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*Research Article***“If I Don’t Take Care of Myself, I Can’t Take Care of Them”:
Exploring Caregiving Grandmothers’ Experiences of a 9-Session
Self-Care Curriculum**

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Abstract

The predominance of research on custodial grandparent caregiving focuses on prevalence, risk factors, and challenges; less attention has been paid to the development of interventions to support this population. In response to a decrease in length of service provision at a local agency, a nine-session self-care curriculum was designed to focus on caregiver health through the empowering, multi-dimensional practice of self-care. The curriculum uses a mind-body approach and was integrated into a pre-existing nine-month support program for grandparents raising grandchildren. Using a basic, interpretive qualitative design, the purpose of this study was to explore how grandparent caregivers: 1) understand and practice self-care in their lives and 2) experienced self-care curriculum introduced within a pre-existing support group. Data were collected through qualitative interviews and analyzed concurrently using basic thematic analysis; techniques used included open and focused coding, cross-checking, and memo-writing. Study findings reveal self-care was most often understood in terms of physical health, caregiving that brought meaning and purpose to one’s life, and preferred activities that focused on introspection, solitude, and spirituality. Participants reported the curriculum was helpful, citing benefits such as present-moment awareness, relaxation, and personal connection. Implications for practice and future research are included.

Key words: caregiving, grandmothers, self-care, mind-body, mindfulness, kinship care

Since the 1980s, the prevalence of grandparents raising grandchildren and the circumstances resulting in kinship care have garnered significant attention in the literature. The 2012 US Census (2014) reports approximately 2.7 million grandparent caregivers take primary responsibility for grandchildren under 18 residing with them. Custodial caregiving can yield a multitude of positive outcomes, including providing caregivers with joy, sense of purpose, and the opportunity to parent for a second time with improved skills (Hayslip & Kaminski, 2005; Tang, Jang, & Copeland, 2015). Yet, custodial grandparents tend to be out of sync with same-age peers and often face additional physical, emotional, mental, interpersonal, legal, and financial stressors that can come with the introduction of a new caregiving responsibility (Hayslip & Kaminski, 2005; Langosch, 2012; Tang, et al., 2015; Whitley, Kelley, & Campos, 2011).

Caregiving demands can take a toll on the caregiver, and in recent decades, researchers have extensively examined the health outcomes of kinship care. Caregivers report less engagement in exercise, demonstrate poorer health choices, and participate in fewer health-promoting behaviors than their non-caregiving counterparts (Acton, 2002; Hoffman, Lee, & Mendez-Luck, 2012; Janevic & Connell, 2004). For example, depression is often an emotional and psychological consequence of caregiving (Covinsky et al., 2003; Pinquart & Sorensen, 2003). In fact, Lu and Austrom (2005) report depressed mood in caregivers is associated with negative outcomes such as higher levels of caregiving stress and increased difficulty performing caregiving tasks than those who experience less depressed mood. Pointing to the variation of caregiving experiences, Kim and Schulz (2008) found physical burden and psychological distress are especially prevalent among those caregiving for individuals with dementia, as compared with other caregiving populations. Caregivers often subjugate their own needs in service of the needs of the care recipient, neglecting their own health (Roth, Perkins, Wadley, Temple, & Haley, 2009). Such findings support the notion that an increase in caregiver attention to personal self-care, defined as “a process of purposeful engagement in practices that promote holistic health and well-being of the self” (Lee & Miller, 2013, p. 98), could be helpful in preventing or mitigating negative health outcomes related to the caregiving role.

While the concept of self-care has not appeared much in the caregiving literature, relevant research provides useful direction. For example, studies report stressors related to informal caregiving can be buffered by physical activity (Castro, Wilcox, O’Sullivan, Baumann, & King, 2002; Edenfield & Blumenthal, 2011). To date, the predominance of extant literature on custodial caregiving focuses on prevalence, risk factors, and challenges associated with custodial kinship care, while less attention has been paid to the development of interventions to support grandfamilies and caregivers. However, a reading of the caregiving literature reveals promise of mind-body interventions in

particular, as these efforts may be uniquely suited to address the interconnected aspects of the caregiving experience.

