason & Pierce, 1987) and Duke-UNC Functional Social Support Questionnaire (FSSQ) (Broadhead, Gehback, deGruy & Kaplan, 1998) as the dependent variable. The sample size, as seen in Table 10, was 138. It is evident in Table 10 that the greatest mean differences, between non-relatives (mean = 3.59 and parents (mean = 3.46) is 0.13. This difference between means does not indicate great differences between the groups. The differences between groups for satisfaction with social support score were not statistically significant, $F(3, 134) = .260, p < .854$.

A weighted SLR was also computed for the mean number of people providing social support for the caregivers, measured by the Social Support Questionnaire (SSQ3) (Sarason, Levine, Basham & Sarason, 1983; Sarason & Pierce, 1987) and Duke-UNC Functional Social Support Questionnaire (FSSQ) (Broadhead, Gehback, deGruy & Kaplan, 1998). In this analysis the mean difference between non-relatives (mean = 4.68) and parents (mean = 2.31) were 3.27, which translated to an average across the seven items of more than 3 people providing social support. With a sample size of 138, the group differences for mean number of people providing social support was statistically significant, $F(3, 134) = 4.04, p < .007$. According to Cohen (1973) the strength of the relationship between the type of caregiver and number of social supports was strong with $r^2 = .190$.

Since there were statistically significant differences among the groups, post hoc tests were computed among the four groups of caregivers. There were statistically significant differences between non-relatives (mean = 4.68) and parents (mean = 2.31), non-relatives (mean = 4.68) and other relatives (mean = 2.79). Table 14 contains the F-tests for the overall test and statistically significant comparisons.

Table 14

F-Tests for Mean Number of Social Supports

Caregiver	Wald F-Test
Overall	4.04*
Parents vs. Other Relatives	3.05
Parents vs. Non-Relatives	10.79**
Grandparents vs. Parents	1.71

Table 14 (continued)

Caregiver	Wald F-Test
Other Relatives vs. Grandparents	.35
Other Relatives vs. Non-Relatives	7.28*
Grandparents vs. Non-Relatives	2.76

* $p < .05$, ** $p < .001$

Parenting Behaviors

To test for the differences between groups of caregivers by parenting behaviors the MULTILOG program in SUDAAN 9.01 was used with six Parent-Child Conflict Tactics Scales (PCCTS): non-violent discipline, psychological aggression, minor physical assault, severe physical assault, very severe physical assault and child neglect (Straus, Hamby, Finkelhor, Moor & Runyon, 1998). MULTILOG was run with each scale as the predictor variable set and the four levels of caregivers as the outcome variable. This analysis, with a sample size of 139 and an estimated population of 11,822, yielded a statistically significant Wald F test for the overall model, $F_{(18, 726)} = 48.97$ $p < .001$. Table 15 lists the weighted means, F tests, and the p-values for each scale.

MULTILOG findings were used to determine which scales would be used for further analysis. The severe physical assault scale was statistically significant, $F_{(18, 726)} = 65.40$ $p < .001$. The very severe physical assault scale was also found to be statistically significant, $F_{(18, 726)} = 4.49$ $p < .05$. Since these two scales resulted in statistically significant differences among the caregivers, post hoc analyses were computed for severe physical assault and very severe physical assault. The weighted SLR was computed in SUDAAN for both scales. Severe physical assault

analyses resulted in no statistically significant differences between caregiver groups, $F(3,135)=1.497$, $p < .2142$. Very severe physical assault analysis also resulted in no statistically significant differences between caregiver groups, $F(3,135)=.98$, $p < .3219$.

Table 15

*MULTILOG Table for Parenting Behaviors**

Source	Mean	Wald F-test	p
Overall		48.97	.000
Non-Violent	31.66	1.43	.234
Psych Aggression	13.19	1.64	.178
Minor Physical Assault	3.74	1.94	.122
Severe Physical Assault	.45	65.40	.000
Very Severe Physical Assault	.01	4.49	.004
Child Neglect	3.72	1.32	.268

* Weighted by National Analysis Weight

Home Environment

Three weighted SLRs were computed for each of the measures of Home Environment that were developed for three age groups to identify differences across groups on the home environment variable. The first analysis was computed for children younger than three years old using The Home Observation for Measurement of the Environment (HOME) for children younger than three years old (Caldwell & Bradley, 1984). With a sample size of 209, the overall group differences were not statistically significant, $F(3, 205) = 2.151$, $p < .0926$. This finding is

not surprising given that the greatest mean difference across groups was 1.81 with grandparents mean score being 14.93 and other relatives mean scores totaling 13.12.

Group differences were computed for the HOME for children between three and six years old (Caldwell & Bradley, 1984). The overall differences were not statistically significant, $F(3, 126) = 1.345$, $p < .2587$ with the greatest mean difference equaling 1.69 when non-relatives (mean = 20.95) was subtracted from the mean for other relatives (mean = 19.26)

The overall group differences on The Home Observation for Measurement of the Environment (HOME) for children between six and ten years old (Caldwell & Bradley, 1984) were not statistically significant, $F(3, 163) = 1.706$, $p = .1643$. The greatest mean difference for this analysis was 2.49 calculated by subtracting the mean for grandparents (mean = 17.48) from other relatives (mean = 19.97).

Quality of Caregiver-Child Relationship

A weighted SLR was computed to evaluate the differences between the four types of caregivers and the quality of the caregiver-child relationship. With a sample of 185, the overall test differences were statistically significant, $F(3, 181) = 2.581$, $p < .0525$. The strength of the relationship between the type of caregiver and quality of caregiver-child relationship as assessed by r^2 was .056.

Since statistically significant differences were found across the groups, comparisons were made among the caregiver types. As table 16 shows, statistically significant differences were found between other relatives (mean = 3.64) and non-relatives (mean = 3.15) using the Wald F-test.

Table 16

Wald F-Test for Quality of Caregiver-Child Relationship

Caregiver	Wald F-Test
Overall	2.58
Other Relatives vs. Grandparents	
Other Relatives vs. Non-Relatives	6.71
Parents vs. Other Relatives	.470
Parents vs. Non-Relatives	3.083
Parents vs. Grandparents	.002
Non-Relatives vs. Grandparents	3.016

* p < .05

Phase 3- Predictive Analysis

Phase 3 addresses the last research question seeking to find the variables that best predict social support satisfaction. The analysis includes using weighted standard multiple linear regression (MLR) analysis with Taylor linearization, equivalent to Generalized Estimating Equations (GEE), computed in SUDAAN. The purpose was to explain variation in the social support satisfaction score given the composite of independent variables. The *best* model consisted of four variables: number of people providing social support, family income (a categorical variable), quality of caregiver-child relationship, and caregiver mental health.

The beta coefficients are included in Table 17 for all independent variables. These beta coefficients are regression coefficients expressed in standardized form, to make them more directly comparable. The standard beta coefficients show the ordered importance of the independent variables in explaining variation in the dependent variable and their entry into the

regression equation. These beta weights show the difference in the social support satisfaction score associated with an increase in one standard deviation of each independent variable when controlling for the effects of the other independent variables. In viewing the variables in the table the variable with the strongest weight is the mean number of people providing social support and the variable with the smallest weight is mental health.

Table 17

Standardized Regression Coefficients (Beta Weights) for Social Support Satisfaction

Variable	T: $\beta=0$	ρ
# of People Providing Social Support	4.260	.0000
Total Family Annual Income	3.458	.0000
Quality of Caregiver-Child Relationship	3.129	.0018
Caregiver Mental Health	2.173	.0300

Standard multiple regression analysis was run with a weighted variable to determine the extent to which the predictor variables accounted for variation in the dependent variable, social support satisfaction. A Wald F test was conducted to determine the statistical significance of the regression model. With a sample of 29, the F test had 9 and 20 degrees of freedom. The $F(9, 20) = 35.31$. The p value $< .001$. The R^2 was .700, indicating that the four variable model explains 70% of the variance in social support satisfaction. The R was .837. In Table 18 the predictor variables and their R , R^2 , and ΔR^2 (change) are listed in the order they entered the regression equation. Wald F-test and p -values are included as they were computed for the full regression model. In this analysis, the mean number of social supports was the most important

variable explaining social support satisfaction, followed by income, quality of the caregiver-child relationship and mental health.

Table 18

Results of Regressing Social Support Satisfaction on Four Independent Variables

Step	Variable	R	R ²	ΔR^2	F	ρ
1	# of People Providing Social Support	.599	.359		18.15	.0000
2	Total Family Annual Income	.703	.495	.136	11.96	.0000
3	Quality of Caregiver-Child Relationship	.791	.626	.131	9.79	.0018
4	Caregiver Mental Health	.837	.700	.074	4.73	.0300

Chapter Summary

Chapter 4 described the results of the data analyses completed in the study. Described in this chapter, were the following analyses and results: descriptive statistics for the sample and independent and dependent variables, comparative analyses, and regression analyses. These statistical procedures were used to address the three research hypotheses, and the research questions framing the study. Chapter 5 follows and includes major findings and conclusions from the study as well as discussion of the implications of the results for theory, future research, and practice.

CHAPTER 5

DISCUSSION

This chapter begins with an overview of the study. The significance, purpose, and intended contributions to the field, are restated. Major findings and conclusions derived as a result of the data analyses follow and these are discussed as they relate to theory, future research, and practice. A brief discussion of limitations to the study is also included. The chapter concludes with a summary of the study.

Overview of the Study

A review of the gerontological and kinship foster care literature showed that there were many similarities between the characteristics of grandparent caregivers in the general U.S. population and all kinship foster care providers in the child welfare system. In both the general population and in kinship foster care, caregivers were primarily women (Bryson & Casper, 1999; Dubowitz et al, 1994; Fuller-Thomson et al., 1997 Gebel 1996; LeProhn, 1994). As with caregiving grandparents, relative foster caregivers tended to be single, older, and have lower incomes than non-kin foster parents (Barth et al., 1994; Berrick et al., 1994; Chipungu et al.,1998; Dubowitz, 1994; Ehrle and Geen, 2002; Harden et al., 1997; LeProhn, 1994; Scannapieco et al., 1996).

Caregiver mental and physical health were found to be important variables in the grandparent caregiver literature. Compared with other caregivers, grandparents experienced more stressful life events, experienced less life-satisfaction, more parenting stress, decreased grandparent satisfaction and more burdens related to caregiving (Bowers & Myers, 1999; Burton,

1992; Fuller-Thompson & Minkler, 2000; Fuller-Thomson et al, 1997; Kelley, 1993; Kelley et al., 2001; Musil & Ahmad, 2002; Strawbridge et al., 1997). Several studies supported that grandparent caregivers report decreased health status compared to other grandparents, had more difficulties with activities of daily living (i.e., bathing, climbing stairs, etc.) and lower satisfaction with their health (Minkler & Fuller-Thomson, 1999, 2000; Minker & Roe, 1993; Minkler et al., 1992; Musil & Ahmad, 2002; Strawbridge, et. al, 1997; Whitley et al., 2001)

The literature also showed that social support, caregiver parenting behaviors, home environment, and the quality of the caregiver-child relationship were important variables related to this study. Grandparent caregivers were found to delay or fail to gain needed support for themselves and their grandchildren (Burnette, 1999; Minkler & Roe, 1993; Shore & Hayslip, 1994). Kinship caregivers were found to have more favorable attitudes toward physical discipline than non-kinship caregivers (Gebel; 1996). Non-kinship foster homes were found to be in significantly better order, more spacious, less threatening, and in better repair than kinship foster care homes (Berrick, 1997). The quality of caregiver-child relationship surfaced in the literature review as a variable that mediated stress in high conflict families (Vanderwater & Landsford, 1998).

Study Variables

As the literature supported, the characteristics of caregivers including age, marital status, income, *caregiver mental health, caregiver health, social support, parenting behaviors, home environment, and positive caregiver-child relationships* were important variables in understanding grandparent caregiver households. The italicized characteristics were the independent variables for this study. The type of caregiver (grandparent, parent, other relative

caregiver, or non-relative caregiver) was also included as an independent variable in some analyses. The primary dependent variable was a measure of social support satisfaction.

