

# **Family relations and health inequalities: Grandparents and grandchildren**

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*Abstract:* A plethora of studies provide evidence of family relationships' key role in individuals' well-being across the entire life course and particularly at older ages. When discussing the relationship between health inequalities and family relations, the present chapter thus places a particular emphasis on grandparents and grandchildren. After briefly reviewing the link between adult parent–child relationship qualities and health inequalities (*Section 2*), we then take the grandparents' perspective (*Section 3*) to discuss, first, the effects of grandparenthood (that is, the transition into a new social and family role in later life and the status of being a grandparent) and, second, the effects of active grandparenting (such as the provision of grandchild care) on grandparents' well-being. We then complement the grandparents' perspective by assessing research on health inequalities in grandchildren (*Section 4*). The chapter concludes with policy recommendations and perspectives for future research (*Section 5*).

**Keywords:** Intergenerational relationships; grandparents; grandparenting; health; well-being; aging

## **1. Introduction**

The ongoing pluralization of family forms, which was initially perceived as a threat for the institution of the family, now takes the role of opportunity, especially for grandparents who are seen as increasingly central for their families, often satisfying demands for childcare (Silverstein, Giarrusso and Bengtson, 2003). Social sciences have thus enlarged their focus of research to the grandparent–parent-child relationship and their health-related consequences. Indeed, family dynamics determine the existence, timing, and extent of critical intergenerational relationships, which in turn affect the health and well-being of the family members involved and do so in heterogeneous ways (Hünteler and Hank, 2021).

Parents share 50% of the same genes with their biological children and 25% with their biological grandchildren. From an evolutionary perspective, parents and grandparents can thus boost their fitness by devoting resources to their children and grandchildren, helping to ensure the growth, development and reproduction of their kin. In answer to the pluralization of family forms, the shared genetic interest has been further developed to also involve in-laws or in general family members who are usually not closely genetically related but become “inversely” genetically related to each other through common descendants (see Tanskanen and Danielsbacka, 2019 for a review).

Classic sociological theory and a growing body of empirical literature has shown that social integration affects well-being throughout the life course (see e.g. Mayer in this volume). Cohen (2004) described two general mechanisms with which social relationships can promote health and well-being. On the one hand, social relations provide resources that are helpful to cope with stress. On the other hand, social integration is conducive to well-being irrespective of the level of stress, as it promotes favorable psychological states. Intergenerational relationships are the main source of support and social integration in later life and are therefore central to older adults’ well-being. Moreover, roles invested with importance are assumed to have a greater impact on mental health than less important roles because they are enacted with more commitment (e.g., Antonucci, Jackson and Biggs, 2007; Koropecj-Cox, 2002).

The family social network constitutes, on the one hand, an important resource to protect individuals’ health by, for example, reducing psychosocial stress and increasing one’s overall

well-being (e.g., Antonucci et al., 2007; Franks, Campbell and Shields, 1992; also see Brandt et al. in this volume). On the other hand, low relationship quality between, for example, parents and adult children (e.g., An and Cooney, 2006; Koropecj-Cox, 2002) or burdens associated with providing care to kin (e.g., Sherwood et al., 2005) have been shown to result in health deterioration, especially if psychological well-being is considered. The individual's trust in the family network as a potential source of support and the emotional stability of family relations appear to be particularly important here. Some evidence suggests that the subjective perception of support might even be more relevant for individuals' health than the actual support one has (or has not) received (e.g., Antonucci, 2001; also see McIlvane, Ajrouch and Antonucci, 2007). Research in this field has largely focused on aspects of the parent–child relation, and in light of the longer shared lives of grandparents and grandchildren, it has extended to consider grandparent–grandchild relationships to explain variation in well-being through later life.<sup>1</sup> The likelihood of being a (grand)parent and the timing of these transitions depend on reproductive behaviors (e.g., the age at first birth and the number of children), which have been shown to be associated with health and mortality (Henretta, 2007; Högnäs et al., 2017). Parenthood and grandparenthood, in both their roles and functions, indeed tend to vary across population subgroups, particularly by sex, generating or even reinforcing inequalities in health and well-being. Indeed, women generally have children younger and live longer than men, making them more likely than men to experience grandparenthood for greater durations.

