

African American Grandparents Raising Grandchildren: Implications for Social Work

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Abstract

The study explored the experiences of eight African American grandmothers residing in rural areas caring for their grandchildren, while suffering from chronic health issues. The research examined the health, physical functioning, well-being, social support, and resources of these grandmothers. The grandmothers reported challenges and needs which included their own health issues, financial difficulties, limited support, transportation difficulties, and childcare concerns. Implications for the study were that developing health education programs and other formal supports focusing on health, resources and social support have a positive influence on grandmother's perceptions of their changing health and support.

Keywords: grandparent caregivers, kinship care, rural grandparenting, grandparent health

Introduction

Over the past decade, the number of children being raised by grandparents has increased significantly (Usita, Hovell, Shakya, Stark, & Liles, 2008; Ruiz, 2008). Approximately 6.4 million children live with their grandparents. Twenty-three percent of African American grandmothers are caring for at-least one grandchild (U.S. Census data, 2011). Frequently, guardians are in this role due to circumstances in which their own adult children are unable or unwilling to perform their role as qualified parents to their children (Cox, 2000). The role of the grandparents caring for their grandchildren occurs due to a family crisis. Changes in family life, related social trends, and child welfare policies may account for some of the increase in grandparents raising grandchildren. Social forces that appear to have contributed to the incidents of grandparents caring for grandchildren include child welfare involvement, placement in temporary foster care, teen pregnancy, divorce, poverty, unemployment, substance abuse, mental illness, HIV/AIDS, incarceration of parents, parental incapacity, and death (Ruiz, 2008; Erbert, 2008).

The purpose of this qualitative phenomenological study was to explore the experiences of eight African American grandmothers residing in North Carolina caring for their grandchildren, while suffering from chronic health issues. The research examined the lived experiences of the grandmothers specifically their health, physical functioning, well-being, social support, and resources.

Theoretical Framework

The theoretical frameworks that guided the study were Wellness theory (Witmer & Sweeney, 1992) and Family development theory (Hill & Rodgers, 1964 as cited in Laszloffy, 2002). The Wellness approach to health is applicable to diabetes as well as other health issues as chronic health issues have an impact on all areas of a person's life (Hattie, et al., 2004). Family development theory examines stressors in the family life cycle with individuals as well as the child and family caregiving process (O'Brien, 2005). Both frameworks were chosen as the theoretical base for the study because they address family changes over time as well as positive versus negative family accommodation to stress and illness.

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Wellness theory

Wellness theory is the premise that the thoughts and feelings we experience directly affect our physical functioning and wellbeing, just as our physical functioning directly affects our emotional states and thought processes (Hattie, et al., 2004). The wellness perspective recognizes the extremely strong and important relationship between body, mind and environment, and health and wellness (Schriver, 2010). The unit of attention is the physical, mental, spiritual, and social well-being of the individual, family, and or specific population involved in the intervention process. Wellness theory recognizes that the development of the wellness state is an ongoing, life long process. Quality of life, rather than the length of life, is of primary concern. Wellness is defined as a state of harmony, energy positive productivity, and wellbeing in an individual mind body emotions and spirit. The state of wellness also extends to the relationships between the individual and his or her family and other interpersonal connections as well as the relationships between, the person and his or her physical environment, social, clinical, ecology, religion, health, and stress management (Hattie, et al., 2004).

Further, wellness supports the perspective that health is viewed in a broad sense that encompasses interrelationships among physical, mental, social, emotional, and spiritual components. This approach to health is particularly applicable to diabetes as well as other health issues as chronic health issues have an impact all areas of a person's life, work, family, social, and recreational (Hattie, et al., 2004). The second theory that guided the study was Family development theory.

Family development theory

This theory is one of the conceptual foundations in family science. Family development theory suggests that each stage of the family is marked by a different set of norms or expectations (Hill & Rodgers, 1964 as cited in Laszloffy, 2002). It is important to recognize that concurrent with roles played at any stage of family development, there are also roles that family members play within the normative venue of other institutions such as work and education (O'Brien, 2005).

