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Kendra A. O'Hora

Virginia Tech, kendraaa@vt.edu

Megan L. Dolbin-MacNab

Virginia Polytechnic Institute and State University, mdolbinm@vt.edu

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Cover Page Footnote

Kendra A. O'Hora, M.MFT is a doctoral student in the Marriage and Family Therapy Program in the Department of Human Development at Virginia Tech. Phone: (740) 223-6303. Email: kendraaa@vt.edu. Megan L. Dolbin-MacNab, Ph.D., LMFT is Associate Professor of Department of Human Development at Virginia Tech and Clinical Training Director at the Family Therapy Center of Virginia Tech. Correspondence related to this article should be addressed to Dr. Megan L. Dolbin-MacNab, Family Therapy Center of Virginia Tech (0515), 840 University City Boulevard, Suite 1, Blacksburg, VA 24060; Email: mdolbinm@vt.edu; Phone: (540) 231-6807; FAX: (540) 231-7209. This project was supported by the Purdue Research Foundation Summer Research Grant and the Indiana Association for Marriage and Family Therapy Graduate Student Research Award.

*Research Article***Practice Recommendations for Mental Health Professionals: Perspectives from Grandparents and their Adolescent Grandchildren**

Kendra A. O'Hora
Megan L. Dolbin-MacNab
Virginia Tech

Abstract

Although grandfamilies are consumers of a variety of mental health services, less is known about what these families, particularly the grandchildren, want from practitioners. To gain insight into how practitioners can best meet the needs of grandfamilies, 40 custodial grandmothers and their adolescent grandchildren were interviewed. Results of a qualitative analysis indicated that grandmothers and grandchildren did not make clear distinctions between various types of services and service providers. Grandchildren emphasized the need for mental health professionals to facilitate mentoring and to provide opportunities for grandchildren to socialize with other grandchildren who have been through similar circumstances. Grandmothers and grandchildren both recommended promoting problem solving, offering services for grandchildren, and being responsive to their families' unique needs. Participants also suggested that practitioners avoid making judgments, educate themselves about grandfamilies, advocate for their families, and attend to the experiences of both grandmothers *and* grandchildren. Implications of the findings for mental health practitioners are discussed.

Keywords: grandfamilies, grandparents raising grandchildren, mental health

Grandfamilies include those families in which primary responsibility for the care of children falls to a grandparent (Littlewood, 2014). In the last 40 years, the percentage of children living in grandparent-headed households has steadily increased from three percent in 1970 to six percent in 2012 (U.S. Census Bureau, 2012). In the United States, approximately 7.8 million children live with a grandparent and approximately 2.7 million grandparents are raising 40% of these children (AARP, 2010; U. S. Census Bureau, 2012). As has been well-documented in the literature, grandfamilies often form because the grandchildren's parents are unable to care for them due to issues such as substance abuse, abuse and neglect, incarceration, HIV/AIDS, mental illness, divorce, emotional immaturity, military deployment, and death (Connealy & DeRoos, 2000; Jendrek, 1994; Kelley, Whitley, & Campos, 2013; Pinson-Millburn, Fabian, Schlossberg, & Pyle, 1996).

Previous research has established that grandfamilies experience wide-ranging needs that, if left unaddressed, can result in negative individual and familial outcomes. For instance, grandchildren raised by grandparents may experience depression, anxiety, posttraumatic stress disorder, health problems, behavior problems, academic difficulties, aggression, and feelings of anger, rejection, and guilt (Billing, Ehrle, & Kortenkamp 2002; O'Reilly & Morrison, 1993; Shore & Hayslip, 1994; Smith & Palmieri, 2007; Solomon & Marx, 1995). For their part, grandparents must cope with legal and financial problems, insufficient knowledge about contemporary parenting practices, difficulties with their adult children, health concerns, social isolation, and psychological distress (Hughes, Waite, LaPierre, & Luo, 2007; Jendrek, 1994; Minkler & Fuller-

Thomson, 1999; Pinson-Millburn et al., 1996; Sakai, Lin, & Flores, 2011).

To minimize negative outcomes and enhance both individual and family well-being, there has been a proliferation of services and programs targeting grandparents raising grandchildren. Many of these services address mental health issues, namely issues related to grandparents' and (to a much lesser extent) grandchildren's emotional, psychological, and social well-being (MentalHealth.gov, 2014). Common services related to mental health issues within grandfamilies include support groups (Cox, 1999; McCallion, Janicki, & Kolomer, 2004; Minkler, Driver, Roe & Bedeian, 1993), resourcefulness training (Zauszniewski, Musil, Burant, & Au, 2013), and psychoeducational programs and workshops (Burnette, 1998). Support groups are "a way to provide emotional, educational, and psychological support and interventions [to participants]" (Littlewood, 2014, p. 33), while psychoeducational programs and workshops focus on providing resources and information about specific topics (Furman, Rowan & Bender, 2009). Although these services address mental health issues (MentalHealth.gov, 2014), it should be noted that the practitioners who facilitate support groups and psychoeducational programs might not uniformly identify these services as being within the purview of mental health treatment.

Support groups and psychoeducational programming are popular means of intervention with and support for grandfamilies. However, grandparents may seek out or require more intensive mental health services, such as family therapy or individual psychotherapy, for themselves and their grandchildren. For instance, family therapy, which involves treating mental health issues and family problems within the family context (AAMFT, 2014), can add value to services for grandfamilies by assessing the contextual systems in which grandfamilies

exist and privileging the voices of all members of the family. Similarly, individual psychotherapy treats mental disorders by helping clients understand their illnesses, manage their symptoms, and improve their daily functioning (National Institutes of Mental Health, 2014). These modes of mental health intervention are important to keep in the service landscape, as grandparents frequently report a desire for more intensive intervention and professional services targeting family-level and grandchild needs (Burnette, 1999; Landry-Meyer, 1999; Yancura, 2013).

