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Exploring self-care practices of African American informal kinship caregivers

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Abstract

African American caregivers providing informal kinship care are vulnerable to chronic stress. Research has indicated stress increases individuals' risk for many adverse physical and mental health outcomes, including cardiovascular disease, Alzheimer's disease and depression. Given the adverse outcomes related to stress, identifying mechanisms to help these caregivers lower and manage their stress is critical to their overall health and well-being. This pilot qualitative study aimed to explore the self-care practices of 12 African Americans providing informal kinship care using a phenomenological approach. Three themes emerged: (a) behaviours to manage stress levels, (b) support network reminding caregivers to take care of themselves and (c) prioritizing my own needs. Specifically, our findings indicate that some caregivers have high-stress levels and engage in maladaptive coping behaviours. The children they cared for reminded them to take care of themselves by attending doctors' appointments or getting their nails done. Nevertheless, some caregivers prioritized their needs by participating in positive self-care behaviours, such as listening to jazz and gospel music and exercising. Prevention and intervention programs that focus on improving caregivers' health should consider the role of self-care practices.

Keywords

black; child welfare; grandparents raising grandchildren; health; mental health; stress

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1 | INTRODUCTION

Stress refers to the response of the brain and body to physical, emotional or psychological demands (National Institute of Mental Health, n.d.). The sources of stress vary, including work, school and significant life changes. This article focuses on stress related to parenting children living with relatives in informal kinship care families (e.g., grandparents raising grandchildren). Considerable research has indicated individuals who take on the primary responsibility of caring for related children often experience high levels of stress (Gleeson et al., 2016; Koh et al., 2022; Lee et al., 2016; Musil et al., 2011; Sharda et al., 2019). Chronic stress places individuals at increased risk of several serious health problems, including cardiovascular disease (CVD; Steptoe & Kivimäki, 2012), Alzheimer's disease (Alkadhi & Tran, 2015; Machado et al., 2014), depression (Wang et al., 2014) and anxiety (Daviu et al., 2019). Consequently, kinship caregivers face elevated risks for many negative outcomes related to high stress, including acute and chronic physical and mental health problems (Leder et al., 2007; Musil et al., 2011; Neely-Barnes et al., 2010). These negative outcomes indicate the urgent need for research on factors to improve kinship caregivers' physical and mental health. One approach to reducing stress applied successfully in multiple professions and populations has focused on improving self-care because self-care practices have been associated with positively coping with stress (Hotchkiss, 2018). To understand ways to improve the overall health of African Americans providing informal kinship care, this pilot study qualitatively explored the self-care behaviours of African American informal kinship caregivers.

2 | DEFINITION AND CHARACTERISTICS OF KINSHIP CARE FAMILIES

A recent 2019–2021 U.S. Census data revealed over 2.6 million children reside in kinship care (Annie E. Casey Foundation, 2020). The term *kinship care* refers to situations in which relatives or persons with strong bonds to a family are raising a child whose biological parents are unable or unwilling to do so (Annie E. Casey Foundation, 2012). Kinship care arrangements are typically referred to as either *formal* or *informal*, with the two forms varying in their extent of involvement with the child welfare system. *Formal kinship care* is the care of children by relatives under the auspices of the child welfare system; this living arrangement is also referred to as *kinship foster care* or *public kinship care* and accounts for about 9% of children in kinship care (Testa, 2017). *Informal kinship care* refers to the care of children by relatives when the care arrangement is not under the auspices of the child welfare system, and the children have not been legally adopted. Over the past several decades, kinship care has become preferred over placement of a child with nonrelatives. During this time, the number of kinship care arrangements has increased significantly, with the greatest increase in the number of informal kinship care arrangements, which accounts for approximately three-fourths of kinship care families. Several of these informal kinship care families (32%) have been investigated by the child welfare system for allegations of abuse or neglect; however, many in this group were not involved with the child welfare system (Testa, 2017). Despite the substantial growth of kinship care, the limitations of the field's current literature are underscored by the dearth of research focusing on the outcomes of children and adults involved in informal kinship care arrangements (Annie E. Casey Foundation, 2012; Testa, 2017).

The majority of relative caregivers are grandparents. However, according to the U.S. Department of Health and Human Services (2014), it was estimated that 22% of children in kinship care resided with relatives other than grandparents (e.g., aunts, uncles and siblings) or persons with a kin bond such as a godparent or close family friend. A recent analysis estimated the number of children living in kinship care with relatives other than grandparents has increased to 38% of kinship care families (U.S. Government Accountability Office, 2020). In general, research has indicated that kinship caregivers are more likely to be single, have low income and have less education than families in which at least one parent is present in the household (Annie E. Casey Foundation, 2012). Kinship caregivers are also challenged because of often experiencing unemployment (Annie E. Casey Foundation, 2012) and adverse health outcomes (Leder et al., 2007; Lee et al., 2016). Caregivers providing informal kinship care are of particular concern. According to a nationally representative study, informal kinship caregivers were more likely than caregivers providing formal kinship care or nonkinship foster parents to be older, have fewer economic resources and be in poorer physical health (Stein et al., 2014).