Mind-body interventions can be characterized as those that acknowledge the interaction between the mind, body, and behavior to improve health and well-being (Wieland, Manheimer, Berman, 2001). Interventions taking this approach offer an often absent prioritization of the caregiver's needs and call attention to self-care through present moment awareness. The observation and acceptance of thoughts, feelings, and bodily sensation—whether pleasant or unpleasant—encourages responsiveness rather than reactivity. Such intentionality brings about the consciousness necessary to proactively take steps to improve and maintain health and well-being (Lee et al., 2013). While few have been implemented with grandparents raising grandchildren, mind-body interventions have resulted in positive outcomes with other caregiving populations (Coogle, Brown, Hellerstein, & Rudolph, 2011; Minor, Carlson, Mackenzie, Zernicke, & Jones, L., 2006; Singh et al., 2004; Waelde, Thompson, Gallagher-Thompson, 2004; Whitebird et al., 2012).

Mind-body interventions often incorporate mindfulness, which is understood as “paying attention in a particular way: on purpose, in the present moment, and non-judgmentally” (Kabat-Zinn, 1994, p. 4). Singh and colleagues (2004) found that caregivers who received mindfulness training were happier and subsequently those being cared for (i.e., individuals with disabilities) were also markedly happier. Mindfulness-based stress reduction (MBSR) is a mind-body intervention designed to reduce stress through practices such as mindful breathing, body scan, and yoga (Chambers, Gullone, & Allen, 2009), and it has been shown to improve mental health, including depressive and anxiety symptomatology, among family caregivers (Whitebird et al., 2012). Further, Rejeski (2008) advocates for mind-body approaches to gerontological work specifically to attend to physical and psychological challenges often associated with aging. As compared to their non-caregiving peers, custodial grandparent caregivers experience elevated risk for numerous health problems, including psychological distress (e.g., depression) and chronic diseases (e.g., hypertension, diabetes) (Kelly, Whitley, & Campos, 2010). While emerging, research on mind-body approaches with caregivers demonstrates initial success in reducing stress and improving health and well-being in combating strains associated with the caregiving role. Despite the absence of empirical research measuring both self-care and mindfulness concepts, the positive outcomes of mindfulness-based interventions suggest that present-moment awareness may increase the likelihood caregivers will intentionally respond to their experiences by increased engagement in self-care behaviors.

Stressing the importance of attending to the needs of this population in practice, Whitley Kelly, Yorker, and White (1999) advocate for a strengths-based approach to working with custodial caregivers, underscoring the value of emphasizing empowerment and resilience. Interventions taking this approach typically focus on psychoeducation and have proved useful for grandparent caregivers, resulting in increased self-advocacy, life

control, self-efficacy, behavioral changes, and coping skills (Carr, 2011; Cox, 2002; Joslin, 2009). In response to the strong body of evidence that outlines the negative impact of kinship care upon caregiver health, a greater focus on interventions specifically designed to promote self-care behaviors is needed (Langosch, 2012; Tang et al., 2015).

**Addressing the Gap with a New Approach:
A Self-Care Curriculum for Custodial Caregivers**

Service providers at an agency serving older adults located in the southeastern United States approached the researchers to explore innovative ways to support grandparent caregivers in attending to their health and well-being. With funding limitations resulting in a reduction in length of service provision, the agency sought to adapt their pre-existing nine-month program for grandfamilies to enable caregivers to prioritize health through self-care, which can be defined as “a process of purposeful engagement in practices that promote holistic health and well-being of the self” (Lee & Miller, 2013, p. 98). The larger program, which serves four counties, offers a host of services to custodial grandparents including: a monthly support group with childcare, case management, nutrition and exercise education, information and referral services, legal education and services, health screenings and monitoring, and grandfamily activities. Informed by the early literature on both mind-body approaches and self-care, a nine-session self-care curriculum was developed and implemented within the agency’s pre-existing program for grandparents raising their grandchildren. A nine-session model was chosen to emphasize self-care across the entirety of the support group program, and the curriculum was developed specifically for this programming. The program includes a rolling admission process; that is, all participants do not enter or exit the program at the same time.

