Grandparents Caring for Grandchildren: Racial Variations in Mental Health*

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ABSTRACT

Although providing coresidential care for a grandchild is negatively associated with mental health, previous research has largely neglected to investigate potential race differences. The prevalence and importance of kin networks and social support for the family life of Blacks may ease the burden of grandchild care. However, Blacks have different economic and structural circumstances from Whites, which may make caring financially for a co-residential grandchild more stressful. Using data from the 2004 Health and Retirement Study, I find that Black and White grandparents providing coresidential care for grandchildren have similar levels of depression, although only Whites experience elevated depression relative to their non-caregiving counterparts. The economic disadvantaged experienced by Black grandparents is consequential for their mental health; after controlling for economic factors, Black coresidential grandparents have lower odds of depression than Whites.

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Approximately 5.8 million grandparents are coresiding with grandchildren in the U.S. today, and over 2.4 million grandparents have primary responsibility for these grandchildren (Simmons & Dye, 2003). Although caring for one's grandchild can have positive consequences for grandparents, it also has potential costs. Studies have shown that being a caregiver for grandchildren can have negative consequences for health. Black grandmothers are more likely to be co-residential caregivers for grandchildren than are Whites, but research has not fully investigated whether there are racial differences in the effect of grandparenting on psychological well-being (Caputo, 2001). However, there are reasons to expect variation. Past work has documented the prevalence and importance of kin networks for the family life of Blacks, which may ease the burden of grandchild care. Further, providing coresidential care for a grandchild is more common among Blacks than Whites, which may make this role more normative and expected among Blacks. On the other hand, Blacks experience different economic and structural circumstances than Whites, which may make it more difficult to care financially for a co-residential grandchild. Further, older Black men and women have lower levels of physical health than Whites, which may also have consequences for their caregiving role. This paper assesses whether there are racial variations in the psychological well-being of grandparentings providing coresidential care for grandchildren using data from the Health and Retirement Study (HRS), a large, nationally representative survey of older adults.

BACKGROUND

There is a substantial and growing number of grandparents providing coresidential care for a grandchild in the U.S. today (Pebley & Rudkin, 1999; Simmons & Dye, 2003). However, the proportion of grandparents raising grandchildren varies considerably by race-ethnicity. Prior

research has shown that Black grandmothers are more likely to be coresidential caregivers for grandchildren than are Whites (Caputo, 2001). In fact, Fuller-Thomson et al. (1997) find that African Americans have 83 percent higher odds of raising their grandchildren. Whereas about 1.1% of Whites over the age of 30 are providing coresidential, primary care for grandchildren, 4.3% of Blacks are doing so (Simmons & Dye, 2003).

The Context of Caring for Grandchildren

Caregiving grandparents can be disaggregated into three major groups: custodial grandparents, "living-with" grandparents, and day-care grandparents (Jendrek, 1994). Custodial grandpernts not only co-reside with their grandchildren, but also retain legal custody of them. The role of "living-with" grandparents is more ambiguous; these grandparents reside with their grandchildren but do not have legal rights to the child. They often provide significant, if not all of, the care for the grandchild, and the child's parents may or may not be present (Jendrek, 1994). Finally day-care grandparents provide daily care for their grandchildren but do not coreside with or have legal responsibility for the children. This study focuses on custodial and living-with grandparents, the groups which comprise the grandparents who provide the most support to grandchildren and have the most responsibility for them.

For many coresidential grandparents, caregiving is not a short-term phenomenon and begins when the grandchild is young. The majority of Black coresidential grandparents begin providing care when the grandchild is younger than the age of one, and another twenty percent begin when the child is between one and five years of age (Fuller-Thomson & Minkler, 2000). Almost forty percent of grandparents responsible for grandchildren have been providing care for five or more years (Simmons & Dye, 2003). In many cases, the grandparent's household includes not only the grandchild, but also one of the grandchild's parents (usually their mother). Although the parent may

be present in the household, the coresidential grandparent often assumes substantial economic and caregiving responsibilities for the grandchild (Pebley & Rudkin, 1999).

