CHILD KINSHIP CARE: AN EXPLORATORY MIXED METHODS STUDY OF SOCIAL SUPPORT, RESOURCES, AND HEALTH ISSUES OF NEBRASKA CHILD KINSHIP CAREGIVERS

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CHILD KINSHIP CARE:
AN EXPLORATORY MIXED METHODS STUDY OF
SOCIAL SUPPORT, RESOURCES, AND HEALTH ISSUES OF
NEBRASKA CHILD KINSHIP CAREGIVERS

by

Toni L. Hill

A Dissertation

Presented to the Faculty of
The Graduate College of University of Nebraska
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Major: Human Sciences
(Child, Youth, and Family Studies)

Under the Supervision of Professors Yan Xia and John DeFrain

Lincoln, Nebraska

May 2010
The purpose of this study was to examine the relationship between both the social support and resources of child kinship caregivers and the caregivers’ health. An exploratory sequential three phase mixed methods design was used. Phase I encompassed a single case study of a Nebraska program serving largely grandparents raising grandchildren. Phase II consisted of multiple individual caregiver case studies, and Phase III consisted of a survey of all caregivers affiliated with the program. Qualitative findings from the first two phases yielded similar caregiver information regarding social support and resources issues. Differing information was received regarding health issues. Quantitative analysis in the third phase found that there was a relationship between a caregiver’s social support and health and a caregiver’s resources and health.
Dedicated to my parents who lovingly nourished
my mind, my soul, and my body
without setting boundaries on my dreams.
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Chapter I

There are only four kinds of people in this world:
Those who have been caregivers
Those who currently are caregivers
Those who will be caregivers
Those who will need caregivers


Introduction

Historically, children without parents have always been cared for by other family members. If a child was orphaned due to the death of her parents, traditionally it was family members who assumed the care and responsibility for the child. The system of care for children without parents moved from informal, familial caretaking to a more formal system of non-relative caretakers beginning in the early 1900s with the infamous Mary Ellen Wilson child abuse case (Barnett, Miller-Perrin, & Perrin, 2005).

The last century saw an increase in formal systems of child care such as group homes and foster homes. However, more recently the care given by relatives of young children is receiving increasing attention and recognition. There are a number of reasons why relative caretakers are coming to the forefront of both policy and legal issues. One issue is the decline of formal foster care homes. Child welfare agencies are being forced to consider relatives because of a dwindling number of non-relative foster homes. Another prominent issue is that relatives are demanding that their *blood*, their *kin* be placed with them due to cultural traditions. A related issue is the increasing demands of existing relative caregivers who are no longer quietly caring for young relatives with limited resources or compensation. These relatives have more recently demanded to be treated equal to non-relative foster parents and expect equal resources and support. As a
result of all these issues, there are a growing number of relatives caring for children, a practice commonly referred to as child kinship care.

Annually in this country, there are an estimated six million children being cared for by relatives (Gibson, 2005). Approximately 4.4 million children are being parented for by grandparents and another 1.5 million by other relatives (Generations United, 2007). Kinship issues impact all communities, whether urban, rural, poor, or rich. Similarly, families impacted are racially and ethnically diverse. Of the 1.5 million children living in relative-headed families (excluding grandparents), 39% are white, 29% are African-American, 2% are American Indian and Alaska Native, 5% are Asian, 0.5% are Native Hawaiian and other Pacific Islander, 20% are some “other” race, and 5% are of two or more races. Of these children, 17% are Hispanic or Latino (Generations United, 2007). In examining grandparent placements, 49% of the 4.4 million children living in grandparent-headed families are white, 32% are African-American, 2% are Asian, 2% are American Indian and Alaska Native, 0.3% are Native Hawaiian and other Pacific Islander, 9% are of some “other” race, and 5.4% are of two or more races. Of these children, 21% are Hispanic or Latino (of any race) (Generations United, 2007).

According to 2000 data from U.S. Census Bureau, in Nebraska there were 8,018 children living with grandparents in both formal and informal placement arrangements. Informal kinship arrangements can occur between the child’s parents and relatives with no government involvement. Formal placements occur with assistance from governmental agencies. The number of children being cared for in formal relative placements in Nebraska is small in comparison to informal placement numbers. The number of Nebraska children in formal placement is 1,016 (State Fact Sheet, 2007).
Nebraska like many other states has a significant portion of children being cared for by relatives, and this number is likely to increase. From 1970 to 1997, there was a 76% increase in the number of children being cared for by relatives (Chase Goodman & Silverstein, 2001). There is little research on kinship care, kinship caregivers, their social support systems, resources, or health; yet, this group constitutes a significant portion of the country and the state of Nebraska. States like Nebraska will need research about this population to adequately provide support and assistance to these families.

The reasons children live with relatives vary widely. The practice of caring for young relatives is commonly referred to in the literature as (child) kinship care. Specifically, child kinship care is the caring of children by nonparent relatives when parents are absent, unwilling, or unable to effectively parent (Gibson, 2002a). There are both formal and informal systems of kinship care. It is important to note that kinship care is not limited to adults taking care of young children. Kinship care has an expanded definition of any relative caring for another relative including elderly or disabled family members. This study focused only on adult relatives caring for young children, specifically children from birth to up to the age of 19 years. Thus, in this study, the term child kinship care was often abbreviated to terms kinship or care. Child kinship placements can occur absent of maltreatment (abuse and/or neglect) situations. However, much of the research on child kinship care is not clear as to what factors lead to the child’s placement in kinship care. This study included children in relative care regardless of the reason for such placement.

Kinship care is a common practice and occurs in all fifty states. Federal law 42 U.S.C. 671 (a) (19) requires states to consider giving preference to an adult relative over
nonrelated caregivers when determining placement for a child provided the relative meets all relevant state protection standards. However, in 2005, less than half (or 24) states had developed laws to promote the use of kinship care (National Adoption Information Clearinghouse (NAIC), 2005). Nebraska was one of 24 states with a law which supported kinship preference for child placement.

**Purpose**

The purpose of this study was to examine the relationship between both the social support and resources kinship caregivers identify and caregivers’ health. An exploratory sequential mixed methods design was used which involved collecting, analyzing, and mixing both qualitative and quantitative data from three separate research phases.

The qualitative data in the form of case studies, file reviews, and observations were used to modify the quantitative phase. In the first phase, the researcher completed a case study of a program focused on serving child kinship caregivers. Multiple forms of data were collected, analyzed and used to inform data collection in the third phase. The second phase, also qualitative, consisted of ten individual caregiver case studies. Data from both Phase I and Phase II were used to review and modify the survey instrument used in Phase III of the study. Phase III consisted of surveying 150 caregivers quantitatively analyzing the results. The research was guided by the following overall research question:

What are the issues related to the social support, resource, and health needs of child kinship caregivers?

**Definitions**

In order to understand kinship issues, it was important to explore some of the key concepts related to the topic. Several key concepts, while relevant to kinship studies,
were complicated by assumptions, unclear definitions, or the lack of consistent definitions.

It was important to examine kinship care in the context of recent relative care, child welfare issues, and policy developments (Simmons, 2005) (see Table 1.1). Both child welfare practice and policy developments in this country indicate an increase in the use of child kinship care. And, studies like this and others are needed to expand on existing knowledge of this issue.

Table 1.1

Timeline of Child Welfare and Kinship Policy Developments

<table>
<thead>
<tr>
<th>Year</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1978</td>
<td>The Indian Child Welfare Act of 1978 stated that a child should be placed near the child’s home and with a member of the child’s extended family (Geen, 2000).</td>
</tr>
<tr>
<td>1979</td>
<td>U.S. Supreme Court decision in Miller v. Youakim provided kinship foster families access to foster care benefits providing that the child was eligible and the family met licensing standards (Ingram, 1996).</td>
</tr>
<tr>
<td>1980</td>
<td>The Adoption Assistance and Child Welfare Act of 1980 required states to find the “least restrictive most family-like setting available located in close proximity to the parent’s home consistent with the best interests and special needs of the child which translated to a preference for kinship placements (Geen, 2000).</td>
</tr>
<tr>
<td>1990s</td>
<td>Welfare reform required states to give preference to relative caregivers for foster care placement. Economic support for grandparent caregivers came from Temporary Assistance to Needy Families (TANF) and food stamps, Social Security benefits, and Medicaid (Flint &amp; Perez-Porter, 1997; Geen, 2000).</td>
</tr>
<tr>
<td>1992</td>
<td>Congressional hearings in 1992 focused on the causes of increased numbers of grandparents caregivers. The legislative focus provided grandparents access to services and sources of support including cash assistance, health insurance, health care, education services, legal services, child care, and workplace policies affecting caregivers (Bryson &amp; Casper, 1999).</td>
</tr>
</tbody>
</table>
Table 1.1 continued.

1996 Congress included a provision in the Personal Responsibility and Work Opportunity Reconciliations Act (PRWORA) of 1996 to mandate the Census Bureau to ask adults over 30 whether they lived with their grandchildren, were financially responsible for them, and the duration of that responsibility.

1997 The Adoption and Safe Families Act (ASFA) of 1997 relaxed the time period for termination of parental rights if a child was placed with a relative (Geen, 2000).

2000 The National Family Caregiver Support Act was established through the reauthorization of the Older Americans Act. It provided grandparent caregivers the same services available to caregivers of older relatives (counseling training and respite care) (U.S. Health and Human Services, 2000b).

2000 Forty-eight states and the District of Columbia give preference to relative placements (Geen, 2000).

2002 Subsidized legal guardianship is now seen as a viable option for permanency when children remain in kinship foster care for longer than one year (Testa 1997, 2002). Subsidies similar to those provided for adoption were provided to 5,000 family members in Illinois through a federal waiver (Testa, 1997). Subsidized guardianship was found to be successful leading to increased permanency for children placed in kinship care (Testa, 2002).

2003 The Living Equitably: Grandparents Aiding Children and Youth Act introduced affordable housing opportunities specifically for families headed by grandparents and other relatives of children (The Orator, 2003).

1 From Grandparent Foster Caregiver Characteristics, Differences between Foster Caregivers, and Predictors of Satisfaction with Social Support (p. 9), by A. Simmons, 2005, Author. Copyright [2005] by Alicia Simmons. Reprinted with permission.

Kinship

The concept of kinship can be traced historically to anthropological studies. Kinship studies are thought to be the most difficult subset of social anthropology due to the intricacies of non-Western families (Barnard, 1985). Initiation into a kinship unit can occur as a result of marriage, birth, childrearing, or through a variety of other social
conventions. Some anthropologists have concluded that kinship’s essential characteristic is seen primarily as social and not biological (Barnard & Good, 1984). The father of kinship studies is Lewis Henry Morgan, an American lawyer. In 1871 Morgan distinguished two types of kinship terminology, *descriptive* and *classificatory* (Barnard, 1985). Descriptive kinship terminology identifies family by general relationship without distinguishing descendents and siblings from other collateral relatives. The Omaha tribe of Nebraska classifies maternal or paternal relatives as the same regardless of relationship order. For example, in the Omaha tribe, a person’s mother’s brother (or uncle) is seen the same as the mother’s brother’s son (or cousin). However, *classificatory* terminology distinguishes all levels of relatives as seen in English groups. In 1914, Rivers determined that kinship classification was based on social relationships (Barnard, 1985). It is important to consider the origins of kinship when examining modern-day kinship or relative issues.

In Western culture, kinship is often defined synonymously with *family* and as a group of related individuals residing together. In the United States, this definition is complicated by the lack of a consistent definition of family (White & Klein, 2002). There is no definition of family in the U.S. Constitution. Scientists like anthropologists tend to use a very broad definition of kinship to reflect more of a communal group connected more by customs and geography.

Family members or relatives can include blood, legal, or adoptive connections. A few states including Nebraska consider members of the same Native American tribe to be family (NAIC, 2005). Besides the biological or legal connections, some define family by social connections, which include family friends. Sociologist Rubin (1992) noted the
definition of family has expanded, “We have single-parent families, blended families, reconstituted families, and ‘divorce-extended’ families, each with its own particular blend of parents, stepparents, siblings, half-sibs, step-sibs, and a variety of fictive aunts, uncles, and grandparents” (p. xxvi).

For the purposes of this study, kinship refers to biological or legal relatives or family members unless otherwise indicated. Similarly, the family refers to all types of related individuals including all legal and social connections. The concept of family includes all concepts previously presented, and the concept of family is intentionally broad to encompass the variety of relations.

Child Kinship Care

The term kinship care is not limited to an adult caring for a child. It can include adult children caring for elderly parents. Additionally, kinship care involves any relative caring for another, such as a niece caring for a disabled aunt. This study was limited to adult relatives caring for child relatives when, as Gibson (2002a) states, the parent is absent, unwilling, or unable to effectively parent.

Child kinship care can occur either formally or informally. Formal kinship placements are usually approved by the courts or social service agencies. Thus, formal kinship caregivers are also known to the state governmental agencies. Informal kinship placements involve an arrangement between parents and relative without formal notice to a government agency or institution. Informal kinship care can start spontaneously when a parent leaves a child with a relative for an extended stay with little or no advance notice. These placements can end as spontaneously as they start with the parent’s return. Caregivers providing informal care are often unknown to governmental agencies. This
study will include both informal and formal kinship placements known to the program. Formal kinship caregivers are also known to the state governmental agencies.

Researchers have tried to classify the various components of kinship care. Anderson (2006) identified three types or definitions of kinship care originally defined by Geen (2000). Three primary categories of kinship care arrangements were defined:

- **Kinship foster care** – the child has been removed by court order and placed with relatives
- **Voluntary kinship care** – child placement occurs with child welfare agency contact but without court order
- **Private kinship care** – child lives with relatives with no agency or court contact.

Generally, researchers reference formal or informal kinship care arrangements which are equivalent to Anderson’s kinship foster care and private kinship care respectively. Anderson (2006) also provides a hybrid option, voluntary kinship care, for child caring arrangements known to a social service or child welfare agency but not receiving court supervision.

Some researchers have presented child kinship care as a continuum of care. There are formal and informal ways to provide care. The families may be on one end of the continuum or the other providing care to a child relative. Additionally, the family may slide from one place to another on this continuum. Walters Boots and Geen (1999) defined *public* kinship care as care provided to a child who was placed by the child welfare authorities whether or not the child was in the custody of the authorities.
This study will include kinship caregivers of children living in kinship care for various reasons. Family members provide care to child relatives for a variety of reasons including parental death, divorce, or incarceration. The reasons for child kinship care vary widely. The reasons relatives provide care include parental physical or mental illness, substance abuse, or military deployment. Researcher Pabustan-Claar (2007) noted *child welfare kinship care* involves caring for children removed from their parents due to abusive and/or neglectful situations. These children would have been placed in traditional foster care but instead were placed with relatives. Gleeson et al. (2008) studied 207 families in Chicago and noted some children were placed with relatives when a parent lost their job or housing. These researchers also noted that some children born to teen parents were simply left with relatives once the teen became an adult and moved out.

This study included caregivers of children with various legal statuses. The majority of kinship research studies have focused on formal care. However, it is important to focus on informal kinship care because this is the most common form of care, and it is growing at a higher rate for low-income families (Gleeson et al., 2008). Some kinship families may legally adopt the child while others take the child into their family and provide care informally without legal proceedings. Kinship families with physical custody have the child physically in their home and can provide for the child’s basic needs. Families with legal custody have the legal right to make all decisions related to the child’s educational, medical, and other needs (U.S. Health and Human Services, 2005). Possessing physical custody does not mean the family also has legal custody. Legal custody may reside with the biological parents, the courts, or the governmental agency.
The legal status of the child may be unknown to the kinship family (Smithgall et al., 2006). While the overall numbers of kinship families continue to increase, many families enter into the kinship care placement or arrangement without a clear understanding of their legal relationship to the child they care for (Glass & Honeycutt, 2002; McLean & Thomas, 1996; Stowell-Ritter, 2004; Testa, 2005). The legal status of the child in kinship care is key to understanding what resources or support can be accessed by the family. One study (Smithgall et al., 2006) found that many of the caregivers could not clearly identify their legal relationship to the child in their care. Some of the caregivers gave the following comments in response to the legal status questions, “He’s just our grandchild. We haven’t gone through any legal.” “I forgot what you call it, well they’re assigned to me… I make all the decisions and everything, he’s mine.” Additionally, the same study found that about half of the 39 study participants had no involvement with the public child welfare system and faced greater challenges accessing services and support. This current study will examine both resources and support issues of kinship families.

Social Support

For the purposes of this study, social support will consist of both informal and formal assistance caregivers receive from friends, family, and professionals. Social support is an umbrella term which encompasses various types of support, without a very precise definition (King, Willoughby, Specht & Brown, 2006). Many researchers have tried to define social support. One definition of social support is the information that a person is loved, cared for, and valued as a member of a network of people interconnected with a mutual commitment to each other (Cobb, 1976). Cobb, whose research focused
largely on life transitions, believed social support and the perception of support helped people get through transitions. And, according to Cobb, social support also protected people from health conditions and illnesses.

Social support has also been defined as the resources provided by other persons that differs in type and function at different periods of life (Cohen & Syme, 1985). Another definition of social support is the emotional, instrumental, and informational assistance from others (Gerard, Landry-Meyer, & Roe, 2006). Ryff and Singer (2000) defined social support as a broad category of protective factors that deal with social relationships and ties to others.

Shumaker and Brownell (1984) characterized social support as "an exchange of resources between at least two individuals perceived by the provider or the recipient to be intended to enhance the well-being of the recipient" (p. 13). Lin (1986) defined social support as "perceived or actual instrumental and/or expressive provisions supplied by the community, social networks, and confiding partners" (p. 18). Tardy (1985) identified five key dimensions to help clarify the differences in definition of social support:

1. Specify the direction of the social support, because support can be given and/or received

2. Note the disposition of the support, as it is important to know the availability vs. utilization of support resources

3. Distinguish between the description of social support versus the evaluation of satisfaction with support because support can be offered but not welcomed

4. Know the content of social support, specifically what form of support is offered or provided

5. Consider the network from which the support comes from and distinguish what social system provided the support.
For the purposes of this study, social support was defined as emotional support and is separated from instrumental or tangible support. Social support and other types of support are important for caregivers. This study distinguishes the social or emotional support from the other forms of more tangible support which will be referred to as *resources* for the purposes of this study (see the definition of *resources* below). It is important to note that social support can be reciprocal. A receiver of social support can also be a giver of social support. The primary focus of this study will be the positive support received by caregivers and not their role as provider of such support.

Research, though limited, has indicated a connection between caregiver health and support. Williamson, Softas-Nall, and Miller (2003) found that the absence of social support made grandmother caregivers feel abandoned and misunderstood. Cobb (1976) stated that social support was a key to helping people deal with life’s stressors and such support helped reduce illnesses. Hence, it was expected that caregivers in this study who had more social support would have better physical and mental health.

**Resources**

This study will define resources comparable to instrumental support.

Instrumental support is the provision of tangible goods or services (House, 1981; Cohen & McKay, 1984; Barrera, 1986; Krause, 1986; Cutrona & Russell, 1990). While providing instrumental support or resources can involve love and care it is distinguishable from social or emotional support because it is concrete assistance such as the loaning of money or providing transportation to a medical appointment (Hinson Langford, Bosher, Maloney, & Lillis, 1997). A resource can be defined as something that is desired or lacking but wanted or required to achieve a goal or attain a particular end (Dunst,
Trivette, & Deal, 1988). Additionally, a resource need is an individual’s judgment of the discrepancy between what is actually going on and what is considered to be desired, normative, or valued from a help seeker’s perspective (Dunst, Trivette, & Deal, 1988, p. 13). A resource need could be a desire for monetary, medical, or transportation assistance.

There are resources specific to kinship caregiving. Families providing care may need any number of the following services:

- Child care assistance in the form of governmental monetary assistance from the Title XX program to pay for or supplement the cost of child care.
- Respite care provided for the child. Respite is the short-term placement of the child with others adults while the full-time kinship providers take a break or vacation from their caretaking duties.
- Health Insurance provided in the form of Medicaid or the Children’s Health Insurance Program (CHIP) to meet the children’s medical needs.
- Therapy, counseling, or other mental health services can be provided to the child, the caregiver, and/or the entire family.
- Transportation can be provided to the family to get the child to school, medical, and other appointments.
- Several financial programs may be accessed by the kinship family including Temporary Assistance to Needy Family (TANF), foster care or kinship care payments, Supplemental Security Income (SSI) disability claims, and Food Stamps (U.S. Health and Human Services, 2005).

Little research exists addressing resources and caregivers’ health, and there is limited research on the social support of caregivers. The limited research in existence would indicate a positive relationship between adequate resources and good health for caregivers. Thus, caregivers reporting adequate (greater) resources would also report fewer health problems in comparison to caregivers reporting inadequate (fewer)
resources. It was expected that assistance with medication, transportation assistance, and other resources will positively impact caregiver health.

Health

This study examined both the physical and mental health of caregivers. Several studies support the focus of this study. Evidence from research on social support (Cohen & Syme, 1985), social network (Gotdieb & Hall, 1980; Salloway & Dillon, 1973), and help-seeking (DePaulo, Nadler, & Fisher, 1983), all suggest that adequacy of resources is likely to affect a person’s health and well-being. Dunst, Leet, and Trivette (1988) found that support from family members, friends, and other social networks was positively related to the well-being of study participants. Several studies have tried to link emotional and physical health and social support. Researchers Cohen and McKay (1984), Gore (1981), and House (1981) found that stress was a moderator for emotional and physical symptoms. They found that for people under stress there was a negative correlation between social support and symptoms.

Research has consistently shown an impact of social support on emotional and physical health. This study examined the non-causal relationship between social support, resources, and health amongst caregivers.
CHAPTER 2

Literature Review

Overview

While the practice of kinship care has a long history, there has been very little research on kinship issues until recently with very limited information on the social support, resources, and health needs of kinship caregivers. And, there are no known research studies on kinship care in Nebraska. There is limited research on the resources provided to kinship caregivers, however, these findings will provide insight for the present study. The kinship studies that do exist use either qualitative or quantitative methods, but there are very few mixed methods studies using both qualitative and quantitative methods.

Background

As previously noted, anthropological and sociological research on kinship is centuries old. However, research focused more narrowly on child kinship care can be traced to the 1990s. Clearly, child kinship research is in its infancy (Pabustan-Claar, 2007). The beginning of child kinship research can be traced to several key publications. The journal *Children and Youth Services Review* dedicated an entire issue in 1994 to the issue of kinship care for young children. This journal has subsequently dedicated two more issues in 2002 and 2004 and has consistently published kinship articles from 1994 to the present. The Child Welfare League of American developed a research-to-practice series that focused entirely on child kinship in 2003. This series included an annotated bibliography of more than 70 articles focused on child kinship care. Researchers provided comprehensive literature reviews in 1999 (Scannapieco) and 2004 (Cuddeback).
It is also important to note groups as varied are Generations United, a multigenerational advocacy group, and the American Bar Association, a professional organization for lawyers, have developed and maintained data bases focused on child kinship care and other issues about relatives caring for children.

**Child Kinship Placements**

Relatives are providing care for approximately six million children in this country without the presence of the biological parent. Research, however, is not clear as to the role of the parent in the lives of either the child or the kinship caregiver. Many studies do not address the whereabouts of parents or do not clearly state the level of parental contact or involvement with the kinship family (Gleeson et al., 2008). Studies often fail to identify all the residents of the kinship home and the roles of individual family members in the kinship home. Analysis of the 2002 National Survey of America’s Families, a nationally representative survey of households, found that 2.3 million children live in households of relatives without a parent present (Murray, Macomber, & Geen, 2004). Additionally, this study found that 200,000 children were placed in the care of relatives by a child welfare agency and, thus, lived in a formal kinship care arrangement. These children were placed with relatives after they were *removed* from the care of their parents due to abuse or neglect. Murray, Macomber, & Geen (2004) found that the majority of children living with relatives are not in the custody of a child welfare agency and, thus, live in an informal care giving arrangement. They reported that 1,760,000 children, or 77% of the 2.3 million, children lived with relatives through private arrangements or *private kinship care*. These children were being cared for informally by relatives or kin without the involvement of child welfare agencies (Murray, Macomber, & Geen, 2004).
There is an estimated group of 300,000 children who are known to a child welfare agency but not under the custody of the agency. These children are voluntarily placed with relatives in an effort to avoid formal case management by a child welfare agency (Ehrle & Geen, 2002). Cases can be diverted to voluntary placements, usually when the issues presented to the child welfare agency are not as serious as cases accepted for custodial supervision. Both private and voluntary kinship placements represent an informal placement arrangement which can be sporadically begun or ended.

