GRANDPARENT CAREGIVERS: FACTORS CONTRIBUTING TO THEIR EXPERIENCE OF LIFE SATISFACTION

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ABSTRACT

Globally, the number of grandparents providing primary, custodial, or co-parenting for biological and legal grandchildren has grown progressively. Often time examination of grandparent caregiving occurs through the lens of burden and deleterious familial, psychological, and medical outcomes. The present cross-sectional research study is a preliminarily exploration of factors that promote grandparent experience of positive life satisfaction.

Bivariate research findings supported an association between grandparent caregivers’ experience of positive life satisfaction and reported resources ($r(94) = .51; p = .000$), choice to parent ($r(94) = .26; p = .006$), and spirituality ($r(94) = .214; p = .019$). Because life satisfaction scores were reversed, the outcome indicated higher life satisfaction is associated with higher reported resources, choice to parent, spirituality, and parental stress. Social support ($r(94) = .093; p = .375$) and parental stress ($r(94) = .181; p = .081$) did not demonstrate significant relationships. Multiple Regression Analysis (MRA) found reported resources ($\beta = .45$) and choice to parent ($\beta = .21$) were the strongest predictors of grandparent caregivers’ positive life satisfaction ($F(2, 91) = 26.54, p < .001$). However, MRA with caregiver satisfaction interaction terms did not contribute significantly to the model ($F(2, 91) = 26.54, p < .001$).

Study findings evidenced grandparent caregivers experienced positive life satisfaction when they engage in spiritual practices; perceive reduced stress, choice in parenting, adequate personal, social, and familial resources to meet life demands. Implications for social work
practice, policy, and research are offered that build on grandparent caregivers’ adaptability, capabilities, and strengths rather than deficits.
DEDICATION

I dedicate this dissertation to my mother, Ophelia Coleman. She was a formidable, spiritual, determined, loyal, and loving person. She taught me to have a firm and abiding love for God, family, friends, learning, community, and fun. She impressed on me the importance of making my words and behavior match. She often said, “Freda, your word is your bond.” She challenged me to stretch myself beyond my comfort zone. Thanks momma for pouring into me a love of books. As usual, you were right; reading did open the world to me with all its infinite possibilities.

'Come to the edge', [s]he said.
They said, 'We are afraid'
'Come to the edge', [s]he said
They came
[S]he pushed them... and they flew.

By: Guillaume Apollinaire, Poet
LIST OF ABBREVIATIONS AND SYMBOLS

$a$ Cronbach’s index of internal consistency

$df$ Degrees of freedom: number of values free to vary after certain restrictions have been placed on the data

$F$ Fisher’s $F$ ratio: A ration of two variances

$M$ Mean: the sum of a set of measurements divided by the number of measurements in the set

$p$ Probability associated with the occurrence under the null hypothesis of a value as extreme as or more extreme than the observed value

$r$ Pearson product-moment correlation

$r_s$ Spearman’s rho

$t$ Computed value of $t$ test

$<$ Less than

$=$ Equal to
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CHAPTER 1 - INTRODUCTION

Background

Over the course of our specie’s social existence, grandparents have performed in various capacities that contribute to the functioning of families. Those roles exist on a continuum from support of parental functioning to custodial parenting (Dunifon and Bajracharya, 2012). All are vital roles, but none more so than grandparents who assume parental responsibility for their grandchildren. Worldwide there is a growing shift in the role of grandparents to that of primary caregivers propelled by social, economic, and political change along with extended life expectancy associated with improved medical and sanitation practices.

Over the last 30 years in the United States, the number of grandparents living with grandchildren, raising grandchildren as co-parenting, primary, or custodial parents has grown significantly. Presently, approximately 10% of all children in the United States living with one or more grandparents in multigenerational homes (U.S. Census Bureau, 2010a). In 2011, grandparents and great-grandparents provided primary or custodial care for about 4% of all children in the U.S. (Livingston, 2013).

Grandparent caregivers elect to provide safe, supportive, and nurturing homes for children who otherwise would be in other forms of alternative care. Challenges and rewards accompany the assumption of the primary grandparent caregiver role. Substantial content exists within the literature concerning challenges and negative outcomes for this population. By contrast, limited investigation of grandparent caregivers’ positive experience is evidenced in the
literature. More specifically, there is scant research on contributors to primary grandparent caregivers’ experience of positive life satisfaction/ well-being in circumstances that are often complex, difficult, and fraught with personal, interpersonal, and societal obstacles.

Grandparent caregivers are not a heterogeneous group. They are found in all income levels, racial, and ethnic groups, and range in age from the early thirties to over eighty-nine years old (U.S. Census Bureau, 2010a). The majority of grandparent caregivers are non-Hispanic Caucasian (51%), African American (22%), Hispanic/ Latino (20%), and Asian (3%). For grandchildren primarily cared for by grandparents, approximately 39% are White, 26% African-American, 25% Latino/Hispanic, and 3% Asian (Livingston, 2013). Research findings note significantly more negative outcomes for grandparents raising grandchildren who belong to ethnic/ racial minority groups such as Indian, Alaskan Native, African American, and Hispanic/ Latino than their White counterparts (Keene, Prokos, and Held, 2012).

Historically, racial/ ethnic minorities encounter political, economic, and social barriers with deleterious economic status, health, education, and housing impacts. Often, African American, Native Americans, Latino/ Hispanic American grandparent-headed households are single female-headed. Generally speaking, they have less formal education, live in poverty, and experience poorer health outcomes than Caucasian grandparent-headed families (Livingston, 2013). Subsequently, grandparent caregivers who are members of racial and ethnic groups are at, even, greater risk to be overburdened than their Caucasian counterparts. These challenges further stress an already tenuous grandparent-headed family system (Chase-Goodman and Silverstein 2006).

A number of studies focus on older, single (60 years >) grandparent caregivers (Bertea and Crewe, 2013; Bullock, 2005; Collins, 2011; Keene, Prokos, and Held, 2012; Marken and
Howard, 2014, Yancura, 2012). However, the majority of grandparent caregivers are middle-aged. Approximately 52% of grandparent caregivers are below 52 years old, 31% are between the ages of 55 and 64, and 17% are over age 65, with the mean age of grandparent caregivers being 60 years old (U.S. Census, 2009). Grandparent-headed families average 2.2 children living in the home five or more years with the majority of grandchildren in their care being below 11 years old; 51% of the grandchildren in these families are younger than six, 29% between 6 -11, 20% between 12 and 17 years old (U.S. Census, 2009). The above statistics indicate grandparent caregivers often navigate multiple developmental stages simultaneously: rearing grandchildren, biological children, caring for older relatives, and managing personal developmental tasks.

About 60% of grandparent caregivers are in the workforce with about 19% of grandparent caregivers living in poverty (U.S. Census Bureau, 2010b). Despite frequently identifying economic challenges (Leder, Nicholson-Grinstead, and Torres, 2007), grandparents raising grandchildren are more likely to cease working outside of the home to raise their grandchildren than grandparents who primarily operate in a supportive capacity (Generations United, 2008). The importance of providing stable, supportive family life appears to outweigh economic well-being. As a result, a number of grandparent caregivers (2.2 million) experience reduced or limited earning potential, which creates economic insecurity (U.S. Census Bureau, 2010).

Although there are tremendous challenges encountered by grandparents raising grandchildren, grandparents step in to provide safety, stability, nurturance, and connection to the extended family, for biological and legal grandchildren (Shakya, Usita, Eisenberg, Weston, and Liles, 2012). Moreover, regardless of known stressors, some caregivers perceive the experience as extremely rewarding, adding to the quality of their life, and in some instances more rewarding
than stressful (Ruiz and Silverstein, 2007). This is not the predominantly documented experience of grandparents raising grandchildren but worthy of further investigation.

However, further research concerning contributors to grandparent caregivers’ experience of positively life satisfaction is warranted. Why? Because, research into this area holds potential to augment existing research knowledge and practice behavior with this population. Results of such research lends itself to the development of research-based strategies and interventions that directly improve grandparent caregivers’ experience of life satisfaction. Additionally, outcomes may support the crafting of empowerment practice efforts that specifically educate and train social workers to promote specific factors evidenced to enhance grandparent caregivers’ positive well-being.

To this end, the present study examined contributors to grandparent caregivers experience of positive live satisfaction in the midst of known caregiver stressors. The study focused on primary grandparent caregivers in the United States, specifically in the Northwest area of Alabama. Extensive research exists on grandparent caregivers as an at-risk group and provides a well-researched foundation to understand the challenges faced by this group. While this study acknowledges the complex challenges encountered by grandparent caregivers, it departed from the examination of grandparent caregivers from a deficit or negative outcomes model. Rather, the study examined the factors that contribute grandparent caregivers’ experience of positive life satisfaction in the midst of known stressors.

**Scope of the Problem**

The literature documents and describes the complex socio-cultural political factors which have multidimensional impacts on grandparent caregivers, grandchildren, biological parents, and the extended family (Hayslip and Goodman, 2007, Longoria, 2010; Poehlman, 2003). Within
these families, there are socio-cultural, ethnic/racial, and gender differences (Bullock, 2005; Chase-Goodman, 2007; Minkler and Fuller-Thomson, 2005; Hayslip and Kaminski, 2005; Ruiz, 2008). A commonality among grandparent caregivers is that the transition from grandparent to primary grandparent or custodial caregiver, frequently, arises out of family crises and provokes interfamilial conflict (Livingston, 2013). As a result, grandparents caregivers are often challenged to manage social, emotional, psychological, economic stressors as they function as primary parents and co-parents to their grandchildren.

In addition to personal stressors, grandparent caregivers are simultaneously navigating accessing complicated community resource systems as well as attending to their grandchildren’s behavioral, psychological, and developmental issues (Hayslip, Blumental, and Garner, 2014; Kolomer and McCallion, 2005). The aforementioned issues are associated with several negative outcomes for grandparents raising grandchildren, which include decreased social interaction with peers, social isolation, economic instability, depression and lowered life satisfaction (Goodman and Silverstein, 2002; Hayslip and Hicks-Patrick, 2005; Leder, Nicholson-Grinstead, Torres, 2007; Musil, Gordon, Warner, Zauszniewski, Standing, and Wykle, 2010). Clearly, a substantial body of research exists on contributors to adverse outcomes for grandparent caregivers (e.g., psychological distress, poor health, extended family discord, poverty, economic distress).

However, there is a paucity of literature on the factors that contribute to the positive well-being and life satisfaction of primary grandparent caregivers (Dunifon and Bajracharya, 2012; Chase-Goodman, 2012; Kelly, Whitley, and Sipe, 2007). Given the significant number of grandparent caregivers providing primary care for grandchildren in the midst of numerous challenges, examination of what supports positive life satisfaction for grandparent caregivers has
the potential to explicate their strengths and adaptability to commonly encountered stressors. Therefore, the problem this study seeks to investigate is factors that enhance life satisfaction for primary grandparent caregivers. Specifically, this study seeks to examine the association of choice to parent, parental stress, spirituality, social supports, resources, and cognitive appraisal with primary grandparent caregivers’ experience of positive life satisfaction.

**Problem Statement**

When functioning as primary caregivers for their grandchildren, grandparents may experience this circumstance on a continuum from diminishing well-being to increasing it. The literature routinely addresses contributors to negative grandparent caregiver well-being, but offers limited research concerning factors that contribute to the grandparent caregivers’ experience of positive well-being or life satisfaction.

**Purpose of the Study**

The study examined primary non-custodial and custodial grandparent caregivers’ cognitive appraisal, choice to parent, parental stress, spirituality, social supports, and resources when assuming the parental role, as it relates to their experience of positive subjective well-being, specifically life satisfaction. The study’s goals were twofold: (1) to add to the existing body of research to narrow the gap regarding contributors to positive grandparent caregiver well-being and (2) to develop empowerment-focused practice strategies and interventions to support positive grandparent caregiver well-being.

**Study Aims**

The significant role grandparent caregivers play in the lives of their grandchildren along with the contributors to their diminished life satisfaction is well explicated in the literature. More recently, there is a growing body of research on grandparent caregivers’ positive well-being that
primarily focuses on stressors, coping strategies, and psychological well-being (Sampson, and Hertlein, 2015; Smith and MacDolbin, 2013). However, the factors associated with grandparent caregivers’ experience of positive subjective well-being, specifically life satisfaction, is understudied (Sands, Goldberg-Glen, and Thornton, 2005). In particular, how the factors of cognitive appraisal, parental stress, spirituality, social supports, reported resources, and choice to parent contribute to grandparent caregivers’ positive subjective well-being.

It is important to understand contributors to grandparent caregivers’ satisfaction with life because it supports caregiver wellness and healthy family functions (Sands et al., 2005). To further that end, the proposed study explored to what extent cognitive appraisal, choice to parent, social supports, resources, spirituality, and parental stress were associated with grandparent caregivers’ experience of positive life satisfaction.

The study sought to expand the existing research knowledge base about grandparent caregivers regarding their experience of positive life satisfaction when operating in a primary parental capacity. Increasing understanding of grandparent caregivers as capable and adaptive caregivers who experience positive outcomes from their experience supports a strengths-based/empowerment perspective rather than a deficit model.

As stated earlier, limited research exists about contributors to positive grandparent caregiver well-being. The majority of such research utilized qualitative approaches. Quantitative studies on the topic frequently use cross-sectional and non-experimental designs, and employed non-probability sampling methods that limit generalizability of findings. The remainder of this chapter addresses the study’s research questions, hypotheses, theoretical and conceptual underpinning, significance to social work, and definitions of terms.
Theories and Conceptual Framework

Grandparent caregivers experience the same individual and family developmental life challenges as parents and grandparents who are not caregivers (Shlomo, 2014). In addition, they experience stressors and demands specific to grandparents raising their grandchildren. As established earlier, family crises, parental stressors/demands, and family conflicts encountered by grandparent caregivers frequently result in adverse psychological, health, economic, and social outcomes. A considerable body of work exists concerning The Resiliency Model of Family Stress, Adjustment, and Adaptation (McCubbin and McCubbin, 1996), Cognitive Theory of Stress and Coping (Lazarus and Folkman, 1984), and Choice Theory (Glasser, 1998). A discussion of the aforementioned model and theories’ relevance to grandparent follows.

Concepts from the above noted theories have applicability and relevance to examine and understand grandparent caregivers experience of positive well-being in the midst of adverse life circumstances. For the purposes of this study proposal, Figure 1 summarizes the conceptualization of the relationships among choice to parent, social supports, resources, parental stress, cognitive appraisal, and grandparent caregiver life satisfaction. To explicate the differences in the experiences in well-being, I offer aspects of the three theories. First, the Resiliency Model of Family Stress, Adjustment, and Adaptation (McCubbin and McCubbin, 1996), which focuses on individual and family resilience in response to stressful events and situations. The model posits individuals have varying responses to stress from maladaptive to bonadaptive with the resulting outcomes impacting life satisfaction.

Next, the Cognitive Theory of Stress and Coping (Lazarus and Folkman, 1984) contributes further to the conceptual framework by adding cognition or the individual’s perception of an event of stress. The theory posits the individual’s experience of well-being
relates to their thoughts about the stress or challenge in a given situation. And, the individual’s appraisal of the availability and assessibility of personal resources and social supports to address the stressful event. Choice Theory (Glasser, 1998) offers a volitional component. It suggests the extent the individual believes they have control over making life choices impacts his or her experience of well-being/life satisfaction. Concepts from these theoretical frameworks can be used to understand grandparent caregivers’ experience of positive well-being/life satisfaction. Explanation of relevant concepts from each theory and their use in this study will be provided in the sections that follow.

**Resiliency Model of Family Stress, Adjustment, and Adaptation**

Over the last 30 years, there has been a growing body of literature and research on family stress, resilience, and coping theories. The origin of these theories and associated models began early in the 1920s with the examination of the individual’s adaptive response to trauma and crisis. Over time, research focus expanded into assessment and intervention models concerning family adaptability, adjustment and resilience under adverse circumstances. Family Stress Theory is a developmental theory that posits through inevitable life difficulties individuals and families develop protective capabilities, and strengths (McCubbin, and McCubbin, 1989). The theory shifts the focus of examination of and interventions for families from their deficits to challenges and protective factors they have under adverse circumstances.

McCubbin and McCubbin’s (1996) Resiliency Model of Family Stress, Adjustment, and Adaptation emanates from stress theory and offers a framework to examine grandparents raising grandchildren. Extensively used in nursing, family science, military and developmental psychology research, the model supports the resilience and functionality of grandparents raising grandchildren rather than concentrating on deficits. It provides a framework to understand how
and why resilient adaptation are found in certain families but not in others, when placed under significant stress related to various health and situational crises (McCubbin and Patterson, 1983; Beardslee et al., 2011).

A central tenet of the model is that individual and family demands result in a change in the family system. Adjustment occurs in the first phase of the model as a response to demands on the individual and family. McCubbin and McCubbin (1996) found socio-demographic and contextual factors influence well-being. An array of variables interact with each other and determine the type of family adjustment and adaptation: stressor(s), family functioning, resources, stressor appraisal, coping strategies, and problem-solving skills. Subsequent to adjustment is adaptation with two possible responses, bonadaptation and maladaptation. “Bonadaptation - references balance and harmony in the families’ experience of well-being, community relationships, spirituality, and interpersonal relationships; maladaptation denotes imbalance and disharmony …. and a return to crisis when demands are placed on the individual or family” (Weber, 2011, p. 180).

Application of the model to grandparent caregivers has potential to explicate the differences in caregivers’ response to demands/ crises. For instance, for some caregivers, crises may provoke negative outcomes, but others demonstrate coping, adaptation, and positive well-being. The model supports grandparent caregivers’ ability to respond effectively to parenting at an unexpected age. Grandparent caregivers who report life satisfaction/well-being note they experience a sense of purpose, reduced anxiety, and positive reward from caregiving (Hayslip and Patrick, 2003). Minkler and Fuller-Thomson (2005) found grandparent caregivers make a number of adaptive shifts to cope with family stressors. They concluded these shifts are vital to caregiver and family adaptivity. Moreover, grandparent caregivers’ ability to make adaptive
shifts is supported by the grandparent caregiver and family members’ ability to positively perceive personal resources, the family systems’ established internal resources, and the use of a social support network.

**Cognitive Theory of Stress and Coping**

Cognitive appraisal refers to an assessment process where an individual assigns meaning to a situation or challenging event (Levy-Shiff, Dimitrovsky, Shulman, and Har-Even, 1998). The Cognitive Theory of Stress and Coping defines transactional processes of stress and coping, which take into account stressors produced by the environment, the individuals’ subjective cognitive appraisal of the meaning attached to stressors, and the individual’s coping mechanisms (Lazarus, 1993). It explains the differential experience of stress, the specific event, the resulting psychological distress, and the psychological resources the individual perceives as required to cope with the event.

Cognitive appraisal of stress occurs through two interconnected processes: primary appraisal – initial evaluation of an event where it is assessed as negative (stressor), positive (challenge), or irrelevant; secondary appraisal – determining whether the individual possesses the abilities and psychological resources to cope with the event (Lazarus and Folkman, 1984). The processes above are iterative rather than independent and sequential. Several theorists have developed models concerning cognitive appraisal. For the purposes of this research, Lazarus and Folkman’s model will serve as one of the conceptual underpinnings of this research study.

Lazarus and Folkman’s (1984) seminal work on stress, coping, and cognition appraisal suggests that meaning results from the person’s assessment of events in their everyday life. Stress is defined as an event or circumstance that exceeds personal resources and affects well-being. Further, the model suggests an individual’s experience of stress is influenced by cognitive
appraisal, coping strategies, and coping resources (e.g. social supports), which can “assist a person in achieving positive outcomes” (Plant and Sanders, 2007, p. 110). The individual’s assessment of change to the personal environment influences the perceptions of well-being.