The Mental Health of Grandparents Raising Grandchildren

Providing primary care for one's grandchildren often means substantial changes in a grandparent's life. Although custodial grandparents do experience positive effects of their care, such as feeling they have more of a purpose for living, there also appear to be consequences. Grandparents raising grandchildren report having less privacy, less time for themselves, less time to get things done, less time for their spouse, less contact with friends, feeling more physically tired, feeling more emotionally drained, worrying more, and having less money than those not raising grandchildren (Jendrek, 1993). These represent major constraints for an older adult, and may have consequences for well-being. Indeed, previous research has found effects for health; grandparents providing primary care for grandchildren have significantly lower satisfaction with their overall health than non-custodial grandparents, and being a coresidential grandparent is associated with higher rates of depression (e.g., Blustein, Chan, & Guanais, 2004; Minkler & Fuller-Thomson, 1999; Thomas, Sperry, & Yarbrough, 2000). Grandparents providing coresidential care for their grandchildren are twice as likely as non-custodial grandparents to report depressive symptoms (Minkler et al., 1997).

Although research has established mental health consequences for grandparents providing coresidential care for grandchildren, potential race differences in the relationship between grandparenting and mental health have received much less attention. There are reasons to expect that Black custodial grandparents may experience more negative mental health consequences than Whites. Blacks, on average, report lower levels of psychological well-being than do Whites (Cochran, Brown, & McGregor, 1999; Williams et al., 1997); the added stress of parenting a

grandchild may make this disparity even larger. Black grandmothers have more grandchildren in their households, are less likely to be married, are more likely to be employed, and have lower incomes than White grandmothers (Pruchno, 1999). Black grandparents also experience custodial grandparenting earlier than do White grandparents (Szinovacz, 1998), and younger grandparents have more anxiety associated with the role than do older grandparents (Sands & Goldberg-Glen, 2000). Further, economic and time constraints associated with custodial grandparenting may prevent grandparents from seeking treatment for depression or depressive symptoms (Minkler, 1999).

Yet when compared to White grandmothers, there appear to be positive effects and greater resiliency among Black grandmothers. In a small sample of White and Black grandmothers, Pruchno (1999) finds Black grandmothers perceive that caring for their grandchildren has less of a negative impact on their well-being than White grandmothers. Compared to Whites, Black grandmothers have higher levels of life satisfaction and lower levels of negative affect (Goodman & Silverstein, 2001; Pruchno & McKenny, 2002). However, other work finds that Black coresidential grandparents have more depressive symptoms than Whites (Blustein, Chan, & Guanais, 2004). In examining the few studies that focus on potential race differences in the mental health of custodial grandparents, results are inconsistent and point to the need for more research on the topic. Further, these studies often use small, non-representative samples, do not focus specifically on mental health outcomes, or focus only on grandmothers, limiting the generalizability of the results (Pebley & Rudkin, 1999).

THEORETICAL PERSPECTIVE

The stress and coping perspective provides a theoretical framework for understanding how providing coresidential care for a grandchild may influence psychological well-being. The stress

and coping perspective posits that stress, and especially chronic stress, is negatively related to both physical and psychological well-being (Pearlin, 1989; Pearlin & Schooler, 1978). Caring for children may be a stressor in itself, and this stress may be enhanced when the caregiver is a grandparent, who may be experiencing an unexpected "second round" of parenting. Further, being a custodial grandparent represents a chronic form stress, both in terms of economic strain, a strain on time, and a strain with respect to parental responsibilities. This may result in role strain and increased stress for caregiving grandparents (Goodman & Silverstein, 2001). Consistent with this idea, stress is the strongest predictor of both depression and other health problems among grandparents raising grandchildren (Musil & Ahmad, 2002).

Coping resources and social support represent ways in which the negative effect of stress on health can be diminished; access to good coping resources aids an individual with his or her problems. However, if coping resources are not sufficient to deal with the stressors, negative consequences can occur, including mental health problems (Pearlin, 1989; Pearlin & Schooler, 1978). Several factors may play a role in the mental health of grandparents providing coresidential care for grandchildren, either by acting as positive sources of social support or by contributing to the stress that caregiving grandparents experience.