3 | AFRICAN AMERICAN KINSHIP CARE FAMILIES

Although kinship care is common among all races, ethnicities and cultures, most research has shown that as compared with other racial/ethnic groups, African American children are more likely to be raised by kin (Amorim et al., 2017; Annie E. Casey Foundation, 2012; Harden et al., 1997; Kreider & Ellis, 2011). For example, Amorim et al. (2017) reported that African American children were almost two times more likely to live in kinship care with grandparents than Hispanic children, three times more likely than white children and six times more likely than Asian children. Underlying these differences is the historic use of kinship care by African Americans. The goal was to overcome challenges such as racial and economic oppression (Fuller-Thomson & Minkler, 2000; Hill, 1977), and currently, many child welfare practices and policies prioritize placements with relatives instead of nonrelatives (Annie E. Casey Foundation, 2012; Williams & Sepulveda, 2019). Given the overrepresentation of African American kinship care families, an examination is overdue and imperative for this population to identify ways of reducing risk to promote positive outcomes.

4 | PREVALENCE OF STRESS IN KINSHIP CAREGIVERS

Prior research has well documented the high-stress levels kinship caregivers experience while they are the primary caregivers for children (Gleeson et al., 2016; Koh et al., 2022; Lee et al., 2016; Musil et al., 2011; Sharda et al., 2019). For example, Gleeson et al. (2016) administered the parental distress subscale of the Parenting Stress Index (PSI) to assess stress levels among a sample of informal kinship caregivers. They found that at the initial interview over 45% of the mostly African American caregivers scored at or above the 80th percentile on the PSI. Notably, Musil et al.'s (2011) study examined a large sample of grandparent kinship caregivers (i.e., 485 grandmothers), observing the caregiving patterns three times over 24 months to identify the effects of stability and change on caregiver roles. The study findings showed that compared with grandmothers not raising grandchildren or those in a multigenerational home, grandmothers who were the primary caregiver for their

grandchildren reported the highest levels of stress and worst physical and mental health problems (e.g., depressive symptoms; Musil et al., 2011).

Several factors contribute to the high-stress levels of individuals who provide kinship care. First, kinship caregivers face unique and complex challenges, such as parenting for uncertain periods, often with insufficient financial resources, while balancing potential conflicts with the child's biological parents. These challenges, whether encountered separately or combined, place kinship caregivers at significant risk for high-stress levels (e.g., Clottey et al., 2015; Gleeson et al., 2016; Lee et al., 2016; Murray et al., 2004). Research has also documented that a significant number of children in kinship care have behaviour problems (e.g., Smithgall et al., 2009; Washington et al., 2018), and children's problem behaviours contribute to kinship caregivers' stress levels (Doley et al., 2015; Gleeson et al., 2008; Smithgall et al., 2009). However, other research has suggested when compared with children living in nonkin foster care placements, children living in kinship care display greater improvements in behavioural functioning over time (e.g., Gleeson, 2017; Washington et al., 2018; Winokur et al., 2014). Additionally, Smithgall et al. (2009) found a positive relationship between children's improved behaviours and better caregiver outcomes. Despite recognizing the multiple sources of stress affecting caregivers, a gap in the literature exists regarding mechanisms and strategies to reduce stress among informal kinship caregivers.

5 | PHYSICAL HEALTH OF KINSHIP CAREGIVERS

Elevated stress levels are associated with increased physical health problems (Spruill, 2010; Steptoe & Kivimäki, 2012; Torres & Nowson, 2007). For example, several scholars and scientists have postulated that ongoing stress leads to neural degeneration and Alzheimer's disease (Alkadhi & Tran, 2015; Machado et al., 2014). Alkadhi and Tran's (2015) study found that chronic psychosocial stress could hasten the appearance of Alzheimer's disease symptoms, including changes in basal levels of cognition-related signalling molecules in persons at risk for Alzheimer's disease. Additionally, research has established the potential for stress to exacerbate CVD problems such as diabetes, hypertension and risk of stroke (Spruill, 2010; Steptoe & Kivimäki, 2012). This well-established connection between stress and poor health outcomes is especially relevant to kinship caregivers because they tend to experience high levels of stress. Also, many kinship caregivers tend to suffer from CVD (Smalls et al., 2020; Smithgall et al., 2009; Taylor et al., 2017) and overall poor health (Clottey et al., 2015; Leder et al., 2007; Lee et al., 2016; Minkler & Fuller-Thomson, 1999; Musil et al., 2011). Smalls et al. (2020) reported that 21% of grandparent caregivers in their rural sample were prediabetic, and 28% of the sample had undiagnosed type 2 diabetes. Notably, the chronic stress African American kinship caregivers experience when caring for children heightens their health risks, making them particularly vulnerable to CVD and Alzheimer's disease (Mozaffarian et al., 2015; Potter et al., 2009).