The remainder of this chapter is structured as follows: *Section 2* provides a brief overview of health inequalities in relationships between older parents and adult children. *Section 3* subsequently discusses health inequalities from the grandparents' perspective, distinguishing between grandparenthood (3.1) and grandparenting (3.2). *Section 4* adds by considering health inequalities among grandchildren. Each section highlights the mechanisms linking the intergenerational family role considered and health before reviewing the relevant empirical evidence from Europe and the USA. In the following sections, we will consider both health

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<sup>1</sup> A further perspective is that of the “sandwich generation” facing competing demands from (elderly) parents and (adult) children (e.g., Fingerman et al., 2010; Wiemers and Bianchi, 2015), which might eventually affect this generation's health outcomes (see, for example, Brenna, 2021; McGarrigle, Cronin, and Kenny, 2014).

(with operationalizations ranging from self-rated general health to specific physician-diagnosed conditions) and the broader concept of well-being (including for example, life satisfaction). *Section 5* then concludes with policy recommendations and perspectives for future research.

## **2. Adult parent–child relationship quality and health inequalities**

A growing number of social science studies investigate the intergenerational reproduction of health inequalities in families, stressing the role of education as an important transmission channel (e.g., Halliday, Mazumder and Wong, 2020; Willson and Shuey, 2019). Another relevant factor in the ‘production’ of health within families and across individuals’ life course is the quality of intergenerational relationships between parents and their adult children (Thomas, Liu and Umberson, 2017). Whereas emotional closeness and relationship quality strongly influence the well-being of parents and adult children (e.g., Lai et al., 2019; Merz et al., 2009a, b), geographic proximity and frequency of contact appear to be unrelated to older parents’ life satisfaction – at least if the exchange of instrumental support is controlled (e.g., Lai et al., 2019; Lowenstein, Katz and Gur-Yaish, 2007). Findings regarding the exchange of intergenerational instrumental support are, however, mixed. Whereas cross-sectional study by Scodellaro, Khlal and Jusot (2012) indicates a positive association of having received large financial transfers on adult children’s health, a longitudinal study by Ong, Nguyen and Kendall (2018) fails to provide systematic evidence of a causal effect of the receipt of such transfers on the younger generation’s health and well-being. Giving financial support to adult children has been shown to be associated with better mental health for older parents (Roll and Litwin, 2010), whereas the receipt of upward instrumental support may even reduce parents’ well-being (e.g., Merz and Consedine, 2009, Merz et al., 2009b; also see Bordone, 2015). This kind of adverse effect appears most likely in situations characterized by a strong imbalance in the exchange of intergenerational support (e.g., Lowenstein et al., 2007, Pillemer et al., 2007). These findings underscore the importance of distinguishing between emotional support (including closeness and relationship quality) on the one hand and instrumental support on the other hand.

Health, however, is not only affected by characteristics of intergenerational family relations but is also a determinant of the latter (e.g., Mao et al., 2020): good health may be an important

resource to provide intergenerational support, whereas poor health might often trigger the need to establish an exchange of instrumental and/or financial support between generations in a family. It is therefore surprising that thus far, only relatively little empirical research has been conducted addressing this causal direction of the intergenerational relations and health nexus (but see Choi et al., 2015; Gilligan et al., 2017). Health outcomes are often merely treated as control variables in multivariate models, without much theoretical or thorough empirical consideration of possible underlying mechanisms. Longitudinal analyses in particular are scarce – despite the obvious relevance of the question as to what extent changes in the individual’s health status might affect various dimensions of intergenerational relations.

