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Grandparents as Parents: Investigating the Health and Well-Being of Trauma-Exposed Families

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Sprang, Ginny; Choi, Moon; Eslinger, Jessica; Whitt-Woosley, Adrienne; and Loeff, Rachel, "Grandparents as Parents: Investigating the Health and Well-Being of Trauma-Exposed Families" (2014). *Center on Trauma and Children Reports*. 1.

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Center on Trauma
and **Children**

Grandparents as Parents:

Investigating the
Health and Well-Being
of Trauma-Exposed Families



UNIVERSITY OF
KENTUCKY[®]



**Center on Trauma
and Children**

Evidence in Action

STUDY PERSONNEL

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**Funding for this project was made possible via an award from
the Eastern Kentucky Health, Education and Welfare Fund**

Suggested citation: Sprang, G., Choi, M., Eslinger, J., & Whitt-Woosley, A. (2014). *Grandparents as Parents: Investigating the Health and Well-Being of Trauma-Exposed Families*, Lexington, KY: University of Kentucky Center on Trauma and Children.

Published by the Center on Trauma and Children document # 14-CSC-001

The University of Kentucky Center on Trauma and Children is dedicated to the enhancement of the health and well-being of children and their families through research, service and dissemination of information about child abuse and trauma.

The Center's primary mission is to develop, assimilate, and disseminate knowledge and best practices that will contribute to reducing and ending violence against children and the effects of violence and trauma exposure across the life cycle. The Center's dissemination of evidence-based knowledge extends to organizations, systems of protection and care, as well as individual provider level interventions. An additional purpose for the Center is to inform federal, state and regional policies with regard to child maltreatment and trauma effects across the life cycle.

INTRODUCTION

Over the past two decades, the number of grandparents serving as primary caregivers for their grandchildren has steadily increased. Nationally, 42% of all grandparents living with grandchildren function as the primary caregivers (U.S. Census, 2006).

In the southern region of the country, this phenomenon is particularly salient, and expected to continue, with estimates that range from 7% to 15% higher than in 2000 (U.S. Census, 2004). **Kentucky is no exception, with 67,394 children living with their grandparents, 58.8% of those grandchildren fall under the responsibility of their grandparents (American Community Survey, 2005).** In fact, Region IV – which includes the state of Kentucky – has the greatest density of grandparents as head of household, many of whom are poor and of advancing age (U.S. Census, 2004). Projected demographic trajectories predict this trend will continue, necessitating the development of programs and services to address the unique needs of these modern day families.

The practice of extended family members participating in the care and raising of children is an American tradition that dates back to the 18th century. However, the reasons for the current trend towards grandparent-headed households are a reflection of more contemporary problems. Caregiver substance abuse, child abuse and neglect, intimate partner violence, and parental incarceration all contribute to increases in kinship care (Dellman-Jenkins, Blankemeyer, & Olesh, 2002). The incidence of exposure to domestic violence is greatly increased in families where substance misuse, especially methamphetamine production occurs (Sprang, Staton-Tindall, & Clark, 2008). The enforcement of drug trafficking and production laws has resulted in additional children being removed from their biological parents and placed in the care of grandparents (Hunt, Kuck, & Truitt, 2006). In this context, many custodial grandparents cope with the loss that placed them in that role, such as the death or incarceration of their adult child, as well as a grandchild's grief related to parental loss (Hayslip & Kaminski, 2005; Miltenberger, Hayslip, Harris, & Kaminski, 2004).

A trauma perspective is rooted in the understanding that **exposure to a traumatic event (any event that causes intense feelings of fear and anxiety) has the potential to interrupt physiological, emotional, and interpersonal processes leading to poor mental and physical health outcomes across the lifespan** (Briere, Kaltman, & Greene, 2008). The development of adverse symptoms following traumatic exposure is well documented and can include symptoms of post-traumatic stress, depression, anxiety, aggression and interpersonal problems (Alisic, Jongmans, van Wesel, & Kleber, 2011; Feldman & Vengrober, 2011; Ozcol, Zucker, & Spinazzola, 2011).

PURPOSE OF THE STUDY

- 1. Using a trauma framework, explore the factors contributing to caregiver stress and poor child and caregiving outcomes in custodial grandparents**
- 2. Identify service needs, and barriers to effective service delivery**
- 3. Investigate subgroup differences so services can be tailored accordingly**

METHODS

Study Participants

A sample of 297 grandparents from the state’s Caregiver Program for Grandparents Raising Grandchildren and related kinship care network events, such as local support group meetings and two regional conferences for grandparents raising grandchildren, was recruited. The sampling process consisted of two steps. First, local conferences and events were attended to solicit participation via verbal invitations by study personnel and announcements by conference organizers. Second, program coordinators for the statewide care network from two multi-county regions sent individual correspondence to each member of their program requesting they complete the survey online or by phone. All participants solicited directly were given the opportunity to complete the survey either in written form, online through Survey Monkey, or via live interview.

TABLE 1: PARENTING GRANDPARENTS IN KENTUCKY

Caregiver Demographics	
Avg age	59.6
Education (in years)	12.1
Gender (% female)	83.2
% with no health insurance	18.1
% married	44.0
% divorced or separated	32.0
% widowed	17.5
% never married	6.5
% employed full-time	29.9
% retired	32.4
% unemployed	20.3
% that engage in religious activities weekly	53.1

Study participants were heterogeneous in terms of sociodemographic characteristics.

Grandparents were relatively young as **the mean age was 59.6 years old**. The youngest in our study sample was 34 years old, while the oldest was 81 years old. About 15% of grandparents were younger than 50 years old, and about a half of them (56.1%) were between 50 and 64 years old. **Only one third (29%) were adults aged 65 and older.**

A majority of grandparents were grandmothers (83%) and White (76.1%). However, **grandparents aged 65 and older were less likely to be female and more likely to be White** compared to younger grandparents. Chi-square tests showed that these differences were statistically significant.

