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Social Support and Survival Strategies of Older African American Grandmother Caregivers

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Research Article

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Abstract

The effects of caring for grandchildren on grandparents' emotional and physical well-being have become a significant area of focus in behavioral and medical research. Research suggests that African American grandmothers may experience increased mental and physical health challenges due to their caregiving stressors. To buffer the adverse influence of stress, caregivers often rely on informal social support from family and/or community members. In this study we explored older, African American caregivers' management of their emotional well-being within the context and conditions of available to minimal social support from family and community. During an 18-month period, seven caregiving grandmothers participated in three face-to-face, audiotaped, semi-structured interviews; eco-map and genogram data were included to understand the contextual complexities of caregivers' social support and their strategies for survival. Using constant comparative analysis, six interrelated themes revealed grandmothers operated along a continuum of reliable to unreliable social support. In the context of these varying ranges of social support, four sub-themes depicting their survival strategies were identified: being strong, self-sacrificing, receiving help and self-compassion. Utilization of each survival strategy was dependent on grandmothers' perception of where they fell on the continuum of reliable to unreliable social support. Grandmothers who engaged in being strong and self-sacrificing engaged in stress-related health behaviors, such as emotional eating, smoking nicotine, disruptive sleep patterns and postponement of self-care. We offer specific practice recommendations for addressing the emotional and physical health needs of grandmother caregivers.

Keywords: *grandmother caregivers, depression, social support, stress, women's health*

Introduction

        In 2012, 2.7 million grandparent caregivers in the United States and about 1 in 3 are grandparent-maintained households with no parent present, often called "skipped-generation households" (Ellis & Simmons, 2014). In skipped generation households, across racial and ethnic groups, African Americans were 13% likelier to live in a "skip" generation household compared to 7% of Whites, 4% of Latinos, and 1% of Asians (Livingston, 2013). It is more likely for an African American child to live in a household with a grandmother and a single parent or a grandmother and no parent compared to their racial counterparts (Ellis & Simmons, 2014). Minkler & Fuller-Thomson (2005) highlighted that African American grandparent caregivers in skipped-generation households were younger, female, less educated and had limited economic resources compared to their caregiving peers. Confirmed by Ellis & Simmons, children in these households are most likely to be in poverty. Caregivers take on this responsibility in response to crises such as substance abuse, incarceration, HIV/AIDS or community violence resulting in death of a parent (Crewe, 2012; Conway, Jones, & Speakes-Lewis, 2011; Joslin, 2002; Stinson, 2010; Young and Smith, 2000). Previous studies have revealed being an African American grandmother, low-income, middle aged, single, with lower levels of education and receiving inconsistent social support are more likely to experience mental health stress and depression than their counterparts (Carr, Hayslip, & Gray, 2012; Kelley, Whitley, & Campos, 2013; Musil, Warner, Zauzniewski, Wykle, & Standing, 2009; Smith & Hancock, 2010; Whitley & Fuller-Thomson, 2017; Whitley, Lamis, & Kelley, 2016).

        Skipped-generation households may be either formal (public) or informal (private). Formal arrangements are commonly referred to as kinship care, the full-time nurturance and protection of a child by extended family members or including non-related persons who have a kinship bond with the child (Harden, Clark, & Maquire, 1997). Informal arrangements occur outside of the child welfare system and are an agreed upon relationship between parent(s) and the grandmother. There have only been a few studies exclusively focused on private, the most common type of kinship care arrangement (Bunch, Eastman, & Griffin, 2007; Simpson, 2008; Simpson & Cornelius, 2007; Simpson and Lawrence-Webb, 2009). African American grandmother caregivers with no parents present are the most vulnerable group of grandparent caregivers and there remains minimal research about how they are coping with the stressors associated with caregiving. We focus on skipped generation households of African American grandmother caregivers who are in private kinship care arrangements, caring outside of the formal kinship care system, as they may not have access to equitable services and funding. Their individual and collectively identities - race, class, gender and age – stigmatized and disadvantage them in countless ways. They are the most marginalized group of caregivers and likely the most distress due to their complex intersection of identities and caregiving demand. Against this background, it is important to recognize the interplay of multiple forms of oppression on African American grandmother caregivers may be mitigated by the support they receive from their family and community. Thus, in this qualitative study we explore how older African American grandmother headed households respond when faced with consistent and inconsistent social support from family and community. We use multiple lenses, ecological perspective (Bronfenbrenner, 1979) and the womanist perspective (Collins, 2000), to highlight how caregivers engage in survival strategies and how it affects their emotional and physical well-being.

Literature Review
        The cost of depression is a disabling chronic health condition placing a burden on families, communities and health care systems (Greenberg, Fournier, Sisitsky, Pike, & Kessler, 2010; Richardson et al., 2012). Although, African American women are less likely to have higher depressive symptoms compared to Whites; they are more likely to have higher depressive symptoms compared to African American men. African Americans are less likely to undergo treatment and the chronicity and severity of depression is greater within the African American population (Simpson, Krishnan, Kunik, & Ruiz, 2007). The mental health needs of older African American women are of public concern and addressing their mental health needs is paramount. Informal grandparent caregivers, particularly African American grandmothers, have experienced mental and physical health cost due to their care demands (Baker & Silverstein, 2008; Musil & Ahmad, 2002).
        Studies have revealed that African American grandmother caregivers have experienced increased stress and numerous health challenges directly related to their caregiving roles (Carr, Hayslip, & Gray, 2012; Clotty, Scott, & Alfonso, 2015; Carthron, Bailey, Anderson, 2014). Longitudinal studies that utilized nationally representative data for examination of depressive symptoms among grandparent caregivers found grandparents residing in multigenerational homes, both caregiving or co-residing, had elevated risk of depression (Minkler, Fuller-Thomson, Miller, & Driver, 1997; Kelley, Whitley, Campos, 2013; Whitley & Fuller-Thomson, 2017). For example, Kelley, Whitley, & Campos (2013) found that nearly 40% of the 480 African American grandmother caregivers in their study scored in the clinical range on psychological distress, which raised considerable concern regarding the well-being of African American caregiving grandmothers. Whitley & Fuller-Thomson in their 2017 study of skipped generation households revealed a quarter (25%) was diagnosed with clinical depression at some point in time.
        Our interest in African American grandmother caregivers' physical health status stems from a common concern that they are at a higher risk of chronic illness, disability and functional impairment due to their caregiving demands (Schulz & Beach, 1999). Women caregivers experience chronic stress as a result of their role leading to adverse health outcomes (Pearlin, Mullan, Semple & Skaff, 1990). Caregivers are at greater risk for morbidity and mortality compared to non-caregivers (Lee, Colditz, Berkman, Kawachi, 2003; Schulz & Beach, 1999; Christakis & Allison, 2006). Caregiving research has yielded mixed results because the relationships are complex and may be attributed to caregivers' prior history of poor health (Baker & Silverstein, 2008; Conway, Jones, Speakes-Lewis, 2011), lack of time devoted to self-care (Carthron, et al, 2015.; Carr, Hayslip, & Gray, 2012; Minkler & Fuller-Thomson, 1999) as well as an increase in depression and anxiety that arises from parenting children experiencing past emotional trauma, various health issues, learning disabilities and challenges related to anger management (Doley, Watt, & Simpson, 2015; Kelley, Whitley, & Campos, 2013; Kelley, Yorke, Whitley, & Sipe, 2001; Whitley, Fuller-Thomson & Brennenstuhl, 2015). To buffer the adverse influence of stress, caregivers often rely on social support from family and/or community members.