Cross-sectional findings suggest that good (poor) health in both the parents’ and the children’s generation is positively (negatively) associated with reports of some dimensions of relationship quality (e.g., Rossi and Rossi, 1990; Stepniak, Sutor and Gilligan, 2021). A longitudinal study by Merz et al. (2009a) supports the notion that the observed cross-sectional associations indeed reflect a causal effect of health on the intergenerational relationship. Stress has been put forward as a possible explanation for this finding. Health deterioration causes stress in parents and children, which eventually affects relationship quality in negative ways (also see Kaufman and Uhlenberg, 1998). Whereas changes in parents’ health status appear to be unrelated to the frequency of contact with adult children (Ward, Deane and Spitze, 2014), studies have found the expected changes in residential proximity (Choi et al., 2015) and instrumental support. Those in poorer health – especially parents – are more likely to receive and less likely to provide help (e.g., Chan and Ermisch, 2012; also see Gilligan et al., 2017).

### **3. Health inequalities from the grandparents’ perspective**

Recently, an increasing number of studies have concentrated on the associations between grandparenthood or grandparenting and grandparents’ health. Grandparenthood refers to the transition that most individuals today will experience in later life from not having grandchildren to having at least one grandchild (Margolis and Verdery, 2019) but also to the status that follows such a transition, that is, being a grandparent. This status is a central role for older people, rated as highly important even before experiencing it (Mahne and Motel-Klingebiel, 2012) and

encompassing expectations and meaning (Thiele and Whelan, 2006). Although the role of grandparent may be enacted in different ways (Silverstein and Marengo, 2001), in answer to the recognized increasingly vital support of grandparents to their families and society by looking after grandchildren, a major strand of research on grandparents has largely focused on behavioral aspects of grandparenthood, i.e., grandparenting. We, therefore, discuss grandparenthood and grandparenting separately below. Concerning the latter, grandparental childcare arrangements can be further distinguished by primary and secondary. Primary carers are grandparents who assume primary responsibility for raising a grandchild for multiple reasons, including teenage pregnancy, drug addiction, incarceration, or health problems (Choi, Sprang and Eslinger, 2016; Glaser et al., 2018; Hayslip, Fruhauf and Dolbin-MacNab, 2019; Pilkauskas and Dunifon, 2016). Secondary care refers to the most common type of care, complementary to parental care. Support from grandparents taking care of grandchildren without replacing the parenting functions of the middle generation can vary from regular to occasional, and its intensity can range from a few hours per year to several per day (Glaser et al., 2013; Herlofson and Hagestad, 2012).

### ***3.1 Grandparenthood and health inequalities***

The majority of individuals aged 50 and older in Europe, Canada, and the United States have faced the transition to grandparenthood (Glaser et al., 2013; Leopold and Skopek, 2015; Margolis, 2016). Such a high prevalence of grandparenthood and the important implications that such an event might have for the experience itself and for its intersection with other life events and roles call for a better understanding of the actual life transition of becoming a grandparent and the relationship between grandparental status and health.

Although grandparents are, on average, more satisfied with their lives than grandchildless people, such a “grandparenthood effect” is mainly driven by the provision of grandchild care. Indeed, grandparents who never look after their grandchildren are less satisfied with their lives compared to their grandchildless counterparts (Arpino, Bordone and Balbo, 2018). The lack of change in health measures for grandparents tends to be more prominent than change, implying that if a grandparent effect exists, it is mainly due to their caregiving role.