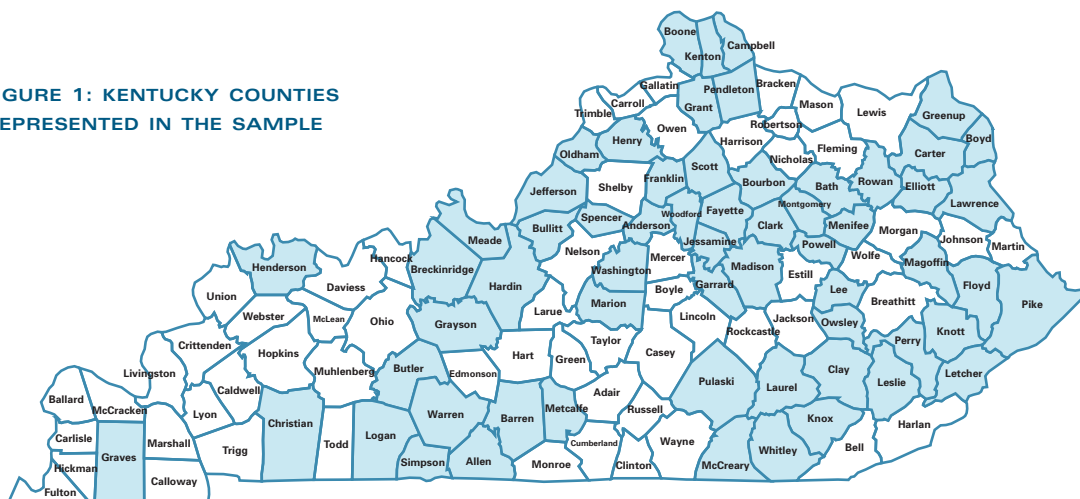
Two distinct groups emerged in terms of their sociodemographic characteristics: (a) younger grandparents, who are often grandmothers and ethnic minorities, and (b) older grandparents, who are mostly White and could be both grandfather and grandmothers.

TABLE 2: GENDER AND RACIAL COMPOSITION OF GRANDPARENTS BY AGE GROUP

	Younger than 50	50-64 years old	65 and older
Female, %	87.2	88.4	71.1
White, %	74.4	73.5	84.2

The average years of education reported was 12.1. Almost half of the sample identified residing in metropolitan areas (Beale codes 1-3), 15.8% in non-metro areas with urban influence (Beale codes 4 & 6), 15.1% in non-metro areas with no urban influence (Beale Codes 5 & 7), 6.3% lived in areas that were completely rural with urban influence (Beale Code 8), and 14% lived in completely rural areas with no urban influence (Beale Code 9). The following map shows the distribution of the sample across the state.

FIGURE 1: KENTUCKY COUNTIES REPRESENTED IN THE SAMPLE



Using the Beale Code classification system (Brown, Hines, & Zimmer, 1975) respondents were assigned a geographic region based on urbanicity that provided a descriptor of their county of practice. Respondents represented the following regions:

TABLE 3: URBANICITY FOR THE SAMPLE

County Designation	Percentage
Metropolitan areas	46.6%
Non-Metro with urban influence	15.8%
Non-Metro with no urban influence	15.1%
Completely rural with urban influence	6.3%
Completely rural with no urban influence	14%

Study participants were offered a \$10 incentive for each completed interview or survey, which was estimated to take approximately 45 minutes to complete. All participation was voluntary and it was communicated to the participants that there were no penalties associated with refusal to complete the survey. All protocols were approved by the University of Kentucky Internal Review Board prior to initiation of the study.

Questionnaire

A 95 item questionnaire was used to guide data collection that included several standardized measures

- Parenting Stress Scale (Berry & Jones, 1995)
- Oslo Social Support Scale (Dalgard et al., 2006)
- Child Parent Relationship Scale (Pianta, 1992)
- Pediatric Symptom Checklist (Jellinek et al., 1988)
- Rand Health Survey (Hays, Sherbourne, & Mazel, 1993)
- Items from the Center for Epidemiological Studies- Depression Scale (Radloff, 1977)
- Life-Space Assessment (Peel et al., 2005)
- General questions about health, access, service needs, etc.

FINDINGS

53.1% are caring for children 12 years of age or older

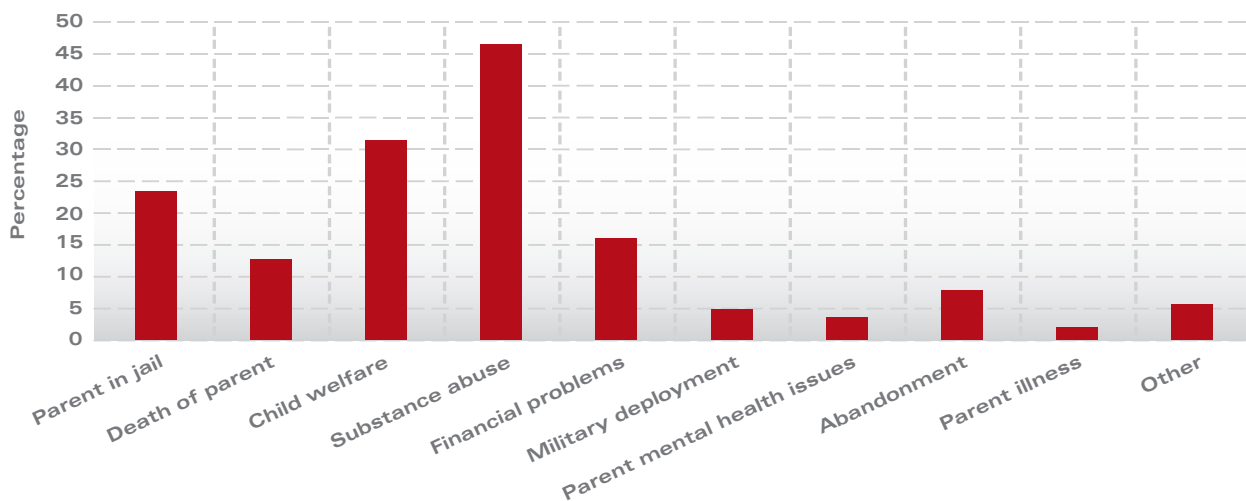
55% are caring for children 6 – 11 years of age