A search of the literature offers various applications of Lazarus and Folkman’s stress, coping, and cognition theory in several areas: parents of disabled children (Plant, and Sanders, 2007), caregivers of the elderly (Brain, Henderson, Tyndel, Bankhead, Watson, Clements, and Austoker, 2008) psychological adjustment to chronic medical conditions (Liu, Fearer, Dwyer, Shaffer, Wright-Pinson, 2009), combat exposure (McCuaig-Edge and Ivey, 2012), and grandparent caregivers (Sands et al., 2005). Concepts of the theory support the significance of cognitive appraisal, social supports, and the utility or resources to explicate grandparent caregivers’ parenting stress as well as life satisfaction/ well-being. Specifically, grandparent caregivers’ perception of having the resources and supports to provide meaningfully for their grandchildren may lend itself to a sense of accomplishment and satisfaction with life. These positive perceptions may mitigate or reduce the experience of parental stressors and increase life satisfaction.

Sands, Goldberg-Glen, and Thornton’s (2005) research concerning stress and positive subjective well-being demonstrates the application of the models’ concepts to grandparent caregivers. The study proposed a relationship exists between cognitive appraisal of stress, sociodemographic variables, resources, and grandparent caregiver’s life satisfaction with the parenting role. In the study, measuring perception of grandparent stress occurred via an amended scale created by Perlin and Schooler (1978) that asked, “When you think of your experiences as a grandparent who is raising your grandchild(ren) how (worried, frustrated, tense, bothered, or upset, unhappy, emotionally worn out, and unsure of yourself) do you feel?” (Sands et al, 2005,
The measure required asking the question sentence seven times (Cronbach Alpha = .84). And, each time a new adjective was inserted from the list above. Grandparent caregivers rated each statement on a scale from (1) not at all to (4) a great deal.

The investigators created a scale to measure informal social supports and community resources. The measurement of grandparent caregiver life satisfaction resulted through the use of the Lawton’s Valuation of Life Scale (Cronbach alpha = .79) (Lawton, Moss, Kleban, Ruckdeschel, and Winter (2001). Outcomes of the study indicated grandparent caregivers experienced life satisfaction when they perceived parenting as beneficial for the grandchild and meaningful for themselves. Additionally, the perception of adequate social supports and resources contributed to positive subjective well-being.

According to McDowell (2010), well-being “is perceived through filters of personality, cognitive, and emotional judgment, [implying] positive self-appraisal” (p. 47). Extending this conception of well-being to grandparent caregivers, their cognitive appraisal of caregiving may generate positive feelings of well-being in the midst of financial, health, and social challenges. Sands and Goldberg-Glen (2000) suggests the experience of life satisfaction/well-being may be associated with grandparent caregivers’ perception of meaningful behavior when caring for their grandchildren.

This conclusion is in keeping with the Cognitive Theory of Stress and Coping Theory (Lazarus and Folkman, 1984). From this theoretical perspective, grandparent caregivers’ life satisfaction may be determined by the individual’s cognitive appraisal of stressors, available social supports, and resources. Thus, the individual’s life satisfaction is moderated by their cognitive appraisal of life circumstances. As a result, the grandparent caregivers may express life
satisfaction or well-being while grappling with numerous stressors associated with parenting their grandchildren.

Choice Theory

Choice Theory (Glasser, 1998) is an internal control psychology that suggests five basic needs guide human behavior: survival and health, love/ belonging, power/ self-worth, freedom, and fun. Glasser (1998) asserts together these basic needs are determinants of all behavior and are the foundation of the individual’s *quality world*. The *quality world* drives our wants and subsequent actions (Glasser, 1990). The creation of the *quality world* begins at an early age and enlarges through life. Glasser asserts humans form picture albums where pictures are perceptions that emanate from our five senses: sight, hearing, touch, smell, and taste.

The external environment does not determine choice. Rather, the individual has control over their lives through the choices they make. Individuals who understand that their choices influence the *quality world* experience a sense of control over their behavior, and their emotional response to life events (Robey, Beebe, Mercherson, and Grant, 2011). Moreover, the basic need of “[f]reedom is essential to the ability to choose. It is the process of making choices…” (p. 85) about how the individual lives their life and expresses themselves. The theory focuses on the individual’s belief in their ability to make appropriate choices as an empowering perspective. It supports the individual’s capability to respond effectively to and address life challenges.

While Choice Theory asserts people are genetically programmed to meet the five basic needs, the accomplishment of this is individualized (Glasser, 1998). According to the theory, the individual chooses all their actions, thoughts and feeling directly or indirectly. Glasser suggests, “As bad as you may feel, much of what goes on in your body when you are in pain or sick is the
indirect result of the actions and thoughts you choose or have chosen every day of your life." (Glasser, 1998, pp. 3-4). The individual is responsible for his/ her behavior, not society.

The theory has utility for grandparents raising grandchildren because it postulates families possess inherent strengths. According to the theory, the individual and the family have the same basic needs. The family system has need fulfilling behaviors and operates in a fashion to meet them “in a quest for wellness” (Holmes, White, Mills, and Mickel, 2011). In fact, our genetically driven needs influence behaviors that impel the family towards wellness. Glasser (1998) suggests the differences in behavior of families lie in each family’s genetically endowed strength of a particular need.

There are several assumptions that are problematic with Choice Theory. The significant impact of racial and ethnic injustice, gender inequity, and socioeconomic barriers are not taken into consideration concerning their effect on the individual and families’ quality world, which shapes needs, wants, and the ability to behave toward wellness (Holmes et al., 2011). The world we live in is not racially/ ethnically, gender, or economically neutral. There are immense challenges, barriers, and negative consequences that exist relative to being a member of the aforementioned groups.

While these areas of omission are not specifically addressed by the theory, Holmes and associates (2011) demonstrated the applicability of Choice Theory to African American women and their families. The researchers’ findings indicated that when Choice Theory was taught to study participants they made positive changes and experienced increased well-being regardless of socioeconomic status. The theory supports the idea the individual and families have control over their thoughts, behavior, feels and ultimately wellness through the choices they make. Relative to this, it holds utility for application to a diverse population of grandparents raising
grandchildren and understanding the differences in experience of subjective well-being in grandparent-headed families. Due to individual drives, cultural beliefs, and familial experiences grandparent caregivers may choose to willingly care for their grandchildren and see their care as preserving individual and family wellness.

The assertions of choice theory mesh with the concept of the resilience, coping, adjustment, and adaptation theory, and cognitive appraisal theory. Choice Theory suggests the individual possesses the ability to adjust and adapt to stress and demand through personal choices to bring about positive life changes. Choice is the volitional assumption of responsibility for life outcomes (Glasser, 1998). Moreover, through the individual's cognitive appraisal of those choices it allows for coping with variability in the perception and emotional experience that result and influences the individual’s experience of well-being. What one person perceives as burdensome may be perceived by another as promotive and positive.

Theoretical assumptions:

1. Grandparents cognitively appraise or perceive whether they have a choice when becoming primary caregivers for their grandchildren.

2. Grandparent caregivers experience parental stress after becoming primary providers for their grandchildren.

3. Grandparent caregivers have limited resources and social supports necessary to cope with parenting after becoming primary caretakers for their grandchildren.

4. Grandparent caregivers may employ spiritual and/ or religious practices to cope with parenting after becoming primary caregivers for their grandchildren.
5. Grandparent caregivers’ cognitive appraisal of choice, parental stress, reported resources, social supports, and spirituality affect their well-being, specifically life satisfaction.

**Conceptual Framework**

This study employed a conceptual framework based on constructs from the above-discussed theories. The goal of underpinning the study with this framework is to enhance understanding of factors that contribute to grandparent caregivers’ experience of positive subjective well-being/life satisfaction. With the significant number grandparents raising grandchildren and grandparent caregiver’s documented negative perception of well-being (Bailey et al., 2009), it is important to understand what contributes to positive well-being for grandparents raising their grandchildren (Kelley, Whitley, and Campos, 2010). Understanding contributors to grandparent caregivers’ positive life satisfaction shifts focus from caregivers’ deficits to capabilities, adaptability, and strengths.

Acquiring empirical data about contributors to grandparent caregivers’ positive perceptions of well-being further expands the current knowledge base on grandparent caregiver well-being. Developing a more comprehensive knowledge base regarding the positive life satisfaction of grandparents raising their grandchildren allows for a holistic understanding of grandparent caregiver well-being. It supports the creation of strength-focused assessment practices as well as evidenced-based interventions with this at-risk population. Moreover, it recognizes factors that grandparent caregivers’ view as beneficial to their experience of caregiving and family functioning.
Figure 1: Conceptual Framework

- Choice to Parent - RQ 1
- Spirituality - RQ 2
- Social Support - RQ 3
- Reported Resources - RQ 4
- Parental Stress - RQ 5
- RQ1+RQ2+ RQ3+RQ4+RQ5 - RQ 6

- Marital Status
- Education level
- Employment Status
- Length of time caregiving

Control variables

Moderating Variable
- Caregiving Satisfaction – RQ 7

Grandparent Caregiver Life Satisfaction/ Well-being
To summarize, the study investigated the relationship between cognitive appraisal, social support, resources, parental stress, choice to parent, spirituality/religiousity and grandparent caregivers’ experience of positive well-being, specifically life satisfaction, supported by theoretical concepts from the resiliency model of family stress, adjustment, and adaptation (McCubbin and McCubbin, 1996), cognitive theory of stress and coping (Lazarus and Folkman, 1984), choice theory (Glasser, 1998), and the literature on factors contributing to grandparent caregiver well-being (See Figure 1).

**Research Questions and Hypotheses**

This study sought to answer the following research questions and subsequent hypotheses.

Research Question 1 - To what extent is choice to parent associated with grandparent caregivers’ life satisfaction?

*Hypothesis 1:* The higher the level of choice to parent the higher the level of life satisfaction experienced by grandparent caregivers.

Research Question 2 - To what extent is spirituality/religiousity associated with grandparent caregivers’ life satisfaction?

*Hypothesis 2:* The higher the level of spirituality/religiousity the higher the level of life satisfaction experienced by grandparent caregivers.

Research Question 3 - To what extent are social supports associated with grandparent caregivers’ life satisfaction?

*Hypothesis 3:* The higher the level of social supports the higher the level of life satisfaction experienced by grandparent caregivers.
Research Question 4 - To what extent are reported resources associated with grandparent caregivers’ life satisfaction?

*Hypothesis 4:* The higher the level of reported resources the higher the level of life satisfaction experienced by grandparent caregivers.

Research Question 5 - To what extent is parental stress associated with grandparent caregivers’ life satisfaction?

*Hypothesis 5:* The lower the level of parental stress the higher the level of life satisfaction experienced by grandparent caregivers.

Research Question 6 - Does choice to parent, spirituality, social supports, reported resources, and parental stress positively influence grandparent caregivers’ life satisfaction?

*Hypothesis 6:* The higher the level of choice to parent, spirituality, social supports, reported resources, and lower levels of parental stress, the higher the level of well-being/ life satisfaction reported by grandparent caregivers.

Research Question 7 - Does cognitive appraisal significantly interact with choice to parent, spirituality, social supports, reported resources, and parental stress positively influence grandparent caregivers’ life satisfaction?

*Hypothesis 7:* When levels of choice to parent, spirituality, social supports, reported resources, and parental stress are moderated by cognitive appraisal, higher levels of well-being/ life satisfaction are reported by grandparent caregivers.

**Significance to Social Work Practice and Research**

Social work is a profession geared to understanding and addressing social problems from a contextual perspective with the intent to mitigate and/ or ameliorate factors that create and maintain barriers to basic human rights and social justice. It aims to create avenues to
empower individuals, groups, organizations, and systems; while reducing barriers and equipping
people to obtain needed resources, benefits, and services to meet life task (Germaine and
Gitterman, 1995). The extant literature on grandparent-headed households delineates their risk
for significant social problems such as poverty, compromised physical health, and mental health

However, this study examined factors that contributed to the positive well-being/life
satisfaction of grandparent caregivers. Studies with this focus have potential to lead to
empowerment social work practice innovations. The emphasis is on the adaptive capabilities of
grandparent caregivers, which acknowledges grandparent caregivers’ strengths and supports
enhancement of their well-being or life satisfaction.

Social Work emphasizes advocating and creating social conditions conducive to the well-
being of people. Engaging in research concerning grandparent-headed families capabilities,
strengths, and adaptability is in-keeping with the articulated values of the National Association
of Social Work. Outcomes of such research supports the dignity and worth of the individual, the
importance of human relationships and achieving optimal well-being. Moreover, such research is
in-keeping with the profession’s long history of empowerment, which is “a central purpose of
social work practice” (Robbins, Chatterjee, and Canda, 2012, p.86).

Empowerment is the process of helping individuals, families, groups, and communities
increase personal, interpersonal, socioeconomic, or political power so that individuals can take
action to improve their life situations (Kirst-Ashman, 2012; Barker, 2013). Research that adds to
enhancing empowerment practices with grandparent caregivers supports identification and use of
the individual’s strengths to engage in actions that promote personal power, well-being, and
social justice. In addition, it creates practice opportunities to develop an integrated scaffolding of community services that utilizes the multi-cultural strengths and capacities of grandparent-headed families. It challenges concepts that pathologize, marginalize, and oppress grandparent caregivers and promotes wellness (Robbins, Chatterjee, and Canda, 2012).

Researching the capacities of grandparent caregivers to adapt and effectively function to meet the numerous family needs adds to the body of literature that supports these families’ competencies, and is commensurate with a Strengths Perspective. It contributes to the building of an expanded body of knowledge regarding what factors promote grandparent caregivers’ well-being. Additionally, expanding the research focus concerning grandparent caregivers’ capability, adaptivity, and self-efficacy has implication for social work practice. Outcomes from such research may yield revised practice assessment, intervention strategies, and methods that shifts focus on grandparent caregiving from deficit and burden to strength and ability. It sets the stage for empowerment practice.

**Definition of Terms**

The definitions of terms listed below are presented here, as they are relevant to content throughout the paper.

*Choice to parent.* The grandparent caregiver’s view of whether they assumed/ performed parenting of grandchildren as an option or requirement (i.e., compelled by events, people or circumstances).

*Caregiving Satisfaction.* Grandparent caregiver’s cognitive assessment of caregiving when providing primary parental care for their grandchildren. More specifically, the positive feelings grandparents experienced from caregiving in the parental role.
**Cognitive Appraisal.** The perception or meaning a person assigns to an event or situation. The meaning assigned to an event, can affect an individual’s experience of it and have positive and negative effects on physical and emotional health (Lazarus and Folkman, 1984).

**Grandparent Caregiver.** For study purposes, grandparent caregivers are biological or legal grandparents who identify themselves as primary caregivers of their grandchildren (20 hours or more per week). Throughout this study, grandparent caregivers are also referred to as grandparents raising grandchildren, primary grandparent caregivers, and caregivers.

**Life Satisfaction.** The individual’s (biological/legal grandparent caregiver) subjective cognitive and affective appraisal of their emotional and social functioning in relationships with others (biological/custodial grandchildren) along a positive-negative continuum (Diener, 2000; Ian, 2010).

**Parental stress.** “Life events or changes to the individual or family that have the capacity of generating psychological stress on the part of the [individual] grandparent” (Sands and Goldberg-Glen, 2000, p. 98) where they perceive threats to their well-being (Lazarus, and Folkman, 1984).

**Psychological stress.** The individual’s emotional and physiological reactions experienced when confronting a situation in which the demands go beyond their coping resource. Psychological stress affects the individual’s behavior, thought patterns, and emotions (Dewe, Driscoll, and Cooper, 2012).

**Resources.** For study purposes, resources are defined as tangible resources such as childcare, counseling services, housing, transportation, medical insurance, and financial support.

**Spirituality:** An internal belief in a [higher] power outside of self. A connection beyond self to something greater can be expressed in non-religious and religious practices. Religion may
be encompassed in the term relative to “something a person holds sacred through beliefs and external practices (e.g., organized meetings, Bible study, public, and private, prayer)” (Shalaby and Mohamed, 2014, p. 206).

Social supports. Informal interpersonal relationships (e.g., family, neighbors, friends, co-workers, and spiritual) that provide assistance to the grandparent caregiver.

Subjective Well-being. Subjective Well-being is an individual’s emotional responses and cognitive judgments about life circumstances, which affect the quality of their lives. Subjective well-being includes the concepts of positive and negative affect, happiness, and life satisfaction (Diener, 1984). The aforementioned components are closely related but represent distinct constructs of Subjective Well-being (Diener, Suh, Lucas, and Smith, 1999).

Dissertation Organization

Chapter I presented the introduction, scope of the problem, problem statement, purpose of the study, study aims, research questions and hypotheses, theoretical and conceptual framework, definition of terms, significance to social work practice and research, and study limitations. Chapter II presents an intensive review of pertinent literature and research related to parental stress, social supports, resources, choice to parent, cognitive appraisal, spirituality, and grandparent caregiver well-being. Methodology, sampling, and instrumentation are detailed in Chapter III. Demographic characteristics, data analyses, and results are discussed in Chapter IV. Discussion of findings, implications, and limitations of research are located in Chapter V. Finally, the Appendix contains examples of instruments used in the study and documentation of IRB approval.
CHAPTER 2 - LITERATURE REVIEW

Primary grandparent caregivers experience challenges and rewards from raising biological and legal grandchildren (Conway, Jones, Speakes-Lewis, 2011; Leder, Nicholson-Grinstead, Torres, 2007). Grandparent caregivers may experience parenting grandchildren on a continuum from positive to a negative experience. A preponderance of the research on grandparents raising grandchildren concentrates on negative impacts for grandparent-headed households (e.g., economic burden, social isolation, increased stress, interfamilial conflict, and lowered life satisfaction) (Ross and Aday, 2006; Longoria, 2009). Extant research contains an emphasis on the stressors and unmet needs associated with caregiving, specifically interfamilial conflict, psychological challenges, inadequate resources, and limited social supports. However, caregivers’ ability to adapt, function, and experience positive life satisfaction is understudied (Sands et al., 2005).

More specifically, there is a lack of research on the factors that contribute to grandparent caregiver’s perceptions and experiences of positive subjective well-being or life satisfaction while managing stress. Due to the paucity of research on the topic of positive effects of grandparent caregiving, this review examined factors and concepts identified in the literature as significant to grandparents caregivers experience of well-being as depicted in the study’s conceptual framework (see p. 29): socio-demographics, parental stress, social supports, resources, religion and spirituality, choice to parent, and grandparent caregivers’ perceptions of
caregiving. In this chapter, the selection and discussion of literature reviewed is organized in a manner to provide a research context for the present study.

The chapter begins with the discussion of well-being/ life satisfaction and grandparent caregivers. Selection of reviewed literature was based on congruence of studies with factors that affect grandparent caregivers’ well-being. Key research findings on grandparent caregiver well-being/ life satisfaction are offered with attention given to the role of choice to parent and cognitive appraisal to the experience of positive well-being/ life satisfaction. Discussion regarding socio-demographic factors, parental stress, social supports, resources, spirituality, and parental stress relative to grandparent caregivers’ experience of well-being follows. In addition, selected conceptual and theoretical perspectives that guide and underpin research on grandparent caregivers and well-being are included. Measurement of life satisfaction as a component of subjective well-being rather than psychological well-being is addressed. The chapter closes with a discussion on the gaps in the extant literature.

**Well-being/ Life Satisfaction**

Investigation of grandparent caregiver (non-residential, intergenerational, and custodial) well-being is considerable. In particular, studies have investigated grandparent caregivers’ psychological (Augusto et al., 2011, Moore and Miller, 2007, Sampson, and Hertlein, 2015), health/ mental health (Dunifon, Ziol-Guest, and Kopko, 2014; Kresak et al., 2014, Smithgall, Mason, Michels, LiCalsi, and Goerge, 2009), and economic (Mutchler and Baker, 2009; Pilkauskas and Dunifon, 2016) well-being in the midst of distress and crisis. However, there has been limited investigation of the life satisfaction component of well-being. In particular, examination of grandparent caregivers and their experience of positive life satisfaction. In order to explicate life satisfaction and grandparent caregiving, the present review examined selected
articles that pertained to grandparent caregiver’s experience of life satisfaction. A discussion of
the term well-being is necessary for a better understanding of the meaning of life satisfaction and
its significance to grandparent caregivers.