From an evolutionary perspective, however, the birth of a grandchild per se tends to improve individuals' fitness (see Tanskanen and Danielsbacka, 2019 for a review), in part due to the positive emotions brought by becoming a grandparent (Thiele and Whelan, 2006). Grandparents might also benefit from a grandchild birth in view of its subsequent opportunities, such as interaction with, nurturing of, and passing on their knowledge to the grandchild. Furthermore, the transition into grandparenthood could also be considered an avenue for improving parenting or as an extension of the provision of support to one's own child that enhances older people's sense of purpose in life (Ellwardt, Hank and Mendes de Leon, 2021). These theoretical arguments suggesting positive effects of entering grandparenthood on older people's well-being are supported by empirical studies from analyses of longitudinal data. Using two waves of a representative sample of the Dutch population, Kalmijn and De Graaf (2012) found that parents whose adult children transitioned into parenthood had lower depression. However, Sheppard and Monden (2019), using a fixed-effects approach on SHARE data from 15 European countries, highlighted inequalities in the effect of becoming grandparents for the first time on (fewer) depressive symptoms, with a beneficial effect only among women. Drawing on the same dataset, Di Gessa, Bordone and Arpino (2020) analyzed the associations between becoming a grandparent and three indicators of well-being (life satisfaction, positive affect, and depression): the first transition matters, but only among women who become grandmothers via their daughter. This finding is in line with the grandmother hypothesis stating that the long postmenopausal lifespan of human females might have evolved to enable postreproductive women to contribute to the fertility of their adult children and the survival of their grandchildren (Hawkes, 2003). In practice, the birth of a grandchild may contribute to the inclusive fitness of older women, whereas older men can potentially have children until they die (Coall and Hertwig, 2011). At the proximate level, this difference may translate into sex differences, with the birth of a grandchild having a greater impact on grandmothers than grandfathers. Grandmothers might also be more strongly affected by the transitions into grandparenthood due to the gendered social prescriptiveness of grandmotherhood (Reitzes and Mutran, 2004) and the different tasks and responsibilities associated with it (Kaufman and Elder, 2003; Winefield and Air, 2010). Moreover, the presence of grandchildren is known to increase the frequency of contact with children, especially among

grandmothers (e.g., Bordone, 2009), reducing their risk of isolation while strengthening their kin-keeping role within the family, which in turn contributes to increasing grandmothers' well-being.

The empirical evidence in this respect not only suggests a matrilineal advantage in the quality of parent–child bonds (Chan and Elder, 2000; Jamieson, Ribe and Warner, 2018) but also hints to the importance of the event itself (i.e., the birth of the (first) grandchild) for (short-term) well-being rather than the role associated with grandparenthood.

Becoming a grandparent might also be associated with negative stereotypes of aging that in turn negatively affect grandparents' well-being. Indirect evidence is provided by studies showing that while in general older people tend to feel younger than their chronological age, grandparenthood may function as an “age reminder”, increasing subjective age for younger grandparents compared to entering this role “on time” (Kaufman and Elder, 2003). Chronological age has been identified as a moderator of the association between being a grandparent and well-being. Both men and women in the younger age group tend to feel older if they have grandchildren, while the significant effect found for the older age group of women highlights a reversed association, with grandmothers feeling younger than grandchildless women (Bordone and Arpino, 2016).

The likelihood and timing of grandparenthood intersects with educational differences as well (Skopek and Leopold, 2017), which are paralleled by educational disparities in adult health. Whereas the subjective importance of the grandparent role does not vary by social class (Mahne and Motel-Klingebiel, 2012), education matters for the types of activities done by grandparents with their grandchildren (King and Elder, 1998) and for their ability to cope with the stress associated with grandparenthood (Mahne and Huxhold, 2015). The null finding about the moderating effect of education in the association between grandparenthood and life satisfaction (Mahne and Huxhold, 2015 on Germany and Arpino et al., 2018 on Europe) suggests, however, that two opposite mechanisms might be at work. On the one hand, highly educated grandparents may engage in a larger variety of social activities independently of their grandchildren, thereby reducing the relative importance of the role of grandparenthood on well-being or even increasing the costs associated with it. On the other hand, higher education may allow a better use of family ties as a barrier against negative life events or stressors.