Along with the growth of interventions for grandfamilies, there has been parallel growth in recommendations for their implementation. Existing intervention guidelines tend to be derived from service providers rather than the actual service recipients. However, scholars and practitioners have suggested that there is much that can be learned from the families who receive the interventions and services designed to assist them (e.g., Cox, 1999; Pinson-Millburn et al., 1996). While some existing research has examined the perspectives of grandparents (Smith, 2003), there has been little consideration of grandchildren's experiences of mental health services or services in general—even though there is consensus among service providers and grandparents that grandchildren are likely to benefit from them (Billing et al., 2002; Shore & Hayslip, 1994; Smith & Palmieri, 2007; Yancura, 2013). To address this issue and further the understanding of how to intervene most effectively with grandfamilies, the purpose of this study was to examine custodial grandmothers' and their adolescent grandchildren's practice recommendations for mental health professionals, though the results may have applicability to the wide variety of practitioners who provide service to grandfamilies.

Literature Review

With the growth in the numbers of grandfamilies and interventions designed to serve them, researchers and practitioners have given more attention to best practices related to services for grandparents and, to a lesser extent, their grandchildren. These practice recommendations tend to center on a variety of services that address mental health-related (MentalHealth.gov, 2014) issues pertinent to grandfamilies. Some of these services include support groups, psychoeducational programs, individual psychotherapy, and family therapy.

Support Groups and Psychoeducational Programs

Much of the literature examining interventions with grandfamilies has focused on support groups. Support groups have been widely recommended and implemented (Burton, 1992; Cox, 1999; Kolomer, McCallion, & Overendyler, 2003; McCallion et al., 2004; Minkler & Roe, 1993; Strom & Strom, 2000; Strozier, 2012) and are the most common type of mental health services used by grandparent caregivers (Littlewood, 2014; Minkler et al., 1993; Smith, 2003). When implemented effectively, support groups provide grandparents with opportunities for social support, communal problem solving, and psychoeducation. Common topics addressed in support groups include parenting, legal rights, social issues, financial support, grief and loss, grandchild behavior problems, and stress management (Wohl, Lahner, & Jooste, 2003).

Despite the potential advantages of support groups, they are not without challenges. Smith (2003), following an examination of 42 custodial grandparents' perspectives on support groups, concluded that many support groups are ineffective and potentially harmful because they foster self-pity and complaining, lack structure and skillful leadership, overemphasize self-help, and lack well-articulated goals

and objectives. Other challenges include encouraging attendance, promoting retention, and ensuring cultural sensitivity. To respond to these challenges, researchers suggest that support groups leaders provide participants with meals, attendance incentives, transportation, and childcare (Burnette, 1999; Dannison & Smith, 2003). Additionally, grandparents should be involved in the conceptualization and implementation of the group, trust the group leaders, and view leaders as credible (Dannison & Smith, 2003; Grant, Gordon, & Cohen, 1997). While there is value in providing time for personal sharing (Dannison & Smith, 2003; Hayslip & Kaminski, 2005; Strom & Strom, 1993), support groups should also address advocacy, education, and skill building (Burnette, 1999; Cox, 1999; Hayslip & Kaminski, 2005; Strom & Strom, 2000; Wohl et al., 2003). Strom and Strom (2000), in particular, encourage group leaders to avoid a negative focus by encouraging optimistic attitudes, providing guidelines for discussion, facilitating social support from outside the group, promoting increased knowledge, and encouraging goal setting and the evaluation of goal attainment.

As support groups and psychoeducational programming with grandparents raising grandchildren have proliferated, researchers have also given more attention to their effectiveness. For example, using a research design that employed random assignment, Hayslip (2003) found that grandparents who participated in a support group targeting parenting skills and psychosocial adjustment displayed decreased negative affect, increased parental self-efficacy, and an improved grandparent-grandchild relationship. However, participants also reported increased role strain, financial strain, and depression. In another study, Kelley, Whitley, and Campos (2014) recruited 504 African American grandmothers raising grandchildren and found that grandparents participating in support groups,

parenting classes, and case management showed benefits in their overall health and satisfaction with life. Similarly, Kolomer, McCallion, and Janicki (2002) found that grandparents participating in a support group reported decreased depression and increased locus of control, while Collins (2011) found that a faith-based support group for African American grandmothers was effective in addressing their financial, legal, health, and socio-emotional concerns. For their study of a two-year community support program, Smith and Dannison (2003) found that grandparents reported decreased depression and isolation, improved parenting knowledge, greater social support, greater willingness to access resources, and greater enjoyment of time with their grandchildren. Finally, Zauszniewski and colleagues (2013) found that resourcefulness training was more effective in minimizing stress and promoting mental health than “expressive writing, verbal disclosure, and attention control conditions” (p. 42). Thus, while there is growing evidence that support groups and other types of psychoeducational programming may be helpful for grandparent caregivers, the rigor of these research studies has improved greatly. However, more information is needed about the long-term impacts of these interventions, especially how well they work in comparison to other types of interventions and what grandparents are most likely to benefit from them (Hayslip & Kaminski, 2005).

In considering the effectiveness of interventions for grandparents, it is important to note that most discussions of programming for grandfamilies have focused on grandparent groups. However, grandparents also report needing help with their grandchildren’s difficult emotions and behaviors (Burnette, 1999; Landry-Meyer, 1999). When support groups provide activities for grandchildren, they often take the form of childcare and do not formally address grandchildren’s psychological and emotional

needs. One exception is the pilot work of Smith and Dannison (2003), in which they found that 3- to 6-year-old grandchildren participating in a therapeutic playgroup had improved self-esteem and peer interactions. Also improved were grandchildren's perceptions of the quality of their relationships with their grandparents. Dannison and Smith (2003) recommend that grandparent support groups provide therapeutic programming for grandchildren. They also recommend that this programming include small adult to child ratios, opportunities for play, consistent routines, and frequent feedback to grandparents. Additional recommendations include emphasizing the development of self-esteem and social skills as well as increased awareness of emotions and diversity in families. Despite these recommendations, in comparison to the work on grandparent interventions, relatively little is known about how to best intervene with the grandchildren in grandfamilies, or how to intervene systemically to address relational issues between the grandparent and grandchild.