6 | MENTAL HEALTH OUTCOMES OF KINSHIP CAREGIVERS

Elevated stress levels have also been linked to mental health problems experienced by kinship caregivers (Daviu et al., 2019; Wang et al., 2014). Over the long term, kinship caregivers can experience mental health challenges, given the cumulative effect of ongoing

stress. Several studies have examined the prevalence of depression among kinship caregivers (Baker & Silverstein, 2008; Minkler et al., 2000; Musil et al., 2013; Smithgall et al., 2009). These studies have found that grandparents who have primary caregiving responsibility for grandchildren are more likely to experience depression than grandparents who have a non-caregiver role. Other researchers have also demonstrated that grandparent kinship caregivers experience anxiety at higher rates than grandparents who are not primary caregivers for their grandchildren (e.g., Dunne & Kettler, 2008; Minkler et al., 2000). However, Musil et al. (2011) also determined that kinship caregivers with positive supports reported overall fewer depressive symptoms; specifically, they found grandmother caregivers who were (a) married, (b) had greater than a high school education and (c) were employed reported fewer depressive symptoms. In addition to associations between stress and physical and mental health, research has established an association between kinship caregivers' mental health status and their physical health. For example, research has indicated kinship caregivers who report poor health report depressive symptoms frequently (Hayslip et al., 2015; Neely-Barnes et al., 2010).

In sum, substantial evidence supports that individuals providing kinship care are at risk for elevated, chronic stress and, consequently, at greater risk for experiencing physical and mental health challenges. However, despite these well-known associations and risks, very few interventions are available to reduce kinship caregivers' stress and mitigate their physical and mental health risks. A critical element in developing interventions to fill this gap is ensuring such interventions incorporate cultural factors relevant to African American informal kinship caregivers. The present pilot study has initiated the first steps in this process by qualitatively examining these cultural factors to inform the development of effective interventions to reduce stress and improve the quality of life among African American kinship caregivers.

7 | PRESENT STUDY

Despite the challenges experienced by kinship care families, many of these families enjoy positive experiences and have successful outcomes. Many kinship caregivers report joy and fulfilment in caring for their related children and believing they are fulfilling their spiritual duties by providing kinship care (Gleeson et al., 2008). Additionally, a growing body of empirical research has suggested that as compared with children in out-of-home placements with nonrelated foster parents, children living with kinship caregivers display more favourable behavioural, academic and mental health outcomes (Gleeson, 2017; Washington et al., 2018, 2021; Winokur et al., 2014). However, a few studies have suggested that compared with children in nonkin foster care, children in kinship care have increased risks of substance abuse, pregnancy and delinquency (Ryan et al., 2010; Sakai et al., 2011). Nevertheless, given the many positive outcomes and experiences of kinship care families, we posit that the kinship care family type has strengths and resources that contribute to successful outcomes and experiences. We assert that caregivers have valuable insight that can inform the work of researchers, practitioners and policy-makers to help produce additional positive outcomes. The current study was guided by one research question: What are the self-care practice experiences of African Americans who provide informal kinship care?

8 | METHOD

8.1 | Study design

This pilot qualitative study sought to better understand the experiences of African American informal kinship caregivers' self-care behaviours (Leech & Onwuegbuzie, 2009). We specifically used phenomenology to investigate how African Americans who provide informal kinship care experience and describe their self-care practices.

8.2 | Recruitment and sample

This study used a convenience sample. We recruited from two public child welfare agencies, one private child welfare agency and one Head Start program, all located in North Carolina. Participants were also recruited using flyers posted in community centres, churches, e-mail LISTSERV and social media platforms. Potential participants were included in the study if they (a) identified as African American, (b) were raising children at the time of the study who were between the ages of 5 and 12 years (children must be of a similar developmental age range), (c) resided in North Carolina and (d) were actively providing informal kinship care for a related child or children. Exclusion criteria included (a) caregivers who were 18 years or younger, (b) children who were legally under the custody of child protective services and (c) children who were legally adopted by relatives. We recruited a sample of 12 African American informal kinship caregivers providing care for one or more related children. Sample demographics are presented in Table 1.

8.3 | Data collection

To gain a better understanding of the stressors and self-care practices of African American informal kinship caregivers, we collected data over 18 months using (a) a demographic questionnaire, (b) a self-rating of overall health, (c) the Family Resource Scale (FRS; Dunst et al., 1988), (d) the PSI (Abidin et al., 2006), (e) the Behaviour Assessment System for Children-3 (BASC-3; Reynolds & Kamphaus, 2015) and (f) semi-structured interviews.

Research assistants administered a demographic questionnaire that included participants' age, income, marital status, number of children for whom they were providing informal kinship care, employment status and self-reported health information. The BASC-3 was used to describe children's behaviours and emotions; it was selected because it is one of the most widely used and recognized multimethod measures in research, clinical and school settings (Perry et al., 2018; Reynolds & Kamphaus, 2015). The adequacy of resources available to kinship caregivers was captured using FRS, created by Leet and Dunst (in Dunst et al., 1988). The FRS is a 31-item scale that assesses the adequacy of various financial, material and other resources in households with children. Items are scored using a 5-point scale (1 = *not at all adequate* to 5 = *almost/always adequate*). For this study, Cronbach's alpha coefficient was .943. To assess caregivers' stress levels, we used the 12-item parental distress subscale of the PSI Short Form (Abidin et al., 2006). Each item captures responses using a 5-point scale (*strongly disagree* to *strongly agree)*. The PSI has demonstrated excellent reliability and validity in several studies focused on kin (e.g., Gleeson et al., 2016; Lee et al., 2016). Cronbach's alpha for the current study was .948.