According to McDowell (2010), well-being “is perceived through filters of personality
and cognitive and emotional judgment, [resulting in] positive self-appraisal” (p. 47). Two
differing views regarding the concept of well-being exist: Eudaemonic (Psychological) and
Hedonic (Subjective) well-being. In general, psychological well-being refers to a feeling of
happiness related to personal development, coping with life challenges, personal growth, and
achieving individual goals (Ryff, 1989). Psychological well-being is conceptualized in six
dimensions “related to positive performance: self-acceptance or positive attitude towards oneself,
personal growth or development, purpose of life, control or mastery of environment, positive
relationships with others, and autonomy or ability to be independent” (Augusto-Landa,

While, subjective well-being is an individual’s emotional responses and cognitive
judgments about life circumstances, which affect the quality of their lives. Subjective well-being
includes the concepts of positive and negative affect, happiness, and life satisfaction (Diener,
1984; Pavot and Diener, 2009). The individual’s perceptual and emotional appraisal of their lives
and how social and cultural influences contribute to the experience of well-being is central to
subjective well-being. Diener (2000) postulated individual characteristics such as temperament,
personality along with an individual’s needed resources, and social skills are strong predictors of
subjective well-being. Additionally, culture, access and involvement with family, community,
and social supports contribute greatly to an individual’s experience of positive subjective well-
being. Other contributors include the individual’s social connectedness, adaptive coping ability, optimism, and perception of social supports (Diener and Chan, 2011).

What then is life satisfaction? Life satisfaction is the judgmental or cognitive and affective component of subjective well-being (Pavot, Diener, Covin, Sandvik, 1991). It is the individuals’ global assessment/appraisal of the quality of their life experienced within the context of sociodemographic factors, resources, supports, family, community, and culture (Shlomo, 2013; Diener, Oishi, and Lucas, 2003). How does this definition apply to grandparent caregivers? What factors are associated with the experience of life satisfaction in grandparent caregivers? The next section will address these questions.

**Life Satisfaction and Grandparent Caregivers**

Extending McDowell’s (2010) conception of well-being to grandparent caregivers, positive cognitive appraisal of caregiving may generate feelings of subjective well-being/life satisfaction in the midst of financial, health, and social challenges. When caregivers perceive themselves as engaging in meaningful parenting behavior that contributes positively to the future of their grandchildren this may enhance their life satisfaction (Haslip, and Kaminski, 2005; Sampson, and Hertlein, 2015; Sands et al., 2005). As a result, some caregivers may express positive life satisfaction or subjective well-being while caregiving under onerous circumstances rather than burden. What factors are associated with grandparent caregivers’ experience of positive life satisfaction? A limited number of researchers have explored factors that contribute to the experience of positive life satisfaction in grandparent caregiving families. (Smith and Dolbin-MacNab, 2013).

In the search of the literature, these studies specifically examined the relationship between parental stress, social support, resources, cognitive appraisal, and grandparents or
grandparent caregivers’ life satisfaction/subjective well-being. Early qualitative research by Waldrop and Weber (2001), using semi-structured interviews \( (N=54) \) explored primary -

Grandparent caregivers’ stressors, response to stressors, resources, coping strategies, and described grandparent caregivers’ experience of positive life satisfaction. Researchers found and interrelatedness between stress and life satisfaction for all caregivers. Grandchildren’s well-being and stability in five areas reduced stress and was a source of caregiver’s satisfaction: joy in grandchildren’s love, joy in task associated with child rearing, participation in grandchildren’s activities, purpose and direction from caring for grandchildren, and pride in grandchildren’s accomplishments (Waldrop and Weber, 2001).

Further research regarding the experience of grandparent caregivers’ and life satisfaction can be found in two quantitative studies that specifically examined parental stress, social support, resources, cognitive appraisal, and grandparents or grandparent caregivers’ life satisfaction/subjective well-being as they related to primary and custodial grandparent caregivers (Sands et al., 2005; Shlomo, 2014). Similarities exist between both studies in several areas. Inclusionary criteria (grandparents 50 years and older identified themselves as primary caregivers for grandchildren 18 years old and younger) were identical. Each study recruited from local community organization with non-probability sampling method (quota). Stress theory served as the guiding framework for both studies. Both studies controlled for sociodemographic variables (e.g., age, marital status, education, dependent children in the home, employment, and health status). Outcomes suggested life satisfaction increased when grandparents and grandparent caregivers perceive themselves to have sufficient resources, supports, and low stress (Sands et al., 2005; Shlomo, 2014)).
Study differences included grandparents as supports versus primary caregiving, research question, definitions of well-being, conceptual framework, and the role of cognitive appraisal. Sands and associates (2005) researched stress in primary grandparent caregivers \((N=129)\) and the factors associated with reducing their stress and supporting positive well-being. The researchers conceptualized well-being as a hedonic concept. They speculated grandparent caregivers’ well-being was related to feeling good about grand parenting or gaining pleasure from caring for their grandchild(ren). Choice to parent and cognitive appraisal were introduced as moderating factors of grandparent caregiver stress and life satisfaction. Notably, moderators affect the strength and association between the dependent and independent variable, but are not related to them (Rose, Holmbeck, Coakley, and Franks, 2004). The researchers used principles of successful aging, ABCX Family Crisis Model (Hill, 1949), Double ABCX Stress and Adaptation Model (McCubbin and Patterson, 1983), and Cognitive Appraisal Theory (Lazarus and Folkman, 1984) as the conceptual framework for the study.

Sands and associates (2005) guiding research question was, “Among grandparent caregivers, to what extent are the perception of grandparental stress and grandparents’ resources associated with grandparents’ well-being, after controlling for sociodemographic and contextual factors?” (p.67) Study findings suggested grandparent caregiver’s perception of high levels of informal supports such as friends and neighbors, use of community agencies, support groups, and the availability of respite care reduced stress and are associated with positive life satisfaction. Resources and supports enabled individuals to meet their needs and manage life demands. Cognitive appraisal served as a moderator of grandparent caregiver stress and level of life satisfaction. However, a significant association between life satisfaction, choice to parent, and sociodemographic variables was not demonstrated. To date, this study is the only one located in
the literature that introduces choice to parent as a moderator of grandparent caregiver life satisfaction.

More recently, Sholomo (2014) examined the relationship between sociodemographic factors, perceived stress, social supports, and cognitive appraisal as contributors to new grandparent life satisfaction ($N=246$). Stress and coping theory (Lazarus and Folkman, 1984) and tenets of positive psychology (Seligman and Csikszentmihalyi, 2000) provided the study’s theoretical framework. Study instrumentation included a sociodemographic questionnaire and three standardized measures: the Parental Stress Index (Abidin, 1995), the Cognitive Appraisal of Stress Scale (Folkman and Lazarus, 1985), and the Satisfaction with Life Scale (Diener, Emmons, Larsen, and Griffin, 1985).

Hierarchical regression analysis findings indicated an association between the age of the grandparent and life satisfaction. The younger the grandparent, the fewer physical health complaints, lower economic stress, lower reported grandparent distress (feelings of depression, isolation, and role constraint), and the higher grandparent life satisfaction. Additionally, cognitive appraisal moderated grandparent’s perception of stress. This outcome is in keeping with Lazarus and Folkman’s (1984) stress and coping model, which contends the individual’s cognitive appraisal of stressful events can moderate the experience of a stressful event.

Factors

Various factors such as socio-demographics (Sands et al., 2005), parental stress (Bundy-Fazioli, Fruhauf, and Miller, 2013), spirituality (Dunifon and Kopko, 2011), social supports (Doley et al., 2015), and resources (Carr et al., 2013) have been examined relative to grandparent caregivers experience of well-being and life satisfaction. A discussion of selected research literature regarding the aforementioned factors for applicability of use in this study follows.
Socio-demographic Factors

Results of studies examining grandparent caregiver well-being suggest certain socio-demographic factors affect caregivers’ experience of well-being in the parental role. More specifically, socio-demographic factors such as age, marital status, employment status, educational level, and dependent children in the home have been both positively and negatively associated with grandparent caregiver well-being (Kelley Whitley, and Campos, 2010; Longoria, 2010; Ruiz, 2008; Sands et al., 2005). In general, these studies are cross-sectional focused on grandparent caregivers’ psychological, physical, or emotional well-being rather than life satisfaction and used non-probability sampling methods.

Differences in grandparent caregiver well-being outcomes relative to age are evidenced in several studies. For instance, Conway, Jones, and Speakes-Lewis’ (2011) study of African American grandparent caregivers’ found age cohort differences in the experience of emotional well-being. Younger grandmothers experienced more emotional and caregiver strain than older grandmothers. Older grandparent caregivers viewed their role as enriching their lives by reducing intra-familial conflict and maintaining social relationships. However, younger grandmother caregivers tended to experience a sense of burden. By contrast, Robinson, Kropf, and Myers (2000) found older grandparent caregivers experienced more health and mental health concerns in their caregiving role performance than younger grandparent caregivers.

Keller and colleagues (2012) found an association between sociodemographic factors, perceptions of adult stress, and their effects on health, mental health, and mortality outcomes. The study’s sample (N= 28,753) was extracted from the National Health Interview Survey (1998). While examining variable interactions, researchers controlled for sociodemographic characteristics such as gender, race/ ethnicity, education, marital status, income, and family size.
Study outcomes indicated an association existed between the amount of stress, perception of stress, health, and mental health outcomes of adults (Keller et al., 2012). Researchers concluded people who experienced high levels of stress, but did not perceive it as harmful, were no more likely to die than those experiencing less stress. Perception of stress appears to mediate health and mental health outcomes in adults. Given the study used a nationally representative adult sample, such sociodemographic factors may influence grandparent caregivers.

Other authors found grandparent caregiver financial status, health status, and number of grandchildren in the home contributed to negative well-being (Kelly, Whitley, Sipe, and Yorker, 2000; Sands et al., 2005). For example, Dowdell’s (2005) correlational study of grandparent caregivers associated financial status, marital status, number of grandchildren in the home, and health status with the study participants’ perceived levels of stress and negative quality of life. Unmarried grandparent caregivers tended to have poorer health, mental health, and financial strain than their married counterparts.

The literature yielded a limited number of studies that specifically examined age as it related to grandparent caregivers’ experience of life satisfaction. Two studies that specifically investigated life satisfaction and age yielded different outcomes. Findings from Doley et al., (2015) cross-section study of custodial grandparent caregivers with emotional and behavioral problems indicated older grandparent caregivers experienced greater life satisfaction than younger caregivers. Regression analyses demonstrated age of caregiver, grandparent’s relationship status, informal supports, and income predicted greater life satisfaction. By contrast, Kresak, Gallagher, and Kelley (2014) grandparents raising grandchildren with disabilities found age of grandparent caregiver, educational level, and age of grandchild did not significantly predict grandparent caregivers’ life satisfaction.
Parental Stress

Research on primary grandparent caregivers frequently assumes parental stress is an integral part of the grandparental role very similar to the demands and stressors experienced by biological parents (Hayslip et al., 2014). When studies examined grandparent caregiver perceptions of parental stress, its relationship to coping, social supports, resources, familial conflict, grandchild behavior, physical health, and well-being is commonly explored (Bundy-Fazioli et al., 2013; Kelly, Whitley, and Sipe, 2007; Keller, et al., 2012). Grandparent caregiver parental stress is multi-dimensional often measured using standardized parental stress instruments in both qualitative and quantitative studies (Butler, and Zakari, 2005; Hayslip et al., 2014; Landry-Meyer, Gerard, and Guzell, 2005; Ross, and Aday, 2006).

For example, Ross and Aday (2006) sought to determine the degree of stress experienced by African American grandparent caregivers (N=50) and coping strategies used to influence their degree of stress. Researchers used the Parental Stress Index/ Short Form (PSI/SF), which has demonstrated efficacy in measuring the concept of parental stress (Abidin, 1995). Approximately, 92% of study participants experienced high stress. The Ways of Coping Questionnaire (WCQ) short version measured caregivers’ coping strategies when stressed. Five coping strategies correlated with lower caregiver stress: positive reappraisal, accepting responsibility, confronting coping, and self-control. The most common form of coping was seeking social support (Ross and Aday, 2006). Study limitations included nonrandom sampling and small homogenous sample, which precluded generalizability of findings.

Bullock (2005) research on grandfather caregivers examined the perceptions of primary grandfather caregivers age 65 years and older living in rural areas about experiencing parenting a second time. On average, study participants provided primary care for approximately 7 years.
The study sample ($N=26$) included African American (54%), Caucasian (35%), and Latino (12%) who lived in a rural area and were primary or co-parenting grandfather caregivers.

Qualitative methods were used to explore parental challenges, adjustment to parental role, and self-efficacy through semi-structured interviews with questions about income, education, household size, health status, and activities of daily parenting (Bullock, 2005). To capture the complete experience of grandparent caregivers, investigators concluded each interview by asking, “Maybe if I tell you about some of the things that other grandparents who raise grandchildren have said about their experiences, this might help you to think about whether or not you have had any of these experiences” (p. 46).

Respondents described significant stress related to daily parenting, limited social supports, and feelings of powerlessness that challenged them to maintain well-being (Bullock, 2005). For study purposes, investigators’ framed powerlessness as “the ability to be aware of what one chooses to do, feeling free to do it, and doing it intentionally. (p.48)”. Participants, overwhelming related feeling they had no choice about assuming parenting responsibility for their grandchildren. Also, grandfather caregivers related powerlessness to their inadequate execution of parenting responsibilities and the necessity to curtail previously enjoyed social activities to meet grandchildren’s needs.

Themes from Bullock’s (2005) work included: grandfathers’ perceptions of transition to the parenting role, adjustment to parenting, and self-efficacy. Participants asserted experiencing common parental stress themes such as managing child behavior, assisting with educational needs, financial constraints, daily living task, and social isolation. Study outcomes suggested choice to parent, parental stress, social supports, and community resources, all have bearing on primary grandfather caregiver well-being and warranted further exploration (Bullock, 2005).
By contrast, the results of Kelch-Oliver’s (2011) qualitative study of six African American grandmothers raising grandchildren yielded different data. The investigator sought to understand the experiences of grandmothers raising grandchildren from their perspective. Study participants lived in an urban setting and were recruited from community-based social support programs. The data suggests grandparent caregivers experienced a change in the complexity of their daily lives when they began parenting for the second time (e.g., diminished social supports and community resources). However, they related experiencing increased purpose, meaning, and pride in providing for their grandchildren.

Findings from research by Lumpkin (2008) compliment the above noted results. The investigator used a quantitative descriptive study design to explore grandparents raising grandchildren and grandparents in near-parental roles ($N=613$) perception of parental stress and coping strategies. Lazarus and Folkman’s (1984) stress and coping theory served as the study’s theoretical framework. Random sampling of 5,000 households matched to state demographics generated a sample representative of the study’s geographic area. Additionally, the proportion of grandparent caregivers in custodial and non-custodial arrangements in the study was consistent with prior research. However, the low survey response rate (12.3%) limits generalizability of study findings.

Researchers sought to measure the stress of study participants through identification of situations that generate stress. Researchers asked participants to “describe the most stressful situation they had experienced in the last few months as a result of being a grandparent” (p.363). Primary grandparent caregivers rated grandchild well-being, caring for grandchild, school difficulties, and disciplining grandchildren as the most stressful situation. The investigator noted difference in stressful situations by age group. Younger custodial grandmothers indicated caring
for grandchildren and discipline compared to caregivers over 70 who cited financial, academic, and “grandchildren in trouble” (p.365).

The Ways of Coping checklist assessed study participants’ management of stressful situations. The checklist is a 50-item measure of problem and emotion focused strategies for dealing with stress developed by Folkman and Lazarus (1985). Outcomes indicated custodial grandparents used positive reappraisal most often to cope with parental stress. The participants perceived stress as positive and “believed that they may be better for having the experience …and reported seeking the advice and support of others (i.e., social support) (p. 369)” While grandparent caregivers in near-parental roles more frequently used problem solving, than positive reappraisal. However, like primary grandparent caregivers, near-parental grandparent caregivers sought social supports to cope with stress.

Spirituality

Spirituality and religion are often used interchangeably. However, the two terms hold distinct and related meanings. For the purposes of this research, Shalaby and Mohamed’s (2014) conceptualization of spirituality is used as a framework for the concept. Spirituality is defined as a belief in a [higher] power outside of self,…and it “encompasses religion as a way of relating to something a person holds sacred through beliefs and external practices (e.g., organized meetings, Bible study, public, and private, prayer)” (p. 206) was used. Research findings indicated spirituality has the capacity to promote mental health and diminish mental illness. More specifically, Shalaby and Mohamed (2014) contend spirituality can support healthy individual functioning, sustaining positive relationships with others, and supports purposeful lives.

Sun and colleagues (2012) studied the effects of religious involvement on 1000 older adults dwelling in southern communities. Levels of depressive symptoms and religious practice
were accessed over a four-year period using standardized measures. Investigators operationalized religiosity as a multifaceted concept that included organized religion, non-organized religion, and intrinsic religiosity. Study outcomes indicated intrinsic religiosity or the importance of religion to an individual might be a particularly salient aspect of religiosity that has a positive effect on depressive symptoms in older adults. Crowther, Parker, Achenbaum, Larimore, and Koenig’s (2002) research on positive spirituality supports its importance to successful aging in older adults. Findings from their work note spirituality contributes to health promotion and well-being “of the self and others (p. 614)”.

According to Koenig, McCullough, and Larson (2001) spiritual and religious practices serve as protective factors that improve life satisfaction, reduce the experience of burden, and support increased coping capacity in caregivers. In regards to grandparent caregivers, the impact of religiosity and spirituality on caregivers and caregiving varies from no impact to a mainstay. The differences in the importance of spirituality to the life satisfaction of grandparent caregivers results from a number of factors.

The caregivers’ personal and family values have bearing on the importance of spirituality and religiosity to the grandparent’s life. Additionally, how religious and spiritual beliefs are transmitted, expressed, and experienced, as well as the significance assigned to religious involvement and spiritual practices are important. Spirituality’s influence on the experience of life satisfaction also varies by the caregivers’ racial, ethnic, and cultural group (Brown, Howard-Caldwell, and Antonucci, 2008).

Research concerning religion and spirituality in grandparent-headed families found custodial grandparent caregiver’s religiosity positively influenced the relationship between grandparent and grandchild as well as the child and the family’s well-being (Dunifon and Kopko,
2011). This supports earlier findings that involvement in a religious belief system is a source of emotional support and psychological well-being, particularly, for African American grandparent caregivers (Moore and Miller, 2007). Latinos and African Americans tend to rely on spiritual and religious beliefs as a source of emotional strength as well as for tangible support through church sponsored peer groups, pastoral counseling, and psycho-educational support groups (Picot, Debanne, Namazi, and Wykle, 1997; Brown and Mars, 2000) more than Caucasian grandparent caregivers (Brown et al., 2008). Additionally, for African Americans the religious practices of the church extended to community organization, advocacy, and campaigns to address social injustice (Moore, 2003).

African American and Native American grandparent caregivers frequently serve as transmitters of religious practices, provide religious instruction and guidance, and promote the importance of religious practices to maintain and sustain family relationships (King, Burgess, Akinyela, Counts-Spriggs, Parker, 2006; Mulder, 2012). Native American and Alaskan Indian grandmother caregivers frequently are the connectors to spiritual traditions and practices for their grandchildren (Mignon and Holmes, 2013). Understanding the significance of religious and spiritual practices to grandparent-headed families can provide insight into their use as an intervention that yields positive psychosocial benefits (e.g., supports adaptive coping, socialization, family stability, management of associated stressors and challenges) with this group (Mulder 2012).