The curriculum aimed to focus on the caregiver’s ability to exert agency over personal health and well-being through the multidimensional practice of self-care. The goal of the curriculum was to support caregivers in prioritizing self-care through 1) regular experiential engagement in self-care practices, 2) the introduction of possibly new self-care strategies, and 3) the creation of a culture of self-care in the support group. The curriculum was designed to be integrated into the support group on a monthly basis, excluding summer and December. The group did not meet in the summer, and the December meeting was an end of the year celebration including the children. The nine self-care strategies included were: 1) mindful breathing, 2) progressive muscle relaxation, 3) self-shoulder and neck massage, 4) adequate and restful sleep, 5) stretching and walking, 6) thinking about support systems, 7) gratitude and journaling, 8) music and relaxation, and 9) self-assessment and reflection. The specific practices were chosen to reflect the physiological, psychological, social, and spiritual aspects that influence health and well-being, recognizing the interconnectedness of the mind and body. Consideration was also given to the need for practices to be safe and feasible for caregivers to engage in outside of the group.

Incorporated specifically into the support group element of the kinship care program, the 9-session curriculum was comprised of nine 20-minute sessions aimed at the discussion and practice of different self-care strategies. Undergraduate social work interns and the program coordinator served as facilitators of the curriculum, and these facilitators were consistent across the weeks of the intervention. Facilitators were provided with a guide for implementation, which included an overview of the session, specific steps to follow, benefits of each practice, and a facilitator script. The first 20 minutes of each support group was dedicated to the self-care component, while the remainder of the support group focused on socialization and topics of interest identified by the group members. To illustrate how sessions unfolded, the following describes the progressive muscle relaxation session. First, the facilitator used guiding questions to follow up on the previous session's content to explore how participants are integrating the self-care practice outside of the group. Next, the facilitator provides an overview of the goals and structure of the self-care curriculum; this is intended to continue to reinforce the importance of self-care and ensure all participants understand this portion of the support group, even if previously absent from group. The experiential piece then takes place, accounting for the majority of the session time. Subsequently, the benefits of the practice are discussed, and participants are reminded that case managers will check in with them about how their self-care practice is going outside of group.

The purpose of this research was to explore 1) grandparent caregivers' understanding of experiences with self-care, and 2) participants' experiences of the pilot nine-session self-care curriculum designed to increase custodial grandparent caregivers' attention to and engagement in self-care practices. As such, the study is guided by two research questions:

1. How do grandparent caregivers understand and practice self-care in their lives?
2. What were grandparent caregivers' perceptions of the self-care curriculum implemented into the support group?

Findings from the present study are intended to support the continued development of this first iteration of the self-care curriculum.

Design and Methods

The present study uses a basic, interpretive qualitative design, which is the most common type of qualitative approach. This methodology was deemed most appropriate given the researchers' goals to understand how caregivers interpret, construct, and assign meaning to their experiences (Merriam & Tisdell, 2015).

Sample Selection and Recruitment

The researchers received support to conduct the study through the agency that provides the program and approval via institutional review board. Participants were recruited using purposive sampling. To ensure confidentiality of clients, staff from the agency contacted all support program participants to determine those interested in the

study; subsequently, staff obtained permission to provide researchers identified caregivers' contact information. Inclusion criteria for the study were as follows: a) participants were custodial caregivers for grandchildren, either formally or informally, and b) participants had attended at least one support group meeting that included the self-care curriculum.

Data Collection

Data was collected using face-to-face, semi-structured interviews based upon a 20-question interview protocol (see Table 1). A 27-item survey was used to gather demographic and personal characteristics, including frequency of engagement in self-care practices measured by the 16-item personal self-care subscale of the Self-Care Practices Scale (SCPS; (Lee, Bride & Miller, 2016; Lee, Miller & Bride, 2017). Using a Likert-scale of 0 (*never*) to 4 (*very often*), the instrument asks respondents to indicate how often they engage in self-care practices spanning physical, emotional, social, spiritual, and leisure domains. Items focus on behaviors such as making healthy nutritional choices, getting adequate sleep, taking action to meet emotional needs, recognizing strengths, being kind to oneself, solving problems when they arise, spending quality time with loved ones, and engaging in spiritual practices. High scores indicate greater frequency in self-care. Reliability analysis suggests good internal validity of the subscale ($\alpha = .883$, $n = 512$; (Lee et al., 2016; Lee et al., 2017). Interviews ranged in length from 30 to 90 minutes and were digitally recorded with participant permission; one participant opted not to be recorded. A \$25 gift card was provided to thank participants for their time.