Conceptual Framework of the Study

The conceptual model, Figure 1 (p. 14), of the study illustrated the context in which grandparent caregivers and their grandchildren reside. The ecological perspective accounted for systems that impacted grandparents and children, such as the school system, religious organizations, the child welfare system, and the family itself. Feminist theory focused on the political and societal factors that impacted women as caregivers. Finally, role theory explained the challenges of grandparent caregivers changing roles and experiencing ambiguity, role conflict and other potentially detrimental stresses related to role changes. The conceptual model included the major variables that were used in the study and suggested that findings would support child welfare practice.

Study Measures

Table 4 listed the variables and measures used to gather data for this study. Caregiver mental health and physical health were measured by the Short-Form Health Survey (SF-12), (Ware et al., 1996). Social support was measured using the Social Support Questionnaire (Sarason et al., 1983; Sarason & Pierce, 1987). The Social Support Questionnaire measures identified satisfaction with social support and the number of individuals providing social support to the caregiver. Parenting behavior was measured using the Parent-Child Conflict Tactics Scale (Straus et al., 1998). Home environment was measured with the Home Observation for Measurement of the Environment- Short Form (Caldwell & Bradley, 1984). The final variable, quality of the caregiver-child relationship was measured with the Rochester Assessment Package

for Schools (RAPS) (Connell, 1990; Lynch & Cicchetti, 1991; Carolina Population Center, UNC-CH, 2002).

Sample and Data Analysis

The National Survey on Child and Adolescent Well-Being (NSCAW) team collected data from caregivers, teachers, and case workers for 6,200 children using a weighted, two-stage stratified sampling design. This study focused on the Long Term Foster Care (LTFC) sample consisting of 727 children and their caregivers (Administration on Children, Youth and Families, [ACYF], 2003). The target population for the LTFC sample was all children in the United States (excluding four states that had laws requiring study participants to receive their first contact from CPS instead of NSCAW study representatives) who had been in out-of-home care for approximately one year, and whose placement in out-of-home care was preceded by an investigation of child abuse or neglect or by a period of in-home services (Administration on Children, Youth and Families, 2003).

The data analysis plan was based on the recommendation by ACYF to use SUDAAN to analyze the data. SUDAAN is a statistical software package that takes into account the lack of simple random selection in this design that leads to selection bias. The software provides weights and methods that account for selection bias and violations of statistical assumptions. It was also developed under the assumption that multiple regression analysis (MRA) is a suitable option to analysis of variance (ANOVA) when comparing the means between groups. Therefore, standard regression analysis was used to compare differences between the means of caregivers.

It is important to note that the SUDAAN analysis for complex samples does lead to different findings when compared to weighted and unweighted analysis in SPSS. For example,

the predictive regression model was cross checked in SPSS using weighted and unweighted standard and stepwise regression. The SUDAAN results, when compared to the results of SPSS analyses showed different ordering of the variables based on t and F tests and with an R of .774 in SPSS, compared with SUDAAN analysis R of .837. One of the contributors to the difference may include the specification of the income variable as categorical in SUDAAN.

Major Findings and Conclusions

In Chapter 4 of this study, statistical findings were reported for characteristics of the sample (s), differences between groups of caregivers, and factors that explained social support satisfaction. The major findings and conclusions derived from the results of the study considered most important for subsequent discussion are presented below.

Major Finding Number One

Although the number of social supports available was the most important variable explaining social support satisfaction, family annual income, quality of the caregiver-child relationship, and caregiver mental health were also important variables that explain caregivers' social support satisfaction.

Conclusions:

1. Distal variables external to the foster care interpersonal context (i.e., number of social supports, family income) are more important sources of caregivers' satisfaction with social support than proximal variables internal to the foster care context (i.e., quality of the caregiver-child relationship, caregiver mental health).
2. Family income is more strongly related to satisfaction with social support than previously recognized.

Major Finding Number Two

After children have been in foster care for a year, grandparent and parent caregivers experience lower mental health scores than non-relatives and other relatives.

Conclusion:

1. Grandparents involved in the complex, intergenerational triad of grandchild, parent, and grandparent, are more emotionally, and negatively impacted by children in foster care than non-relatives or other relatives.

Major Finding Number Three

Although there were no differences among caregiver groups in satisfaction with social supports, non-relatives reported significantly more social supports than kinship care providers.

Conclusions

1. Kinship care providers are probably not as aware of, or actively involved in seeking social supports as non-relative foster care providers because of the lack of requirements for kinship caregivers to attend foster parent training and/or because caseworkers tend to spend less time with kinship caregivers than with non-kinship caregivers.

2. Satisfaction with social supports for kinship care providers is determined by a different constellation of factors than those for non-relative care providers.

Discussion and Implications

The findings of this study support recognition of grandparent caregivers as individuals invested in the lives of their families. As the conceptual framework for the study shows, there are many factors that potentially impact grandparent caregivers (see Figure 1). Despite society's lack of value for the caregiver role; the power and gender-based inequities in the U.S. political system; the difficulties that grandparents experience adjusting to role changes when they assume

the full-time caregiver role; the increased difficulties in parenting related to age, deterioration of physical health, single marital status, lower mental health status, and fewer social supports, this study suggests that grandparent caregivers are providing their grandchildren with quality interpersonal relationships that exceed those provided by non-relative foster caregivers. In addition, the results of this study showed that grandparent foster caregiver homes provide environments comparable to other foster caregivers. There were no statistical differences among caregiver types in the home environment measures. Although these findings say much for what grandparent caregivers are willing to do to support their families, the findings also have practical implications for theory, research, and practice.

Implications for Theory

As described in Chapter 2, three theories/perspectives were used to create the context of this study: role theory, feminist theory, and ecological perspective. Role theory explains the difficulty that particularly kinship caregivers have in changing roles within the family. It is explained by concepts such as role ambiguity, role overload, and role conflict and focuses on the internal struggle of self-concept while meeting the needs of the family in an ambiguous role. Feminist theory contributes to understanding the political and power structure of our society and the devalued role of caregivers. It suggests that since caregivers are primarily women in our society, the role of caregiver isn't as valued as roles primarily filled by men. The ecological perspective takes into account the impact that systems within the family and outside the family have on family functioning. It focuses on an individual's relationship within the social contexts and recognizes that all of systems operate together to influence what individuals become as they develop.

The findings of this study have several important implications for theory. Although this study does not test theoretical constructs directly, theoretical constructs, such as role conflict, role overload, and role ambiguity provide a framework for understanding the findings of this study. Family roles play an important part in understanding mental health, caregiver-child relationships, the number of social supports available, and social support satisfaction. Family ties seem to present a powerful force and sense of connection for both child and caregiver. Role theory is also useful in explaining findings related to social support satisfaction by explaining why caregiver mental health and quality of the caregiver-child relationship (microsystem factors) have an impact on social support satisfaction. Role theory would predict that role ambiguity, role conflict and role overload have an impact on caregiver mental health and the quality of the caregiver-child relationship and therefore, if these factors are needs within the family, the caregiver would either be less likely to seek social support (possibly due to embarrassment or lack of knowledge of supports available) and, at the same time, feel a greater need for social support. Grandparent caregivers in particular may be ostracized from their peers when they begin caring for their grandchildren. Peers are often not interested in the caregiving role, and frequently, grandparents isolate themselves from peers due to embarrassments related to their own child's failure to parent.

Role theory would predict that grandparent caregivers had significantly poorer mental health compared to other relatives and non-relative caregivers. This difference is presumed to be related to the role grandparents have as the parent to the middle generation. The stress of dealing with the failure of the middle generation to parent, to see the child removed from their home, and to make the transition to the role of primary caregiver are all believed to have an impact on mental health for grandparents. Role theory suggests that the transition between the role of

grandparent to caregiver is a difficult one. Findings from the study show that grandparent caregivers are accomplishing the relational aspects of the transition well; while struggling with the mental health and stress related aspects of the transition.

Role theory could be further developed by expanded conceptualization of caregiving as a dyadic concept involving a relational process and an internal process; in other words, care for others and self-care. Grandparent caregivers, for example, take on the role of caregiver of their grandchildren because they want the best for them and because they are invested in their families. On the other hand, taking on the role of grandparent caregiver is an internal process that requires adjustment of how grandparents see themselves and how they are able to take care of their own emotional, physical and service needs.

As explained in the conceptual model (p. 14), feminist theory influences the understanding of why caregivers may not have the social supports they need. On a societal level, responsibility for caregiving lies at the feet of families who are already stressed and under-resourced. Society doesn't seem to value the role of caregiving enough to ensure there are sufficient social supports, i.e. services and income, for caregivers. Feminist theory recognizes that society does not value the caregiving role because it is largely assigned to women. Feminist theory could also develop further to advance the dyadic operationalization of caregiving. Although feminist theory contributes to the conceptual understanding of caregivers not having resources they might need, the theory does not provide direct explanation of the results of this study.

The ecological perspective provides a rich explanation of the major findings of this study. Social support satisfaction was found to be explained by the number of people available to a caregiver, annual family income, the quality of the caregiver-child relationship and caregiver

mental health. The ecological perspective explains why factors outside the microsystem, number of social supports and family income, are important. The family achieves balance by having people and income from outside the family to stabilize it. Figure 3 distinguishes between the microsystem factors and the mesosystem factors that explain social support satisfaction.

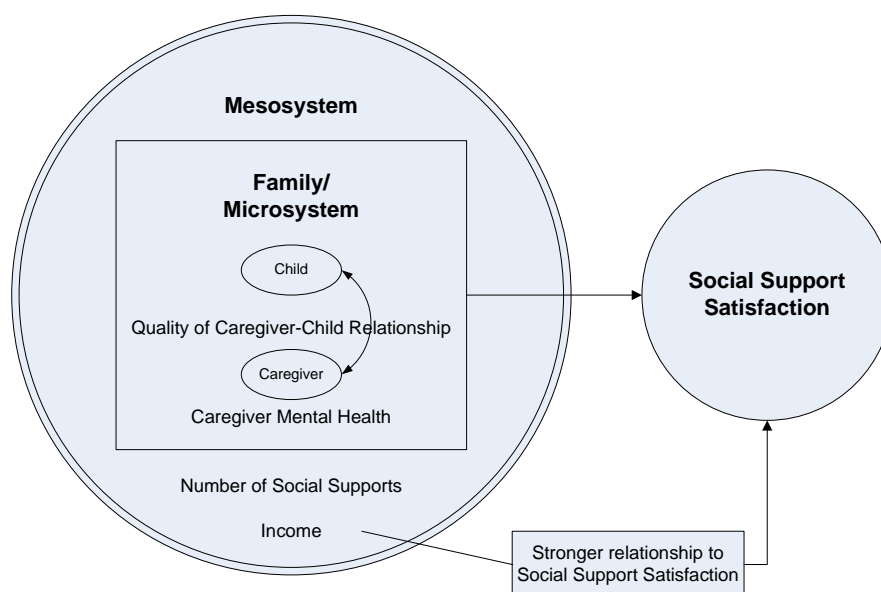


Figure 3. Ecological Perspective Explanation of Social Support Satisfaction Findings

The ecological perspective recognizes the interdependence of individuals on the family, and the family on larger societal systems. This study supports that child well-being (caregiver-child relationship) is related to the well-being of the caretaker (income, mental health, social supports). As this concept is further discussed in the Implications for Practice section, it is important to remember that the ecological perspective supports viewing the individual and microsystem factors as interdependent.

The findings of this study support the ecological perspective as a means of explaining the interconnectedness of social, family and individual factors. The study supports the use of theoretical frameworks that attempt to explain the complexity of family functioning in a multi-dimensional manner. For example, in this study variables that have an impact on caregivers were identified from the literature. These variables include microsystem level variables, such as caregiver mental health, caregiver physical health and the quality of the relationship between caregiver and child. Variables in the study also represented mesosystem level variables, such as annual family income, and the number of social supports available to the family.