Family development theory examines stressors in the family life cycle with individuals as well as the child and family caregiving process. The theory delineates a normative order of developmental processes for individuals and families. Divergence from this order may lead to stress. The developmental changes that occur within the various family stages and the resulting individual expectations of these stages are important to understanding the family. Family development theory supports the framework that individuals and their families become healthier in their relationships and interactions as they mature and grow. It is assumed that families will increase their positive productive interactions and behaviors as time goes on.

In fact, the theory emphasizes changes in role expectations in the family over time as a function of changes in family membership, individual developmental needs, and direct societal expectations. Two key tenets of Family development theory are that individuals and families construct their expectations and behaviors according to family stage requirements. Furthermore, family stages have qualities that introduce life uncertainties that alter their perceptual frame for current and future behaviors and decisions. The theory predicts differences in behavioral expectations and decision-making contingencies for children and adults in the family based on differences in societal expectations (O'Brien, 2005).

Development refers to the progression through the life cycle, along with the multiple tasks and tension that need to be resolved, at each life stage. Similar to individual development, families also undergo developmental stages that require families to progressively adapt their structures and functions to the various evolving changes with members (Walsh, 2006). Family evolution is embedded in historical, social, and cultural contexts, and expressed through the narratives that are derived from families, their individual members, and the larger social cultural worlds. These stories organize and prescribe the multiple ways in which to cope with the challenges posed by development, both in individuals and families. Issues that arise in intergenerational families are often defined by transitions within the life cycle. These transitions may involve births, illnesses, deaths, as well as the adjustment of grandparents becoming parents for a second time (Spira & Wall, 2006).

The goal of research into individual and family development is to understand the processes by which individuals and families adapt successfully to the challenges that confront them, particularly when considering non-normative roles such as raising children in late adulthood.

Family development theory offers a different way of thinking about and studying families because of its emphasis on the evolution of families over time, the developmental tasks facing families and their individual members, and the recognition of family stress and illness at critical periods of development (Duvall, 1988). As a result, Family development theory may provide implications of parenting again and life cycle issues; specifically, examining the stressors of second time around parenting issues. The grandmothers presented in this study are not only caring for a grandchild but doing so with a chronic health issue. The health issues affect family issues across the life span in terms of intergenerational caregiving in the family. The research is applicable and will strengthen Family development theory in considering this phase of family development (individual life cycle health issues and parenting a second time around).

Methodology

Design

An exploratory phenomenological design was used involving collecting, and analyzing the data. Through phenomenology, the accounts of events of caregiving, experiences and challenges were understood. This study sought to expand human service professionals' understanding of intergenerational caregiving, specifically parenting again from the grandmother caregivers' perspectives. It also allowed grandmothers the opportunity to share their stories, which permitted a more personal view in their world.

Sample

A local grandparent's support group granted permission to recruit the participants from their program. At one of the support group meetings, the study and the sample criteria were explained. The grandmothers in attendance were given a recruitment flyer and were requested to contact the number provided if they believed they met the criteria and were interested in participating in the study. Flyers describing the study as well as the criteria were also disseminated to local public libraries and grocery stores in an attempt to recruit participants. The requirements for the study included being an African American grandmother between the ages of 35 and 65, caring for at least one grandchild, being diagnosed with a chronic health issue and residing in a rural community in North Carolina. Purposeful criterion-based sampling, convenience sampling as well as snowball sampling were used in selecting the eight participants for the study. All eight participants were from different rural communities within two counties in North Carolina. A sample size of eight participants provided enough information to reach a level of saturation of the data. Saturation was reached when participants began to report reoccurring information throughout the study and themes began to emerge (Patton, 2002).

