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Parenting stress of grandparents and other kin as informal kinship caregivers: A mixed methods study☆

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ABSTRACT

Informal kinship caregivers provide the majority of out of home care to children who can no longer safely stay with their biological parent. Yet their parenting challenges are understudied since they are often left out from child welfare and other service systems. This mixed methods study, using a survey and focus groups of grandparent and other kin, examined predictors and sources of parenting stress. Quantitative findings suggested that the kinship family's needs and the caregiver's health and emotional well-being adversely affected parenting stress. Grandparent caregivers experienced an elevated level of parenting stress compared to other kin caregivers. Qualitative findings suggested that financial strains, concerns over children's behavior, navigating service systems and difficult relationships with birth parents contributed to their stress. It appeared that grandparent caregivers faced special challenges due to generational gaps, guilt and concerns over birth parents.

1. Introduction

Kinship care is the oldest and largest out of home care option for children in the US and in other countries who cannot live with their parents (Ann E. Casey Foundation (AECF), 2012; Broad, 2007; CWIG, 2012; Dunne & Kettler, 2008; Selwyn & Nandy, 2014). A national survey estimated that about 2.3 million children lived in homes without a parent present between 2012 and 2013, representing 3.1% of all children in the US (U.S. DHHS, 2014). The vast majority of these children were not in formal foster care but in informal[1] kinship care, where out of home care was arranged either privately between parents and kin or "voluntarily" through child welfare services (AECF, 2012; CWIG, 2016; U.S. DHHS, 2014). Grandparents are most likely to become kinship caregivers but other kin, such as aunts, uncles, siblings and even family friends, are unexpectedly filling the role of full-time parent.

Studies have indicated significant economic vulnerability and elevated service needs for these kinship families (Feldman & Fertig, 2013; Gibbs, Kasten, Bir, Duncan, & Hoover, 2006; Gleeson & Seryak, 2010; Yancura, 2013). A recent study revealed that compared to relative and non-relative kinship foster care families, informal kinship families were less likely to receive assistance or support (Stein et al., 2014). Caring for children who have experienced trauma is challenging under any circumstances, but limited resources and lack of supportive services are likely to exacerbate stress (Baker & Silverstein, 2008; Dunne & Kettler, 2008; Kelley, Whitley, Sipe, & Yorker, 2000; Minkler & Fuller-Thomson, 1999).

Literature on parenting challenges of kinship caregivers outside of the formal foster care system is limited since the children in their care are not likely to be present in official child welfare databases (Cuddeback, 2004; Whitley, Kelley, Williams, & Mabry, 2007) and often fall in between social service systems (Bavier, 2011; Gibbs et al., 2006; Walsh, 2013). In particular, we have limited knowledge of challenges faced by informal kinship caregivers who are not grandparents. Furthermore, available studies have relied on either surveys or interviews, thus limiting knowledge development either to stress predictors or contextual data.

To address this gap in the literature, the present study uses a mixed methods design to examine predictors and sources of parenting stress among informal kinship caregivers who provided full-time care for

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[1] We define "informal" broadly in this study. The use of term "informal" in kinship care has been fluid. Here we include both voluntary and private kinship care (CWIG, 2012). See the discussion in the background for further clarification.

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children without biological parents present and outside of the foster care system. Our study includes both grandparents and other kin caregivers and relies on both survey and focus group data to offer a deeper understanding of the experiences of informal kinship families.

2. Kinship care and stress of raising children

2.1. Definition and types of kinship care

Kinship care in the U.S. is defined as "full-time care and nurturing of a child by a relative or someone who has a significant emotional relationship with the child" (CWIG, 2012, p.1). Two accepted tenets of kinship care are full time care and no presence of parents at the kinship caregiver's home where children either temporarily or permanently live (AECF, 2012). While this definition is clear, the types of kinship care are not always consistent across studies and reports, except the formal kinship foster care. The federal government defined three types of kinship care: informal, voluntary, and formal (CWIG, 2012, 2016) depending on whether the state has legal custody of the children and whether the child welfare system is involved. Others use similar criteria, but divided into private and public (AECF, 2012) or formal and informal (Stein et al., 2014; Testa, 2013). Some define informal kinship care more narrowly as the out of home care setting where children do not receive TANF child only grants (Bavier, 2011) while others include children who had been involved in child protective services but not in foster care (Gleeson, Wesley, Ellis, Talley, & Robinson, 2009; Stein et al., 2014; Winokur, Holtan & Bachelder, 2014). The lack of consistency and blurred boundaries in the types of kinship remains as a challenge.