In summary, two of the three theories/perspectives provide insight into the findings of this study. Although feminist theory informs the conceptual framework of the study, the study did not test societal explanations for why caregivers don't have the social supports they need. Role theory explains why individual and relationship factors have an impact on social support satisfaction and why mental health is an issue for grandparent caregivers who care for their grandchild. Role theory has the greatest promise for providing greater understanding of grandparent caregiver stress and the concept of caregiving as a dyadic process. The ecological perspective, however, best explains the results of this study by allowing the differentiation of mesosystemic and microsystemic factors as predictors of social support satisfaction among caregivers. Bronfenbrenner's (1979) discussion of distal and proximal variables will also support understanding of the social support satisfaction regression model and its application to social work practice.

Implications for Future Research

Continued research on the service needs of grandparent caregivers will be critical to future research. Which services have the greatest impact on social support satisfaction? Social

support is important because several studies found that grandparent caregivers' tend to delay or fail to gain needed support for themselves and their grandchildren (Burnette, 1999; Minkler & Roe, 1993; Shore & Hayslip, 1994). Since quality foster care is defined as including child safety, educational support, mental health and behavioral support, developmental support, the furtherance of attachment, caregiver characteristics, and foster children's quality of life, it is clear that gaining social supports for the child and caregiver play an important role in quality of care for the child (Shlonsky and Berrick, 2001).

The intergenerational triad is important in helping to develop clearer understandings of the bond between grandparents and grandchildren. As this study indicated, it is a double-edged sword that grandparents are able to provide comparable home environments and nurturing relationships with the child, while experiencing decreased mental health status and decreased physical health, due to age. This concept can be understood better by applying a dyadic definition to caregiving that recognizes the care for others component and the self-care component. Self-care may be largely ignored by grandparents, resulting in mental health issues. Additional research that examines the role that age plays in mental health status of grandparent caregivers could advance the knowledge in the field and support practice.

When conducting future secondary analysis with large data sets, this study informs the precariousness of incomplete data and the importance of developing strategies for dealing with this early on in development of the research plan. Sample sizes should be identified very early in the development of the research plan to ensure that samples are large enough for findings to be useful. This study also informs the need to use SUDAAN or other statistical package developed for complex surveys with unbalanced sampling designs. Analysis computed in both SUDAAN and SPSS confirmed that differences were found in statistical tests and p-values.

What the study does not address is also important in furthering our understanding of grandparent caregivers. First, how can grandparent caregivers be better supported; second, are the social support needs of grandparent caregivers the same over time; and third, how can these findings improve child welfare practice?

Future research could build on the findings of this study by replicating this study with the National Survey on Child and Adolescent Well-Being (NSCAW) Child Protective Services (CPS) sample, which is a much larger sample of over 5000 children. This study would further our understanding of how caregivers' needs are different before and after a child is in out-of-home placement for a year. In addition, further research could include analysis of the social support satisfaction model and of ways that service delivery impacts the four components that explain social support satisfaction can support practice by caseworkers. It is hoped that this sample would be large enough to test the regression model predicting social support satisfaction with each of the caregiver groups.

Other studies can build on the findings of this study by comparing grandparents in states that provide relative income subsidies beyond TANF with grandparents in states that do not received this income support to raise their children. In addition, using the NSCAW data to develop a longitudinal study of foster care outcomes for children raised by grandparent families compared to parent/other relative/adoption/foster families would expand on the findings of this study. A longitudinal study of grandparents' abilities to raise children to adulthood might answer questions about emotional stress of grandparents and its impact on permanency of placement. A study that focuses on grandparent caregiver age and its relationship to their abilities to manage children's behavior might also show considerably more stress on older grandparents than on younger grandparents. It might also be useful in future research to

complete within group regression analyses (e.g., grandparents, other relatives, non-relatives) to assess the extent to which the independent variables in this study explain variation in satisfaction with social support. The order of importance of these variables might look somewhat different than the order identified in this study when all caregiver groups were combined.

Implications for Practice

As a result of this study the greatest priority for change in practice is around the topic of preparing grandparent caregivers for the role of caregiver. The system prepares non-relative caregivers through foster parenting classes, while many states do not require this training for relative caregivers. As this study shows, grandparent caregivers are different from other caregivers across several variables, including mental health. Given the theoretical framework, developing a system that prepares grandparents for the change in role (Landry-Myers, 2004) may ease the stress that negatively impacts mental health. It also provides an opportunity for social support development for grandparents with similar role sets.

Clearly the number of people providing social support is not the only factor that explains social support satisfaction. Caregiver income, mental health, and quality caregiver-child relationship are also important factors, combining to explain almost 70 percent of the variance in social support satisfaction. These findings support the need for caseworkers to consider income, mental health, and quality of relationship in their practice when designing support services for foster caregivers.

The study results can be further understood by applying Bronfenbrenner's discussion of distal and proximal variables and how multiple factors influence development (Bronfenbrenner, 1979, 1989). The influence of these levels of variables can be either proximal, related to experiences or resources in individuals that are difficult to change, or distal, related to

experiences or resources that reach beyond the individual and are more alterable. Depending on how immediate the influence is, it may be more or less easily perceived and understood. In the social support satisfaction regression model, the variables with the stronger relationship to social support satisfaction are distal variables. Providing additional social supports and increased income are variables beyond the individual that can be altered through policy and practice that creates additional social support services and income and makes them available to caregivers. The other two variables in the model are proximal variables. Quality relationships between caregivers and children and caregiver mental health are more difficult to change and are not influenced by policy driven decisions. This means that social work practice can best focus on the distal variables of increasing the number of social supports and increasing supplemental income for caregiver families. Child welfare professional training that incorporates this information would increase the sensitivity of professionals in understanding the increased emotional impact of having the child in foster care and would increase the effectiveness of professionals in identifying the need for and provision of services that address the importance of networking and supplemental income.

Ultimately, the important role of grandparent caregiver must be understood so that grandparent caregivers in the child welfare system are facilitated in role transition and assessed for mental health needs. This study indicated that not only are there age-related issues that impact physical health, grandparents experience stress, comparable only to the parents' stress, a year after their grandchild has been removed from the home. Formal assessment for networking, income support, and mental health needs could include using the short social support measure used in this study to identify lack of satisfaction with social support. If lack of satisfaction is

identified, further assessment and connection to services that increase social supports, provide income support, and mental health services can be provided.

Practice that institutes and supports social support for and between foster caregivers is important. The support might include increased interaction between caseworkers and relative foster caregivers, in addition to peer support and connection to community resources. Methods for determining the impact of other factors, such as mental health, income, and the quality of the caregiver-child relationship on the caregiver's acceptance of social support will help professionals design social support plans that meet the needs of all foster caregivers.

Caseworkers tend to provide less supervision to children of kinship caregivers (Geen, 2000; Berrick et al., 1994; Brooks & Barth, 1998; Dubowitz, 1999). This may be due to the fact that kinship caregivers provide more emotionally secure relationships to the child, as supported by the findings pertinent to research question seven. However, as the social support satisfaction regression model suggests, the caregiver-child relationship could be compromised if the caregiver isn't satisfied with the social support available to them. Specifically, the types of social supports that are most needed by caregivers tend to be networking (# of social supports available), income support and mental health services. Further study on the impact of services received would broaden this study and potentially create a link between caregiver services, social support satisfaction and child well-being. As explained before, Shlonsky and Berrick (2001) define child well-being/quality in kinship care as being made up of the following domains: child safety, educational support, mental health and behavioral support, developmental support, the furtherance of attachment, caregiver characteristics, and foster children's quality of life. These outcomes are clearly linked to acquisition of social supports and resources. This is especially important for grandparent caregivers who tend to delay or fail to gain needed support for

themselves and their grandchildren (Burnette, 1999; Minkler & Roe, 1993; Shore & Hayslip, 1994).

Figure 4 provides a potentially useful system for caseworkers to identify caregivers who need increased support services. This model suggests that the emotionally secure relationship is related to caregiver social support satisfaction. Social support satisfaction is related to networking supports available, income support and mental health support services. Optimal placements for children are those in which social support satisfaction is strong. If social support satisfaction is weak, caseworkers could assess needs in the areas of networking support, income support and mental health service needs. When those services are provided it is hypothesized that the relationship between the caregiver and child is enhanced and child-wellbeing is enhanced as well.

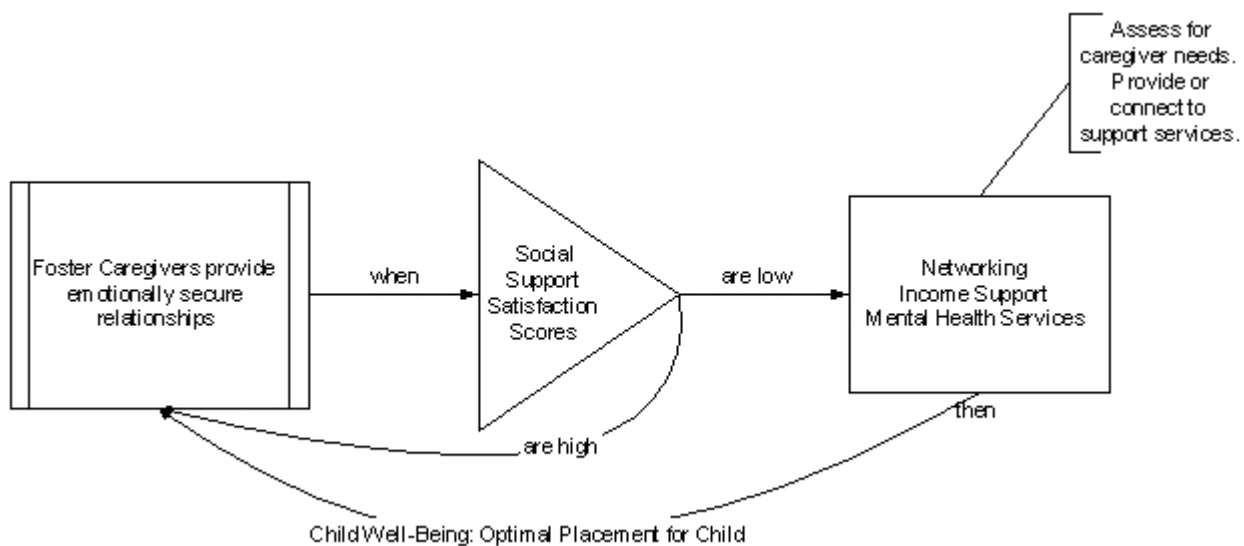


Figure 4. Caregiver Needs and Service Model Related to Child Well-Being

Further research and testing of this practice model are needed. For example, an experimental and control group of caregivers may take pre- and post-tests of the emotionally secure relationship measure used in this study. The treatment phase would involve one group of child welfare professionals being trained to assess and focus on meeting caregivers' needs using the seven-item social support satisfaction survey used in this study, while the control group does not receive the training. Comparing the means of the post-test and identifying the services actually received by caregivers would help to determine if spending a short amount of time identifying caregiver service needs, then making referrals for networking, income, and mental health services is the best way to ensure the child is in an optimal placement. Particularly in the case of grandparent caregivers, this model could potentially answer the broad questions presented in Chapter 1:

- Do we know if foster placements with grandparents are optimal?
- Do we know enough about the impact of the placement of the grandparent and the grandchild to support the practice of grandparent placement in child welfare despite its convenience?

Although this study doesn't answer these questions, it builds on the knowledge we do have about kinship caregivers and gives a direction for further analysis. What we do know, supported by this study and the literature, is that children feel more secure and nurtured when living with family members than when living with non-relatives. The pairwise comparison on the quality of caregiver-child relationship in this study indicates that children feel more nurtured with relatives than with non-relatives. This is a strength of the system of placing foster children with kin. However, it is only part of the story. The predictive model in this study suggests that the quality of the caregiver-child relationship works with the number of people providing social

support, annual household income, and caregiver mental health are related to social support satisfaction. Therefore, it is possible that kinship placements are not optimal unless the service needs of caregivers are met. Further research would expand on this question to determine if service delivery has an impact on the quality of caregiver-child relationship, which services have an impact on social support satisfaction and whether social support satisfaction (a three question measure) is a useful tool in practice for determining caregiver service needs that serve to enhance child well-being.