All of the grandmothers had been diagnosed with chronic health issues and suffered from more than one illness. Four of the grandmothers suffered from diabetes, four had high blood pressure, three had arthritis, one had high cholesterol, three were overweight, one had a heart condition, one was a breast cancer survivor, and one had a sinus condition. All eight women categorized themselves as Christians and reported a strong sense of spirituality.

Instrumentation/Measures

Data were collected through semi-structured in-depth interviews. These participants were asked about caregiving responsibilities for their grandchildren, their health, grandchild caregiving activities, circumstances leading to custodial grand parenting, grandmother-grandchild relationship, challenges of parenting a second time, positive and negative effects of caregiving, and resources in a rural area.

Data Analysis

In this study, the interviews were audio taped and detailed field notes were taken while listening for repeating phrases and statements. All audio tapes were transcribed into written format, within two weeks of meeting with each participant. Transcripts were reviewed several times and compared to the audio tapes to ensure accuracy. To give validity and credibility to the six themes of this study, member checking was conducted. During this second interview, the participants were given their transcripts for review. If requested, the transcripts were read aloud. While reading the transcripts aloud, listening for additional patterns continued. Participants validated that the data collected at the initial interviews were what they expressed.

The individual textual descriptions consisted of participants' verbatim statements regarding their lived experiences. The emerging textual themes consisted of the following and are listed below in the grandmother's own words: circumstances leading to care, the grandmother's health and their ability to provide care, resources, money/transportation, the parental responsibility and their social support, becoming a parent again, and their spirituality.

Table 1: Themes and Universal constituents

Theme	Invariant constituents	Sample quotations
Circumstances surrounding care	Most of the grandmothers took on the parenting role due to the substance abuse of the mother. They explained that they assumed the care of their grandchildren to prevent placement in the foster care system.	"The kid's mama was using crack and leaving the kids home; she came back when she came back" "My oldest was on drugs and on the street all the time."
Ability to provide care/health	Each grandmother was providing care to the best of their ability. They all admitted to suffering from more than one chronic health issue	"I'm tired from my heart problems and my high blood pressure. I just don't move as fast as I used to but I'm doing alright." "I have all these issues (diabetes and arthritis) and I feel bad sometimes but I do what I can with them grandkids."
Financial hardship/resources	Most of the participants reported being on a fixed income. They all stated that they were receiving some financial assistance from their local social service agency.	"I am on a fixed income. I just don't have the money. If I could I would pay to put Jawn in Prime Time." "Things are expensive. It costs a lot to raise children. I'm not proud of it but we get help from social services. We need it."
Parenting again	The grandparents had taken on the parenting role unexpectedly. They all had views of what grand parenting should be.	"Grandkids are supposed to come visit, not live with us." "I'm 64 years old. I'm supposed to be retired. Taking care of these kids is a lot of sacrifice."
Parental responsibility/social support	Most of the participants felt that it was the parent's responsibility to provide care. Most admitted to getting minimal informal or formal support.	"Help, if they helped me I could do more but I will continue to do what I need to do. My sister helps out when she can. The mama could get herself together if she wanted to. She states that she does not have a lot of support outside the church and does need anything she can get." She says, "My daughter hurt everybody. She is just selfish and, I mean, she wasn't raised like that."
Spirituality	All participants admit that caring for their grandchildren had been challenging yet a blessing. They all shared a strong sense of spirituality.	"When things get rough, I go to my favorite scripture: We learned this when I was a little girl. Trust in the LORD with all your heart and lean not on your own understanding; "It's hard sometimes. I don't always see it this way but the Pastor says God gave me a second chance. I thank God every day."

Continuing the data analysis process included reviewing the meaning units for textural themes and then assessing the textural themes for universal structures. The structural descriptions consisted of descriptions participants provided in regard to the setting or context in which their experiences took place (Stake, 2010; Mertens, 2010; Moustakes, 1994). These universal structures resulted in the following and are listed below: family obligation, determination, frustration, and resentment, a sense of loss, and coping and strength.