Individual Psychotherapy and Family Therapy

Despite the potential value of support groups and psychoeducational programming, grandparent caregivers often need or seek more intensive mental health services for themselves and/or their grandchildren. These services may include individual psychotherapy or family therapy. For instance, in a case study of a boy orphaned and cared for by his grandparents, Lander (2011) advocates for family therapy with grandfamilies and explains how family therapy can help ameliorate grandchildren's posttraumatic stress symptoms, while transforming communication patterns surrounding distress, trauma, and pain. Additionally, in her study of 74 Latino grandparents, Burnette (1999) found that 52.7% of grandparents had obtained counseling for a grandchild, 45.9% had received individual counseling, and 9.5% had sought marital or

family therapy. Similarly, Landry-Meyer (1999) found that counseling for the grandchild was a significant need for 72.9% of a sample of 186 grandparent caregivers. Sixty-one percent of grandparents also indicated a need for individual counseling. As these studies demonstrate, grandparents see the value of therapy, particularly for their grandchildren, and some actively seek these services.

Though grandparents and grandchildren may experience individual mental health problems that may benefit from therapy (e.g., depression and anxiety), many of these issues have relational components and grandfamilies may experience family or relational challenges as well. Common family challenges within grandfamilies include family conflict, difficulties with the middle generation, marital distress, trauma, parenting, and finances (Strong, Bean, & Feinauer, 2010). With its emphasis on relational dynamics and patterns of interaction, family therapy is a treatment modality especially suited to the needs of grandfamilies. Although there have been no published examinations of family therapy's effectiveness with grandparent caregivers and their grandchildren, several theoretical perspectives have been highlighted as being uniquely applicable to this population. These theoretical perspectives emphasize the importance of examining and supporting proper family boundaries and hierarchies (Bartram, 1994), addressing issues of loyalty and feelings of debt/entitlement (Brown-Standridge, & Floyd, 2000), targeting resilience in grandparents to nurture resilience in grandchildren (Zuckerman & Maiden, 2013) and supporting a positive family narrative (Bachay & Buzzi, 2012). In terms of working with grandchildren, several theories highlight the value of play techniques (Bratton, Ray, & Moffit, 1998) and attachment concepts (Strong et al., 2010). The assumption is that strong attachment bonds and a secure space for play between the grandparent and grandchild will

promote healing for the grandchild and the family system (Bratton et al., 1998; Strong et al., 2010).

Regardless of the specific theoretical basis or constellation of therapy (i.e., individual vs. family), many practitioners recommend a multimodal approach that includes individual therapy for the grandparent and grandchild, as well as conjoint family sessions (Strong et al., 2010). Yet, a multimodal approach would also suggest that grandfamilies can benefit from being connected to community services such as health care or emergency assistance (O'Reilly & Morrison, 1993), as well as to other programs offering nutrition assistance, legal assistance, or financial management training (Yancura, 2013; Letiecq, Bailey, & Porterfield, 2008). Whatever the exact combination of services being utilized or provided, cultural competence and humility among professionals working with grandfamilies has also been deemed as being very important to grandfamilies' successful outcomes (Bachay & Buzzi, 2012)—clinicians being a crucial tool in bridging gaps in order to provide grandparents and grandchildren with the help they need.

The Present Study

As numbers of grandfamilies continue to grow and more grandparents and grandchildren seek a variety of services, particularly mental health-related services (e.g., support groups, individual therapy, family therapy, and psychoeducational programming), it becomes essential to examine their experiences related to accessing available interventions and resources. Existing practice recommendations, while fairly extensive, have focused on support groups rather than other approaches to intervention. Moreover, with a few exceptions (Burnette, 1999; Landry-Meyer, 1999; Smith, 2003), practice recommendations have not been obtained from the actual service recipients. Moreover, and perhaps most significantly, these

recommendations rarely take into account the perspectives of the grandchildren—despite evidence that grandparents report desiring services for their grandchildren (Landry-Meyer, 1999; Yancura, 2013).

The current study was developed to address these limitations and to gain insight into how to best intervene with custodial grandmothers and their adolescent grandchildren in the context of mental health services. The goal of this exploratory study was to answer the research question, “What recommendations do custodial grandmothers and their adolescent grandchildren have for therapists interested in improving mental health services with grandfamilies?” Through this exploration of grandmothers and grandchildren’s recommendations for intervention, aspects of mental health treatment and service provision central to the satisfaction of both grandparents and their grandchildren are identified.

Methods

This study uses data from a larger mixed-method study examining grandchild adjustment and family functioning within grandfamilies. Participation in the larger study involved grandparents and adolescent grandchildren completing self-report questionnaires. Grandparents and grandchildren were also invited to participate in semi-structured, qualitative interviews. Fifty-two grandparent/grandchild pairs completed questionnaires, with 41 dyads consenting to the interviews. This analysis examines only the interview data.

Participants

Participant families were recruited nationally. Thirty-nine dyads were recruited through support groups listed on AARP’s Grandparent Information Center. One pair was recruited through a website dedicated to grandparents raising grandchildren. The final pair was

recruited via word-of-mouth. Because of this approach to recruitment, the majority of participant families had some exposure to services and programs for grandfamilies. While specific information about the nature of the participants' current and previous service utilization was not obtained, some families anecdotally reported experience with support groups, psychoeducational programs, as well as individual and family therapy. Participants also informally reported accessing other services including financial assistance and low-cost medical care.