In conclusion, this study has the most potential impact on practice. It appears that practice that incorporates social support satisfaction for foster caregivers could have a positive impact on caregiver-child relationships and therefore, child well-being and stability. Caseworkers can be aware of the relationship of different factors, such as the number of people providing social support, income, and mental health to caregiver's satisfaction with social support. Although caseworkers are saturated with increasing needs and fewer resources to support foster caregivers, it is believed that these practices will increase the level of satisfaction workers feel when working with relative caregivers, while providing opportunities for increased contact through group activities and social support building among caregivers.

Limitations of the Study

The limitations of the general release version of the NSCAW created issues for the analysis plan. Although NSCAW documentation suggests that complex procedures for correcting selection bias be implemented when analyzing NSCAW data, the general release version of the dataset does not provide strata and primary sampling unit (PSU) information to use in the analysis. Therefore, the geographic representation of the small samples available from the larger sample could not be verified as representative of the original sampling plan. Thus, the

NSCAW sample used in this study should be considered a convenience sample that places some limitations on the generalizability of the results.

The limitations of the general release version of the dataset also had an impact on the statistical package used for analysis. However, it became apparent that the general release version of the dataset does not include data for the *strata* and *PSU* necessary for this analysis. Therefore, the standard errors were not corrected for clustering. According to the NSCAW statisticians, most of the added variance in the NSCAW data is due to weighting and not clustering (Christ, 2004). Therefore, standard errors should be very close to correct by including the weights found in the *nanalwt* variable in the NSCAW dataset.

Missing data was an issue related to this dataset. Several variables were limited regarding the numbers of cases available. In addition, when variables were combined in multivariate models the sample sizes were decreased further due to missing data across variables. For this reason, simple regression was used in the comparative phase and all caregivers were included in the multiple regression analysis. In previous plans this analysis was to include only grandparent caregivers and their grandchildren. However, only five cases could be identified with complete data.

Another limitation of the study was the measures used for physical and mental health. Gerontological research shows that measures are more reliable when they are developed and tested for the use of senior adults. The self-report items for physical and mental health could be less effective with senior adults than with other adults.

Chapter Summary

Chapter 5 presented a discussion of the study's major findings and conclusions. The discussion included implications for theory, research, and future practice.

Dissertation Summary

This document describes a study of 727 foster caregivers in the child welfare system caring for children who have been in out of home placement for one year. The study was designed to examine the characteristics of grandparent caregivers, differences between caregivers and predictors of social support satisfaction among caregivers.

Previous literature from gerontology and kinship foster care defined the primary variables in the study: caregiver mental health, caregiver physical health, social support, parenting behaviors, home environment and caregiver-child relationship. A variety of statistical procedures were used to derive information regarding characteristics of caregivers, comparisons between types of caregivers, and predictors of caregiver satisfaction with social supports.

Major findings of the study showed that: (a) the number of social supports available to caregivers is the most important variable that explains satisfaction with social supports, followed by total family income, quality of the caregiver-child relationship, and mental health; (b) after a child has been in foster care for a year, grandparent and parent caregivers experience lower mental health scores than non-relatives and other relatives; and (c) although there were no differences in social support satisfaction between types of caregivers, non-relatives reported significantly more social supports than kinship care providers. A set of conclusions was derived from the major findings of this study and implications of the findings for theory, future research, and practice were discussed.

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APPENDIX A
STUDY MEASURES

PHYSICAL HEALTH

>P_PHOFC<

[# IF INTNUM = 2, GOTO P_PHEND]

>P_PH1<

The next questions are about your health and the activities you might do. This information will be used to keep track of how you feel and how well you are able to do your usual activities. If you are unsure about how to answer a question, please give the best answer you can.

In general, would you say your health is...

- 1 = excellent
- 2 = very good
- 3 = good
- 4 = fair, or
- 5 = poor?

@a

>P_PH2<

How much does your health now limit you in [r]**moderate activities**[n], such as moving a table, pushing a vacuum cleaner, bowling, or playing golf. Would you say you are...

- 1 = limited a lot
- 2 = limited a little, or
- 3 = not limited at all?

@a

>P_PH3<

How much does your health now limit you in climbing [r]**several**[n] flights of stairs? Would you say you are...

- 1 = limited a lot
- 2 = limited a little, or
- 3 = not limited at all?

@a

NOTE: "SEVERAL" MEANS TWO OR MORE.

>P_PH4<

During the past [r]4 weeks[n], have you accomplished less than you would like in your work or other regular daily activities as a result of your [r]physical[n] health?

1 = YES
2 = NO
@a

>P_PH5<

During the past [r]4 weeks[n], were you limited in the [r]kind[n] of work or other activities you could do as a result of your physical health?

1 = YES
2 = NO
@a

>P_PH6<

During the past [r]4 weeks[n], have you accomplished less than you would like in your work or other regular daily activities as a result of any [r]emotional[n] problems such as feeling depressed or anxious?

1 = YES
2 = NO
@a

>P_PH7<

During the past [r]4 weeks[n], did you feel you didn't do work or other activities as carefully as usual as a result of any emotional problems such as feeling depressed or anxious?

1 = YES
2 = NO
@a

>P_PH8<

During the past [r]4 weeks [n], how much did [r]pain [n] interfere with your normal work, including both work outside the home and housework? Would you say...

- 1 = not at all
- 2 = a little bit
- 3 = moderately
- 4 = quite a bit, or
- 5 = extremely?

@a

>P_PH9<

USE CARD 29. The next questions are about how you feel and how things have been with you during the past [r]4 weeks [n]. For each question, please look at Card 29 and tell me which answer comes closest to the way you have been feeling.

During the past [r]4 weeks [n], how much of the time have you felt calm and peaceful? Would you say...

- 1 = all of the time
- 2 = most of the time
- 3 = a good bit of the time
- 4 = some of the time
- 5 = a little of the time, or
- 6 = none of the time?

@a

>P_PH10<

USE CARD 29. During the past [r]4 weeks [n], how much of the time did you have a lot of energy? Would you say...

- 1 = all of the time
- 2 = most of the time
- 3 = a good bit of the time
- 4 = some of the time
- 5 = a little of the time, or
- 6 = none of the time?

@a

>P_PH11<

USE CARD 29. During the past [r]4 **weeks**[n], how much of the time have you felt downhearted and blue? Would you say...

- 1 = all of the time
- 2 = most of the time
- 3 = a good bit of the time
- 4 = some of the time
- 5 = a little of the time, or
- 6 = none of the time?

@a

>P_PH12<

USE CARD 29. During the past [r]4 **weeks**[n], how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)? Would you say...

- 1 = all of the time
- 2 = most of the time
- 3 = a good bit of the time
- 4 = some of the time
- 5 = a little of the time, or
- 6 = none of the time?

@a

>P_PHEND<

SOCIAL SUPPORT

>P_SS0FC<

[# IF INTNUM = 2, OR IF RESPONDENT = FOSTER PARENT (OR OTHER TYPE OF
NON-PERM CG), GOTO P_SSEND]

>P_SS0<

Next, I'm going to read you a list of some things that people do for
each other or give each other that may be helpful or supportive. For
each question, please tell me how many different people give you this
type of help.

PRESS [ENTER] TO CONTINUE.

>P_SS1<

How many different people can you count on to invite you to go out and
do things?

NUMBER: @a

>P_SS2FC<

[# IF P_SS1 = RE, GOTO P_SS3]

>P_SS2<

[# IF P_SS1 = 0, FILL: USE CARD 28. Please look at Card 28. How
satisfied are you with that amount of help and support? Would you say
you are...]

[# ELSE, FILL: USE CARD 28. Please look at Card 28. How satisfied are
you with this help and support? Would you say you are...]

1 = very dissatisfied,
2 = dissatisfied,
3 = satisfied, or
4 = very satisfied?

@a

>P_SS3<

How many different people help you with taking care of your child(ren)?

NUMBER: @a

>P_SS4FC<

[# IF P_SS3 = RE, GOTO P_SS5]

>P_SS4<

[# IF P_SS3 = 0, FILL: USE CARD 28. How satisfied are you with that amount of help and support? Would you say you are...]

[# ELSE, FILL: USE CARD 28. How satisfied are you with this help and support? Would you say you are..]

1 = very dissatisfied,
2 = dissatisfied,
3 = satisfied, or
4 = very satisfied?

@a

>P_SS5<

How many different people you count on give you chances to talk about money matters like budgeting or money problems?

NUMBER: @a

>P_SS6FC<

[# IF P_SS5 = RE, GOTO P_SS7]

>P_SS6<

[# IF P_SS5 = 0, FILL: USE CARD 28. How satisfied are you with that amount of help and support? (Would you say you are...READ CATEGORIES AS NEEDED.)]

[# ELSE, FILL: USE CARD 28. How satisfied are you with this help and support? (Would you say you are...READ CATEGORIES AS NEEDED.)]

1 = very dissatisfied,
2 = dissatisfied,
3 = satisfied, or
4 = very satisfied?

@a

>P_SS7<

How many different people give you useful advice about important things in life?

NUMBER: @a

>P_SS8FC<

[# IF P_SS7 = RE, GOTO P_SS9]

>P_SS8<

[# IF P_SS7 = 0, FILL: USE CARD 28. How satisfied are you with that amount of help and support? (Would you say you are...READ CATEGORIES AS NEEDED.)]

[# ELSE, FILL: USE CARD 28. How satisfied are you with this help and support? (Would you say you are...READ CATEGORIES AS NEEDED.)]

1 = very dissatisfied,

2 = dissatisfied,

3 = satisfied, or

4 = very satisfied?

@a

>P_SS9<

How many different people give you help when you need transportation?

NUMBER: @a

>P_SS10FC<

[# IF P_SS9 = RE, GOTO P_SS11]

>P_SS10<

[# IF P_SS9 = 0, FILL: USE CARD 28. How satisfied are you with that amount of help and support? (Would you say you are...READ CATEGORIES AS NEEDED.)]

[# ELSE, FILL: USE CARD 28. How satisfied are you with this help and support? (Would you say you are...READ CATEGORIES AS NEEDED.)]

1 = very dissatisfied,

2 = dissatisfied,

3 = satisfied, or

4 = very satisfied?

@a

>P_SS11<

How many different people give you help when you're sick in bed?

NUMBER: @a

>P_SS12FC<

[# IF P_SS11 = RE, GOTO P_SS13]

>P_SS12<

[# IF P_SS11 = 0, FILL: USE CARD 28. How satisfied are you with that amount of help and support? (Would you say you are...READ CATEGORIES AS NEEDED.)]

[# ELSE, FILL: USE CARD 28. How satisfied are you with this help and support? (Would you say you are...READ CATEGORIES AS NEEDED.)]

1 = very dissatisfied,

2 = dissatisfied,

3 = satisfied, or

4 = very satisfied?

@a

>P_SS13<

How many different people give you help with cooking and housework?

NUMBER: @a

>P_SS14FC<

[# IF P_SS13 = RE, GOTO P_SSEND]

>P_SS14<

[# IF P_SS13 = 0, FILL: USE CARD 28. How satisfied are you with that amount of help and support? (Would you say you are...READ CATEGORIES AS NEEDED.)]

[# ELSE, FILL: USE CARD 28. How satisfied are you with this help and support? (Would you say you are...READ CATEGORIES AS NEEDED.)]

1 = very dissatisfied,

2 = dissatisfied,

3 = satisfied, or

4 = very satisfied?

@a

>P_SSEND<

DISCIPLINE & CHILD MALTREATMENT (ACASI)

>P_DS0FC<

[# IF INTNUM = 2, OR IF RESPONDENT = FOSTER PARENT (OR OTHER TYPE OF
NON-PERM CG), GOTO P_DSEND]

>P_DS0<

Children sometimes do things that are wrong, disobey, or make their
parents angry. For the next set of questions, we would like to know
what you have done when your child [r][fill CHILD][n] did something
wrong or made you upset or angry.

For each question pick an answer that says how many times this has
happened in the past [r]12 months[n]. If it hasn't happened in the past
[r]12 months[n], but it did happen before that, pick the answer "not in
the past [r]12 months[n], but it happened before. If it has never
happened, pick the answer "this has never happened".