Social Supports

A number of published works note the importance of social supports to manage the perceived stress related to the demands of caregiving and their impact on grandparent caregiver’s well-being (Goodman and Silverstein, 2002; Keene et al., 2012, Kelch, 2011; Livingston, 2013;
Ross and Aday, 2006, Whitley, Kelly, and Campos, 2012). In an intensive review of the literature on family functioning and resilience, Walsh (2003) suggests informal social supports are a significant factor in a family’s capacity to be resilient and tolerate stress in the midst of a crisis. Outcomes from a quantitative study by Sands and Goldberg-Glen’s (2000) are commiserate with this assertion. In a cross-sectional research study of grandparent or great-grandparent primary caregivers \( N=129 \) 50 years and older, researchers investigated stressors experienced by grandparents in the parenting role. Specifically, they examined the effect availability, access, and utilization of social supports has on grandparents as a possible moderator of stress.

Drawing from Stress and Coping Theory (Lazarus and Folkman, 1984), the investigators examined the three constructs of support, contextual factors, and stress as they manifested in grandparent-headed families. Researchers hypothesized, “Grandparents who receive a high level of support from their family and community will have a low level of stress” (p.98). Findings revealed lack of social support and resources increased caregiver stress and diminished well-being when controlling for sociodemographic contextual factors (e.g. caregiver age, education, race, health, employment, and number of grandchildren in the home).

Landry-Meyer, Gerard, and Guzell’s (2005) study the association between grandparent caregivers’ life satisfactions, generativity’, parental stress, and social supports (informal support, formal support, enacted social support). Study outcomes differed from prior research on social support (Hill, 1949) as a moderator of grandparent caregiver well-being. Guided by Family Stress Theory and Psychosocial Development Theory (Erickson, 1963), the researchers conducted survey research on a non-probability sample of 133 primary grandparent caregivers in
Northwest Ohio. Investigators hypothesized social support moderated the association between grandparent caregivers’ parental stress, life satisfaction, and generativity.

Landry-Meyer et al. (2005) operationalized study variables using five standardized measures each with documented evidence of reliability and validity. The instruments are as follows: the Parental Stress Index-Modified (Berry and Jones, 1995) (grandparent caregiver parental stress), Lubben’s Social Network Scale Social Support (Lubben, 1998) (informal support), Multidimensional Scale for Perceived Social Support (Zimet, Dahlmen, Zimet, and Farley, 1988) (perceived social support), Life Satisfactions Index-Z (Neugarten, Havighurst, and Tobin, 1961) (life satisfaction), and the Loyola Generativity Scale (McAdams and de St. Aubin, 1992) (generativity). Control variables included age, race, marital status, education, income, and employment status.

Landry-Meyers and associates (2005) analyzed study data using regression analysis, which produced mixed outcomes. Social support did not moderate caregiver stress and life satisfaction or caregiver stress and generativity. Findings indicated a negative association exist between grandparent caregiver stress and life satisfaction. In fact, under high stress perceived informal and formal supports negatively affected the grandparent caregiver relative to feelings of low generativity. However, a positive association existed between enacted formal support (actual support received from family, friends, community, etc.) and grandparent caregiver life satisfaction. Investigators concluded the benefits of social support vary depending on the type of social support and social environment (Landry-Meyer et al., 2005).

However, more recent research by Musil and associates (2010) supported an association with access to informal and formal social support, parental stress, and grandparent caregiver well-being. Researchers conducted a longitudinal study of 485 primary grandmother caregivers,
co-parenting grandmothers in intergenerational families, and non-residential grandmothers.
Specifically, investigators examined changing caregiver roles as they relate to caregiver stress,
reward, intrafamily strain, social support, resourcefulness, depressive symptoms, mental and
physical health, perceived family functioning and caregiver well-being.

The Resiliency Model of Family Stress, Adjustment, and Adaptation (McCubbin, Thompson, and McCubbin, 1996) served as the conceptual underpinning for Musil and colleagues (2010). The theory posits stressors or demands on the individual and family
moderated by social supports, resources, and appraisal will affect adaptation and well-being. Six
standardized measures and one question were used to measure study variables: The Family
Inventory of Life (family strain), Duke Social Support Index (social supports), Center for
Epidemiological Study-Depression Scale (depressive symptoms), Family Assessment Device
(family functioning), Self-Control Schedule (resourcefulness), and Short Form-36 (SF-16)
(physical and mental health). Ascertaining the level of caregiver stress and reward occurred by
response to the question, “How much stress (or reward) do you have in your role as a
grandmother? (p. 90)” marked on a 100 mm visual analog scale (Musil et al., 2010).

Out of the three groups studied by Musil et al. (2010), primary grandmother caregivers
reported the most stress, intrafamily strain, and perceived problems in family functioning. As
well as, the worst physical health and more depressive symptoms, and the least reward and social
support. Investigators concluded grandmothers, especially custodial grandmothers’ who did not
perceive themselves to have adequate social support from family members experienced
diminished well-being and increased family strain. Overall findings point to access to resources
and social support, perceptions about the caregiving role, and family functioning correlated to
family strengths and well-being leading to positive outcomes (Musil et al., 2010).
The importance of social supports as a contributor to grandparent caregiver well-being cuts across all racial and ethnic groups (Goodman and Silverstein, 2002; Livingston, 2013). The literature demonstrates racial and ethnic minority grandparents raising grandchildren are at higher risk to be overburdened, experience clinical levels of stress (Keene et al., 2012, Kelch, 2011; Ross and Aday, 2006), and require more informal supports to assist with parenting responsibilities (Whitley, Kelly, and Campos, 2012). Similar findings hold true for studies concerning other racial and ethnic groups such as Hispanics and Latino (Chase-Goodman, and Silverstein, 2006), Native Americans (Mignon, and Holmes, 2013), and Native Hawaiian (Yancura, 2013) grandparent caregivers.

Resources

Grandparent headed household are diverse, and the reasons grandparents assume care for their grandchildren for a varied. Because of the complexity and diversity of grandparent-headed families, the resources required to meet caregiver and family members’ needs are wide-ranging (Hayslip and Kaminski; 2005; Liu and Anderson, 2010; Livingston, 2013). In some instances resources are not available and in others they exists. However, grandparent caregiver access to resources maybe impaired by the grandparent lacking information about available resources, service providers attitudes, structural barriers, and caregivers willingness to seek services (Simpson and Lawrence, 2009; Smithgall, Mason, Michels, LiCalsi, and George, 2009).

For instance, Carr et al. (2012) explored the relationship between perceived need for information about resources, service use, and resource used in custodial African American grandmothers (N=93). Theoretical perspectives guiding the study included concepts of the Social Behavioral Model of Service (Andersen, 1995), and Stress and Coping Theory (Lazarus and Folkman, 1984). The study’s sample was composed of grandmother caregivers 36-78 years old,
and the majority (69%) of participants cared for 1-2 grandchildren. Instrumentation for the study relied on 21 questions from prior studies by Binette and Cicero (2003) and King, Kaminski, and Hayslip (2006) concerning grandparent caregivers’ information needs, resource needs, and services used. The resource items surveyed included grandchild day care, child support, counseling for family members, recreational resources, school tutoring, legal assistance, and transportation all rated on a five-point Likert scale. Hierarchial multiple regression analysis assessed relationships between variables while controlling for sociodemographic characteristics.

Carr and colleagues (2012) found environmental context (age, grandchildren in the home, education, income, and health) influenced the need for information about resources, need for service, and use of services. Findings illustrated grandparent caregiver’s need for information on resources such as financial, community, education and support group resources. Further, when grandparent caregivers appraise themselves as having insufficient knowledge and resources, this created stress because grandparent caregivers could not meet environmental demands (Carr et al., 2012). As grandparent caregivers aged, the need for information about resources, resources needed, and service use decreased. Investigators speculated grandparent caregivers might perceive themselves as experienced and knowledgeable without the need for additional parenting resources (Carr et al., 2012).

Researchers noted the larger the number of grandchildren in the home, the less likely grandparent caregivers perceived a need for services (Carr et al., 2012). The health of grandparent caregivers “did not predict the need for information about resources, the need for services, or service use” (p.58). Investigators postulated grandparent caregivers’ perception of environmental factors influenced need for information about resources, need for services, and resource use. Researchers suggested further research using an interventional design that
evaluated the perceived impact of resources on grandparent caregiver well-being, parenting skills, and family relations was warranted to further explicate findings (Carr et al., 2012).

Other studies highlight the importance of resources to grandparent caregiver well-being (Bailey et al., 2009, Ross and Aday, 2006; Simpson and Webb, 2009). Themes from Bailey et al.’s (2009) study of grandparent caregiver’s adaptation to parenting noted grandparent well-being was impacted by the caregiver’s abilities to positively perceive personal resources, the family system's internal resources, and use of a social support network. Additionally, availability and involvement with community resources such as counseling, school programs and tutoring, income maintenance, and healthcare programs, facilitated positive grandparent caregiver adjustment to the demands and stressors of parenting grandchildren (Bailey et al., 2009; Ross and Aday, 2006).

**Measurement of Life Satisfaction**

According to Hervas and Vasquez (2013), well-being is a significant element of an individual’s life; they assert well-being requires examination in terms of when it occurs (retrospectively or currently) as well as analyzing well-being beyond one aspect such as psychological functioning, social well-being, life satisfaction, and emotional well-being. Further, McDowell (2010) suggests it is necessary to use an integrative instrument to comprehensively measure well-being. He asserts an integrated comprehensive measure captures the construct of well-being in three ways. The measure contains content that targets the temporal aspects of well-being. Eudaimonic (psychological) well-being regarding the individual’s satisfaction with the overall quality of life through maximizing happiness and reducing pain is assessed. Moreover, eudaemonic (psychological) well-being concerning personal growth, adaptation, and doing what’s right…” (p.71) is a focus of attention.
However, there is scholarly debate concerning the ability to accurately measure psychological well-being (eudaemonic) independent of subjective well-being (hedonic). The two well-being construct mechanisms appear to be interrelated. McDowell (2010) asserts the two constructs are not independent, but rather they overlap. He states, “Eudaimonic personal fulfillment leads to pleasure, and pleasure has many sources so does not only imply eudaemonic well-being” (p.71). Thus, employing a measure that comprehensively captures eudaemonic, hedonic, and temporal well-being is unlikely. However, being mindful of examining these three constructs of well-being through more than one measure would provide a more holistic experience of well-being.

An instrument such as Diener’s Satisfaction with Life Scale (SWLS) assesses subjective well-being as positive affect, the absence of negative affect, and overall life satisfaction (1985). With demonstrated sensitivity to change over time, its constructs represent the hedonic (subjective) view of well-being. It is complimentary to eudaemonic measures such as Ryff’s Scales of Psychological Well-being and the World Health Organization-5 (McDowell, 2010). The SWLS is a psychometrically sound measure of subjective well-being. However, SWLS is not limited to measuring hedonic (subjective) well-being, only.

SWLS captures current life satisfaction, life satisfaction over time, and the individuals’ personal characteristics. Even though the SWLS was not designed specifically to measure well-being comprehensively, it appears to have some utility to measure temporal and eudaemonic (psychological) well-being. The measure assesses personal characteristics as they relate to the change in life satisfaction over time; it has the ability to examine personal growth and the impact of whether personal goals are reached or not. These aforementioned areas capture some temporal and eudaemonic constructs of well-being. While the instrument was not designed to be a
comprehensive measure of well-being, it does possess psychometric properties somewhat
broader than subjective well-being. Because of this, it may offer a unique utility in measuring
well-being. Because of differing conceptualization of well-being, study and measurement of the
constructs that comprise the two types of well-being requires instrumentation with psychometric
properties amenable to their measurement.

Gaps in the Literature

There is a substantial body of literature concerning grandparent caregivers as a high-risk
group. With a preponderance of the existing literature centered on grandparent-headed families
where the grandparent caregiver is single, female-headed, a member of a racial/ethnic minorities,
lower economic status, and in later adulthood (Bailey et al. 2009, Hayslip and Goodman, 2007;
Musil et al., 2010). Authors consistently note the crises in the nuclear family, which result in
grandparent-headed families (e.g., death of the child’s parent, incarceration, substance
dependence, child maltreatment, teen pregnancy, military deployment, and physical illness such
as HIV/ AIDS ) (Chase-Goodman, 2012; Minkler and Fuller-Thomson, 2001; Leder, Nicholson-
Grinstead, Torres, 2007; Musil et al, 2010; Orthner, Jones-Sanpei, and Williamson, 2004; Ruiz,
2008). To date, very little attention is given to contributors to positive perceptions about
caregiving, and life satisfaction in grandparent-headed families. More attention is needed in
several areas to broaden the existing knowledge base concerning grandparent caregiver’s
experience of positive life satisfaction.

Much of the research on well-being and grandparent caregivers focuses on psychological
well-being (Goodman, and Silverstein, 2005; Longoria, 2010; Hayslip, and Kaminski, 2005;
Moore, and Miller, 2007). Notably, fewer studies have researched grandparent caregivers’
subjective well-being specifically life satisfaction with parental role assumption, younger
grandparent caregivers’ life satisfaction, grandparent caregiver’s cognitive appraisal of parenting, or their healthy adaptive capabilities (Chase-Goodman, 2012; Hayslip and Kaminski, 2005). Moreover, even fewer studies examine the role of choice to parent and cognitive appraisal in grandparent caregiver life satisfaction (Sands et al., 2005).

To date, the investigator located only one study that explicitly examined choice to parent as a factor in grandparent caregiver life satisfaction (Sands et al., 2005). Exploring the role of choice offered an opportunity to examine the differences in the effect of volitionally choosing to become a grandparent caregiving rather than feeling compelled to assume the function. Similarly, there exist minimal investigation concerning cognitive appraisal as a moderating factor in grandparent caregivers’ experience of life satisfaction. Further investigation of cognitive appraisals’ role in life satisfaction holds potential to extend our present knowledge factors related to grandparent caregivers’ positive life satisfaction. The present study sought to address the aforementioned gaps in the literature by investigating the relationship of social supports, spirituality, resources, parental stress, choice to parent, and cognitive appraisal to grandparent caregivers’ experience of positive life satisfaction.
CHAPTER 3 - METHODS

Research Design

This study employs a cross-sectional survey research design to address the identified research questions and hypotheses. According to Faulkner and Faulkner (2013), cross-sectional design is useful because it allows for representation of a broad segment of the population at one point in time. While, using probability sampling “allows the researcher [to draw a representative sample] to make relatively few observations and generalize from those observations to a wider population” (p. 76). However, non-probability sampling methods (convenience and snowball), which are a second form of sampling, are used for the present study.

Sampling error may occur with these methods, which is a tendency for the sample to differ from the population (Weinbach and Grinnell, 2007). For example, researcher bias is a type of sampling error. With this type of bias, the researcher may tend to select participants to yield the most favorable study outcome (Martin and Bridgmon, 2012). Sampling error can be reduced in two ways: (1) the larger the sample, the smaller the sampling error; (2) homogenous samples yield smaller sampling error than heterogeneous samples.

Notably, when probability sampling techniques (random, stratified random, cluster sampling) are employed study outcomes are generalizable, because the resulting sample is more likely to be representative of the population under study. However, probability sampling is not used in this study, because a list of possible respondents is not available. Rather, grandparent caregivers are self-identifying. A consequence of this is the lengthy time investment involved in
identifying willing participants through probability sampling methods from the population of interest can pose a substantial barrier to study completion (Faulkner and Faulkner, 2013).

However, to increase the utility of non-probability sampling, Faulkner and Faulkner (2013) suggests the researcher ask himself or herself the following question: “How much does the sample reflect the population from which it is drawn?” (p.81). To address that question and the limitations of probability sampling, detailed description of the population under study and the sample is provided in an effort to cautiously apply the study’s significant results to similar populations. Additionally, power sample analysis is executed to determine a sample size adequate to detect a true relationship exists between variables (Bannon, 2013).

The present study sought to determine the extent to which a positive relationship exists between primary or custodial grandparent caregivers’ choice to parent, spirituality, social support, resources, parental stress, cognitive appraisal, and grandparent caregivers’ experience of positive life satisfaction when performing the parental role. This chapter details the study’s participants, instrumentation, data collection procedure, human subject’s compliance, and limitations.

Participants

The population of the study consisted of primary or custodial grandparent caregivers who resided in three northwest Alabama counties. Geographically the counties are considered rural and its largest city metropolitan (U.S. Census, 2010b). The averaged racial/ethnic composition of the studied area is Caucasian (85%), African American (10%), Hispanic/ Latino (3%), Other (2%) (U.S. Census Bureau, 2014).

Non-probability convenience and snowball sampling methods are employed. Inclusionary critieria are participants who self-identified as (1) primary or custodial grandparent or great
grandparent caregivers, (2) caring for biological or legal grandchildren 18 years and younger, (3) providing parental care for them 20 or more hours per week, and (4) grandchildren and biological parent(s) may or may not reside within the same household as the grandparent caregiver, and (5) when two grandparents in a household provide care, grandparents are asked to designate the person who provided primary care to be the study participant. Participants of any age, gender, socioeconomic status, racial/ethnic group, and spoke English who met inclusionary criteria are eligible for the study.

To test study hypotheses, this study used bivariate and multiple regression analyses. When these type of analyses are performed, power analysis has been demonstrated as a dependable method to determine sample size necessary to identify any effects that result from the independent variables (Rudestam and Newton, 2007). An a priori power analysis with five predictor variables was performed using a power of .80, $d_{.15}$, and $p = .05$ arriving at a study sample size of 92 primary or custodial grandparent caregivers. The final sample ($N = 94$) consist of 37 Caucasians and 67 African Americans grandparent caregivers. Participants range in age from 40 to 80, with a mean of 60 ($SD = 8.2$).

**Recruitment of Participants**

Participants were recruited through agencies serving children, social services agencies, public and private schools, churches, public libraries, grandparent caregiver support groups, and other grandparent caregivers. Over a ten-month period, the investigator participated in speaking engagements, emails, and phone calls to schools, agencies, social groups, and individuals to recruit study participants. Additionally, fliers with the researchers’ telephone number and email address were posted at places of worship, schools, churches, and libraries.
Potential participants contacted the researcher directly via telephone or email and a description of the study along with informed consent information was provided by telephone. The researcher made an initial determination whether the potential participant met the study’s inclusionary criteria, and the participants’ willingness to participate. Subsequent to this, an individual face to face, Skype, or a small group (2-6 participants) survey completion meeting is scheduled. Prior to study participation, the researcher reviewed inclusionary criteria, informed consent, and completes a cognitive screening with potential study participants.

Cognitive screening with the Six Item Screener (SIS) is employed to ascertain potential participants’ ability to fully participate in making informed decisions. When SIS cut-off criteria (two or less errors) for cognitive acuity to participate in informed decision making is met, survey instruments are administered. If potential participants commit three or more SIS errors, they are advised the study is not suitable for them and thanked for their willingness to participate. All potential participants and participants are provided a copy of the informed consent. At the conclusion of the meeting, participants are given a copy of the research study announcement. For snowball sampling purposes, participants are asked to share the flyer with other grandparent caregivers who may have in interest in study of this type and possibly meet study criteria.