To be included in the study, grandparents had to meet the United States Census Bureau (2002) definition of a grandparent raising a grandchild. Specifically, grandparents were required to have at least one grandchild residing in their home and be primarily responsible for meeting that grandchild's needs. Additionally, due to IRB requirements, grandparents were required to have a legal relationship with their grandchild. Finally, as the larger study examined the adjustment of adolescent grandchildren, grandparents had to be raising at least one grandchild between the ages of 11 and 18. Of the 41 grandparents interviewed, 40 were female. Only data from the 40 grandmothers and their grandchildren were used in this analysis, as a means of providing clarity about who participated in the study and precision about the potential transferability of the findings (Gale & Dolbin-MacNab, 2014). Families were from 14 states in the Northeast, Midwest, South, and Southwest. Table 1 reflects the demographic information of the participant families.

Table 1*Demographic Information for Participant Families (N = 40)*

	Grandchildren (GC)			Grandparents (GP)		
	<i>n (%)</i>	<i>M (SD)</i>	Range	<i>n (%)</i>	<i>M (SD)</i>	Range
Age (Years):		14.1 (1.74)	11 – 18		61.08 (7.59)	48 - 76
Race:						
African-American	10 (25)			9 (23)		
White, Non-Hispanic	22 (55)			26 (65)		
Multiracial	8 (20)			4 (10)		
Native American				1 (3)		
Gender:						
Female	19 (48)			40 (100)		
Male	21 (53)					
Contact with Parents (Yes):						
Mother	28 (70)					
Father	18 (45)					
Caregiving Arrangement:						
GP Years Caregiving		10.31	1 – 17			
Number of GC		(4.52)	1 – 5			
		2.10 (1.13)				
Annual Household Income:						
< \$15K	12 (29)					
\$15K - \$25K	13 (33)					
\$25K - \$50K	9 (23)					
> \$50K	4 (3)					
				GP Education:		
				Less than HS	2 (5)	
				HS Degree	28 (70)	
				College Graduate	10 (25)	
				Relation to GC:		
				Maternal GP	30 (75)	
				Paternal GP	10 (25)	

Procedure

Interested grandmothers and grandchildren were screened over the telephone for eligibility. If they met the inclusion criteria, a data collection session was scheduled in a location of the grandmother's choosing ($n = 7$) or over the telephone ($n = 33$). Telephone data collection occurred when participants lived beyond a reasonable driving distance. For face-to-face data collection, participants completed the consent forms, filled out the questionnaires, and were then interviewed separately. For telephone data collection, verbal consent was obtained, families completed the questionnaires, and separate grandmother and grandchild interviews were conducted. All interviews were audio-taped and transcribed verbatim. During data analysis, any potential differences in the interviews, based on type of data collection, were examined. These analyses revealed no notable differences in terms of the length of interviews or the depth of responses based on face-to-face versus telephone data collection. Grandmother interviews were approximately 30 to 45 minutes in length, although one lasted two hours. Grandchild interviews tended to be shorter, primarily as means of preventing participant fatigue, and ranged in length from 15 to 30 minutes. As compensation, each grandmother-grandchild pair received a \$15 gift certificate to a local restaurant.

Interview Protocol

During the interviews, grandmothers provided their age, gender, racial and ethnic background, and educational attainment. Grandchildren also provided their age, gender, grade level, and racial and ethnic background. Additionally, grandmothers identified their household income, relationship status, the length of the caregiving arrangement, and whether their grandchild had contact with his/her parents. Open-ended interview questions elucidated participants' recommendations for improving mental health

services. Beyond asking about overarching recommendations, participants were also asked to describe any positive and negative experiences with mental health services and to provide specific recommendations for how mental health professionals could better support and treat grandfamilies.

In describing the interview questions, it should be noted that the questions originally focused on grandfamilies' recommendations for family therapists. In fact, in advance of asking the interview questions, the interviewer defined family therapists as mental health professionals who are trained to work with families to address their relationship challenges (AAMFT, 2014). Despite giving this definition, it became apparent from the initial data analysis (which began while the interviews were ongoing; Charmaz, 2006) that most dyads failed to distinguish family therapists from other practitioners who might provide mental health services. In reflection of this observation, as the interviews progressed, the protocol was refined (Charmaz, 2006) so that participants were encouraged to provide recommendations for family therapists as well as any professional whose job it was to provide mental health (i.e., emotional, psychological, or social health) services to grandfamilies. Participants were given examples of these types of practitioners, including counselors, therapists, and some types of group leaders.

Data Analysis

To identify patterns in grandmothers and grandchildren's recommendations for mental health professionals, the constant comparison method was employed (Glaser & Strauss, 1967; Strauss & Corbin, 1990). This method, which is most often associated with the grounded theory approach, allows for an examination of themes within the data that can then be organized for the purposes of providing an explanation of the phenomena

under investigation (Glaser & Strauss, 1967; Strauss & Corbin, 1990). A goal of this method is to accurately give voice to participants and to highlight how they make meaning of their lives (Glaser & Strauss, 1967).

Data analysis began by reading each interview transcript in its entirety. The family was the unit of analysis. Using the strategy of open coding, each transcript was reread and margin notes were made regarding possible categories of information (Strauss & Corbin, 1990). Next, transcripts were reread again and axial coding was used to identify the conditions of and relationships between categories. Categories were then organized into themes (Strauss & Corbin, 1990). Following this step, themes were either confirmed or disconfirmed by returning to the transcripts. Finally, transcripts were reviewed to identify passages that represented the various themes and to calculate their frequency or variation.

Because qualitative research is evaluated through evidence of trustworthiness, multiple strategies were used to enhance trustworthiness of the data analysis process (Lincoln & Guba, 1985). First, to account for researcher bias, process notes were made during data collection and analysis. As mental health professionals, reviewing and discussing these notes helped us stay aware of our biases and realize, for instance, that participants might not make clear distinctions between family therapists and other mental health practitioners. To obtain a critical evaluation of the themes, as well as to consider alternative explanations of the data, results were discussed with colleagues familiar with grandparents raising grandchildren. These discussions resulted in the realization that grandfamilies may be more concerned with quality of services received versus the type of services or type of practitioner. Similarly, conversations with colleagues challenged us to more carefully identify the recommendation made by the grandchildren. Finally,

because few new themes arose after coding approximately 25 interviews, it was possible to conclude that saturation had been reached (Patton, 2001).