Table 1

Semi-Structured Interview Protocol Questions to Address Research Questions

<i>Research Question 1: How do grandparent caregivers understand and experience self-care in their lives?</i>
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| <ol style="list-style-type: none"> 1. What is your understanding of “self-care?” – what does it mean to you? 2. For you, what does your self-care look like? How do you take care of yourself? 3. What motivates you to take care of yourself? 4. What have you noticed are the benefits of taking care of yourself for you? 5. What would it look like if you could have more self-care? 6. How could you go about adding more self-care to your life? 7. What would you have to do differently to make this happen? 8. What are challenges to taking care of yourself? 9. What would you need to be in place to help with these challenges? |
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Research Question 2: How did grandparent caregivers experience the self-care curriculum implemented into the support group?

1. What do you remember about the self-care part of the support group?
2. What did you think about the self-care part of the support group?
3. What did you like most about the self-care part of the support group?
4. Which, if any, self-care activities did you find helpful in the support group?
 - a. How were they helpful?
5. Which, if any, self-care activities that you learned in the group have you been doing outside of group?
 - a. How often?
6. Which, if any, self-care activities in the group that you would not use on your own?
 - a. Could you tell me more about that?
7. Are there any other self-care strategies you would like to see included into the group?
8. What, if anything, did you learn about through the self-care focus of the group that you didn't know before?
9. Did your caseworker check in on you and your self-care plan?
 - a. What was useful about this check-in?
 - b. How could this be improved?
10. How could this program support you in taking care of yourself?
 - a. In the support group?
 - b. In the program in general?

How could the program support you in taking better care of yourself outside of the support group?

Sample

A total of 14 possible participants meeting the above criteria were identified through recruitment procedures. Two grandmothers could not be reached, and one was unavailable due to time constraints. Eleven grandmothers were interviewed, and one interview was excluded from data analysis due to limitations in the caregiver's cognitive capacity to respond to interview questions. All participants were in the same group; the total number of participants per session is unavailable. Demographic and personal characteristics of participants are displayed in Table 2; pseudonyms are used to protect participants' confidentiality. All participants were female, and of the 10 participants, seven identified as Black / African American, two White/Caucasian, and one chose not to identify her race. Participants ranged from 41 to 70 in age, with a mean age of 58.5. The highest level of education completed ranged from high school to graduate school, and most participants did not work outside of the home. When asked to rate their overall health using a five-point Likert-scale (0 = poor – 4 = excellent), most participants reported *fair* (1) or *good* (2) health. The Self-Care Practices Scale scores ranged from 31 to 52, with a mean score of 40.2. Participants' attendance varied from three to nine

sessions. The rolling admission design of the program did not allow for selection of a cohort of participants who could participate in the entire curriculum. However, the nine-month period of curriculum implementation did allow for any participants present to experience the curriculum together.

Data Analysis

Transcripts derived from digital recordings and researcher notes from the interviews yielded data across the cases. As suggested by Merriam and Tisdell (2015), data were collected and analyzed concurrently, using basic thematic analysis. After the completion of all interviews and transcription, the initial reading of transcripts involved open-coding procedures; the two-person research team independently reviewed transcripts and derived initial codes. As suggested by Creswell (2009), this cross-checking method utilizing independently derived results strengthens the reliability of study findings. Focused-coding, the practice of using the most significant and frequent codes to examine and analyze data (Charmaz, 2014) was then used to narrow data most relevant to the research questions. Memo-writing was used to help the authors shift from categorizing to