Perceptions of Social Support and Well-Being
        A line of research has revealed social support is a major protective factor against psychological distress (Hayslip & Kamaniski, 2005; Hughes, Waite, LaPierre, & Lou, 2007).

Dressler (1991) posited social support is based on a person's perception of help or assistance from other individuals during difficult times. The type of social support received may be instrumental aid from members, such as child care, emotional support, financial assistance, physical care, transportation, decision making and providing for necessities such as food, clothing, and shelter (Billingsley, 1992; Hill, 2003; Martin & Martin, 1978, McAdoo, 1982; Stack, 1974; Taylor, 1985). Research examining the link between social supports and well-being among grandparent caregivers revealed an association between social support and depression (Musil, Gordon, Warren, Zausznieswski, Standing, Wykle, 2011; Warren-Findlow, Laditka, Laditka & Thompson, 2011). Severely fragile grandmother maintained households with strained family resources had the worst physical health, greater depressive symptoms and problems in family functioning (Musil, et al, 2011). Grandmother caregivers who received emotional support from family members and friends reported better emotional health (Warren-Findlow, Laditka, Laditka & Thompson, 2011). They also reported that familial support as well as support from friends buffered the effect of daily discrimination. Grandmother caregivers who perceived lower social support and poor physical health were linked to greater levels of depression (Musil & Ahmad, 2002; Musil, et al, 2011; Carr, Hayslip & Gray, 2012). Musil & Ahmad (2002) found that instrumental support was not associated with decrease levels of depression; however, perception of support was linked to lower levels of depression.

There is a clear indication that social support may serve to prevent and treat the adverse influence of stress on physical and mental health (Dressler, 1991; Pearlin, Mullan, Semple & Skaff, 1990; Carr, Hayslip & Gray, 2012; Kelley, Whitley, & Campos, 2013; Warren-Findlow, Laditka, Laditka & Thompson).   In the grandparenting literature, family resources have been conceptualized as "those instrumental resources that are essential for raising children and include income, food, shelter, and access to health care" (Kelley, Whitley, Sipe, & Yorker, 2000, p. 313). Kelley, Whitley, Sipe and Yorker (2000) investigated the predictors of psychological distress across social supports, subjective family resources and physical health among 102 African American grandmother caregivers. They found that grandmothers who reported fewer family resources and poorer physical health tended to score higher on the psychological distress measure. In their follow-up study (Kelley et al., 2013), similar results indicated elevated psychological distress was explained by poor physical health of grandparents and perceived inconsistency of family resources. In a one-year longitudinal study, researchers found that grandparent caregivers reported better health with greater informal social support, over time (Hayslip, Blumenthal, Garner, 2015).

Several studies found that grandparent caregivers are overwhelmed with their caregiving responsibilities and may not be receiving support from extended family members (Burton, 1992; Carr, Hayslip & Gray, 2012; Jendrek, 1994; Musil, et al, 2011; Smith, 1994; Stokes and Greenstone, 1981). In Burton's (1992) study, African American grandmother caregivers reported not receiving support from their relatives. Similar to Stokes and Greenstone (1981) and Smith (1994) studies, primarily African American grandmothers, found that caregivers did not perceive their support from kin and extended kin as consistent and reliable. Social support is an important resource to leverage for grandmothers meeting the demand of caregiving. African American grandmothers caring outside of the child welfare system often draw upon informal social support, family or community members, to mobilize resources (Clotty, 2012). They often perceive formal social services as unreliable and unavailable to meet their caregiving needs (Carr, Hayslip & Gray, 2012; Simpson & Lawrence-Webb, 2007).

There are findings about the consistent support they receive from family and community (Burton and Jarrett, 2000; Simpson, Smith & Davis, 2016) but minimal about the absence of some caregivers' ability to solicit support from family members on a regular basis. The relationship among caregiving demands, social supports and well-being are further complicated by existing health disparities, such as race, class, gender, age, and other sociodemographic attributes (Hughes, Waite, LaPierre, & Luo, 2007). Older African American grandmother caregivers are in a uniquely vulnerable position because as older adults age, sources of emotional and instrumental support often decrease. Particularly for caregivers who family members have been hampered by structural inequalities such as poverty, substance abuse, disease, and community violence (Simpson, 2009).

Survival Strategies of African American Women
Based on Lazarus & Folkman's (1984) cognitive theory of psychological stress and coping, coping strategies have been categorized into two domains, problem-focused (direct action taken to resolve the source of stress) and emotion-focused (engaging in behavior to reduce emotional distress caused by the stressful situation). According to Lazarus & Folkman's (1984), the use of both problem-focused and emotion-focused forms of coping reduces stress. A majority of the grandparenting literature have used elements of this theory to examine the coping strategies of caregivers. A study reported that caregivers who utilized less active coping and more avoidant coping methods experience depressive symptoms (Musil & Ahmad, 2002); while caregivers who utilized problem-focused and emotion focused forms of coping, such as counseling and after-school programs, had reduced stress (Ross and Aday, 2006). These forms of coping serve as protective factors against stressors perceived by grandmother caregivers. The most common coping strategies employed by African American caregivers are cognitive coping and affective coping; behavioral and active coping (Picot, 1995). Unfortunately, African American grandmother caregivers who experience higher levels of acute and chronic stress have developed adaptive and maladaptive coping mechanisms (Kane, 2007) but tend to use spirituality as a primary coping strategy (Navaie-Waliser et al., 2001). This finding confirms studies that found caregivers tend to rely on prayer and biblical scriptures (Dilworth-Anderson, Boswell, & Cohen, 2007; Minkler & Roe, 1993; Poe, 1992).

The race and gender of African American grandmother caregivers creates a unique stress experience resulting in different coping strategies (Black, Murry, Cutrona, & Chen, 2009; Woods-Giscombé, 2010; Woods-Giscombé & Lobel, 2008). A cultural adaptive response to pain and suffering is the expression of strength (Beauboeuf-Lafontant, 2007, 2009), furthered conceptualized as Strong Black Woman/Superwoman Role of Strength (SWS); Woods-Giscombé, 2010). Accordingly, Woods-Giscombé and Black (2010) finds that SWS manifested as a superwoman role with attributes of: "(a) an obligation to manifest an image of strength; (b) an obligation to suppress emotions; (c) resistance to being vulnerable or dependent; (d) determination to succeed, even in the face of limited resources; and (e) an obligation to help others" (p. 3). These coping mechanism are survival strategies learned by their fore mothers through their lived experiences. African American women have historically "included an accumulation of racial inequality; social, political, and economic exclusion; and medical under service. These inequities decrease access to resources and heighten susceptibility to psychological stress and premature stress-related illness" (Woods-Giscombe, 2010, p. 669). Women who embrace the superwoman role encounter negative consequences,

such as delayed self-care, emotional eating, inadequate sleep, anxiety, depression, and impaired physical health (Woods-Giscombé, 2010).

African American women exercise a survival process that they have grown accustomed to by making sacrifices to promote the collective well-being of their self, family and community (Giddings, 1984). These adaptations may come at a high cost to their own emotional and physical well-being. We need further exploration to how caregivers manage their own mental and physical well-being within the context and conditions of informal social support that may not always be available. We pay attention to how grandmothers manage when faced with weakened informal social support from family and community. We explore heterogeneity on these dimensions and the need to understand grandmothers' survival strategies and how it affects their well-being.