Findings

One of the most notable findings to come from the overall analysis was that grandmothers and their grandchildren did not differentiate between types of mental health providers, mental health services, or even other types of services and human service professionals. Although the interview questions were originally about recommendations for family therapists, the analysis revealed that grandmothers, in particular, seemed most concerned about getting needed assistance and having their needs met—regardless of who delivered those services and in what format. Thus, the findings presented here reflect our dyads' suggestions for a variety of professionals who address mental health issues, broadly defined, in grandfamilies.

Beyond this overall finding, our analysis identified five specific themes related to service recommendations for mental health professionals. These include tailoring service provision, offering services for grandchildren, monitoring biases, creating space, and engaging in advocacy. In the following sections, each theme is discussed and illustrated with participant quotations.

Tailoring Service Provision

Twenty-two (55%) grandmothers suggested that mental health professionals, when leading support groups or psychoeducational programs, could improve their services by being more responsive to the needs of custodial grandmothers and grandchildren. More specifically, grandmothers suggested that support groups offer meals, provide educational content, create socialization opportunities, and develop respite activities. For example, a 76-year-old grandmother suggested:

“Feed the kids. Give them pizza and juice, and stuff like that. Give the kids help with their homework or play games. The grandparents can be in another place, and they can meet with experts who come in to talk about things.”

Grandmothers also reported that interventions focusing only on empathy or venting did not fully meet their needs. When the focus was only on obtaining support or expressing difficulties, grandmothers believed that the tone became too problem-focused. Thus, while grandmothers appreciated the opportunity to discuss their challenges, they also wanted to move past venting to finding ways to solve problems. A grandmother raising three grandchildren described her frustration with the atmosphere of her local support group:

“I don’t go anymore because I really get tired of hearing people constantly whine. The whining and dwelling upon problems only makes you feel terrible. It’s sort of like, if the milk spills wipe it up and buy a new gallon instead of saying, ‘I spilled the milk all over the floor, blah, blah, blah.’ I find that there’s a lot of that.”

Grandmothers described mental health professionals as being the key to shifting the focus from venting to problem solving. That is, participants saw practitioners as being responsible for effectively managing group dynamics so that group could be as productive as possible. To illustrate, one grandmother suggested:

“It’s important that support groups be led by someone who has an understanding of grandparents and who is able to assert themselves and take charge, because in some of the groups that I have gone to, the facilitator didn’t have the skills to

intervene, when someone was monopolizing the time, or when someone got off on a tangent.”

Finally, in terms of tailoring services to the specific needs and experiences of grandparents raising grandchildren, one grandmother recommended that mental health professionals use counseling skills or individual interventions to work specifically on grandparents' problem-solving and coping skills:

“Work one-on-one with the grandparent to identify problems they can do something about, and problems they can't do anything about. Then taking the problems that they can't do anything about, and asking what they can do to make themselves feel better.”

Offering Services for Grandchildren

Both grandmothers and grandchildren ($n = 21$, 53%) recommended that mental health professionals develop and offer services specific to the emotional and behavioral needs of grandchildren. Grandmothers described a need for individual or group therapy targeting grandchildren's feelings about their parents, experiences of being different from their peers, and reactions to their family arrangement. For example, a 51-year-old grandmother raising her 13-year-old granddaughter stated, “It's natural [for the grandchild] to have feelings about the situation. They need to talk about it. They need to get it out. And a professional person can help them understand their feelings.” Similarly, a 13-year-old granddaughter suggested:

“They [professionals] can do like a program, to like all the kids that are raised by their grandparents, and they can talk to each other. If one of the kids is having a problem, they can ask some of the other

kids who have went through it already, and get good advice from them.”

For their part, grandchildren recommended that practitioners provide children being raised by grandparents with mentoring, career counseling, tutoring, and outlets for safe socializing. For example, an 18-year-old grandson suggested that service providers could help him reach his future goals when he said, “Help me more with my school, or things about my future.” If the professionals themselves did not offer these services, grandchildren thought that they should develop these types of services or connect grandchildren with existing resources. For grandchildren, mental health professionals were viewed as the people most able to help them locate and access resources they felt unable to access themselves, but knew that they needed.

Monitoring Biases

Twenty-four (60%) grandmothers and grandchildren described situations where they felt judged by the mental health professionals working with them. They referenced feeling judged by a variety of professionals including family therapists, support group leaders, and social workers, among others. Grandmothers believed that, because they were parenting a second generation of children, professionals often assumed they had dysfunctional parenting skills or family dynamics. They also felt judged regarding their motivations for raising their grandchildren. A grandmother raising four grandchildren shared her experience:

“It’s like you’re constantly being judged. Whether it is verbally spoken aloud or not, you are. The other thing that I hear is ‘If you were a better parent, then this wouldn’t have happened.’ Or, ‘Why don’t you let your kid raise their own kid?’ And it’s totally out of ignorance. Most grandparents who are raising

grandchildren never wanted to be put in that spot. They actually wanted to be grandparents.”

Grandmothers were not alone in feeling judged by service providers. Grandchildren were also aware of these judgments and experienced them as well. For instance, a 16-year-old grandson described his experience of being judged by his family’s caseworker:

“It tends that kids who are adopted by their grandparents tend to be troublemakers. They [professionals] need to not be so judgmental of them. Because a lot time, some of the people who are adopted by their grandparents come from homes where they had been pretty much taught to lie, cheat, and steal.”