37.8% are caring for children 5 years of age and younger

Child Age and Development

There are unique parenting challenges for grandparents caring for grandchildren across the developmental continuum. Caregivers of children ages 5 years and younger are faced with providing 24 hour care that requires substantial time and energy. Children in this age group experience periods of disrupted sleep, increasing mobility and defiance (the “terrible twos”), along with increased bossy behaviors (American Academy of Pediatrics, 2014). While children between the ages of 6 and 11 gain independence and develop increased reasoning skills and improved self-control, parenting grandparents must also grapple with an increase in testing of rules. Children in this age group may also experience increased anxiety as they become more aware of life events (such as death) and learn to manage social dynamics (DeBord, 1996). Grandparents parenting teens are faced with navigating the physical changes and fluctuations in emotions that result from hormonal changes in this age group (Morgan & Huebner, 2009). Grandparents may see their previously affectionate grandchild become more aloof, moody, and self-focused. This period of developmental is often very stressful for both grandparents and grandchildren as the family adjusts to the teen’s increasing independence from family and reliance on peers.

FIGURE 2: REASONS GRANDPARENTS ARE RAISING GRANDCHILDREN



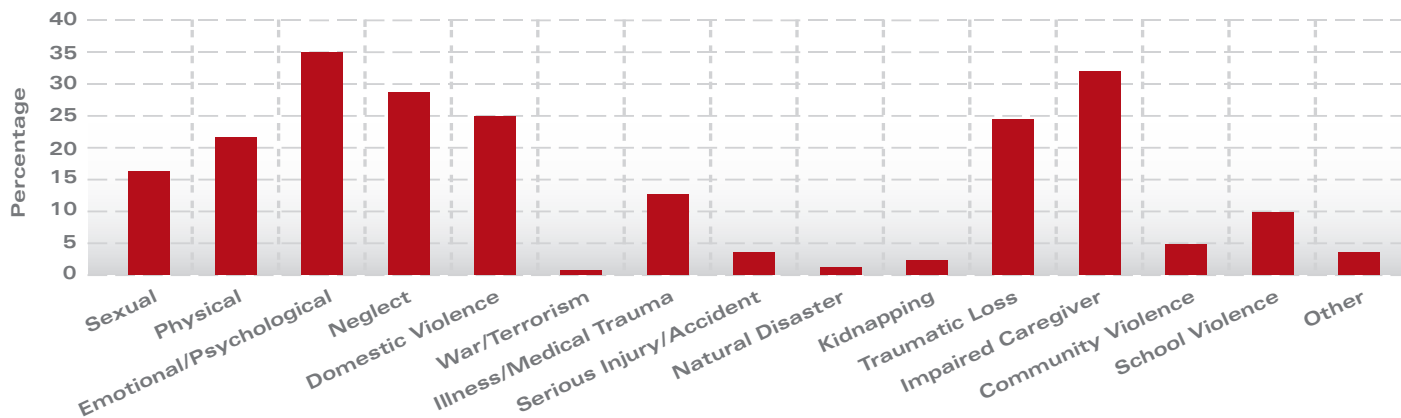
Caregiver substance abuse, child abuse and neglect, intimate partner violence, and parental incarceration all contribute to the need for grandparent led care (Crewe, 2006; Goodman & Rao, 2007; Kropf & Robinson, 2004; Dellman-Jenkins, Blankemeyer, & Olesh, 2002; Hirshorn, VanMeter, & Brown, 2000). In this context, parenting grandparents must cope with a wide range of personal reactions (e.g. loss, disappointment, anxiety) in response to their changing role as primary caregiver, as well as challenges to parenting children with high rates of trauma exposure who may be physiologically and behaviorally dysregulated (Hayslip & Kaminski, 2005; Miltenberger, Hayslip, Harris, & Kaminski, 2004). In Kentucky, parental substance abuse problems, child welfare involvement, and parent incarceration are the predominant pathways to custodial grandparent care.



Trauma Exposure

Participants were asked whether any grandchild in their care had been exposed to a traumatic event in their lifetime. Options of no, yes, suspected or unknown were offered on this item. If the caregiver positively endorsed this item, then they were asked to check all types of traumatic experience that might apply. Options offered on this item included no trauma exposure, sexual maltreatment, physical maltreatment, emotional maltreatment, neglect, domestic violence, war/terrorism/political violence, illness/medical trauma, serious injury or accident, natural disaster, kidnapping, traumatic loss, impaired caregiver, community violence, school violence or other (participant defined category).

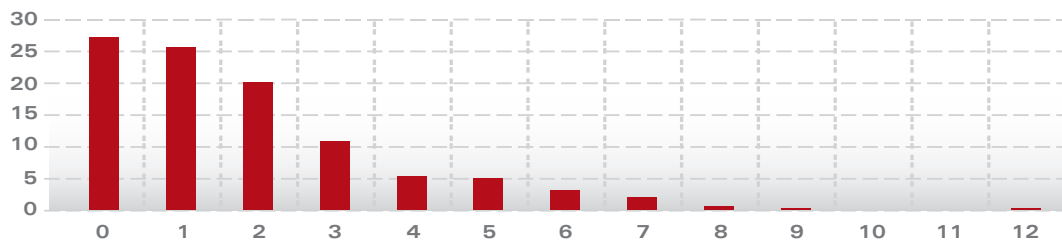
FIGURE 3: KENTUCKY GRANDFAMILIES AND TRAUMA EXPOSURE



Kentucky children living in the care of their grandparents have been exposed to a wide variety of experiences that can lead to trauma-related responses. Identified trauma experiences fell into 15 separate categories, including sexual abuse, physical abuse, emotional abuse, neglect, domestic violence, war/terrorism, medical trauma, unintentional injury/accident, natural disaster, kidnapping, traumatic loss/bereavement, impaired caregiver, community violence, and school violence. An unspecified category was also provided for grandparents to report traumatic experiences for their grandchildren. Responses within this other category included exposure to experiences of parental drug use and parent abandonment.