Theoretical Frameworks

The ecological perspective (Bronfenbrenner, 1979) and the womanist perspective (Collins, 2000) provided multiple lenses to explore how caregivers managed within the context and conditions of available to minimal informal social support. Through these lenses we increased our understanding of how participants' gender, race, class, age, and access to resources shape their experiences and perceptions of reality. The ecological perspective recognizes the relationships between and among the four levels within a social system: microsystem, mesosystem, exosystem and macrosystem. In this study, the micro system included family relationship patterns among any members residing inside the home (i.e., grandmother, grandchildren, and any adult children). The meso system included interrelationships between any person(s) or setting(s) affecting grandmother caregivers (i.e., relationships among caregivers, their adult children, and family members; caregivers and social service programs or other communities' entities). The exo-system level included social factors such as neighborhood conditions that affect the micro-system and mesosystem elements (i.e., gangs, drugs, or violence). The macro-system level included broad ideologies within society that influence grandmother caregivers (i.e., culture, politics, economics, religion, etc.).

To address how gender, class, race, and power intersect to shape inequities, a womanist perspective (Collins, 2000) was utilized to examine grandmother caregiving within a broad sociohistorical-political context of gender, race, age, income, and class. Grandmother caregivers' values and life experiences were at the center of analysis and their voices define their own life experiences as they see themselves rather than how others see them (Collins). In this case, the perspective frames questions for understanding how African American grandmother caregivers define their own realities and survival strategies. Womanism fits well with the purpose of this study because it provided a framework for understanding how African American grandmother caregivers define their own realities and coping abilities. Grandmothers were viewed from a culturally relevant perspective, through which to examine, interpret, and understand the enduring resilience of adaptive strategies. Womanism perspective provided the researcher with the ability not only to assess the strengths of grandmother caregivers but also to be conscious of the challenges faced by their role as caregivers. As proposed by Dickerson (1995) and supported by other female scholars (Banks-Wallace, 2000; Barbee, 1994; Bryson and Lawrence-Webb, 2001; hooks, 1989), the best approach to understanding the lives of African American women is to seek information and explore all dimensions of a African American woman's standpoint with and for African American women. Both the ecological and womanist perspectives support qualitative investigation. The assumptions within these

perspectives require exploration of the issues directly from the lived experiences of participants which cannot be obtained through standardized measures or secondary databases; they rather require entry into the world of grandmother caregivers and their environment.

Methods

Sample. The sampling technique for the study was purposive sampling of grandparent caregivers, which came from the closed client roster of the University of Maryland School of Social Work's Family Connections program, a community based prevention and intervention program targeted toward families "at risk" of child neglect. The sample of participants selected for the study was based on the following criteria: 1) race--African American; 2) gender—female; 3) household arrangement--grandmother - maintained household with no parent present or one parent present and 4) legal arrangement –voluntary caregivers, not involved in kinship foster care. The final seven grandmothers who completed the study were no longer involved in Family Connections. All of the names used in this report are pseudonyms

A fairly homogeneous sample (n=7), respondents ranged in age from 52 to 74 years. Four grandparents were either widowed or divorced and the remaining were never married (n=3). With regard to formal education, most (n=5) had not completed high school education. Two women, however, did report having "some college," both had an associate's degree or professional trade certification. Majority (n=6) were not working at the time of the interview. One participant retired from her job due to her disability, three had resigned as a result of their full-time caregiving role, and the remaining two did not have an extensive history of paid employment. As unpaid laborers they primarily worked in rearing their siblings, children and grandchildren most of their lives.

Caregivers' status was informal, meaning grandmothers were not involved in kinship care services at the time of the interview. The number of grandchildren cared for by these participants ranged from 1 to 7. Five caregivers were caring for at least one child with behavioral/emotional problems. Six caregivers were caring for their grandchildren due to drug-related deaths, drug abuse and/or incarceration of parents. Only one caregiver, Mrs. Truth, had two parents living in her home. This great-grandmother was interviewed because she had four remaining great-grandchildren whose parents were not present in her home.

Depression Scale and Caregiver Well-being Scale. Two measures of well-being were used in this study: depressive symptoms and caregiver well-being (Table 1). Depressive symptoms was assessed by the 20-item, Center for Epidemiological Studies Depression (CES-D) survey (Radloff, 1977) with an emphasis on affect. Responses were coded on a scale ranging from 0 (symptom experienced less than 1 day in past week) to 3 (symptom experienced 5-7 days in past week), and totaled with higher scores indicating more depressed mood. Thus, the range of scores is 0-60. The traditional cut point is a score of 16 or higher used to identify those at risk for developing clinical depression. Three of the seven grandmothers, Ms. Coppin, Ms. Ferebee and Ms. Moses, had scores higher than 16 and all three were receiving mental health treatment. In the grounded theory section, a discussion about these grandmothers' use of social supports and their coping strategies will be examined.

The Shortened Version of the Caregiver Well-Being scale, developed by Tebb (1995), rated the extent to which caregiver activities have been met in a timely manner. This scale consists of two sub scales: caregiver activities (e.g. buying food, home repairs, rewarding self and financial future); and caregiver needs (e.g. eating a well-balanced diet, getting enough

sleep, expressing love and anger). Each sub scale consists of eight items scored 1 (rarely) to 5 (usually) and was totaled and averaged which allowed the researcher to compare one participant to another. Thus, the range of averaged scores is 0-5. See Table 1 for individual scores.

Data Collection and Design. Data collection took place over an 18-month period, between the years 2000 and 2001, which included three face-to-face, audiotaped, semi-structured interviews. Data collection consisted of the primary author, a 34-year old, African American, female, who conducted each interview which lasted between 1.5 hours to 2 hours, and was conducted in the grandmother's home. Additional support with the design and implementation was provided by a 46-year-old African American male with numerous years of training and teaching qualitative research methodology.

The study protocol consisted of an observation of the participant in their environment and three face-to-face, audiotaped, semi-structured interviews. The interviewed addressed many facets including demographics data to perceived social supports from extended family members and community; family and community stressors, survival strategies and mental well-being. Genograms and ecomaps were utilized to capture caregivers' variations in their informal and formal social support structures. The purpose of these tools was to have a diagrammatic view of the presence or absence of family and non-family resources within the informal and formal social support structures of the grandmothers. Initial genogram and ecomap data were verified during the second and third interviews. Interviews lasted between one hour and thirty minutes and two hours. During each interview, observations were noted and following each interview, field notes were reviewed for accuracy. Documentation included verbal and nonverbal cues of the participant and the researcher-participant interaction, as well as the setting of the participants' home.

Data Analysis. Data analysis occurred concurrently with data collection and was analyzed using constant comparative method (Strauss & Corbin, 1998). Through the process of "open coding" a core variable which occurs frequently in the data, linked various data together and explain much of the variation in the data (Strauss & Corbin, 1998). Following identification of core variables, these concepts are grouped into categories and then compared with each other to ensure that they were mutually exclusive and covered behavioral variations (Strauss & Corbin, 1998). Once categories were defined, the researcher identified the specific *properties and dimensions* of each category and identified subcategories. The formulation of properties and dimensions assisted with the formulation of patterns along with their variations (Strauss and Corbin, 1998). In this stage, data was compared with other data in a category to evaluate whether that data belonged in that particular category or another, which is known as axial coding (Strauss and Corbin, 1998). Axial coding involved the examination of structure, the contextual events related to why a phenomenon occurred and the process, which is how one acts when an event occurs related to a phenomenon over a period of time. Because of the data analysis technique, the researcher was able to understand how grandmothers managed within a context of minimal social support and how these strategies affect caregivers' well-being.