For the semi-structured interviews, we collected data from 2017 to 2018, and the phenomenological approach guided our work (Creswell & Poth, 2016; Moustakas, 1994). We used individual semi-structured interviews to examine the following areas: birthparent involvement in child rearing, kinship care family functioning and the kinship caregiver's self-care practices and experience with stress. For this study, the individual semi-structured interviews examined kinship care family functioning and the kinship caregiver's self-care practices and experience with stress. Individual interviews lasted between 1 and 2 h but, on average, were slightly longer than an hour. Interviews were transcribed verbatim by a professional transcription service. The research team then reviewed the transcripts to ensure accuracy and to remove identifying information. Transcripts were uploaded to the web-based program Dedoose (SocioCultural Research Consultants, 2018) for data management and analysis. All participants received a $35 (USD) cash incentive for completing a semi-structured interview. The [redacted for peer review] Institutional Review Board approved the study design, protocols and materials.

8.4 | Data analysis

To gain knowledge on the population in this study, we used descriptive statistics to analyse quantitative data. For categorical variables, the univariate analyses included frequency distributions. For continuous variables, the univariate analyses included measures of central tendency (e.g., mean and median) and measures of spread (e.g., standard deviation and range).

Phenomenology offers a process for examining the lived experiences of a specific phenomenon among a group of people by enabling researchers to better understand how individuals make sense of their experience of that particular phenomenon (Moustakas, 1994). In addition, this approach acknowledges how people interact with, interpret and experience their worlds before any theories can be developed to explain their experiences (Creswell & Poth, 2016; Moustakas, 1994). Thus, our data analysis was guided by the systematic analytic procedures outlined by Moustakas (1994), and we began analysing data as soon as the first set of data was available.

Specifically, we followed the core processes of Moustakas's (1994) approach to phenomenology: (a) bracketing, (b) horizonalization, (c) clustering into themes, (d) textural description of the experience, (e) structural descriptions of the experience and (f) textural-structural synthesis. For example, we conducted a textural description of the experience of self-care. In this context, we were able to understand the *what* of the participants' experiences with self-care, meaning we used the participants' words to convey their unique perceptions of self-care to essentially allow us to represent all of the participants' experiences with self-care (Eddles-Hirsch, 2015; Moustakas, 1994).

The following analytic phase included structural descriptions of the experience of self-care. Creating structural descriptions of participants' self-care required the research team to gain an understanding of *how* each participant understood and experienced self-care. The textural-structural synthesis enabled the research team to integrate the *what* and *how* of participants' experiences with self-care using their different perspectives. The results of this analytic process were a description of self-care and an underlying essence of shared

self-care experiences among African American informal kinship care providers. Essentially, the textural-structural descriptions that emerged represented the meaning and essence of the experience of self-care. Each participant's experiences were integrated into a universal description of the group's self-care experiences through the use of analogies, metaphors and contradictions (Creswell & Poth, 2016; Eddles-Hirsch, 2015; Moustakas, 1994). Ultimately, our analysis yielded a synthesized description of the shared phenomena of self-care among African American informal kinship care providers.

8.5 | Data credibility

We used several methods to ensure the credibility of the data. First, we developed a codebook and used multiple coders for coding. Second, we used analytic memos to record what we heard, saw, thought and experienced during data collection and analysis (Miles & Huberman, 1984). Additionally, our memos allowed us to record our reflective notes on any theoretical, methodological or analytical notes that emerged during the research process. Last—and critical to the Moustakas (1994) approach to phenomenology—was the use of bracketing. Bracketing requires researchers to set aside their perspectives and refrain from judging (Mouton & Marais, 1990). By following bracketing procedures, we were able to capture a deeper understanding of the factors that facilitated or hindered the participants' self-care practices.

9 | RESULTS

9.1 | Sample description

Most participants identified as female (n = 10; 83%), and two were male. Most participants were not married (75%), six reported their status as divorced or separated, and three reported single status. Almost half of the participants reported they had some college or trade school education (n = 5; 42%), and three (25%) caregivers had graduated from college. More than half of the sample reported incomes of less than $50,000 per annum. See Table 2 for further information about the sample demographics.

On the PSI parental distress subscale, 33% of caregivers reported high or clinically significant levels of distress (n = 4). Responses captured on the FRS indicated most kinship caregivers faced resource challenges. Only one participant reported their family resources were *almost always adequate*, whereas 50% of the caregivers reported their family resources were *seldom or sometimes adequate* (n = 6). The majority of respondents (9 of 12) rated their health as either *fairly healthy* (n = 5) or *very healthy* (n = 4); however, 25% of caregivers reported they were *somewhat unhealthy* (n = 3).