Through recruitment activities, 109 individuals contacted the researcher and self-identified as primary or custodial grandparent caregivers with an interest in participating in the study. However, twelve potential participants did not follow through with study participation: two declined to participate after initial review of the informed consent stating discomfort with the process, six no-showed two small group appointments, and four did not return phone calls after initially indicating interest in study participation.
Instrumentation

Examination of the extant literature regarding grandparent caregivers and life satisfaction guided the inclusion of seven variables with appropriate measurement instruments. In keeping with the positive focus of the research study, all of the identified instruments are selected for their demonstrated ability to measure the positive aspects of the selected variables. The seven study variables are: (a) **choice to parent** which represents grandparent’s perception of their ability to freely chose to parent rather than being compelled to assume parenting responsibility for their grandchild or grandchildren. To measure **choice to parent**, this study uses the Likert scaled choice question posed in a study of grandparent caregivers conducted by Sands, Goldberg-Glen, and Thornton (2005); (b) **the Duke Religion Index** (DUREL) measures Spirituality; (c) the **Caregiving Satisfaction** subscale score of the Revised Caregiver Appraisal Scale (RCAS) measures cognitive appraisal of caregiving; (d) the **Family Social Support** subscale score of the Duke Social Support and Stress Scale (FS) measures social supports; (e) the **Family Resources Scale –Revised** (FRS-R) total score represents adequacy of resources; (f) **Parental Stress Scale** (PSS) measures perception of parental stress; (g) the **Satisfaction with Life Scale** (SWLS) score measures subjective life satisfaction.

Because of the significant number of grandparent caregivers over 65 years old who are at higher risk for cognitive impairment due to medical conditions and normal aging, a cognitive screener is employed. The **Six-item Screener** (SIS) assisted with determining cognitive integrity and suitability for participating in the study. SIS cut-off criteria (two or less errors) indicates cognitive acuity is present. Three or more SIS errors indicates potential study participants’ possible cognitive impairment suggesting probable inability to participate in informed decision making regarding study participation.
Socio-demographic information is captured through the administration of the demographic survey developed by the researched. **Control variables** for the study are gender, race/ethnicity, employment status, marital status, education, and the presence of grandparent’s dependent biological children in the home. The literature consistently identifies these variables influence on the experience of grandparent caregiver well-being (Kelley, Whitley, and Campos, 2010; Longoria, 2009; Ruiz, 2008). The procedure section that follows provides in-depth information on study measures employed.

**Human Subjects’ Compliance.**

Prior to initiation of the study, the study’s research proposal was submitted to the University of Alabama’s Institutional Review Board. The approved IRB proposal is found in Appendix I. The approved IRB specifically addresses study procedures, protection of human subjects, and benefits and risk of participation.

**Procedure**

In order to execute the approved study, identification and recruitment of study participants occurred through announcements at local libraries, senior adult groups, clubs, schools, grandparent caregiver meetings, and church events. The investigator posted fliers, presented the project at community events, and organization meetings, which resulted in direct contact by event attendees and respondents to fliers face through face, via phone, or email contact. Additionally, event attendees referred others potential study participants.

After the initial contact where an overview of the study was reviewed, the investigator arranged a face-to-face or Skype interview. Potential participants are screened for cognitive acuity and when deemed appropriate for the research study, meetings are arranged in their homes or another private setting of their choosing. The meeting addresses review of inclusion criteria,
informed consent, and administration of survey packet materials. The investigator offers to read the informed consent and instruments to potential participants, in anticipation of variance in reading levels. Fifty – four participants requested the survey packet be read to them.

The survey packet for participants included 10 items: an informed consent (5 – 10 minutes), cognitive screener (SIS) (1 -2 minutes), a demographic survey (5 minutes), choice to parent survey question (1 minute), Caregiver Satisfaction subscale (CS) of the Revised Cognitive Appraisal Scale (RCAS) (1 -2 minutes), the Family Resources Scale- Revised (FRS-R) (10 minutes), Duke Religion Index (DUREL) (1 – 2 minutes), Family Support subscale of the Duke Social Support and Stress Scale (DUSOCS) (5 minutes), the Parental Distress (PD) subscale of the Parental Stress Index-Short Form (PSI/ SF) (10 minutes), and the Satisfaction with Life Scale (SWLS) (5 minutes). A copy of the informed consent is given to all study participants.

Measures

The investigator used psychometrically suitable instruments with demonstrated levels of good reliability and validity in prior research regarding grandparent caregivers and well-being/life satisfaction. Administration of all study measures occured in English.

Dependent Variable. Life satisfaction is the study’s outcome variable and the following instrument measured the variable:

Satisfaction with Life Scale (SWLS) (Diener, Emmons, Larsen, and Griffin, 1985) (5 minutes). Life Satisfaction is the cognitive judgment of subjective well-being. For this research, life satisfaction is measured using the Satisfaction with Life Scale. The measure consists of five items scored on a 7-point Likert scale ranging from strongly agree to strongly disagree. Responses are summed. Higher SWLS response scores indicate higher life satisfaction (30 – 35
very high, 25 - 29 high, 20 - 24 average, 15 - 19 slightly below average, 10 – 14 dissatisfied, and 5 – 9 extremely dissatisfied).

Diener and associates (1985) originally designed the SWLS to ascertain adult’s global satisfaction with life. The SWLS has a validated history of appropriate internal consistency with Cronbach alphas ranging from 0.79 – 0.89 and test-retest reliability scores ranging from 0.5 – 0.84 (McDowell, 2010). Pavot et al. (1991) demonstrated the scales convergent validity through comparison with other measures of well-being as well as its discriminant validity from emotional/ psychological well-being scales.

Independent Variables: For the purposes of this study, parental stress, spirituality, social supports, resources and choice to parent are predictor variables. The following question and instruments measure the independent variables:

Choice to parent (1 minute). Choice to parent is measured via one five-item Likert scale statement regarding choice in caregiving with scoring ranging from strongly disagree to strongly agree. Sands, Goldberg-Glen, and Thornton (2005) used the statement, “I feel I have a choice about caring for my grandchildren.” in a study concerning grandparent caregiver well-being and stress to measure the caregivers’ perception of choice to parent their grandchildren. Higher ratings indicate grandparent caregivers endorse more choice in caregiving.

Spirituality (1 – 2 minutes). The Duke Religion Index (DUREL) (Koenig, H.G., Meador, K.G., Parkerson, G., 1997) is a five-item instrument that measures three dimensions of religiosity: intrinsic, organized, and non-organized. Organizational and non-organizational questions are rated on a six-point frequency scale: (1) = never, (2) = once a year or less, (3) = a few times a year, (4) = a few times a month, (5) = once a week, and (6) = several times a week. Intrinsic questions are rated on a five-point frequency scale: (1) definitely not true, (2) tends not
to be true, (3) Unsure, (4) Tends to be true, and (5) = definitely true. Responses are summed.
Higher scores are equivalent to higher levels of spirituality/ religiosity.

The instrument demonstrates good internal consistency (current sample, \(\alpha = 73\)). Initial
convergent validity established with the Santa Clara Strength of Religious Faith Questionnaire-
Short Form in a study with two separate samples \((n_1 = 628, n_2 = 244)\) of undergraduate college
students (Storch, Roberti, Heidgerken, Storch, Lewin, Killiany, Baumeister, Bravata, and
Geffken, 2004).

Parental Stress Scale (PSS) (Berry and Jones, 1995) (10 minutes). The PSS is an 18-item
measure and parents respond to each item to indicate the degree to which an item describes their
belief about stress associated with the parenting role. Items are responded to on a 5-point Likert
scale rated 1 (Strongly disagree), 2 (Disagree), 3 (Undecided), 4 (Agree) 5 (Strongly agree).
Originally, the PSS was developed as an alternate to the Parental Stress Index to measure the
positive and negative stressful effects of parenting. Scores for the measure range from 18 – 90.
To compute the PSS score items 1, 2, 5, 6, 7, and 8, are reversed scored to (1=5), (2=4), (3=3),
(4=2), (5=1). The item scores are then summed. Lower scores are indicative of lower stress.

The PSS has demonstrated test-retest reliability (.81) and internal reliability (.83) which
is consistent with the current sample (\(\alpha = .87\)). Berry and Jones (1995) established convergent
validity with the 120-item Parental Stress Index and the Perceived Stress Scale.

Family Support subscale (FS) (Parkerson, Michener, Wu, Finch, Muhlbaier, Magruder-
is a subscale of the Duke Social Support and Stress Scale. It is used to examine the individual’s
perceptions regarding how supportive or stressful his or her relationship are from their
perspective. It also allows the identification of an individual’s most supportive and most stressful
relationships, and has been applied to young adult and elderly populations. The measure consists of 12 social support and 12 stress items on a self-report Likert scale. Items refer to specific supports and are rated on a scale from 0 (none), 1 (some), 2 (a lot), and 0 (There is no such person). All items are added together, divided by 10 if a family member or 14 if a non-family member, and multiplied by 100 to obtain the total family social support score. Higher scores indicate caregiver perception of more social supports.

The FS demonstrates good internal consistency (current study, $\alpha = .77$) and test-retest stability ($r = .76$). Parkerson et al. (1989) confirmed convergent validity between the FS and Olson’s Family Strengths with a sample of 249 adult consumers at a family medicine clinic.

*Family Resources Scale-Revised (FRS-R)* (Dunst and Leet, 1987; Dunst, Trivette, and Deal, 1988; Van Horn, Bellis, and Snyder, 2001) (5 - 10 minutes). The FRS-R measures perceptions regarding the adequacy of family resources and is a modification of the 30-item Family Resources Scale. The measure has demonstrated utility with parents, grandparents, low income, and culturally diverse populations (Lopez and Cooper, 2011). FRS-R 17 item self-report Likert scale derived from a conceptual framework that predicts that an inadequacy of resources will negatively impact personal well-being and parental commitment. The measure acquires information about all types of resources. Additionally, the FRS-R “contains items relating to social support but does not have a separate social support subscale” (Lopez and Cooper, 2001, p. 63). Items refer to specific resources and are rated on a 5-point Likert scale from 1 (*does not apply*) to 5 (*almost always adequate*). The measure has four subscales: Basic Needs, Money, Time for Self, and Time for Family. All items are added together to obtain the total score. Higher scores indicate caregivers’ perception of possessing more resources.
The FRS-R has very good internal consistency (current sample, $\alpha = .87$) and high test-retest stability ($r = .84$). Van Horn et al. (2001) established construct, convergent, and predictive validity of the FRS-R with other measures of resources on a large diverse national sample.

**Moderating Variable.** The impact of the grandparent caregivers’ cognitive appraisal of caregiving satisfaction on their experience of life satisfaction is introduced as a moderating variable. Variables of this type may influence the relationship between two variables by changing the strength of an effect or relationship between the two (Remler and Van Ryzkin, 2011). The interaction effect of caregiving satisfaction is examined by employing the measure that follows:

*Caregiving satisfaction (CS)* (Lawton, Kleban, Moss, Rovine, and Glicksman, 1989) (5 minutes). The CS is a subscale of the Revised Caregiving Appraisal Scale (RCAS) composed of six items designed to measure the positive, neutral, and negative appraisals of caregiving satisfaction. Caregiving satisfaction is conceptualized as caregivers perceiving the “caregiving experience as a source of satisfaction” (Lee, Friedmann, Picot, Thomas, and Kim, 2007, p. 409). Items are scored on a 5-point Likert-type scale regarding the extent to which the caregiver agrees with a statement 1 (*not at all*) to 5 (*a great deal*). Response scores are summed. An item example is, “You get a sense of satisfaction from helping your family member.”

**Six-item Screener (SIS)** (Callahan, Unverzagt, Hui, Perkins, and Hendrie, 2002) (1 – 2 minutes). The SIS is a six-item measure to identify cognitive impairment in older adults who are potential study participants. The SIS contains items such as “What year is this?”, “What month is this?”, “What is the day of the week?”, “What were the three objects I asked you to remember?” Potential participants who make two or less errors are cognitively suitable for study participation. Potential participants who make three or more errors may indicate cognitive impairment. While this score may not be indicative of an inability to make informed decisions, it does suggest cognitive impairment and increases the likelihood the potential participant does not possess the cognitive capacity to make informed decisions. (Callahan et al., 2002).

**Demographic Survey** (5 minutes). The Demographic developed by the researcher specifically for Survey was developed such as: gender (male = 1 and female = 2); number of grandchildren; age of grandchildren in years; total length of time in the grandparent caregiving role in years; age in years of primary grandparent provider; race/ethnicity (White = 1, African American = 2, Hispanic/ Latino = 3, Other =4); marital status (married/ living with a partner = 1 and not married; i.e., divorced, separated, widowed, never married = 0); work status (Employed Full Time = 1, Employed Part-Time = 2, Unemployed = 3, and Retired = 4); and education level (Less than High School = 1, High School grad/ GED = 2, Some college = 3, and College degree plus = 4).

This chapter addressed the methods used to test the extent relationships may exist between primary or custodial grandparent caregivers’ choice to parent, spirituality, social support, resources, parental stress, cognitive appraisal, and positive caregiver life satisfaction when performing the parental role. The research design used several instruments. The data were
collected according to the methods detailed in this chapter, and they were entered into SPSS 23 for analysis. The results from analysis of the data are presented in Chapter 4.
CHAPTER 4 - DATA ANALYSIS AND RESULTS

This study investigated the relationship between and among grandparent caregivers’ choices to parent, spirituality, parental stress, social supports, resources, cognitive appraisal, selected demographic variables, and life satisfaction. Preparation of data and descriptive statistics are presented first in this chapter to characterize the sample. A statistical summary of measures used is presented. Hypotheses testing follows which includes: (1) bivariate analyses to examine how the variables relate to one another and to determine which variables significantly relate to the dependent variable; (2) multivariate analyses to examine the relationship between multiple independent variables, and the dependent variable.

Inferential statistics procedures are used in this study to analyze data. Inferential statistical tests are used to examine association between variables and use significance tests and other measures to make inference about data. (Faulkner and Faulkner, 2014). There are two types of inferential statistical test: parametric and non-parametric. According to Falkner and Faulkner (2014), parametric statistical tests have a set of assumptions that must be met: “(1) normal distribution of the data, (2) dependent variable is measured at the interval or ratio level, and (3) sample size of at least fifty. Nonparametric statistical tests are used when the data depart from the criteria established for parametric statistics” (p. 198). Inferential statistical tests include bivariate as well as multivariate test.

Bivariate tests used in the study are the one-way analysis of variance (ANOVA), Spearman’s rho, and Pearson’s r correlation coefficient. The results of bivariate test are
presented. Additionally, outcomes from the Pearson’s \( r \) indicated when more than one independent variable had significant Pearson \( r \) correlations with the dependent variable. Subsequently, the independent variables could be combined in multiple regression analysis, and a meaningful outcome predicted on the dependent variable (Matin and Bridgmon, 2012). In keeping with this assertion, once correlations were executed to determine significance of independent variables relationship with the dependent variable, Multiple Regression Analysis (MRA) was conducted. MRA is appropriate for analysis, because the relationship between multiple independent variables and one continuous dependent variable is under study (Martin and Bridgmon, 2012).

For all analyses, the alpha level was set at .05. In addition, for MRA, the power level was set at .80, and the effect size .15. The MRA used five predictors. To conduct the moderation MRA, interaction terms were created for each predictor. Within the chapter, answers to Research Questions 1 – 5 are provided through bivariate analyses. Results of multiple regression analyses (MRA) follows to answer Research Question 6 and 7.

**Preparation of Data**

Prior to data analysis, the investigator insured data integrity by conducting the following checks of the data: (1) Statistical Power analysis – to determine sample size that is at “a sufficient level of statistical power to reveal whether a true relationship exists between the variables” (O’Bannon, 2012, p.5) to reduce the likelihood of Type II error occurred. G*Power Analysis conducted with an alpha level of .05, medium effect size .15, and power level of .80 determined a sample size of \( N = 92 \); (2) Data cleaning to examine for errors of data entry and correct them occurred; (3) Missing data values were identified and addressed. five were identified on Likert-type scales and an average rating score was entered; (3) Evaluation of
whether test assumptions were met to support use of parametric statistical tests, such as normality, homoscedasticity, multicollinearity, linearity, undue impact of outlier scores on findings, etc. occurred.

**Evaluation of Normal Distribution**

The results of both Fisher and Pearson’s Coefficient skewness coefficients and looking at both histogram and normal Q-Q plots for parental distress, social support, and cognitive appraisal showed that each distribution approached a normal curve, one that is not severely skewed. Pearson’s correlation coefficient was suitable to examine the relationship between these variables and life satisfaction.

Life satisfaction, reported resources, and spirituality distributions were negatively skewed. Choice to parent was positively skewed. Transforming life satisfaction to its square root (.10) fell within ±.20 Pearson’s skewness coefficient and the Fisher’s skewness coefficient (.73) fell within ± 1.96. Transforming significantly enhanced the shape of the distribution to approach a normal curve (See figures 2 and 3). The transformed variable was used in all analyses.

Transformations were conducted on reported resources, spirituality, and choice to parent. Evaluation of the transformations of distributions for reported resources, spirituality, and choice to parent did not significantly enhance the distributions and produce normal distributions. Spearman’s rho was used to examine the relationship between these variables and life satisfaction since normality was violated. Evaluation of additional assumptions required for multiple regression are addressed later in the document, prior to answering Research Questions 6 and 7.
Figure 2: The Distribution of Square Root of Satisfaction with Life

Figure 3: Normal Q-Q Plot of Square Root Satisfaction with Life
Outliers were examined by calculating Mahalanobis’ distance (Mertler and Vannatta, 2010). Two cases were excluded because they exceeded the chi-square criteria of $\chi^2 (5) = 20.52$ at $p = .001$. This resulted in a sample size of $N = 94$, which exceeded the minimum required sample size of 92.

**Cronbach Alpha Coefficients**

Muijs (2004) proposed that instruments that have a Cronbach’s coefficient alpha of .70 or greater may be deemed reliable. Six measures used in this study met this standard: SWLS (.86), FRSR (.87), PSS (.87), DUREL (.73), DUSCOS (.77), RCAS (.75). The Choice to parent measure variable was addressed through one five-item Likert question. Table 1 illustrates reliability of these four measures.