As the grandparent role often extends across several decades, well into grandparents' later life and grandchildren's adulthood, when the provision of grandchild care is no longer part of the grandparent role, recent studies have investigated the long-term health consequences of grandparenthood, i.e., whether there are any survival benefits. The work by Christiansen (2014), however, suggested a significant survival disadvantage among grandfathers in Norway. Grandmothers also exhibited elevated mortality risks, but only if they were married, had four or more grandchildren, or made the transition to grandparenthood early in the life course (i.e., before age 50). More recently, using longitudinal data from twelve waves of the Health and Retirement Study, Ellwardt et al. (2021) did not find statistically significant survival differences by grandparental status or heterogeneity across gender, Whites and non-Whites, or across different levels of educational attainment and work status in the USA. However, elevated risks of mortality were confirmed for grandmothers living with a partner, below 65 years old, or having a larger number of grandchildren compared to nongrandmothers. The authors explain the general finding of grandparental excess mortality along the lines of parental depletion models (Barclay and Kolk, 2019), according to which emotional or social stress associated with the (grand-)parent role may result in adverse health effects. The related heterogeneities may derive from the role strain resulting from gendered role expectations and obligations, making partnered, younger, less educated grandmothers face contemporaneous overlap with other roles (e.g., spousal caregiving or employment) more often. In contrast, there was a survival advantage for widowed grandmothers over widowed nongrandmothers, possibly reflecting the role of grandchildren as a buffer to adverse events such as loss of a spouse.

### ***3.2 Grandparenting and health inequalities***

Although the definition of grandchild care can vary across studies and countries (Hank et al., 2018), a considerable body of work shows that around the globe, grandparents are significant providers of secondary grandchild care (Di Gessa, Zaninotto and Glaser, 2020; Grundy et al., 2012; Ko and Hank, 2014; Ku et al., 2013; Laughlin, 2013). In Europe, for instance, 58% of grandmothers and 49% of grandfathers looked after at least one of their grandchildren under the age of 16 (Hank and Buber, 2009), with 12% providing care almost daily or at least 15 hours a week (Di Gessa, Glaser and Tinker, 2016a).

Numerous studies have investigated the impact of grandchild care provision on grandparents' health and well-being in different societal contexts (ranging from Chile to the U.S., Europe, and China) and have considered both primary and secondary grandchild care (see Danielsbacka, Křenková and Tanskanen, 2022, for a recent systematic review). The starting point of most of these studies is that caring for grandchildren may have both positive and negative health effects. According to role enhancement theory, which suggests that occupying multiple roles may provide individuals with a sense of usefulness and competence, enhancing control and reinforcing meaning in later life, grandparents caring for their grandchildren may benefit from the emotional rewards and gratification stemming from this activity, and a sense of belonging, attachment and usefulness, which in turn may enhance health and life satisfaction (Grinstead et al., 2003). Moreover, it is plausible that grandparents providing childcare have stronger social ties with both grandchildren and their parents and are, therefore, likely to benefit from greater emotional, instrumental, and social family support, which may act to buffer the potential negative effects of caregiving and have a direct positive impact on health by promoting healthy behaviors (Hayslip, Blumenthal and Garner, 2014). Looking after grandchildren may also lead to grandparents maintaining or increasing their levels of physical activity and health behaviors, which in turn are associated with better physical health and well-being (Holmes and Joseph, 2011). Providing grandchild care, however, might also be demanding both physically and emotionally. Role strain theory postulates that multiple roles are associated with poor health outcomes because of the psychological and physical stressors caused by demanding and potentially competing role responsibilities. For instance, if an individual's obligations exceed their physical and psychological capacity to cope, this situation may cause an increase in stress and physical demands, which in turn may be detrimental for health. This problem may exist for those grandparents who act as primary carers or who provide full-time care for their grandchildren (e.g., Ellwardt et al., 2021).

The effect of grandchild care on grandparents' health is quite complex and seems to depend on a number of factors, including the type of care provided (primary vs. secondary), the health measure considered, the intensity and hours of care provided, the regional/cultural context, and grandparents' sociodemographic characteristics (Arpino and Bordone, 2014; Chen and Liu, 2012; Di Gessa, Glaser and Tinker et al., 2016a, b; Hank et al., 2018; Tsai, Motamed and

Rougemont, 2013). Evidence (largely from the US) suggests that grandparents raising grandchildren and those coresiding with them tend to report a higher prevalence of health problems, including limitations in daily living activities, chronic conditions, depressive symptoms, and poorer self-rated health (Blustein, Chan and Guanais, 2004; Grinstead et al., 2003; Hughes et al., 2007; Minkler and Fuller-Thomson, 2001). However, in some Asian countries, the experience of coresiding with grandchildren or being a custodial grandparent is associated with better rather than worse health and well-being (Cong and Silverstein, 2012; Silverstein, Cong and Li, 2006). Ku and colleagues (2013), for instance, found that coresident grandparents in Taiwan were more likely to report better self-rated health and fewer problems with physical health, whereas Chen and Liu (2012), using the longitudinal China Health and Nutrition Survey, found no differences in health between coresiding and noncoresiding grandparents, but coresiding grandparents who provided more than 15 hours per week of grandchild care were more likely to report worse self-rated health.