Information about kinship placements indicated differences between African-Americans and other groups. Using the Current Population Survey, Harden, Clark, and Maguire (1997) found that African-American children were more likely to be living with relatives than other racial or ethnic groups. Compared to non-Hispanic white children, African-American children were four to five more times more likely to be living with kin. There was a significant increase in African-American child kinship placements from 1983 to 1994. Research shows that similar reasons exist for the placement of children in formal or informal kinship care, regardless of race or ethnicity (U.S. Department of Human Services, 2000a).

Research has shown that kinship caregivers are disproportionately poor, with 40% of the families living below the poverty line (Ehrle, Geen, & Clark, 2001). Thirty-six percent of kinship caregivers do not have a high school diploma, 55% do not live with a spouse, and 19% live in households with four or more children. Subsequent analysis (Ehrle & Geen, 2002) concluded that children in kinship care face greater hardships than children in non-relative placements. The research also indicated there was a lack of supervision and oversight by child welfare agencies. Kinship care represents a large
segment of child placements, yet, there are many unanswered questions about kinship care. There are many questions related to the role of biological parents and other family members in kinship placements. Issues such as child abuse or parental mental illness in the family of origin have not been fully explored or addressed as related to kinship care. It is also unclear what issues impact kinship families related to accessing educational, medical, and other needed services.

**Child Well Being**

It is important to understand the impact of kinship care on child well-being. Some research has indicated that child well-being improves with placement in relative homes. Using a small sample, Altschuler (1999) found children adjusted well and began to excel in kinship placements. The researcher used both quantitative and qualitative data to assess child-well being of 62 randomly selected children. They found children placed in kinship care were able to adjust themselves to the removal from their parents and felt the removal was necessary. These children reported enjoying being placed with relatives due to the stability of care they received.

A retrospective study of adult functioning of former foster and kinship children found no significant difference in education, income, housing, physical health, mental and emotional health, life stresses, and social support between these two adult groups. However, there were differences when the study participants were children and placed in either foster or kinship care settings. Researchers interviewed the 214 adults, age 18 years and older, who had formerly been placed in either foster or kinship care and asked questions related to education, employment, housing, physical and mental health, and other areas. The data indicated that children placed with kinship caregivers were more
likely to remain in the same placement. These children also showed fewer developmental and behavioral problems (Benedict, Zuravin, & Stallings, 1996). Similar findings were revealed in a study of California caregivers. Children remained in the kinship homes longer and the majority of the kinship providers maintained contact with the birth parents. This comparative study of kinship and foster parents revealed that kinship parents were more likely single parents, and African-Americans with lower annual income (Berrick, Barth, & Needell, 1996).

Researchers found that children who had only been placed in kinship settings experienced more placement stability than children who had been placed in both kinship placements and foster care placements or a more restrictive placement (Leslie, Landsverk, Horton, Ganger, & Newton, 2000). Gleeson et al. (2008) studied 207 informal kinship families in Chicago and found that 75% of the children were in the same kinship home 18 months after the start of the study. The emotional relationship between the child and caregiver also impacted placement stability. A study of 900 foster children found that kinship caregivers were more likely to terminate a placement if there was poor relationship with the child (Testa & Shook-Slack, 2002). Kinship care was seen as a way to maintain uninterrupted familial care and a positive reciprocal attachment for children (Shlonsky & Berrick, 2001). While the current study is not focused on child well being, it is important to understand the impact of kinship on one aspect, the child. This study hopes to expand on the knowledge of kinship issues by examining social support, resources, and health of kinship caregivers.

**Child treatment.** When examining kinship issues, it is important to understand child treatment. Children in kinship care receive and perceive different treatment than
children in foster care. Berrick (1997) conducted interviews with both foster and kinship caregivers. Kinship providers reported the children were less traumatized by removal due to maltreatment. Children in kinship homes were generally surrounded by a group of caring adults. Better indicators were reported for kinship children even though both foster and kinship providers reported similar discipline practices.

A study by Berrick (1998) found that non-kin foster parents were twice as likely as licensed kinship caregivers to have confirmed reports of maltreatment. However, non-kin foster parents showed greater knowledge of child development and appropriate expectations of young children. This study found that kinship parents received less support, services, and contact than non-kin foster parents. Children in kinship homes reported they were happy and always felt loved as compared to children in foster care.

**Reasons for Caregiving**

The reasons relatives care for children is also important. There are several reasons kinship caregivers give for caring for children. Gibson (2002b) found that African-American grandmothers provided kinship care because of a tradition of caring for their own or kinkeeping. They also wanted to maintain a relationship with their grandchild. Another reason for providing care was the grandmothers’ distrust of the foster care system. A study by Jendrek (1994) found that grandmothers provided custodial care to their grandchildren because of parental problems. This study found that 73% of the biological mothers had emotional problems, 53% had drug problems, 48% had mental health problems, and 44% had alcohol problems. This study found that the majority (53%) of the grandparents became custodial caregivers because they did not want their grandchild placed in foster care. Another study found that children were in
kinship placements due to parental substance abuse (41% of the cases), alcohol abuse (26%) or mental health issues (18%) (Link, 1996).

Gleeson, et al. (2008) studied Illinois kinship caregivers and found eight reasons parents were unable to care for their children: 1) parental substance abuse/addiction; 2) parental neglect, abandonment or abuse; 3) parental incarceration; 4) youth or inexperience of parents; 5) unstable home life/homelessness; 6) lack of resources and general inability; 7) parental mental illness; and 8) parental physical illness or death.

**Grandparent Caregivers**

Both census and research reports show a disproportionate number of grandparents caring for their grandchildren compared to other relative caregivers. This study, given the research site and population, had a disproportionate number of grandparents represented. Research shows that most grandparents have raised their grandchildren even if only temporarily. Approximately one in ten grandparents has or will raise a grandchild for a period of at least six months (Minkler & Fuller-Thomson, 2000). In a 1994 national sample of 10,293 grandparents, researchers found that 8.2% of the grandparents had a grandchild in their home full-time (Blustein, Chan, & Guanais, 2004). An increasing number of grandparents were parenting again. This phenomenon is referred to as “second time around parenting” and is specific to grandparents being caretakers of their grandchild (Gibson, 2005). Much of the research focused on grandparent kinship caregivers has emerged within the last ten years and grandmothers are disproportionately represented in the studies.

Child welfare studies have compared outcomes of children placed with relatives to the outcomes for children placed with traditional, non-relative foster parents while also
examining caregiver characteristics. These child welfare studies (Chipungu, Everett, Verdieck, & Jones, 1998; Dubowitz, Feigelman & Zuravin, 1993; Gleeson, O’Donnell & Bonecutter, 1997; Harden, Clark, & Maguire, 1997; Hegar & Scannapieco, 1995; U.S. Department of Health and Human Services, 2000a) have concluded that, compared with non relative caregivers, kinship caregivers are more likely to be female, African-American, older, single, less educated, unemployed, and lower socioeconomic status. Because kinship caregivers tend to be older, the gerontology field has also examined kinship care within its own framework. Instead of focusing on children’s outcomes, the aging system of care is concerned with the outcomes for older adults and what kinds of effects rearing a second generation have on individual health, mental health, and life satisfaction. Compared with grandparents not caring for their grandchildren, kinship caregivers report more limitations of daily activities, increased depression, lower levels of marital satisfaction, and poorer health (U.S. Department of Health and Human Services, 2000a).

Grandparent caregivers face a variety of challenges when they assume their full-time parenting role. One significant issue is maintaining healthy family relations. Grandparent caretakers often experience role overload due to the added or increased parenting responsibility (Hayslip & Kaminski, 2005, 1999; Jendrek, 1994). They often suffer from role confusion or role ambiguity because they must be a mother or father to their grandchild. Similarly, the grandparent’s role with his or her own child, the parent of the grandchild, becomes complicated and sometimes tense due to resentment of having to parent full-time. Other family relationships are impacted when a non-custodial grandchild resents the grandchild living full-time with the grandparent. Even the
grandparent’s adult children can resent this non-traditional parenting role. Further, the grandparent’s friendships can also suffer resulting in social isolation from same-age peers.

In addition to complications of social relationships, the grandparent caregiver also experiences other issues. Researcher Jendrek (1994) found that grandparent caregivers have less privacy and less time for self or spouse. These caregivers also experience greater financial burdens and some have had to interrupt or postpone retirement. Studies have shown that in spite of the costs and complications, grandparent caregivers report benefits and rewards including having a sense of purpose, commitment to and continuity of family, and renewed activity and energy (Gibson 2002b; Jendrek 1994; Johnson-Garner & Meyers 2003). Researchers Hayslip and Kaminiski (2005) found that 90 percent of grandparent caregivers in their study, despite the parenting challenges, would care for their grandchildren again if needed.

In 1994, researchers Dressel and Barnhill noted five aspects of grandparent caregiving that are important (Davis-Sowers, 2006). First, women are largely the everyday caretakers. Second, caregiving responsibilities can negatively impact the caregiver’s employment. Third, caregivers can experience stress due to the new or expanded caretaking responsibilities. While there are negatives such as stress and employments issues with grandparent caretaking, Dressel and Barnhill also found some positives outcomes. The fourth aspect of caretaking is the psychosocial rewards for the caregiver. And lastly, they found that caregiving grandmothers viewed their work at the same level as a career.
**Demographics.** Grandparent kinship caregivers are representative of larger society. They vary across many areas including age, gender, educational attainment, socioeconomic status, race, and ethnicity.

**Gender.** Both grandmothers and grandfathers are involved in kinship caregiving. However, the majority of grandparent caregivers are female. Approximately 80% of all grandparent caregivers are female regardless of race (Fuller-Thomson & Minkler, 2000; Fuller-Thomson, Minkler, & Driver, 1997). As a result, there are few studies focused on kinship care by grandfathers. One study (Kolomer & McCallion, 2005) found that grandfathers identified three recurrent issues. The grandfathers reported parenting the second time was different than the first time, with their traditional grandparent role impeded by an expanded parental role. Grandfathers reported they were not able to just *spoil* their children but had to take on full parental responsibilities. Additionally, the grandfathers reported concerns about their loss of freedom. The grandfathers’ activities were limited due to caretaking responsibility. Also, the grandfathers reported concern about their own health impacting the child’s placement. They were concerned that an illness could cause the grandchild to be placed elsewhere.

Kolomer and McCallion (2005) also compared the grandfathers to a matched set of grandmother caregivers. They found that grandfathers were more likely to be Caucasian, married and working, and to own their homes. Grandfathers reported they were significantly less likely to be depressed than the grandmother caregivers. Other researchers (Watson & Koblinsky, 1997) found that grandmothers reported being more actively involved in parenting their grandchild and reported being more successful as parents the second time.
**Race.** Non-white grandparents provide care in higher percentages than white non-Hispanic grandparents. However, white non-Hispanic grandparents represent the largest actual numbers of grandparent kinship providers. Nearly two-thirds of all grandparent caregivers are white non-Hispanic (Fuller-Thomson, Minkler, & Driver, 1997). Higher percentages of African-American (12%), Hispanic (6%), and American Indian/Alaska Native (6%) children live in grandparent households and compared to white Non-Hispanic (4%) children (Saluter, 1996; Fuller-Thomson & Minkler, 2005).

African-American grandparents, especially grandmothers, were more likely to be caregivers compared to other racial and ethnic groups. Gibson (2002a) refers to the grandparent-grandchild family structure as *skipped generation* families. Skipped generation families are disproportionately represented among African-American or black families and are significantly poorer, less likely to have a high-school education, generally single, and more likely to be older than non-kin foster parents (Dressel & Barnhill 1994; Gibson 2002a; Jendrek 1994; Minkler & Roe, 1993). In general, racial and ethnic minority families were more likely to provide kinship care for their child relatives.

**Social Support**

Social support received by caregivers is important. However, little research has focused on this area. Historically, families have always relied on informal social support from other members of the family. Kinship families have been reluctant to use formal social support for a variety of reasons (Littlewood, 2008). Informal support has been easier to access than more formal supports because, until recently, very few formal support systems existed for kinship families. In addition, caregivers are often reluctant to
seek formal support because in order to receive services they have to provide often
difficult and disappointing details as to why their own children or relatives can not
provide the necessary care (Gleeson & Hairston, 1999; Gleeson, Talley & Harris, 2003).
Smithgall et al. (2006) found that majority of the 39 grandmother caregivers studied
relied on faith-based networks for support in their caretaking responsibilities. Their faith,
church attendance, and praying helped 41% of the grandmothers cope. Others stated that
friends (15%) and family (10%) helped them cope. Moreover, approximately one-fifth of
the grandmothers used formal support such as counseling for themselves, their
grandchildren, or both.

Caregiving has a stressful impact on both the caregiver’s nuclear and extended
family (Gleeson et al., 2008; Jendrek, 1994; Gibson, 1999; Minkler, Roe, & Robertson-
Beckley, 1994). Studies differ in the level of support received from family and friends.
Some studies report that kinship caregivers receive inadequate levels of assistance from
families and friends (Burton, 1992) while other studies report high levels of social
support (Minkler, Roe & Robertson-Beckley, 1994). Even when social support is high,
caregivers report that caretaking interferes with relationships, resulting in less time spent
with spouses, other family, and friends (Minkler, Roe & Robertson-Beckly, 1994). The
caregiver’s role in the family is often altered due to the care taking roles (Crumbley &
Little, 1997). For example, grandmothers must now become mothers again while
abandoning their role as grandmother to other grandchildren. Additionally, the
grandmother may have little time to mother her own children due to the more immediate
needs of the custodial grandchild. The grandmother, especially with formal kinship
placements, may be responsible for supervising visits between a child and a parent. The
various role changes can lead to family relationship stress. One study (Richardson, 2002) found clinically significant problems with the functioning of the kinship families studied. Richardson (2002) interviewed 120 caregivers using the Family Assessment Device and found family functioning ratings clinically significant on six of the seven subscales related to communication, roles, and affective responses.

**Resources**

Little research has examined the impact of resources or services on kinship caregiving. There have been a few studies related to the resources, not necessarily support, that kinship caregivers receive. Much of this research compared kinship care to foster care. Studies have shown that resources often differ between traditional foster care homes and kinship care homes. In some states, kinship caregivers received fewer services than traditional foster parents. Kinship providers are often reimbursed at lower rates than foster parents (Hornby & Zeller, 1995). A national study revealed that kinship parents often have fewer personal resources. Kinship providers tend to be poorer, older, and less educated than foster parents. Yet, kinship providers often receive less financial and nonfinancial assistance from agencies compared to foster parents (U.S. Department of Health and Human Services, 2000a). One study found that kinship providers received fewer services and had less contact with the social workers, although the family appeared to need more services and more contact (Berrick, 1998).

A qualitative study of African-American grandmother caregivers noted they were concerned about finances and health insurance. Most of the grandmothers needed formal assistance (Gibson, 1999). They needed assistance in the form of both support and resources. The grandmothers reported a deep distrust of the foster care system and as a
result were reluctant to request services (Gibson, 2002b). Littlewood (2008) found that informal kinship caregivers described finding and accessing affordable community services as “a daunting undertaking” (p.28). A study of Latino grandparent kinship caregivers revealed that financial support for foster children went to meet basic needs and not for other areas. Even though the caregivers received on average of six services, 85% reported having an unmet service need. It is noted that many kinship providers did not receive services because the care-taking agreements were often informal or case workers do not see these families as a high priority (Burnette, 1999). One study showed that social workers offered services more often to traditional foster parents than to kinship caregivers (Berrick, Barth, & Needell, 1996).

**Social Workers.** Related to resources and resource delivery is the role of social workers to kinship families. Research has shown that social workers have a significant influence on kinship placements. A study of kinship care indicated that social workers were concerned about paying relatives to care for their own family members. Some workers believed it was the family’s duty to care for family members and payment for this duty was not necessary (Ingram, 1996). Findings from the Kinship Adoption Project found that caseworkers needed to improve sensitivity to the needs of kinship families (Lorkovich, Groza, Brindo, Marks, & Rush, 2001). A qualitative study in Illinois identified worker bias as one of the barriers to permanency for children placed in kinship placements (Mason & Gleeson, 1999).

**Health**

Few studies have focused on kinship caregivers’ mental or physical health. Yet, many caregivers have risk factors that may impact their health including being older and
experiencing changes in lifestyle, employment, and family relationships. Many caregivers are older with the majority being grandparents providing full-time, custodial care to their grandchildren. Parenting has the potential to impact social relations with family and friends and the caregiver’s work environment.

**Mental Health.** Caregivers’ mental health is a significant issue which can impact parenting. Using a standardized measure to assess how much caregivers were worried, frustrated, fearful, or discouraged regarding their health, Smithgall et al. (2006) found that 23.7% reported above average levels of distress relative to a chronically ill population. Many of the grandmothers reported that their health had changed since caring for their grandchildren and approximately one-third reported their health had worsened or they were increasingly tired. Many of the grandmothers reported being depressed at some point. The Center for Epidemiological Studies Depression (CES-D) Scale used in this study revealed that 36.8% of grandmothers scored above the clinical cutoff point for depression.

In one of the few longitudinal studies, researchers Blustein, Chan, and Guanais (2004) found increased depression scores for non-white grandmother caregivers. Researchers used a national sample (N=10,293) of grandparents over four waves, (1994, 1996, 1998, and 2000) and identified 1,510 of the sample as being grandparent caregivers. Study participants were asked to complete the Center for Epidemiologic Studies Depression (CES-D) scale with a range from 1 to 8, with a score ≥ 4 associated with depression. Findings showed single, nonwhite grandmothers were more likely to be depressed (reporting a CES-D score ≥ 4) when a grandchild was in their home, compared to when a grandchild was not in the home, controlling for changes in health care, income,
and household composition over time. Blustein et al. (2004) did not indicate how the role of caregivers was defined, the legal status of the grandchildren, or the role and location of the biological parents.

The formal kinship caregivers interviewed by Petras (1999) displayed moderate levels of depression and those interviewed by Cimmarusti (1999) displayed a moderate level of caregiver burden and emotional distress. Cimmarusti’s (1999) study demonstrated that the degree of emotional distress was associated with the degree of burden. Petras’ (1999) study revealed a positive relationship between caregiver depression and behavioral problems of the most challenging child in care, using the Child Behavior Checklist.

Several studies report high levels of health problems experienced by these caregivers and the tendency of kinship caregivers to minimize or neglect their own health and symptoms (Minkler, Roe, & Price 1992). Some researchers attribute these health problems to caregiver burden (Burton 1992; Minkler, Roe, & Price 1992). The burden of caregiving is further complicated by the environment in which caregiving is undertaken. Researchers Minkler, Roe, and Price (1992) report many caregivers experience fear due to the raising children in high crime neighborhoods. Similarly, Petras (1999) found that kinship caregivers attribute their stress to many sources beyond kinship care including community violence and personal losses.

Other studies examined caregivers’ mental and physical functioning with similar results. A study of 102 grandparent caregivers, found that the level of psychological distress experienced by grandparent caregivers was predicted by family resources, the caregiver’s physical health, and to a lesser degree, social support (Kelley, Whitley, Sipe,
Researchers used several instruments to measure physical and mental functioning, i.e., the Brief Symptom Inventory for psychological distress, the General Health Questionnaire for physical health, the Family Resource Scale for resources, and the Family Support Scale for social support.

Research indicates caregivers experience various psychological and physical issues related to the added responsibility of caring for a child relative. Caretaking impacts quality of life and activities of life. Using a subsample of 3,477 from the National Survey of Families and Households conducted in 1992 and 1994, researchers Minkler and Fuller-Thomas (1999) found a difference between custodial grandparents and noncustodial grandparents related to daily living activities such as doing tasks at home, climbing stairs, or working. Custodial grandparents reported more limitations or impairments. The researchers speculated the difference among caregivers may be due to caregiver depression or stress and limited resources.

Physical Health. Like mental health, the physical health of caregivers is a significant issue which can impact their parenting. Williams, Dilworth-Anderson, and Goodwin (2003) found that while African-American women are often believed to be strong and resilient, many African-American grandmothers serving as kinship caregivers disproportionately suffered from diabetes, heart disease, strokes, lupus, or other chronic diseases that may undermine their strength and resiliency. A study of 39 grandmother caregivers (Smithgall et al., 2006) reported 79% of the grandmother caregivers had, at least, one health problem with many reporting three or more health problems. Similarly, 81% of the grandmothers’ spouses reported at least one health problem with fewer
reporting three or more problems. The most frequently reported health problems were arthritis, high blood pressure, and diabetes.

A national survey of 54,412 female nurses aged 46 to 71 years found increased incidence of coronary heart disease (CHD) among those who provided care to children and/or grandchildren (Lee, Colditz, Berkman, & Kawachi, 2003). This four-year study included women who provided care to their own children, their grandchildren, or both. Researchers found in 321 cases that caring for their own children 21 hours or more a week and caring for grandchildren 9 hours or more a week was associated with increased risk of CHD. Lee et al. (2003) concluded a high level of caring for grandchildren and children was a risk factor for CHD.

**Theoretical Perspective**

This study used as a theoretical framework an ecological model of human development (Bronfenbrenner, 1986). This model focuses on biological and environmental contexts of an individual. The individual influences as well as is influenced by both biological and environmental factors. Bronfenbrenner examined the five systems (microsystem, mesosystem, exosystem, macrosystem, and chronosystem) in which the individual develops. The microsystem focused on the immediate environment that the individual experiences. The second level, mesosystem, focused on interconnections between microsystem components. The exosystem is not directly experienced but affects the person. The macrosystem is the larger context encompassing all of the other three. Lastly, the chronosystem relates to changes in person or environments over time (Bronfenbrenner, 1986; White & Klein, 2002).
Human Ecology Model and Kinship Care

The human ecology perspective provided a theoretical framework under which this kinship care study was conducted. The microsystem would be the kinship and biological families to which the child belongs. The mesosystem would be the connection between the two families, the family of origin and the kinship family. Additionally, the connection between the caregivers’ extended family and friendship networks would be part of the mesosystem. The exosystem would be the social service agencies, the courts, or other institutions which may not be directly involved with the child but that influence the child’s placement. The macrosystem would be the laws that govern placement of children into kinship homes. And, the chronosystem would be the changes that occur to the caregiver, the child, and family over time.

Bronfenbrenner’s model has continued to evolve to include four central concepts of Process-Person-Context-Time (PPCT) model (Tudge, Mokrova, Hatfield, & Karnik, 2009). This study considered the process of caregiving, the caregiver, the context of this care, and reviewed caregivers over time across the three phases. The PPCT concepts supported the basic premise of the study that there would interaction and interconnection of various components related to caregiving.

Families engaged in kinship care are impacted by the changes in their family structure and also by the changes in family interactions and interpersonal relationships. With the addition of a relative’s child, the kinship caregiver’s family increases. In addition, the caregiver has to parent someone else’s child and may have to establish a new relationship with the child in care, the biological parent, and several systems of service including health care providers and schools. The immediate and extended family
and community programs all influence the caregiver. The systems connected to the
caregiver influence the caregiver and the caregiver has influence on the system. This
study focused on just one system, the grandparents raising grandchildren’s program,
connected to the caregiver. The study also focused on the interpersonal relationships
influencing caregivers. The evolving human ecology model also encompasses health
issues as influenced by social support and resources.

The multiple layers involved in kinship caregiving contexts correspond to the
ecological framework. Kinship care encompasses both biological and environmental
issues, thus, making kinship uniquely suited to be examined within a human ecological
framework.

This study used two instruments based on the ecological model. In developing
both the Family Support scale (FSS) and the Family Resource scale (FRS), Dunst and his
fellow researchers used the human ecology model as their theoretical guide (Dunst,
Trivette, & Deal, 1988; 1994). A completed explanation of the FSS and FRS instruments
is provided in Chapter 3 of this paper. The selection of both the FSS and FRS in this
study supported the exploration of caregiver social support and resource issues.

**Biopsychosocial Model**

Both the human ecology model and the biopsychosocial model guided this
exploration of caregiver health issues. In 1980, offering an alternative to the existing
biomedical model, George Engle developed the biopsychosocial model. Engle believed
that clinicians needed to understand the biological, psychological, and social dimensions
of illness before they could adequately respond to the patient’s suffering (Borrell-Carrio,
Suchman, Epstein, 2004). He objected to the dualist nature of the dominant biomedical
model which separated body and mind. Engle also objected to the linear cause-effect model used to describe a clinical phenomenon. He believed the clinical reality was more complex. Engle believed the appearance of illness resulted from diverse causal factors including molecular, individual and social levels. Moreover, psychological alterations may under certain circumstances manifest as illnesses or forms of suffering that constitute health problems (Borrell-Carrio, Suchman, Epstein, 2004). To understand a person’s health, mental or physical, it was necessary to understand the individual, their society, and their relationships. Consistent with the biopsychosocial model, the health of the caregivers was expected to be related to their perceived levels of social support and resources.