When grandchildren and grandmothers felt judged, they typically attributed it to a lack of awareness on the part of practitioner. That is, participants perceived mental health professionals as being generally unaware of grandchildren’s issues, the challenges associated with the grandchild’s parents, and the impact of contextual factors (e.g., grandparent health problems and age-related limitations, being a racial and/or ethnic minority, and inadequate financial resources) on personal well-being and family interactions. For example, a 67-year-old grandmother shared how she wished that mental health professionals were more aware of the impact of her age on her caregiving ability:

“They need to take into consideration that my energy level at my age is far less than it was 10 years ago. People expect me to be available to go there, to do this. I think they really must know that the grandparent raising a grandchild’s energy level is going to be lower. It’s doesn’t mean that they aren’t capable, but if the energy level is low enough

then they need to take this into consideration when expecting grandparents to attend or do for the grandchild.”

Grandchildren, for their part, tended to share their grandmothers' perspectives that mental health professionals needed to be more educated about grandfamilies and needed to carefully monitor their biases and negative stereotypes. For example, a 14-year-old granddaughter suggested that mental health professionals learn more about how grandchildren view their family situations: “They [professionals] don't really get it sometimes. You know, they're [grandparents] just like your parents.” Similarly, a 15-year-old grandson suggested that therapists recognize the diversity that exists within grandparent-headed families: “Most of them pretty much think all grandparents and grandchildren are basically the same, but they're not. They think the kids are misbehaving. They might need to change that.” As these quotes illustrate, grandchildren were acutely aware that professionals were making negative assumptions about them and their families, and attributed to this to a lack of knowledge or general insensitivity.

Creating Space

Beyond monitoring their biases and becoming more educated about grandfamilies, grandmothers and grandchildren ($n = 11, 28\%$) also recommended that mental health professionals be more intentional about listening to the concerns of *each* family member. They suggested that practitioners should listen to everyone's perspective on their problem or situation, especially before offering solutions. Grandchildren, in particular, believed that professionals needed to be more active in ensuring that their voices are heard in therapy sessions or other practice settings. For example, a 16-year-old granddaughter suggested, “Listen to the kids more, and don't take sides.

Just listen to both sides.” Grandchildren were also reactive when they perceived professionals as giving them advice, instead of focusing on listening to them and trying to understand their experiences. For example, a 13-year-old granddaughter suggested, “If you say something and you don’t want advice, don’t me give advice, just listen. Then they [counselors] always give you advice anyway. I know they’re counselors, but I think sometimes they should listen to you and then if you don’t want advice don’t give it to you. Just talk.” Grandmothers also echoed the importance of practitioners avoiding giving advice or assuming that they know what grandfamilies are experiencing. For instance, a 69-year-old grandmother raising two grandchildren stated, “Unless you [practitioners] walk in our shoes, you really don’t know what’s going on. They can go by what they pick up and read, but unless they’ve truly walked in our shoes, they really don’t know what’s going on.”

Engaging in Advocacy

Finally, grandmothers ($n = 19, 48\%$) wanted mental health professionals to work alongside them to engage in advocacy efforts. Grandmothers believed that influential members of their communities were largely unaware of the presence and needs of grandfamilies. Therefore, grandmothers suggested that professionals work alongside them to help community leaders realize the scope of the issue and respond to their needs. For example, a grandmother raising three grandchildren suggested that professionals “network with us. We need to let the community know the numbers [of grandparent caregivers] because sometimes grandparents feel embarrassed. We want professionals to join our strength in numbers.” In addition to perceiving more power in numbers, grandmothers also believed that service providers have the status and power necessary to meaningfully impact larger

systems such as schools, agencies, and governments for the purpose of creating positive social change. Specifically, grandmothers suggested that practitioners advocate for increased grandparent rights such as access to affordable medical care, financial assistance, and legal authority. For example, a grandmother raising a 14-year-old grandson said, “grandparents need more rights. They shouldn’t have to fight for everything. [Professionals] should help get more legislation for grandparents. Financial help in some cases too.” Grandchildren tended to focus less on these types of suggestions for advocacy, as their concerns and recommendations primarily revolved around their individual needs and relationships.

Discussion

As numbers of grandfamilies continue to grow, their needs have come to the attention of mental health professionals and a variety of other service providers. Existing practice guidelines offer professionals, particularly those leading support groups, important suggestions regarding effective group leadership and implementation (e.g., Dannison & Smith, 2003; Kolomer et al., 2003; McCallion et al., 2004). Additionally, applications of family therapy models to grandfamilies highlight various theoretical approaches for addressing the relational needs of custodial grandparents and their grandchildren (Bachay & Buzzi, 2012; Bartram, 1994; Bratton et al., 1998; Brown-Standridge & Floyd, 2000; Strong et al., 2010). Individual psychotherapy, family therapy, psychoeducational programs, and other mental health services are seen as important interventions for grandfamilies (Burnette, 1999; Strozier, 2012). However, there has been limited information about custodial grandparents’ suggestions and recommendations for mental health practitioners. More significantly, prior to this study, there has been virtually no information about grandchildren’s perspectives on best

practices for mental health interventions with grandfamilies.

To begin addressing these needs, this study explored practice recommendations custodial grandmothers and their adolescent grandchildren had for mental health professionals. One of the most significant findings was that grandparents and grandchildren did not seem to distinguish between various types of mental health services (e.g., support groups, psychoeducational programs, individual therapy, or family therapy) or types of mental health professionals. While this is useful in terms of the applicability of the findings to a variety of practitioners and practice settings, it also suggests that grandfamilies may benefit from education about different types of mental health professionals, what they do, and the range of services available to them. They may also benefit from guidance on selecting services and providers that can best meet their needs. More specifically, as grandfamilies may believe that support groups are the only option available or appropriate for them (Szinovacz & Roberts, 1998), it is imperative that families become educated consumers about available resources, and about how multimodal approaches may benefit their family and individual well-being (O'Reilly & Morrison, 1993; Strong et al., 2010; Valentine, Jenkins, Brennan, & Cass, 2013).