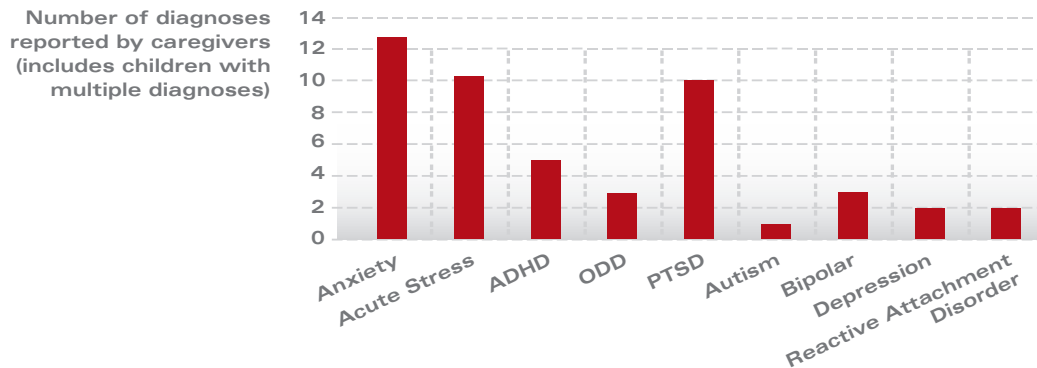
FINDINGS, CONTINUED

FIGURE 4: NUMBER OF DIFFERENT TYPES OF TRAUMA EXPOSURE REPORTED FOR GRANDCHILDREN

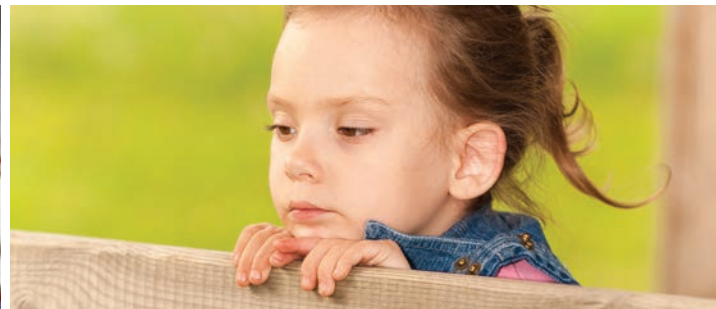


In order to examine the frequency of exposure for the children in the sample, the numbers of different traumatic events endorsed were summed to provide the frequency of exposure to discrete types of events for each child. Almost three-fourths (73.1%) of the children in the study were reported to experience at least one type of traumatic exposure; and 16.5% of the children represented in the sample had four or more trauma exposures, which places them at high risk for adverse lifetime outcomes according to the Adverse Childhood Events Study (Felitti, Anda, Nordenberg, Williamson et al., 1998).

FIGURE 5: CHILD DIAGNOSES



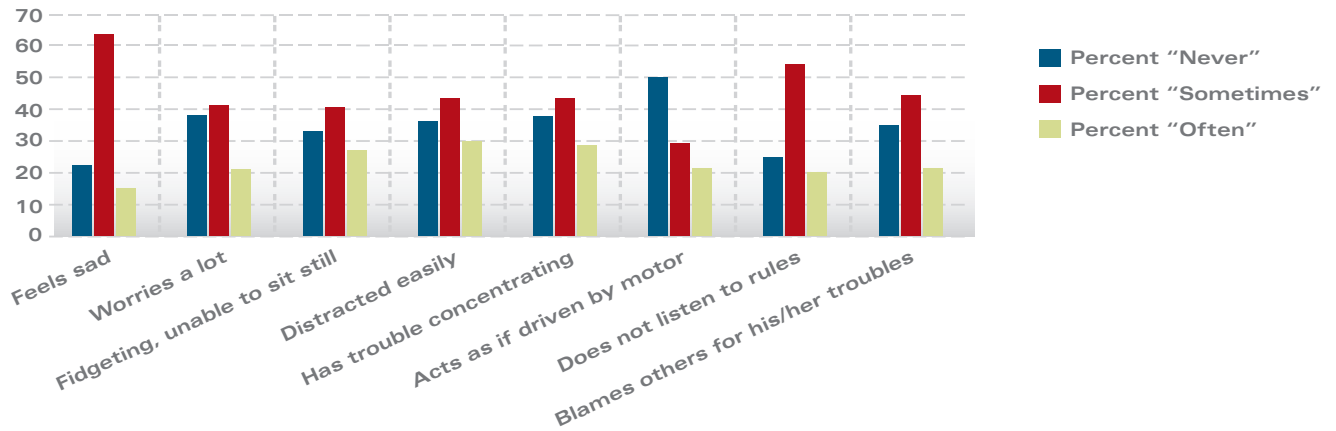
43.7% of grandparents reported caring for a grandchild with a special health or mental health need with 17.4% of grandparents reporting that the child in their care had been diagnosed with a trauma-related disorder. The most common diagnoses reported were Acute Stress Disorder, ADHD, Anxiety Disorder, and Post Traumatic Stress Disorder.



Pediatric Symptoms

Grandparents were asked to describe their grandchildren’s behavioral and emotional status. For each of the following behaviors—worries a lot, fidgets/unable to sit still, distracted easily, has trouble concentrating, acts as if driven by a motor, blames others for his/her troubles—over 20% of grandparents reported that their grandchildren often exhibit the behavior. 62.9% of grandparents identified that their grandchild sometimes feels sad and/or unhappy, with over 40% reporting a grandchild in their care sometimes not listening to rules, feeling down on his or her self, worrying a lot, or having less fun than others.

FIGURE 6: PEDIATRIC SYMPTOMS



Trauma Services

While most grandparents reported that they were able to receive the services needed for their grandchildren, they were least likely to receive the special services for traumatic stress or abuse-related problems (22.7%) or mentoring programs for their children (14.4%). 42.4% of grandparents also reported that they were not able to receive the financial support required to care for their grandchildren. **The most common reasons cited for why they were unable to receive necessary services were that the services were either too expensive, were not available in their community, or they were not sure which services were needed.** Those who listed “other” barriers to access to care for their grandchildren were most likely to cite lack of child support or inability to qualify for necessary services as the reason they were not able to receive services.