Summary

Kinship caregiving research is still in its infancy. There are a limited number of studies focused on child kinship caregivers and even fewer studies exploring the relationship between caregiver social support, resources, and health. Additionally, there is no known research specific to or inclusive of Nebraska’s child kinship families and caregivers.

Based on a review of the literature, it appears caregivers’ commitment to children often goes beyond their available social support and resources. And, there seems to be a link between caregiving and compromised health. Additionally, caregivers have often provided kinship care with a potentially negative impact on other relationships with other family members and friends resulting in jealousy and resentment. The role of caretaker can mean a change in roles and function with a grandmother even acting as supervisor for parent-child visits. Caregivers seem to be committed to provide care in spite of their own
medical needs often neglecting their health to provide care. This literature review was focused disproportionately on grandparents due to the significant number of grandparent caregivers relative to other kin (e.g., aunts, siblings) and the number of studies of this group. Additionally, the focus on grandparents was supported by the research site which primarily serves grandparent caregivers.

Both theoretical models used in this study were comprehensive and provided the necessary framework to explore the complexity of kinship caregivers’ social support, resources, and health issues. Bronfenbrenner’s model guided the examination of social support and resources. Kinship caregiving involves multiple family members engaged in multiple relationships across multiple levels and across time. The biopsychosocial model provided the framework for the examination of caregiver health.
CHAPTER 3

Methods

Purpose of the Study

The purpose of this study was to explore social support and resources that kinship caregivers identify and examine the relationship between social support and resources and the caregivers’ health. An exploratory sequential mixed methods design was used which involved collecting, analyzing, and mixing both qualitative and quantitative data from three separate research phases.

Design

This three-phase mixed methods study examined issues related to child kinship caregivers using multiple sources of data including observations, case file reviews, interviews, and surveys. Researchers Creswell and Plano Clark (2007) define mixed methods as focusing on collecting, analyzing, and mixing both quantitative and qualitative data in a single study or series of studies. This study sought to combine the two forms of research methods by connecting or mixing both qualitative and quantitative data. The specific type of mixed methods design used for this study was exploratory sequential.

Exploratory Sequential Design. The exploratory sequential design is characterized by an initial phase of qualitative data collection and analysis followed by a phase of quantitative data collection and analysis (Creswell & Plano Clark, 2007). Priority is given to the qualitative phase of the study. The results from the qualitative phases help develop and inform the quantitative phase.

There are several reasons for using mixed methods research design. Mixed methods research allows the use of both words and numbers to obtain a better
understanding (Caracelli & Greene, 1993). Results can be generalized through the use of quantitative data while providing individual voices through the use of qualitative data (Tashakkori & Teddlie, 2003). Specifically, mixed methods research creates a deeper understanding of research by using the strengths of qualitative and quantitative research to inform both (Creswell & Plano Clark, 2007). In this study, the exploratory sequential mixed methods design used qualitative data results from Phase I and II to inform the quantitative data collected in Phase III.

**Mixed Methods Research Rationale.** There are very few studies on child kinship care issues using mixed methods research design. A mixed methods approach was necessary for this study because no single data source could provide the depth and range of data necessary to address the research questions (Morell & Tan, 2009). From the study’s conception to results, the mixed methods approach was used to guide all aspects of the study including research design, data collection, data analysis, and the reporting of findings.

Exploratory sequential design was appropriate for this study because of the lack of specific instruments and the lack of a guiding theory related to child kinship caregiver issues. This design was best suited for this study because it began with the exploration of the kinship caregiving phenomenon and the discovery of an emergent framework. The exploratory sequential design permitted the researcher to explore the phenomenon in depth before generalizing the results to a different or broader group. Phase III of this design tested propositions developed from existing literature and confirmed by the results from data collected in the qualitative phases, Phase I and Phase II. Greater emphasis or weight was placed on the qualitative methods from Phase II in the exploratory sequential
There are several considerations for placing greater weight on either qualitative or quantitative methods including the research goals, research questions, or the use of specific research procedures (Creswell & Plano Clark, 2007).

Given the focus of this study, it was important to gather detailed information from the actual caregivers. Phase II of the study involved collecting and analyzing data directly from caregivers in the form of one-on-one interviews. Greater emphasis was placed on Phase II case studies because detailed information or qualitative data gathered directly from the caregivers would continue to shape the survey used in Phase III. The caregivers’ perspectives were essential to validate the context of social support, resources, and health. Information received from caregivers influenced changes to the survey instrument in Phase III.

The sequence or implementation of data collection and data analysis in mixed methods research is referred to as timing (Creswell & Plano Clark, 2007). Timing in mixed methods research refers more to when the data were collected than when the data were analyzed. Data can be collected in varying order or sequence. The timing of collection and analysis are often interrelated, thus the order in which data were collected influences the order in which the data were analyzed. The temporal timing of the three phases of the study was influenced by the need to gather some general information on the social support, resource, and health needs of caregivers as a group in Phase I before information specific to individual caregivers was gathered in Phase II. Taken together, Phase I and Phase II informed Phase III data collection. The overall timing of the design was sequential with Phase I data being partially collected first. However, Phase II data collection began before all of Phase I data were collected. Thus, some aspects of Phase I
data were collected concurrently with Phase II, but the majority of Phase I and Phase II data were collected before Phase III data collection began.

**Research Site**

The researcher spent more than one year at the research site. The researcher spent several months at the site in preparation for the research project and additional months at the site completing the research design and data collection. The research site focused exclusively on grandparents raising grandchildren. It is important to note the researcher’s focus includes not just grandparents raising grandchildren but also other relatives raising young relatives and kinship relationships, which include non-relatives. This study revealed that the participants in the researched program were not limited to grandparents raising grandchildren but included several other relatives and non-relatives raising children.

The program researched was part of a much larger agency. The grandparents raising grandchildren program was one of many programs focused on senior citizens with a minimum age requirement of 60 years and older. The program, however, has no minimum age requirement, but stipulates participants must be grandparents raising grandchildren. The program began approximately ten years ago when the local agency received funding from the Brookdale Foundation, a national social services organization, to begin a Relatives Assisting Parents Parent (RAPP) program. The Brookdale Foundation provided the initial or seed grant to fund the program. There are numerous RAPP programs nationally as a result of this initial funding. Although the research program no longer received RAPP grant funds, it was still connected with the Brookdale Foundation and remained eligible to apply for other Brookdale funds. The program
coordinator was also invited to a biannual Brookdale conference. The coordinator’s transportation and attendance at the biannual conference in Denver, Colorado were funded by Brookdale.

Since it began ten years ago, the program has had three different coordinators. The current coordinator has been with the program approximately three years. Under the current coordinator, participant numbers, level of participation, activities, and funds generated have increased. As part of a larger umbrella organization (agency) the research program and the participants benefit directly from the other programs in the same agency. The program coordinator is able to connect participants to other services or resources outside the scope of the grandparents’ program.

**Participants of the Study (Sample)**

Participants in the study included the coordinator and the caregivers affiliated with the program. There were several criteria that all study participants in all phases of the study met. All caregivers were legal adults over the age of 19 years and currently providing care for a young child relative in their home. The child relative had to be between the ages of 0 months and 19 years. The child’s biological parent had to be absent from the caregiver’s home. Families providing either formal or informal care were included in the study. All caregivers regardless of their legal or biological relationship to the child were included in the study. Families possessing only physical custody of the child without legal custody and families possessing both physical and legal custody of the child were included in the study. Lastly, caregivers had to be affiliated with the program and had to live within the five-county area served by the program.

**Sampling Method Rationale.** This study used purposeful sampling for both
Phase I and Phase II. The researcher intentionally chose to study one particular grandparent caregiver program because it was a program in Nebraska focused on providing services to grandparent caregivers. The researcher chose the individual caregivers and the site because they are both *information rich* and possess information based on their location and participation in a phenomenon (Warren & Karner, 2005). There are several types of purposeful sampling types (see Table 2.2) (Creswell, 2005). The specific purposeful sample strategy used in this study was maximal variation sampling in order to present varied perspectives of caregivers. With maximal variation sampling, the researcher intentionally sampled cases or individuals that differ in some characteristic or trait (e.g., race, gender, age, marital status). The researcher used maximum variation sampling because of a desire to have a diverse sample differentiated by various demographics.

It is necessary to use maximal variation sampling in a population to obtain a diverse group. Based on the literature review, caregivers differ by characteristics of race, gender, age, and other characteristics. There is little information known about the Nebraska caregivers. In Phase I and Phase II, the study used maximal variation to ensure a diverse population and to ensure diverse perspectives.
Table 2.2

*Sampling Types*

<table>
<thead>
<tr>
<th>Strategies (Types)</th>
<th>Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confirming/Disconfirming Sampling</td>
<td>Permits the exploration of confirming or disconfirming cases. Used after data collection started; an emergent design.</td>
</tr>
<tr>
<td>Critical Sampling</td>
<td>Presents the case that <em>dramatically</em> illustrates the situation.</td>
</tr>
<tr>
<td>Extreme Case Sampling</td>
<td>Used to describe particularly troublesome or enlightening cases.</td>
</tr>
<tr>
<td>Homogeneous Sampling</td>
<td>Describes some subgroup in-depth.</td>
</tr>
<tr>
<td>Maximal Variation Sampling</td>
<td>Helps to develop many perspectives.</td>
</tr>
<tr>
<td>Opportunistic Sampling</td>
<td>Takes advantage of whatever case unfolds. Used after data collection has started, emergent design.</td>
</tr>
<tr>
<td>Snowball Sampling</td>
<td>Helps to locate people or sites to be studied. Used after data collection has started, emergent design.</td>
</tr>
<tr>
<td>Theory or Concept Sampling</td>
<td>Used to generate a theory or explore a concept.</td>
</tr>
<tr>
<td>Typical Sampling</td>
<td>Describes what is <em>typical</em> to those unfamiliar with the case.</td>
</tr>
</tbody>
</table>

**Recruitment of Participants.** Study protocol was developed consistent with ethical and responsible research guidelines. Approval for the study was received from the university Institutional Review Board (IRB) (see Appendix A). Additionally, approval
was received from the research site. The researcher developed a memorandum of understanding for the program studied (see Appendix B). Both the administrative and legal departments of the researched program approved the memorandum.

With both agency and university approvals received, the researcher contacted the caregivers initially through a separate cover letter announcing the study and seeking participant permission (see Appendix C). The researcher provided subsequent announcements and written reminders through the mail, through the program support group meetings, and through the monthly program newsletter. For Phase III of the study, caregivers were asked to return, using a pre-paid envelope, the completed survey to the researcher. Caregivers were given the option of requesting the researcher’s assistance in completing the survey either in-person or on the phone. Providing participants several options was necessary to increase response rates (Dillman, 2000). Caregivers were informed by letter that their participation in the study and the completion of the survey were completely voluntary and would not affect any benefits or services received from the program.

The researcher worked with the program coordinator to receive contact information for the caregivers. Anonymity was preserved throughout the study through the assignment of unique identification numbers for participants for all phases of the study. Pseudonyms were used throughout the research study to permit attribution while maintain anonymity of the caregiver and coordinator. Whenever possible, all identifying information of the program, the umbrella agency, and location were removed from this study. No compensation was provided by the researcher in Phase I of the study. Compensation was provided to caregivers participating in Phase II and Phase III of the
study (see Appendix D). Research has shown that survey completion and response rates are increased significantly if a financial incentive is provided when the survey is initially sent (Dillman, 2000).

**Qualitative Data Analysis**

Analysis of qualitative data begins with the collection of data. The researcher begins analyzing the data while still collecting the data and analysis continues throughout the study. Qualitative data analysis is done simultaneously with data collection (Merriam, 1998). The data are reviewed multiple times seeking themes that either emerged during analysis (emergent themes) or are established *a priori* (predetermined themes) (Tashakkori & Teddlie, 2009).

The case study interviews were recorded and transcribed. Qualitative software, MAXqda, was used to assist with data management. All interviews were given a case number and imported into MAXqda. The researcher reviewed each interview multiple times to uncover emergent themes and subthemes. Interviews were reviewed to determine the whole picture or *context* (Tashakkori & Teddlie, 2009). Context makes the relationships in a case understandable (Stake, 2006). A case study calls for the examination of experience within a situation or within context. Categories or clusters of themes were developed based on the analysis of the interview data. The researcher recorded themes within an individual case and across case studies. With case study research, emphasis is placed on the descriptive narrative of the case or cases and emphasis is placed on the researcher’s interpretation of the data (Stake, 2006). The process of case study analysis can involve individual case descriptions and within case themes and multiple case descriptions with cross-case themes (see Figure 1.1) (Creswell, 2006).
Qualitative Phases

Case Study Rationale for Phases I and II. Of the five commonly accepted qualitative traditions, this study used the case study methodology for Phase I and Phase II (see Appendix E) (Creswell, 2007). Case study involves the study of an issue explored through one or more cases within a bounded system, and more specifically:

Case study research is a qualitative approach in which the investigator explores a bounded system or multiple bounded systems over time, through detailed, in-depth data collection involving multiple sources of information (e.g., observations, interviews, audiovisual material, documents, and reports), and reports a case description and case based themes (Creswell, 2007, p.157).

Phases I and II of this study were best suited for the case study tradition because of the program and individual caregivers were part of a bounded system within a natural environment. The case study permitted a close examination of caregiver issues through multiple forms of data which served to illustrate the complexity of the issue.
**Phase I -- Agency Case Study.** The grandparent caregiver program was the focus of Phase I of the study and multiple forms of data were collected. Data were collected through interview, case file review, and observation during the first phase of the study. The researcher interviewed the program coordinator using a semi-formal interview format.

**Overall research question:**

What social support, resource, and health needs of Nebraska child kinship caregivers were identified by the supporting program?

The following interview questions were asked of the program coordinator in Phase I of the study and similar questions were asked of the caregivers during Phase II of the study:

1. What social support, both formal and informal, exists for caregivers?
2. What social support, either formal or informal, is provided directly by the program to caregiver?
3. What social support, either formal or informal, is provided indirectly by the program to the caregiver?
4. What resources, both formal and informal, exist for caregivers?
5. What resources, both formal and informal, are provided directly by the program to the caregiver?
6. What resources, both formal and informal, are provided indirectly by the program to the caregiver?
7. What are some of the health needs, both physical and mental, that exist for caregivers?
8. In what ways does the program address the physical and mental health needs of the caregivers?
9. What support, resource, and health needs are unmet by the program?
10. What impact does the either social support or resources have on caregiver health?
The researcher visited the program weekly and attended monthly caregiver support group meetings. The researcher conducted structured observations based on the research questions and focused on information related to caregiver social support, resources, and health issues. Field notes were recorded by the researcher during the weekly program observations. Observations were recorded during attendance at monthly support group meetings. An observation tool was developed to record observations from the monthly support meetings (see Appendix F). Also in Phase I, the researcher worked with the program coordinator to identify ten families for an in-depth case file review.

**Case File Sample.** Part of Phase I of the study included a review of the program case files. Both caregiver case files and administrative files were reviewed. The researcher with the assistance of the program coordinator identified ten family case files for an in-depth review. The case file review form format (see Appendix G) reflected the research questions and examined the demographic, social support, resource, and health information of ten families.

**Phase II – Caregiver Case Studies.** Case study research is based on very small numbers of cases with some research being focused on only one case (Creswell, 2007). Researchers consistently emphasized that importance of reaching saturation or the point where no new information is being received from the case studies (Creswell, 2006; Tashakkori & Teddlie, 2008). When exploring a phenomenon (such as child kinship caregiving), saturation is reached as early as the fifth case examined (Creswell, 2007). This study included ten cases to ensure data saturation and sample diversity. The researcher used the case of a child kinship caregiver program in Nebraska.

In Phase II, the researcher interviewed the same ten individual caregivers used for
case file reviews in Phase I and all ten caregivers were included in the survey of all program participants in Phase III. The caregiver interviews were audio recorded with the participants’ permission and transcribed verbatim for analysis. The researcher developed a script to inform caregivers of the research study and interview process (see Appendix H). The individual interviews were semi-structured and the following open-ended questions were developed to facilitate the interviews:

**Interview Protocol:**
1. From a child kinship caregiver perspective, what are the social support, resources, and health needs?

**Questions:**

1. What social support systems, both formal and informal, do you use?

2. What social support system, either formal or informal, is received directly by you from the program?

3. What social support, either formal or informal, is received indirectly by you from the program?

4. What resources, both formal and informal, are used by you?

5. What resources, both formal and informal, are received directly from the program to the caregiver?

6. What resources, both formal and informal, are received indirectly by you from the program?

7. What are your health needs, both physical and mental?

8. In what ways does the program meet your physical and mental health needs?

9. What social support, resource, and health needs are unmet by the program?

10. What impact do either social support systems or resources have on your health?

The researcher developed *descriptive* individual case studies for each participant (see Appendix K). Each interview was analyzed for *within case* themes and supported
with descriptive statements or *in vivo* comments. Within case analysis can apply to a single case or collective case studies when themes are unique to the case or cases (Creswell, 2006). Additionally, all interviews were reviewed for *cross-case* analysis to determine similarities and differences across cases. Cross-case analysis was applied to several cases to examine themes to discern themes that are common to all cases and follows within case analysis (Creswell, 2006).

Several steps were taken to analyze the data. The data were reviewed multiple times to discover codes or words that describe a category. The researcher used *emic* categories or categories based on the participants own perspective and own language. Summaries or clustering of similarly coded items were developed. Sentences were developed to describe the *essence* of the data. The researcher continued to review the data until patterns emerged and themes were developed that reflected and made sense of the data. The same steps were taken to develop both the within and cross-case themes for an example see Table 3.3).

Table 3.3

*Theme Development*

<table>
<thead>
<tr>
<th>Codes</th>
<th>Categories</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent</td>
<td>Considerate of others</td>
<td>Altruism</td>
</tr>
<tr>
<td>Thoughtful</td>
<td>Community minded</td>
<td></td>
</tr>
<tr>
<td>Generous</td>
<td>Resistant to charity</td>
<td></td>
</tr>
<tr>
<td>Self-less</td>
<td>Placing others first</td>
<td></td>
</tr>
<tr>
<td>No hand-outs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proudful</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Giving, giving back</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sacrifice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Connecting the Data – Phase I and Phase II

The agency observations, coordinator and caregiver interviews, and the case file reviews helped inform the survey questions asked of all program caregivers. Based on data from the observations, the interviews, and the case file reviews from Phase I and Phase II, the researcher reviewed and modified the survey instrument specific to demographic and health questions.

Phase I and Phase II data helped the researcher gain an increased understanding of caregiver social support, resources, and health issues. Both phases provided information as to what were the caregiver social support, resources, and health needs. Phase I data largely provided information related to resources from the program’s perspective and Phase II data provided information related to social support, resource, and health needs from the caregiver’s perspective.

Quantitative Phase

Phase III - Survey Study

Survey Study Rationale for Phase III. The survey was used in combination with the qualitative data from Phase I and Phase II to examine the associations of caregiver social support, resource, and health needs. The hypotheses were developed to focus on social support, resources, and health needs. The use of a survey permitted the collection and analysis of data from multiple caregivers on multiple issues. The survey permitted cross-case analysis. The depth of information needed from both Phase I and Phase II was best suited for a case study while understanding of the overall caregiver social support, resource, and health issues and relationships between them was best suited for a survey study.
Research questions

The following research questions were examined in Phase III of the study:

1. Is there a negative relationship between Nebraska child kinship caregivers’ age and their social support, resources, and health, respectively?

2. Is there a difference in the social support of Nebraska child kinship caregivers across demographic groups (based on race/ethnicity, gender, educational level, and income)?

3. Is there a difference in the resources of Nebraska child kinship caregivers across demographic groups (based on race/ethnicity, gender, educational level, and income)?

4. Is there a difference in the health issues of Nebraska child kinship caregivers across demographic groups (based on race/ethnicity, gender, educational level, and income)?

5. Is there a relationship between social support and health among Nebraska child kinship caregivers?

6. Is there a relationship between resources and health among Nebraska child kinship caregivers?

Hypotheses

The following hypotheses were tested in Phase III of the study:

Hypotheses:

H₁ There is a negative relationship between caregivers’ age and their social support, resources, and health, respectively. Older Nebraska kinship caregivers would report less social support, fewer resources, and poorer health.

H₂ There is a difference in social support of Nebraska child kinship caregivers across demographic groups (based on race/ethnicity, gender, educational level, and income).

H₃ There is a difference in resource needs of Nebraska child kinship caregivers across demographic groups (based on race/ethnicity, gender, educational level, and income).
There is a difference in the health of Nebraska child kinship caregivers across demographic groups (based on race/ethnicity, gender, educational level, and income).

There is a positive relationship between caregivers’ social support and their health. Nebraska kinship caregivers with greater social support will also report better health compared to caregivers with less social support.

There is a positive relationship between caregivers’ resources and their health. Nebraska kinship caregivers with greater resources will also report better health compared to caregivers with fewer resources.

Sample

The Phase III sample was taken from the program participants. The program serves annually approximately 150 child kinship caregivers and other relatives caring for children. Based on initial conversations with agency staff, the majority of the families served by the program were grandparents but other relative caregivers were also served by the agency. Phase III of this research study consisted of a survey of all caregivers or a total of 150 families. All families listed on the agency program’s roster were recruited for Phase III, the survey phase. The entire population was surveyed.

Survey Instrument

The survey instrument for this study was developed by combining three separate questionnaires and adding demographic questions (see Appendix I). The instrument was revised based on analysis of data from Phase I and Phase II specific to demographic and health questions. The demographic questions were developed by the researcher to capture varied information about the caregiver and caregiver’s family. Demographic questions pertaining to the caregiver focused on several areas including the age, gender, and marital status. Questions pertaining to the caregiver’s family included questions about household size, legal relationship to child, and frequency of contact with biological parent.
Each of the three survey instruments used addressed one of the three factors being studied. The Family Support Survey (FSS) addressed the social support variable (Dunst, Trivette, & Deal, 1994). The Family Resources Survey (FRS) addressed the resources variable (Dunst, Trivette, & Deal, 1988). And, the General Health Questionnaire – Short Form 12 (GHQ –SF12) addressed the health variable. Permission was received to use all three instruments. The authors provided use of both the FRS and FSS with proper acknowledgement and citation (Dunst, Trivette, & Deal, 1988, 1994). Permission to use the GHQ –SF12 was received by purchase agreement from GL Assessment. All three surveys have been used successfully in many other research studies.

Family Support Survey. The Family Support Survey (FSS) was developed in 1986 to assess the support systems parents have when raising young children (Friends National Resource Center, 2006). The FSS is a tool used by research to assess parental self-report of support. The FSS reportedly takes 5 to 10 minutes to complete. The FSS scale consists of 18 items covering such sources of support as immediate family, relatives, friends and others in the family’s social network, social organizations, and specialized and generic professional services. Additionally, the scale provides two open-ended items for parents to assess other sources of support not included in the 18 items. The parent rates each source of support on a 5-point Likert scale (ranging from not at all helpful (score 1) to extremely helpful (score 5), thus, the FSS uses interval variables for individual items and a continuous variable for the total score.

The psychometric properties of the FSS survey include internal consistency reliability with a coefficient alpha (on the 18-item scale) =.77. The split-half reliability
(using the Spearman-Brown formula): .75. The test-retest reliability (1 month interval): correlation was .75 for the average correlation among the 18 scale items and .91 for the total scale scores. Test-retest reliability (18-month interval): correlation was .41 for the 18 scale items and .47 for the total scale scores (Friends National Resource Center, 2006).

Criterion validity was verified by comparing the results on the FSS scale to results on the Parent-Child Play Scale and selected subscales on the Questionnaire on Resources and Stress. The FSS total scale score was consistently, but weakly, related to a number of parent and family outcomes, including personal well-being (correlation = .28), the integrity of the family unit (correlation = .18), parent perceptions of child behavior (correlation = .19), and opportunities to engage in parent-child play (correlation = .40) (Friends National Resource Center, 2006).