Studies that have focused on secondary grandchild caregivers have generally found that grandparents providing grandchild care are more likely to report either better health (including better self-rated health, lower levels of loneliness, fewer depressive symptoms and better cognition) compared to grandparents with primary care responsibility for a grandchild or no childcare at all or no major widespread health effects once previous characteristics (and prior health status in particular) are considered (Arpino and Bordone 2014; Chen and Liu, 2012; Di Gessa et al., 2016a, b; Ku et al., 2013; Tsai et al., 2013). For noncoresiding grandparents, however, the association between grandchild care provision and health might depend on the outcomes and on the intensity of care considered. For instance, Di Gessa et al. (2016a) found that grandparents looking after grandchildren, whether intensively or nonintensively, experienced better self-rated health but no beneficial effects in terms of depressive symptoms or limitations in daily living activities. Many studies have found a positive impact of grandparental childcare on mental health and well-being, mostly among grandparents providing *lower* intensity levels of grandparental care (Chen and Liu, 2012; Grundy et al., 2012; Ku et al., 2013). However, if the cognitive abilities of grandparents were considered, it is grandparents who provide *more* care who experience greater increases in their cognition (Arpino and Bordone, 2014; Ahn and Choi, 2019; Sneed and Schultz, 2019; Silverstein and Zuo, 2020),

even if the positive effect might be relevant to the verbal fluency of grandparents but not to other measures of cognitive function (Arpino and Bordone, 2014).

It should, however, be noted that the abovementioned positive associations between grandchild care provision and grandparents' health and wellbeing were based on between-person variations. This finding means that the health differential between grandparents who provide and those who do not provide grandchild care may not be due to grandparenting per se. Recent studies using fixed-effects models, thus drawing on within-person variation (Ates, 2017; Bordone and Arpino, 2022; Danielsbacka et al., 2019; Sheppard and Monden, 2019), found no beneficial effects of secondary grandparenting, pointing at a strong selection bias (with healthier grandparents more likely to provide grandchild care to start) and highlighting the presence of unobservable third factors that might explain the associations between grandchild care provision and better health (see Gebel in this volume for a more general methodological discussion).

#### **4. Health inequalities from the grandchildren's perspective**

Grandparents can influence grandchildren's health in different ways (e.g., Delgado-Angulo et al., 2020). One mechanism is through social class and the intergenerational transmission of material resources, where grandparents need not necessarily be in direct contact with grandchildren (see Anderson, Sheppard and Monden, 2018, for a related discussion of grandparent effects on educational outcomes). Other mechanisms require more direct intergenerational interaction, where grandparents act as role models and provide childcare or emotional support, for example. Sound empirical evidence on grandparents' influence on children's health is, however, scarce. This lack of research seems unfortunate against the background of, first, grandparents' important role as providers of care (see Bordone et al., 2021) and, second, an accumulating body of research stressing the role of childhood family structure and living conditions for individuals' well-being across the life course (e.g., Brandt, Deindl and Hank, 2012; Gaydosch and Harris, 2018; also see Dekhtyar and Fors in this volume). Moreover, the results of previous studies investigating health inequalities from the grandchild perspective