On the BASC-3, almost 30% of scores for children's internalizing behaviour, as reported by kinship caregivers, were in the at-risk range (n = 5). Scores on children's externalizing behaviours showed that 12% of children's behaviour t scores were clinically significant (n = 2), and 18% were in the at-risk range (n = 3). See Table 2 for further information on the sample.

9.2 | Key themes from individual semi-structured interviews

In individual semi-structured interviews, caregivers were asked to share their experiences with stress and self-care practices. Caregivers' responses noted how they experienced stress from interactions with their family and society. Most participants reported a shared experience of feeling other stressors (e.g., their health, finances and lack of access to critical resources) compounded by stress from their caregiver role. Thus, three themes emerged that illuminated a holistic understanding of stressors and self-care practices of African American informal kinship caregivers: (a) behaviours to manage stress levels, (b) support network reminding caregivers to take care of themselves and (c) prioritizing my own needs.

9.3 | Theme 1: Behaviours to manage stress levels

We defined behaviours to manage stress levels as potentially harmful behaviours that some caregivers employed to relieve their stress. Among the study sample, many caregivers reported a range of behaviours they engaged in as self-care to manage them. For instance, one caregiver shared how they 'just drink, smoke, and work' to manage the daily stress they experience while providing kinship care. They said:

> That [self-care routine] may be a problem because I do not do that. I mean I was doing it a while back. Like I was going to the gym and stuff like that, tried to stop smoking, tried to stop drinking, but right now I have not been to the gym in probably 6 months—still drinking, still smoking. The only thing I do is just get up every day and do what I got to do. You know, I go to work. I got to bring money in the house.

When this caregiver was asked to discuss how they handled stress given that they 'do what I got to do,' they replied:

> Other than getting up and going to work and taking care of as much business as I can—getting the stress off me but … Other than drink … I should stop drinking but I'm drinking right now. Like I said, tried to solve problems—you know stress comes from problems—so I try to solve problems.

Other caregivers reported that the behaviours they engaged in—smoking, drinking, etc.—to manage their stress were due to some factors that affected their stress levels due to financial challenges, not having time for themselves and feeling overwhelmed. For example, one caregiver stated:

> It's been times where I did not have like uh money to pay my … Like if I needed to go have a doctor's appointment. I did not have money to pay my uh copay and like [put] gas in the car. Because you know, there's a lot of ripping and running when you got kids.

In this study, kinship caregivers consistently discussed their feelings of being overwhelmed by their caregiving responsibilities, which impacted their ability to seek the help they needed to manage increasing stress. Notably, these caregivers' quotes also illustrated that, in addition to caregiving impacting their stress level, they also had other life challenges that impacted their stress (e.g., health conditions, work and other responsibilities).

9.4 | Theme 2: Support network reminding caregivers to take care of themselves

Without prompting on the topic of self-care, many of the kinship caregivers in our sample shared that their support networks routinely reminded them to take better care of themselves. The most impactful sources of self-care messages kinship caregivers received were from those in their close personal networks, particularly their loved ones (e.g., grandchildren, significant others, close friends or close relatives). These reminders highlighted the consequences caregivers endured for not taking care of themselves and encouraged the caregivers to give priority to their self-care practices and their own health needs. For instance, one kinship caregiver reported different challenges with caring for herself because of the care and attention she gave her grandchildren. In fact, this caregiver commented that her significant other was upset because she was sacrificing her self-care because she had to care for her grandchildren. She stated:

> I've been doing this for years now and so um suddenly it was a gentleman that I met that um really screamed at me about this. When I say screamed he kept, like I cannot believe that you are doing this and why, why, why? Why cannot mom get it together? And he's a grown man but he did not understand to the degree that he accepted it and I understand that because when you are a person of a certain age you really want to have the liberty to do whatever you want and when you have small children you cannot do that. He kept like, I just—I hate that you are doing this to yourself. I hate that they are doing this to you … that's one thing that I am grateful that um the Lord allowed us to meet which is for that reason to bring attention to myself.

This caregiver shared she interpreted her significant other's concern for her lack of self-care. She felt as if he did not understand what she had to do to care for her grandchildren instead of recognizing the importance of caring for herself.

Other caregivers had similar responses, but more concern came from their grandchildren. For example, one caregiver shared how her grandson noticed she was not caring for herself and reminded her that she did not do things for herself anymore. She said:

> No actually even G tells me that. Nana, you do not get your nails done anymore. You do not—you do not go to the lady to get your haircut, stuff like that and G even tells me sometimes, well when are you gonna do something for yourself Nana?

She went on to share that her priority was taking care of her grandson and not the little extravagant things because if something happened to her, who would take care of her grandson? She noted:

> And I'm sitting here thinking, my way of thinking is right now you are my priority and I know I should take better care of myself because if something happened to me at this point where's my grandson gonna go? But at least I can say that I make sure I go to my doctor's appointments, I get physicals and that, the health stuff, I take care of. The other little extravagant things that's really not needed I just do not bother with them anymore.