Social Support

Previous research suggests that sources of social support, such as a spouse, friends, relatives, or religious involvement, may play an important role in mediating the relationship between caregiving responsibilities for one's grandchildren and psychological well-being (Grinstead, 2003). Black grandparents providing primary care to their grandchildren are more likely than their non-caregiving counterparts to be widowed, never married, divorced, or separated (Fuller-Thomson & Minkler, 2000). The absence of a second grandparent in the household to aid in parenting may put

more stress on the sole grandparent. However, other research finds that Black grandmothers received more help from others than do White grandmothers (Kivett, 1993), highlighting the importance of kin networks and social support systems in the Black community. While friendships may provide an important coping resource for grandparents caring for grandchildren, parenting responsibilities for grandchildren may have a detrimental impact on the grandparent's access to social support. Almost half of the respondents in Jendrek's (1993) analysis of custodial grandparents experienced conflict or other problems with family and friends due to their caregiving role. Further, custodial grandparents are often subjected to isolation from their former social relationships due to their new responsibilities (Minkler, 1999).

Economics

Socioeconomic status is negatively associated with depression (Miech & Shanahan, 2000). Grandparents raising grandchildren have lower incomes than non-caregiving grandparents (Fuller-Thomson, Minkler, & Driver, 1997), and the financial responsibilities of raising a grandchild may deplete a grandparent's savings and assets. The availability of reasonably priced housing is another consideration, as public housing for older adults often does not allow for co-residential grandchildren (Barer, 2001). Lack of affordable childcare may also force some employed grandparents out of the labor force (Caputo, 2001). Reduced labor force participation, in turn, may decrease not only income but also retirement savings and Social Security contributions (Caputo, 2001). The economic costs of caring for grandchildren takes a toll on grandparents; coresidential grandparents are more likely than their non-caregiving counterparts to be in poverty (Caputo, 2001; Fuller-Thomson, Minkler, & Driver, 1997). Black grandparents providing coresidential care for their grandchildren are particularly vulnerable economically, having lower income, education, and

higher poverty rates than Whites (Minkler & Fuller-Thomson, 2005; Pruchno, 1999; Pruchno & McKenney, 2002)

Other Factors

Gender may play an important role in understanding the relationship between providing primary care for a grandchild and mental health. Women are much more likely to be providing coresidential care for a grandchild than are men, and even when both grandparents are present in the household, women assume greater responsibility for the care of a grandchild (Minkler & Fuller-Thomson, 2005; Simmons & Dye, 2003). As such, women may experience more stress as a result of coresidential grandparenting than men. There may also be racial variations in the relationship between the custodial grandparent's gender and mental health. Pruchno and McKenney (2002) find that the caregiver role appears to be more central in the lives of Black grandmothers. If this is the case, the association between caring for a grandchild and mental health may be different for Black women than for White women.

Age and physical health may also play a role. While younger grandparents are more likely to be custodial grandparents, older grandparents appear especially at risk for negative mental health consequences (Simmons & Dye, 2003). Older adults face more health problems than younger adults, and physical health problems are positively associated with depressive symptoms (Miech & Shanahan, 2000). For older adults providing care to their grandchildren, physical health limitations may impair a grandparent's ability to care for their grandchild and serve as an added form of stress in the grandparent's life. Black grandparents raising grandchildren are more likely than those not providing care for grandchildren to have limitations in activities of daily living (Minkler & Fuller-Thomson, 1999; Fuller-Thomson & Minkler, 2000). Black grandparents may also be less likely to receive medical attention for their physical health problems, as Blacks face a

more precarious economic situation and are less likely to have health insurance than Whites. After channeling limited financial resources to grandchildren, there may be little money left for grandparents' health needs (Grinstead et al., 2003).

HYPOTHESES

Race may differentially influence the relationship between custodial grandparenting and psychological well-being, and I offer competing hypotheses with regard to the possible relationships. On one hand, Black custodial grandparents may exhibit higher levels of psychological well-being than Whites, as they have larger social support networks available to help them with their grandchildren. These social networks may act as important coping mechanisms to buffer the stress these grandparents experience. Further, as coresidential grandparenting is much more common for Blacks (Simmons & Dye, 2003), this type of caregiving may be more anticipated and more normative for Blacks than for Whites, resulting in fewer negative effects on psychological well-being. Consistent with this hypothesis, some previous research has found that Black grandmothers caring for grandchildren exhibit lower levels of depression than do White grandmothers (Pruchno & McKenney, 2002).