Table 2
Participant Demographics and Personal Characteristics

Participant	Age	Race / Ethnicity	Highest Level of Education	Work Outside of Home	Health Status	SCPS Score (range = 0–64)	Sessions Attended
Beverly	46	White/ Caucasian	GED	No	Fair	31	4
Natalie	60	Black/African American	Some College	No	Fair	33	7
Anita	60	Black/African American	High School	No	Fair	34	3
Shirley	41	Black/African American	11 th grade	No	Good	34	7
Harriet	56	White/ Caucasian	GED	Yes	Fair	35	4
Yolanda	69	Declined to answer	Some College	No	Fair/ Good	40	5
Gladdis	67	Black/African American	High School	No	Good	44	7
Phyllis	65	Native American Black/African American	Bachelor Degree	No	Very Good	49	4

Maureen	50	Black/African American	9 th grade	No	Fair	50	6
Gail	70	Black/African American	Master Degree	No	Good	52	9

interpreting the data following the aforementioned coding procedures (Creswell, 2009).

Findings

Caregivers' understanding and practice self-care in their lives as well as their perception of the self-care curriculum are presented in the following section. Themes derived from the data are organized by research question (RQ).

RQ 1: Understanding and Practice of Self-Care

Conceptual Emphasis on Physical Health. When asked to define or provide their understanding of self-care, most participants discussed the concept singularly in terms of physical strategies. References to diet, sleep, and medication were most commonly included in responses. Yolanda, a 69-year-old grandmother who has been caring for her 18-year-old granddaughter for about seven years, explains what self-care means to her, "There is an element of exercise. There is an element of taking care of you in a physical sense. As you grow older, [...] things become a case of being able to take care of yourself, literally." Phyllis, a 65-year-old grandmother of two grandchildren (ages 4 and 13), has been a caregiver for two years. Similar to Yolanda, she focuses on the importance of dietary habits and safety, noting, "[Self-care means] being healthy, taking care of my body, doing the right [thing], eat the right stuff. I guess trying to be safe [...] just stay focused. Get a lot of sleep, drink water more than other stuff." Gail (age 70), custodial caregiver to three grandchildren (ages 13, 19, and 22), adds:

Basically, for me, I need to get the proper sleep, and I need to lay in bed until about 9 'cause I get up around 5 o'clock or somewhere in there, and I try to, you know, organize the children where I won't have to stress in the mornings.

Avoidance of health-impeding behaviors was also mentioned. Harriet, the youngest of the caregivers interviewed, said, "I'm in the process of quitting these [points to cigarettes]. I have no choice but to quit and lay my cigarettes down. Right now, I'm on medication to help me stop smoking." At 50, Maureen has been for caring for your five grandchildren for nine years. She emphasized the importance of weight control, exercise, and healthy eating.

Caregiving Provides Motivation and Purpose. For participants in the present study, the caregiving role itself served as a primary motivation for self-care. Shirley (age 56) summarized the sentiment with her statement, “In order for us to see about our grandkids, we got to see about ourselves. So, that’s what self-care means to me.” Anita expressed a similar idea, “You have to take care of yourself in order to take care of our kids, cause if you don’t take care of yourself, you can’t take care of them. You’ll be lacking in some way.” Phyllis commented, “I love them. I can’t imagine them being anywhere else. I wouldn’t want anyone else to have them, not even their mama [...]. It [caregiving] keeps you motivated, keeps you moving.”

The notion that caregiving benefits participants’ well-being was apparent as caregivers talked about the sense of purpose they have in raising their grandchildren. Phyllis commented,

I think it [caregiving] gives you something to live for [...] I wouldn’t feel right if [my grandchildren] had to go to a foster home, so I’m just thankful that they can come here and be safe and cared for.

Natalie, age 60, comments,

They keep me laughing and keep me going. There’s no negative side to it. [...] Some days I don’t feel like doing anything, but you know, I have to keep going because of the kids. They would be my motivation.

In fact, caregiving was even considered a primary source of fulfillment. Harriet explains,

My grandkids—yep, I think that’s one of my purposes because they love me, and I love them. [...] They’re what makes me want to keep going, because I just can’t see no other way of somebody taking care of them or something. As far as me taking care of them, I just want to make sure everything is right, full of love, giving them attention.

Solitude and Introspection. When participants described activities they engaged in to take care of themselves, a theme of solitude and introspection emerged. Related self-care practices included deep breathing, quiet/alone time, journaling, relaxing and/or listening to gospel music, and reading. Natalie explains how she uses many of these strategies, “Listen to music and just while I’m listening, doing the breathing. I do that and just go off, have free time. Go to the room by myself and sit there and listen to my music and just relax.”