Table 1: Alpha Coefficients of Reliability (n = 94)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Instrument</th>
<th>Number of Items</th>
<th>Cronbach's Alpha</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life Satisfaction</td>
<td>SWLS</td>
<td>5</td>
<td>.86</td>
<td>94</td>
</tr>
<tr>
<td>Reported Resources</td>
<td>FRSR</td>
<td>17</td>
<td>.87</td>
<td>94</td>
</tr>
<tr>
<td>Parental Stress</td>
<td>PS</td>
<td>18</td>
<td>.87</td>
<td>94</td>
</tr>
<tr>
<td>Spirituality</td>
<td>DUREL</td>
<td>5</td>
<td>.73</td>
<td>94</td>
</tr>
<tr>
<td>Social Support</td>
<td>DUSCOS</td>
<td>12</td>
<td>.77</td>
<td>94</td>
</tr>
<tr>
<td>Cognitive Appraisal</td>
<td>RCAS</td>
<td>6</td>
<td>.75</td>
<td>94</td>
</tr>
</tbody>
</table>

**Characteristics of the Sample**

Sample characteristics are presented in Table 2. There were considerably more females (94%) than males (6%) in the sample ($N = 94$) and participants ranged in age from 40 – 80 years ($M = 60$). Approximately, 32% were unmarried/divorced, 54% were married, and 14% widowed. In terms of education level, 33% attended or completed high school and 67% of grandparent caregivers were college/post-college graduates. By ethnicity, the sample was composed of African Americans (63%) and Caucasians (37%). More than half of study
participants were retired (54%), about 37% worked full or part-time, and 9% were unemployed. Only eight minor birth children resided in grandparent caregiver homes ranging in age from 1 – 18 years ($M = 12$ years). Grandparents provided primary caregiving for 162 grandchildren who ranged in age from 1-6 (49%), 7-12 (32%), and 13-18 (19%) ($M = 11$ years). In terms of length of time grandparent caregivers provided care, 89 (55%) grandchildren received care from 1-6 years, 45 (28%) from 7-12 years, and 28 (17%) 13-18 years. On average grandparent caregivers provided care for approximately 7 years ($M = 6.6$). Most of the grandchildren sampled (87%) were not identified as having a disability. However, 13% (12) of grandchildren were identified as disabled: physical (3), emotional (5), intellectual (3), and multiple disabilities (2).
Table 2: Demographic Characteristics of Participants (N = 94)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>n</th>
<th>%</th>
<th>M</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>87</td>
<td>94</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>7</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Grandparent age</td>
<td>60</td>
<td></td>
<td></td>
</tr>
<tr>
<td>40-50</td>
<td>13</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>51-60</td>
<td>34</td>
<td>36</td>
<td></td>
</tr>
<tr>
<td>61-70</td>
<td>36</td>
<td>38</td>
<td></td>
</tr>
<tr>
<td>71-80</td>
<td>11</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Age of Caregiver's minor birth children</td>
<td>12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-6 years old</td>
<td>2</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>7-12 years old</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>13-18 years old</td>
<td>6</td>
<td>72</td>
<td></td>
</tr>
<tr>
<td>Caregiver’s ethnicity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>59</td>
<td>63</td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>35</td>
<td>37</td>
<td></td>
</tr>
<tr>
<td>Caregiver’s marital status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>15</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>50</td>
<td>53</td>
<td></td>
</tr>
<tr>
<td>Separated/Divorced</td>
<td>15</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Widowed</td>
<td>14</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Caregiver education level</td>
<td></td>
<td></td>
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<tr>
<td>≤ High School</td>
<td>31</td>
<td>33</td>
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</tr>
<tr>
<td>College</td>
<td>49</td>
<td>52</td>
<td></td>
</tr>
<tr>
<td>Post College</td>
<td>14</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Caregiver work status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full time</td>
<td>18</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>Part time</td>
<td>17</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td>8</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Retired</td>
<td>51</td>
<td>54</td>
<td></td>
</tr>
<tr>
<td>Grandchildren’s age</td>
<td>11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-6 years old</td>
<td>79</td>
<td>49</td>
<td></td>
</tr>
<tr>
<td>7-12 years old</td>
<td>53</td>
<td>33</td>
<td></td>
</tr>
<tr>
<td>13-18 years old</td>
<td>30</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Grandchild’s length of time w/ caregiver</td>
<td>6.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-6 years</td>
<td>89</td>
<td>55</td>
<td></td>
</tr>
<tr>
<td>7-12 years</td>
<td>45</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>13-18 years</td>
<td>28</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>Grandchild disability</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>12</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>82</td>
<td>87</td>
<td></td>
</tr>
<tr>
<td>Grandchild disability type</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Emotional</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Intellectual</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Multiple</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Not applicable</td>
<td>82</td>
<td>87</td>
<td></td>
</tr>
</tbody>
</table>
Independent Samples t-test

One independent samples t-test was conducted to compare African American ($M = 3.296$, $SD = .9036$) and Caucasian ($M = 2.969$, $SD = .9715$) grandparent caregivers’ life satisfaction. The results revealed no significant differences between African American and Caucasian grandparent caregivers experience of life satisfaction ($t(92) = 1.616; p = .109$).

One-way Analysis of Variance (ANOVA)

Four one-way between groups analyses of variance (ANOVA) were conducted to explore the effect of grandparent caregivers’ work status, marital status, education level, and length of time caregiving. The work status variable consisted of four categories (Group 1 – fulltime employed, Group 2 – part-time employed, Group 3 - unemployed, and Group 4 – retired). The ANOVA assumptions of homogeneity of variances was met as demonstrated by the Levene’s test of homogeneity ($F = .918, p = .285$). The ANOVA results revealed a statistically significant difference between work status groups on grandparent caregivers’ life satisfaction [$F(3, 90) = 3.363, p = .022$].

The Bonferroni post hoc test evaluated pairwise differences between the four groups. The results of the Bonferroni test indicated part-time employees reported significantly ($p = .018$) more life satisfaction ($M = 2.84$) than their retired counterparts ($M = 3.04$) or unemployed grandparent caregivers ($M = 4.05$). On the other hand, no significant difference was detected between employed fulltime and unemployed grandparent caregivers with regard to life satisfaction. Refer to Figures 4 and 5 for more details.
<table>
<thead>
<tr>
<th>Work Status</th>
<th>Mean</th>
<th>SD</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fulltime Employed</td>
<td>3.02</td>
<td>.77</td>
<td>18</td>
</tr>
<tr>
<td>Part-time Employed</td>
<td>2.84</td>
<td>2.84</td>
<td>17</td>
</tr>
<tr>
<td>Unemployed</td>
<td>4.05</td>
<td>4.05</td>
<td>8</td>
</tr>
<tr>
<td>Retired</td>
<td>3.04</td>
<td>3.05</td>
<td>51</td>
</tr>
<tr>
<td>Total</td>
<td>3.09</td>
<td>.9552</td>
<td>94</td>
</tr>
</tbody>
</table>

Figure 4: Group Means of Work Status Groups on Life Satisfaction

Figure 5: Work Status - Bonferroni Plot

The marital status variable consisted of four categories (Group 1: single, Group 2: married, Group 3: divorced, and Group 4: widowed). The ANOVA assumption of homogeneity of variances was met as demonstrated by the Levene’s test of homogeneity (F 1.694 = p = .174). The results revealed no statistically significant relationship between grandparent caregivers’ life satisfaction and marital status [$F(3, 90) = .918, p = .436]$. 

70
The education level variable consisted of five categories (Group 1: attended high school, Group 2: high school graduate, Group 3: some college or trade school, Group 4: college degree, and Group 5: post college). The ANOVA assumption of homogeneity of variances was met as demonstrated by the Levene’s test of homogeneity ($F = 1.249; p = .296$). The results revealed no statistically significant relationship between grandparent caregivers’ life satisfaction and education level [$F(4, 89) = .784, p = .539$].

The length of time caregiving variable consisted of three categories (Group 1: 1 - 6 years, Group 2: 7 - 12 years, and Group 3: 13 - 18 years). The ANOVA assumption of homogeneity of variances was met as demonstrated by the Levene’s test of homogeneity ($F = .706; p = .496$). The results revealed no statistically significant relationship between grandparent caregivers’ life satisfaction and education level [$F(2, 91) = 2.942, p = .58$].

**Statistical Summary of Measures**

A discussion of the results of measures employed follows with the statistical summary for all measures used in the study shown in Table 3. In general, lower scores on Parental Stress (PSS) indicated lower stress experienced by grandparent caregivers. For spirituality, social supports, reported resources, cognitive appraisal, and life satisfaction, higher scores indicated higher levels of the concept being measured. However, after transformation of life satisfaction scores, lower scores were interpreted as indicating higher levels of life satisfaction.

Results from the Parental Stress Scale (PSS) revealed a range of scores from 18 to 72 with an average total score of 41 ($M = 41.84$ total score, $SD = 15.06$). A total of 18 items were rated using a 5-point Likert scale from strongly disagree to strongly agree. To calculate the total score, 9 items were reverse scored and then all scores were totaled. The scoring range on the
PSS is 18 (low stress) to 90 (high stress). Respondents in the current study scored an average total score of 41 which indicated average scores between low to moderate stress.

The Duke Religion Index (DUREL) revealed a range of scores from 6 to 16 with an average total score of 14 ($M = 14.18$ total score, SD = 1.311). The instrument measured three dimensions of religiosity: intrinsic, organized, and non-organized. Organizational and non-organizational questions are rated on a six-point frequency scale: (1) = never, (2) = once a year or less, (3) = a few times a year, (4) = a few times a month, (5) = once a week, and (6) = several times a week. Intrinsic questions are rated on a five-point frequency scale: (1) definitely not true, (2) tends not to be true, (3) Unsure, (4) Tends to be true, and (5) = definitely true. Responses to a total of 5 items are summed to calculate the total score. Higher scores are equivalent to higher levels of spirituality/ religiosity. The scoring range on the DUREL is 5 (low spirituality) to 27 (high spirituality). Respondents in the current study scored an average total score of 14, which indicated mid-level spirituality.

Results from Family Social Support (FSS) subscale of the Duke Social Support and Stress Scale revealed a range of scores from 23-91 with an average total score of 54 ($M = 54.49$ total score, SD = 17.728). A total of 12 social support and 12 stress items were rated on a scale from 0 (none), 1 (some), 2 (a lot), and 0 (There is no such person). All items are added together, divided by 10 if a family member or 14 if a non-family member, and multiplied by 100 to obtain the total family social support score. Higher scores indicate caregiver perception of more social supports. The scoring range on the FS is 0 (no social support) to 100 (high social support). Respondents in the current study scored an average total score to 54 which indicated medium social support.
The Family Resources Scale-Revised (FRS-R) revealed a range of scores from 36 to 83 with an average score total score of 67 \((M = 67.04, \text{ SD } = 9.948)\). A total of 17 items were rated on a 5-point Likert scale from 1 \((\text{does not apply})\) to 5 \((\text{almost always adequate})\). The measure has four subscales: basic needs, money, time for self, and time for family. To obtain the total score, all ratings are summed. Higher scores indicate caregivers’ perception of possessing more resources. The scoring range for the FRS-R is 17-85. Respondents scored an average total score of 67, which indicated a high perception of resources.

Results from Choice to parent ranged from 1 -5 on a 5-point Likert scale from 1 \((\text{strongly agree})\) to 5 \((\text{strongly disagree})\) with an average score of 4 \((M = 4.05, \text{ SD } = 1.239)\). Higher ratings indicate grandparent caregivers endorse more choice in caregiving. Respondents scored an average total score of 4, which indicated a high perception choice in parenting grandchildren.

The Caregiver Satisfaction (CS) is a subscale of the Revised Caregiving Appraisal Scale composed of 6 items designed to measure the positive, neutral, and negative appraisals of caregiving satisfaction. The CS revealed a range of scores from 19-30 with an average score of 27 \((M = 27.39, \text{ SD } = 2.859)\). Items are scored on a 5-point Likert-type scale from 1 \((\text{not at all})\) to 5 \((\text{a great deal})\). Response scores are summed. Higher scores indicate caregivers perceive themselves as experiencing more caregiving satisfaction. The scoring range for the CS is 6-30. Respondents scored an average total score of 27, which indicated a high caregiver satisfaction.

Results from Satisfaction with Life Scale ranged from 10-35 with an average score of 25 \((M = 25.54, \text{ SD } = 6.19)\). The measure consists of five items scored on a 7-point Likert scale ranging from \textit{strongly agree} to \textit{strongly disagree}. Responses are summed. Higher SWLS response scores indicate higher life satisfaction. The scoring range is very high \((30 – 35)\), high \((25 - 29)\), average \((20 – 24)\), slightly below average \((15 – 19)\), dissatisfied \((10 – 14)\), and
extremely dissatisfied (5 – 9). Respondents scored an average total score of 24, which indicated high life satisfaction.

Table 3: Statistical Summary of Independent, Moderator, and Outcome Measures (N = 94)

<table>
<thead>
<tr>
<th>Variable/Measure</th>
<th>Mean</th>
<th>Median</th>
<th>SD</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Independent Variables</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parental Stress (PSS)</td>
<td>41.84</td>
<td>40.50</td>
<td>15.056</td>
<td>18-72</td>
</tr>
<tr>
<td>Spirituality (DUREL)</td>
<td>14.18</td>
<td>15.00</td>
<td>1.311</td>
<td>6-16</td>
</tr>
<tr>
<td>Social Supports (FSS)</td>
<td>54.49</td>
<td>50.00</td>
<td>17.728</td>
<td>23-91</td>
</tr>
<tr>
<td>Reported Resources (FRS-R)</td>
<td>67.10</td>
<td>69.50</td>
<td>9.948</td>
<td>36-83</td>
</tr>
<tr>
<td>Choice to parent</td>
<td>4.05</td>
<td>4.00</td>
<td>1.239</td>
<td>1-5</td>
</tr>
<tr>
<td><strong>Moderator Variable</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cognitive Appraisal (CS)</td>
<td>27.39</td>
<td>28.00</td>
<td>2.859</td>
<td>6-30</td>
</tr>
<tr>
<td><strong>Outcome Variable</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life satisfaction (SWLS)</td>
<td>25.54</td>
<td>27.00</td>
<td>6.186</td>
<td>10-35</td>
</tr>
</tbody>
</table>

**Hypotheses Testing**

**Correlational analysis**

Correlation analyses were conducted to investigate the existence of significant relationships between the variables. Possible relationships between the dependent and independent variables were explored. The independent variables were choice to parent, parental distress, social supports, reported resources, and spirituality. The dependent variable was life satisfaction.

**Research Questions 1-5**

Research questions (RQ) 1-5 are addressed in order. These questions were answered through Spearman’s rho and Pearson’s r correlation analysis. The results of each correlation may be found in Table 4.
Research Question 1

The first research question asked, to what extent choice to parent was associated with grandparent caregivers’ life satisfaction.

Hypothesis 1

The higher the level of choice to parent the higher the level of life satisfaction experienced by grandparent caregivers.

The results of the Spearman’s rho for RQ 1 showed a significant ($r_s(94) = .26, p = .011$) relationship between life satisfaction and choice to parent. These results show that choice to parent explains about 7 percent [$p = .006; r^2 = (.26)^2 = 6.8\%$] of the variance in life satisfaction, thus indicating a very weak correlation. Because life satisfaction scores were reversed, the outcome indicated higher life satisfaction is associated with higher choice to parent. Hypothesis 1 was supported.

Research Question 2

The second research question asked, to what extent spirituality was associated with grandparent caregivers’ life satisfaction.

Hypothesis 2

The higher the level of spirituality/ religiosity the higher the level of life satisfaction experienced by grandparent caregivers.

The results of the Spearman’s rho for RQ 2 were not significant ($r_s(94) = .214, p = .038$) relationship between life satisfaction and spirituality. These results showed that spirituality explains about 5 percent [$p = .019; r^2 = (.214)^2 = 4.6\%$] of the variance in life satisfaction. The outcome indicated higher life satisfaction is associated with more spirituality. Hypothesis 2 was supported.
Research Question 3

The third research question asked to what extent social supports are associated with grandparent caregivers’ life satisfaction.

Hypothesis 3

The higher the level of social supports the higher the level of life satisfaction experienced by grandparent caregivers.

The results of the Pearson’s correlation for RQ 3 was not significant ($r(94) = .093$, $p = .375$) indicating a relationship did not exist between life satisfaction and social support. The third hypothesis was not confirmed.

Research 4

The fourth research question asked to what extent are reported resources associated with grandparent caregivers’ life satisfaction.

Hypothesis 4

The higher the level of reported resources the higher the level of life satisfaction experienced by grandparent caregivers.

The results of the Spearman’s rho for RQ 4 show a significant ($r_{s}(94) = .484$, $p = .000$) relationship between life satisfaction and reported resources. The outcome indicated participants who indicated more reported resources endorsed higher life satisfaction. These results show that reported resources explained about 23 percent [$p = .000; r^2 = (.484)^2 = 23\%$] of the variance in life satisfaction. The outcome indicated higher life satisfaction is associated with more reported resources. The fourth hypothesis was confirmed.
Research Question 5

The fifth research question asked, to what extent parental stress was associated with grandparent caregivers’ life satisfaction.

Hypothesis 5

The lower the level of parental stress the higher the level of life satisfaction experienced by grandparent caregivers.

The results of the Spearman’s rho for RQ5 were significant ($r(94) = .181, p = .081$) indicating a relationship did not exist between life satisfaction and social support. The third hypothesis was not confirmed.

Furthermore, Table 4 illustrates the summary of results for correlations between each independent variable and the dependent variable.

Table 4: Summary of Bivariate Correlations for Research Questions 1 - 5 (N = 94)

<table>
<thead>
<tr>
<th>Research Question</th>
<th>Variable</th>
<th>Life Satisfaction</th>
<th>X</th>
<th>SD</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Choice to Parent</td>
<td>.260* .011</td>
<td>4.05</td>
<td>1.239</td>
<td>1-5</td>
</tr>
<tr>
<td>2</td>
<td>Spirituality</td>
<td>.214* .038</td>
<td>14.18</td>
<td>1.311</td>
<td>6-16</td>
</tr>
<tr>
<td>3</td>
<td>Social Support</td>
<td>.093 .375</td>
<td>54.49</td>
<td>17.728</td>
<td>23-91</td>
</tr>
<tr>
<td>4</td>
<td>Reported Resources</td>
<td>.484*** .000</td>
<td>67.10</td>
<td>9.56</td>
<td>36-83</td>
</tr>
<tr>
<td>5</td>
<td>Parental Stress</td>
<td>.181 .081</td>
<td>41.84</td>
<td>15.056</td>
<td>18–72</td>
</tr>
</tbody>
</table>

***Correlations at ≤ 0.000, ** Correlations ≥ 0.01, *Correlations ≤ 0.05
Multiple regression analyses

Correlations analyses were computed to examine the intercorrelations of the variables. Table 4 shows that choice to parent was significantly correlated with life satisfaction,
\[ r (94) = .26 \quad p = <.01, \]
reported resources was significantly correlated with life satisfaction,
\[ r (94) = .51 \quad p = <.01, \]
spirituality was significantly correlated with life satisfaction,
\[ r (94) = .21 \quad p = <.05. \]
Because social support (\( r (94) = .38, \quad p = .093 \)) and parental stress (\( r(94) = .181, \quad p = .081 \)) were not significantly correlated with life satisfaction, both variables were not entered in the multiple regression model.

A step-wise standard multiple regression was conducted using life satisfaction as the dependent variable (DV) and choice to parent, spirituality, reported resources, and parental stress as the independent variables (IV). Control variables marital status, work status, education level, and length of time grandchildren living in the home were added to the model.

Research Questions 6

Research question 6 asked, does choice to parent, spirituality, social supports, reported resources, and parental stress to influence grandparent caregivers’ life satisfaction positively.

Hypothesis 6

The higher the level of choice to parent, spirituality, social supports, reported resources, and lower levels of parental stress, the higher the level of well-being/life satisfaction reported by grandparent caregivers.

A stepwise multiple regression analysis was conducted with four independent variables (choice to parent, spirituality, and reported resources). The dependent variable was life satisfaction. Control variables length of time caregiving, marital status, level of education and work status were introduced in to the model. Social support (IV) (\( p = .093 \)) and parental distress
(IV) \((p = .181)\) did not evidence a significant bivariate association with life satisfaction. Therefore, it was not included in the analysis. Only data for the second model is included here as it was found to be most parsimonious. The results of this analysis are found in Table 5.

The stepwise multiple regression analysis revealed that two of the five predictors emerged as significant predictors of life satisfaction \((F = 21.46, p < .001)\). With a beta of .44 \((p < .001)\), reported resources emerged as the strongest predictor of life satisfaction accounting for 25 percent of the variance in life satisfaction. The second strongest factor was choice to parent \((\beta .28, p = .002)\) accounting for 7 percent of the variance in life satisfaction. The results indicated that higher life satisfaction among grandparent caregivers was a function of greater resources and higher levels of choice in parenting their grandchildren. Overall, the model explained 32 percent of the variance in life satisfaction \((R = .57)\). Approximately, 68 percent of the variance in life satisfaction remains unaccounted for by this model.

Table 5: Multiple Regression Analysis - Predictors of Life Satisfaction

<table>
<thead>
<tr>
<th></th>
<th>(R^2)</th>
<th>Adjusted (R^2)</th>
<th>(R^2) Change</th>
<th>(\beta)</th>
<th>(t)</th>
<th>(p)</th>
<th>(F) Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resources</td>
<td>.25</td>
<td>.24</td>
<td>.25</td>
<td>.44</td>
<td>4.965</td>
<td>.000</td>
<td>30.016</td>
</tr>
<tr>
<td>Choice to Parent</td>
<td>.30</td>
<td>.31</td>
<td>.74</td>
<td>.28</td>
<td>3.195</td>
<td>.002</td>
<td>9.976</td>
</tr>
</tbody>
</table>

Research Question 7

A step-wise standard multiple regression was conducted to address RQ 7 using life satisfaction as the dependent variable (DV), choice to parent, spirituality, reported resources, and parental stress as the independent variables (IV), and with interaction terms for each IV.
Hypothesis 7

When levels of choice to parent, spirituality, social supports, reported resources, and parental stress are moderated by cognitive appraisal, higher levels of well-being/ life satisfaction are reported by grandparent caregivers.