**Family Resources Survey.** The Family Resources Survey (FRS) was developed in 1986 to assess the services parents receive while raising young children and to measure the extent to which different types of resources are adequate in the households of young children (Friends Resource Center, 2006). The lack of resources may be barriers to the family's involvement in their child’s program, as families with unmet basic needs may not have the time or energy to participate actively in the child's program. It reportedly takes parents 10 minutes to complete the FRS self-report instrument. The 31-item FRS measures the adequacy of a family’s tangible and intangible resources using a 5-point Likert scale, ranging from (1) not at all adequate to (5) almost always adequate, thus, the FRS uses interval variables for individual items and continuous variables for the total score. The scale covers such resources as food, shelter, financial resources, transportation, health care, child care, family time, and time for self. The resources are
generally organized from the most to the least essential.

The psychometric properties of the FRS include internal reliability (Cronbach’s alpha): .92; split-half reliability (using the Spearman-Brown formula): .95. The test-retest reliability (2- to 3-month interval): .52. The research sample used to test both reliability and validity consisted of 45 mothers of preschool-age developmentally at-risk children participating in an early intervention program. The stability coefficient for the total scale score was $r = .52$ (p<.001) (Friends Resource Center, 2006; Littlewood, 2008).

Validity for the FRS included concurrent validity of both the personal well-being and maternal commitment measures were significantly related to the total scale score (.57 and .63, respectively) (Friends Resource Center, 2006). Brannan, Manteuffel, Holden, and Heflinger (2006) examined the reliability and validity of the FRS among families caring for children who are receiving mental health services (Littlewood, 2008). This study used two separate samples from two children’s mental health services evaluation projects. Exploratory and confirmatory factor analyses supported similar factor structures across different economic variables. Overall, they found that the FRS holds promise as a reliable and valid tool for assessing perceived adequacy of concrete resources among economically diverse families of children with emotional and behavioral disorders.

**General Health Questionnaire, SF-12.** The General Health Questionnaire, Short Form - 12 (GHQ, SF-12®), is a shortened version of the GHQ developed in 1972, which has been used in over 200 studies (Campbell, Walker, & Farrell, 2003; Littlewood, 2008). The GHQ is a well-researched instrument originally developed with 60 items to assess the mental and physical health of the general population. Over the years, the GHQ has been shortened to versions with 36, 30, 28, 20, or 12 questions. Respondents are asked to select one of either three or five response choices which are in order, thus, the GHQ,
SF-12 uses ordinal variables for individual items and continuous variables for total score. Studies have found that the GHQ, SF-12 is just as valid as the GHQ, SF-28 for examining psychological disorders in general populations (Goldberg et al., 1997). One study used the Cronbach’s alpha to determine the internal reliability of the GHQ, SF-12 and found high alpha scores (Littlewood, 2008). Higher alpha scores were associated with higher reliability, and the alpha for the physical health index resulted in .837 with five items and the mental health index resulted in a .823 alpha with four items.

**Survey Data Analysis**

Survey data were analyzed using descriptive statistics and test statistics including t-tests, ANOVAs and correlations. Descriptive information was provided on all caregiver demographic information in the form of percentages, ranges, means, and standard deviations of age, race/ethnicity, gender, educational level, and income. This researcher used PASW 18 to assist with the analysis. PASW 18, formerly known as SPSS Base or main program, is a comprehensive statistical software package (Aspire, 2010). PASW permits multiple comparisons with large data bases more efficiently. Independent t-tests or Analysis of Variance (ANOVA) were used to test Hypotheses 2-4. Correlations were used to explore Hypotheses 1, 5, and 6 and to determine if there was an association between the variables.

**Mixed Methods Data Analysis and Connecting Data**

All phases of the research study were connected. Data collection and analysis were linked with all three phases addressing the same substantive issues of social support, resources, and health. (For the detailed information of connecting data in mixed methods, see Woolley, 2009). Additionally, all three phases used a subsample of the survey sample.
The same ten caregivers were used in Phase I case file reviews, Phase II interviews, and the researcher verified the same ten were part of the 57 caregivers who completed the surveys in Phase III. The program observations made by the researcher prior to data collection informed all phases of and stages of the research process, i.e., research design, data collection, analyses, results, and syntheses. Both qualitative and quantitative data were used to develop an understanding of caregiver social support, resources, and health issues.

Quantitative data from the surveys were connected to qualitative data collected through the semi-structured interviews, observations, and case file reviews. Interpretations were made at the end of the study to determine how the qualitative data helped to explain the quantitative data. The following mixed methods questions were used to connect the data beginning with the general question to study-specific questions:

General Mixed Methods question:

In what way does the qualitative data inform the quantitative data?

Study-specific Mixed Methods questions:

In what ways do the interview, file review, and observation data inform the survey data?

In what way does Phase I (program case study) help inform Phase III (survey)?

In what way does Phase II (caregiver case studies) help to inform Phase III (survey)?

The researcher developed a brief schematic diagram of the mixed methods used in this study (see Figure 2.2). A more detailed mixed methods diagram was developed (see Appendix J).
Mixed methods research requires validity checks at each phase of the study and across the mixed methods. Measures were taken to determine the validity of the survey instrument. The researcher considered several forms of validity in this study. The researcher focused on face validity with the survey because of concern about readability and understandability of each item from a non-expert and non-professional perspective. The program coordinator and several staff members of her agency were provided copies of the survey for review. Additionally, the researcher met with one caregiver to complete the survey and read each item to the caregiver recording responses.

The survey developed was intended for a range of audience, and there was no minimum educational level expected of caregivers. Previous research showed that caregivers were largely older females with some high school education. There was little information specific to Nebraska’s caregivers, so the survey needed to account for potentially a wide range of backgrounds, including educational levels. Content validity was also considered with the survey. The opinions of the experts were necessary because there were so few instruments developed for kinship and caregiver issues. The survey was reviewed by a university program which specializes in survey design and data collection. Additionally, the survey was reviewed by another university program which specializes in quantitative data analysis. The hope was for the survey to be valid for use
with the current study and subsequent studies. Internal consistency reliability was also considered to determine which set of items in the survey produce consistent responses when examining different respondents’ surveys.

The qualitative data were validated by using the researcher, co-researchers, and others to verify accuracy. Member checking was used during the interview. A large sample should be used for the quantitative data and a small sample for the qualitative data (Creswell & Plano Clark, 2007). Efforts were made to triangulate the data at each phase of the study. Information gathered from the Phase I coordinator interview, observations, and case file reviews will be compared to information collected during the Phase II case studies and the Phase III survey. Triangulation of data occurred by using the same families for both the case file reviews, the case study interviews, and in the survey sample.

**Benefits to Mixed Methods Research**

This research was needed to provide some baseline information about Nebraska’s caregivers. The study will add to mixed methods research literature because it will be one the few family science mixed methods studies (Plano Clark et al., 2008). This study will help to support the use of mixed methods in this discipline. Additionally, this study had direct benefit to the population being studied. Kinship caregivers were afforded an opportunity to educate the researcher, the program coordinator, state stakeholders and others on issues relevant to them while advancing the field of study. It is also hoped that the stakeholders and others will benefit from the information received from caregivers.

**Researcher**

**Researcher Resources.** Personally, the researcher has always offered support to and cared for young family members. The researcher also provided formal kinship care
for a young relative needing to complete his last year of high school in an academically supportive environment away from his former social environment, i.e., friends.

Professionally, the researcher has worked as a child welfare social service worker for more than 15 years and has worked with multiple child kinship care and foster care families in several states. Extensive experience as a child welfare worker provided the researcher the skills necessary to communicate effectively with very diverse families about very sensitive subject matter. Skills related to respective engagement, rapport-building, and establishing trust were developed from years of direct service work. In addition to field work, the researcher worked with state and national professionals focused on child kinship care issues while developing training on child kinship issues for other social service workers. Since returning to graduate school, the researcher has continued to study issues related to child kinship care. The researcher has presented nationally on issues related to kinship care. The researcher’s extensive background and continued research lead to focus and question in the research.

The researcher has extensive experience conducting interviews, observations, and case file reviews. This researcher has conducted and participated in evaluations based on concepts similar to mixed methods in which some form of both quantitative and qualitative data were collected and analyzed to examine an issue. The researcher has taken several classes which were useful in designing and implementing a mixed methods study. This researcher completed a course in both educational research design and program evaluation design. Additionally, the researcher completed course work in introductory and advanced qualitative research methods. This researcher has taken a course in survey design as well as introductory and advanced statistics courses. The
researcher completed one of the few university courses focused on mixed methods research. Lastly, the research has benefitted from individual consultations with university mixed methods researchers.

**Potential Ethical Issues.** As with all research, there was the potential for ethical issues to arise with this research. During either the quantitative or qualitative phase, there was the potential that information could be revealed to the researcher that is unethical or illegal or both. Since the topic was based on child kinship placements, there could have been issues related to child abuse or neglect, worker bias or discrimination, or other issues.

All attempts were made to ensure all ethical and legal guidelines were adhered to by the researcher. If information related to abuse, neglect, or other issues was revealed to the researcher that required reporting, the appropriate agencies would have been contacted. This possibility of reporting was addressed in Institutional Review Board (IRB) consent form shared with each participant. Additionally, only adult populations were included in this study.

**Researcher Bias.** This researcher, like all other researchers, is biased. Often a researcher’s choice of research topic is influenced by personal or professional experiences. Rarely are these experiences neutral. There is a positive or negative or mixed perspective based on the researcher’s experience but rarely a neutral perspective.

This researcher’s experiences influenced the decision to focus on child kinship caregiving. Personally, this researcher provided kinship care to a nephew for approximately one year to help that nephew focus and successfully complete his senior year of high school. Professionally, this researcher has worked with both child foster
families and kinship families for nearly two decades. This researcher has largely favorable experiences with both foster and kinship families. In addition to work experience with child kinship families, the researcher has studied kinship for several years at the graduate level.
Chapter 4

Findings

The purpose of this research study was to examine the issues related to the social support, resources, and health of child kinship caregivers and to determine if there was a relationship between these issues. Using a mixed methods format, the study was divided into three separate phases. The study was largely sequential with the Phase I preceding Phase II and Phase II preceding Phase III. Observations of the agency and of the caregiver support groups from Phase I continued throughout the study. The first two phases were case studies and the final phase was a survey of caregivers. Multiple sources of data were collected across the three phases of the study (see Table 4.4).

Table 4.4

Data Sources and Collection Matrix for Multiple Phase Study

<table>
<thead>
<tr>
<th>Phase (Type)</th>
<th>Interviews</th>
<th>Documents</th>
<th>Observations</th>
<th>Surveys</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase I</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Program Case Study</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phase II</td>
<td>Yes</td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Caregiver Case Studies</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phase III</td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Caregiver Surveys</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Similar open-ended questions were asked during both phase I and phase II. The interviews conducted during the first two phases were semi-formal. In phase III, a survey consisting of largely closed-ended questions was administered to the caregivers. The survey also included several open-ended questions.
Phase I -- Program Case Study

A case study was conducted of the program focused on grandparents raising grandchildren and other relatives raising young children. It is important to note that a case study can assume a variety of formats including detailed descriptions of a case or cases, it can be used to generate theory, or be more analytical in nature and display cross-case or inter-site comparisons (Creswell, 2006). Further, “there is no standard format for reporting a case study” (Merriam, 1998, p. 193).

This study used case studies in two separate phases (both Phase I and Phase II). The initial case studied was the program. Several sources of data were collected for the program case study and included case file reviews, documents, observations, and an interview. The coordinator of the program was the gatekeeper, specifically the coordinator served as a liaison between the researcher, the program, and the caregivers. The coordinator provided the researcher access to both programmatic and caregiver information.

Case file reviews

All program case files were reviewed. Case file types consisted of individual files of caregiver families and various program administrative files including monthly activity reports and funding sources. Additionally, program files included community and agency contact and resource information. The program coordinator had worked in the program for approximately three years at the time of the research study. In three years, the coordinator developed relationships with a wide variety of community organizations and agencies. A review of the program files revealed contacts with various locals groups including:
- Schools (elementary and secondary)
- Universities and colleges
- Grocers
- Retailers (clothing, shoes)
- Taxi cab and other transportation companies
- Recreational/leisure activities (including zoo, children’s museum, YWCA/YMCA)
- Public and private social service agencies (including state agencies, Salvation Army, Lutheran Social Services, Catholic Social Services)
- Churches, religious organizations
- Medical providers (hospitals, clinics, physicians, therapists)
- Alternative medical providers (non-traditional medical procedures)
- Attorneys, legal services
- Grant, funding providers (various sources national and local)

Additional program file information revealed on-going collaboration with other programs within the same agency. The umbrella agency provides a variety of services to senior citizens age 60 years and older. Case files for the program include approximately 150 participant files and numerous miscellaneous files related to community contacts and resources.

The participation and membership in the program was fluid based on review of case files and other program records including attendance records from monthly support group meetings. Very few participants have been with the program since its beginning approximately ten years ago. Some participants participated sporadically with the program, meaning they participated for several months or years then became inactive for a period of time.

All caregiver family case files were reviewed. The family files often included a formal program intake form. Due to coordinator changes over ten years, there was no consistency in items found in the individual case files. The researcher and program coordinator identified ten families for more in-depth case reviews and subsequent individual interviews. The items reviewed in the in-depth file reviews corresponded with
the interview questions for participants in Phase II. The researcher developed a case review form based on the participant research questions (see Appendix G). The time required to review case files varied and did not correspond with the length of time a participant had been in the program, the complexity of the case, or frequency of contact with program staff. The range of time for reviewing ranged from 10 minutes to 100 minutes. The average time to review records was 39.5 minutes using the ten sample cases (a total review time of 395 minutes for 10 cases) (see Table 5.5).

Table 5.5

*Case Rile Review Information*

<table>
<thead>
<tr>
<th>Case Names</th>
<th>Time in Program / Intake Date</th>
<th>Time for File (in minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rae</td>
<td>More than one year / 10-08-08</td>
<td>10</td>
</tr>
<tr>
<td>Lin</td>
<td>More than one year / 01-26-01</td>
<td>10</td>
</tr>
<tr>
<td>Jae</td>
<td>Less than one year / 04-29-09</td>
<td>30</td>
</tr>
<tr>
<td>Lee</td>
<td>More than one year / 11-02-05</td>
<td>30</td>
</tr>
<tr>
<td>Mia</td>
<td>More than one year / 07-12-00</td>
<td>65</td>
</tr>
<tr>
<td>Mee</td>
<td>More than one year / 10-15-01</td>
<td>25</td>
</tr>
<tr>
<td>Sia</td>
<td>More than one year / 08-13-04</td>
<td>20</td>
</tr>
<tr>
<td>Lia</td>
<td>More than one year / 10-07-03</td>
<td>100</td>
</tr>
<tr>
<td>Dee</td>
<td>More than one year / 06-01-06</td>
<td>45</td>
</tr>
<tr>
<td>Bae</td>
<td>More than one year / 08-25-03</td>
<td>60</td>
</tr>
</tbody>
</table>

Total time for review: 395 minutes  
Average time for review 39.5 minutes
**Social support.** The case file review revealed that personal support from the program was provided by the program coordinator with assistance from her immediate supervisor. There was little indication of the frequency or nature of such contact in the case file. There were indications based on phone message slips, letters or other case file notations that some caregivers do regularly call the coordinator requesting support and resources.

**Resources.** A review of all the caregiver case files revealed a variety of resources which had been provided to caregivers with the years. A partial list of resources provided to participants of the program included:

- Referral to local food pantries
- Food vouchers to a local grocer
- Taxi vouchers to program meetings
- Holiday gifts for family
- School supplies (e.g., paper, pens, pencils, glue, etc)
- School clothing and shoes
- Gift certificates to local general retail or merchandise stores
- Free or reduced memberships to area attractions (e.g., zoo, children’s museum, city recreation swimming, etc)
- Camperships (scholarships to attend summer day or week camps)

A review of program administrative files revealed information related to the delivery of resources to families. The coordinator produces monthly reports of program developments detailing recruitment of new members, training, community partnerships, and budgetary issues. The monthly program report for June 2009 included the following items under the Budget section:

**Food Vouchers for four families from local grocer:**
- Grandmother A $75.29 in groceries
- Grandmother B $40.91 in groceries
- Grandmother C $73.92 in groceries
- Great Aunt A $37.42 in groceries

**Recreational activities purchased for 27 families:**
- 11 individual summer camperships
6 family memberships to local children’s museum, $50.00 per family
8 family memberships to local zoo, $83.00 per family
1 family swimming pass, $150.00
1 individual local museum campership

Additionally, the program was awarded a $3,000 grant from a state respite program to assist caregivers. The respite funds were intended to be used to pay for alternative care for the children while the caregivers attended the program’s monthly support group meetings.

**Health.** The case file reviews revealed very limited information on the medical issues of caregivers. Of the existing documented health issues, caregiver medical problems varied from temporary, short term to long term. For example, caregiver Mia’s file indicated that she broke her leg in 2005 and had to be hospitalized. One of the program’s previous coordinators assisted Mia with extensive childcare for her grandson. The program paid her daughter to care for the grandson during Mia’s recuperation of several weeks.

**Coordinator Interview**

A lengthy semi-formal interview was held with the program coordinator, Nae, to discuss issues related to social support, resources, and health of caregivers. Nae had been with the program for approximately three years at the time of the study. She reported there had been a lot of activity within the program over the last three years. According to Nae, there had been an increase in the number of caregivers in the program. According to the coordinator, the program had 150 caregivers in November 2009, and the number increased to 162 caregivers by February 2010. The variety of activities and services provided to caregivers also increased (see Table 6.6).
Nae stated she has done a lot in order to offer varied and relevant activities during the monthly support group meetings. She identified the support meetings as psychoeducational with an emphasis on educating the caregivers about something new and relevant. Nae’s strong educational background was evident in the focus and organization of the monthly support group meetings. According to Mia, a caregiver with the program for ten years, prior to Nae’s arrival, the caregiver support groups consisted of monthly meetings to talk about the experiences of parenting grandchildren. Mia described the session as a chance to share and listen to daily experience of grandparenting. There were no speakers or special topics in the earlier meetings.

Table 6.6

Summary of Program Activities

<table>
<thead>
<tr>
<th>Type</th>
<th>Frequency</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support Meetings</td>
<td>Monthly</td>
<td>Coordinator, community</td>
</tr>
<tr>
<td>Birthday Closet</td>
<td>As needed</td>
<td>Community</td>
</tr>
<tr>
<td>School Supplies</td>
<td>Annual</td>
<td>Agency staff, community</td>
</tr>
<tr>
<td>Holiday Gifts</td>
<td>Annual</td>
<td>Community</td>
</tr>
<tr>
<td>Clothing</td>
<td>As needed/ as available</td>
<td>Community</td>
</tr>
<tr>
<td>Educational events</td>
<td>As available</td>
<td>Coordinator, community</td>
</tr>
</tbody>
</table>

**Social support, resources, and health.** The program coordinator stated she works with both internal and external programs to meet the needs of the caregivers. Nae does not have strict guidelines on specific services provided to families. She stated the she tries to meet the needs of the families as identified by the families. Nae noted social support was often provided by the caregiver’s own family. Moreover, it was difficult for
her to address social support needs since she only worked part-time or 20 hours per week, and there were 150 caregiver families at the time of the study. As to health, Nae reported she provided some information on health care resources to caregivers but did connect to the families directly to services.

The program coordinator interview was transcribed and reviewed multiple times by the researcher to develop an overall concept of caregiver social support, resource, and health issues from the coordinator’s perspective. Based on analysis of the coordinator’s interview, the majority of the caregiver’s rely on someone or some group other than the coordinator for social support. The coordinator stated other family members often provide social support for caregivers. It seemed that caregivers were not seeking social support from the coordinator. However, Nae made it clear that she was unable to provide such support due to the numbers of families and her limited work hours.

Based on analysis of the coordinator interview, the coordinator’s primary role is to provide or facilitate resources for caregivers. The type, amount, and frequency of resources varied. As noted earlier, the coordinator responded to varied resource requests from caregivers. The resources provided were determined by request and ability to meet the need within the program or with outside assistance. The coordinator seemed willing to partner and coordinator with any group or entity to meet the needs of caregivers. Based on the interview data, transportation and food were in the greatness need. These resources were the two most provided resources each month of the study.

The coordinator interview analysis revealed the coordinator was aware of the various health needs of caregivers, but she was not directly involved in health issues of individual caregivers. She often received information and updates from caregivers about
their health issues. The coordinator provided information on health related topics such as nutrition and exercise through the monthly caregiver support group.

The coordinator interview was reviewed for key concepts or themes. Several within case themes emerged from analysis of the coordinator interview data (see Table 7.7). This interview data provided information directly related to the primary research question of this study. The data provided information pertinent to understanding the caregiver’s social support, resource, and health issues. Information obtained from the interview analysis informed data collected in subsequent phases of the study specifically the survey in Phase III.

Table 7.7

Coordinator Interview Within Case Themes and Supporting Data

<table>
<thead>
<tr>
<th>Theme</th>
<th>Supporting quotation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meeting Needs</td>
<td>They [caregivers] call about anything. They are calling to see how we can help. And, so I see my job. I may not know how to resolve these issues, but I am a resource to try to help them find out and get back to them. Like for instance, paying utilities bills or getting the car repaired. They call here to see how we can help them. Then I get a lot... from the other divisions here in the building about resources to help them.</td>
</tr>
</tbody>
</table>

Supporting comment

Coordinator discussed the varying needs of families and the need for many different resource like help with household utilities, food, transportatic clothing needs.

Many grandparents [caregivers] are not over 60 yrs and not eligible for services. The coordinator then has to find services in the community at large. She has to find out programs and then find
<table>
<thead>
<tr>
<th>Theme</th>
<th>Supporting Quotation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Interpreting the Real Issue</strong></td>
<td><em>It is really challenging too. When you call you call for one reason, but you are really calling for something deeper. Some people tell you sooner than later. She called originally to tell me about coming to meeting and school supplies. I think school supplies and shoes. I don’t know if that was the focus to say school supplies. That was not real issue. Then quickly it got to the real issue. ‘We were in church Sunday, and [child] slammed the church door on [child] finger’. I did say the child that did it must feel really, really bad, and she said ‘no’ he doesn’t, he meant to do it. I could tell she was really getting stressed. I asked if she was familiar with the respite program. I offered to get her some information.</em></td>
</tr>
<tr>
<td>Support Comment</td>
<td>The coordinator explained that caregivers will call for one reason, but they actually may be calling for an entirely different, deeper issue. With the example provided, the caregiver started with school supplies mentioned child assaulting other child. And, the real issue was not the school supplies or the actual finger slamming incident. The real issue may be that the aggressive child actually needs services to address behavior beyond the isolated church incident.</td>
</tr>
<tr>
<td><strong>Social Support</strong></td>
<td><em>The family members. For instance, [Omit name] she is always telling me how wonderful her children are and they look after her. Cherishes and honors her relationship with children that they care. Even an educator that has taken upon herself to be a guardian for her very mentally challenged grandson because he does not have much to look as far someone helping him out. His mother is deceased. It has been just wonderful.</em></td>
</tr>
</tbody>
</table>
Support Group Meetings

Observations were conducted of the monthly caregiver support group meetings beginning in May 14, 2009 and continued until January 21, 2010. The researcher had informally attended support group meetings beginning in September 2008. Observations of the support groups continued throughout all three phases of data collection and analysis. Monthly support group meetings occur for this program typically from January to June and September to December each year. Of the ten monthly support groups, two meetings (in June and December) are focused on the children in care and the meeting’s activities are designed to be child-centered. For the purposes of this study, the researcher formally observed six months of support group meetings including four regular meetings and two child-centered meetings.

The program coordinator served as gatekeeper and introduced the researcher to the participants initially. By the time the formal observations began of the support group meetings in May 2009, the researcher was known to most of the participants through formal and informal introductions facilitated by the program coordinator. The researcher made all effort not to become a participant in the support group meetings and physically sat at a distance from the group whenever feasible. The researcher rarely spoke in the support group meetings unless asked a direct question.

The researcher attended and recorded field notes at each support meeting using an observation form developed for this purpose (see Appendix F). The form was used at
each meeting to record behaviors and conversations classified by support, resources, and health. Most of the meetings observed were focused directly on providing resource information to the participants. Two of the monthly meetings focused directly on physical health issues specifically the activity of yoga and the use of acupuncture. The meetings focused on children were unique from the general focus of the other monthly support group meetings.