Table 2: Structural Themes and Invariant Constituents

Theme	Invariant constituents	Sample quotation
Family obligation	All of the participants expressed that they loved their grandchildren and it was their obligation to take care of their grandchildren.	<p>“The CPS (child protective services) they called me after they were put in jail. They wanted to give me temporary custody. I, I asked myself if I could live with myself if I didn't help take those children and the answer was no.”</p> <p>“I never made a decision to take the children. I never thought about it. I had to do it.”</p>
Determination	Each participant was determined to care for their grandchildren even though they were not in the best of health.	<p>She explained that taking care of these kids is added stress on her but she states “I will take care of these kids, I am their grandmother.”</p> <p>While clenching her hands together she states with assurance, “it tires me out sometimes but I will takes good care of them kids; yes mam.</p>
Frustration	Most of the participants verbalized a frustration with services in a rural community.	<p>“Everything is so far. We walk to the store. I depend on my sister for rides. I don't always have money to pay her. The three year old has a lot of Dr.'s appt. in town. Transportation will take us but they are always too early. They don't take me to my doctor's appointments so I have a hard time matching my sister's schedule to go to the doctor. I get stressed out trying to get to places so sometimes I don't make my appointments. Things are expensive. It costs a lot to raise children. I'm not proud of it but we get help from social services. We need it.”</p> <p>“We have a car but everything is so far away. We have to go to town to the doctor or for any appointments. Sometimes I just don't feel like the long ride.”</p>
Resentment	Each participant reported that they received minimal support from family. Each specifically resented the mothers for the lack of support they provided.	<p>“The mama doesn't really help. She'll have to deal with that when it's time for her to meet her maker.”</p> <p>She says her daughter hurt everybody. “She is just selfish and wasn't. I mean, she wasn't raised like that.” She felt compelled to add that she will do what she has to do with or without her daughter.</p>
Sense of loss	All of the participants were caring for their grandchildren unexpectedly. They all expressed the losses associated with their new role.	<p>“I'm 64 years old. I'm supposed to be retired. Taking care of these kids is a lot of sacrifice.</p> <p>“I don't have money to go to lunch on Saturdays with my club members. I can't even pay the dues. I used to make excuses all the time; now they just, just don't even ask anymore.”</p> <p>“We don't have private time. My marriage is not like it was. It's been hard for us. At this age it was supposed to be just us two. Now it's us and the children. They, they just take so much of my time. I don't know when was the last time I bought something for myself or gone out to eat with my husband. I get frustrated sometimes.”</p>
Coping and strength	All of the participants reported that God is their one constant source of strength and use the power of prayer as a coping mechanism.	<p>“I have relied on my trust and faith in God.”</p> <p>“My granddaughter is why I'm here. My daughter went to heaven but I have a part of her. My granddaughter was placed with me for God's purpose.”</p>

Results

The results of the study support the body of scholarly findings cited in the literature relevant to the experiences of African American grandmothers with chronic health issues raising their grandchildren in rural communities (Baker & Silverstein, 2008; Bullock, 2004; Ruiz, 2008; Minkler & Fuller-Thomson, 2000; Gould & Kendall, 2007; Hughes, et al., 2007).

All of the participants in this study had assumed the additional responsibility of care for at least one grandchild. The findings were consistent with studies that African American relative caregivers assume the role of caregiving for their relative children due to substance abuse, death of the parent, homelessness, parental incarceration, mental illness, HIV/AIDS, and poverty (Ehrle, Geen, & Clark, 2001; Simpson & Cornelius, 2007). For this study substance abuse was the main factor in the grandmothers taking on the parenting role. They were providing care due to their adult children's involvement with substance abuse and the child welfare system and not wanting their grandchildren to enter or remain in foster care. The participants felt a strong family obligation to prevent placement in the foster care system. Social support and spirituality were also recurring themes. Most of the findings are consistent with other studies that report many challenges for grandmothers including chronic health issues, a lack of resources in their rural communities, and limited social support.