Research question 7 asked does cognitive appraisal of caregiving satisfaction significantly interact with choice to parent, spirituality, reported resources, and parental stress to positively influence grandparent caregivers’ life satisfaction. The dependent variable was life satisfaction. Control variables length of time caregiving, marital status, level of education and work status were introduced in to the model. In bivariate analysis, social support (IV) \( (p = .093) \) and parental stress \( (p = .081) \) did not evidence a significant relationship with life satisfaction. Therefore, they were not included in the Multiple Regression Analysis. Two models were found to be significant at \( p < .05 \). However, interaction terms did not significantly contribute to the model. In step 3, of the model interaction terms were not significant for caregiver satisfaction and resources \( (t(85) =1.282, p = .20) \), caregiver satisfaction and spirituality \( (t(85) =.936, p = .35) \), and caregiving satisfaction and choice to parent \( (t(85) =1.192, p = .24) \). The results of this analysis are found in Table 6.

Table 6: Multiple Regression Analysis - Predictors of Life Satisfaction with Interaction Terms

<table>
<thead>
<tr>
<th></th>
<th>( R^2 )</th>
<th>Adjusted ( R^2 )</th>
<th>( R^2 ) Change</th>
<th>( \beta )</th>
<th>( t )</th>
<th>( p )</th>
<th>( F ) Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resources</td>
<td>.25</td>
<td>.24</td>
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<td>.44</td>
<td>4.965</td>
<td>.000</td>
<td>30.016</td>
</tr>
<tr>
<td>Choice to Parent</td>
<td>.30</td>
<td>.31</td>
<td>.74</td>
<td>.28</td>
<td>3.195</td>
<td>.002</td>
<td>9.976</td>
</tr>
</tbody>
</table>

Correlational statistics were used to investigate Hypotheses 1-7. The results of Spearman’s rho Correlation Coefficients supported Hypotheses 1, 2, and 4. After executing
Pearson’s r to investigate hypothesis 3 and Spearman’s Rho to investigate hypothesis 5, no significant relationships were found. For Hypotheses 6 and 7, multiple regression analyses were completed using the independent variables choice to parent, spirituality, and reported resources, along with control variables marital status, work status, education level, and length of time grandchildren living in the home. Life satisfaction was entered as the dependent variable. For Hypothesis 7, interaction terms were included in the multiple regression analysis. Hypotheses 6 and 7 were significant. Adding interaction terms to the model for Hypothesis 7 yielded a significant interaction with caregiver satisfaction and reported resources. Further discussion on the findings and implications for future practice and research will be provided in the next chapter.
CHAPTER 5 - DISCUSSION AND IMPLICATIONS

This chapter provides a discussion of major study findings presented in chapter 4. The current study explored the relationship between choice to parent, social support, resources, parental stress, spirituality, cognitive appraisal, and grandparent caregivers’ experience of positive well-being, specifically life satisfaction. Theoretical concepts from the resiliency model of family stress, adjustment, and adaptation (McCubbin and McCubbin, 1996), cognitive theory of stress and coping (Lazarus and Folkman, 1984), and choice theory (Glasser, 1998) provided the conceptual framework for the study. The conceptual framework provides an underpinning for the study with an emphasis on the individual’s unique strengths, resilience, and adaptability under life’s challenges and stressors.

Previous research on grandparent caregivers’ well-being predominantly focused on psychological well-being. However, this study shifts the focus to an understudied aspect of grandparent caregiver well-being, positive life satisfaction, and yielded several interesting findings. Notably, in the midst of managing numerous demands and life challenges, grandparent caregivers’ perception of choice to parent grandchildren, resources, parental stress, and spirituality promotes their positive experience of life satisfaction. Finally, the chapter concludes with suggestions for social work practice, policy, and research based on study findings.

Choice to Parent

The most interesting and compelling study finding was the evidence grandparent caregiver’s choice to parent grandchildren is related to caregiver’s experience of positive life
satisfaction. Heretofore, the investigation of grandparent caregiver’s positive life satisfaction has been an understudied area in the extant literature. In addition, the literature is virtually silent on choice to parent as a factor in grandparent caregivers’ experience of positive life satisfaction. In a search of the literature, I located only one other research study, Goldberg-Glen, and Thornton’s (2005) investigation of factors associated with the positive subjective well-being of grandparent caregivers, which introduced choice to parent as a moderating variable without significant effect.

The present study examined choice to parent’s relationship with the cognitive evaluative component of subjective well-being, life satisfaction. Choice to parent was hypothesized to have a direct effect on grandparent caregivers’ positive life satisfaction. Study outcomes provided evidence that choice to parent has a direct effect on grandparent caregivers’ experiences of positive life satisfaction. What accounts for the differences in the two studies’ outcomes and why is it important?

One consideration is this study examined the life satisfaction component of subjective well-being rather than the more commonly explored affective emotional component. More specifically, when examining grandparent caregivers’ subjective well-being investigation frequently centers on the pleasure or happiness grandparent caregivers experience from caregiving. As previously noted, there are two components of subjective well-being: an affective component, which is further divided into pleasant and unpleasant affect; and life satisfaction, which is an individual’s cognitive evaluation of the quality of their life relative to resources, social, and cultural influences (Pavot and Diener, 2009). It is reasonable to suspect factors may contribute differently or not all to the experience of both components.

For example, in Sands and colleagues’ (2005) study, well-being was conceptualized as the affective component of subjective well-being. Grandparent well-being was described as
“inner feelings of pleasure and accomplishment” (p.67) with choice to parent introduced as a factor that moderated grandparent caregiver’s experience of positive well-being. However, choice to parent did not significantly moderate grandparent caregiver’s affective well-being (Sands et al., 2005). By contrast, the present study examined choice to parent’s relationship with the cognitive evaluative component of subjective well-being, life satisfaction. Study outcomes provided evidence that choice to parent had a statistically significant direct positive effect on grandparent caregivers’ experiences of life satisfaction.

Another difference in the two studies’ outcomes is each study conceptually examined choice to parent from different perspectives: indirect and direct. In the present study, grandparent caregivers’ perception of choice to parent their grandchildren could be considered a volitional assumption of responsibility rather than a burden thrust upon them. From this perspective, the grandparent caregivers’ ability to choose to parent is under their control and maybe experienced as empowering. Grandparents are making individual judgements whether they have the requisite abilities, resources, and supports necessary to care for grandchildren. For grandparent caregivers in this study, increased positive life satisfaction appears is related to choice over whether to be a primary caregiver for grandchildren.

A conceptual underpinning of the present study is William Glasser’s perspective on choice. Glasser (1990) suggests choice has direct rather than indirect bearing on an individual’s experience of demands and stressors. Individuals who perceive they have choice tend to experience control over their lives. Response to life stressors and demands are viewed as volitional. The individual has the ability to adjust and adapt to stress and demand through personal choices to bring about positive life changes (Glasser, 1998). This study’s outcomes hold potential to extend understanding of the beneficial impact of choice on grandparent caregivers’
life satisfaction and to provide a fuller understand of grandparent caregivers’ positive response to the demands and challenges inherent to parenting.

**Resources**

In the present study, resources were the strongest predictor of positive grandparent caregiver life satisfaction. Resources included grandparent caregivers’ perception of adequate community resources (financial, health care, day care) and personal resources such as adequate food, sleep, time for self, and time with family. Prior research supports the positive association of adequate resources to improved caregiver well-being (Kelly et al., 2007; Whitley, Lamis, and Kelley, 2016). However, very limited knowledge exists that specifically relates to resources influence on grandparent caregivers experience of positive life satisfaction (Sands et al., 2005).

Diener (2009) suggests life satisfaction “forms a separate factor from the affective indexes of [subjective] well-being” (p.109). This study focused specifically on the life satisfaction component of subjective well-being’s relationship with resources. Outcomes confirm grandparent caregivers’ perception of the adequacy and availability of personal, family, financial, and community resources influence grandparent caregivers experience of positive life satisfaction. Findings are in concert with stress and coping theory’s assertion that adequate resources mitigate life demands, reduced stress, and influence well-being (Lazarus and Folkman, 1984).

Additionally, when well-being is considered through the lens of life satisfaction, happiness and pleasure in providing parental care is not necessarily experienced by grandparent caregivers. Rather, Diener (2009) asserts an individual has a unique set of criteria by which they judge the quality of their life. A high degree of match between the individual’s perception of life circumstances and personal criteria standard results in the person endorsing high life satisfaction.
Carr et al.’s (2014) research concerning the importance of knowledge and use of resources to grandparent caregivers illustrated that when grandparent caregivers perceived themselves to have sufficient knowledge of resources to meet parental, personal, social, and emotional demands, they experienced greater life satisfaction.

In this study, 38% of grandparent caregivers worked full-time, 30% possessed a college degree or greater and 53% were married. As a group, due to advanced education and marital status, it is probable participants have a greater likelihood to be aware of community resources and possess adequate economic resources. With this in mind, it is possible study participants’ experience of positive life satisfaction is garnered, in part, from the caregiver’s judgement that they possess necessary resources to adequately care for their grandchildren under circumstances many consider onerous.

**Spirituality**

Previous studies on caregivers’ religious involvement and spirituality indicated such practices promote caregivers’ well-being, reduce the experience of caregiver burden, and support increased coping capacity (Koenig, McCullough, and Larson, 2000). Dunifon and Kopko (2011) demonstrated custodial grandparent caregiver’s religiosity positively influenced individual and family well-being. Outcomes from this study concur with previous research on caregiver well-being. However, earlier research did not explore spiritual/ and religious practices as they relate to the grandparent caregivers’ experience of positive life satisfaction. Evidencing this study’s findings are distinctive.

The majority (63%) of study participants were African American compared to 37% Caucasian. Prior studies indicated impact of spirituality/ religiosity vary by racial/ ethnic group. Involvement in a religious belief system was a source of emotional support and psychological
well-being particularly for Latinos and African Americans grandparent caregivers (Picot, Debanne, Namazi, and Wykle, 1997; Brown and Mars, 2000, Moore and Miller, 2007). Latinos and African Americans tended to rely on spiritual religious beliefs as a source of emotional strength more often than their Caucasian counterparts (Brown et al., 2008). However, the current study found no significant difference in the experience of life satisfaction between African Americans and Caucasian grandparent caregivers.

Difference in this study’s outcome may be related to similarity in study participants’ lifestyle regarding sociodemographic characteristics such as marital status, work status, and education. The majority of participants were married (53%), retired (54%), and were educated beyond high school (67%). Such similarities in grandparent caregivers’ lifestyle characteristics may reduce racial differences evidenced in other studies. Also, in this study, spirituality was demonstrated to have a weak positive association with grandparent caregiver life satisfaction. However, based on previous research and this study’s sample composition a stronger correlation was anticipated.

Approximately, 98% of participants indicated their religious beliefs were behind their approach to life. With a majority (77%) of those participants engaging in spiritual religious practices daily such as prayer, bible reading, mediation, etc. This demonstrates the importance of religious beliefs and practices in the lives of these grandparent caregivers. However, other factors such as the caregivers’ personal and family values may have bearing on the significance of spirituality to the participants in this study’s experience of positive life satisfaction. These factors were not the focus of this research study.
Non-significant Findings - Parental distress

Numerous studies indicate grandparent caregivers experience parental stress that effects well-being when parenting grandchildren (Bullock, 2005; Bundy-Fazioli, Fruhauf, and Miller, 2013; Kelly, Whitley, and Sipe, 2007 Keller, Litselman, Wisk, Maddox, Cheng, and Creswell, 2012). This study provides evidence that lower parental distress is associated with higher life satisfaction. According to Lazarus and Folkman’s (1984) theory on stress, coping, and cognitive appraisal, stress is defined as an event or circumstance that exceeds personal resources and affects well-being.

When grandparent caregivers operate in the parental role, they encounter parental responsibilities and demands comparable to biological and legal parents. Hayslip and associates (2014) found grandparent caregivers’ experienced parental stress as a fundamental part of the parental role similar to the stressors experienced by biological parents. Contrary to findings by Sands and associates (2005) were stress was negatively correlated to grandparent caregiver well-being, parental stress was not significant factor.

What accounts for the differences in outcomes between the studies? By age group and number of caregivers’ working, the study samples were very similar. Differences were present in education level of grandparent caregivers. In the present study, the majority of participants were high school graduates or greater (67%) and most were married (53%). As stated earlier, it is possible grandparent caregivers in the present study have less parental stress due to higher income that often comes with higher education level. This may result in less economic stress than that experienced by caregivers with less than a high school degree. In addition, due to education level grandparent caregivers may have access to more information about effective
parenting practices that augment parenting skills practiced within the family. This information could support less parental stress.

A significant relationship was not found between life satisfaction and social support. This outcome is contrary to several studies on grandparent caregivers where social support was a significant predictor of grandparent caregiver well-being (Gerard, Landry-Meyer, and Roe, 2006; Hayslip et al., 2014; Kelly, Whitley, Sipe, and Yorker, 2000; Kresak, Gallagher, and Kelly, 2014; Musil et al., 2011). In retrospect, the family support subscale of the Duke Social Support Scale (DUSOCS) was not the most efficacious measure. The instrument was selected for its ability to differentiate between different types of social support. The family support subscale assessed social supports provided by family and non-family members, only.

Lopez and Cooper (2011) reviewed 12 social support measures for use with culturally diverse groups of parents with young children. The reviewers suggested effective social support measures assess material and interpersonal social relationships. Further, they assert the measure should assess supports that are meaningful to the individual, helps them cope with stressful life events, and engenders positive well-being. It is probable the family support subscale measured social support too narrowly, because these areas are not addressed by the measure.

In regards to the cognitive appraisal as a moderating factor, in multiple regression analysis the interaction term did not moderate grandparent caregivers’ positive life satisfaction. This outcome is contrary to findings in Sholomo’s (2014) study of sociodemographic characteristics, perceived stress, and cognitive appraisals of grandparenthood to life satisfaction among new grandparents. Comparing the population and methods of the current study to Sholomo’s research, non-probability methods, sample composition, and two of the measures employed were similar in both studies.
However, Sholomo’s (2014) approach differed in the instrument used to measure grandparents’ cognitive appraisal. The three subscales of the Cognitive Appraisal Scale (Folkman and Lazarus, 1985) were employed: self-efficacy, threat, and challenge. Shlomo (2014) found the self-efficacy subscale moderated the negative correlation between grandparent distress and life satisfaction, and higher appraisal of self-efficacy correlated positively with life satisfaction. The finding from the aforementioned study is in keeping with Stress and Coping Theory’s perspective that self-efficacy can lead to improved well-being.

The present study used the Caregiver Satisfaction subscale of the Caregiver Appraisal Scale (Lawton et al., 1989), which measured participants’ cognitive appraisal of satisfaction with caregiving. As stated earlier, this study found cognitive appraisal of caregiver satisfaction did not moderate grandparent caregivers’ experience of positive life satisfaction. This finding may indicate that grandparent caregivers perceiving themselves as capable is the moderating relationship associated with life satisfaction rather than caregivers’ satisfaction with caregiving.

In conclusion, Diener’s (2000) work asserted the individual assesses their life satisfaction across a positive negative continuum, which is influenced by the individual’s judgment of connection to family, access to community resources, and social supports. Bivariate research findings supported positive life satisfaction’s association with choice to parent, parental stress, spirituality and reported resources. However, caregiver appraisal of satisfaction did not moderate grandparent caregiver life satisfaction. Future research should examine self-efficacy as a moderator of in grandparent caregivers’ experience of positive life satisfaction.

**Study Strengths and Limitations**

The strengths and limitations of the present study follow. The first strength is the study addressed positive life satisfaction an understudied aspect of grandparent caregivers’ subjective
well-being. To date, very few studies have examined grandparent caregiver subjective well-being from this strengths-focused point of view. Therefore, findings from the present research are important because outcomes add to an understudied area that holds potential to improve the quality of life of an at-risk population. Second, the study confirms and extends the very limited extant knowledge concerning choice to parent’s influence on grandparent caregivers’ experience of positive life satisfaction. Third, findings support earlier findings that resources are critical to grandparent caregivers’ experience of positive life satisfaction. Lastly, the study can help to inform the design and development of empowering life enhancing community-based services for grandparent caregivers.

Of course, the study had several limitations. First, the study was a cross-sectional survey design, and data were collected at one point in time. Causal conclusions could not be drawn about the data, because the design does not employ the rigor of quasi-experimental or experimental designs (Rudestam and Newton, 2007). Also, because the design is cross-sectional, it does not permit examination of the factors contributing to change in grandparent caregivers’ positive life satisfaction over time.

Second, the study relied exclusively on self-report. To gain a broader perspective, data should be derived from other relevant sources in future studies (grandchildren, spouses, other family members). Third, non-probability (convenience and snowball) sampling techniques were used rather than through probability techniques, which are less likely to yield a representative sample of the population under study (Faulkner and Faulkner, 2014). Primary grandparent caregivers are not a discrete population. Because of this, a sampling frame with a list of all members does not exist to provide the opportunity for all members of the population to have the same probability of being drawn. Rather, primary grandparent caregivers are nested within the
general population and many times virtually invisible. Nevertheless, application of the knowledge gained from this study may be possible to the population from which this study was drawn and with communities with similar geographic and sociodemographic characteristics to this study. However, generalizability of study findings to a larger population relative to parental stress, spirituality, cognitive appraisal, social supports, resources, choice to, parent, and grandparent caregiver life satisfaction are prohibited.

Finally, measures were self-administered or orally administered by the researcher. Variability in administration of measures may cause validity issues when the original measure was designed for self-administration. Also, due to the researcher’s direct involvement in reading measures to participants, a Hawthorne effect may result. Respondents may answer measures more positively, because they are being observed and want their caregiving to be viewed in a positive light.

**Implications for Social Work Practice**

The following definition of direct social work practice sets the foundation for examination of this study’s outcomes as they relate to implications for Social Work practice:

“the application of social work theory and or methods to the resolution and prevention of psychosocial problems experienced by individuals, families, and groups … Social work practice is grounded in the values of the social work profession and, as such, promotes social and economic justice by empowering clients who experience oppression or vulnerability to problem situations. Direct practice is based on an application of human-development theories within a psychosocial context and is focused on issues of human diversity and multiculturalism. Social workers help clients to enact psychological and
interpersonal change, increase their access to social and economic resources, and maintain their achieved capacities and strengths.” (Walsh, 2013, p.1)

The aforementioned definition of direct social work practice reflects the breath of social work theories, practice settings, and interventions. All of which are important to grandparent caregivers to address issues of social justice, empowerment, and quality of life.

Inherent in direct practice is the focus on building on clients’ strengths and capacities through various levels of practice: micro, mezzo, and macro. The most common practice interventions with grandparent-headed families originate out of collaborative community partnerships focused on coordinating community agencies, providing resources for advocacy, education, social support, therapeutic intervention, and maximizing available economic resources (Fruehauf and Hayslip, 2013). Out of these interventions, social support programs are the most frequently offered and used in direct service to grandparent caregivers (Shaklee et al., 2013).

Social support programs are designed to ameliorate the negative outcomes, generally, ascribed to grandparent caregivers (Goodman and Silverman, 2002; Hayslip and Hicks-Patrick, 2005; Leder et al., 2007, Musil et al. 2010). Social workers frequently operate as the expert identifying, developing, and delivering program services (Joslin, 2009). Grandparent caregivers are considered program participants who are perceived as burdened by the parenting role that is diminishing their quality of life. Findings from this study support a change in the design and execution of social support programs. Rather than social workers operating solely as experts, they would engage grandparent caregivers as collaborative experts. With this change, the design and delivery of social support programs shifts from a deficit model driven social workers’ conceptualization of supports that reduce burden. An alternate model where grandparent
caregivers are partners with social workers to create programs and services, centered on supports that reduce challenges, encourage caregivers’ adaptive capabilities, and promote life satisfaction.