Rigor. Prolonged engagement and persistent observations, peer debriefing, member checking and triangulation were five methods used to ensure findings were credible. Prolonged engagement and persistent observation was ensured by the length of time spent in

the field in order to learn the culture of participants. The peer debriefing group consisted of two African American females and one African American male, who had years of experience managing qualitative data analysis and who were engaged in their own research with African American women using qualitative methods. Face-to-face meetings on a bi-weekly basis were conducted to discuss the development of codes, categories and themes. They provided feedback as well as challenged the working themes derived from the data. Additional steps were taken to engage in member checking which involved having grandmothers review the themes and interpretation, and conclusions to ensure findings reflected their lived experiences.

Peer support group members provided feedback, challenged working hypotheses and ensured that the researchers' findings accurately reflected the experience of grandmother participants. Member checking involved reviewing with each grandmother participant the accuracy of data collected which was conducted during the second interview and the third interview when grandmothers had an opportunity to alter or change their input regarding the data collected for genograms and ecomaps. Also, grandmothers were presented with major themes developed from their interviews to ensure research findings reflected their caregiving experiences. Furthermore, the use of interviews, observation notes, memos, code notes and theoretical notes were documentation utilized to ensure dependability and confirmability. These documents were the groundwork for an audit trail, which is important for it linked the findings back to the data collected. Based on the activities discussed above it can be said that this researcher did a reasonable job of ensuring methods of credibility were adhered to throughout the study.

Ecological Context of Grandmother Caregivers

This section presents the community context in which grandmothers were raising their grandchildren. Grandmothers resided in the west side of Baltimore City, known for its challenges in addressing community violence, drugs, and pockets of poverty (Simon & Burns, 1997). Baltimore city has a population of roughly 614,664 people, African American children represent the largest ethnic group in the city, representing 68%; Whites represent 17%; Asians represent 2 % and Hispanics represent 6 % (U.S. Census Bureau, Kids Count Data Center, Baltimore City, Maryland, 2016). In Baltimore City, 24% of families were living below the poverty level and of those families, 15,637 or 28% have children younger than age 18 (U.S. Census Bureau, Quick Facts, Baltimore City, Maryland, 2016).   Similar to impoverished urban cities, Baltimore City had been hit hard by the crack-cocaine epidemic. The high rates of drug activity, crime, unemployment, and juvenile delinquency have affected the structure and functioning of family and community resources. In the state of Maryland, 141,040 grandparents are co-residing with their grandchildren and of those 30 % are skipped generation households, no parent present, 39% are aged 60 years and over and 14% are living in poverty (Ellis & Simmons, 2014). The legal arrangements of these grandparent-maintained households are unknown; however, it can be estimated that large proportions of grandparents are providing informal care (Mayfield, Pennucci, & Lyon, 2002).

Results

Through analysis of transcripts, six interrelated themes contributed to understanding the context of how African American grandmother caregivers coped within the context and environments of informal social support. Grandmother caregivers operated along a continuum of *reliable* to *unreliable* informal social support. Unreliable support described family members

as being overburdened with their own responsibilities. Grandmothers felt they did not have the emotional, financial or social resources to assist with caregiving as result of their own challenges with poverty, health, or other life challenges. At the other end of this continuum, *reliable support*, grandmothers described family members grandmothers depended on to assist with grocery shopping, medical appointments, finances, and occasional respite care. In the context of these varying degrees of *reliable* and *unreliable* social support, four survival strategies emerged: ***being strong***, ***self-sacrificing***, ***receiving help*** and ***self-compassion***. Grandmothers' survival strategy employed was dependent on the continuum of *reliable* to *unreliable* informal social support. Below we describe the two opposite ends of the continuum of unreliable to reliable support. Within each context the narratives presented describe how caregivers operated on a continuum from ***being strong*** to ***self-compassion*** as they had greater access to resources. We conclude with how their survival strategies affected their emotional and physical well-being.

Unreliable Social Support
         Unreliable social support was depicted as family members who were not able to participate in exchange of family resources due to being absent or deceased as a result of drugs, community violence or poor health (e.g., HIV/AIDS, cancer, or heart disease). As depicted by Ms. Coppin, a 68-year-old, retired, divorced grandmother caring for three grandchildren; four of her five adult children, with the exception of her son, were affected by drug abuse and incarceration

> *[Daughter's name] was a long-distance operator, telephone operator. Blew it for drugs. [second daughter] is an artist and she could, she laid the tile in my house when I needed it, and could do all kinds of work … [third daughter] is a tailor and interior decorator…and Yvonne [fourth daughter] is a licensed plumber, and they [daughters] want drugs. And they come to me on the third [pay day] looking for loans, for money. Steal. I've lost microwaves; the children lost games, TV's because of them.*

Ms. Coppin's depiction above describes how her entire family was adversely influenced by the crack cocaine epidemic thus destroying the helping traditions of her family. These exo-system forces undermined the familial social support structures necessary for the healthy maintenance of family systems. Caregivers' descriptions represent the aftermath of distressed families suffering from the crack-cocaine era (Dunlop, Golub & Johnson, 2006). As a result, these family members were not able to assist due to drug dependency, community violence, or medical conditions. Her support primarily came from one male family member (adult son) residing outside the grandmother's home, who helped in all areas except shopping, cooking and cleaning. Female support came from Mrs. Coppin's siblings in the area of emotional support. Remaining females (four daughters) were affected by drug abuse and incarceration but these daughters would provide support only in times of crisis. There were no adult family members residing inside the home to provide daily support in the area of household chores (e.g. cooking and cleaning).
         Even when family members co-resided in the home, caregivers still faced difficulty with seeking contributions toward caregiving as they were overburdened with their own hardships. Grandmothers described family members as being too busy coping with their own stressors to contribute toward caregiving on a consistent basis. For example, Mrs. Truth, a 74-

year-old great-grandmother caring for her seven great-grandchildren; Mrs. Truth had four adult children. She lost her only two sons to drug overdose between the years of 1995-1996. These two sons left a generation of grandchildren and great-grandchildren that was cared for by Mrs. Truth. The biological mothers of these grandchildren were not providing support due to drug addiction, incarceration and death. Mrs. Truth's two daughters also left a legacy of grandchildren and great-grandchildren. Biological mothers of these children were also not able to provide support as two mothers were killed and the remaining was addicted to drugs or neglected their children. Similar to Ms. Coppin, as well as remaining grandmothers in this study, families were distressed by the devastation of crack cocaine era which occurred most often in inner cities in the 1980s and 1990s, resulting in sub-cultural behaviors, such as child abuse and neglect and family dissolution (Dunlop, Golub & Johnson, 2006).