Similarly, another caregiver shared their concern about who would care for her grandchildren if something happened to her despite her support networking reminding her to take care of herself. She shared, 'Well, I have to [take better care of myself] because in the end, if anything happens to me who's gonna take care of them? Where do they go, you understand?'

9.5 | Theme 3: Prioritizing my own needs

Prioritizing my own needs for the kinship caregivers in this study focused on the caregivers engaging in different activities and creating structure in their households. For the caregivers, prioritizing my needs could be categorized as activities they enjoyed regularly doing and/or had engaged with before becoming a caregiver. Several caregivers noted that to prioritize their own needs, they had to make positive self-care practices a consistent part of their lives. In prioritizing their own needs, they cantered activities they enjoyed, which helped them renew their energy and strength to provide care for their grandchildren. For example, some kinship caregivers in this study shared that they prioritized their own needs before taking on the responsibility of caring for their grandchildren. Other caregivers identified essential forms of self-care as participating in certain activities (e.g., exercising and religious or spiritual practices) and focusing on having a routine for their grandchildren as a way in which they prioritized their own needs. For instance, one caregiver described that going to the YMCA made her feel better when asked about what she does to prioritize her own needs. She reported, 'Oh, the Y. I go to the Y. The YMCA. Yes. The treadmill. The treadmill, then they got the bike. Then I—I go from one to the other. Whichever one I feel like.' Similarly, another caregiver shared how she went for walks and listened to jazz and gospel music to prioritize her needs. She stated, 'What I do is I walk. Uh, I love jazz. I, you know, listen to my music. Um, on my car I have Sirius XM, and I listen to Kirk Franklin, uh, gospel.'

Caregivers who reported engaging in faith-based activities as an essential part of prioritizing their own needs shared the following comments highlighting the solace they found in religious activities. One shared, 'I'm going to choir rehearsal, going to different events we have at the church, going to the doctors and whatever. … Everything I do is about prayer, prayer and reading my Bible.' Another stated, 'My self-care routine is going to church every Sunday and Tuesday. And any time with my Creator is good time so.'

Another way caregivers prioritized their own needs was through routines and structure. They indicated having to create a structure for their households to meet their grandchildren's and their own needs. For example, one caregiver shared that changing the grandchildren's bedtime to an earlier hour was a way of prioritizing her own needs and ensuring she could get much-needed rest. She said:

> At night on the weekend I have learned to appreciate just not go to bed. Before I used to go to bed with them. Um eight-thirty, nine o'clock we are all asleep and then I stopped doing that because I realized that I am not spending enough time with myself and so I'll stay up especially on Friday night. It's very quiet and peaceful, the dishes are washed and I just kinda sit on the couch, sometimes there's something on TV, sometimes there's not, I'll read but I enjoy that solitude of just quiet where it's like it's just me.

Another kinship caregiver shared how she had to create some structure to better care for her grandchildren. She stated, 'I kind of started putting things in place in order to take care of me. For about six months. It's new. But I've got it pretty structured. I—it's—consciously I'm aware, I'm very aware consciously.'

All kinship caregivers in this study discussed how important their grandchildren were to them. Part of their prioritizing personal needs included gratefully accepting the positive feedback they got from their grandchildren and acknowledging they are doing an excellent job as caregivers. Kinship caregivers also consistently reported that they were happy to care for their grandchildren despite the stressors experienced. Additionally, all kinship caregivers said they love their grandchildren, they knew their grandchildren loved them, and they knew their grandchildren understood their grandparents' sacrifices.

10 | DISCUSSION

This qualitative pilot study aimed to explore the self-care practices of African American informal kinship caregivers. To accomplish this goal, we gathered descriptive data from the caregivers regarding their stress levels, health and other socio-demographics. In our study, 33% of the caregivers reported high or clinically significant stress levels. This finding is not surprising given that several studies have found high-stress levels among informal kinship caregivers (Gleeson et al., 2016; Koh et al., 2022; Lee et al., 2016; Washington et al., 2013). However, this study added new knowledge. It is one of the only studies that has qualitatively and exclusively examined African American informal kinship caregivers, despite over 70% of kinship caregivers being informal and an overrepresentation of African Americans in kinship care (Testa, 2017). Additionally, in this study, most kinship caregivers perceived themselves as fairly healthy or very healthy, and 25% seemed concerned about their overall health. One-quarter of the study's sample reported health concerns, consistent with other studies that found many kinship caregivers suffer from CVD and other poor health outcomes (Clottey et al., 2015; Musil et al., 2011; Smalls et al., 2020; Taylor et al., 2017).

Even though many of the caregivers in this study perceived themselves as fairly healthy or very healthy, some of the behaviours they were engaging in—smoking and drinking—to manage their stress were maladaptive behaviours that placed them at risk for adverse health consequences. In fact, challenges with finances were one of the most frequently talked about factors related to stress among kinship caregivers in this study. Interestingly, research has indicated a relationship between low household socio-economic status and caregiver stress levels (Assari et al., 2019; Gleeson et al., 2016; Xu et al., 2020). Decades of research have documented a disproportionate number of kinship care families live in poverty (Annie E. Casey Foundation, 2012; Fuller-Thomson & Minkler, 2000; Xu et al., 2020). Notably, a recent study using national data found substance use exacerbated the association between stress and psychological distress among older African Americans (Mouzon, 2022). Assari et al. (2019) also found that financial need, which is a stressor, is associated with smoking cigarettes and drinking alcohol among older African American adults.