From this perspective, grandparent caregivers’ individual’s sense of mastery, control, and personal competence is considered to be a positive influence on life decision making and community activism (Israel, Checkoway, Schulz, and Zimmerman, 1994). Grandparent caregivers are viewed as possessing expert knowledge important to the development of education, advocacy, support groups, and clinical interventions that are beneficial to them. The positive power of caregivers’ choice to parent, perception of self-efficacy, and their ability to identify needed personal and community resources is validated.

Additionally, study outcomes contribute to empowerment social work practice with this population. According to Robertson and Minkler (1994), empowerment is a process and an outcome where individuals “act effectively to transform their lives and their environment” (p. 300). Grandparent caregivers’ choice to parent their grandchildren is a deliberate volitional decision. Social workers can empower grandparent caregivers and professionals by validating grandparent caregivers’ decision making capabilities and identifying both challenges and benefits associated with the decision. In this manner, caregivers’ strengths and capabilities as well as challenges are focus of attention. The grandparent caregiver is not, merely, being swept along by events, but they are active decision makers who elect to care for their grandchildren.

Considering this, social supports programs are an excellent venue for empowerment social work practice with grandparent caregivers (Joslin, 2009). A notable example of empowerment social work practice with grandparent caregivers is the Empowerment Program. Cox (2014) detailed this international and nationally acclaimed social support-training program’s focus on building grandparent caregivers’ strengths and capacities. In this program, grandparent
caregivers collaborate with program administrators to create core curriculum topics. Also, social workers join with program participants to promote individual strengths and encourage community advocacy. Grandparent caregiver are viewed as experts and a partnership is formed with the social worker to identify needs, goals, and personal resources. Grandparent caregivers have power and choice about making life decisions rather than circumstances being orchestrated for them.

The underpinning of empowerment practice is its utilization of the multi-cultural strengths and capacities. When social workers and the diverse group of grandparent caregivers begin to identify and build on factors that promote self-determination and self-efficacy for grandparent caregivers, this is in keeping with empowerment social work practice. It acknowledges the benefits of being a grandparent caregiver such as increased life satisfaction (Sands et al., 2005), improved relationships with grandchildren (Chase-Goodman, 2012), and increased involvement in the community (Whitely, Kelly, and Campos, 2013).

Finally, social workers should embrace a multidimensional conceptualization of the experience of grandparent caregiving. Practice attention with this population should be comprehensive acknowledging the positive life enhancing benefits to caregivers as well as the negative aspects.

**Implications for Research**

This study adds to the small, but growing body of research concerning the positive outcomes that result when grandparents assume parental responsibility for their grandchildren (Chase-Goodman, 2007, Dolbin-McNab, 2006, Hayslip and Kaminski, 2007, Sampson and Hertlein, 2015; Smith and MacDolbin, 2013). Studies examined grandparent caregivers’ adaptive responses to stressors, coping strategies, social networks, unanticipated rewards, and
well-being promoting interventions. While positive grandparent caregiver wellbeing was the focus of these study’s investigation, they did not specifically examine factors related to grandparent caregivers experience of positive life satisfaction.

Findings from the present study suggests a concerted effort should be made to devise and execute research studies concerning positive grandparent caregiver life satisfaction that are academically, economically, ethnic/ racial, and geographically diverse. Probability sampling techniques should be employed to afford generalizability of study outcomes. Longitudinal studies are needed to investigate factors that contribute to grandparent caregiver’s experience of positive life satisfaction over time.

Further research that builds on the findings of this study exist in several areas:

- Quantitative, qualitative, and mixed-methods research designs targeting grandparent caregivers’ subjective well-being. With the specific examination of the life satisfaction component of subjective well-being, which is the individual’s cognitive and affective evaluation of the quality of life (Diener, Oishi, and Lucas, 2003). Studies of this type focus on grandparent caregivers’ resources, social relationships, and ability to positively adapt and cope in the midst of stressful events.

- Executing phenomenological research concerning choice to parent and grandparent caregivers’ experience of life satisfaction. Research of this type will provide a fuller understanding of life satisfaction and choice to parent grandchildren through the lived experience and language of grandparent caregivers. Such research holds potential to ascertain themes that may be illustrative to existing theories concerning grandparent caregivers’ experience of life satisfaction.
• Many grandparent caregivers are 65 years old and above. Adults who experience limitations performing activities of daily living (ADL) and instrumental activities of daily living (IADL) are more likely to be older (Sprang, Choi, Eslinger, and Whitt-Woosley, 2014). They may experience declines in physical health and functional capacity, which have impact on caregivers managing the physical and emotional demands of caregiving (Baker and Silverstein, 2008). Inclusion of functional status measures for ADLs and IADLs in future research may yield additional information concerning factors relevant to caregivers’ experience of positive life satisfaction.

• Examination of contributors to positive life satisfaction for understudied groups such as grandfather caregivers, LGBTQ-identified grandparent caregivers, Grandparents with disabilities, and grandparent caregivers who are under 60 years old.

• Examination of other factors that may have bearing on the experience of positive life satisfaction such as grandparent caregivers’ relationship with adult children who are biological parents, adult children who have and do not have grandchildren, custodial and non-custodial grandchildren, and the impact of sibling relationships of grandchildren under care.

• Executing community-based interventional studies centered on empowerment education, advocacy, and support crafted with the involvement of grandparent caregivers.

Research in the areas listed above lends itself to an empowerment framework and holds potential to develop knowledge to inform, empower, and enhance the quality of life for individual grandparent caregivers, grandchildren, service programs, agencies, and communities.
Implications for Policy

Social policy has not adapted to the growth in grandparent-headed families, specifically out-of-step are policies concerning child welfare, financial support, housing, and healthcare policies (Baker, Silverstein, and Putney, 2008; Cox, 2014). Such policies are frequently residual requiring grandparent caregivers to meet specific, often restrictive, eligibility criteria in programs such as Temporary Assistance to Needy Families (TANF), Supplemental Nutritional Assistance Program (SNAP), Supplemental Security Income (SSI), and Medicaid (Dinitto, 2011).

Additionally, public policy within the U.S. is frequently fragmented rather than seamless. Grandparent caregivers must be “policy literate”, educationally literate, and highly motivated to locate information about programs, navigate and accessing services, and maintain benefits created by existing policy (Baker et al., 2008). Many grandparent caregivers are unaware of existing services, live in poverty, particularly racial and ethnic minorities, and struggle to support their families with limited resources (Cox, 2014). Alternatively, caregivers may elect not to seek assistance fearful that meeting policy requirements will interfere or disrupt their relationship with their adult children and minor grandchildren (Brateli et al., 2008; Shaklee, Bigbee, and Wall, 2012).

According to Gutiérrez (1994), when control and influence over resources occurs, individuals experience empowerment. How does this relate to outcomes from this study and policy? Study findings indicate grandparent caregivers are judging and evaluating whether the social environment has the resources to meet the grandparent caregiver’s individual criteria to promote life satisfaction. This suggest it is important to actively empower grandparent caregivers to engage in: (1) understanding existing policy, (2) creating new policy, (3) reducing barriers to
program and service use, and (4) identification of gaps in the provision of beneficial services and resources perceived as necessary to positive life satisfactions.

To that end, social workers can work with grandparent caregivers to educate them about the policy that affect them and to identify policies that are obstructive and unresponsive. In addition, social workers can educate, support, and train grandparent caregivers to identify individual and collective strengths that enable them to be agents of change. Empowering grandparent caregivers to advocate for policies that are accessible and responsive to caregivers and their families has potential to increase caregivers’ life satisfaction and family wellbeing.

**Conclusion**

Despite the tremendous stressors and challenges encountered by grandparent caregivers, grandparents step in as primary or custodial grandparent caregivers to provide stability, safety, and love to their grandchildren. Drawing from the Resiliency Model of Family Stress, Adjustment, and Adaptation, the Cognitive Theory of Stress and Coping, and Choice Theory, this study examined the associations among choice to parent, reported resource, social support, parental stress, spirituality and grandparent caregivers’ life satisfaction. Study findings indicate grandparent caregivers’ experience positive life satisfaction when they perceive themselves to have choice in parenting and adequate personal, social, and familial resources to meet life demands. The study’s outcomes highlight the benefits of grandparent caregivers’ experiencing positive life satisfaction goes beyond the caregiver. It holds potential to contribute to healthy family functioning and improve family life for millions of vulnerable American children.
REFERENCES


APPENDIX
APPENDIX A – DEMOGRAPHIC SURVEY

This Survey is ANONYMOUS, please do not place your name on it. I want to protect your confidentiality. I would like to know a little more about you to help me get a better understanding of grandparent caregivers, please answer the following items.

Please circle or write in the appropriate response.

1. Gender: Male    Female

2. Your age: Please write your age in the blank__________

3. Do you have birth or legal children younger than 18 years old who live with you?
   ___ Yes   _____ No

4. If you have birth or legal children younger than 18 years old who live with you list their initials and ages below.
   Child (Initials): __________ age: ________
   Child (Initials): __________ age: ________
   Child (Initials): __________ age: ________

5. Please list the initials and ages of grandchildren or great grandchildren for whom you provide care for 50% or more of the time.
   Grandchild (Initials): __________ age: ________
   Grandchild (Initials): __________ age: ________
   Grandchild (Initials): __________ age: ________
   Grandchild (Initials): __________ age: ________

6. Please write the total length of time you have been a grandparent caregiver in years _____

7. Race/Ethnicity: Caucasian/White    African American/Black    Hispanic/Non-White    Other

8. Marital Status: Single    Married    Separated/Divorced    Widow/ Widower

9. Education:
   Attended High School    High School diploma/ GED    Some College    Trade School
   College diploma    Post College

10. Work Status:
    Employed Full Time    Employed Part-Time    Unemployed    Retired

THANK YOU FOR YOUR TIME!
YOUR HELP IS TRULY APPRECIATED!!!
APPENDIX B – CHOICE TO PARENT SURVEY

Choice to Parent

This is an anonymous survey. Please DO NOT write your name on it. The purpose of this survey is to determine your opinion on being a grandparent caregiver. For the purpose of this survey, grandparent caregivers are defined as biological or legal grandparents who provide support and parenting 20 hours or per week for grandchildren who reside in the same home.

Please circle your response to the following statement. Select the response that fits closest to your thoughts about being a grandparent caregiver using the choices below:

- strongly disagree
- disagree
- undecided
- agree
- strongly agree

As a grandparent caregiver:

I feel I have a choice about caring for my grandchildren.

1= strongly disagree  2=disagree  3=undecided  4=agree  5=strongly agree
The questions below are about how you feel about the caregiving situation. Please indicate your amount of agreement with each statement.

1=not at all 2=a little 3=moderately 4=quite a bit 5=a great deal
APPENDIX D – PARENTAL STRESS SCALE (PS)

Parental Stress Scale (PS)

The following statements describe feelings and perceptions about the experience of being a parent. Think of each of the items in terms of how your relationship with your child or children typically is. Please indicate the degree to which you agree or disagree with the following items by placing the appropriate number in the space provided.

1 = Strongly disagree 2 = Disagree 3 = Undecided 4 = Agree 5 = Strongly agree

____ 1. I am happy in my role as a parent.
____ 2. There is little or nothing I wouldn't do for my child(ren) if it was necessary.
____ 3. Caring for my child(ren) sometimes takes more time and energy than I have to give.
____ 4. I sometimes worry whether I am doing enough for my child(ren).
____ 5. I feel close to my child(ren).
____ 6. I enjoy spending time with my child(ren).
____ 7. My child(ren) is an important source of affection for me.
____ 8. Having child(ren) gives me a more certain and optimistic view for the future.
____ 9. The major source of stress in my life is my child(ren).
____ 10. Having child(ren) leaves little time and flexibility in my life.
____ 11. Having child(ren) has been a financial burden.
____ 12. It is difficult to balance different responsibilities because of my child(ren).
____ 13. The behavior of my child(ren) is often embarrassing or stressful to me.
____ 14. If I had it to do over again, I might decide not to have child(ren).
____ 15. I feel overwhelmed by the responsibility of being a parent.
____ 16. Having child(ren) has meant having too few choices and too little control over my life.
____ 17. I am satisfied as a parent.
____ 18. I find my child(ren) enjoyable.

Scoring: To compute the parental stress score, items 1, 2, 5, 6, 7, 8, 17, and 18 should reverse scored as follows: (1=5) (2=4) (3=3) (4=2) (5=1). The item scores are then sum
APPENDIX E – FAMILY SOCIAL SUPPORT SUBSCALE OF THE DUKE SOCIAL SUPPORT AND STRESS SCALE (DUSCOS)

Family Social Support subscale of the Duke Social Support and Stress Scale (DUSCOS)

Copyright © 1986-2014 by Department of Community and Family Medicine, Duke University Medical Center, Durham, NC, USA

Date Today:_________ Name: ID#:_____________ Date of Birth:_________ Female__ Male__

SUPPORT

1. People Who Give Personal Support
   [A supportive person is one who is helpful, who will listen to you, or who will back you up when you are in trouble.]

INSTRUCTIONS: Please look at the following list and decide how much each person (or group of persons) is supportive for you at this time in your life. Check ( ) your answer.

How supportive are these people now:       There Is No None  Some  A Lot  Such Person

1. Your wife, husband, or significant other person ...............____  ____  ____     ______
2. Your children or grandchildren ......................................... ____  ____  ____    ______
3. Your parents or grandparents ............................................ ____  ____  ____    ______
4. Your brothers or sisters ......................................................____  ____  ____    ______
5. Your other blood relatives ..................................................____  ____  ____    ______
6. Your relatives by marriage (for example: in-laws, ex-wife, ex-husband) ……….____  ____  ____    ______
7. Your neighbors ...................................................................____  ____  ____    ______
8. Your co-workers ................................................................____   ____  ____    ______
9. Your church members .......................................................____  ____  ____    ______
10. Your other friends ...........................................................____    ____  ____    ______
11. Do you have one particular person whom you trust and to whom you can go with personal difficulties? ..................................................________  ______
12. If you answered "yes", which of the above types of person is he or she? (for example: child, parent, neighbor)__________________________
APPENDIX F – SATISFACTION WITH LIFE SCALE (SWLS)

Satisfaction with Life Scale (SWLS)

Below are five statements that you may agree or disagree with. Using the 1 - 7 scale below, indicate your agreement with each item by placing the appropriate number on the line preceding that item. Please be open and honest in your responding.

7 - Strongly agree
6 - Agree
5 - Slightly agree
4 - Neither agree nor disagree
3 - Slightly disagree
2 - Disagree
1 - Strongly disagree

1. ____ In most ways my life is close to my ideal.

2. ____ The conditions of my life are excellent.

3. ____ I am satisfied with my life.

4. ____ So far I have gotten the important things I want in life.

5. ____ If I could live my life over, I would change almost nothing.
This scale is designed to assess whether or not you and your family have adequate resources (time, money, energy, and so on) to meet the needs of your family as a whole as well as the needs of individual family members. For each item, please circle the response that best describes how well the need is met on a consistent basis in your family (that is, month-in and month-out). (FRS-R)

<table>
<thead>
<tr>
<th>To what extent are the following resources <strong>adequate</strong> for you and your family?</th>
<th>Does Not Apply</th>
<th>Not At All Adequate</th>
<th>Seldom Adequate</th>
<th>Sometimes Adequate</th>
<th>Usually Adequate</th>
<th>Almost Always Adequate</th>
</tr>
</thead>
<tbody>
<tr>
<td>68. Food for two meals a day</td>
<td>NA</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>69. Money to buy necessities</td>
<td>NA</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>70. Clothes for your family</td>
<td>NA</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>71. Money to pay monthly bills</td>
<td>NA</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>72. Good job for yourself or spouse/partner</td>
<td>NA</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>73. Medical care for your family</td>
<td>NA</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>74. Public assistance (SSI, food stamps, Medicaid, etc.)</td>
<td>NA</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>75. Time to get enough sleep/rest</td>
<td>NA</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>76. Time to be by yourself</td>
<td>NA</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>77. Time for family to be together</td>
<td>NA</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>78. Time to be with your child(ren)</td>
<td>NA</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>79. Time to be with spouse/partner or close friend</td>
<td>NA</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>80. Dental care for your family</td>
<td>NA</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>81. Someone to talk to</td>
<td>NA</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Question</td>
<td>Value</td>
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<td>-------------------------------------------------------------------------</td>
<td>-------</td>
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<td></td>
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<td></td>
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<tr>
<td>82. Time to socialize</td>
<td>NA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>83. Time to keep in shape and looking nice</td>
<td>NA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>84. Toys for your child(ren)</td>
<td>NA</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX H – DUKE RELIGIOSITY INDEX (DUREL)

Duke Religiosity Index (DUREL)

Please answer the following questions by selecting the one answer that best describes how frequently you engage in the activities.

(1) How often do you attend church or other religious meetings?
   6 - More than once a week
   5 - Once a week
   4 - A few times a month
   3 - A few times a year
   2 - Once a year or less
   1 – Never

(2) How often do you spend time in private religious activities, such as prayer, meditation or Bible study?
   6 - More than once a day
   5 - Daily
   4 - Two or more times/week
   3 - Once a week
   2 - A few times a month
   1 - Rarely or never

The following use the scales provided to select the single answer that best characterizes how true each of the statements is for you.

(3) In my life, I experience the presence of the Divine (i.e., God)
   5 - Definitely true of me
   4 - Tends to be true
   3 – Unsure
   2 - Tends not to be true
   1 - Definitely not true

(4) My religious beliefs are what really lie behind my whole approach to life
   5 - Definitely true of me
   4 - Tends to be true
   3 – Unsure
   2 - Tends not to be true
   1 - Definitely not true

(5) I try hard to carry my religion over into all other dealings in life
   5 - Definitely true of me
   4 - Tends to be true
   3 – Unsure
   2 - Tends not to be true
   1 - Definitely not true
I would like to ask you some questions that ask you to use your memory. I am going to name three objects.

Please wait until I say all three words, then repeat them. Remember what they are because I am going to ask you to name them again in a few minutes. Please repeat these words for me: **APPLE—TABLE—PENNY.** (Interviewer may repeat names 3 times if necessary but repetition not scored.)

<table>
<thead>
<tr>
<th>Did patient correctly repeat all three words?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incorrect Correct</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. What year is this?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>2. What month is this?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>3. What is the day of the week?</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

What were the three objects I asked you to remember?

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Apple</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Table</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Penny</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX J – IRB APPROVAL

IRB Approval: IRB# - 15-OR-220-R1

July 14, 2016

Freida Coleman-Reed, MSW
School of Social Work
The University of Alabama
Box 870314

Re: IRB # 15-OR-220-R1 “Grandparent Caregivers: Factors Contributing to their Life Satisfaction”

Dear Ms. Coleman-Reed:

The University of Alabama Institutional Review Board has granted approval for your proposed research. Your renewal application has been given expedited approval according to 45 CFR part 46. Approval has been given under expedited review category 7 as outlined below:

(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Your application will expire on July 13, 2017. If your research will continue beyond this date, complete the relevant portions of the IRB Renewal Application. If you wish to modify the application, complete the Modification of an Approved Protocol Form. Changes in this study cannot be initiated without IRB approval, except when necessary to eliminate apparent immediate hazards to participants. When the study closes, complete the appropriate portions of the IRB Study Closure Form.

Should you need to submit any further correspondence regarding this proposal, please include the above application number.

Good luck with your research.

Sincerely,

[Signature]

Carpanato T. Mylen, MSW, CRM, CIF
Director & Research Compliance Officer
Office for Research Compliance