Even though the grandmothers in this study indicate connections between their level of social support, fiscal resources and health, they did not report any impacts on the quality of care they provided to their grandchildren. These findings are unexpected and contribute to the existing research about the phenomenon of African American grandmothers with chronic health issues raising grandchildren in rural communities.

Implications for the social work

Although most of the findings are consistent with other studies that report many challenges for grandmothers including chronic health issues, a lack of resources in their rural communities, and limited social support, this study found that their health did not impact their caregiving roles. Wellness theory states that the thoughts and feelings that a person experiences directly affects their physical functioning and well-being, just as our physical functioning directly affects our emotional states and thought processes (Schriver, 2010). This theory of health is particularly applicable to chronic health issues since they can have an impact on all areas of a person's life, including work, family, social, and recreational (Hattie, et al., 2004). The state of wellness also extends to the relationships between the individual and his or her family or other interpersonal connections. This also can include the relationship between the person and his or her physical, social, clinical, and ecological environments (Hattie, et al., 2004). According to this theory, the stressors of parenting again can have an impact on their physical functioning. However, these grandmothers have managed this additional stress through using social support and spirituality as coping mechanisms. In fact, these grandmothers viewed their spirituality and the social support provided by their religion and their religious communities as essential coping components to their survival as caregivers.

Family development theory divides the family experiences into stages over the life span and describes changes in family structure and roles during each stage. The role expectations of being a grandparent and enacting a grandparent role follow normative behavior patterns according to an individual's life cycle timing. The normative expectation is for adults from about age 50 to 70 to experience the empty nest stage. The unexpected role gain of being a primary parent to a grandchild changes the timing of one's life course events, such as experiencing retirement and the freedom from the costs associated with child rearing. Becoming a second-time-around parent requires a recycling of family development stages (Hill, 1999) that prolongs the time one spends in the parenting stages and the time until one enters the empty nest stage.

Family development theory may provide implications of parenting again and life cycle issues; specifically, examining the stressors of second time around parenting issues. As there are many transitions and losses associated with the role of parenting again, the grandmothers must learn to adapt to their role, their changing needs and demands, as well as attending to tasks that are necessary to ensure family survival. This unique perspective that Family development theory provides has contributed to human services practitioners' understanding and ability to work effectively with families (Carter & McGoldrick, 2009). Both frameworks address life span issues and family changes over time as well as positive versus negative family accommodation to stress and illness. These grandmothers have been forced to deal with both negative and positive aspects of their caregiver role (Lumpkin, 2008).

Developing health education programs and other formal supports may have a positive influence on grandmother's perceptions of their changing health and support. Providing these grandmothers with an active role in problem solving and acquiring support and resources can be an effective coping strategy for these grandmothers.

Further research

It is important that social workers, health care professionals, educators, and policy makers gain a better understanding of grandparent kinship care providers, particularly with minority populations (Hebblethwaite & Norris, 2011; Hurme, Westerback & Quadrello, 2010; Kelley, et al., 2010; Longoria; Monserud, 2010; Postigo & Honrubia, 2010; Smith & Hancock, 2010). Based on the literature to date, it is clear that further research is needed related to rural grandmothers, particularly from an interventional perspective. Promoting the health of rural grandmothers will serve to strengthen this critical family resource (Bigbee, et al., 2011). Continued research in the areas of rural kinship care, health, and child welfare policies is crucial. The study's findings indicated several areas for future research which would provide family life programs focusing on health, resources and social support.

Conclusion

Reviewing the research on the perceived impact of chronic health issues on African American grandmothers raising their grandchildren in rural areas was important in addressing the gap in research. Additional research is needed to further understand the impact of their health issues as well as their unique challenges. Continued research in the area of kinship caregiving specifically rural custodial grand parenting and their health is vital to ensure that research, teaching, and practice are all informed by the best evidence based information.

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