“They have been through a lot and I’m not sure that I can get help for them here in our area.”



“{what I need most is} the strength and energy to consistently love, discipline, and interact with these children in the way that is most beneficial for them. I second guess and agonize about how we do things in a way I never did with our own children.”

TABLE 4: THE CHILD-GRANDPARENT RELATIONSHIP

	Total Relationship Score
State Average	21.56

A Child-Parent Relationship Scale (Pianta, 1992) was also utilized to analyze the level of conflict present in grandparent-grandchild relationships. Questions included asking about whether there are struggles in the relationship, degree of comfort with physical affection and impact of relationship on caregiver’s energy level. Higher scores on this measure indicated increased levels of grandparent–child conflicts.

The average total relationship score that grandparents reported for level of conflict with their most challenging grandchild was 21.56 (the maximum was 40). Grandparents reported the most conflict due to their grandchild’s feelings being unpredictable and changing suddenly.

Grandparenting Stress

The Parental Stress Scale was included to measure caregiver stress by assessing positive and negative themes associated with parenting including emotional benefits, self-enrichment, demand on resources and restrictions (Berry & Jones, 1995). Sample items asked respondents to rate whether they strongly disagree, disagree, are undecided, agree or strongly agree with statements such as, “I am happy in my role as a grandparent,” “Having grandchildren is a financial burden,” or “I am satisfied as a grandparent.” A mean score of 37.1 has been established in studies with non-clinical samples (Berry & Jones, 1995).

TABLE 5: LEVELS OF GRANDPARENTING STRESS

PSS Domain	Mean
Parental Satisfaction	10.8
Lack of control	7.4
Parental stressors	16.2
Parental Rewards	19.2
Total	55.26

Grandparents with a child who had been exposed to trauma reported a higher level of parental stress compared to those with a child who had not been exposed to trauma (Parental Stress Scale Score: 56.5 and 53.1, respectively). The mean Parenting Stress Score (55.26) in this sample is lower than those reported by parents of children with severe disabilities (Johnson, Freen, Feetham, & Simpson, 2011), but higher than clinical samples of mothers of children with severe behavioral problems, and those qualifying for special education services (Barry & Jones, 1995). The study findings also indicate Kentucky grandparents experience a higher level of stress as compared to a previous study that examined parenting stress and depression for parenting grandmothers (Rodgers-Farmer, 1999). In this context, the degree of parenting stress in this community sample is noteworthy, and underscores the need for interventions to interrupt the transactional process that creates such family distress.

Social and Instrumental Support

The *Oslo-3 Social Support Scale* was included to measure the presence of social support for grandparents. (Dalgard et al., 2006). Survey participants were asked the following three questions: How many people are so close to you that you can count on them if you have great personal problems (none, 1-2, 3-5, 5 or more)? How much interest and concern do people show in what you do (none, little, uncertain, some, a lot)? and How easy is it to get practical help from neighbors if you need it (very difficult, difficult, possible, easy, very easy)?

On average, participants reported having 2.52 trustworthy supports they could count on if they had great personal problems. On the whole, the average total support score was 9.17 (possible range = 3 to 15), indicating that the caregivers felt they had moderate support from others in their lives.

However, almost half of the grandparents in this study identified being single caregivers, with little weekly interaction with the biological parents of their grandchildren, raising concerns about the level of daily instrumental support available to these caregivers.

Average total support score was **9.17**, indicating that the caregivers felt they had moderate support from others in their lives.

66.4% reported that people showed either some or a lot of concern in what they did

32.7% felt it would be easy or very easy to get practical help from neighbors if they needed it

19.2% reported it would be very difficult to receive help

49.6% reported being single caregivers to their grandchildren

Average of 2 (SD 1.15) children per respondent in care (range 1-7 children per household)

Custodial grandparents interact with their grandchild's biological parent **4.3** hours per week



GRANDPARENTS HEALTH AND WELL-BEING

To access the health status of study participants, an assessment tool called the SF-36, a multi-purpose, short-form health survey was used (http://www.rand.org/health/surveys_tools/mos/mos_core_36item.html). Scores on each health characteristic range from 0-100, with higher scores indicating better health.

Mental Health

Overall, grandparents rated their mental health lower than the general population. In particular, grandparents indicated substantially lower scores on their social functioning (mean score=47.93) compared to the general population (mean score=78.77). Among grandparents, younger grandparents' scores on social functioning were statistically significantly lower than older grandparents' scores. This may be related to the fact that grandparenting may have limited their social activities, and younger grandparents may be more likely to feel social constraints than older grandparents.

TABLE 6: MENTAL HEALTH OF GRANDPARENTS COMPARED TO THE GENERAL POPULATION

		Grandparents		
	General population	All	Younger than 65	65 and older
Vitality, M (SD)	52.15 (22.39)	46.17 (22.84)	45.48 (22.52)	47.82 (23.77)
Social functioning, M (SD)	78.77 (25.43)	47.93 (14.23)	46.91 (14.30)	50.81 (14.06)
Role limitations due to emotional problems, M (SD)	65.78 (40.71)	67.04 (42.43)	68.16 (42.05)	62.61 (44.47)
Emotional well-being, M (SD)	70.38 (21.97)	66.44 (21.31)	67.57 (19.80)	61.63 (24.95)

Physical Health

Overall, grandparents rated their physical health poorer than the general population. In particular, grandparents **indicated substantially lower scores on their physical functioning and pain** (mean scores=60.27 and 41.40, respectively) compared to the general population (mean scores=70.61 and 70.77, respectively). There was no statistically significant difference in physical health between younger and older grandparents.