On the other hand, there are also reasons to expect that White custodial grandparents may exhibit higher levels of psychological well-being than Blacks. Black grandparents, on average, experience a much more vulnerable economic situation, which may represent an added form of chronic stress (Minkler & Fuller-Thomson, 2005). Further, although White custodial grandparents have smaller kin networks than Blacks, they are more likely to be married, and a spouse may represent an important source of social support by sharing the parenting responsibilities for a coresidential grandchild. Consistent with this hypothesis, Blustein et al. (2004) find that Black coresidential grandparents exhibit higher levels of depressive sympotoms than do Whites.

It is also possible that the mental health of custodial grandparents may vary based on both race and gender, as described previously. If caring for grandchildren is more central to the lives of White women than Black women (Pruchno & McKenney, 2002), it would suggest that Black women may see fewer negative mental health consequences associated with their care.

METHOD

Data. I use data from the 2004 wave of the Health and Retirement Study (HRS). This data set is a nationally representative sample of those over the age of 50. Use of survey is advantageous as it focuses on the age group most likely to be grandparents and contains oversamples of Blacks. The total sample size of 20,142 respondents includes respondents' spouses or partners, some of whom are younger than 50. As the survey is representative only of non-institutionalized adults over the age of 50, respondents outside of this age range or who are institutionalized are excluded from the sample, resulting in a loss of 1,622 respondents (8.5%). Further, those who are missing responses for the dependent variable are also not included, resulting in a loss of 1,458 respondents (7.2%). The final sample for the full analysis of all older adults is 17,062 respondents. This sample is then further limited for the analysis of grandparents raising grandchildren (n=520); those respondents who are not non-Hispanic Black or non-Hispanic White grandparents currently raising a grandchild are excluded.

Measures. Mental health is scale measuring depressive symptomatology using nine items from the CES-D scale (Radloff, 1977). These items include how often during the past week the respondent felt depressed, felt everything he/she did was an effort, felt his/her sleep was restless, was happy (reverse coded), felt lonely, enjoyed life (reverse coded), felt sad, couldn't get going, and had a lot of energy (reverse coded). These items are added to form a scale that ranges from (1) no symptoms to (10) nine symptoms (alpha=0.80). Previous assessments of this measure find that it

has acceptable reliability and validity (Gallo, Bradley, Siegel, & Kasl, 2000). This scale is not evenly distributed, with the majority of respondents reporting no symptoms, and therefore cannot be treated as a continuous variable. Due to the skewed nature of this scale, ordinary least squares (OLS) regression is inappropriate. Poisson and negative binomial models are also inappropriate, as there is a clear upper bound for the scale (Amirkhanyan & Wolf, 2006). Therefore, I use a dichotomous measure of depression, in which those who report more than three symptoms of depression are considered to be depressed. This is consistent with the way this variable has been measured by previous researchers (e.g., Zhang & Hayward, 2001). According to this definition, approximately 19% of the respondents in the full sample are considered to be depressed, which is consistent with previous work finding that about 20% of respondents exhibit depression when using a dichotomous measure (Koropeckyj-Cox, 1998; Zhang & Hayward, 2001).

Grandparent status is measured by three mutually exclusive dichotomous variables. *Grandparents coresiding with grandchildren* are those who indicate that they (or their spouse) are the head of the household and either (a) have no adult children in the household, and report at least one coresident grandchild on the household roster; or (b) have both adult children and grandchildren in the household, but indicate that they are raising the grandchildren, or (c) have both adult children or grandchildren in the household, but indicate that they have spent over 100 hours caring for the grandchild in the previous year. *Grandparents providing non-residential care* are those who report providing over 100 hours of care for a grandchild in the previous year, but who are not residing with the grandchild. *Not providing care for a grandchild* are those who do not report providing the previous types of care for a grandchild.

For those providing coresident care for a grandchild, three measures of grandchild characteristics are included. *Number of grandchildren* indicates the number of grandchildren that

are coresiding with the grandparent; this variable ranges from no grandchildren (0) to four or more (4). *New household member* is a dichotomous variable indicating the grandchild has moved into the home within the previous two years. The age of the youngest grandchild in the household is measured by a set of three mutually-exclusive dichotomous variables: *age 0 to 5*, *age 6 to 11,* and *age 12 to 18*.

Four measures of social support are used. *Married* is a dichotomous variable indicating that the respondent is currently married. *Friends nearby* is a dichotomous variable coded one if the respondent indicates that he or she has close friends living in his or her neighborhood. *Relatives nearby* is a dichotomous variable coded one if the respondent indicates that he or she has at least one child residing within 10 miles or has relatives in his or her neighborhood. *Religiosity* is the answer to a question asking the respondent how important religion is in his or her life; responses are (1) not at all important, (2) somewhat important, or (3) very important.