The availability of supportive resources in Mrs. Truth's informal social support network was limited by the impact of drugs, alcohol and mental health. Both granddaughters resided in Mrs. Truth's home and had young children that were primarily cared for by Mrs. Truth. One granddaughter was described as being unable to provide consistent support for she suffered from a mental disorder and was addicted to alcohol. In the excerpt below, Mrs. Truth presented difficulties she had with getting support from this granddaughter,

> *She don't take her medication [for manic depression]. She drinks (alcohol)*
> *every night on that step. Every night she's drinking. And then in the morning,*
> *she don't want the children to say nothing to her…she does nothing but stay up*
> *in that room all day…And she's just miserable. She wakes up miserable…she's*
> *not stable, she's an unstable young lady….She done cut her wrist four times*
> *behind a sorry low-lifed. And she had these children. She don't want them…And*
> *the only way I keep her in my house is so I can watch them [great-*
> *grandchildren], cause she will hurt them…She is what you call a manic*
> *depressive.*

 The other granddaughter was described as "trying to get on her feet". This daughter was recently released from incarceration, and sought treatment for her drug addictions. Mrs. Truth related,

> *She was out there, but she straightened herself up. And she's ready to take*
> *[her] grandson and I am ready to give him to here….She's been clean now for*
> *six years and she's working. So I think she can have her son back…Her*
> *apartment should be coming through by the end of this month and than she will*
> *be taking [him].*

Mass incarceration is no longer affecting just Black men. Women of color are the hardest hit. As noted by Lee & Wildeman (2011), Black women's social networks are riddled with imprisoned family members and neighbors compared to White women, men and even Black men. Mass incarceration of Black women have resulted in added harm to grandmother headed households who are left to care for children often in state-sanctioned poverty due to the unresponsiveness of human service agencies (Simpson & Lawrence-Webb, 2009).

Remaining family members residing outside of Mrs. Truth's home were her sister, two daughters and the biological mothers of her great-grandchildren. These family members were

largely burdened by their own responsibilities or dealing with drug abuse:

> *So even when she [biological mother of three grandchildren] come to get the children, now during the summer, I would ask her to keep them, but she is a rock head, she's a crack head, she's in and out of jail…Well, yes she (grandmothers' biological sister), she's not what you call flat down in the bed. She gets up, she goes to the store and everything, she cooks dinner for just her and her husband, she has a granddaughter and she's in school now. So, I wouldn't put, I wouldn't really disrupt her (grandmother's biological sister) to say, 'Well, you keep all of this,' because I got one, I wouldn't put that on my worse enemy. So, and then the rest of them is not gonna volunteer. To keep them, nobody really wants to keep him [grandson with emotional and behavioral problems]….*

Although Mrs. Truth's sister was not able to provide support in the areas of household, respite, appointments and at times of crisis, she could count on her sister to provide informational and emotional support. She related discussing concerns with her sister on a daily basis. Mrs. Truth reported her sister was her primary source of emotional support. However, she related not having anyone else to talk to,

> *…there are times that I would like to have someone to talk to. I don't have no one because everybody in the neighborhood, outside the neighborhood, bring all their problems here….*

Grandmother caregivers having limited emotional support from family members were consistent among grandmother caregivers in family networks with a limited pool of supportive resources. The types of support Mrs. Truth reported not receiving any help were in the areas of respite care and crisis. The lack of support for respite and crisis in family social support networks with unreliable support was a common theme. She shared the following,

> *…Last year I had pneumonia, I had the walking pneumonia, I went to the doctor's and he wanted to hospitalize me and I said how can I with all those kids and no one to take care of them. (the doctor said) So what'd you do if you dropped dead or go into the hospital? I told my doctor I'll cross that bridge when I come to it; I wasn't dead yet.*

Survival Strategies: Being Strong or Self-sacrificing
    In this context of unreliable support, caregivers managed by ***being strong*** or ***self-sacrificing***. These were survival strategies caregivers employed when they were minimal to no supportive resources in maintaining their caregiving role. In the present study, being strong was a culturally appropriate and expected survival strategy when faced with adversity. As previously discussed, all grandmothers were coping with the effects of drugs, poverty and oppression in their families and communities.

    Being strong: Attributes of being strong were keeping emotions hidden, not allowing one to release negative emotions for fear of breaking under pressure, relying only on their

internal resources to manage their caregiving role. Being strong meant that they maintained a false sense of self-composure by not revealing their true feelings. This sense of self-composure was important for it allowed them not to emotionally break down under adversity. For example, Mrs. Truth had two sons who died from drug addiction between the years of 1995-1996 and were caring for their offspring. She stated,

> *...And sometimes, honey, it's not easy. It's so hard to, I just don't cry anymore; I cried out. And crying don't help. And I'm at the point now that if I start crying, I will never stop. I won't know how to stop because I've held it back so long and I went through so much with my second husband and his family. And then I lost my two sons back to back; and there wasn't no one that I could lean on. So there had to be nobody but God that brought me through all of this...a couple of times this year...I feel like I wanted to cry, just wanted to holler and scream. But I knew I couldn't do that because if I did that, they wouldn't of have no one because I'd would of been gone. And I just can't give in to those kinds of things because it bothers me and it hurts. I've never cried behind either one of my sons because that's their life.*

Embedded in Mrs. Truth's statement was that she had to be emotionally strong in order to continue her role as a caregiver. She was left with the responsibility of caring for her grandchildren and to allow feelings associated with sadness and grief would interfere with her role of caregiving. In her statement, "…it bothers me and it hurts" revealed that she was feeling pain associated with these losses and her added responsibility of caring for others. However, dwelling on these feelings would only weaken her resolve and her ability to care for others. Carthron, Bailey and Anderson (2015) found similar findings in their study as African-American grandmothers engaged in self-silencing believing there was no other choice but to quietly carry their adversities without breaking down physically or mentally.

Self-sacrificing*:* Attributes of self-sacrificing captured caregivers' survival strategies who did not have the time ***nor*** took the time for self. They often did not enjoy a personal life outside of caregiving. Self-sacrificing captured the lived experiences of African American caregivers who had to rely on their own internal resources to meet their personal needs and grandchildren's needs. This was a necessary survival skill for grandmother caregivers who had fewer resources in their informal and/or formal social support. Women acted in this capacity because they needed help from family but oftentimes this help was not forthcoming. For example, Ms. Ruffin aged 53 and caring for four grandchildren, described how family members are coping daily with poverty, health, and responsibilities of their own,

> *My oldest sister, she's got, what is it, cerebral palsy… she can't get around too good . . . And my next oldest sister, she's a foster mother, so she got about four foster kids of her own, and a little grand boy. And my next sister, she's a heart patient, so she's not capable of taking care of them or helping me. . . My next sister . . . she works and she has three kids of her own, so she's not capable of really helping me. All of them have their own responsibility. And if they could help, like I say, they may call on the phone, do a little talking.*

When grandmothers were asked about why they engaged in self-sacrificing behavior, they consistently responded that asking for help was not the problem but rather who was available to provide help. As stated by Ms. Chinn, a 65 year-old, caring for two grandchildren, "I ask for help and don't get it a lot [of] times. Ask for help and don't get it!" Ms. Coppin, 68 caring for three grandchildren related,

> *Well, some people have help in their households from their grandmothers or aunts, uncles who raise them. But they also have a younger, a sister-in-law or might [have a] daughter or somebody in the household. I don't have anybody in my household to do anything...*

Grandmothers often felt internal and external pressure to operate independently in a context of limited or inconsistent support from various social structures. Grandmothers sacrificed their own lives to meet their family members' expectations to care, and social service agencies who often threatened that their grandchildren would be removed if they did not assumed full parental authority. Ms. Moses, aged 52, shared her experience about how she sacrificed her career goals to fulfill family expectations,