TABLE 7: PHYSICAL HEALTH OF GRANDPARENTS COMPARED TO THE GENERAL POPULATION

	General population	Grandparents		
		All	Younger than 65	65 and older
Physical functioning, M (SD)	70.61 (27.42)	60.27 (31.39)	61.66 (31.49)	56.20 (30.92)
Role limitations due to physical health, M (SD)	52.97 (40.78)	51.03 (43.42)	53.06 (42.83)	44.79 (44.59)
Pain, M (SD)	70.77 (25.46)	41.40 (28.26)	41.06 (28.90)	43.28 (27.60)
General health, M (SD)	56.99 (21.11)	54.83 (17.00)	55.34 (15.48)	52.78 (20.74)

In addition, grandparents had an average of 2.3 chronic illnesses. The most prevalent chronic illnesses were hypertension (61.8%), arthritis (50.9%), diabetes (30.3%), and heart problems (21.3%).

Vision and Hearing

About 39% of grandparents reported that their eyesight was poor/fair, which was much higher than the report (24.4%) from the nationally representative study on the aging population—Health and Retirement Study (Juster & Suzman, 1995).

About 21.6% of grandparents reported that their hearing was poor/fair; this ratio was similar to the report from the nationally representative aging population, which was 20.5%. However, 8.1% of grandparents reported wearing a hearing aid as compared to 2.9% of the nationally representative aging population.

EASTERN KENTUCKY

In order to understand the needs of Eastern Kentucky grandfamilies, this area of the state was purposely oversampled resulting in 34.9% of the sample representing eastern Kentucky counties.

The rate of trauma exposure for Eastern Kentucky grandchildren was comparable to exposure in other areas of the state (68.6% and 70.2%, respectively). No significant differences were found in either the types of trauma experienced or in the prevalence of trauma-specific diagnoses for grandchildren in Eastern Kentucky and those in other parts of the state.

However, significant differences were found in the presence of special health and/or mental health needs between the two groups with 52% of Eastern Kentucky grandparents identifying caring for a grandchild with a special health or mental health need compared to 37.2% of grandparents in other parts of the state. The high prevalence of trauma exposure for Eastern Kentucky grandchildren and the high rates of reported ADHD diagnoses suggest the presence of a potential overlap between trauma-related symptoms and other types of diagnoses.

Significant differences were also found between the two groups on certain demographic factors. Eastern Kentucky grandparents were more likely to identify Medicaid as their primary form of insurance, were less likely to be married, more likely to be widowed, and reported higher levels of unemployment compared to their counterparts in other areas of the state. Grandparents in other parts of the state were found to have higher levels of education and more frequently endorsed being employed.

TABLE 8: COMPARISON OF DEMOGRAPHICS

Caregiver Demographics	Eastern Ky	Non-Eastern Ky
Avg age	60.5	59.2
Education (in years)***	11.2	12.6
Gender (% female)	87.4	80.5
% with no health insurance	20.8	16.8
% with Medicaid as primary***	31.3	11.7
% married*	34.3	48.6
% divorced or separated*	38.2	28.0
% widowed*	24.5	14.3
% never married*	2.9	9.1
% employed full-time**	10.8	22.1
% retired**	30.4	32.0
% unemployed**	29.4	16.9
% that engage in religious activities weekly	51.5	54.9

*Significant differences found for Eastern Kentucky counties and other parts of the state
 $p \leq .05$, $p \leq .01$ **, $p \leq .001$ ***

Additionally, significant differences were found in the reasons for care for the two groups. Eastern Kentucky grandparents reported higher incidences of grandparent care due to incarceration of a parent and parental substance abuse problems, while grandparents in other parts of the state identified higher prevalence of assuming primary care of a grandchild due to parental financial problems.

TABLE 9: COMPARISON OF REASONS FOR CARE

Reason for Care	Total %	% Eastern Ky	% Non-Eastern Ky
Parent in jail*	23.5	31.1	19.7
Death of parent	12.8	15.5	10.9
Child welfare	31	32	31.4
Substance abuse**	46.1	57.3	40.6
Financial problems	16.2	12.6	19.4
Military deployment**	4.4	0	6.9
Parent mental health issues	3	4.9	2.3
Abandonment	7.4	6.8	7.5
Parent illness	1.7	1	2.3
Other**	5.4	1	8.6

**Significant differences found for Eastern Kentucky counties and other parts of the state
 $p \leq .05$ *, $p \leq .01$ ***

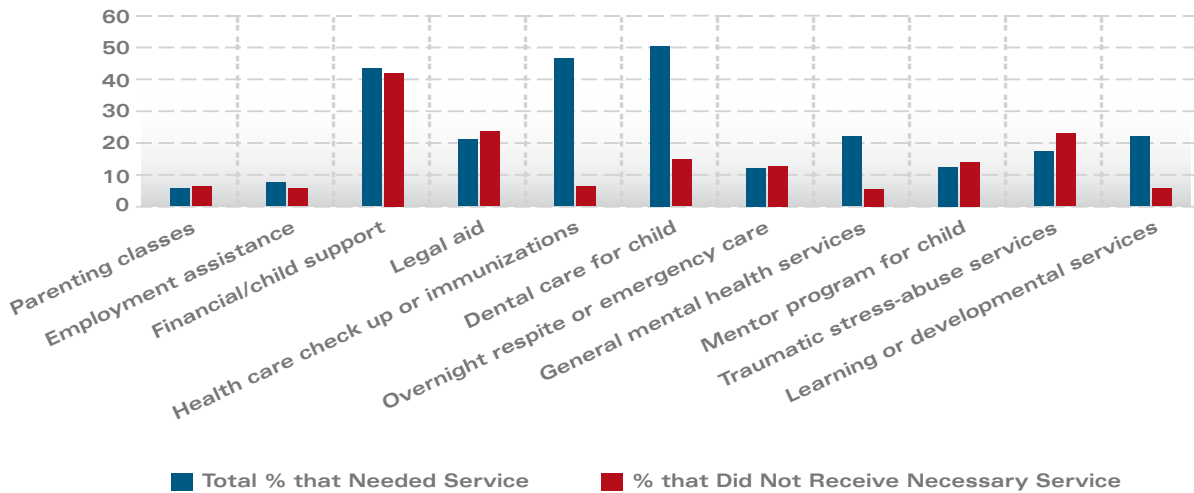


SERVICE NEEDS OF KENTUCKY GRANDFAMILIES

In an effort to better understand the service needs of grandfamilies across the state, respondents were asked to identify services needed for themselves and/or a grandchild within the last year, services needed but not received for the last year, and reasons why services were not received.