Several measures of socioeconomic status are also included. *Education* is a continuous variable coded as the number of years of education one has completed. Employment status is measured as a set of mutually exclusive dummy variables. *Employed* is a dichotomous variable indicating that the respondent is working for pay. *Household income* is the total household income the respondent reports. *Wealth* is the respondent's total net worth. The HRS uses sophisticated bracketing techniques to minimize non-response and allow for better imputations for missing data for income and wealth. The logged value of income and wealth are used in the multivariate analysis to reduce skewness; those with negative values of wealth are considered to have zero wealth. *No health insurance* is a dichotomous variable indicating that the respondent does not have any form of health insurance.

Race is measured by three mutually exclusive dichotomous variables: non-Hispanic *White*, non-Hispanic *Black*, and *other race-ethnicity*. Gender, age, and activities of daily living (ADL) limitations, which is an indicator of physical health, are included as control variables. *Female* is a dichotomous variable indicating the respondent is female. *Age* is the respondent's age in years. Finally, *ADL limitations* is a scale is composed of the responses to six items asking the respondent if, because of a health or memory problem, he or she has difficulty dressing, walking, bathing, toileting, eating, getting into/out of bed. For each question, any reported difficulty is coded (1), while no difficulty is coded (0). Responses to each item are then added together to form the physical limitations scale (alpha = 0.72).

PLAN OF ANALYSIS

The data will be analyzed in several steps in order to test the hypotheses. First, I will compare the means for both Black and White coresidential grandparents providing care for a grandchild to those of older adults who are providing non-residential care for a grandchild and those who are not providing a substantial amount of care for a grandchild. This will aid in better understanding how the mental health of grandparents providing coresidential care may differ from older adults not providing this type of care. I will then compare the means of all variables by race for coresidential grandparents only, in order to understand how mental health, sociodemographic factors, household characteristics, social support, and economics of Black and White coresidential grandparents compare.

Logistic regression will then be used to examine the odds of depression for grandparents providing coresidential care for grandchildren. The first model will include only race to examine the relationship between race and mental health among coresidential grandparents. The next model will include the grandparent's sociodemographic factors and characteristics of the grandchildren in

the household. The third model will include social support factors, and the fourth model will include economic factors in order to examine how social support and economics may play a role in race differences in the mental health of custodial grandparents. The fifth model will include all variables. Finally, I will test a race by gender interaction term in a subsequent model. All analyses use the "svy" commands in Stata to correct for the complex sampling design of the HRS, and all analyses utilize the 2004 HRS individual weight in order to ensure the sample is representative.

RESULTS

Table 1 shows the means for all variables by race and caregiving status. Respondents are separated into those providing co-residential care for a grandchild, those providing non-residential care for a grandchild, and those not providing substantial care for a grandchild. Table 1 shows that White grandparents providing coresidential care for a grandchild have higher depression, on average, than are those who are providing non-residential care for a grandchild or no care for a grandchild. However, among Blacks, coresidential caregiving grandparents are not more depressed than non-residential caregiving and non-caregiving older adults. While Black non-residential and Black non-caregiving respondents report higher depression, on average, than do their White counterparts, there is no significant difference in depression between White and Black grandparents providing coresidential care for a grandchild.

Table 1 also reveals some important differences in the sociodemographic background, household characteristics, social support, and economics of coresidential caregiving grandparents. White grandparents providing coresidential care are more likely than non-residential and non-caregiving older adults to be female, to lack health insurance, and to have lower education, income, and wealth, on average. Further, they tend to be younger than those who are not providing substantial care to a grandchild, and are less likely to be married or have

relatives nearby, on average, than those providing non-residential care for a grandchild. Black coresidential grandparents providing care for a grandchild are more likely to be female and to have a lower education than older adults who are not caring for grandchildren or who provide non-residential care. They are also younger and have a lower income, on average, than those who do not provide care for a grandchild, and are less likely to be married or have relatives nearby than grandparents providing non-residential care.