2.2. Characteristics of kin caregivers

Grandparents, especially grandmothers, are most likely to be kinship caregivers, but it is estimated that other relatives or close family friends provide 22% of care to children not living with parents and not in foster care (U.S. DHHS, 2014). Aside from a few studies (Davis-Sowers, 2012; Denby, Brinson, Cross, & Bowmer, 2014), the experience of kinship caregivers who are not grandparents is largely absent from kinship literature. One study suggests that grandparent and other kin caregivers face similar challenges in raising children, but their experiences may vary due to age and resources (Denby et al., 2014). In general, kinship caregivers are likely to be older (AECF, 2012; Bavier, 2011) and have disadvantages, such as being less educated than other caregivers (Bavier, 2011; Ehrle & Geen, 2002) as well as poorer physical health (Fuller-Thomson & Minkler, 2000; Leder, Grinstead, & Torres, 2007) than non-kinship caregivers.

Kinship care is more prevalent in African American communities than others (Bertera & Crewe, 2013; Hayslip & Kaminski, 2005). Studies suggest that the caregiving role for grandchildren is more important in the lives of Black grandmothers while caregiving burden and negative affect are greater for White grandmothers (Pruchno, 1999; Pruchno & McKenney, 2002). Latino culture has a strong basis in familism, and it may influence the way in which grandparents accept and enact their caregiving role (Goodman & Silverstein, 2002; Hayslip & Kaminski, 2005).

2.3. Parenting stress and sources among kinship caregivers

A substantial body of literature is devoted to the psychological well-being of grandparents raising grandchildren (Choi, Sprang, & Eslinger, 2016; Doley, Bell, Watt, & Simpson, 2015; Kelley, Whitley, & Campos, 2013; Neely-Barnes, Graff, & Washington, 2010). It is generally agreed that caregiver distress is elevated as grandparent caregivers take on caregiving responsibilities (Baker & Silverstein, 2008; Minkler, Fuller-Thomson, Miller, & Driver, 1997; Neely-Barnes et al., 2010; Ross & Aday, 2006). Even after an initial adjustment period, grandparent caregivers' psychological functioning continues to experience challenges. For example, grandmother caregivers were more likely to have depressive symptoms than grandmothers who were not caregivers (Baker & Silverstein, 2008; Fuller-Thomson & Minkler, 2000).

Empirical research focusing specifically on parenting stress among kinship caregivers is rather limited, especially for those who are not grandparents. One study found that 30% of custodial grandmothers scored above a clinical cut-off on Parenting Stress Index (Abidin, 1995) suggesting a need for clinical intervention with this population (Kelley et al., 2000). Lack of social support exacerbates parenting stress, and in turn parenting stress adversely affects depression (Hayslip, Bluementhal, & Garner, 2015). The lack of economic resources, caregiver health, and children's behavior are known as possible sources of caregiver distress in general, parenting stress in particular.

2.3.1. Economic vulnerability of kinship families

A large body of literature exists documenting the economic hardships of kinship families (Bavier, 2011; Ehrle & Geen, 2002; Gleeson et al., 2009; Harris & Skyles, 2008; AECF, 2012). It is estimated that 38% of all kinship families, both formal and informal, live below the federal poverty line (AECF, 2012). Kinship households headed by grandmothers are particularly vulnerable; 48% of children living in grandmother-only households live in poverty (Baker & Mutchler, 2010).