Positivity. Several of the grandparents describe various practices intended to cultivate positivity as a means of taking care of themselves. Gladdis, a 67-year-old caregiver, suggests, “Positive thinking. Be positive—it’s the best way to go.” Similarly,

Beverly, age 46 and caregiver to two young grandchildren, reflects on how focusing on the good things in her life helps her. She recalls:

When you start to write in your journal you think of more positive than negatives, so it makes you feel better. And you know there's a reason for everything. When you start writing all your positives down, you know that there's a good reason they're here with us.

Spirituality. Almost all participants described spirituality as an important aspect of their self-care practice. Prayer, the reading of religious texts, and meditation were the behaviors mentioned that contribute to this theme. Engagement in spiritual practices appeared central to managing various stressors (e.g., parenting, financial strain) and garnering strength, hopefulness, and gratitude. Beverly describes the helpfulness of spirituality in relation to the challenging aspects of parenting:

It helps because if I didn't pray, there's no telling what kind of emotional [state] [...] I would be in because I have really bad nerves, really bad and I do take medicine for it. But with the grandkids they really know what buttons to push. Every morning I pray that it is a good day.

Likewise, Anita, a 60-year-old caregiver, viewed spirituality as a way to deal with the frustration accompanying caregiving. She states,

I mean it [prayer and meditation] helps 'cause I know strength that I have—it comes from above. It comes from God. [...] Stressful times, you know, when you know how kids are - teach you to be patient sometimes and blow your top but if you pray and meditate, it helps keep from blowing your top.

Emphasizing the strength spiritual practice provides, Gail comments,

It's a difficult task; it's not easy, and you know I have to pray and have to read my bible. I have to pray for myself; I have to pray for them—pray for her [the participant's daughter and children's mother]. You know, I couldn't do it without God, I just couldn't cause I would be all out of sorts.

Harriet explains, “I like to read spiritual stuff and anything to boost my spirit or hopes or increase my faith or make me think differently.” Shirley describes how spirituality promotes persistence:

I just try to make things work out the best way I can, and I've been doing good. I thank God for that because every day you be wondering how you're going to make it, and then with prayer, things work out.

RQ2: Perception of the Self-Care Curriculum

By and large, caregivers spoke of the usefulness of the self-care curriculum, both in the group and in their personal lives. General positive comments about the curriculum include Shirley's assertion: "I've been feeling better since I just do some of the things that they told me." Anita commented, "It helped in the way they [...] a lot of times you're raising kids, grandkids, it's stressful and to take time for yourself to do the exercises that will relax you—it helps." Gladys noted, "It was very helpful we had demonstration, and it was very helpful and relaxing. [...] If they had grandchildren to raise, I would advise anybody to join it."

Some caregivers expressed that they had learned new self-care strategies. Beverly shared what she gained from the curriculum with her statement, "I learned they [self-care strategies] help. They're good to do and good to know, especially in times when you're really stressed." Shirley expressed a similar sentiment, stressing the usefulness of the strategies outside of the group in her statement,

Before you get into the program, you don't know anything about a lot of stuff and by them giving me info on a lot of the help, self-care techniques [...] it was helpful because I began to use them.

For others, the value of the curriculum was less in education about new practices, but rather in the prioritization of self-care and motivation that the group offered. Natalie explains,

It's not about not knowing [what self-care is], it's just about not doing it or taking the time to do it. I know the breathing exercises can relax you. [...] Just when I go to group and when we do it, it reminds me that I need to think about me sometimes too and focus on me so that I can be better, and that's what, you know, keeps me going when I'm there. It helps remind me of the things that I need to do to take care of myself.

Yolanda stated, "I think [the practice of self-care exercises] are good because it's very hard to be self-motivated in that area." Similarly, Shirley shared, "Some people like me need that little push, that motivation—that encouragement, and if they offer it, I'm pretty sure we will do it."