The following support group meetings were held in 2009:

- February – Parents and Friends of Lesbians and Gays (PFLAG)
- March - Adoption
- April – Grieving and loss
- May - Yoga
- June – Family Event, tour of animal shelter
- September – Legal Issues including child support
- October – School bullying
- November - Acupuncture
- December – Family Holiday Event, drumming education and entertainment

Observation of the support groups provided information about the caregivers’ interactions with each other, the coordinator, and several others from local community groups. Based on analysis of the field notes, caregivers continually shared and received information about social support, resources, and health. Caregivers discussed calling each other to share information about children or themselves or sharing transportation to attend meetings. Caregivers provided information to other caregivers on a variety of subjects including a local alternative medical provider or summer recreational activities. Observational data from the support groups contributed to the knowledge of issues impacting caregivers.
Self-help Group

The researcher observed that the program regularly partners with a variety of other internal and external programs. One program partnership included a service learning project with a local university’s social work class. Beginning in 2008, the program partnered with this university to offer a short-term self-care workshop. Reports from the program coordinator indicated the workshop was favorably received by caregivers, and the caregivers requested additional workshops. In 2009, the program again partnered with the same university social work class and offered another short-term workshop. The researcher participated in several planning meetings between the program coordinator and the university students to ensure the 2009 workshop was not a duplicate of the 2008 workshop. The program coordinator selected ten participants to partake in a psychoeducational experience with the social work students. Some of the participants had participated in the 2008 workshop also.

The researcher observed all four weeks of the workshop. Participation in the workshop fluctuated. The initial workshop session had the primary purpose to provide participants an introduction to the group and to set ground rules. Subject matter for the remaining three sessions focused on discipline, caregiver stress, legal issues, and recreational activities. Three of the four sessions were conducted by the university student facilitators. One session was conducted by two local attorneys presenting information on legal issues such as guardianships and adoptions impacting relative caregivers.

Analysis of observations and field notes from the self-help group sessions indicated the caregivers were interested in a variety of issues from the day-to-day issues
of running a household with children to long range planning. Concerns about the legal status of the children in their care were the focus of two of the four meetings. Caregivers were concerned about various legal issues including the difference between establishing guardianship versus adopting a child to what legal happens to the child if they die or become incapacitated. Based on this one aspect of the Phase I case study, legal issues seemed to be the primary focus of caregivers.

**Program Observations**

The researcher met weekly with the program coordinator and participated in a variety of activities in addition to the weekly face-to-face meetings. The researcher also met other agency staff to explore other programs and resources. Some of the program participants, the grandparents, were receiving multiple services from the agency. Because the other agency programs serve people over the age of 60 years, some of the grandparents and other relatives are eligible for a variety of services including nurse case management services to assist with medical needs.

**Social support.** Regular phone calls and occasional drop-in visits by caregivers were observed by researcher. The researcher while in the agency would hear or see interactions between the coordinator and caregivers. Few of the contacts, whether in person or via phone, were social or casual in content. The caregivers often called to report a change within their family or to discuss a problem.

Very few caregivers called the coordinator weekly or monthly. While there were regular calls weekly, the calls were from different caregivers each time. Only a small group of caregivers called regularly (weekly, biweekly) to update the coordinator on family developments.
Resources. Greater emphasis in terms of both requests and planning was on resource or service issues. The researcher observed when caregivers called or dropped in it was often for something they needed. Caregivers called from taxi vouchers or food voucher requests. It seemed some simply called to tell of a problem with utilities or home repair. The coordinator shared that it was a challenge meeting caregiver needs and equally challenging, in some cases, trying to decipher their real needs or issues (see Table 7.7). The majority of the drop-in visits were from caregivers wanting to get toys from the Birthday Closet. The Birthday Closet was created and funded by donations from two local elementary students and their classmates. The two students made the initial toy donations to the program because they had too many toys and thought there may be children who needed them more. The students have developed annual toy drives to continue replenishing the Birthday Closet. Caregivers are allowed to shop in the Closet anytime to get birthday gifts for the children in their care. It was observed the coordinator spent a lot of her time trying to secure funding or in-kind gifts for caregivers.

Health. During the observations of the program, there was very little information received about caregivers’ health. Calls or visits about caregiver health were rarely received. The researcher is aware of one caregiver who asked the program coordinator to accompany her to surgery. The caregiver also needed respite care arranged for her five grandchildren during the surgery. The program assisted with paying for respite and food costs for the grandchildren while the grandmother was in the hospital overnight. The researcher received information about two other caregivers receiving surgeries directly from those caregivers during the course of doing interviews. The two caregivers later
shared this information with the coordinator. In general, health issues were not discussed by the caregivers.

**Phase I -- Summary**

Based on the various forms of data analyzed, the primary function of the program was that of resource provider and resource liaison. The program coordinator noted her limited ability to engage with 150 caregiver families on an individual basis. Caregivers often contacted her when they needed something. The flexibility of the program allowed the coordinator to meet a variety of needs. She noted she tried to meet the needs identified by caregivers, and the program did not offer a set menu of deliverable services for families. This flexibility made it difficult to know what resources were regularly accessible to families. A family needing a particular resource may not contact the program because they would not know what resources were available. However, the family that asked for resource assistance from the program may benefit by simply seeking assistance.

A review of the program administrative and caregiver case files revealed varying resources provided to caregiver families. Transportation and food assistance were the most commonly requested and provided caregiver resources. These two services were requested monthly by caregivers.

Observation of the monthly support meetings revealed specific types of social support among the caregivers. The majority or, in some cases, the entire support group meeting was devoted to an educational forum. The majority of the support groups involved a guest speaker(s) discussing an issue with questions or comments from
caregivers. Twice a year the entire caregiving family was invited to a family-centered activity. In general, the support meetings were more topic or activity driven.

**Phase II -- Individual Case Studies**

The second phase of the study consisted of interviews conducted with ten caregivers. The program coordinator identified ten families for interviews. All ten families agreed to participate in the study interviews. Interviews were conducted individually and average approximately one hour in length per participant. Participants were paid $20.00 in compensation for the interview. Interviews were conducted at a location of the participant’s choosing, thus, some interviews (50%) were conducted in the caregiver home and other locations in the community including the program site (20%) and a Native American service agency (30%). All interviews were conducted in-person, one-on-one with the caregiver and the researcher. Each caregiver was provided a description of the research study and a consent form approved by the university’s institutional review board. All participants consented to have the interviews audio taped, and all interviews were digitally recorded. The recorded interviews were then transcribed verbatim. Caregivers interviewed varied across demographic characteristics (see Table 8.8).
Table 8.8

Demographic Characteristics of Interviewees

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Number of Participants</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>4</td>
<td>40</td>
</tr>
<tr>
<td>African-American</td>
<td>3</td>
<td>30</td>
</tr>
<tr>
<td>Hispanic (non Caucasian)</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Native American</td>
<td>2</td>
<td>20</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under age 60 years</td>
<td>5</td>
<td>50</td>
</tr>
<tr>
<td>Age 60 years and older</td>
<td>5</td>
<td>50</td>
</tr>
<tr>
<td>Gender</td>
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<td></td>
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<tr>
<td>Female</td>
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<td>70</td>
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<tr>
<td>Marital Status</td>
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<tr>
<td>Single/Divorced/Widowed</td>
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<td>60</td>
</tr>
<tr>
<td>Married</td>
<td>4</td>
<td>40</td>
</tr>
<tr>
<td>Number of children in care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>5</td>
<td>50</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>20</td>
</tr>
<tr>
<td>3 or more</td>
<td>3</td>
<td>30</td>
</tr>
</tbody>
</table>

Case Study Analysis

The data for each case study received multiple reviews and case specific themes were uncovered and developed. Within case themes were recorded (see Table 9.9). The case studies were also reviewed for cross-case themes. The themes that crossed over more than one case were recorded (see Table 10.10).

The case study analysis revealed many similarities and fewer differences amongst the caregivers. Review of the data revealed some unique issues for families (see Table 9.9). The researcher chose to use ten case studies in the analysis. Efforts were made to ensure a diversity of experiences were included in both the within case and cross-case analysis. Saturation was evident by the fourth case study.
**Within case analysis.** There were several issues apparent in each case study. While not the focus of this present study, each family’s history, composition, and journey to caregiving was unique. Descriptions of each caregiver were part of the case study analysis (see Appendix K).

**Social support.** The families seemed to rely on various forms of informal social support. One caregiver, Mia, spoke of the program coordinator offering a form of social support. She had also been with the program for approximately ten years and was one of the few caregivers to have worked with all three of the program’s coordinators.

All the caregivers spoke of family and friends as their social support system. All of the caregivers spoke of their adult children as being supportive and providing invaluable assistance to them. These adult children often helped the caregivers with the young children in their care and with the caregiver’s personal needs. One caregiver (Lin, Case # 2) discussed her limited amount of social support even from her family members which the researcher interpreted as isolation (see Table 9.9). Lin has one daughter out of her three that helps her daily. This daughter lives with her, and they co-parent the children in the home. She stated she is estranged from one daughter and another daughter is reluctant to help. Lin’s only son had problems she stated and during the course of this study died from an apparent suicide. One caregiver (Jae, Case # 3) discussed his years of involvement in his community which was interpreted as his connectedness. Jae had been a community leader since the 1960s. He stated he has had a number of positions and played an active role in his community, and he reported still being very active.

**Resources.** Caregiver resource needs varied across cases. Transportation was a need identified by many of the caregivers. Transportation was an issue whether the
caregivers had a mode of transportation or not. During the interview, some caregivers complained of not having a vehicle and others complained of not being able to get the children to all the places they needed to get to. Thus, transportation was an issue for most of the families. Caregivers identified a variety of formal resources they used including:

- Temporary Assistance for Needy Families (TANF) payments
- Disability payments for children
- Title XX day care assistance
- Medicaid for children
- Public and private schools
- Public libraries
- Psychiatrist, therapists
- Recreational activities (zoo, museums, parks)

None of the caregivers stated specifically they needed more financial assistance for the children in their care. Some indicated they were having financial difficulties, but there was no indication additional funds were needed because they were caretakers. One caregiver (Sia, Case # 7) stated as a grandparent caregiver she did not feel she should be paid (see Table 9.9). She told this researcher her family did not receive assistance for her five grandchildren by choice.

**Health.** All the caregivers reported health problems. Some received disability benefits due to their physical health. During the course of the study, two of the ten caregivers interviewed underwent surgery and one went to the emergency room and was hospitalized briefly. Several of the caregivers reported mental health issues. Specifically, four of the ten caregivers interviewed reported being treated for depression. Treatment for three of the four included both medication and therapy with one caregiver receiving only brief therapy.
Like with many aspects with these families, the specifics of an issue are unique to the individual as was true with health issues. One grandmother (Mia, Case #5) has suffered from back problems for over 40 years due to slight scoliosis. She stated her back was further injured with the *hard births* of her three children. Mia also reported brief episodic depression for several weeks in the summer 2009 due, she felt, to her grandson’s acting out behaviors. One grandfather (Jae, Case # 3) stated he has *tremendous* health problems and was being treated for high blood pressure, arthritis, and has a stent in his back artery. Another grandmother (Mee, Case # 6) reported having anemia, diabetes, hypertension, and osteoporosis (see Table 9.9). All of the grandparents reported physical health problems and several reported mental health issues. Yet, none of the caregivers’ health issues seemed to impact their caregiving.

Table 9.9

*Within Case Theme Analysis and Supporting Data*

<table>
<thead>
<tr>
<th>Theme</th>
<th>Supporting quotations</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Isolation</em></td>
<td>I don’t have anyone that I can call and just cry and b—tch, I moved here and right away all I have done is raise kids. Eleven, twelve years ago. I don’t have any friend here. I just stay home and do nothing.</td>
</tr>
<tr>
<td>Case # 2</td>
<td>Supporting comments</td>
</tr>
<tr>
<td></td>
<td>Grandmother described parenting all her life and not having any friends, family for support. She did not work outside of the home and did not have any social activities outside of family life.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Theme</th>
<th>Supporting quotations</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Connectedness</em></td>
<td>I use to be the president of the neighborhood organization. I use to be the president of [civic</td>
</tr>
</tbody>
</table>
**Case # 3**

I stay active. I use to do a lot of the counseling at [center]. Helping your people. We are trying to work toward that at church now. We are trying to get a bond between young people and older people.

Supporting comments

Grandfather described being involved and engaged in family, community, and church activities all his life. At 79 years old he was still involved in number of community activities.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Supporting quotations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthful perspective</td>
<td>I’m diabetic, on dialysis, high blood pressure pills, iron put in intravenously due to being anemic. I got diabetes when I was 41 yrs, high blood pressure when I got on the machine. Use chiropractor for osteoporosis. I quit taking pain medication, Tramadol. Surgery on my hands. Doctor explains when you stretch and the tendons stretch then snap back and went to a knot, and he is going to do them both at a time. Yeah, I said let’s do them both and get them done.</td>
</tr>
</tbody>
</table>

My family is always there to help me if I get sick. [My sister] is good like that. Another sister might pick up my medicines. My oldest son doesn’t live too far and he is the best. He set up all my bags and he unpacks my bags. He breaks down all the boxes. I am never home Tues- Wed-Thurs, and I try to stay home Mon and Fri. My cousin moved back from Lincoln, and she calls me, and she says lets go.

I don’t see how people get stressed because they don’t know how to live their live. There are a lot of things that happens in people’s live. If I can’t have it then I didn’t need it. There’s are a lot. I am as easy going as I can be. Only time I am stressed if someone made me mad.

Support comments

The caregiver had a lengthy list of ailments, but her
attitude, her perspective was so positive. She did not seem to be concerned that either mental or physical health issues would impair her. She had a very positive attitude about both her mental and physical health.

<table>
<thead>
<tr>
<th><strong>Theme</strong></th>
<th><strong>Supporting quotations</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Taking Care of My Own</strong></td>
<td>I can’t comprehend having someone to pay me for my grandchildren. The state didn’t say to my daughter to have these children neither did I. They are my grandchildren. You gotta do what you to do. We work around it. We make it work.</td>
</tr>
<tr>
<td><strong>Case # 7</strong></td>
<td>Supporting comments</td>
</tr>
<tr>
<td></td>
<td>Grandmother felt strongly that her grandchildren are her responsibility and not the state.</td>
</tr>
</tbody>
</table>

**Cross-Case Analysis.** Several themes emerged across cases (see Table 10.10).

First, many of the caregivers felt keeping the child in the family or kinkeeping was paramount. Several of the caregivers demonstrated the child in kinship care was of primary concern for the entire family unit including extended family members. Another theme was the altruistic view that some of the caregivers expressed regarding resources. Some were unwilling to take resources if they felt others needed it more.

Table 10.10

**Cross-Case Theme Analysis and Supporting Data**

<table>
<thead>
<tr>
<th><strong>Theme</strong></th>
<th><strong>Supporting quotation, comments</strong></th>
</tr>
</thead>
</table>
| **Kinkeeping** | Case # 1 – grandfather describing his granddaughter being cared for by his sister:  
*He don’t like the grand baby, so she put her out. My oldest sister took her in. If they got the last name of [Omit], they won’t be left out in the cold.*  
Case # 2 – grandmother lives in mutigenerational household |
with adult daughter, daughter’s two children (ages 12, 3 years), a pregnant 19 year old granddaughter, granddaughter’s six month old baby, and grandmother cares for a 12 year old grandson.

Case # 4 – great aunt risk her own arrest by hiding from the police to keep her now four year old great nephew out of the foster care system.

Case # 5 – grandmother hires an attorney and searches for her autistic grandson in another state after discovering he had been abused by his father and placed in foster care.

**Theme**

**Child First**

Supporting quotations:

Case # 1

*My daughter wants to be a boy. This is why we took the baby. She just turned 21. Her life is her life. She is at the age where she is going to do what she wants to do, but, in the process, my grandson is not going to suffer.*

Case # 3

*I have to concentrate on keeping him out of the ‘element’. We have a strong family. If there is something one of the cousins know he could be in involved in (swimming other different events). I have a lot of help as far as family is concern. That helps out.*

**Theme**

**Altruism**

Supporting quotations:

Case #2

*If we can do it on our own then we don’t want to take away from some one else that might need it more. That’s the way we do it at our house. Somebody else might need it more. We have always taken our kids to buy other gifts for other kids.*

Case #1

*Like the pantries and stuff I would rather somebody to have it that needs it ... save that for somebody that really needed [it]; some people just take. If I don’t need why take it .... Leave it for somebody else.*

Case # 5
When I have needed help with groceries I have asked. But, I don’t ask unless I absolutely need. Because there are others also that need, others with little, little kids. We make it. I shop wise.

Case # 7
If you need, I believe it is there for people that need it. I think there are people that take advantage of it and that really upsets me. Because they get it and someone that needs it can’t get it.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Supporting Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multi-generational care</td>
<td>Case # 7</td>
</tr>
</tbody>
</table>

Grandmother Sia cared for both her parents for several years. She stated she drove over fours to another state every weekend for several years to help care for her mother. Upon her mother’s death, she moved her father into her home care and cared for him full-time for two years until his death from Alzheimer’s disease.

Case # 2
Lin co-parented three grandchildren and a great-grandchild. Her adult live-in daughter is her parenting partner.

Case # 3
Grandfather Jae was caring for his wife after she suffered a stroke and his grandson.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Support Quote and Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>System Alert</td>
<td>Case # 4</td>
</tr>
</tbody>
</table>

I brought him home from the hospital. We had planned it that I was gonna take him. And then they let him go with me. But, they sent the cops after him when he was two days old. They had my house surrounded. [Crying] I was not home at the time. I had him over to my sister’s house because she wanted to see him. They came to my house and the kids and their dad was there. My other kids. They came and they said we came to pick up [Omit Name]… he had tested positive for cocaine. So they came back and the next time came back they had my house surrounded with cops with their guns drawn.
Comment:
Great Aunt Lee cried as she described an incident approximately four years ago when social services requested a police pick-up order for her then two day old great nephew. The police, acting on the order, surrounded Lee’s home. Lee hid with the newborn baby for several days until she could work with social services to clear up the misunderstanding. She has since adopted her great nephew. She trembled as she recounted the incident.

Supporting Comments:

Case # 8

Grandmother Lia described problems with getting the court to recognize the father of both of her granddaughters. Although they have the same father, the court did not adjudicate the father for both girls. The father died before he could be adjudicated the father of the youngest grandchild. It will take a lot of effort to have this process done. As a result, the girls receive different services and financial support.

Case # 9

Grandmother Dee adopted both her grandsons but reported she must complete annual written reports to the court, and if she is late with the reports she is threatened that she will have to appear before a judge.

Case # 5

Grandmother Mia stated she does not want to have anything to do with the social services system after her multi-state, multi-year battle to adopt her Autistic grandson. Mia stated she is willing to care for a second grandson who is foster care as long as there is no system involvement.

Case # 6

Great Aunt Mee will not work with social services because of a very negative experience with social services more than ten years ago. Mee received medical assistance for her great niece until she had problems with a dishonest social worker who threatened to suspend medical assistance to then infant child because Mee’s allegedly failed to complete paperwork. While confronting the worker in his office, Mee stated she
found her missing paperwork on his desk.

Case # 7
Grandmother Sia described the frustration with social services in getting services for her grandson with severe behavior issues.

<table>
<thead>
<tr>
<th>Phase II -- Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Although the circumstances leading to a child kinship caregiving relationship varied widely, the caregivers possessed many similarities in terms of needs and views. All caregivers had health problems. There seemed to be no evidence of a negative impact on caregiving due to health-related issues. Several of the caregivers were or had been involved in multi-generational caregiving. Most of the caregivers interviewed expressed needs for resources or services. In addition, the majority (60%) of the caregivers interviewed expressed concern about and, in some cases, distrust of formal systems like social services and the courts.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Phase III</th>
</tr>
</thead>
<tbody>
<tr>
<td>The third and last phase of the study was a mail survey completed by caregivers from the program. Surveys were sent to all 150 families currently being served by the program and 57 (38%) completed surveys were returned. The researcher consulted with a university program which specialized in measurement and assessment. Several efforts were made to encourage participation in the survey. First, caregivers received information about the survey through phone calls from the researcher and through mention of the survey in the monthly program newsletter. Post card reminders were sent and follow-up calls were made to encourage caregiver survey completion. Second,</td>
</tr>
</tbody>
</table>
financial incentives were provided. The survey was mailed with a one dollar incentive attached to the mailed survey. Participants received the dollar for simply opening the survey. Participants were then paid $10.00 if they completed and returned the survey. In addition to the $10.00 stipend, participants completing and returning the survey were entered into a random drawing for one $100.00 prize.

Survey Revision

The survey developed for the study consisted of five components. The first component consisted of seven questions of individual demographic information. The second component consisted of five questions of family demographic information. The specific demographic questions were based on information gathered from the literature review, agency review, and case studies. The questions included were comparable to questions asked in other caregiver research studies reviewed. Some questions were based on information received from the agency and from the individual caregiver interviews. For example, a question was added to the survey to address the issue of family relationship. The researched program served grandparents raising grandchildren. However, not all of the caregivers in the program were grandparents. Of the ten individuals interviewed, three (30%) were not grandparents. Two of the caregivers were great aunts to the children in care and one of the caregivers was a step grandfather who remarried.

The third component of the survey consisted of the Family Support Scale (FSS), an instrument with 20 questions which asks respondents to identify the sources of their support. Based on findings from both phase I and II of this study, the items on the scale were similar to previously noted sources of social support for caregivers. Information
from Phase I and Phase II identified family members as the primary source of social support. Eight of the 18 questions on the FSS referred to family. A Cronbach’s alpha was run on the FSS, .865.

The fourth component of the survey consisted of the Family Resources Scale (FRS), a 31-item instrument seeking information on basic needs of respondents ranging from food and clothing to adequate time for self. Based on the literature review and information from the previous phases of the study, the FRS instrument was best suited to explore caregiver needs. A Cronbach’s alpha was run, .969.

The fifth component consisted of a modified version of the General Health Questionnaire, short form 12 (GHQ, SF-12). The caregiver case studies suggested that both physical and mental health were issues for the caregivers. The GHQ, SF-12 was modified to also include questions related to physical health (Littlewood, 2008). Of the twelve items, five items focused on physical health, four items focused on mental or emotional health, and three items focus on health in general. Cronbach’s alphas were run using all 12 items of the GHQ, SF-12 (.906), run using just the five physical health items (.887), and ran using just the four mental health items (.913). The last section of the survey was an open-ended question asking respondents to provide any additional information that they felt the researcher needed to know.

Survey Results

Caregiver demographics

The results of the study revealed basic demographic information about the caregivers involved in the program and specifically about the 57 program participants who completed and returned the survey (see Table 11.11). The majority (94.7 %) of the
survey respondents were female, with 54 of the 57 respondents being female. The disproportionate number of female caregivers was consistent with the literature which identifies females as being the majority of child kinship caregivers. The mean age of the caregiver respondents (N=55) was 62.31 years with an age range from 39 years to 84 years (SD 8.934).

The majority of the respondents were Caucasian, non-Hispanic (25). The second largest racial group of respondents was African-American (AA), non-Hispanic (22). While AA’s constituted 38.6% of the respondents, in the actual state population AA constituted less than 5% of the state’s population. Native Americans (NA) constituted 12.3% of the survey respondents while constituting only 3% of the actual state population. There were 3 (5.3%) of respondents that identified themselves as both AA and NA.

The majority of the caregiver respondents are either widowed (31.6%) or married (29.8%). An equal number (17.5%) of respondents were divorced or single. Almost half of the caregivers had at least two years of college or more (47.4%). The majority (72.5%) of the respondents reported an annual income of less than $30,000.
Table 11.11

*Caregiver Demographics*

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Number (N= 57)</th>
<th>Percentages (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age, years (N=55)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>62.31 (SD 8.93)</td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td>39-84</td>
<td></td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>54</td>
<td>94.7</td>
</tr>
<tr>
<td>Male</td>
<td>3</td>
<td>5.3</td>
</tr>
<tr>
<td><strong>Race/Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>25</td>
<td>43.9</td>
</tr>
<tr>
<td>African-American</td>
<td>22</td>
<td>38.6</td>
</tr>
<tr>
<td>Native American</td>
<td>7</td>
<td>12.3</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>5.3</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Widowed</td>
<td>18</td>
<td>31.6</td>
</tr>
<tr>
<td>Married</td>
<td>17</td>
<td>29.8</td>
</tr>
<tr>
<td>Divorced</td>
<td>10</td>
<td>17.5</td>
</tr>
<tr>
<td>Single</td>
<td>10</td>
<td>17.5</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non college</td>
<td>26</td>
<td>45.7</td>
</tr>
<tr>
<td>2+ years college</td>
<td>27</td>
<td>47.4</td>
</tr>
<tr>
<td><strong>Income (N=51)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 30,000</td>
<td>37</td>
<td>72.5</td>
</tr>
<tr>
<td>More than 30,000</td>
<td>14</td>
<td>27.4</td>
</tr>
<tr>
<td><strong>Relationship</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grandparent</td>
<td>53</td>
<td>93.0</td>
</tr>
<tr>
<td>Non- grandparent</td>
<td>4</td>
<td>7.0</td>
</tr>
</tbody>
</table>

**Family demographics**

Household sizes of the kinship families varied from two to nine family members, and between one to seven grandchildren were in family care. The majority (70.2%) of the respondents were related to the mother of the child in care. Some (7.0%) of the families have children from both maternal and paternal relations in their care. Four of
the 57 caregiver respondents were not grandparents. Two of the respondents were great aunts caring for young relatives, one was a step grandfather with a second wife caring for three step grandchildren, and one person was caring for a child not biologically related to her.