In terms of specific findings, given the lack of empirical attention that has been given to grandchildren's experiences with interventions for grandfamilies, their recommendations for mental health professionals are particularly valuable. First, grandchildren reported feeling judged by the professionals tasked with helping them. Thus, grandchildren's recommendations that professionals monitor their personal biases about grandfamilies and try to understand the unique experiences of each family member highlights the necessity of a strong professional relationship between grandfamilies and mental health

providers. Without it, grandchildren may not feel comfortable opening up to or accepting help from practitioners. Similarly, grandparent caregivers may choose not to reach out for needed services because of a lack of trust or a fear of being judged (Gladstone, Brown, & Fitzgerald, 2009; Strom & Strom, 2000). Clearly, both the grandmothers and grandchildren in this study were attuned to feeling judged and wanted practitioners to avoid making negative assumptions about their family structure and interactions.

Although components of a strong professional relationship were central to participants' recommendations for mental health professionals and other service providers, grandmothers and grandchildren also wanted mental health professionals to offer services that were tailored to their instrumental and emotional needs. This was especially true for grandchildren, who wanted mental health practitioners to hear their voices and not take sides in a conversation. Further, they wanted practitioners to respect their ideas and stay away from advice giving—an important distinction, as grandchildren may merely want to be heard, whereas grandmothers may want direction, instruction, or suggestions.

Although the literature on grandfamilies frequently discusses the difficulties experienced by grandchildren and their need for mental health services (Billing et al., 2002; Lander, 2011; Smith & Palmieri, 2007; Yancura, 2013), intervention with grandchildren has been largely neglected. Dannison and Smith (2003) recommended population-specific services for young grandchildren. Additionally, Smith (2003) found that grandparents wanted their grandchildren to participate in grandchild or family groups. Yancura (2013) identified unmet services needs of grandparents raising grandchildren and determined that the vast majority of grandparents desired programs for their grandchildren and were not having this service need met.

Despite these studies, little existing work has examined grandchildren's own ideas about accessing and utilizing services. In this study, grandchildren and their grandmothers indicated that mental health professionals should develop more interventions for grandchildren. Their ideas for beneficial interventions included therapy and support groups, as well as other services such as mentoring, career counseling, academic support, and structured opportunities for safe socializing. Perhaps because of the awareness of their grandparents' limitations (e.g., energy and generational differences) and their nontraditional family structure, grandchildren seemed most interested in services that would help them feel more like their peers and plan for their futures. Grandchildren's diverse ideas for services offers additional support for O'Reilly and Morrison's (1993) argument for a multimodal approach to working with grandfamilies and remind all practitioners of the importance of looking beyond one type of intervention and connecting grandparents and grandchildren to multiple resources in the larger community. Utilizing a multimodal approach when working with grandfamilies would provide grandparents and grandchildren with a viable option for addressing a variety of relational, personal, and instrumental needs.

Grandmothers' recommendations regarding tailoring interventions to meet their specific needs largely reflect existing practice guidelines (Burnette, 1999; Dannison & Smith, 2003; Smith, 2003) regarding the structure and delivery of interventions, namely support groups. Although this particular theme may seem less relevant to practitioners who do not lead support groups, it does draw into focus the importance of working with grandparents to remove as many barriers (e.g., lack of childcare or transportation) to service utilization as possible. It also highlights the importance of professionals becoming sensitive to how grandfamilies' barriers to

service utilization might impact their ability to access needed supports.

In terms of how mental health professionals can tailor their services to meet the needs of grandfamilies, one interesting subtheme was that grandmothers wanted practitioners to move away from venting and toward solving problems and attaining goals. Many scholars have already argued that support groups can be counterproductive when there is too much emphasis on self-pity and complaining (Smith, 2003; Strom & Strom, 2000; Szinovacz & Roberts, 1998). Therefore, in addition to providing support, support groups should include opportunities for advocacy, goal setting and evaluation, education, and skill building (Burnette, 1999; Cox, 1999; Hayslip & Kaminski, 2005; Strom & Strom, 2000; Wohl et al., 2003). By confirming this information, from the perspective of grandparents themselves, it is apparent that focusing on solutions (de Shazer, 1988) is an important practice recommendation. Where this study extends previous work is revealing that grandmothers viewed practitioners as being primarily responsible for maintaining a focus on problem-solving and goal attainment, and that a lack of training in group dynamics can seriously undermine the effectiveness of an intervention.

Somewhat unexpectedly, the grandmothers in this study were also able to take a more macro perspective and recommended that mental health professionals take a stance and become active in advocating for grandparent rights. Perhaps paralleling the emphasis that grandmothers put on their relationship with service providers, it seemed important for the grandmothers in this study to know that the professionals working with them were on their side and willing to speak (and advocate) on their behalf. This finding also points to the recognition by grandmothers that mental health professionals and service providers possess the power necessary to help them obtain the resources and

services (e.g., health insurance, financial support, legal rights) necessary for parenting a second generation of children. Scholars have advocated for policies that support grandparent caregivers (Smith, Beltran, Butts, & Kingson, 2000). To hear this same recommendation from grandmothers themselves further highlights the broader nature of the issue and the need for all professionals to consider their roles in advocating for grandparents and grandchildren within their local communities, as well as nationally.

Limitations

Although the findings from this study provide useful suggestions for mental health professionals working with grandfamilies, its limitations are acknowledged. First, while the demographic characteristics of the current sample compare favorably to national samples, the families who volunteered for the study were primarily White and do not fully reflect the diversity that is present in grandfamilies. Thus, findings may not be applicable to all grandfamilies, particularly to groups with a history of negative experiences with mental health services. Also, as recruitment occurred primarily through support groups, it is possible that participants differed from other grandfamilies in terms of their exposure to and comfort in talking about mental health and community services. Another limitation of the study is that participants' history of mental health treatment or service utilization was not obtained, although some participants did offer this information spontaneously. Further, because participants did not make clear distinctions among various mental health services and professionals, the degree to which grandmothers and grandchildren were making fully informed recommendations is unknown. Finally, the formal legal status within these grandfamily relationships raises concerns about how grandfamilies with informal caregiving arrangements might differentially experience mental health

services. Despite these limitations, the findings of from the study still provide important insights into ways that mental health professionals can improve services for custodial grandmothers and their adolescent grandchildren.