Present Moment Awareness. Of the nine strategies included in the curriculum, mindful breathing was most often mentioned in participants' reflections. Caregivers described how present moment awareness, cultivated through breathing or other practices, served as a means of decompression and, at times, a way to disengage and appreciate solitude. When asked what was memorable about the curriculum, Shirley responded,

The breathing part – that right there was what really stood out. Just kind of take a quiet time. That right there seemed to help a lot. [...] So when we done that, it was just like a big load of tension had been lifted. That’s how it felt. [...] It calmed and relaxed me.

Like others, she went on to describe other benefits of this practice in stating,

I never thought about sitting down and taking deep breaths and getting my mind right, because I was always racing and always moving as you can kind of see. I go to bed moving and wake up moving, so I just never took that time to even think about breathing or never took that time I just need for myself. And you know they say either like ten or fifteen minutes is good. I just never thought about it. I just thought I never had time, so it all helps out; it works.

Phyllis described, “You know how you can massage your shoulders and all that to get your problems out and just focus on the moment, so I liked that.”

Relaxation. Nearly all participants described valuing the self-care portion of the group experience because of the identified benefit of relaxation. Harriet even commented on the impact of including the curriculum at the start of the group, noting, “It made it kind of open you up and relaxed you more, that way you could listen better and respond better.” Phyllis described how she used mindful breathing outside of group to reap this benefit. She stated,

The breathing, taking time, and you know, taking time for yourself if it isn’t but 10 minutes a day or whatever to actually just to go a quiet place and be able to calm down [...] Raising grandchildren isn’t easy and you get overwhelmed. Even if it’s just going to another room for 10 minutes to calm down, to gather your thoughts.

Connection. While interview questions were specific to the self-care content of the support group, most participants described the importance of the group itself, fellowship with other caregivers, and the availability, attention, and support of the staff. Engaging in the curriculum (and support group) alongside others served as a means of self-care, perhaps promoting caregivers’ continued involvement and commitment in the group.

A few caregivers noted connection with other caregivers and staff was encouraging and a means of decreasing feelings of isolation. Gail commented,

Sometimes you feel like you’re the only one that’s going through stuff but you’re not. [...] The telephone calls are very encouraging because you know somebody

else outside of the family cares about you, and that's very important because in taking care of the grandchildren, they don't seem to appreciate what you do for them. [...] That's very supportive to me. Just a phone call.

Inspired by other caregivers, Beverly describes the importance of connection. She noted, *Just knowing that you're not the only one in that situation. [...] I don't consider myself very old, but there are a lot of women there that are a lot older than me, and I just sit and wonder 'How did they do this?' 'Cause I think some of them are like great-grandparents, makes me wonder. There's one lady there, she's got like 4 of her grandkids and she's just as jolly as can be. I'm like, I want to be like that.*

Others noted their relationships with fellow caregivers outside of group and thoughtfulness of the staff checking in with them. Yolanda indicated the emotional benefits of this aspect:

That's an important part of it. It's the socialization, being able to present what are our issues and hear that we're not alone. And our case may not be the worst, may not be the best, but it can get you out of that self-pity mode that will always lead us down a downward slope. That's something we can always use—that little mental boost.

Finally, participants were invited to comment on any changes or additions to the curriculum they believed would be beneficial. Many people did not have any particular suggestions, but several participants requested the continuation of the mindful breathing. Yoga, meditation, nutrition, more exercise, different ways of breathing for relaxation, and a spa day were suggested for future iterations of the curriculum.

Limitations and Discussion

The present study was designed to ascertain custodial grandparents' understanding and practice of self-care as well as their experience as participants in a nine-session self-care curriculum implemented into a pre-existing support group. Grandparents' conceptualization of self-care was predominantly defined by physical health, and caregiving provided motivation and a sense of purpose for caregivers. Themes defining the most common self-care practices were solitude and introspection, positivity, and spirituality. The curriculum was reported to be very beneficial to caregivers, and the most salient elements noted were present-moment awareness, relaxation, and connection.

As with any research, findings from the present study should be considered in the context of its limitations. The qualitative methodology, small sample size, and lack of geographic variability present threats to external validity. Given that data were self-reported, bias or social desirability could be limitations. As is often the case with support group interventions, attendance was variable, and while attendance was generally strong

and consistent, this irregularity does present a limitation for interpretation. While the interview protocol invited participants to reflect solely on the self-care curriculum, isolating this aspect of the program could be challenging for participants, therefore potentially influencing or limiting the evaluative nature of feedback provided.