The majority of the caregivers were female, single parents (widow, divorced, or never married) caring for at least one child (43.9 percent) with limited income. The majority of caregivers were related to the child’s mother, and the majority (54.4 %) had established a legal relationship with the child in the form of a guardianship. Some of the caregivers (21.1 %) report a more informal, non-legal relationship with the child(ren) in their care. These caregivers report no involvement with the court or agency. The majority (35.1 %) of the caregivers have cared for the child more than ten years.

**Relationship between social support, resources, and health**

Phase III of the study focused on examining the relationship between social support, resources, and health. The study also examined the difference of these three factors across demographic groups (e.g., age, race/ethnicity, educational level, and income). Gender was not tested because males constituted a very small proportion of the sample size. Only three (5.3 %) out of 57 respondents were male.

Once the surveys were collected, data from all 57 surveys were entered into an Excel spreadsheet by the researcher. All survey instrument responses were coded. Data were analyzed using quantitative software PASW 18 (formerly SPSS Base software). The mean score and standard deviation for each item of the FSS, FRS, and GHQ – SF12 were computed (see Appendix M).
The following hypotheses were tested using T-tests, ANOVAs, and correlations:

**H$_1$** There is a negative relationship between caregivers’ age and their social support, resources, and health, respectively. Older Nebraska kinship caregivers would report less social support, fewer resources, and poorer health.

**H$_2$** There is a difference in social support of Nebraska child kinship caregivers across demographic groups (based on race/ethnicity, gender, educational level, and income).

**H$_3$** There is a difference in resource needs of Nebraska child kinship caregivers across demographic groups (based on race/ethnicity, gender, educational level, and income).

**H$_4$** There is a difference in the health of Nebraska child kinship caregivers across demographic groups (based on race/ethnicity, gender, educational level, and income).

**H$_5$** There is a positive relationship between caregivers’ social support and their health. Nebraska kinship caregivers with greater social support will also report better health compared to caregivers with less social support.

**H$_6$** There is a positive relationship between caregivers’ resources and their health. Nebraska kinship caregivers with greater resources will also report better health compared to caregivers with fewer resources.

**Survey Findings**

**Age**

To examine hypothesis 1, correlations were run to examine the relationship between age and the three other variables of social support, resources, and health (see Table 12.12). There was no statistically significant relationship between age and the other three variables, respectively for age and social support, $r = -.083$, $p = .548$; for age and resources, $r = -.056$, $p = .687$; and for age and health, $r = -.144$, $p = .293$. A caregiver’s age does not seem to be associated with his or her social support, resources, or health issues.
Table 12.12

*Pearson Correlation Matrix Age and Social Support, Resources, and Health*

<table>
<thead>
<tr>
<th></th>
<th>Social Support</th>
<th>Resources</th>
<th>Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>-.0833</td>
<td>-.056</td>
<td>-.144</td>
</tr>
<tr>
<td>Social Support</td>
<td>.272*</td>
<td>.287*</td>
<td>.469**</td>
</tr>
<tr>
<td>Resources</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*p < .05; **p < .01

**Race**

To examine hypotheses 2, 3 and 4, a one-way analysis of variance (ANOVA) was conducted to evaluate the relationship between caregiver social support, resources, health and race/ethnicity (see Table 13.13). The independent variable, race/ethnicity, was separated into three categories, Caucasian, African-American, and Other (encompassing the remaining racial and ethnic groups). The dependent variables examined were social support, resources, and health. The ANOVA was significant for social support and race/ethnicity, $F(2, 54) = 3.41, p < .05$. The ANOVA was not significant for resources or health and race/ethnicity, $F(2, 54) = 1.61, p > .05$ n.s., $F(2, 54) = 3.06, p > .05$ n.s., respectively.
Table 13.13

*ANOVA for Social Support, Resources, and Health*

<table>
<thead>
<tr>
<th></th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Social Support</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between Groups</td>
<td>5.314</td>
<td>2</td>
<td>2.657</td>
<td>3.405</td>
<td>.040*</td>
</tr>
<tr>
<td>Within Groups</td>
<td>42.131</td>
<td>54</td>
<td>.780</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>47.445</td>
<td>56</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Resources</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between Groups</td>
<td>1.599</td>
<td>2</td>
<td>.800</td>
<td>1.607</td>
<td>.210</td>
</tr>
<tr>
<td>Within Groups</td>
<td>26.873</td>
<td>54</td>
<td>.498</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>28.473</td>
<td>56</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Health</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between Groups</td>
<td>4.134</td>
<td>2</td>
<td>2.067</td>
<td>3.058</td>
<td>.055</td>
</tr>
<tr>
<td>Within Groups</td>
<td>36.501</td>
<td>54</td>
<td>.676</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>40.635</td>
<td>56</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*p < .05

A post hoc, Least Significant Difference (LSD), was conducted to evaluate the pairwise differences between group means. There was a significant difference in reported social support between Caucasian and African-American caregivers ($F = .024$, p < .05) (see Table 14.14). There was also a significant difference in reported social support between African-American and Other caregivers ($F = .046$, p < .05). There was not a significant difference between the social support reported by Caucasian and Other caregivers ($F = .788$, p > .05, n.s.). There were no significant differences across three racial categories and resources (Caucasian and AA, $F = .997$, p > .05; Caucasian and Others, $F = .101$, p > .05; AA and Others $F = .108$, p > .05) (see Table 15.15). There was a significant difference between AA and Other caregivers on reported health issues ($F = .017$, p < .05), but no significant difference between Caucasian and AA caregivers and
health ($F = .222, p > .05$) or Caucasian and Other caregivers and health ($F = .129, p > .05$) (see Table 16.16).

Table 14.14

$LSD$ Pairwise Comparison Follow-Up for Social Support

<table>
<thead>
<tr>
<th>(I) Race</th>
<th>(J) Race</th>
<th>Mean Diff (I-J)</th>
<th>Std. Error</th>
<th>Lower Bound</th>
<th>Upper Bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>-.59822*</td>
<td>.25821</td>
<td>-1.1159</td>
<td>-.0805</td>
</tr>
<tr>
<td>1</td>
<td>3</td>
<td>.08950</td>
<td>.33050</td>
<td>-.5731</td>
<td>.7521</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>.59822</td>
<td>.25821</td>
<td>.0805</td>
<td>1.1159</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>.68773*</td>
<td>.33687</td>
<td>.0123</td>
<td>1.3631</td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>-.08950</td>
<td>.33050</td>
<td>-.7521</td>
<td>.5731</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
<td>-.68773</td>
<td>.33687</td>
<td>-1.3631</td>
<td>-.0123</td>
</tr>
</tbody>
</table>

* $p < .05$

Table 15.15

$LSD$ Pairwise Comparison Follow-Up for Resources

<table>
<thead>
<tr>
<th>(I) Race</th>
<th>(J) Race</th>
<th>Mean Diff (I-J)</th>
<th>Std. Error</th>
<th>Lower Bound</th>
<th>Upper Bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>.00083</td>
<td>.20622</td>
<td>-.4126</td>
<td>.4143</td>
</tr>
<tr>
<td>1</td>
<td>3</td>
<td>.44080</td>
<td>.26395</td>
<td>-.0884</td>
<td>.9700</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>-.00083</td>
<td>.20622</td>
<td>-.4143</td>
<td>.4126</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>.43997</td>
<td>.26905</td>
<td>-.4143</td>
<td>.4126</td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>-.44080</td>
<td>.26395</td>
<td>-.9700</td>
<td>.0884</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
<td>-.43997</td>
<td>.26905</td>
<td>-.9794</td>
<td>.0994</td>
</tr>
</tbody>
</table>

* $p < .05$
Table 16.16

LSD Pairwise Comparison Follow-Up for Health

<table>
<thead>
<tr>
<th>(I) Race</th>
<th>(J) Race</th>
<th>Mean Diff (I-J)</th>
<th>Std. Error</th>
<th>Lower Bound</th>
<th>Upper Bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>-.29669</td>
<td>.24034</td>
<td>-.7785</td>
<td>.1852</td>
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<tr>
<td>3</td>
<td>.47467</td>
<td>.30763</td>
<td>-.1421</td>
<td>1.0914</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>.29669</td>
<td>.24034</td>
<td>-.1852</td>
<td>.7785</td>
</tr>
<tr>
<td>3</td>
<td>.77136*</td>
<td>.31356</td>
<td>.1427</td>
<td>1.4000</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>-.47467</td>
<td>.30763</td>
<td>-1.0914</td>
<td>.1421</td>
</tr>
<tr>
<td>2</td>
<td>-.77136</td>
<td>.31356</td>
<td>-1.4000</td>
<td>-.1427</td>
<td></td>
</tr>
</tbody>
</table>

* p < .05

Social Support

**Education.** An independent samples t-test was conducted to evaluate hypothesis 2 that caregivers with different levels of education would report different levels of social support. Caregivers with a maximum of a high school education were compared to caregivers with post high school education. The results indicate there was no difference when considering educational level and social support, $t(55) = -.738$, $p = .463$. There was no significant difference between the social support reported by caregivers with a maximum of a high school education ($M = 2.63$, $SD = 1.02$) and those caregivers with more than a high school education ($M = 2.82$, $SD = .87$). The 95% confidence interval for the difference in means was quite wide ranging from -.712 to .329.

**Income.** An independent t-test was also conducted to evaluate hypothesis 2 that caregivers with different income levels would report different levels of social support. Caregivers with annual income levels below $30,000 were compared to caregivers with
annual income levels of $30,000 or more. The results indicate there was not a difference in social support, $t(55) = -0.997, p = .323$. There was no significant difference between the social support reported by caregivers with reported annual income levels below $30,000 ($M = 2.66, SD = .94$) and those caregivers with income levels of $30,000 or more ($M = 2.90, SD = .89$). The 95% confidence interval for the difference in means was quite wide in range from $-.741$ to $.249$.

**Resources**

**Education.** An independent t-test was conducted to evaluate hypothesis 3 that caregivers with different educational levels would report different levels of resources. Caregivers with a maximum of a high school education were compared to caregivers with post high school education. The results indicate there was no difference when considering resources and educational level, $t(55) = -1.714, p = .092$. There was no significant difference between the resources reported by caregivers with a maximum of a high school education ($M = 3.21, SD = .71$) and those caregivers with more than a high school education ($M = 3.55, SD = .70$).

**Income.** An independent t-test was conducted to evaluate hypothesis 3 that caregivers with different income levels would report different levels of resources. Caregivers with annual income levels below $30,000 were compared to caregivers with annual income levels of $30,000 or more. The results indicate that was not a difference when considering income level and resources, $t(55) = -1.63, p = .109$. There was no significant difference between the resources reported by caregivers with reported annual income levels below $30,000 ($M = 3.31, SD = .69$) and those caregivers with income
levels of $30,000 or more ($M = 3.62, SD = .72$). The 95% confidence interval for the
difference in means was quite wide in range from -.685 to .071.

**Health**

**Education.** An independent samples t-test was conducted to evaluate hypothesis
4 that there would be a difference in caregiver health across demographic groups. It was
hypothesized that there would be a difference in the health issues reported by caregivers
with different educational levels. Caregivers with a maximum of a high school education
were compared to caregivers with post high school education. The results indicate there
was no difference when considering educational level and health, $t(55) = -1.925, p =
.059$. There was no significant difference between the health issues reported by
caregivers with a maximum of a high school education ($M = 3.20, SD = .99$) and those
caregivers with more than a high school education ($M = 3.65, SD = .73$). The 95% confidence interval for the difference in means was quite wide ranging from -.918 to
.0184.

**Income.** An independent t-test was also conducted to evaluate the hypothesis that
caregivers with different income levels would report different levels of health.
Caregivers with annual income levels below $30,000 were compared to caregivers with
annual income levels of $30,000 or more. The results indicate that there was no
difference when considering income level and health, $t(55) = -1.192, p = .238$. There
was not a significant difference between health reported by caregivers with reported
annual income levels below $30,000 ($M = 3.39, SD = .92$) and those caregivers with
income levels of $30,000 or more ($M = 3.65, SD = .73$). The 95% confidence interval
for the difference in means was quite wide in range from -.728 to .185.
Social support and resources. To test hypotheses 5 and 6, correlation coefficients were conducted on social support, resource, and health (see Table 12.12). It was hypothesized there would be a positive relationship between the amount of social support a caregiver reported and his or her health. It was also hypothesized that there would a positive relationship between a caregiver’s resources and health. Correlations were statistically significant for both social support and health \( (r = .287, p = .030) \) and resources and health \( (r = .496, p = .000) \).

Phase III -- Summary

As consistent with the literature, the majority of the caregivers were female and single parents. Also, African-Americans caregivers were disproportionately represented in this and other studies reviewed. The survey results indicated a caregiver’s demographics did not have a significant relationship on his or her social support, resources, or health. Thus, there was no difference in social support, resources or health across the various demographic groups. As hypothesized, there was a relationship between caregiver’s social support and health and caregiver’s resources and health.

Mixed Methods -- Connection

Each phase of this exploratory sequential study provided an important component of understanding child kinship caregivers and informed the next phase of the study. In the exploratory design, the initial qualitative information is used to develop or test an instrument that can be used with a larger group of participants (Creswell & Plano Clark, 2007). The purpose of the instrument in the quantitative phase is to permit the generalization of information to a larger population. The agency case study in Phase I provided a clear overview of resource and resource delivery issues. Information from
Phase I about resources was used to review the Family Resources Scale’s (FRS) items and helped to determine the appropriateness of the FRS instrument. Many of the items on the FRS were related to information discovered in Phase I of the study, thus supporting the use of FRS. For example, information related to food voucher and food pantry requests from caregivers corresponded with item 1 of the FRS focused on adequate food. Similarly, information from the Phase I case study addressing caregiver transportation needs corresponded with item 11 of the FRS focused on transportation needs. Only limited, general information was obtained from Phase I about the social support or health needs of caregivers. However, across all three phases of the study, it was clear caregivers sought social support from family and friends including the biological parent of the child in care.

During Phase I of the study the researcher was able to develop rapport with caregivers. The researcher was present at monthly support group meetings and regularly present at the program site when caregivers sought services such as gifts from the Birthday Closet or school supplies. This regular contact with caregivers helped with the facilitation of interviews conducted in Phase II. Because the researcher had already established rapport, caregivers were willing to participate in individual interviews and provide detailed personal information.

The individual case studies in Phase II provided in-depth details of the social support, resource, and health needs from the caregiver’s perspective. This phase provided the most detailed information about the caregivers. Information received from Phase II was used to review all three instruments, the Family Support Scale (FSS), the Family Resource Scale (FRS), and the General Health Questionnaire, SF-12 (GHQ, SF-
12). Information received from caregivers’ about their social support corresponded with items of the FSS. Caregivers identified similar persons in their family as providing support. Caregivers’ indentified parents, spouses, and other relatives as sources of social support which corresponded with the first five items identified on the FSS. Similarly, caregivers’ in Phase II identified many of the same resources indentified in Phase I and which corresponded with items in the FRS. Based on information received from Phase II, the GHQ, SF-12 was modified from twelve questions focused largely on mental health to include five questions related to physical health. Information received from Phase II demonstrated the need to inquire about physical health given the significant amount of caregiver health issues reported.

Information from the Phase III survey was compared to information received from the individual caregiver interviews in Phase II (see Appendix L). This comparison was possible because of all the participants were given unique identifier numbers, and; thus, the researcher was able to match caregivers interviewed to their completed survey. Two of the surveys were completed by the wives of the male caregivers interviewed, but both wives were present during all or part of the interviews. And, one wife was an active participant in the interview. Statements made during the interview were compared to select items from the survey. In general information was consistent across interview and survey. Table 17.17 represents the comparison of interview statements and survey responses across the three research areas of social support, resources and health for one caregiver. There was consistency between what the caregiver shared in the interview and what responses to the survey.
Table 17.17

*Case Comparison Phase II and III*

<table>
<thead>
<tr>
<th>Case Number/Name</th>
<th>Interview Statements</th>
<th>Survey Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>8/ Lia</td>
<td>Lia identified her son as her primary source of support</td>
<td>FSS noted “own” child, other relatives as <em>extremely helpful</em></td>
</tr>
<tr>
<td></td>
<td>Lia identified financial difficulties; limited available time</td>
<td>FRS noted money, limited job, time for rest or self <em>sometimes adequate</em> Money for self or entertainment; time to socialize or keep in shape <em>seldom adequate</em></td>
</tr>
<tr>
<td></td>
<td>Lia identified several health problems; No mental problems, some physical problems, dental problems</td>
<td>GHQ noted physical problems <em>some of the time</em>; emotional problems <em>a little of the time</em></td>
</tr>
</tbody>
</table>

It is clear that both Phase I and Phase II helped inform the data collected in Phase III. Phase I information helped to identify the resource issues of caregivers while Phase II information helped identify the issues of social support, resources, and health. And, data from Phase III helped identify the relationship between social support and health and resources and health for caregivers.
Chapter 5
Discussion

A significant number of families are engaged in providing child kinship care, especially grandparents raising grandchildren. Although the numbers of caregivers are increasing, little is known about caregiver issues. This research examined the issues related to caregivers’ social support, resources, and health in Nebraska. The results from this study indicate there is a relationship between caregivers’ social support and health, and caregivers’ resources and health. Both qualitative and quantitative data from this study indicate there is a connection between these dimensions.

Caregivers in this study clearly identified their family and friends as their primary source of social support. Caring for a child relative has an impact on both the caregiver and other family members. Past studies have found that the responsibilities of caregiving impact many aspects of a caregiver’s life (Gibson, 202b; Hayslip & Kaminski, 2005; Jendrek, 1994; Johnson-Garner & Meyers, 2003). Researchers have found that caregivers suffer from role overload and role confusion. Grandparents experience overload with the increased or added parenting duties. Similarly, grandparents have the added burden of clarifying their role as parent to a grandchild while balancing their other roles in the same family unit. These role issues apply to other relative caregivers, too. Researchers have found that caregivers experience other life changes including limited time for self and friends. All of participants in this study had assumed the additional responsibility of care for a grandchild or child relative.

When seeking social support, researchers have found that caregivers often turn to family, friends, and even religious organizations for this support (Burton, 1992;
Littlewood, 2008; Minkle, Roe & Robertson-Beckley, 1994; Smithgall et al., 2006). This study is consistent with existing research findings with family and friends being the primary providers of social support for caregivers. Evidence from the program case study identified family as the primary source that caregivers used for social support. All caregivers interviewed for the individual case studies identified family and friends as their social support. Specifically, many of the caregivers identified their adult children as providing the most consistent support. These adult children also included the biological parent of the child in care.

In the limited number of studies addressing resource needs, findings indicate a variety of reasons that impact caregiver access and utilization of resources. Some researchers note that services are not offered to kinship caregivers at the same level as they are offered to foster caregivers (Berrick, 1998; Berrick, Barth, & Needell, 1996; Burnette, 1999; Gibson, 1999; Gibson, 2002b; Horby & Zeller, 1995; Ingram, 1996; Littlewood, 2008; Lorkovich, Groza, Brindo, Marks, & Rush, 2001; Mason & Gleeson, 1999; U.S. Department of Health and Human Services, 2000a). Caregivers received different levels of services. Researchers found that some caregivers received no reimbursement or lower reimbursement payments in comparison to foster care providers. Similarly, kinship caregivers had limited contact with social service workers and received fewer benefits as compared to foster care providers. Litigation in the form of a 1979 Supreme Court case, Miller v. Youakim, was brought to ensure kinship caregivers received benefits and services equivalent to foster care providers. Subsequent legislative actions including 1992 Congressional hearings were necessary to address the continued imbalance of resources between kinship and foster care.
While not a comparative study between foster and kinship care, this study provided support for caregivers’ resource needs. The findings from all phases of the study indicate caregivers use a variety of services. The program case study yielded information about resource needs for caregivers as varied as food vouchers to local zoo memberships. Individual caregivers interviewed indicated use of a variety of resources also.

Researchers have found that other issues impact caregiver access and use of resources. Gibson (1999) found that grandmothers were reluctant to request services because of their distrust of formal systems. Some caregivers found trying to access services daunting (Littlewood, 2008). Other researchers found that caregivers did not want to seek services because it required disclosing embarrassing facts about their family and the non-custodial parent (Gleeson & Hairston, 1999; Gleeson, Talley & Harris, 2003). The majority (60%) of the caregivers in this study reported some concern about formal systems like social services and the courts. Some of the caregivers indicated a distrust of the formal systems. It was clear that many of the caregivers had negative experiences with the formal systems. These past experiences may influence the caregivers’ use of resources.

The health issues of caregivers in this study paralleled health issues reported in other studies (Smithgall et al., 2006; Blustein, Chan, and Guanais (2004; Petras, 1999; Cimmarusti, 1999; Burton 1992; Minkler, Roe, & Price 1992). Research showed caregivers experience high levels of depression and stress. One study found that grandmothers’ stress and depression levels increased while caring for their grandchild. Other studies found increasing stress and depression levels with increasing caregiving
responsibilities. Factors such as a child’s behavior and community violence also led to increased caregiver mental health issues. Other research found non-white grandmother caregivers were more depressed compared to white caregivers. The individual caregivers interviewed in this study reported mental health issues, specifically problems with depression. In contrast to previous research, this study found that three of four caregivers reporting depression were Caucasian or White.

A review of the literature revealed the majority of caregivers had significant physical health issues. Earlier studies found that grandparent caregivers suffered from many chronic diseases, including diabetes, heart disease, lupus, and high blood pressure. One study of AA grandmother caregivers found 79% had, at least one, chronic disease, and 81% of their spouses suffered from at least one chronic disease. Consistent with the literature, all the caregivers interviewed in this study reported significant physical health problems. Study participants reported chronic health problems including high blood pressure, diabetes, anemia, and high cholesterol.

Information from Phase I revealed very little information about caregivers’ health issues. Conversely, information from Phase II revealed that all the caregivers’ interviewed suffered from several chronic diseases. The reasons for the difference between Phase I and Phase II reported health issues was not clear. Caregivers’ may have minimized health issues or not reported health issues to the program for several reasons. The caregivers may have simply not wanted to volunteer unnecessary information such as their health issues to the program which was not a health program. Alternatively, caregivers may have been concerned with how they were perceived as caregivers. They may have wanted to seem healthy enough to care for grandchildren or other young
children; thus, minimizing their health issues. Another issue could have been they simply had never been asked about their health issues and when the research asked the health questions all reported a variety of illnesses.

It is necessary to examine the whole person if any part of the person is to be fully understood. Both the human ecological and biopsychosocial models encourage a complete examination of a person or system. In addition, this perspective was used in this study to examine the relationship between a caregiver’s social support, resources, and health.

Only a few existing studies have examined the relationship between caregiver support, resources, and health (Kelley, Whitley, Sipe, and Yorker, 2000; Lee, Colditz, Berkman, & Kawachi, 2003; Minkler and Fuller-Thomas, 1999). One study found that the grandparent caregiver’s stress level was predicted by resources, physical health, and social support. In comparing custodial and noncustodial grandparents, one study found custodial grandparents had more physical limitations and impairments which the researchers speculated was due to depression or stress and limited resources. Researchers found an association between grandparent coronary heart disease and higher levels of child caretaking.

The theoretical perspectives supported the hypotheses that there would be a link between caregiver’s social support, resources, and health. Further, it was necessary to gather information from other areas such as support or resources to understand health. As would have been expected with the guiding theoretical models, findings from this study indicate there is a relationship between a caregiver’s level of support and better
health. Similarly, there seems to be a relationship between a caregiver’s level of resources and better health.