Press the [Enter] key to continue

>P_DS1<

In the past [r]12 months[n], how many times have you explained to your
child [r][fill CHILD][n] why something was wrong?

- 1 = 1 time
 - 2 = 2 times
 - 3 = 3-5 times
 - 4 = 6-10 times
 - 5 = 11-20 times
 - 6 = More than 20 times
 - 7 = Not in the past [r]12 months[n], but it happened before
 - 8 = This has never happened
- @a

>P_DS2<

In the past [r]12 months[n], how many times have you put your child [r][fill CHILD][n] in "time out" or sent your child [r][fill CHILD][n] to [fill based on CHILD'S GENDER: his/her] room?

- 1 = 1 time
 - 2 = 2 times
 - 3 = 3-5 times
 - 4 = 6-10 times
 - 5 = 11-20 times
 - 6 = More than 20 times
 - 7 = Not in the past [r]12 months[n], but it happened before
 - 8 = This has never happened
- @a

>P_DS3<

In the past [r]12 months[n], how many times have you shaken your child [r][fill CHILD][n]?

- 1 = 1 time
 - 2 = 2 times
 - 3 = 3-5 times
 - 4 = 6-10 times
 - 5 = 11-20 times
 - 6 = More than 20 times
 - 7 = Not in the past [r]12 months[n], but it happened before
 - 8 = This has never happened
- @a

>P_DS4<

In the past [r]12 months[n], how many times have you hit your child [r][fill CHILD][n] on the bottom with something like a belt, hairbrush, a stick or some other hard object?

- 1 = 1 time
 - 2 = 2 times
 - 3 = 3-5 times
 - 4 = 6-10 times
 - 5 = 11-20 times
 - 6 = More than 20 times
 - 7 = Not in the past [r]12 months[n], but it happened before
 - 8 = This has never happened
- @a

>P_DS5<

In the past [r]12 months[n], how many times have you given your child [r][fill CHILD][n] something else to do instead of what [fill based on CHILD'S GENDER: he/she] was doing wrong?

- 1 = 1 time
- 2 = 2 times
- 3 = 3-5 times
- 4 = 6-10 times
- 5 = 11-20 times
- 6 = More than 20 times
- 7 = Not in the past [r]12 months[n], but it happened before
- 8 = This has never happened

@a

>P_DS6<

In the past [r]12 months[n], how many times have you shouted, yelled, or screamed at your child [r][fill CHILD][n]?

- 1 = 1 time
- 2 = 2 times
- 3 = 3-5 times
- 4 = 6-10 times
- 5 = 11-20 times
- 6 = More than 20 times
- 7 = Not in the past [r]12 months[n], but it happened before
- 8 = This has never happened

@a

>P_DS7<

In the past [r]12 months[n], how many times have you hit your child [r][fill CHILD][n] with a fist or kicked [fill based on CHILD'S GENDER: him/her] hard?

- 1 = 1 time
- 2 = 2 times
- 3 = 3-5 times
- 4 = 6-10 times
- 5 = 11-20 times
- 6 = More than 20 times
- 7 = Not in the past [r]12 months[n], but it happened before
- 8 = This has never happened

@a

>P_DS8<

In the past [r]12 months[n], how many times have you spanked your child [r][fill CHILD][n] on the bottom with your bare hand?

- 1 = 1 time
 - 2 = 2 times
 - 3 = 3-5 times
 - 4 = 6-10 times
 - 5 = 11-20 times
 - 6 = More than 20 times
 - 7 = Not in the past [r]12 months[n], but it happened before
 - 8 = This has never happened
- @a

>P_DS9<

In the past [r]12 months[n], how many times have you grabbed your child [r][fill CHILD][n] around the neck and choked [fill based on CHILD'S GENDER: him/her]?

- 1 = 1 time
 - 2 = 2 times
 - 3 = 3-5 times
 - 4 = 6-10 times
 - 5 = 11-20 times
 - 6 = More than 20 times
 - 7 = Not in the past [r]12 months[n], but it happened before
 - 8 = This has never happened
- @a

>P_DS9a<

Was this reported?

- 1 = YES [# GOTO P_DS10]
 - 2 = NO
- @a

[# IF INTNUM > 3, GOTO P_DS9c.]

>P_DS9b<

Did this happen since [FILL Close of Investigation Date], that is, since the close of the investigation?

- 1 = YES
- 2 = NO

>P_DS9c<

Did this happen in the past week?

1 = Yes [#GOTO P_DS10]

2 = No

@a

>P_DS9d<

Did this happen in the past month?

1 = Yes [#GOTO P_DS10]

2 = No

@a

>P_DS9e<

Did this happen in the last 3 months?

1 = Yes [#GOTO P_DS10]

2 = No

@a

>P_DS10<

In the past [r]12 months[n], how many times have you sworn or cursed at your child [r][fill CHILD][n]?

1 = 1 time

2 = 2 times

3 = 3-5 times

4 = 6-10 times

5 = 11-20 times

6 = More than 20 times

7 = Not in the past [r]12 months[n], but it happened before

8 = This has never happened

@a

>P_DS11<

In the past [r]12 months[n], how many times have you beat your child [r][fill CHILD][n] up by hitting [fill based on CHILD'S GENDER: him/her] over and over as hard as you could?

- 1 = 1 time
- 2 = 2 times
- 3 = 3-5 times
- 4 = 6-10 times
- 5 = 11-20 times
- 6 = More than 20 times
- 7 = Not in the past [r]12 months[n], but it happened before
- 8 = This has never happened

@a

>P_DS11a<

Was this reported?

- 1 = YES [# GOTO P_DS12]
- 2 = NO

@a

>P_DS11bFC<

[# IF INTNUM > 3, GOTO P_DS11c.]

>P_DS11b<

Did this happen since [FILL Close of Investigation Date], that is, since the close of the investigation?

- 1 = YES
- 2 = NO

@a

>P_DS11c<

Did this happen in the past week?

- 1 = Yes [#GOTO P_DS12]
- 2 = No

@a

>P_DS11d<

Did this happen in the past month?

- 1 = Yes [#GOTO P_DS12]
- 2 = No

@a

>P_DS11e<

Did this happen in the last 3 months?

1 = Yes [#GOTO P_DS12]
 2 = No
 @a

>P_DS12<

In the past [r]12 months[n], how many times have you said your child [r][fill CHILD][n] would be sent away or kicked out of the house?

1 = 1 time
 2 = 2 times
 3 = 3-5 times
 4 = 6-10 times
 5 = 11-20 times
 6 = More than 20 times
 7 = Not in the past [r]12 months[n], but it happened before
 8 = This has never happened
 @a

>P_DS13<

In the past [r]12 months[n], how many times have you burned or scalded your child [r][fill CHILD][n] on purpose?

1 = 1 time
 2 = 2 times
 3 = 3-5 times
 4 = 6-10 times
 5 = 11-20 times
 6 = More than 20 times
 7 = Not in the past [r]12 months[n], but it happened before
 8 = This has never happened
 @a

>P_DS13a<

Was this reported?

1 = YES [# GOTO P_DS14]
 2 = NO
 @a

>P_DS13bFC<

[# IF INTNUM > 3, GOTO P_DS13c.]

>P_DS13b<

Did this happen since [FILL Close of Investigation Date], that is, since the close of the investigation?

1 = YES
 2 = NO

>P_DS13c<

Did this happen in the past week?

1 = Yes [#GOTO P_DS14]
 2 = No
 @a

>P_DS13d<

Did this happen in the past month?

1 = Yes [#GOTO P_DS14]
 2 = No
 @a

>P_DS13e<

Did this happen in the last 3 months?

1 = Yes [#GOTO P_DS14]
 2 = No
 @a

>P_DS14<

In the past [r]12 months[n], how many times have you threatened to spank or hit your child [r][fill CHILD][n] but did not actually do it?

1 = 1 time
 2 = 2 times
 3 = 3-5 times
 4 = 6-10 times
 5 = 11-20 times
 6 = More than 20 times
 7 = Not in the past [r]12 months[n], but it happened before
 8 = This has never happened
 @a

>P_DS15<

In the past [r]12 months[n], how many times have you hit your child [r][fill CHILD][n] on some other part of the body besides the bottom with something like a belt, hairbrush, a stick or some other hard object?

1 = 1 time
 2 = 2 times
 3 = 3-5 times

- 4 = 6-10 times
- 5 = 11-20 times
- 6 = More than 20 times
- 7 = Not in the past [r]12 months[n], but it happened before
- 8 = This has never happened

@a

>P_DS16<

In the past [r]12 months[n], how many times have you slapped your child [r][fill CHILD][n] on the hand, arm, or leg?

- 1 = 1 time
- 2 = 2 times
- 3 = 3-5 times
- 4 = 6-10 times
- 5 = 11-20 times
- 6 = More than 20 times
- 7 = Not in the past [r]12 months[n], but it happened before
- 8 = This has never happened

@a

>P_DS17<

In the past [r]12 months[n], how many times have you taken away privileges or grounded your child [r][fill CHILD][n]?

- 1 = 1 time
- 2 = 2 times
- 3 = 3-5 times
- 4 = 6-10 times
- 5 = 11-20 times
- 6 = More than 20 times
- 7 = Not in the past [r]12 months[n], but it happened before
- 8 = This has never happened

@a

>P_DS18<

In the past [r]12 months[n], how many times have you pinched your child [r][fill CHILD][n]?

- 1 = 1 time
- 2 = 2 times
- 3 = 3-5 times
- 4 = 6-10 times
- 5 = 11-20 times
- 6 = More than 20 times
- 7 = Not in the past [r]12 months[n], but it happened before
- 8 = This has never happened

@a

>P_DS19<

In the past [r]12 months[n], how many times have you threatened your child [r][fill CHILD][n] with a knife or gun?

- 1 = 1 time
- 2 = 2 times
- 3 = 3-5 times
- 4 = 6-10 times
- 5 = 11-20 times
- 6 = More than 20 times
- 7 = Not in the past [r]12 months[n], but it happened before
- 8 = This has never happened

@a

>P_DS20<

In the past [r]12 months[n], how many times have you thrown or knocked your child [r][fill CHILD][n] down?

- 1 = 1 time
- 2 = 2 times
- 3 = 3-5 times
- 4 = 6-10 times
- 5 = 11-20 times
- 6 = More than 20 times
- 7 = Not in the past [r]12 months[n], but it happened before
- 8 = This has never happened

@a

>P_DS21<

In the past [r]12 months[n], how many times have you called your child [r][fill CHILD][n] dumb or lazy or some other name like that?

- 1 = 1 time
- 2 = 2 times
- 3 = 3-5 times
- 4 = 6-10 times
- 5 = 11-20 times
- 6 = More than 20 times
- 7 = Not in the past [r]12 months[n], but it happened before
- 8 = This has never happened

@a

>P_DS22<

In the past [r]12 months[n], how many times have you slapped your child [r][fill CHILD][n] on the face or head or ears?

- 1 = 1 time
 - 2 = 2 times
 - 3 = 3-5 times
 - 4 = 6-10 times
 - 5 = 11-20 times
 - 6 = More than 20 times
 - 7 = Not in the past [r]12 months[n], but it happened before
 - 8 = This has never happened
- @a

>P_DS23<

Sometimes things can get in the way of caring for your child the way you would like to: for example, money problems, personal problems, or having a lot to do. For the next set of items, please tell me how many times in the past [r]12 months[n] this has happened to you in trying to care for your child.

Press the [Enter] key to continue

>P_DS24<

In the past [r]12 months[n], how many times have you ever had to leave your child [r][fill CHILD][n] home alone, even when you thought some adult should be with [fill based on CHILD'S GENDER: him/her]?

- 1 = 1 time
- 2 = 2 times
- 3 = 3-5 times
- 4 = 6-10 times
- 5 = 11-20 times
- 6 = More than 20 times
- 7 = Not in the past [r]12 months[n], but it happened before
- 8 = This has never happened

@a

>P_DS25<

In the past [r]12 months[n], how many times were you so caught up with problems that you were not able to show or tell your child [r][fill CHILD][n] that you loved [fill based on CHILD'S GENDER: him/her]?