> *... training for Return to Independence [fictional name of program for job training]. And every day they kept calling me, my sisters and they, "you need to take your grandchildren. My sisters kept calling me on the job, getting on my nerves, saying I need to take the grandchildren. Because they had no one else to take them. The mother, she wasn't taking care of them properly. She [biological mother] could no longer... and she got so she couldn't even take care of him. You would go around where she [biological mother] was living at, she'd be sitting up there shaking up drug needles in a box, sitting there in the door all highed-up, he (grandson) wandering the street and he wasn't no more than about a year old, all around [name of] Street, could of got killed, eating out the garbage can. Well she fixed food and stuff, but she wasn't stable at that time of taking care of him. So they [sisters] kept calling me about him [grandson]. So it took me maybe about a month and I decided I would go and get 'em all. So I stopped the training and I took all four....*

Self-sacrificing, placing her own personal goals on hold in order to meet the needs of her grandchildren were necessary for the well-being of her grandchildren. Ms. Moses reported that after assuming care for her grandchildren, she had very little time for herself and her own personal needs. She reported:

> *"...but a lot of times I let myself go lacking so that I can take care of them [grandchildren], what their needs are. And after their needs are all taken care of, and then I reach back or relax and work on mines."*

Sacrificing their own needs to meet the needs of their grandchildren was a necessary adaptive strategy to meet their caregiving demands. Grandmother caregivers felt they were not offered any other alternative from family members and/or community providers regarding the care of their grandchildren. This required that they remain strong and/or self-sacrifice their

own needs to meet societal expectations of their caregiving role.

Reliable Social Support

On the opposite end of the continuum, grandmothers described a few of their family members as reliable. These family members assisted with grocery shopping, medical appointments, finances, and occasional respite care. Although both men and women fell into this category, grandmothers perceived their sons as more reliable as they had the economic and material resources to regularly assist grandmothers (Simpson & Cornelius, 2007). The following themes are grandmothers' perspective of their family supportive resources. Ms. Chinn, 65 year old, caring for two grandchildren, described how her son, uncle of the grandchildren, who assisted her on a daily basis by providing male mentorship to her grandchildren, she reported, *"My son is basically my backbone. He's my back-up person."* This quote captures the perceptions of grandmother caregivers' reliance upon their sons or other family members to assist in their caregiving role. Ms. Moses', aged 52, caregiver of 4 grandchildren had a significant male friend who was available to provide additional support in the areas of material means, emotional support during times of crisis. She also had an adult son (uncle of grandchildren) who resided in her home who assisted with her grandchildren. In the excerpt below, Mrs. Jones, who cares for one granddaughter, adult daughter with Downs Syndrome and mother, with Alzheimer's describes how her son, who once had an alcohol addiction and does not live in the home, was currently a source of support and could be relied upon to meet her caregiving, needs,

> *...my son used to be an alcoholic. Now he says he's, what you, he call himself, an inactive alcoholic. He hasn't drunk in about 4-5 years. Now, I can call on him, like I need something from the store…*

She furthered described her son's role:

> *"Like, now I have a meat man who brings all my meats but like my vegetables. He picks up all the vegetables …buys all the vegetables like, beans, cabbage, corn, our canned goods, potatoes, onions. He buys all of that…And he takes her (dependent grandchild) when she needs new shoes; she goes to [name of store] in Maryland Parkway. And he sees that she gets to the store to get her shoes. And what else? And he'll come down if I need anything. Yeah, he'll fix the doors for me if they need to be fixed. But most of my children are very helpful"*

As depicted below, remaining family members in her informal social support network were available to assist her with grocery shopping, meeting medical appointments, finances and sometimes respite care. Mrs. Jones described how female and male family members played primary roles in caring for her grandchild and herself:

> *"[Name of person], that's my son's daughter, she's the one that will come and see that [name of person] (dependent grandchild) has a dental appointment, a eye appointment, any kind of appointment she has to go to; she does….And my oldest daughter….she sees that I get to all my doctors' appointments. She's a*

*correctional officer over at [name of job site]; and she works the night shifts.
And she works the night shift just so she can ensure that I get all my
appointments… And she buys all of the like soap powder, soap, bleach, washing
liquid, paper towels, toilet tissue. She does that. She gets it at Sam's Club
because she's a member….The godmother [of her dependent grandchild] goes
to the school when they have functions because her godmother is now retired
from Social Security. She was one of the biggies up there. And she goes up and
the teacher knows she can always call me or call the godmother and we can get
it together…".*

Survival Strategies: Receiving Help and Self-compassion

In the context of reliable support, caregivers managed by receiving help from their
family social support. Grandmother caregivers with available supportive resources in a desired
area were able to engage in asking and receiving help. As summarized by Ms. Chinn, in order
to move beyond self-sacrificing, help had to be available. Their ability to operate from this
framework was possible only when they received the needed resources desired from informal
and formal social support structures. Grandmother caregivers who received support from
informal and formal structures primarily operated from this framework.

   Receiving Help. The key to receiving help was based on caregivers' willingness to seek
help from family members ***and*** family members' having available resources to meet their
needs. Ms. Chinn, cared for one child with behavioral/emotional problems, had no family
members residing inside her home. Support came from paternal grandmothers in the areas of
emotional, respite and informational. Support from other family members (siblings and
biological mother of grandchild) were minimal due to drug addiction, medical conditions and
poverty. She described how her son provided support when she was faced with the reality of
giving up her grandchildren after being denied community services for clothing and food:

   *"When I moved over East Baltimore … I done moved all over town with these
   children trying to hold on to em, but I can't get no help! You know! (Long
   pause) And my son, he came up and I started telling him about they didn't have
   no clothes and I was giving them up (respondent is tearful). That was a time
   too. He cried and I cried…. So he said, "Come on, let's go get them clothes."
   …Took me and bought their clothes, you know. Thank God I don't have to go
   through it no more (tears in her eyes, voice choking up)…"*

   Prior to her son's involvement, Ms. Chinn shared how she requested help from various
agencies and help was not forthcoming. In her above excerpt, she stated "…I done went to my
limit…" meaning she relied upon and used all of her internal resources to feed, clothed and
provide shelter for her grandchildren. Although she asked for help from community providers,
it was not provided and she turned to her family for assistance. Ms. Chinn's ability to maintain
her role as a caregiver was possible by the help she received and continued to receive from her
son. If help was not forthcoming from either family or community, she would have been left
with no other alternative but to release her grandchildren to state custody. Asking and not
receiving help can push caregivers to manage by being strong or engaging in self-sacrificing
behavior.

Given the limited availability of support in grandparenting households, three grandmothers sought help from mental health agencies to assist with managing their care demand. Ms. Coppin, Ms. Ferebee and Ms. Moses, had scores higher than 16 on the CES-D depressive scale (Table 1) and all three received mental health treatment. Ms. Moses clinical score was 23, Ms. Ferebee, 41 and Ms. Coppin was 43. Their entry into therapy was precipitated by a crisis event related to their grandchildren. All felt being in therapy provided them with a safe forum to discuss their emotions related to their caregiving role. Ms. Coppin's therapist was once her grandson's therapist and she viewed her therapist as her primary source of social support. Ms. Ferebee received various services from community agencies due to her granddaughter's disability. As with Ms. Coppin, her mental health services were initiated during a crisis episode with her grandchild. This finding of African American grandmother caregivers receiving services from mental health agencies is new to the grandparent literature. For the three grandmothers receiving mental health services, they no longer felt they had to be strong in all areas to cope and they were provided a safe forum to discuss their concerns.