Table 2 shows the means and standard errors of all variables for only those older adults who are coresidential grandparents providing care for a grandchild. When comparing Black and White coresidential grandparents, Blacks are more likely to be female, have more ADL limitations, and have higher levels of religiosity. Whites are more likely to be married and have higher education, income, and wealth, on average, than Blacks. Although there are no race differences with respect to the age of the grandchildren in the household or whether the grandchild is a recent addition to the household, Blacks do have more grandchildren in the household, on average, than Whites.

Table 3 shows the logistic regression of depression for grandparents providing coresidential care for grandchildren. Model 1 shows that, at the bivariate level, there are no race differences in depression for coresidential caregiving grandparents. Model 2 adds the sociodemographic and grandchild characteristics; none of the grandchild characteristics are significantly related to depression. Of the sociodemographic factors, only ADL limitations are significantly related to depression. Even after accounting for these factors, there are not significant race differences in depression.

The third model examines whether social support variables may be related to depression among custodial grandparents. Having friends nearby is associated with lower odds of

depression, while religiosity is related to higher odds of depression. After controlling for social support factors, Black coresidential grandparents have significantly lower odds of depression than do Whites. Although Black coresidential grandparents do not differ significantly from White grandparents in terms of depression at the bivariate level, accounting for religiosity reveals a significant race difference in depression. The fact that religion is positively associated with depression is an unexpected finding. Subsequent analyses (results not shown) find that religiosity is positively associated with depression only for grandparents providing coresidential care for grandchildren; religiosity is not associated with depression in the full sample of all older adults. It is possible that religiosity is acting as a proxy for another factor, such as self efficacy. The religiosity measure asks how important religion is overall to the respondent; it is possible that those coresidential grandparents indicating that it is "very important" are those that feel most helpless or in need of religious intervention (and least efficacious). This may explain the positive association with depression.

The fourth model includes economic variables in order to understand how these factors may be related to depression among coresidential grandparents. Results show that education, wealth, and employment all decrease the odds of depression. Further, after controlling for these variables, Black coresidential grandparents have significantly lower odds of depression than Whites. This indicates that Black and White coresidential grandparents exhibit similar levels of depression partially due to the lower economic resources of Blacks; after accounting for these factors, Blacks actually have lower odds of depression.

The full model is shown in Model 5. After controlling for all variables, Black coresidential grandparents have 0.39 times the odds of depression as White coresidential grandparents. Age, friends nearby, education, wealth, and employment are associated with lower

odds of depression among coresidential grandparents, while ADL limitations, religiosity, and a grandchild younger than age five are associated with higher odds of depression. In a subsequent model (results not shown), an interaction between race and gender was tested. This interaction was not significant, suggesting that the relationship between gender and depression for coresidential grandparents is similar regardless of race.

DISCUSSION

This study uses data from the Health and Retirement Study (HRS) to examine depression among Black and White grandparents providing coresidential care for their grandchildren, and tests competing hypotheses regarding race differences. Results show that, at the bivariate level, there are no race differences in depression between Black and White coresidential grandparents. However, the fact that Black and White coresidential grandparents exhibit similar levels of depression is due to the elevated depression of White coresidential grandparents compared with Whites not providing coresidential care. Among older adults not providing care for grandchildren, Whites have lower levels of depression than Blacks (18% versus 24%, respectively). The comparable figures for coresidential grandparents providing care find that 27% of Whites and 25% of Blacks are depressed. While White coresidential grandparents report significantly higher depression than non-residential grandparent caregivers and non-caregiving older adults, there are no significant differences among these groups for Blacks.

After accounting for sociodemographic background, grandchild characteristics, social support, and economic factors, Black coresidential grandparents have lower odds of depression than Whites. Subsequent analyses (results not shown) reveal that this significant race difference exists after controlling specifically for wealth. In other words, it is because Black coresidential grandparents have lower levels of wealth that they exhibit similar levels of depression to Whites;

given the same economic situation as Whites, Black coresidential grandparents have lower odds of depression than Whites.

These results are consistent with previous studies finding that providing coresidential care for a grandchild is particularly consequential for White grandparents' mental health (Goodman & Silverstein, 2001; Pruchno, 1999; Pruchno & McKenny, 2002). This suggests greater resiliency among Black coresidential grandparents, who do not exhibit elevated depression relative to White coresidential grandparents *or* Blacks not providing coresidential care, despite having a more precarious economic situation than both groups. Controlling for social support factors does not explain this difference. Previous work suggests grandparenting may be a more central role in the lives of Blacks (Pruchno & McKenney, 2002), which may have protective benefits for mental health. Results of this study may lend support to this hypothesis.