- 1 = 1 time
- 2 = 2 times
- 3 = 3-5 times
- 4 = 6-10 times
- 5 = 11-20 times
- 6 = More than 20 times
- 7 = Not in the past [r]12 months[n], but it happened before
- 8 = This has never happened

@a

>P_DS26<

In the past [r]12 months[n], how many times were you not able to make sure that your child [r][fill CHILD][n] got the food [fill based on CHILD'S GENDER: he/she] needed?

- 1 = 1 time
- 2 = 2 times
- 3 = 3-5 times
- 4 = 6-10 times
- 5 = 11-20 times
- 6 = More than 20 times
- 7 = Not in the past [r]12 months[n], but it happened before
- 8 = This has never happened

@a

>P_DS27<

In the past [r]12 months[n], how many times were you unable to make sure your child [r][fill CHILD][n] got to a doctor or hospital when [fill based on CHILD'S GENDER: he/she] needed it?

- 1 = 1 time
- 2 = 2 times
- 3 = 3-5 times
- 4 = 6-10 times
- 5 = 11-20 times
- 6 = More than 20 times
- 7 = Not in the past [r]12 months[n], but it happened before
- 8 = This has never happened

@a

>P_DS28<

In the past [r]12 months[n], how many times were you so drunk or high that you had a problem taking care of your child [r][fill CHILD][n]?

- 1 = 1 time
- 2 = 2 times
- 3 = 3-5 times
- 4 = 6-10 times
- 5 = 11-20 times
- 6 = More than 20 times
- 7 = Not in the past [r]12 months[n], but it happened before
- 8 = This has never happened

@a

P_DS29<

In the past [r]12 months[n], has [fill CHILD] been touched in a sexual way by an adult or older child when [fill he/she] did not want to be touched that way? Or has [fill he/she] been forced to touch an adult or older child in a sexual way -- including anyone who was a member of your family, or anyone outside the family?

- 1 = YES
- 2 = NO [# GOTO P_DS31]

@a

>P_DS29a<

Was the person responsible for taking care of the child when the incident occurred?

- 1 = YES
- 2 = NO

@a

>P_DS29b<

Was this reported?

1 = YES
 2 = NO
 @a

>P_DS30<

[# IF P_DS29 = 1]

Has it happened more than once in the past [r]12 months[n]?

1 = YES [# GOTO P_DS32]
 2 = NO [# GOTO P_DS32]
 @a

>P_DS30a<

Did this happen in the past week?

1 = Yes [#GOTO P_DS32]
 2 = No
 @a

>P_DS30c<

Did this happen in the past month?

1 = Yes [#GOTO P_DS32]
 2 = No
 @a

>P_DS30d<

Did this happen in the last 3 months?

1 = Yes [#GOTO P_DS32]
 2 = No
 @a

>P_DS31<

[# IF P_DS29 = 2, DK, RE]

Has it [r]ever[n] happened?

1 = Yes
 2 = No
 @a

>P_DS32<

In the past [r]12 months[n], has your child [r][fill CHILD][n] been forced to have sex by an adult or an older child -- including anyone who was a member of the family?

1 = Yes

2 = No [# GOTO P_DS34]
@a

>P_DS32a<

Was the person responsible for taking care of the child when the incident occurred?

1 = YES
2 = NO
@a

>P_DS32b<

Was this reported?

1 = YES
2 = NO
@a

>P_DS32c<

Did this happen in the past week?

1 = Yes [#GOTO P_DS34]
2 = No
@a

>P_DS32d<

Did this happen in the past month?

1 = Yes [#GOTO P_DS34]
2 = No
@a

>P_DS32e<

Did this happen in the last 3 months?

1 = Yes [#GOTO P_DS34]
2 = No
@a

>P_DS33<

[# IF DS32 = 1]

Has it happened more than once in the past [r]12 months[n]?

1 = YES [# GOTO P_DSEND]
2 = NO [# GOTO P_DSEND]
@a

>P_DS34<

[# IF P_DS32 = 2, DK, RE]

Has it [r]ever[n] happened?

1 = YES

2 = NO

@a

>P_DSEND<

1-15 172
16-36
32-48

THE HOME (Scripted Items)

(For all current caregivers at Waves 1, 3, and 4)

>P_HO1FC<

```
[# IF INTNUM = 2, GOTO P_HOEND]
[# IF CHILD AGE 3-5, GOTO P_HO16. IF CHILD AGE 6-10, GOTO P_HO32.
ELSE, IF CHILD AGE > 10, GOTO P_HOEND.]
```

>P_HO1<

My next questions are about your family's lifestyle and rules.
About how often does [fill CHILD] have a chance to get out of the house,
either by [fill himself/herself] or with an older person? Would you
say...

- 1 = Not at all,
 - 2 = About once a month or less,
 - 3 = A few times a month,
 - 4 = About once a month,
 - 5 = A few times a week,
 - 6 = 4 or more times a week, or
 - 7 = Every day
- @a

```
[# SCORE P_HO1]: IF 1-5, OR DK/RE, SCORE 0.
IF 6-7, SCORE 1.
```

>P_HO2<

About how many children's books does [fill CHILD] have of [fill his/her]
own?

- 1 = NONE
 - 2 = 1 OR 2 BOOKS
 - 3 = 3 TO 9 BOOKS
 - 4 = 10 OR MORE BOOKS
- @a

```
[# SCORE P_HO2]: IF 1-2, OR DK/RE, SCORE 0.
IF 3-4, SCORE 1.
```

>P_H03<

How often do you get a chance to read stories to [fill CHILD]? Would you say...

- 1 = Never,
- 2 = Several times a year,
- 3 = Several times a month,
- 4 = Once a week,
- 5 = About 3 times a week, or
- 6 = Every day?

@a

[# SCORE P_H03]: IF 1-4, OR DK/RE, SCORE 0.
IF 5-6, SCORE 1.

>P_H04<

About how often do you take [fill CHILD] to the grocery store? Would you say...

- 1 = Twice a week or more,
- 2 = Once a week,
- 3 = Once a month, or
- 4 = Hardly ever?

@a

[# SCORE P_H04]: IF 1, SCORE 1.
IF 2-4, OR DK/RE, SCORE 0.

>P_H05<

About how many, if any, cuddly, soft, or role-playing toys, like a doll, does [fill CHILD] have? (Toys may be shared with sister or brother.)

@a

CUDDLLY TOYS

[# SCORE P_H05]: IF 0, OR DK/RE, SCORE 0.
IF >= 1, SCORE 1.

>P_H06<

About how many, if any, push or pull toys does [fill CHILD] have? (Toys may be shared with sister or brother.)

@a

PUSH TOYS

[# SCORE P_H06]: IF 0, OR DK/RE, SCORE 0.
IF >= 1, SCORE 1.

>P_H07<

Some parents spend time teaching their children new skills while other parents believe children learn best on their own. Which of the following best describes [r]your[n] attitude? (READ LIST.)

- 1 = Parents should [r]always spend time[n] teaching their children.
- 2 = Parents should [r]usually spend time[n] teaching their children.
- 3 = Parents should [r]usually allow[n] their children to learn on their own.
- 4 = Parents should [r]always allow[r] their children to learn on their own.

@a

[# SCORE P_H07]: IF 1-2, SCORE 1.
IF 3-4, OR DK/RE, SCORE 0.

>P_H08<

Think for a moment about a typical [r]weekday[n] for your family. How much time would you say [fill CHILD] spends watching television on a typical weekday?

@a

HOURS PER WEEKDAY

- 0 = LESS THAN 1 HOUR PER WEEKDAY
- 95 = DO NOT HAVE A TV

[# SCORE P_H08]: IF < 1 HOUR, SCORE 1
IF >= 1 HOUR OR 95, OR DK/RE, SCORE 0

>P_H09<

Now, think about a typical [r]weekend day[n] for your family. How much time would you say [fill CHILD] spends watching television on a typical weekend day?

@a

HOURS PER WEEKEND DAY

- 0 = LESS THAN 1 HOUR PER WEEKEND DAY
- 95 = DO NOT HAVE A TV

[# SCORE P_H09]: IF < 1 HOUR, SCORE 1
IF >= 1 HOUR OR 95, OR DK/RE, SCORE 0

>P_HO10<

About how many hours is the TV on in your home each day?

@a

HOURS PER DAY

0 = LESS THAN 1 HOUR PER DAY

95 = DO NOT HAVE A TV

[# SCORE P_HO10]: IF < 1 HOUR, SCORE 1
 IF >= 1 HOUR OR 95, OR DK/RE, SCORE 0

>P_HO11<

Does [fill CHILD] ever see [fill his/her] father, stepfather, or father-figure?

1 = YES

2 = NO

3 = NO FATHER, STEPFATHER, OR FATHER-FIGURE

@a

[# SCORE P_HO11]: IF 1, SCORE 1.
 IF 2-3, OR DK/RE, SCORE 0.

>P_HO12FC<

[# IF P_HO11 = 2 OR 3, GOTO P_HO14.]

>P_HO12<

Does [fill CHILD] see this person on a [r]daily basis[n]?

1 = YES

2 = NO

@a

[# SCORE P_HO12]: IF 1, SCORE 1
 IF 2, OR DK/RE, SCORE 0

>P_HO13<

How often does [fill CHILD] eat a meal with [r]both[n] mother and father (or stepfather or father-figure)? Would you say...

- 1 = More than once a day,
 - 2 = Once a day,
 - 3 = Several times a week,
 - 4 = Once a week,
 - 5 = Once a month or less often, or
 - 6 = Never?
- @a

[# SCORE P_HO13]: IF 1-2, SCORE 1.
IF 3-6, OR DK/RE, SCORE 0.

>P_HO14<

Children seem to demand attention when their parents are busy, doing housework, for example. How often do you talk to [fill CHILD] while you are working? Would you say you...

- 1 = Always talk to [fill CHILD] when you're working,
 - 2 = Often talk to [fill him/her] when you're working,
 - 3 = Sometimes talk to [fill him/her] when you're working,
 - 4 = Rarely talk to [fill him/her] when you're working, or
 - 5 = Never talk to [fill him/her] when you're working?
- @a

[# SCORE P_HO14]: IF 1-2, SCORE 1.
IF 3-5, OR DK/RE, SCORE 0.

>P_HO15<

Sometimes kids mind pretty well and sometimes they don't. [r]In the last week[n], about how many times, if any, have you had to spank [fill CHILD]?

@a
TIMES

0 = DID NOT SPANK CHILD LAST WEEK

[# SCORE P_HO15]: IF 0-1, SCORE 1.
IF > 1, OR DK/RE, SCORE 0

>P_HO15aCK<

[# THE FOLLOWING THREE QUESTIONS SHOULD NOT GET SCORED.]

>P_HO15a<

About how many times in the past month did you hug or show physical affection to [fill CHILD]? Would you say...

- 1 = never in the past month,
- 2 = less than once a week,
- 3 = about once a week,
- 4 = several times a week, or
- 5 = every day?

@a

>P_HO15b<

About how many times in the past month did you tell [fill CHILD] you love [fill: him/her]? Would you say...

- 1 = never in the past month,
- 2 = less than once a week,
- 3 = about once a week,
- 4 = several times a week, or
- 5 = every day?

@a

>P_HO15c<

About how many times in the past month did you tell [fill CHILD] you appreciated something [fill: he/she] did?

(READ RESPONSE CATEGORIES AS NEEDED.)

- 1 = NEVER IN THE PAST MONTH
- 2 = LESS THAN ONCE A WEEK
- 3 = ABOUT ONCE A WEEK
- 4 = SEVERAL TIMES A WEEK
- 5 = EVERY DAY

@a

[# GOTO P_HOEND]

>P_HO16<

About how often do you read stories to [fill CHILD]? Would you say...

- 1 = Never,
- 2 = Several times a year,
- 3 = Several times a month,
- 4 = Once a week,
- 5 = At least 3 times a week, or
- 6 = Every day?