83.3% of respondents reported that they had needed at least one type of service in the past year with 46.2% reporting that they were not able to receive a needed service. 22.3% of grandparents reported that they had needed special help for their grandchild’s mental health condition (with 6.1% saying they did not receive the treatment needed), and 16.9% required special services for child traumatic stress or abuse-related problems.

FIGURE 7: NEEDED SERVICES

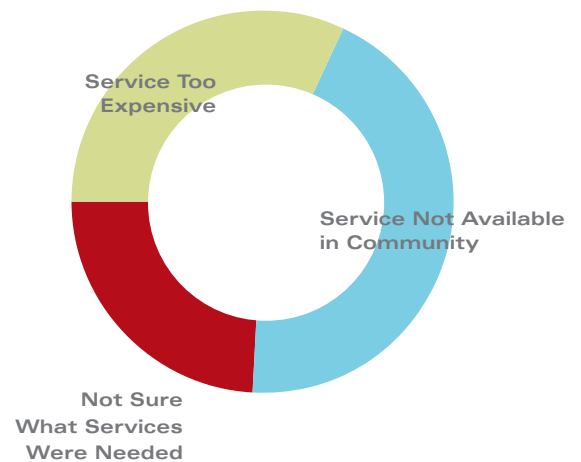


Outside of trauma related services, caregivers most needed financial/child support, health care, dental care, legal aid, overnight emergency care, mentoring programs, and special help for learning or developmental problems for their children.

While most grandparents reported that they were able to receive the services needed for their grandchildren, **they were least likely to receive the special services for traumatic stress or abuse-related problems** such as legal assistance, and financial aid or child support.

The most common reasons cited for why they were unable to receive necessary services were that the services were either too expensive (26.5%) or were not available in their community (36.1%), or they were not sure which services were needed (19.7%).

BARRIERS TO NEEDED SERVICES



SUMMARY

Summary – The Children

- High rates of trauma exposure are found for Kentucky children receiving primary care from a grandparent. Trauma is mostly interpersonal violence, though there is evidence that there is a shortage of trauma-informed care being provided in some areas (Sprang, Craig, & Clark, 2008).
- Almost half of survey respondents identified caring for a grandchild with more than one trauma exposure, 16.5% of the sample met the threshold identified by ACE study as indicating high risk for poor adult outcome.
- A third of the grandparents in the study are parenting very young children (5 or under), who have had a caregiving disruption at a critical stage of development. Disruptions in attachment and/or insecure attachment relationships can confound healthy adaptation throughout life.
- Over half of the respondents in Eastern Kentucky are caring for children with special health or mental health needs. This region of the state may be under-resourced to serve these needs.

Summary – The Grandparents

- 37% -57% of grandparents report health problems that impact their activities of daily living. Many cite pain as affecting mobility, energy and interactivity with others.
- Grandparent pain and child mental health issues may be primary issues impacting the child-caregiver relationship and grandparenting stress.
- Grandparenting stress is within the moderate range. 14% say they are not sure they would assume custody of grandchildren if they had to do it over again.
- A high percentage of single caregivers suggests the need for supplemental support services will be significant.
- 42% cite unmet financial needs.

Summary – The Context

- These children have exposure to negligent caregiving, poor supervision, and exposure to disinhibited and impulsive adults (while in biological homes). This impacts current behavior and presents significant caregiving challenges. For example, substance misuse/dependence by adult children is a primary reason for placement in the grandparent's home. A third of the cases necessitated child welfare involvement. A quarter of these parents are in jail.
- The conditions that led to care disqualify the biological parents as adjunctive or supportive caregivers to parenting grandparents.
- There is a lack of awareness of or deficit in specialized services to treat child traumatic stress and child abuse in many communities. Confidence in service providers to address the needs of children in care of their custodial caregivers is lacking in some areas.
- Findings suggest geographic concerns for Eastern Kentucky grandfamilies. These children are more likely to be in care due to parent incarceration and substance misuse, raising concerns about the availability of traumatic grief services in the area.

SUMMARY

A Call to Action:

- Relational interventions for grandparents should be integrated with trauma care and perhaps with services they are already receiving. Faith-based services may be helpful in meeting this need — consider faith based services (53% reported using faith-based services and 65% attend a place of worship weekly).
- Specialized services for child traumatic stress and abuse related problems are needed to address the reasons these children are in the care of the grandparents.
- ADHD evident at rate of 3 to 1 in Eastern Kentucky suggest a need to consider overlap with trauma conditions and comorbidity and misdiagnosis. Training of mental health providers on the importance of providing a trauma assessment may lead to diagnostic clarity.
- Psychoeducation/safety skills training is needed regarding biological parent substance abuse.
- Results suggest a high need for support and respite care, but less than 15% identified this as a need. The impact of cultural and financial reasons on this area of need should be considered.
- Some evidence that grief related psycho-education in schools may be effective- may be a vehicle for addressing need in Eastern Kentucky.
- Policies are needed that address financial strain experienced by custodial grandparents (i.e. re-instatement of kinship programs or the development or revision of programs that address financial needs specific to this population).
- Increase the availability of legal aid for grandparents who need assistance keeping children safe from biological parents. Also, the provision of education for grandparents to help raise knowledge of the legal processes involved in custody issues.
- The respondents represent a group of adults who have taken on the significant responsibility of raising their grandchildren, resulting in a situation where their own needs become subordinate. For example, being a custodial grandparent may “accelerate the aging process” — grandparents may neglect their own health and suffer from chronic and/or acute pain unnecessarily. Therefore attention to caregiving stressors, and the impact of this new role on overall health and well-being is indicated during health care visits.
- Health professionals working with grandparents need to pay attention to their access to health care, medication compliance and provide pain management services, especially non-pharmaceutical pain management strategies.