Directions for Practice and Research

The themes identified in this study highlight important ways that mental health professionals can tailor their work with grandfamilies. The finding that participants wanted services that are more responsive to their particular needs suggests that, when applicable and appropriate, programming for grandfamilies could include childcare, meals, and transportation. Opportunities for education, support, and socialization for both grandparents *and* grandchildren can also be included. Additionally, particular consideration could to be given to offering enjoyable family activities (e.g., picnics or family outings). While many interventions for grandfamilies are already structured in these ways, they may be less available and accessible to grandparents living in rural areas or to those experiencing compromised health. Thus, professionals might consider offering home-based therapy services or services located in settings grandparents already frequent (e.g., schools, churches). Further, mental health professionals might consider partnering with other community services and practitioners, or taking a multimodal approach, to better address the breadth of needs grandfamilies often experience.

Because grandchildren experience difficulties that are stressful for their grandparents and have significant potential consequences for the grandchildren's future development, the findings from this study suggest that mental health professionals should actively work to address the needs of grandchildren and support grandparents in their efforts to raise healthy, well-adjusted children. For example, family therapists, with their knowledge of family systems dynamics, are especially suited to treat

grandchildren's needs within the context of their larger family system. More specifically, family therapists could address problematic family dynamics (e.g. hierarchy, boundaries, power, communication), which are likely to have been in place for multiple generations, and can provide grandchildren with opportunities to express themselves and process their reactions to their family situation (Bartram, 1994; Bratton et al., 1998; Brown-Standridge & Floyd, 2000; Lander, 2011). As grandchildren's needs tend to be varied, connecting grandchildren to other resources and services such as medical care, mentoring, career counseling, and tutoring suggests that a multimodal perspective would best address grandchildren's needs.

The finding that mental health professionals could improve their services by monitoring their own biases and learning more about grandfamilies highlights the need for enhanced training. It is essential that professionals become knowledgeable about grandfamilies, as service recipients may feel frustrated when they perceive that they must teach others about their family. The content of trainings could include information about the formation of grandfamilies, challenges facing grandparents, resilience among grandfamilies, and the experiences of grandparents and grandchildren. Trainings could also address diversity within grandfamilies. Certainly, as demonstrated by the finding that grandfamilies wanted everyone's voice to be acknowledged and heard, mental health professionals should be cautious to avoid a one-size-fits-all approach. However, some basic knowledge may positively impact grandfamilies' relationships with mental health professionals and enhance their view of the services and resources within their communities.

Related to enhancing professional training, mental health professionals could also benefit from attending to the personal assumptions underlying their work. In this study,

grandmothers and grandchildren felt judged by the professionals with whom they have had contact. As such, these professionals could examine their feelings about grandfamilies and obtain adequate supervision and guidance to discuss how these feelings might be impacting their work. In particular, mental health professionals could explore their assumptions about grandfamily formation, grandparents' motivations, grandparents' parenting abilities, and grandchildren's level of functioning.

Grandmothers also indicated a preference for action-oriented treatment focused on helping them achieve their goals. As such, mental health professionals and other service providers might consider incorporating solution-focused therapy (de Shazer, 1988) techniques such as setting achievable goals, finding exceptions to problems, and identifying solutions that have worked in the past. A related approach that may be beneficial is narrative therapy (White & Epston, 1990), which focuses on helping grandparents create new, more resilient narratives about themselves and their families. Several participants shared that their experiences were not like others and that they wanted the professionals they work with to value their experiences, rather than make assumptions about them. Narrative therapy (White & Epston, 1990) has become known for its not-knowing, curious stance and its ability to honor clients' stories. Narrative therapists can help grandparents and grandchildren understand, address, and build upon the empowering stories in their lives (Freedman & Combs, 1996). This modality would also give grandfamilies the ability to process and reflect on their journey without feeling judged. Thus, combining a strong professional relationship, a multimodal perspective, future-oriented problem solving, and resilient narratives may provide grandfamilies with the most efficacious approach to intervention. Grandfamilies can feel heard and

supported, while also taking an active role in overcoming the challenges within their everyday lives.

The findings from this study also have implications for research. Grandmothers and grandchildren's recommendations for mental health professionals focused on facets of the relationship with the service provider and components of service. Despite this important information, the overall effectiveness of interventions with grandfamilies continues to receive limited empirical attention. Therefore, future research could examine the effectiveness of family therapy, support groups, psychoeducational programs, and community programs in terms of improving outcomes for custodial grandparents and their grandchildren. Part of this research could also examine the process of treatment and intervention, for the purpose of determining what specific facets of interventions have the most significant impact on desired outcomes. Finally, although this study considered the perspectives of grandchildren, which others have not done, researchers still need to know more about grandchildren's experiences with services.

Conclusion

Grandfamilies frequently access or are referred to mental health professionals and community services. To improve professional work with grandfamilies, service providers need to know how actual service recipients, including grandchildren, experience the services they utilize. The findings from this study suggest that various professionals working with grandfamilies can improve their work by attending to a genuine professional relationship and designing services that are responsive to grandfamilies' unique needs. However, to truly support grandfamilies, professionals should also consider joining grandparent caregivers in their efforts to advocate for increased rights and recognition.

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Correspondence: Kendra A. O’Hora, Family Therapy Center of Virginia Tech (0515), 840 University City Boulevard, Suite 1, Blacksburg, VA 24060; Email: kendraaa@vt.edu; Phone: (540) 231-7201; FAX: (540) 231-7209.

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