Self–compassion. Self-compassion related to grandmother caregivers creating a space in which they could enjoy themselves without feelings of guilt. It meant taking time **and** having the time to enjoy their personal activities. To achieve this need, grandmother caregivers required support for child sitting services from informal and/or formal social support structures. The need for self-compassion was often expressed by caregivers but not fulfilled by many. Expressed by Mrs. Jones *"…if I can get an hour just for me to do nothing…then I can sit here and watch a program without having to do something for somebody…"* and confirmed by Mrs. Truth, *"if I can just get an hour just for me…."* And shared by Ms. Coppin *"…I need some time off and they're [adult children] not giving it to me…I can't get anybody to watch my children [referring to grandchildren]".* Evident in their statements was the desire to have time for themselves but not having consistent support in their informal and formal social support structures to meet this need. Oftentimes when questioned about what they did in their free time, caregivers expressed *"what free time…"! [Mrs. Truth]*. Ms. Chinn was one of two grandmother caregivers who created the time and had support from her informal social support network so that she could enjoy her own personal needs. Ms. Chinn shared how her son planned to care for her grandchildren, while she took an overnight trip to Connecticut on Mother's Day with fellow employees,

> *My son, they're [grandchildren] are going over to Maryland, they leaving tonight. I just finishing talking to him, he picking them up tonight. They going out of here (laughs).*

 Ms. Chinn was not the only grandmother to create a space for herself. Ms. Moses related creating a space for a personal relationship could be difficult when a person is responsible for rearing grandchildren:

> *Yes, but you got to carve hard because it's really not a life. That's why I say it takes a strong man to date a woman or say he loves, that's raising her grandchildren. These days and times it takes a strong one. And a lot of times they may want you to go places with them, but you can't. So therefore, he got to be very understanding. And if he's not the understanding type, you might as well forget it. But by him being in God,*

> *God often change a person's ways. So far, he's been faithful. If I say, 'well, come and take me to the market,' and he's not working 'cause he works all the time, he'll say, 'okay, are the kids getting on your nerves?' and when we go shopping, if I got to go shopping for clothes or something, he take the children into another part of the store and he'll deal with them and let me shop.*

In summary, all of the grandmother caregivers have functioned at some point during their caregiving experience from both ends of the continuum. Grandmothers did not operate at one end of the continuum in all areas; there was fluidity between the two ends. Some grandmothers operated primarily from one end while others move from one end to the other, depending upon availability of supportive resources. In the final area, a discussion regarding these adaptive strategies and caregiver well-being are addressed.

Survival Strategies and Mental Health
The survival strategies, being strong and self-sacrificing, had a negative emotional reaction, such as over-eating or not eating at all, excessive cigarette smoking, alcohol consumption or emotionally distancing themselves from stressful situations. Mrs. Coppin, who primarily operated from being strong or self-sacrificing, shared the following:

> *...I don't smoke until about 8:30 or 9:00 at night. And then I sit down and I might want a beer that we had leftover or a glass of wine and a cigarette; and I sit there and read or watch television and I'm happy. That keeps me, ain't no need in worrying about not getting out, going out with my friends that I don't have anymore. But it relaxes me; I just feel that I haven't missed out on anything...it [drinking] doesn't cause me not to get up and do what I have to do in the morning. But before I was dreading getting up in the morning. Now it makes me feel better, I have a better attitude about it. You still gotta do the same things, but it gave me a better attitude.*

Mrs. Coppin's family resources were oftentimes unreliable and inconsistent. She primarily relied upon her son and therapist for support. The remaining members in her family were affected by drug abuse, incarceration, poverty and medical conditions. According to Mrs. Coppin, their ability to provide consistent and reliable support was hampered by these conditions. Mrs. Truth's explanation of a possible outcome for grandmother caregivers who primarily operated from this end of the continuum:

> *... you will eventually crack under the strain and the stress or either you just walk out that door and go to the bar and become an alcoholic...and you drink til you, think you drinking to yourself, easing it, but you're only destroying yourself without even knowing it....*

Grandmother caregivers, who had minimal to no supportive resources from informal and/or formal social support, felt they had to be strong, rely solely upon their own internal resources and sacrifice their own needs for the needs of their grandchildren. In doing so, they minimized and neglected their own emotional and health conditions. Mrs. Truth reported that taking care of her grandchildren with minimal support from others interfered with her physical

health. Mrs. Truth was a diabetic and has undergone several laser surgeries to stop her eyes from leaking fluid. Being strong or self-sacrificing required grandmothers to use an enormous amount of internal resources to manage stressors related to their caregiving situation. She related:

> *You have to be calm and you can't get upset, and it just doesn't help….Sometimes I feel bad, I mean, I get hungry and when I go to eat I gets full up. If I continue eating, I'll get sick. Or my sugar have a tendency to drop drown; its dropped down as low as 30-34. And then it'll just jump back up, Saturday it went up to 205. And then Sunday morning it was down to 179. Then it just dropped right on down to 150, and it'll keep on dropping all day through. Sunday night it was down to 91. And it's just up and down. But the kids come home and act like, don't know which way is up…everybody's trying to talk at the same time. Everybody's telling me what happened. They don't want to talk one at a time…and then they gets angry when I say, 'one at a time, or give me a break, or sit and do your work, we'll talk after while.*

Being strong and self-sacrificing required grandmothers to use an enormous amount of internal resources to manage stressors related to their caregiving situation. In the context of their social support structures, grandmother caregivers employed the necessary adaptive strategies in order to meet their caregiving role expectations. Oftentimes, this was done at the expense of their own emotional and physical health. Grandmother caregivers often spoke of being tired, exhausted and frustrated with their caregiving role but at the same time feeling committed to caring for their kin. Mrs. Truth's words echo grandmothers' concerns: "God's always gonna have somebody here to take care of these little ones, somebody. As I said, sometimes, I cry, 'Why'd it have to be me!?'

In summary, grandmother caregivers' coping strategies were primarily influenced by the availability of supportive resources within their informal and formal social support structures. Grandmother caregivers operated from both ends of the continuum depending upon the availability of resources received or not received in a specific area. In the context of their social support structures, grandmother caregivers employed the necessary adaptive strategies in order to meet their caregiving role expectations. Oftentimes, this was done at the expense of their own emotional and physical health. Grandmother caregivers often spoke of being tired, exhausted and frustrated with their caregiving role but at the same time feeling committed to caring for their kin.

Discussion

Prior to discussing these findings, a quote from Jacqueline Jones, author of *Labor of Love*, is necessary to set the stage for the coping strategies employed by grandmother caregivers resulting from "having nothing to fall back on: not maleness, not whiteness, not ladyhood, not anything. And out of profound desolation of [her] reality she may very well have invented herself…" (p. 315). This article examined how older African American grandmother headed households respond when faced with consistent and inconsistent social support from family and community. We use multiple lenses, ecological perspective (Bronfenbrenner, 1979) and the womanist perspective (Collins, 2000), to highlight how caregivers engage in survival strategies and how it affects their emotional and physical well-being. The framework from

which grandmothers engaged in survival strategies was based on their interactions with society, the African American community, family and self. Social conditions influenced the structure of grandmother caregivers' informal social support network and the flow of supportive resources.