References

- Alicis, E., Jongman, M. J., van Wesel, F., & Kleber, R. J. (2011). Building on Child Trauma Theory Across Longitudinal Studies: A Meta-Analysis. *Clinical Psychology Review*, 31, 736-747.
- American Academy of Pediatrics (2014). Retrieved from: HealthyChildren.org.
- American Community Survey (2005). Retrieved from: <http://www.census.gov/acs/www/>
- Berry, J. O., & Jones, W. H. (1995). The Parental Stress Scale: Initial Psychometric Evidence. *Journal of Social and Personal Relationships*, 12, 463-472.
- Briere, J., Kaltman, S., & Green, B. L. (2008). Accumulated Childhood Trauma and Symptom Complexity. *Journal of Traumatic Stress*, 21(2), 223-226.
- Brown, F. K., Hines, D. L., & Zimmer, J. M. (1975). *Social and Economic Characteristics of the Population in Metro and Nonmetro Counties*, 1970. Agricultural Economic Report No. 272. Washington, DC: U.S. Department of Agriculture Economic Research Service.
- Crewe, S. E. (2006). Different Pathways to a Common Destiny: Grandparent Caregivers in the District of Columbia. *Journal of Health and Social Policy*, 22(3-4), 199-214.
- Dalgard, O., Dowrick, C., Lehtinen, V., Vazquez-Barquero, J., Casey, P., Wilkinson, G. et al. (2006). Negative life Events, social support, and gender differences in depression: A multinational community survey with data from ODIN study, *Social Psychiatry Psychiatric Epidemiology* 41, 6, 444-451.
- DeBord, K. (1996). Childhood Years: Ages six through twelve. North Carolina Cooperative Extension Service.
- Dellman-Jenkins, M., Blankemeyer, M., Olesh, M. (2002). Adults in Expanded Grandparent Roles: Considerations for Practices, Policy, and Research. *Educational Gerontology*, 28, 219-235.
- Feldman, R., & Vengrober, A. (2011). Posttraumatic Stress Disorder in Infants and Young Children Exposed to War-Related Trauma. *Journal of the American Academy of Child and Adolescent Psychiatry*, 50(7), 645-658.
- Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V.,...Marks, J. S. (1998). Relationships of Childhood Abuse and Household Dysfunction to many Leading Causes of Death in Adults: Adverse Childhood Experiences (ACE) Study. *American Journal of Preventative Medicine*, 14(4), 245-258.
- Goodman, M. R., & Rao, S. P. (2007). Grandparents Raising Grandchildren in a US-Mexico Border Community. *Qualitative Health Research*, 17, 1117-1136.
- Hays, R. D., Sherbourne, C. D., & Mazel, R. M. (1993). The Rand 36-item Health Survey 1.0 *Health Economics*, 2, 217-227.
- Hayslip, B., & Kaminski, P. L. (2005). Grandparents Raising Grandchildren: A Review of the Literature and Suggestions for Practice. *The Gerontologist*, 45(2), 262-269.
- Hirshorn, B., VanMeter, J. V., & Brown, D. R. (2000). *When Grandparents Raise Grandchildren Due to Substance Abuse: Responding to a Uniquely Destabilizing Factors*. New York: Springer.
- Hunt, D., Kuck, S., & Truitt, L. (2006). Methamphetamine Use: Lessons Learned, Document 209730. Washington, DC: U.S. Department of Justice.
- Jellinek, M. S., Murphy, J. M., Robinson, J., Feins, A., Lamb, S., & Fenton, T. (1988). The Pediatric Symptom Checklist: Screening School-Age Children for Psychosocial Dysfunction. *Journal of Pediatrics*, 112, 201-209.
- Johnson, N., Frenn, M., Feetham, S., & Simpson, P. (2011). Autism Spectrum Disorder: Parenting Stress, Family Functioning, and Health-Related Quality of Life. *Families, Systems and Health*, 29(3), 232-252.
- Juster, F. T., & Suzman, R. (1995). An overview of the Health and Retirement Study. *Journal of Human Resources*, S7-S56.
- Kropf, N. P., & Robinson, M. M. (2004). Pathways into Caring for Rural Custodial Grandparents. *Journal of Intergenerational Relationships*, 2(1), 63-77.
- Miltenberger, P., Hayslip, B., Harris, B., & Kaminski, P. (2004). Perceptions of the Losses Experienced by Custodial Grandfathers. *Omega: Journal of Death and Dying*, 48, 245-262.
- Morgan, E., & Huebner, A. (2009). Adolescent Growth and Development. Virginia Cooperative Extension, Publication 350-850. Virginia Polytechnic Institute and State University.
- Ozcol, H., Zucker, M., & Spinazzola, J. (2011). Pathways to Aggression in Urban Elementary School Youth. *Journal of Community Psychology*, 39(6), 733-748.
- Peel, C., Baker, P. S., Roth, D. L., Brown, C. J., Bodner, E. V., & Allman, R. M. (2005). Assessing Mobility in Older Adults: The UAB Study of Aging Life-Space Assessment. *Physical Therapy*, 85(10), 1008-1019.
- Pianta, R. C. (1992). *The Child-Parent Relationship Scale*. Charlottesville: University of Virginia Press.
- Radloff, L. S. (1977). The CES-D Scale: A Self-Report Depression Scale for Research in the General Population. *Applied Psychological Measurement*, 1(3), 385-401.
- Rodgers-Farmer, A. Y. (1999). Parenting Stress, Depression, and Parenting in Grandmothers Raising their Grandchildren. *Children and Youth Services Review*, 21(5), 377-388.
- Sprang, G., Craig, C., & Clark, J. (2008). Factors Impacting Trauma Practice Patterns: The Convergence/Divergence of Science and Practice. *Journal of Anxiety Disorders*, 22, 162-174.
- Sprang, G., Staton-Tindall, M. & Clark, J. (2008). Trauma Exposure and the Drug Endangered Child, *Journal of Traumatic Stress*, 21, 1-7.
- U.S. Census Bureau (2004, 2005, 2006). Retrieved from: <http://www.census.gov/>



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