Related, the rolling admission of participants prevented a cohort-model of program completion, resulting in all nine sessions being unavailable to all participants. The number of intervention sessions attended varied by each participant. Though unavoidable given the design of the program, this aspect does limit evaluation of the self-care curriculum. Further, logistical limitations prevented the collection of pretest quantifiable health outcome data, making it difficult to determine if the posttest data available (e.g., SCPS scores) was a direct result of the intervention. Similarly, data regarding the frequency and nature of check-ins with the case managers is unavailable at this time. Despite these limitations, the present study can be useful in the development and implementation of future interventions as well as alternation of pre-existing programming, particularly in light of the dearth of intervention research focused on self-care programming for caregivers.

Findings provide implications for the development and implementation of interventions targeting health behaviors of grandparent caregivers. Participants reported that the curriculum offered benefits beyond physical health and even engaged in practices that attended to other aspects of self-care, yet caregivers defined self-care narrowly. Grandparents' perception of self-care was predominantly concerning physical health, and caregivers may benefit from increased education related to the other dimensions of self-care. Lee and Miller (2013) propose a conceptual framework that suggests personal self-care is supported by five "structures of support" (p. 99), which are domains capturing self-care practices aimed at attending to needs in a holistic sense. Incorporating a broader, multi-dimensional understanding of self-care, like the one offered by Lee and Miller, may result in caregivers seeking increased support for the emotional, social, leisure, and possibly spiritual realms of self-care. Intentionally prioritizing caring for oneself across these domains may have greater impact than a more reductionist perspective of health (Lee et al., 2013).

In addition, emphasis on self-care practices that cultivate solitude, introspection, relaxation, and spirituality may be particularly beneficial to custodial grandparent caregivers. The curriculum also brought forth the importance of stress reduction and social support in taking care of oneself. Consequently, attending specifically to stress reduction and taking steps to build rapport between clients and workers, as well as amongst peers, may also be particularly helpful for caregivers. Finally, attending to the specific challenges of this population offers important considerations for practice (e.g., time constraints often reported by caregivers, lack of transportation, or other causes of absenteeism).

Findings lend support to the notion that interventions aimed at increasing self-care, particularly if inclusive of mindfulness-based strategies, may be promising. A

bourgeoning line of inquiry examines mindfulness-based interventions with older adults and caregiving populations. For example, mindfulness-based interventions used with caregivers of those with dementia have been effective in reducing stress and anxiety and improving emotional functioning and well-being (Waelde et al., 2004; Whitebird et al., 2012). Similarly, such interventions have been shown to decrease in stress symptoms and mood disturbance in older adults reporting clinically significant depression and anxiety (Splevins, Smith, & Simpson, 2009; Young & Baime, 2010), caregivers of children with chronic conditions (Minor et al., 2006), and those providing care to people with Alzheimer's (Coogle et al., 2011). Mindfulness practice positions caregivers to be responsive (versus reactive) to the range of thoughts, feelings, and sensations that can accompany the caregiving role, any or all of which can be complicated in the context of aging. Mindfulness encourages personal agency, recognition of strengths, and proactive attention to one's health and well-being; these outcomes are consistent with the strengths-based (Whitley et al., 1999) and empowerment approaches (Whitley et al., 2011) advocated for in practice with caregivers.

Future Directions

Continued evaluation of the present intervention would strengthen support for its use. Standardized instrumentation to measure self-care, specifically in the context of caregiving, is needed to assess intervention efficacy more rigorously. Replication studies including various caregiving groups would cultivate a more nuanced understanding of the variables that may impact positive outcomes for each population. Given the short length of the sessions developed, the presented model would be more appropriate for pre-existing groups than as an independent curriculum. However, the intervention content could serve as a starting point to develop a standalone curriculum if the context of service provision makes a more intensive self-care intervention feasible. Given the scarcity of mind-body approaches for caregivers—and custodial grandparent caregivers in particular—continued development and evaluation of interventions grounded by these approaches would make a meaningful contribution to practice and research.

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