Assari et al. (2019), Mouzon (2022), and our study provide culturally relevant information about substance use among older African Americans. For instance, one way to think about

the culturally relevant information about substance use among older African Americans who are caregivers is to take into consideration older African Americans' history and explore whether or not there are historical familial patterns of substance use when there are financial or other stressors. Furthermore, given that the older African American caregivers in this study experienced financial stress, the behaviours they used to deal with their financial stress were not surprising, could be how they learned how to manage stress from previous generations in their family and could actually be a consequence of lacking access to buffering resources (Assari et al., 2019). Therefore, intentionally using a historical lens and working to understand the lived experiences of older African Americans who are caregivers is one way to understand the unique ways their identities and past influence the ways in which they manage the stress in their lives.

Our study also revealed that African American informal kinship caregivers were not fully aware of how harmful these substance use behaviours were to their health and overall well-being. We found several other behaviours affecting caregivers' stress levels, including lack of time for themselves and being overwhelmed by too many caregiving duties. Although some caregivers recognized that they needed to take care of themselves, their support network routinely reminded them to do so because they were not consistent or stopped doing things, like getting their hair and nails done.

Furthermore, when caregivers' support networks questioned them about their self-care practices, some caregivers would instead express concern about who would care for their children if they fell ill or died. Additionally, though caregivers were concerned about their children's well-being if they could no longer provide care, their grandchildren were also concerned about their caregivers' health. Their grandchildren wanted their kinship caregivers to enjoy their lives by engaging in activities they did before the children arrived in their homes. In this finding, it is important to note that African American informal kinship caregivers have not been receiving many benefits caregivers formally involved in the child welfare system receive. Yet, they can still build—or already have—a support network critical to their survival and success as a caregiver. It is also essential to highlight the resilience of African American informal kinship caregivers. Despite the stressors African American informal kinship caregivers experience, they persist in meeting their grandchildren's needs. In some ways, their grandchildren's care and concern for their well-being keep them going. This study finding adds new knowledge about the intergenerational approach to self-care among African American informal kinship families. Additionally, this highlights the importance of support networks for overall well-being, similar to other literature that has found support beneficial to individuals and families (Gleeson et al., 2008; Thomas et al., 2017).

Lastly, interviews revealed that some caregivers participated in positive self-care activities. For example, caregivers reported listening to gospel music, praying and attending church as critical practices for prioritizing their own needs. These practices among study participants are consistent with scholarship that has found the black church or spirituality as a historical and contemporary strength of the African American family and community (Billingsley & Morrison-Rodriguez, 2007; Hill, 1999; Schiele, 2017). In fact, 'The Black Church was the cultural cauldron that Black people created to combat a system designed to crush their

spirit' (Gates, 2021, p. 6). Because African Americans/blacks have a long history of using spirituality and the black church as a source of courage and to overcome adversities (from slavery until now), listening to gospel music, praying and attending church are examples of the unique critical cultural practices among older African American caregivers that help them to sustain during times of great stress.

Another strength of the African American community is flexible family roles (Hill, 1999). We found this among caregivers who changed the structure of their households and lives to better serve their and their grandchildren's needs (e.g., accepting help from immediate and extended family members and changing traditional duties). In fact, the flexible family roles within the informal kinship caregivers homes in this study served as sources of support, a buffer for some of the negative impacts black families experience in society, and provided emotional support and help with transportation, all of which echos other findings regarding the strength of the African American community and flexible family roles (Lloyd et al., 2021).

Furthermore, a few participants talked about exercising and going to the gym or pool at the YMCA, and they spoke about being willing to or changing their eating habits to get healthy. Many positive self-care activities that study participants were planning to carry out or were engaged in have been found to reduce stress and improve the overall health of individuals (e.g., National Institute of Mental Health, n.d.; Mouzon, 2022). However, it must be acknowledged that it may be difficult for many to engage in these practices given their limited income, resources and time and health challenges many were already experiencing.

It is also important to note that we are providing specific information about what African American informal kinship caregivers find useful and we are not debating whether other racial/cultural groups participate in these activities. However, with our study, we can only begin to confirm that these are self-care activities that work for African American informal kinship caregivers. We also recognize that our study is one of the only studies that looked qualitatively and exclusively at African American informal kinship caregivers and that provided specific culturally relevant self-care activities in which this population has been engaging or would like to engage in.