are fairly mixed, suggesting that grandparent effects, if they exist at all, are neither unambiguously good nor bad (see Pulgaron et al., 2016; Sadruddin et al., 2019, for reviews). For example, grandmothers were shown to play a potentially important role in grandchildren's nutrition (e.g., Rogers, Bell and Mehta, 2019; also see Aubel, 2012), but some studies found grandmaternal involvement to be associated with higher risks of childhood *obesity* (e.g., Tanskanen, 2013), whereas others reported the reverse association (e.g., Lindberg et al., 2016). Both salutary and health-damaging effects are likely to be driven by grandparental care practices (e.g., Chambers et al., 2021), which have also been proposed as an explanation of the overall adverse impact of grandparents on their grandchildren's *cancer* risk factors (Chambers et al., 2017). Studies investigating the role of grandparents in grandchildren's psychological well-being found that greater cohesion with grandparents reduced *depressive symptoms* in adolescent/adult grandchildren, whereas more frequent contact increased symptoms (e.g., Ruiz and Silverstein, 2007; Moorman and Stokes, 2016). Previous research provided no indication, however, of a grandparent effect on grandchildren's self-esteem (Ruiz and Silverstein, 2007) or risky health behaviors (Dunifon and Bajracharya, 2012), but coresidence with a grandparent was found to be associated with an increased risk of child mental health problems (externalizing or internalizing problems) in a European sample (Masfety et al., 2019). Recently, Tanksanen and Danielsbacka (2018) suggested that previously proposed positive 'grandparent effects' might actually reflect 'grandchild effects' in the sense that grandparents invest more resources (time or money) in healthier grandchildren performing better. Conversely, one could argue that grandparents may be more involved in relationships with less healthy grandchildren who are in greater need of support. Accordingly, the authors' 'within-child' (longitudinal) analysis does not indicate a causal association between grandparental investment (contact frequency or financial support) and grandchildren's cognitive development or emotional and behavioral problems.

Importantly, studies assessing physical and socioemotional health and cognitive development of children raised by *custodial grandparents* generally indicate poorer health outcomes (Sadruddin et al., 2019: Table 2; also see Hayslip et al., 2014; Smith, Cichy and Montoro-Rodriguez, 2015, for example). However, these findings do not necessarily reflect causal effects

of grandparents' involvement with their grandchildren, who are the most economically vulnerable.

Previous research in this field indeed suffers from a variety of more general methodological and conceptual shortcomings (such as lack of longitudinal data and representative samples, inconsistent measurement of predictors and outcomes, or poorly identified theoretical mechanisms). Thus, more work seems necessary to better understand the causal role of grandparents in children's health outcomes (see Sadruddin et al., 2019). Specifically, it would be important to further investigate the extent to which the observed relationships might be specific to particular family constellations (e.g., Jappens and Van Bavel, 2019; Krueger et al., 2015) or welfare state contexts (see Bordone et al., 2021).

## **5. Conclusions**

In aging societies, family relationships across more than two generations are becoming increasingly important, driven by changes in terms of low fertility and increasing life expectancy that result in an age structure for families described increasingly as a 'beanpole' rather than a 'pyramid' (Bengtson, 2001). In this chapter, we, therefore, discussed health inequalities in view of intergenerational relationships by reviewing parent-child relationships first and giving particular emphasis to grandparents and grandchildren. The research we reviewed in this chapter shows that there is a link between intergenerational relationships and the health of the family members involved. However, the direction of such an association can be both ways, with better intergenerational relationships promoting well-being but also poor health being an explanatory factor for less intergenerational exchange (e.g., Mao et al., 2020). The most recent research drawing on panel data and relying on within-individual estimations has also hinted at possible unobservable third factors playing a role in the association between intergenerational relationships and health heterogeneities, especially when considering grandparental outcomes from the grandparent-grandchild relationship.

Future research in this area should thus aim at disentangling grandparent-parent-grandchild relations by considering a multigenerational perspective across different institutional and cultural environments (Price et al., 2018). A better understanding of how the

sociodemographic characteristics of all actors involved simultaneously interact with each other and with contextual characteristics might shed further light on the complex intergenerational relationships between family members. Moreover, it is likely that grandparent–parent–grandchild relations change over time as family members age (e.g., Silverstein, 2019). It is thus important to monitor these dynamics over longer periods of time. Such studies could further help inform family policies on how the roles that individuals hold in family life can be best supported throughout the life course.

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