Findings also suggest greater vulnerability among White coresidential grandparents. White coresidential grandparents exhibit much higher depression than those providing non-residential care or no care for a grandchild. Further, after accounting for their better economic situation, they have higher odds of depression than Black grandparents. These differences obtain despite the fact that Whites are much more likely than Blacks to have a spouse present to help with parenting responsibilities. As providing coresidential care for a grandchild is less common for Whites than Blacks, it is possible that Whites have a more difficult time adjusting to this non-normative family structure, making it more stressful.

This study has several limitations. First, this is a cross-sectional study examining mental health at only one point in time. It is possible that there is some selectivity in coresidential grandparenting; those grandparents who have the poorest mental health may not assume caregiving responsibilities for a grandchild. Future work should use longitudinal data to examine

whether there are race differences in mental health over the transition to grandparenting, and also to examine the health trajectories of custodial and non-custodial Black and White grandparents. Second, HRS data do not include measures of grandchild characteristics such as behavioral problems or quality of the grandparent-grandchild relationship. Previous research finds that measures such as these are important to understanding the mental health outcomes of grandparents (Pruchno & McKenney, 2002). Third, there are no measures of why the grandchild is living with the grandparent, and whether or how much the parent of the grandchild contributes to the grandchild's care. Past work finds that the intergenerational relationships between the grandparent, parent, and grandchild are often complex and may have important implications for the mental health of the grandparent (Jendrek, 1994; Pebley & Rudkin, 1999; Pruchno & McKenny, 2002). Finally, the small sample sizes of Black and White coresidential grandparents used in this study suggest that the results should be interpreted cautiously.

This study builds on previous work examining the mental health of coresidential grandparents caring for grandchildren by specifically investigating potential race-ethnic differences in depression using a nationally representative sample of older adults. I find that Black and White coresidential grandparents have similar levels of depression, although the similarities are partially due to the fact that Blacks have a poorer economic situation than Whites. Although I expected that sources of social support such as a spouse or relatives nearby may play a role in race differences in the mental health of coresidential grandparents, this is not the case. White coresidential grandparents appear particularly vulnerable to their caregiving responsibilities, having significantly higher depression than Whites not providing coresidential care. This study suggests that policies focused on grandparents caring for grandchildren should target economic well-being, which may be particularly beneficial for Black grandparents.

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Table 1. Weighted Means All Variables by Race and Grandparent Caregiver Status

	Whites			Blacks		
	Coresident Caregivers	Nonresident Caregivers	Not Caregivers	Coresident Caregivers	Nonresident Caregivers	Not Caregivers
	Mean	**Mean**	**Mean**	**Mean**	**Mean**	**Mean**
Dependent Variables						
Depression	0.27	0.16 *** ^^	0.18 *** ^	0.25	0.24	0.24
Sociodemographic Factors						
Female	0.63 ***	0.57 *** ^	0.54 ^^	0.78	0.68 ^	0.55 ^^
Age	62.04	63.16 ***	66.15 *** ^^	61.80	60.93	63.17 ^
ADL Limitations	1.27 *	1.16 ***	1.22 ***	1.57	1.39	1.40
Social Support						
Married	0.66 ***	0.80 *** ^^	0.60 ***	0.36	0.49 ^	0.36
Friends Nearby	0.60	0.65 **	0.67 **	0.59	0.55	0.61
Relatives Nearby	0.58	0.75 ^^	0.51 ***	0.68	0.80 ^	0.60
Religiosity	2.52 ***	2.54 ***	2.45 **	2.91	2.89	2.85
Economic Factors						
Education	12.35 ***	13.15 *** ^^	13.29 *** ^^	11.34	11.91 ^	12.05 ^^
Household Income	53976.68 **	76976.62 *** ^^	71156.66 *** ^	33227.34	42620.25	43383.78 ^
Wealth	303250.20 **	508851.20 ** ^^	517455.40 *** ^^	103809.90	210549.70	124884.30
Employed	0.44	0.46	0.43	0.40	0.44	0.41
No Health Insurance	0.14	0.04 *** ^^	0.05 *** ^^	0.14	0.13	0.11

[1]Reference Category

Significantly different from Blacks: *$p < .05$. **$p < .01$. ***$p < .001$.