10.1 | Limitations and directions for future research

In addition to our study's contributions, our findings should be understood in light of some limitations. First, our pilot qualitative study included a small convenience sample; thus, although findings provide valuable insight into stress, health and self-care behaviours among African Americans providing informal kinship care, generalizability is limited. A second limitation stems from the study's reliance on only one interview with caregivers. This limitation is important because the amount of stress the caregivers experienced due to health, financial and other stressors could have been examined over time to better understand their daily experiences with stress and the kinds of support they receive from their support network when they are stressed. Third, caregivers' health status was assessed with a single-item measure, and the reliability and validity of single-item measures are prone to be weak. Thus, our study would be strengthened if biological measures of stress and health were used. For example, future research should obtain objective measures of stress based on cortisol

levels, an established stress biomarker and self-reported stress outcomes. It would also be beneficial to use biomarkers of health or standardized measures for health. Future research should also use these biomarkers of health to investigate the effects of interventions on the stress and health of caregivers providing informal kinship care.

10.2 | Implications for practice

Despite the study's limitations, we want to note some critical implications for practice with African American informal kinship caregivers. First, many caregivers in our study lacked time to engage in self-care practices, and consequently, these limits contributed to increased stress among caregivers (Xu et al., 2020). Thus, it would be necessary for social workers to provide services to caregivers to assist in creating opportunities for them to have more free time to engage in self-care activities. For instance, social workers who provide services to caregivers could identify activities—make a priority list, locate a grandparent support group, and, if needed, locate a therapist—they could engage in together. Additionally, social workers should work with caregivers to identify stress reduction activities in their community that are free or have a nominal fee because many have financial challenges.

Across the systems that informal kinship caregivers are involved in, there should be culturally responsive support for them to address their elevated stress levels to counter adverse mental and physical health outcomes. For example, caregivers support groups geared towards African Americans should incorporate activities or programming such as jazz and gospel music because they are both of interest to this population and may reduce stress. Additionally, several parenting interventions targeting kinship caregivers have been found to improve parenting capacities and reduce parental stress (Wu et al., 2020). However, practitioners who have used parenting interventions and have had fewer promising results should consider culturally relevant modifications to these interventions when working with diverse kinship caregivers.

Lastly, we know that despite informal kinship caregivers not having access to formal resources or support creates stress, we know that when they do rely on their support they have less stress which in turn means improved caregiver's health. We also know that when the supports are utilized, the benefit to the children is noted such as positive outcomes in the child's academic performance, as well as an improvement in the child's mental and physical health (Washington et al., 2018). In fact, Washington et al. (2021) found that children in informal kinship care settings had academic performance similar to children who were not in out-of-home placement. Washington et al. (2021) speculated that the improved academic performance was plausible for several reasons:

> only a small percentage of the formal homes were licensed and received foster care payments, all of these families were served by a social worker who could assist in addressing the children's educational needs, such as attending Individual Education Program meetings with the families and referring children for tutoring services and academic summer camps.

Essentially, such supportive activities contribute positively to children's academic success and overall well-being, and having a human service worker that could provide food and

clothing vouchers and referrals to programs that support families during the holidays is critical for relieving stress for African American informal kinship care providers as well.

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CONFLICT OF INTEREST STATEMENT

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DATA AVAILABILITY STATEMENT

Research data are not shared.

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TABLE 1

Characteristics of kinship care families.

Variable	***N* = 12% (*n*)**	**Variable**	***N* = 12% (*n*)**
Gender		Household income	
Male	16.7 (2)	0–24 999	58.3 (7)
Female	83.3 (10)	25 000–39 999	25.0 (3)
		40 000–49 999	8.33 (1)
		500 000 +	8.33 (1)
Marital status			
Married	25.0 (3)	Employment status	50.0 (6)
Divorced or separated	50.0 (6)	No	25.0 (3)
Single		Yes, part-time	25.0 (3)
	25.0 (3)	Yes, full-time	
Educational status			***N* Mean (*SD*)**
Some high school	16.6 (2)	Number of children in the Household	12 1.75 (2.98)
High school graduate	16.6 (2)		
Some college or trade school	41.6 (5)		
College grad or above	25.0 (3)	Age of children in the household	12 7.48 (2.98)
		Number of children per household	***N* = 12**
		1 child	33.3 (4)
		2 children	41.6 (5)
		3 children	8.33 (1)
		4 children	16.6 (2)

TABLE 2

Kinship caregivers and children's outcomes.

Caregiver variables	***N* = 12%(*n*)**	**Children variables**	***N* = 17% (*n*)**
Parenting distress subscales			
Low	16.6 (2)	BASC-3 internalizing Behaviour *T*-scores Clinically significant	0
Normal	50.0 (6)		
High	8.3 (1)	At risk	29.5 (5)
Clinically significant	25.0 (3)	Average	47.0 (8)
		Low risk	23.5 (4)
Family resources scale			
Not at all adequate	0	BASC-3 externalizing Behaviour *T*-scores Clinically significant	11.7 (2)
Seldom adequate	25.0 (3)		
Sometimes adequate	25.0 (3)	At risk	18.0 (3)
Usually adequate	41.6 (5)	Average	65.0 (11)
Almost always adequate	8.3 (1)	Low	5.0 (1)
Self-reported health			
Very unhealthy	0		
Somewhat unhealthy	25.0 (3)		
Fairly healthy	41.6 (5)		
Very healthy	33.3 (4)		