**Limitations**

As with most research, there are limitations. Small sample sizes at each phase of the study impacted the generalizability of the study. The study presented one agency case study and several individual case studies. The initial survey sample size, 150, was small to begin with and the response rate (38 % or 57 respondents) further limited the generalizability of the findings. The small number of male survey respondents prevented analysis by gender. Other limitations included the use of self-reported information. A significant amount of the data collected were based on self-reported information. The use of self-reports could increase the chance of incorrect or misleading information. A more in-depth study cross-referencing of self-reported information with other sources would be recommended for future studies.

Another limitation was the inability of the current study to fully explore the components of both the human ecology and biopsychosocial models. The study was limited in terms of access to complete caregiver environment. As noted, most of the information was based on self-reports. There was little opportunity due to the study design for the researcher to truly observe or investigate caregivers’ social support, resources, or health. The researcher was not able to examine the caregiver across various settings or contexts and only over a limited time as this was not a longitudinal study.

As noted earlier the researcher, like many researcher, possessed bias. The researcher, felt families are natural caregivers and the majority of families have more strengths than weaknesses. Also, the researcher believed that the apple does fall far from
the tree; thus, a biological parent incapable or unwilling to care for child likely has relatives that can care for the child. In the more than a year of investment in the research site, the researcher’s biased beliefs were only reinforced. The researcher met families that against many obstacles such as poor health or poverty were caring for grandchildren or young relatives.

**Implications for the Program**

This study had direct implications on the program serving caregivers. There have been several systemic or programmatic changes including changes in protocol, communication, and documentation of the program. The program coordinator discussed and modified protocol for some of the program’s activities based on observations or comments from the researcher. The researcher supported the program dissemination of information by formatting and editing written communication including the caregiver monthly newsletter.

The researcher assisted in contacts with caregivers. In support of the research project, the researcher attempted to contact all of the 150 caregivers on two separate occasions within a six-month period. The researcher made initial calls to inform the caregivers of the research project and later to encourage caregivers to return the completed surveys. The phone contacts provided valuable information to the researcher and to the program coordinator. The researcher was able to forward information to update caregivers’ case files based on the researcher’s contacts, including information on births, deaths, illnesses, unemployment, and other issues.

Based on the research and contact with the program staff and caregivers, it is
recommended that the following areas be addressed:

1. Establish a detailed data-base that identifies active and inactive program participants
2. Establish annual and semi-annual phone and/or in-person contacts with all active program participants
3. Explore alternative communication options such as websites including social networking sites
4. Explore alternative funding sources to expand program service delivery.

It is further recommended that the following efforts be continued:

1. A monthly newsletter and other regular forms of correspondence be maintained with program participants
2. Relationships be maintained with current grant funding sources
3. Continued transportation assistance for some caregivers and their families
4. Continued legal assistance be provided and expanded for all active caregivers and their families.

**Implications for Program Caregivers**

The study provided all program caregivers an opportunity and forum to make comments related to social support, resources, health, and other issues. Information from this study will be shared with both the program and the agency. The study provided an opportunity for caregivers to share information directly with the coordinator. Through phone and survey contacts, the researcher received information from caregivers that they wanted shared with the coordinator, including decisions not to be a part of the program or changes in family composition such as a spouse’s death or a child leaving home. A
grandmother caregiver, a 76-year-old widow caring for her 15-year-old granddaughter, wrote the following statement at the end of her survey:

*I think most of the way I feel is because of my teeth. I only have ten left. They are all bad. Because Medicare doesn’t pay for dental, I have pulled all of them out myself. I don’t eat good because I can’t chew. I only weigh about 85 lbs. I feel weak and very tired all the time.*

Upon reading the statement, the researcher immediately contacted the program coordinator and asked that she call to check on the grandmother. When contacted, the grandmother shared similar comments with the coordinator about her health. The coordinator working with an agency case manager visited the caregiver in her home within a week. The grandmother appeared to have several serious medical needs in addition to her dental problems. Additionally, the coordinator and case manager discovered the grandmother’s house was in need of repairs with carpets over 30 years old and a bathroom that was barely useable. The grandchild was sleeping on an air mattress on the floor. With assistance, the grandmother was able to get medical and dental services and a bed and bedding for her granddaughter.

The impact on caregivers may never be fully known. The caregivers that participated in the study did so voluntarily and enthusiastically. The caregivers were eager to share their opinions and their thoughts about kinship and other related issues. This researcher was able to interact and engage the caregivers. All the caregivers contacted offered to assist with any future research needs. One caregiver noted a willingness to be involved in developing state legislation related to child kinship caregiving.
Implications for the Study of Child Kinship Care

This study has expanded the knowledge of child kinship caregivers, and it represents one of the few family science studies and one of the few kinship care studies using a mixed methods design. In a review of 2,142 family science articles, researchers found only 19 articles which met the definition of mixed methods research (Plano Clark et al., 2008). Mixed methods design is relatively new but holds promise for use in kinship research.

This study is one of the few studies to examine both formal and informal caregivers and to examine other caregivers concurrently with grandparent caregivers. While it stands to reason that issues related to social support and resources are important factors in a caregiver’s life, few studies have examined the impact of these on caregiver health. The results of this study indicate there is a relationship between social support and health and resources and health.

Future Research Directions. Studying male kinship caregivers would be important. The literature offers very limited information about male caregivers, and it would be important to explore kinship issues from a male perspective, which is absent in the current literature. There may be a difference in male caregivers that co-parent with female caregivers and single-male caregivers. It would be important to explore differences in male and female caregivers and implications for the individual caregiver, the caregiver’s family, and the child in care.

Future research is needed to examine children impacted by child kinship care. It is important to understand the impact of this type of familial caregiving on a child’s development. Few studies have explored the differences kinship placements precipitated
by child abuse or neglect and non-abusive placements. Researchers have noted there are a variety of reasons why children need to be cared for by relatives, including child abuse, parental drug abuse, or parental incarceration. There may be differences between a child forcibly removed from an abusive home and a child living with grandparents while a parent is deployed in the military. Very few researchers have distinguished child welfare kinship care involving children removed from abusive and/or neglectful situations from non-maltreatment kinship care such as children cared for during a parent’s military deployment (Pabustan-Claar, 2007). Research has treated kinship children as a collective group regardless of their family of origin issues. Researchers Murray, Macomber, and Geen (2004) found that 77% of the kinship placements they studied involved informal placements or private family arrangements for care. Few studies have explored the impact of precipitating issues on child placement outcomes.

Another needed area of kinship care research is the examination of the role of the non-custodial parent on kinship families. Previous research and this study suggest that the absent parent influences kinship arrangements. The non-custodial parent may be an important factor in kinship care because of the varied relationships that can exist among the child, the caregiver, and the non-custodial parent. The parent may have access to and influence on the kinship family more than in a traditional foster care situation. Issues related to the maternal versus paternal relationships may be important to explore. This study found that over 70% of the caregivers surveyed were related to the child’s mother.

Finally, based on the comments shared by caregivers about formal systems, including social services and the courts, caregiver perceptions and utilization of services need to be examined. Further research is needed in the area of caregiving. The practice
of child kinship caregiving is centuries old, yet, formal study is less than two decades old.
Continued research in the area of kinship is vital to ensure that research, teaching, and practice are all informed by the best evidence-based information.

This study is unique in both focus and methodology. This study represents one of the few studies to examine social support, resources, and health for caregivers. It also represents one of the few family science mixed methods studies. The study’s findings further support the need for continued research in the area of child kinship caregiving from multiple perspectives.
References


Appendix A

INFORMED CONSENT FORM

IRB# (Labeled by IRB)

Identification of Project:
Child kinship care: An exploratory mixed methods study of support, resources, and health issues of Nebraska agency child kinship caregivers

Purpose of the Research:
There are millions of children currently living with adult relatives due to the absence of biological parents. Little information exists as the support, resources, and health of the adult caregivers. And, very little information exists on Nebraska’s kinship providers. This research will examine adult relatives that provide care for child relatives. Participants will be asked questions about themselves, the child, and their support, resources, and health. This research will allow Nebraska kinship caregivers an opportunity to provide information unique to kinship families. To participate in this study, you must be an adult, 19 years of age or older. You are requested to participate in this study because you are currently a kinship caregiver to a child relative.

Procedures:
A select number of participants will be asked to participate in face-to-face or phone individual interviews with the researcher which will last approximately 45 – 60 minutes. The participants will be asked to answer several questions about themselves and the child in their care. Interviews will be conducted in the participant’s homes or a community location of their choosing that affords privacy. Participants can grant permission for audio taping during the interview. Following the interviews, participants in this study will be asked to complete a mail survey which will take approximately 60 minutes to complete. Participants will be given the opportunity of requesting to complete this survey with the researcher via phone or in person.

Risks and/or Discomforts:
Given the subject matter of this research, there may be some psychological stress and discomfort to participants. In the event of psychological problems resulting from participating in this study, participants are encouraged to contact the Nebraska Department of Health and Human Services (NDHHS), Division of Behavioral Health helpline 1-800-836-7660 or their local mental health provider. Participants are responsible for any service fees incurred.

If at anytime during the study, the researcher discovers that the child or children in your care have been abused or neglected, the investigator will report the abuse or neglect to the NDHHS’ local or statewide hotline, 1-800-652-1999, as required by state law.

Page 1 of 3 Pages (____________ initial) 

ID #______
**Benefits:**

The information you provide through the interview may be used to help others caring for child relatives. Your information may help inform support and resource development for families providing kinship.

**Alternatives:**

Information received through this study will be shared with others. Any changes in the area of kinship as a result of this information will be shared with participants.

**Confidentiality:**

Any information obtained during this study which could identify you will be kept strictly confidential. The data will be stored in a locked file cabinet in the principal investigator’s office and will only be seen by the investigator during the study and for five years after the study is complete. The information obtained in this study may be published in scientific journals or presented at scientific meetings but the data will be reported as aggregated data. The audiotapes will be erased five years after the completion of the study.

**Compensation:**

All participants completing the interview phase will receive a $20.00 gift certificate from a local business or cash. All participants will receive $1.00 with the initial mailing of the cover letter and survey. All participants completing and returning the survey will receive a $10.00 gift certificate from a local business or cash and will be automatically entered into a drawing for a chance to receive a $100.00 gift certificate from a local business or cash.

**Opportunity to Ask Questions:**

You may ask any questions concerning this research and have those questions answered before agreeing to participate in or during the study. You may call the principal investigator at any time, (XXX) XXX-XXXX. You may contact Dr. Yan Ruth Xia, (XXX) XXX-XXXX, if you have questions about the research or the researcher. If you have questions concerning your rights as a research subject that have not been answered by the investigator or to report any concerns about the study, you may contact the University of Nebraska-Lincoln Institutional Review Board at (402) 472-6965.

**Freedom to Withdraw:**

You may decide not to participate in this study or to withdraw from the study at any time without adversely affecting your relationship with the investigators and the University of Nebraska. Your decision will not result in any loss or benefits to which you are otherwise entitled.
Consent, Right to Receive a Copy:

You are a volunteer participating in this study. It is entirely your decision whether or not to participate in this research study. Your signature certifies that you have decided to participate having read and understood the information presented. You will be given a copy of this consent form to keep.

___________ Check if you agree to be audio taped during the interview.

Signature of Participant:

_______________________________ Signature of Research Participant _____________ Date

Name and Phone number of investigator

Toni Hill-Menson, M.S., Principal Investigator  Cell: (XXX) XXX-XXXX (Omaha)
Yan Ruth Xia, Ph.D., Secondary Investigator  Office: (XXX) XXX-XXXX (Omaha)

ID# ________________
Appendix B

Memorandum

TO: [PROGRAM] Nebraska
FROM: Toni Hill-Menson, Ph.D. candidate, Child, Youth, and Family Studies, University of Nebraska –Lincoln; email XXXX; cell # XXX-XXX-XXXX
RE: Agency approval for research on kinship caregivers (grandparents and other relatives that provide care to child relatives)

This request is to begin the formal research phase of data collection and analysis. Beginning in July 2008, an informal relationship was begun between student researcher (Toni Hill-Menson) and the [PROGRAM] (coordinator) to develop a research project focused on relatives that provide care for young children. The [PROGRAM] represents a program focused exclusively on relative caregivers or kinship caregivers. This project is anticipated to begin in May 2009 and complete no later than May 2010. Several documents have been attached to this memorandum which will help clarify the specific goals of the proposed research. The actual data collection is anticipated to take six months and be completed by December 2009. Participation in this research project is entirely voluntary for all participants and the participant agency. Participants will be formally informed of the study in a cover letter and consent form (see attached).

The primary purpose of the research study is to explore the relationship between kinship caregiver’s support systems, resource needs, and their health.

The research is guided by the following research questions:

1. Is there a difference in support across demographic groups (based on age, race/ethnicity, gender, educational level, or income) for Nebraska child kinship caregivers?
2. Is there a difference in resources across demographic groups (based on age, race/ethnicity, gender, educational level, or income) for Nebraska child kinship caregivers?

3. Is there a difference in health across demographic groups (based on age, race/ethnicity, gender, educational level, or income) for Nebraska child kinship caregivers?

4. Is there a positive relationship between support systems of Nebraska child kinship caregivers and their health?

5. Is there an inverse relationship between the resource needs of Nebraska kinship caregivers and their health?

This study has been developed based on research standards established by federal and institutional guidelines according to the Institutional Review Board (IRB) of the University of Nebraska-Lincoln (see IRB consent form attached). Formal written IRB approval will be provided to [PROGRAM], the participant agency, and individual participants prior to beginning the formal collection of research data. All data collected and analyzed will be done so confidentially. The student will not have access to any participant or participant agency information without the knowledge and approval of the [PROGRAM] coordinator or agency designee. All data collected and analyzed will be reported in the student research final paper (dissertation) without agency or individual information. The participant agency is permitted complete access to data collected and analyzed by the student researcher throughout the study; however, due to confidentiality, participants are only allowed access to data collected and analyzed directly from that individual participant.
The student researcher will conduct all phases of the research, and the student researcher will cover all expenses related to the collection and analysis of data including the printing and mailing of surveys. The only anticipated indirect cost to the participant agency is the time of the [PROGRAM] coordinator. The student will continue to work closely with the [PROGRAM] coordinator at every phase of the study. All participants will receive a small monetary stipend for participating in the study. The cost of the study including the monetary stipend will be covered by the student researcher. The products produced from this study with direct benefit the participant agency, [PROGRAM], include:

1. Comprehensive and current data collection of demographic (e.g., age, gender) information which can be used to seek and secure grant and other financial opportunities.

2. Information obtained from the study will be used to assist in [PROGRAM] coordinator-identified program changes including but not limited to the modification of the [PROGRAM] intake form, development of [PROGRAM] presentation materials used in educational and networking opportunities, and documentation of program activities.

3. Information obtained from grandparent and other relative caregivers will help guide [PROGRAM] resource and service development and delivery.

4. Information obtained about grandchildren and other child relatives will help guide [PROGRAM] resource and service development and delivery.
Attachments:
  Cover letter and consent
  Survey Instrument
  IRB Consent Form
Appendix C

Cover letter

(Date)
(Inside Address)

Dear (name),

I am requesting your help in completing important research on adults caring for young child relatives or kinship providers in Nebraska. Your responses may be used to inform kinship programs and practices throughout the state of Nebraska.

I received information from the [PROGRAM] that you provide care for, at least, one child that is part of your kinship group (e.g., grandchild, nephew/niece, etc.). This survey is not affiliated with the [PROGRAM], but the information gathered may be beneficial to [PROGRAM] in enhancing agency knowledge and information related to improved services and support. As a kinship caregiver, you possess unique knowledge and information about the care of children living apart from their parent(s).

I am asking that you please complete the enclosed consent form and survey to help increase the knowledge of kinship issues. The results will be shared with governmental and nonprofits organizations interested in meeting the needs of kinship families. No identifying information about you will be provided. Some caregivers will be invited to complete a separate interview.

Your survey will be submitted in confidence to me. Neither the survey nor the return envelope has identifying information about you. Please keep the cover sheet with the survey. Any information obtained during the study which could identify you will be kept strictly confidential. Your responses will be released only as summary information in which no identifying information will be provided. If you would like assistance in completing the survey please call me to arrange an in-person or phone meeting.

Your participation in the study is completely voluntary and will not affect your benefits or services from [PROGRAM]. You are free to decide not to participate in this study. Please accept the enclosed $1.00 as a token of my appreciation for your participation. By completing and returning the survey, you will receive $10.00 gift certificate from a local business or cash, and you will be automatically entered in a drawing for a chance to receive a $100.00 gift certificate to a local business or cash. You may be contacted for a separate interview focused on kinship issues and receive an additional $20.00 gift certificate from a local business or cash for your participation in the interview.
If you have any questions or concerns please contact me. I will be glad to speak with you. You may contact me by phone XXX-XXX-XXXX or email XXXXX.

Thank you very much for taking time to help with this important study.

Sincerely,

Toni L. Hill-Menson
Graduate Student
Child, Youth, and Family Studies
University of Nebraska-Lincoln
### APPENDIX D

**Compensation by Phase**

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<th>Phases of Study</th>
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<tr>
<td>Phase II</td>
<td>Interview participants paid $20 for the interview</td>
</tr>
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</table>
| Phase III       | → Initial mailing included $1 with each survey  
                 | → Participants returning a completed survey received $10  
                 | → Participants completing survey also entered into drawing for chance to win $100; one $100 winner |
## Appendix E

### Qualitative Traditions

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<th>Approach</th>
<th>Defined</th>
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<td>Case study</td>
<td>A specific case is examined often with the extent of examining an issue with the case illustrating the complexity of the issue.</td>
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<tr>
<td>Ethnography</td>
<td>A design used to study the behaviors of a culture-sharing group.</td>
</tr>
<tr>
<td>Grounded Theory</td>
<td>Systematic procedures used to analyze and develop a theory.</td>
</tr>
<tr>
<td>Narrative</td>
<td>The gathering of data through the collection of stories, reporting experiences, and chronologically ordering the meaning of those experiences.</td>
</tr>
<tr>
<td>Phenomenology</td>
<td>The concept or phenomenon and the <em>essence</em> of the lived experiences of persons affected by that phenomenon.</td>
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### Appendix F

**Observation Support Group**

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<td>Resources</td>
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## Appendix G

### Case File Review Sheet

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</thead>
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<td>ID#</td>
<td>_______________</td>
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</tbody>
</table>

Gender

Age

Race/ethnicity

Marital status

Language use

Education

Income

People in home

Relationship to child

Placement type

Parental contact

Support

Family

Professional

Resources

Health

Physical

Mental
Appendix H

Script

Qualitative Interview Protocol

In-person and Phone Script

Thank you for taking time to learn more about my research. My name is Toni Hill-Menson, and I have been observing programming with the [PROGRAM] for approximately one year. I am currently a Ph.D. graduate student with the Child, Youth, and Family (CYAF) department at the University of Nebraska – Lincoln. I am interested in finding more information about grandparents and other relatives that care for young child relatives full-time without the child’s parent present which is also known as child kinship caregivers. Specifically, I am interested in the caregivers’ levels of support, resources, and health issues. This research will impact the knowledge about kinship caregivers and their needs. And, this research will potentially impact the services provided to relative caregivers in Nebraska. The information gained from this study will be shared with [PROGRAM].

This research is being conducted with the knowledge and approval of [PROGRAM], but it is not being conducted by this organization. Your participation in the study is truly voluntary and in no way impacts the services or other benefits you receive from [PROGRAM]. All information gathered will be kept confidential by me, the researcher. No identifiable information about you or your family will be shared or reported.

If you choose to participate in this study, you will be asked to complete an in-person interview with me. The interview will be approximately 60 minutes in length and will be conducted at a date, time, and location of your choosing. The interview will be recorded for later analysis by me. You will need to review and sign a consent form about the research. You will be compensated $20.00 for your time in the form of cash or gift certificate. In order to participate, you must be over 19 years of age and provide care for, at least, one child relative.

If you have questions, you may contact me by phone (cell # XXX-XXX-XXXX) or email (XXXX). You may schedule the interview now or contact me later to confirm an interview time. Thank you for helping to inform others about child kinship caregiving.
Appendix I

NEBRASKA KINSHIP SURVEY

Please complete the following survey questions about yourself and your family as accurately as possible. The information you provide will be used to develop services and programs for you and other child kinship caregivers in Nebraska. The entire survey should take less than an hour to complete. If you require assistance in completing the survey or require an alternative language or format, please contact the researcher.

I. Demographic Sheet

1. Tell us your gender (please check)
   _____ Female _____ Male

2. Tell us your age __________

3. Tell us your race/ethnicity (please check)
   _____ White / Caucasian, non Hispanic
   _____ Black / African-American, non Hispanic
   _____ Hispanic
   _____ Native American / American Indian
   _____ Asian / Pacific Islander
   _____ Other, specify ____________________

4. Tell us your marital status (please check)
   _____ Single, never married
   _____ Separated
   _____ Divorced
   _____ Widowed
   _____ Other, specify ____________________

5. Tell us about your use of language (please check)
   a. Is English your native language? _____ Yes _____ NO
      If your response is “Yes”, please go question 6.
      If your response is “No”, and English is not your native language, please describe your level of comfort with the following (Please write a number from 5 to 1 based on the scale):

      | Very Poor (I have a very difficult time with English) | Poor | Acceptable | Good | Very Good (I do very well with English) |
      |-----------------------------------------------|------|------------|------|---------------------------------------|
      | 1                                             | 2    | 3          | 4    | 5                                    |

   b. How would you describe your ability to speak English __________
   c. How would you describe your ability to write English __________
   d. How would you describe your ability to understand spoken English __________
   e. How would you describe your ability to understand written English __________
6. Tell us your educational level (please check highest level completed)
   _______ Grade school
   _______ Middle or Junior High School
   _______ High School or GED
   _______ Vocational or Trade school
   _______ Junior or Community college (2 year)
   _______ College or University (4 year)
   _______ Graduate school
   _______ Other, specify ________________________________

7. Tell us your family income level (please check)
   _______ Less than $10,000
   _______ $10,000 to 19,999
   _______ $20,000 to 29,999
   _______ $30,000 to 39,999
   _______ $40,000 to 49,999
   _______ More than $50,000

II. Family

8. Tell us the total number of people residing in your home ___________
   a. The number of adults _________________
   b. The number of biological children __________
   c. The number of kinship children ____________

9. Tell us your relationship to the child(ren) in kinship care (please check)
   _______ Grandparent
   _______ Aunt / Uncle
   _______ Cousin
   _______ Brother /Sister
   _______ Other, describe your relationship _______________

10. Tell us the type of placement (please check)
    _______ Child (ren) was adopted by me
    _______ Child (ren) is under guardianship with me
    _______ Child (ren) is under foster care placement with me
    _______ Child (ren) is under a family placement with court or agency involvement
    _______ Other, describe the placement type ____________________________

11. Tell us how often you have contact with the child (ren)’s parent(s) (please check)
    _______ Never
    _______ At least once a year
    _______ At least twice a year
    _______ At least once a month
    _______ At least once a week
    _______ At least once a day
    _______ Other, specify ________________________________
**Family Support Scale (FSS) (Dunst, et al., 1994)**

**[ITEMS LEFT BLANK]**

Listed below are people and groups that oftentimes are helpful to members of a family raising a young child. This questionnaire asks you to indicate how helpful each source is to your family. **Please circle** the response that best describes how helpful the sources have been to your family during the past 3 to 6 months. If a source of help has not been available to your family during this period of time, circle the NA (Not Available) response.

<table>
<thead>
<tr>
<th>How helpful has each of the following been to you in terms of raising your relative’s child (DURING THE PAST 3 to 6 MONTHS) :</th>
<th>Not Available</th>
<th>Not at all helpful</th>
<th>Sometimes Helpful</th>
<th>Generally Helpful</th>
<th>Very helpful</th>
<th>Extremely Helpful</th>
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</table>
**Family Resources Scale** (FRS) (Dunst et al., 1988), part 1 of 2

[ITEMS LEFT BLANK]

This next set of questions is designed to assess whether or not you or your family have adequate resources (e.g., time, money, etc) to meet the need of the whole family as well as the needs of individual family members. For each item, **please circle** the response that best describes how well the need is met on a consistent basis in your family (from one month to the next month).