Significantly different from coresident caregivers: ^$p < .05$. ^^$p < .01$. ^^^$p < .001$.

Table 2. Weighted Means and Standard Errors of All Variables for Grandparents Providing Coresidential Care

	Whites		Blacks	
	Mean	**S.E.**	**Mean**	**S.E.**
Dependent Variable				
Depression	0.27	0.03	0.25	0.03
Sociodemographic Factors				
Female	0.63 ***	0.02	0.78	0.03
Age	62.04	0.60	61.80	0.60
ADL Limitations	1.27 *	0.06	1.57	0.13
Social Support				
Married	0.66 ***	0.03	0.36	0.04
Friends Nearby	0.60	0.04	0.59	0.04
Relatives Nearby	0.58	0.04	0.68	0.04
Religiosity	2.52 ***	0.05	2.91	0.03
Economic Factors				
Education	12.35 ***	0.18	11.34	0.22
Household Income	53976.68 **	6253.18	33227.34	3108.61
Wealth (Logged)	303250.20 **	53636.85	103809.90	25148.52
Employed	0.44	0.03	0.40	0.05
No Health Insurance	0.14	0.03	0.14	0.04
Grandchild Characteristics				
Number of Grandchildren	1.42 *	0.06	1.63	0.08
Grandchild New Addition	0.33	0.04	0.30	0.04
Age 0 to 5 Years	0.33	0.04	0.27	0.04
Age 6 to 11 Years	0.29	0.04	0.33	0.04
Age 12 to 18 Years[1]	0.38	0.04	0.40	0.04
N	276		244	

[1]Reference Category

Significantly different from Blacks: *$p < .05$. **$p < .01$. ***$p < .001$.

Table 3. Logistic Regression Predicting Depression among Grandparents Providing Coresidential Care

	Model 1		Model 2		Model 3		Model 4		Model 5	
	b	Odds	b	Odds	b	Odds	b	Odds	b	Odds
Sociodemographic Factors										
Black	-0.093	0.91	-0.359	0.70	-0.678 *	0.51	-0.658 *	0.52	-0.950 **	0.39
Other Race-Ethnicity	0.019	1.02	-0.086	0.92	-0.226	0.80	-0.640	0.53	-0.755	0.47
(White)	--	–	--	–	--	--	--	–	--	--
Female			0.280	1.32	-0.039	0.96	0.189	1.21	-0.099	0.91
Age			-0.017	0.98	-0.024	0.98	-0.037	0.96	-0.049 *	0.95
ADL Limitations			0.724 ***	2.06	0.700 ***	2.01	0.563 ***	1.76	0.532 ***	1.70
Grandchild Characteristics										
Number of Grandchildren			-0.088	0.92	-0.145	0.86	-0.144	0.87	-0.222	0.80
Grandchild New Addition			0.217	1.24	0.195	1.22	0.121	1.13	0.071	1.07
Age 0 to 5 Years			0.336	1.40	0.418	1.52	0.433	1.54	0.559 *	1.75
Age 6 to 11 Years			-0.202	0.82	-0.173	0.84	-0.182	0.83	-0.108	0.90
(Age 12 to 18 Years)			--	–	--	--	--	–	--	--
Social Support										
Married					-0.507	0.60			-0.413	0.66
Friends Nearby					-0.559 *	0.57			-0.574 *	0.56
Relatives Nearby					-0.028	0.97			-0.185	0.83
Religiosity					0.658 ***	1.93			0.775 ***	2.17
Economic Factors										
Education							-0.117 **	0.89	-0.122 **	0.89
Household Income (Logged)							-0.055	0.95	-0.069	0.93
Wealth (Logged)							-0.068 *	0.93	-0.059 *	0.94
Employed							-0.588 *	0.56	-0.731 **	0.48
No Health Insurance							-0.146	0.86	-0.147	0.86
Intercept	-0.991		-1.104		-1.399		3.443		3.335	
F	0.15		4.18 ***		4.76 ***		4.32 ***		5.56 ***	

*p < 0.05 **p < 0.01 ***p < 0.001

N = 520

Data source: 2004 Health and Retirement Study (HRS) Note: All analyses weighted using the HRS individual-level weight