These social conditions included death by HIV/AIDS, drug addiction and/or community violence, incarceration, poverty, severe medical conditions, and drug abuse, all of which are disproportionately affecting the African American community. These conditions also affected those who were remaining in the informal supportive network and the type of support grandmother caregivers could receive from these family members. Grandmother caregivers received a majority of their support from family members who were largely unaffected by these conditions. Grandmother caregivers that reported lack of consistent and reliable support from female family members felt they were not providing help because of their drug addiction, medical conditions and/or poverty.

We know from previous studies that grandparent caregivers are overwhelmed with their caregiving responsibilities and may not be receiving support from extended family members (Burton, 1992; Carr, Hayslip & Gray, 2012; Jendrek, 1994; Musil, et al, 2011; Smith, 1994). These studies suggest that the context of caregiving is very important. We provided some insight into how low-income, African American grandmothers from inner-cities are struggling to meet their caregiving demand within fragile communities and families struggling with urban poverty.

We highlight in the context of varying degrees of *reliable* and *unreliable* social support, four themes: **being strong**, **self-sacrificing**, **receiving help** and **self-compassion.** The myth of women **being strong** and meeting the stressors of caregiving in unavailable social support without experiencing physical and psychological detriments to their health and well-being is a lack of understanding the impact of social, economic, and personal issues endured by African American mothers (Collins 1990). Strong black women are portrayed as taking on more responsibility than an average person can handle. They require no help nor do they ask for help. As described in black feminist literature, they are called upon by society to sacrifice their own well-being in order to meet societal expectations (Gillespie, 1984). Glorification of the strong black woman leads to absence or lack of recognition around social, economic and personal issues endured by African American mothers (Hill-Collins, 1990; hooks, 1989; Wallace, 1999). In review of the literature about African American grandmothers, their role of caregiving is often glorified. As observed by Hill-Lubin (1991):

> the most visible portrait of the black grandmother in all of the literature is one of action, involvement, hope, and dignity. Although advanced in age, she is not an old woman enjoying the leisure of having no family responsibilities or lamenting that she is nearing death. Most often, she is so busy trying to save others, especially her grandchildren, that she has little time for herself (p. 174).

The role of the African American grandmother being romanticized or idealized in African American communities, is reflective of the " … idea that mothers should live lives of sacrifice…" (Christian, as cited in Hill-Collins, 1990, p. 116). We explored how African American women caregivers fought to preserve their family members often in the context of unavailable social support. We also show that despite their fragile systems of care, there are a few members who are available to provide care. Although studies have examined mental health

and well-being among African-American grandmother caregivers, few studies have explored this phenomenon within the context of informal social support.

Our findings note how the detrimental effects of strength and self-sacrifice coupled with the absence of family and community support puts the grandmother in the precarious position of ignoring her mental and physical well-being. The challenges grandmother caregivers faced were largely dictated by their location in the social hierarchy and concerns expressed by these grandmothers reflected their unique position in society. Primarily because there are African American, female, older and of limited economic independence they are faced with different realities.

Practice Implications

This qualitative study has implications for service providers working with grandmothers from inner cities. Social workers, mental health clinicians, medical professionals and other human services providers must take into consideration the unique circumstances of African American grandparents caring for their grandchildren in our nation's inner cities. With most of them dealing with the loss of their own children and family members to drug addiction, crime, incarceration and/or death within the context of having to parent again in impoverished, crime riddled communities, adds an additional level of stress to an already difficult situation. It will be important that clinicians and human service providers conduct individualized, client specific assessments and develop multilevel interventions to meet the needs of these grandparent caregivers and their grandchildren. These interventions must be implemented in ways that honor and respect the history and culture of grandparent caregiving in the African American community. Realizing that members of this community have engaged in the practice of community self-help, caring for their own, including its children, will enable workers to provide more relevant and culturally sensitive services.

As part of the comprehensive assessment process, clinicians must evaluate the survival strategies used by these African American grandparent caregivers and the level of support, including the informal supports available to them. As with most of the participants in our study, family social support is often limited or unavailable. For this reason, clinicians must work with these parents to identify fictive kin, neighbors, community members, religious congregations and informal social services who can provide some degree of support. For example, service providers or community leaders can work with family members to collectively create a caregiver respite plan for caring of the caregiver. When possible, workers will need to work with the birth parents of the children to provide encouragement, supportive services and referrals in order to empower them to provide some level of support to grandparents. Mental health and counseling services must be offered and encouraged, especially to address the potentially negative impact of "being strong" and "self-sacrificing" behaviors. In order to cease the transmission of these survival strategies from one generation to the next, we must intervene with our elders. This may be possible with connecting the younger generation with the older generation in developing a new script that is gender-specific and culturally responsive to the health and wellness of African American women.

As we contemplate how to best address the issues and concerns related to grandparent caregiving, clinicians will need to "think outside the box" and offer therapeutic sessions in unique ways such as in the home or at local places of worship. Further, it is important family members and service providers pay respect to the rewards of caregiving. Research studies have found grandmothers experience improved health and emotional well-being in their role as

caregivers, including a sense of purpose (Giarrusso, Feng, Wang, & Silverstein, 1996; Hayslip & Smith, 2013; Fuller-Thomson, Serbinski, McCormack, 2014).

In order to transform current caregiving challenges, women must exercise their "voice," that is when individual voices of black women are honored (Collins 2000) and their right to define their own caregiving experiences. Reliance upon extended kin is essential for caregivers to maintain healthy caregiving practices (Simpson, 2009).This can be done when we target interventions to improve structure and functioning of family, including extended family members. This would make it possible for caregivers to engage in healthy caregiving practices within a family context, which would allow them to engage in preventive health-care practices.

Limitations

The findings from this study came from qualitative data obtained from a small sample of African American grandmother caregivers living in a single urban area in the state of Maryland. The west side of Baltimore City where the participants resided is known for its challenges in addressing community violence, drugs, and pockets of poverty. It will therefore be challenging to generalize the findings to African American grandmothers, living in different areas from a different socio-economic status, region, racial and ethnic backgrounds. Readers of this study may be able to link the findings of this research to their own experiences and decide for themselves if it is applicable to their situation. It is important that we better understand how limited social supports impact the mental health of grandparent caregivers and their ability to care for themselves or their grandchildren, as well as how to effectively develop and implement more appropriate services and interventions to best meet their needs.

Conclusion

All grandmother caregivers experienced significant losses in their informal social support network, which was experienced as drain or depletion on their informal social support resources. These losses represent social conditions (e.g. drug abuse, incarceration and urban poverty) which disproportionately affect the African American community. Despite the depletion of resources, grandmother caregivers had at least one reliable person they could call upon in times of need. Family members they primarily relied upon were described as holding working class jobs and having the economic means to provide support. Grandmother caregivers' sons played a major role in assisting caregivers with meeting their needs.

The survival strategies grandmothers employed under inconsistent resources, ***being strong*** and ***self-sacrificing*** increases women's susceptibility to mental and physical distress. Grandmother caregivers who operated from this framework acted in this capacity because they were called upon by individuals in their informal and formal structures to cope at this level. It was not considered a maladaptive strategy when faced with limited support from social support structures. It was viewed as an adaptive strategy situated in the context of their current social support structures. In order to move beyond these survival strategies, we must reinforce needed resources desired from informal and formal social support structures.

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