<table>
<thead>
<tr>
<th>To what extent are the following resources adequate for your family:</th>
<th>Does Not Apply</th>
<th>Not at all Adequate</th>
<th>Seldom Adequate</th>
<th>Sometimes adequate</th>
<th>Very adequate</th>
<th>Almost always adequate</th>
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Appendix J

Mixed Methods Diagram

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Appendix K

Descriptive Caregiver Case Studies

Case # 1

Rae is a 67-year-old grandfather caregiver. He is married and together with his wife is raising their daughter’s three-year-old son. They are also raising their own son who is a senior in high school and graduating in May 2010. The interview was conducted in the family’s home in a central section of the city. The family’s home, like the rest of the neighborhood, is an older home. Rae’s home and yard were very neat and well-maintained. The exterior of the house looked recently remodeled. The interior of the home was equally impressive with lovely hard wood floors throughout the living room and dining room. The furnishings in the home were contemporary. Rae shared with the researcher that he liked to do home maintenance and repair projects and had done many of the home’s repairs and improvements himself.

He stated he was retired and was the primary caretaker for their grandson. During the interview, it seemed obvious from the number of interruptions by his grandson, that the grandson was use to receiving a lot more attention from his grandfather. With each interruption, Rae would simple say, “He [the grandson] just wants to play.” Rae talked freely about his family’s decision to take his grandson from his 21-year-old daughter. He said that neither he nor his wife approved her lifestyle and from the very beginning of his grandson’s life they had concerns. His daughter chose to live an unstable life with frequent and unplanned moves and friends that were not responsible or employed. Rae stated from the very beginning the baby would visit his home and the baby was always sick and dressed improperly for the weather. He stated if they would
buy the baby items like shoes and these items would be missing or misplaced the next time they saw the baby. After one particular visit with his grandson, Rae said he became frustrated and told his wife he was going to go get the baby. They went to get the baby from their daughter and have had him ever since. Soon after getting the baby, they hired an attorney and received guardianship of their grandson. Rae said there are no plans for their daughter to again parent her son, but she is allowed to see him whenever she wants. Rae said the guardianship requires his daughter to show she can be a responsible parent to her parents and also the court system before she is allowed to parent her son again.

During the interview, the daughter was in another room watching cartoons with her son. Rae said his daughter wants to be a boy and has difficulty being stable. She moves frequently and abruptly. He said she had just returned to town from Chicago. Rae said his daughter and his wife regularly clash over the daughter’s lifestyle choices. Rae stated both maternal and parental family members assist with his grandson. The primary legal and physical custody of his grandson lies with Rae and his wife. However, the grandson’s father and the father’s family were also active in the child’s life. If Rae and his family need to take a break or have help, the father and paternal grandmother are always willing to help. Rae stated his grandson was doing well, and his family was able to provide for all his grandson’s needs.
Case # 2

The researcher interviewed Lin at the program site because Lin felt it would be quieter than her home. She also joked about wanting an excuse to get out of the house. Lin is a 65-year-old widow raising her 12-year-old grandson in a blended, multiple-generational household. She lives in the home with her grandson and several other family members including an adult daughter and that daughter’s two children (ages 12 and 3 years). Additionally, Lin’s pregnant 19-year-old granddaughter lives in the home with her six month old baby and the second baby due in April 2010. Lin was the legal guardian of her 19-year-old granddaughter from for several years. While she is responsible for her 12-year-old grandson, she does not have guardianship or any other legal relationship to provide care for her grandson. She stated she has just “manipulated” the system to make it work for her family.

The blended family provides for separation of roles. Lin identified her daughter and herself as parenting in partnership with her daughter taking on more of the father role and her taking on more of the mother role. Lin is on disability due to physical injuries and her daughter works outside of the home. Lin said she is responsible for the primary care of the children and her daughter supports her and provides the discipline. She stated she must be the task-master ensuring the older children get to school and provide full-time care to the three year old. Lin describes her 19-year-old granddaughter has a pain in the neck and the source of much frustration. She describes her as lazy and oppositional. The 19-year-old pregnant mother of one will not even care for her own child because Lin says she cannot handle the “mess” her baby creates.
Lin talked about most of her support coming from the adult daughter that shares her home. She reported there was little support from other family members, friends, or other sources. Like other caregivers, Lin suffered with a number of physical ailments.

Lin’s son is the father of her 12-year-old grandson. Her grandson’s mother is not allowed to have contact with the grandson, and his father only had sporadic contact. Several months after the research interview, Lin’s son, the father of her grandson, was found dead in a family member’s garage. Lin called the program coordinator and told her that her son been missing for several weeks, and it was believed he had been in the garage for most of that time. He died of an apparent suicide. The family planned to begin counseling to deal with the loss. The program coordinator referred the family to a local counseling agency that works with her program and has provided in-service trainings to program participants.
Case # 3

The researcher interviewed Jae at a local social service agency serving urban Native Americans. Jae, a 79-year-old African-American, requested his interview be conducted at the Native American site because he worked there a few hours a week. Jae is retired but has variety of activities he participates in including his part-time job. Jae is raising his 12-year-old grandson with his wife. He also states that since April 2009 he has been primary caretaker for his wife after she suffered a stroke. He jokes about having to care for both his wife and his grandson since her stroke. Jae and his wife have been married for more than 60 years celebrating their 60th wedding anniversary in August 2009. The couple has six children, 28 grandchildren, and 14 great grandchildren. Most of their children and their children’s children reside in the same city with them. Jae said his family is very close and very supportive. His home serves as the hub or meeting place for many family activities.

In addition to family providing support, Jae mentioned his church and church family as a source of support and resources. He shared how his church has provided travel and educational activities for his grandson. Moreover, it is through the church network that he has located a variety of services for his family. For example, he was able to find a church member to help clean his home following his wife’s stroke. Jae said he pays the church member a small amount to clean several times a month. Similarly, Jae was able to find a church member to offer piano lessons to his grandson. Jae said his family and social network are to provide for most of his grandson’s needs.
Case # 4

Lee, 58-year-old Native American, is raising her four-year-old great nephew. She also has two of her biological children in the home. Her adult daughter is 21-years-old and helps her mother with the nephew and with Lee’s 15-year-old special needs son who also resides in the home. Lee is divorced and does not work outside of the home due a physical disability.

Lee is one of five sisters who all are caregivers to either grandchildren or other child relatives in their family. All five sisters are also active in the program being studied. Lee reports the sisters are all very close emotionally and talk on the phone every day. The sisters also are involved in several activities in the community together including the program and a center serving urban Native Americans. The sisters are also politically active especially Lee’s oldest sister.

Due to a scheduling conflict, the researcher was unable to interview Lee at her home. However, the researcher was able to see the home, a two level town home. Lee and her family reside in an upper income neighborhood in a newly developed area of the city. She told me the townhomes were approximately ten years old. Because of the scheduling conflict, the interview was conducted the same afternoon at an urban Native American center near the city’s downtown.

Lee has cared for her nephew since he was two days old. Her niece, the mother of the nephew, was and still is chemically dependent. Because of the niece’s addiction, the family with the niece’s support decided it would be best if Lee raised the child. Lee stated before the baby was born she received a notarized statement from the niece giving her custody of the child. Once the child was born, Lee said she went to the hospital to get
the baby with the notarized statement. However, the same day she picked the baby up from the hospital the police came to her home with a pick-up order for the baby. The baby had tested positive for drugs. Lee and her nephew were not home at the time the police arrived there because they were visiting her sister. Through tears, Lee described her own children being at home while the police, guns drawn entered and searched the home looking for the two-day-old baby. Lee said she hid out at her sister’s home for several days until she could talk social services into allowing her to keep the baby and to withdraw the police pick-up order. Lee now has guardianship of her nephew, but she was visibly shaken recounting the police incident which occurred nearly four years earlier.
Case # 5

Mia is 62-year-old Caucasian raising her 18-year-old autistic grandson. They live in an older, working-class neighborhood in the city known for its historically ethnic enclaves. Some sections are still described by names such as “Little Italy” or “Poland”. The properties in this grandmother’s neighborhood are a mixture of single family homes and converted single family homes now functioning as duplexes or other multi-family houses. Mia has lived in her duplex housing for more than 17 years. Her home consists of a main or first floor unit where she and her grandson live. The basement or the second unit is occupied by two Mexican-American males who have rented this unit for more than five years. The grandmother reports they are great neighbors because they are very quiet and rarely at home due to long work hours.

The physical home is older like many of the other homes in the neighborhood and in need of repair. The grandmother’s unit is very small and does not seem to have clear partitions between each room. The living room blends into another room which in turn blends into a kitchen area. There are no clear walls around the bedroom which is located between the living room and the kitchen areas. The current bedroom could be considered a dining room as it is positioned between the living room and kitchen areas. There is no clear indication that there is a bedroom in the home. There are the three rooms and bathroom and then two separate porch-like areas at the back of the house which are both used for storage.

The grandmother shares the bedroom area with the 18-year-old grandson. At one point, the larger of the two porch-like areas in the home was converted into bedroom for the grandson, but this sleeping arrangement did not last long. The grandson no longer
sleeps in the porch area. The researcher viewed the former bedroom-porch area. This area currently was so packed with items that the researcher could barely see the bed underneath the mound of items.

This grandmother openly shares the reason for being the sole caretaker of her grandson. Her grandson came to live with her when he was 7 years old following abuse allegations against his biological father. This grandmother said she was not allowed to have contact with her daughter (the mother of her grandson) or her grandson because the biological father did not like her and did not want her intervening in their lives. She suspects he also abused her daughter. Her grandson was placed in foster care in a neighboring state without her knowledge following allegations of child abuse. Reports from the child protection agency indicate her grandson was removed from his parents after he came to school with whip marks all over his body, and it was alleged that his father had beat him with a horse whip. The grandmother states she would not have found out her grandson had been abused and placed in foster care if it were not for another one of her daughter’s reading mail belonging to her grandson’s mother. The letter stated the parents would have their parental rights terminated to their child (her grandson) if they did not comply with court orders. Upon receiving this information, the grandmother said she hired an attorney to help find her grandson and to gain custody of him. It took several months to locate her grandson and to get custody because her grandson was in another state.

The grandmother reports once her grandson was placed in her custody, it took even longer to get guardianship. The grandmother stated the courts did not want to terminate her daughter’s parental rights because they felt the daughter was also a victim
of abuse. The grandmother’s daughter died from cancer several years after the grandmother received physical custody of her grandson. Following the daughter’s death, the court proceeded with terminating the biological father’s rights. The grandmother currently has legal guardianship on her grandson. The grandson has two younger siblings, one currently living in a group home due to his out-of-control behaviors and the other child resides with the biological father. A third younger sibling died several years ago from cancer.

In the eleven years that the grandson has been with her, the grandmother reports He had made tremendous progress. Initially her grandson would repeatedly and randomly break windows in the house. He would throw objects from inside the house to the outside. He did not know how to eat with utensils or even how to blow his nose. She describes her grandson as wild and untamed when she got him. The grandson can now groom himself and attends special education classes in high school. He is preparing to graduate from high school in May 2010, and this is quiet worrisome for the grandmother. She does not what he is going to do when he is no longer in school. Her grandson is able to work with supervision. The grandson can not be left home alone and requires a “babysitter”. The grandmother pays a younger, male, teenage neighbor to babysit her grandson if she has meetings or errands.
Case # 6

Mee is a 63-year-old Native American great aunt caring for two of her younger relatives. The children are her niece’s children, and she has cared for them most of their lives. Mee began babysitting for her niece while her niece worked. When her niece had a second child, Mee continue to help care for the children while her niece continued working. Eventually the niece left the children with Mee full-time. However, the niece has been committed to the financial needs of her children. The niece works providing financial support and insurance for her two children. The niece visits the children often and assists with any of their needs including school visits or transportation.

The researcher met Mee at a local center providing services for Native Americans. Mee is a long time community activist and been recognized for her efforts to address poverty, homelessness, and other issues related to families. Mee recently received both state and city recognition from her activism and for being a caregiver. She also very active with the center’s programming and formerly worked for the center.

Mee describes her support system as being her sisters. They are very close and talk every day. Her sisters are also active in the center and most are also caregivers to grandchildren or great nieces and nephews.

Mee is a very active person and involved in a variety of activities in the community. Surprisingly, Mee spends approximately ten hours a night, every night receiving home dialysis. Mee is a diabetic and currently disabled due her diabetes. She discussed remaining active in spite of her medical issues. The children in her are thriving, and she is very proud of them. Mee’s family was recognized for being an outstanding family.
A person’s childhood experiences and particularly their family relations influence their parenting according to Sia, a 50-year-old grandmother raising five grandchildren full-time. Sia and her husband have differing views on family, in part, because she was raised in a loving family and her husband was not. Sia and husband are raising her daughter’s five children. They also care for another of her daughter’s children on a part-time basis which includes daily visits. Sia’s daughter’s sixth child lives full-time in a foster home because of his behaviors, but he spends three to four hours at her home daily.

Sia reported she and her husband are committed to giving her grandchildren the best life possible. While her husband is actually a step-grandfather to her grandchildren, he considers himself their grandfather. She says her daughter does not know how to be a parent and has made several attempts to parent. The oldest grandchild, a boy, has not been willing to return to his mother during her attempts to parent. The other, younger children have all been moved in and out of Sia’s home. Sia currently has guardianship of all six of her grandchildren. Her daughter is involved in her children’s lives and often visits them daily. The children even have weekend visits with their mother.

Sia considers her husband as an invaluable support in raising their grandchildren. She noted they can often handle any issues about the children. Her daughter is also helpful. Sia relies on her sister who lives out of town for emotional support. Other support comes from friends and community contacts. Sia said the local public librarians have been wonderful with her grandchildren. The librarians will engage the children in activity to give Sia a break. Also, school staff have been wonderful in supporting her family and seeking any services that will be helpful.
At one point, Sia and her husband were caretakers at different times for her mother and her father. She describes driving out of state, over a four-hour drive, every weekend to care for her ailing mother. After her mother’s death from cancer, Sia and husband moved her father to their home to care for him because he had Alzheimer’s disease. Sia laughs as she described being told she was part of the sandwich generation, a generation of caregivers caring for both parents and children or grandchildren.

The death of her parents within two years of each other was devastating for Sia. She stated her father’s death was particularly difficult because she was a “daddy’s girl”. Because of the way he was raised, her husband did not understand her grief. He thought Sia should be able to move through the grief sooner. Sia stated she was not sure if it was grieving or if she was truly depressed, but she sought medical assistance. She describes taking the children to school and climbing back in bed because she did not feel like doing anything. Sia says her doctor who prescribed her medication for depression which she said helped, but she asked to be taken off the medication after six months. She did not want to be on medication. Sia said she also attended a grieving support group which helped her depression. This depressive episode was several years ago, but Sia said she still has days where she wants to be left alone. Sia also reported having other medical issues including high blood pressure and high cholesterol both controlled with medication. She also suffers from what may be permanent memory loss as the result of a stroke she suffered several years ago.
Case # 8

Lia, 66-years-old, is currently caring for four grandchildren. The researcher met her at her home in a higher income section of town. Lia has lived in the neighborhood for several decades. The home, a duplex, is spacious and nicely furnished.

Lia’s grandchildren came into her at care separately. She was raising her daughter’s two sons for several years before the daughter had two more children, two little girls. Lia’s daughter was having some difficulties in life which prompted her to care for her two grandsons initially, and her daughter was eventually incarcerated prompting her to take her granddaughters’ into care. Lia was not prepared to take on the girls but felt she had no choice when one of her grandsons said he would take babysitting and CPR classes, so that he could help care for his little sisters. Lia said she knew she had to take her granddaughters after their brother had expressed such commitment. Interestingly, it was this grandson’s CPR training that saved Lia from choking to death several years later, and he was recognized for his heroic efforts that saved his grandmother’s life.

Prior to raising four grandchildren, Lia was divorced and living alone and running her own business. She still manages her company while juggling the needs of four children including school visits, sports, volunteering, and church. Lia talked about the change raising four children has brought her life. Her social life is focused around the children and their activities. She is still close to her friends, but does not have the time to socialize with them. Additionally, most of her friends are not still raising children. Lia said her friends support her and will attend some of the children’s events.

Lia said her greatest support comes from her son. However, he has his own family and career, so she does not want to overwhelm him. Lia said she does not have
any other relatives or close friends that can help with the children. The children’s
mother, due to her incarceration, is unavailable. Her grandsons’ father is unavailable and
her granddaughter’s father is deceased.

One of the greatest challenges for Lia has been going from one income for one
person to sharing the same income with five people. Lia admitted to struggling
financially to support her family. In addition to needing to stretch her budget to meet the
needs of a family five, Lia also needed to stretch her time. Lia felt there were not enough
hours in the day for both working and single parenting. Several years ago Lia and her
grandchildren were recognized for being an outstanding family.
Case # 9

Raising two active grandsons has been challenging for Dee. She shared this information with the researcher during an interview conducted at the program office. Dee wanted to conduct the interview in a place quiet without interruptions. Dee is a 56-year-old, divorced, African-American grandmother with significant medical issues. Dee counts her mother has one of her greatest sources of support. While they do not share a home, Dee and her mother are active “co-parents”. Both of Dee’s grandsons have behavioral issues and have been diagnosed with Attention Deficit with Hyperactivity Disorder (ADHD), thus, additional support is needed. School has been an on-going issue with the boys. Dee has asked the program coordinator to attend school meetings with her to provide support and information.

Dee became full-time parent to her grandsons when her daughter, their mother decided she could not parent them. She has had her grandsons most of their lives, and she has adopted both boys. There are two different fathers for the boys, but only one father visits. At the time of the interview, Dee’s daughter had recently moved back to town and was pregnant with her third child, a girl. The immediate plans were for Dee’s daughter to raise the baby.

Dee is a relatively young grandmother. She is, however, disabled and unable to work. She shared that much of her disability is due to a violent assault by her ex-husband. Dee’s ex-husband was a professionally trained martial artist. It was during an argument soon after their marriage that he attacked her breaking several bones. Dee has had numerous surgeries over many years to address the damage from the assault. She
also suffered additional injury when she tripped over her grandson’s toys damaging both her shoulders.

In spite of her own medical issues, Dee meets the needs of her grandsons and keeps them involved in a variety of school and community activities. Dee discussed the financial difficulties in caring for her two grandsons. She is stated she is resourceful and uses community resources to help stretch the family income. Dee talked about using a food program called Angel Food, which allows families to purchase items in bundles at reduced price. Dee discussed the art of stretching food for a family three to last at least one month or longer.
Case # 10

Although not traditional retirement age, Bae at age 54 years was already retired. He was on disability due to severe back problems. The researcher interviewed Bae, a married Hispanic grandfather, in his mid-town home located in an older neighbor. His home looked recently remodeled with new looking siding on the exterior. Inside the home, the wood floors looked new or newly refinished and the wall paint looked fresh. Bae stated his family had just moved into the home.

One reason for the recently move was to be next door to his daughter and her family. It eventually became evident that Bae’s family was a blended family. It was not until the end of the interview that the researcher was able to connect all the children and grandchildren. Bae is currently married to his second wife, and they do not have children. His first wife had one daughter when he married her. Bae refers to his ex-wife’s daughter as his daughter. He also had a daughter with his first wife. He helped raise both daughters, and they both refer to him as their father. He now lives next door to his daughter. And, the step-daughter had just recently moved from Texas to be close to Bae and her children. She was in the home during the interview. Bae and his wife are raising her three children. Thus, Bae is actually grandfather to three of the six children and step-grandfather to the other three children. His wife is step-grandmother to all six of the children.

The family is continuing to change. Bae’s wife’s nephew who has Spina Bifida recently joined the family and would be staying with them for an unknown period of time. The child is in a wheelchair, and, since the house was not wheelchair accessible,
Bae had to carry the child in and out of the house. He was also responsible for getting the child on the bus in the morning and taking the child off the bus in the evening.

Bae and his wife share the child caring responsibilities. They also received assistance from their daughter. Bae’s wife was present for the interview and often interjected comments. The couple referred to more formal services used by their family. Their resource needs were met through various social service agencies and religious organizations like churches. They discussed their oldest granddaughter’s involvement with volunteering at a local church. The same granddaughter is graduating in May 2010, and she will be the first in her family to do so. Both Bae and his wife stated how proud they were of all she has accomplished.

During the interview, the researcher met two of the grandchildren. One granddaughter was home from school because she injured her ankle playing sports, and the oldest granddaughter was home because she had a reduced course load her senior year of high school. She used some of her free time to volunteer at the local church.
## Appendix L

### Case Comparisons Phase II and Phase III

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<tr>
<th>Case Number/Name</th>
<th>Interview Statements</th>
<th>Survey Responses</th>
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| 1 / Rae (Spouse completed survey) | Rae identified his wife and the child’s paternal relatives as support  
Rae indentified very few resources used  
Rae identified major health problems; no mental health problems | FSS noted spouse extremely helpful; own children generally helpful  
FRS noted most resources very adequate or almost always adequate  
GHQ noted physical and mental problems a little of the time |
| 2 / Lin | Lin identified one daughter as her support; limited support from anyone  
Lin identified financial and community resources used  
Lin identified both physical and mental health problems | FSS noted own children generally helpful; others were sometimes helpful; groups and clubs very helpful  
FRS noted time for self, friends was seldom adequate; money sometimes adequate  
GHQ noted physical health and mental problems most of the time |
| 3/ Jae | Jae indentified his family; his children including child’s parents; his wife’s sister as support  
Jae indentified financial and medical resources, school and community resources used  
Jae indentified tremendous medical problems; no mental health problems | FSS noted spouse, friends, own children as extremely helpful  
FRS noted most services very adequate  
GHQ noted physical health problems some of the time; mental health problems none of the time |
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<th>Problems Identified</th>
<th>Helpfulness</th>
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<td>Lee identified her daughter and her sisters as support</td>
<td>FSS noted own children as extremely helpful; relatives as very helpful</td>
<td>Lee identified financial, medical, and community resources</td>
<td>FRS noted most resources very adequate; time for self sometimes adequate</td>
<td>Lee identified both physical and mental health problems</td>
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<td>Mia identified the program coordinator, her friends, the babysitter and his family as support</td>
<td>FSS noted friends and parent group as generally helpful</td>
<td>Mia identified financial, medical, and community resources used</td>
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<td>Mia identified physical health problems and short-term mental health problems</td>
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<td>Mee identified her family (sisters, son, niece) as support</td>
<td>FSS noted own children and relatives as very helpful</td>
<td>Mee identified community resources used</td>
<td>FRS noted money and times sometimes adequate</td>
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<td>7 / Sia</td>
<td>Sia identified her husband as primary support; her daughter (mother of the children); sister as support</td>
<td>FSS noted spouses as extremely helpful; friends, own children as generally helpful</td>
<td>Sia identified medical assistance, community resources; does not receive financial assistance</td>
<td>FRS noted most resources were very adequate; money for self, entertainment sometime adequate</td>
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<td><strong>Lia</strong></td>
<td>Lia identified her son as her primary source of support; Lia identified financial difficulties; has limited available time</td>
<td>Lia identified several health problems; no mental problems, some physical health problems, dental problems</td>
<td>FSS noted own child as extremely helpful; FRS noted money, limited job, time for rest or self sometimes adequate; Money for self, entertainment; time to socialize or keep in shape seldom adequate; GHQ noted physical problems some of the time; emotional problems a little of the time</td>
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<td><strong>Dee</strong></td>
<td>Dee identified mother, close friend, and other grandparents as support; Dee identified financial needs as primary; Dee reported a number of significant health problems issues; 10 surgeries in 20 years; no mental health problems</td>
<td>FSS noted mother, friends, parent groups as extremely helpful; FRS noted money to buy necessities, pay bills, supplies public assistance as sometimes adequate; GHQ noted physical health problems most of the time; mental health problems none of the time</td>
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<td><strong>Bae</strong></td>
<td>Bae identified his wife, his daughter as support; Bae identified financial, medical, community resources used; Bae identified physical health problems; no mental health problems</td>
<td>FSS noted spouse extremely helpful, relatives very helpful; own children sometimes helpful; FRS noted resources seldom adequate; GHQ noted physical health problems all of the time; mental health problems most of the time</td>
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Appendix M

Means and Standard Deviations

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Family Support Scale
Likert Scale 1-5 (1 = Not at all helpful; 5 = Extremely helpful)
## Family Resource Scale

Likert Scale 1-5 (1 = Not at all helpful; 5 = Extremely helpful)

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General Health Questionnaire – Short Form 12

Likert Scale 1-5 (1 = Not at all helpful; 5 = Extremely helpful)

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