@a

[# SCORE P_HO16]: IF 1-4, OR DK/RE, SCORE 0
 IF 5-6, SCORE 1

>P_HO17<

About how many children's books does [fill CHILD] have of [fill his/her] own?

- 1 = NONE
- 2 = 1 OR 2 BOOKS
- 3 = 3 TO 9 BOOKS
- 4 = 10 OR MORE BOOKS

@a

[# SCORE P_HO17]: IF 1-3, OR DK/RE, SCORE 0
 IF 4, SCORE 1

>P_HO18<

About how many magazines does your family get regularly?

- 0 = NONE
- 1 = ONE
- 2 = TWO
- 3 = THREE
- 4 = FOUR OR MORE

@a

[# SCORE P_HO18]: IF 0, OR DK/RE, SCORE 0
 IF > 0, SCORE 1

>P_HO22<

About how many hours is the TV on in your home each day?

@a

HOURS

0 = LESS THAN 1 HOUR PER DAY

95 = DO NOT HAVE A TV

[# SCORE P_HO22]: IF 0-4, SCORE 1
 IF >=5, OR DK/RE, SCORE 0

>P_HO23<

Think for a moment about a typical [r]weekday[n] for your family. How much time would you say [fill CHILD] spends watching television on a typical weekday?

@a

HOURS PER WEEKDAY

0 = LESS THAN 1 HOUR PER WEEKDAY

95 = DO NOT HAVE A TV

[# SCORE P_HO23]: IF 0-4, SCORE 1
 IF >=5, OR DK/RE, SCORE 0

>P_HO24<

Now, think about a typical [r]weekend day[n] for your family. How much time would you say [fill CHILD] spends watching television on a typical weekend day?

@a

HOURS PER WEEKEND DAY

0 = LESS THAN 1 HOUR PER WEEKEND DAY

95 = DO NOT HAVE A TV

[# SCORE P_HO24]: IF 0-4, SCORE 1
 IF >=5, OR DK/RE, SCORE 0

>P_HO25<

Most children get angry at their parents from time to time. If [fill CHILD] got so angry that [fill he/she] hit you, what would you do?

CODE ALL THAT APPLY.

1 = HIT HIM/HER BACK	Y/N
2 = SEND HIM/HER TO HIS/HER ROOM	Y/N
3 = SPANK HIM/HER	Y/N
4 = TALK TO HIM/HER	Y/N
5 = IGNORE IT	Y/N
6 = GIVE HIM/HER HOUSEHOLD CHORE	Y/N
7 = TAKE AWAY HIS/HER ALLOWANCE	Y/N
8 = HOLD CHILD'S HANDS UNTIL HE/SHE WAS CALM	Y/N
9 = OTHER	Y/N

PRESS F9 TO CONTINUE. @a

[# SCORE P_HO25]: IF 1 OR 3 (SEPARATE OR IN COMBINATION WITH OTHER CHOICES), OR DK/RE, SCORE 0
IF 2 OR 4-9, SCORE 1

>P_HO26<

How often does a family member get a chance to take [fill CHILD] on any kind of outing (shopping, park, picnic, drive-in, and so on)? Would you say...

1 = A few times a year or less,
2 = About once a month,
3 = About 2 or 3 times a month,
4 = Several times a week, or
5 = About once a day?

@a

[# SCORE P_HO26]: IF 1-2, OR DK/RE, SCORE 0
IF 3-5, SCORE 1

>P_HO27<

[r]In the last year[n], how often has a family member taken or arranged to take [fill CHILD] to any type of museum (children's, scientific, art, historical, etc.)? Would you say...

- 1 = Never,
 - 2 = Once or twice,
 - 3 = Several times,
 - 4 = About once a month, or
 - 5 = About once a week or more often?
- @a

[# SCORE P_HO27]: IF 1, OR DK/RE, SCORE 0
 IF 2-5, SCORE 1

>P_HO28<

Does [fill CHILD] ever see [fill his/her] father, stepfather, or father-figure?

- 1 = YES
 - 2 = NO
 - 3 = NO FATHER, STEPFATHER, OR FATHER-FIGURE
- @a

[# SCORE P_HO28]: IF 1, SCORE 1
 IF 2-3, OR DK/RE, SCORE 0

>P_HO29FC<

[# IF P_HO28 <> 1, GOTO P_HO31]

>P_HO29<

Does [fill CHILD] see this person on a [r]daily basis[n]?

- 1 = YES
 - 2 = NO
- @a

[# SCORE P_HO29]: IF 1, SCORE 1
 IF 2-3, OR DK/RE, SCORE 0

>P_HO30<

How often does [fill CHILD] eat a meal with [r]both[n] mother and father (or stepfather or father-figure)? Would you say...

- 1 = More than once a day,
 - 2 = Once a day,
 - 3 = Several times a week,
 - 4 = Once a week,
 - 5 = Once a month or less often, or
 - 6 = Never?
- @a

[# SCORE P_HO30]: IF 1-2, SCORE 1.
 IF 3-7, OR DK/RE, SCORE 0.

>P_HO31<

Sometimes kids mind pretty well and sometimes they don't. [r]In the last week[n], about how many times, if any, have you had to spank [fill CHILD]?

@a
TIMES

0 = DID NOT SPANK CHILD LAST WEEK

[# SCORE P_HO31]: IF 0-1, SCORE 1.
 IF > 1, OR DK/RE, SCORE 0

>P_HO31aCK<

[# THE FOLLOWING THREE QUESTIONS SHOULD NOT GET SCORED.]

>P_HO31a<

About how many times in the past month did you hug or show physical affection to [fill CHILD]? Would you say...

- 1 = never in the past month,
 - 2 = less than once a week,
 - 3 = about once a week,
 - 4 = several times a week, or
 - 5 = every day?
- @a

>P_HO31b<

About how many times in the past month did you tell [fill CHILD] you love [fill: him/her]? Would you say...

- 1 = never in the past month,
- 2 = less than once a week,
- 3 = about once a week,
- 4 = several times a week, or
- 5 = every day?

@a

>P_HO31c<

About how many times in the past month did you tell [fill CHILD] you appreciated something [fill: he/she] did?

(READ RESPONSE CATEGORIES AS NEEDED.)

- 1 = NEVER IN THE PAST MONTH
- 2 = LESS THAN ONCE A WEEK
- 3 = ABOUT ONCE A WEEK
- 4 = SEVERAL TIMES A WEEK
- 5 = EVERY DAY

@a

[# GOTO P_HOEND]

>P_HO32<

About how many books does [fill CHILD] have?

- 1 = NONE
- 2 = 1 OR 2 BOOKS
- 3 = 3 TO 9 BOOKS
- 4 = 10 OR MORE BOOKS

@a

[# SCORE P_HO32]: IF 1-3, OR DK/RE, SCORE 0
 IF 4, SCORE 1

>P_HO31b<

About how many times in the past month did you tell [fill CHILD] you love [fill: him/her]? Would you say...

- 1 = never in the past month,
- 2 = less than once a week,
- 3 = about once a week,
- 4 = several times a week, or
- 5 = every day?

@a

>P_HO31c<

About how many times in the past month did you tell [fill CHILD] you appreciated something [fill: he/she] did?

(READ RESPONSE CATEGORIES AS NEEDED.)

- 1 = NEVER IN THE PAST MONTH
- 2 = LESS THAN ONCE A WEEK
- 3 = ABOUT ONCE A WEEK
- 4 = SEVERAL TIMES A WEEK
- 5 = EVERY DAY

@a

[# GOTO P_HOEND]

>P_HO32<

About how many books does [fill CHILD] have?

- 1 = NONE
- 2 = 1 OR 2 BOOKS
- 3 = 3 TO 9 BOOKS
- 4 = 10 OR MORE BOOKS

@a

[# SCORE P_HO32]: IF 1-3, OR DK/RE, SCORE 0
 IF 4, SCORE 1

>P_HO33<

About how often do you read stories to [fill CHILD]? Would you say...

- 1 = Never,
- 2 = Several times a year,
- 3 = Several times a month,
- 4 = Once a week,
- 5 = At least 3 times a week, or
- 6 = Every day?

@a

[# SCORE P_HO33]: IF 1-4, OR DK/RE, SCORE 0
IF 5-6, SCORE 1

>P_HO34a<

USE CARD 30. Please look at Card 30. How often is [fill CHILD] expected to do each of the following?

Make [fill his/her] bed? Would you say...

- 1 = Almost never,
- 2 = Less than half the time,
- 3 = Half the time,
- 4 = More than half the time, or
- 5 = Almost always?

@a

[# SCORE P_HO34a]: IF 1-2 OR DK/RE, SCORE 0.
IF 3-5, SCORE 1.

>P_HO34b<

(USE CARD 30. How often is [fill CHILD] expected to...)

Clean [fill his/her] room? Would you say...

- 1 = Almost never,
- 2 = Less than half the time,
- 3 = Half the time,
- 4 = More than half the time, or
- 5 = Almost always?

@a

[# SCORE P_HO34b]: IF 1-2 OR DK/RE, SCORE 0.
IF 3-5, SCORE 1.

>P_HO33<

About how often do you read stories to [fill CHILD]? Would you say...

- 1 = Never,
- 2 = Several times a year,
- 3 = Several times a month,
- 4 = Once a week,
- 5 = At least 3 times a week, or
- 6 = Every day?

@a

[# SCORE P_HO33]: IF 1-4, OR DK/RE, SCORE 0
IF 5-6, SCORE 1

>P_HO34a<

USE CARD 30. Please look at Card 30. How often is [fill CHILD] expected to do each of the following?

Make [fill his/her] bed? Would you say...

- 1 = Almost never,
- 2 = Less than half the time,
- 3 = Half the time,
- 4 = More than half the time, or
- 5 = Almost always?

@a

[# SCORE P_HO34a]: IF 1-2 OR DK/RE, SCORE 0.
IF 3-5, SCORE 1.

>P_HO34b<

(USE CARD 30. How often is [fill CHILD] expected to...)

Clean [fill his/her] room? Would you say...

- 1 = Almost never,
- 2 = Less than half the time,
- 3 = Half the time,
- 4 = More than half the time, or
- 5 = Almost always?

@a

[# SCORE P_HO34b]: IF 1-2 OR DK/RE, SCORE 0.
IF 3-5, SCORE 1.

>P_HO34c<

(USE CARD 30. How often is [fill CHILD] expected to...)

Clean up after spills? READ CATEGORIES AS NEEDED.

- 1 = Almost never,
- 2 = Less than half the time,
- 3 = Half the time,
- 4 = More than half the time, or
- 5 = Almost always?

@a

[# SCORE P_HO34c]: IF 1-2 OR DK/RE, SCORE 0.
IF 3-5, SCORE 1.

>P_HO34d<

(USE CARD 30. How often is [fill CHILD] expected to...)

Bathe [fill himself/herself]? READ CATEGORIES AS NEEDED.

- 1 = Almost never,
- 2 = Less than half the time,
- 3 = Half the time,
- 4 = More than half the time, or
- 5 = Almost always?

@a

[# SCORE P_HO34d]: IF 1-2 OR DK/RE, SCORE 0.
IF 3-5, SCORE 1.

[# SCORE P_HO34a-d]: SUM 34a,b,c,d
If SUM >=3, SCORE 1.
If SUM <3, SCORE 0.

P_HO34e<

(USE CARD 30. How often is [fill CHILD] expected to...)

Pick up after [fill himself/herself]? READ CATEGORIES AS NEEDED.

- 1 = Almost never,
- 2 = Less than half the time,
- 3 = Half the time,
- 4 = More than half the time, or
- 5 = Almost always?

@a

[# SCORE P_HO34e]: IF 1, OR DK/RE, SCORE 0
IF 2-5, SCORE 1

>P_HO35<

Is there a musical instrument, for example, a piano, drums, or guitar, that [fill CHILD] can use (here) at home?

1 = YES
2 = NO
@a

[# SCORE P_HO35]: IF 1, SCORE 1
IF 2, OR DK/RE, SCORE 0

>P_HO36<

Does your family get a daily newspaper?

1 = YES
2 = NO
@a

[# SCORE P_HO36]: IF 1, SCORE 1
IF 2, OR DK/RE, SCORE 0

>P_HO37<

About how often does [fill CHILD] read for enjoyment? Would you say...

1 = Every day,
2 = Several times a week,
3 = Several times a month,
4 = Several times a year, or
5 = Never?
@a

[# SCORE P_HO37]: IF 1-2, SCORE 1
IF 3-5, OR DK/RE, SCORE 0

>P_HO38<

Does your family encourage [fill CHILD] to start and keep doing hobbies?

1 = YES
2 = NO
@a

[# SCORE P_HO38]: IF 1, SCORE 1
IF 2, OR DK/RE, SCORE 0

>P_HO39<

Does [fill CHILD] get special lessons or belong to any organization that encourages activities such as sports, music, art, dance, drama, etc?

1 = YES
2 = NO
@a

[# SCORE P_HO39]: IF 1, SCORE 1
 IF 2, OR DK/RE, SCORE 0

>P_HO40<

[r]In the last year[n], how often has a family member taken or arranged to take [fill CHILD] to any type of museum (children's, scientific, art, historical, etc.)? Would you say...

1 = Never,
2 = Once or twice,
3 = Several times,
4 = About once a month, or
5 = About once a week or more often?
@a

[# SCORE P_HO40]: IF 1, OR DK/RE, SCORE 0
 IF 2-5, SCORE 1

>P_HO41<

[r]In the last year[n], how often has a family member taken or arranged to take [fill CHILD] to any type of musical or theatrical performance? Would you say...

1 = Never,
2 = Once or twice,
3 = Several times,
4 = About once a month, or
5 = About once a week or more?
@a

[# SCORE P_HO41]: IF 1, OR DK/RE, SCORE 0
 IF 2-5, SCORE 1

>P_HO42<

About how often does your whole family get together with relatives or friends?

- 1 = Once a year or less,
- 2 = A few times a year,
- 3 = Once a month,
- 4 = Two or three times a month, or
- 5 = Once a week or more?

@a

[# SCORE P_HO42]: IF 1-3, OR DK/RE, SCORE 0
 IF 4-5, SCORE 1

>P_HO43<

Does [fill CHILD] spend time with [fill his/her] father, stepfather, or father-figure?

- 1 = YES
- 2 = NO
- 3 = NO FATHER, STEPFATHER, OR FATHER-FIGURE

@a

[# SCORE P_HO43]: IF 1, SCORE 1.
 IF 2-3, OR DK/RE, SCORE 0.

>P_HO44FC<

[# IF P_HO43 <> 1, GOTO P_HO47.]

>P_HO44<

About how often does [fill he/she] spend time with [fill his/her] father or father-figure? Would you say...

- 1 = Once a day or more often,
- 2 = At least 4 times a week,
- 3 = Once a week,
- 4 = Once a month, or
- 5 = A few times a year or less?

@a

[# SCORE P_HO44]: IF 1-2, SCORE 1
 IF 3-5, OR DK/RE, SCORE 0

>P_HO45<

About how often does [fill CHILD] spend time with [fill his/her] father or father-figure in outdoor activities? Would you say...

- 1 = Once a day or more often,
 - 2 = At least 4 times a week,
 - 3 = Once a week,
 - 4 = Once a month, or
 - 5 = A few times a year or less?
- @a

[# SCORE P_HO45]: IF 1-3, SCORE 1
 IF 4-5, OR DK/RE, SCORE 0

>P_HO46<

How often does [fill CHILD] eat a meal with [r]both[n] mother and father (or stepfather or father-figure)? Would you say...

- 1 = More than once a day,
 - 2 = Once a day,
 - 3 = Several times a week,
 - 4 = Once a week,
 - 5 = Once a month or less often, or
 - 6 = Never?
- @a

[# SCORE P_HO46]: IF 1-2, SCORE 1.
 IF 3-6, OR DK/RE, SCORE 0.

>P_HO47<

When your family watches TV together, do you or [fill CHILD]'s father or father-figure discuss TV programs with [fill him/her]?

- 1 = YES
 - 2 = NO
 - 3 = DO NOT HAVE A TV
- @a

[# SCORE P_HO47]: IF 1, SCORE 1.
 IF 2-3, OR DK/RE, SCORE 0.

>P_HO48<

Sometimes children get so angry at their parents that they say things like "I hate you" or swear in a temper tantrum. What actions would you take if this happened?

READ LIST. CODE ALL THAT APPLY.

1 = Grounding?	Y/N
2 = Spanking?	Y/N
3 = Talk with child?	Y/N
4 = Give [fill him/her] household chore,	Y/N
5 = Ignore it,	Y/N
6 = Send [fill him/her] to [fill his/her] room for more than 1 hour, or	Y/N
7 = Something else?	Y/N

PRESS F9 TO CONTINUE. @a

[# SCORE P_HO48]: IF 2, OR DK/RE, SCORE 0
IF 1 OR 3-7, SCORE 1

>P_HO49<

Sometimes kids mind pretty well and sometimes they don't. [r]In the last week[n], about how many times, if any, have you had to spank [fill CHILD]?

@a
TIMES

[# SCORE P_HO49]: IF 0-1, SCORE 1.
IF >1 OR DK/RE, SCORE 0.

>P_HO49aCK<

[# THE FOLLOWING THREE QUESTIONS SHOULD NOT GET SCORED.]

>P_HO49a<

About how many times in the past month did you hug or show physical affection to [fill CHILD]? Would you say...

1 = never in the past month,
2 = less than once a week,
3 = about once a week,
4 = several times a week, or
5 = every day?

@a

>P_HO49b<

About how many times in the past month did you tell [fill CHILD] you love [fill: him/her]? Would you say...

- 1 = never in the past month,
- 2 = less than once a week,
- 3 = about once a week,
- 4 = several times a week, or
- 5 = every day?

@a

>P_HO49c<

About how many times in the past month did you tell [fill CHILD] you appreciated something [fill: he/she] did?

(READ RESPONSE CATEGORIES AS NEEDED.)

- 1 = NEVER IN THE PAST MONTH
- 2 = LESS THAN ONCE A WEEK
- 3 = ABOUT ONCE A WEEK
- 4 = SEVERAL TIMES A WEEK
- 5 = EVERY DAY

@a

>P_HOEND<

[# CALCULATE TOTAL SCORES FOR CHILD.]

RELATIONSHIP WITH CAREGIVER

>Y_RC0FC<

[#IF AGE < 11, GOTO Y_RCEND. IF INTNUM = 4, CHILD IS LEGALLY EMANCIPATED, AND DOES NOT LIVE WITH A CAREGIVER PER CID, GOTO Y_RCEND. ELSE, CONTINUE.]

>Y_RC1<

Now I want to ask you about your relationship with your [fill CAREGIVER_A]. I am going to read a list of different statements and for each one I want you to tell me how true the statement is about you. Remember that your answers are private. Please tell me what you really feel or think.

When I'm with my [fill CAREGIVER_A], I feel good. How true is this?

- 1 = not at all true
- 2 = not very true
- 3 = sort of true, or
- 4 = very true?

@a

>Y_RC2<

When I'm with my [fill CAREGIVER_A], I feel mad. How true is this?

- 1 = not at all true
- 2 = not very true
- 3 = sort of true, or
- 4 = very true?

@a

>Y_RC3<

When I'm with my [fill CAREGIVER_A], I feel unhappy. How true is this?

- 1 = not at all true
- 2 = not very true
- 3 = sort of true, or
- 4 = very true?

@a

>Y_RC4<

My [fill CAREGIVER_A] enjoys spending time with me. How true is this?

- 1 = not at all true
- 2 = not very true
- 3 = sort of true, or
- 4 = very true?

@a

>Y_RC5<

My [fill CAREGIVER_A] does a lot to help me. How true is this?

- 1 = not at all true
- 2 = not very true
- 3 = sort of true, or
- 4 = very true?

@a

>Y_RC6<

My [fill CAREGIVER_A] doesn't seem to have enough time for me. How true is this?

- 1 = not at all true
- 2 = not very true
- 3 = sort of true, or
- 4 = very true?

@a

>Y_RC7<

My [fill CAREGIVER_A] doesn't seem to know how I feel about things. How true is this?

- 1 = not at all true
- 2 = not very true
- 3 = sort of true, or
- 4 = very true?

@a

>Y_RC8<

My [fill CAREGIVER_A] trusts me. How true is this?

- 1 = not at all true
- 2 = not very true
- 3 = sort of true, or
- 4 = very true?

@a

>Y_RC9<

My [fill CAREGIVER_A] doesn't let me make any of my own decisions.
How true is this?

- 1 = not at all true
- 2 = not very true
- 3 = sort of true, or
- 4 = very true?

@a

>Y_RC10<

My [fill CAREGIVER_A] is fair with me. How true is this?

- 1 = not at all true
- 2 = not very true
- 3 = sort of true, or
- 4 = very true?

@a

>Y_RC11<

My [fill CAREGIVER_A] doesn't think I can do very much. How true is this?

- 1 = not at all true
- 2 = not very true
- 3 = sort of true, or
- 4 = very true?

@a

>Y_RC12<

I don't know what my [fill CAREGIVER_A] wants from me. How true is this?

- 1 = not at all true
- 2 = not very true
- 3 = sort of true, or
- 4 = very true?

@a

>Y_RC13FC<

[# IF CAREGIVER_B IS BLANK, GOTO RCEND]

>Y_RC13<

Now I want to ask you about your relationship with your [fill CAREGIVER_B]. I am going to read a list of different statements and for each one I want you to tell me how true the statement is about you. Remember that your answers are private. Please tell me what you really feel or think.

When I'm with my [fill CAREGIVER_B], I feel good. How true is this?

- 1 = not at all true
- 2 = not very true
- 3 = sort of true, or
- 4 = very true?

@a

>Y_RC14<

When I'm with my [fill CAREGIVER_B], I feel mad. How true is this?

- 1 = not at all true
- 2 = not very true
- 3 = sort of true, or
- 4 = very true?

@a

>Y_RC15<

When I'm with my [fill CAREGIVER_B], I feel unhappy. How true is this?

- 1 = not at all true
- 2 = not very true
- 3 = sort of true, or
- 4 = very true?

@a

>Y_RC16<

My [fill CAREGIVER_B] enjoys spending time with me. How true is this?

- 1 = not at all true
- 2 = not very true
- 3 = sort of true, or
- 4 = very true?

@a

>Y_RC17<

My [fill CAREGIVER_B] does a lot to help me. How true is this?

- 1 = not at all true
- 2 = not very true
- 3 = sort of true, or
- 4 = very true?

@a

>Y_RC18<

My [fill CAREGIVER_B] doesn't seem to have enough time for me. How true is this?

- 1 = not at all true
- 2 = not very true
- 3 = sort of true, or
- 4 = very true?

@a

>Y_RC19<

My [fill CAREGIVER_B] doesn't seem to know how I feel about things. How true is this?

- 1 = not at all true
- 2 = not very true
- 3 = sort of true, or
- 4 = very true?

@a

>Y_RC20<

My [fill CAREGIVER_B] trusts me. How true is this?

- 1 = not at all true
- 2 = not very true
- 3 = sort of true, or
- 4 = very true?

@a

>Y_RC21<

My [fill CAREGIVER_B] doesn't let me make any of my own decisions. How true is this?

- 1 = not at all true
- 2 = not very true
- 3 = sort of true, or
- 4 = very true?

@a

>Y_RC22<

My [fill CAREGIVER_B] is fair with me. How true is this?

- 1 = not at all true
- 2 = not very true
- 3 = sort of true, or
- 4 = very true?

@a

>Y_RC23<

My [fill CAREGIVER_B] doesn't think I can do very much. How true is this?

- 1 = not at all true
- 2 = not very true
- 3 = sort of true, or
- 4 = very true?

@a

>Y_RC24<

I don't know what my [fill CAREGIVER_B] wants from me. How true is this?

- 1 = not at all true
- 2 = not very true
- 3 = sort of true, or
- 4 = very true?

@a

>Y_RCEND<