Despite their significant financial needs, informal kinship caregivers are less likely to receive financial and other services than non-kinship foster parents (Ehrle & Geen, 2002; Yancura, 2013). Compared to children living with both parents, children in kinship care—especially children in "informal arrangements" –are not supported by TANF, SSI, or foster care payments (Bavier, 2011).

Limited resources contribute to increased distress among caregivers (Kelley et al., 2000). However, a single measure of household income does not seem to play a significant role in predicting distress (Doley et al., 2015). Rather, it is the inadequacy of various resources ranging from food to housing that significantly elevates psychological distress, particularly among African American grandmothers (Kelley et al., 2013).

2.3.2. Caregiver's physical and mental health

Many grandparents have their own medical and behavioral health needs, which are separate from parenting demands and caregiver roles and are frequently ill-equipped to manage the behavioral needs of kinship children, who have experienced the trauma of separation and/or maltreatment (Billing, Ehrle, & Kortenkamp, 2002; Ehrle & Geen, 2002; Harnett, Dawe, & Russell, 2014). The majority of custodial grandparents in one study scored below US population means on health indicators (Neely-Barnes et al., 2010).

Studies suggest caring for grandchildren negatively impacts grandparents' physical health (Leder et al., 2007; Minkler & Fuller-Thomson, 1999; Whitley, Kelley, & Sipe, 2001). Informal kinship caregivers, in particular, are in poorer health compared to those who are either formal kinship or non-kinship foster caregivers (Stein et al., 2014).

Not surprisingly, poor physical health is associated with increased distress among custodial grandmothers (Kelley et al., 2013). And grandparents reporting poor health are likely to experience clinically significant depression (Neely-Barnes et al., 2010). Another study confirms the relationship between poor health and depression although social support mitigates this adverse relationship (Hayslip et al., 2015).

2.3.3. Children's behavior and emotional issues

Children in kinship fostercare have more emotional problems and poorer health than children living with biological parents (Billing et al., 2002; Vandivere, Yrausquin, Allen, Malm, & McKlindon, 2012), but they also have better behavioral and mental health outcomes than those in non-kinship foster care (Winokur, Holtan, & Batchelder, 2014). Overall, involvement in the child welfare system increases children's' mental health risk factors (Burns et al., 2004). A recent study (Stein et al., 2014) using the National Survey of Child and

Adolescent Well-Being (NSCAW) examined the physical and mental health of children in different types of out-of-home care. Children in informal kinship care had better overall physical and mental health than children in non-kinship foster care, but they fared worse than children in kinship foster care.

Not only do kinship caregivers view children's behavior more positively than non-kinship foster caregivers (Timmer, Sedlar, & Urquiza, 2004), they are also aware of children's emotional and behavior problems. In one study, custodial grandmothers reported almost a quarter of children in their care having emotional or conduct issues (Doley et al., 2015). The high prevalence of emotional difficulties and behavioral problems presents an additional challenge to caregivers assuming surrogate parenting roles and is a primary source of distress (Kelley et al., 2013).

2.4. Study purpose and specific aims

Research on informal kinship care remains underdeveloped due to the challenges of accessing reliable data. Consequently, little is known about caregivers who are not grandparents even though they are estimated to be a significant minority (AECF, 2012; U.S. DHHS, 2014).

The current study uses survey data to examine the caregivers' relationship to their kinship children and parenting stress. We further explore focus group data to gain insight into kinship caregivers' experiences and understand sources of parenting stress for this population. Our specific aims are to: 1) present a profile of grandparent caregivers and other kin caregivers outside of foster care; 2) examine predictors of parenting stress; 3) explore sources of stress in order to better explain identified predictors; and 4) present policy and practice suggestions to better serve this underappreciated and overlooked population.

3. Methods

3.1. Research design

The study was part of a demonstration project focusing on improving collaboration between local public child welfare and temporary assistance services to better serve kinship families who were not in the foster care system. Five counties in one northeastern state were selected for the project. Four large counties had rural and urban areas while one small county was predominantly rural.

An explanatory sequential mixed methods approach (Creswell, 2014) examines factors associated with parenting stress among caregivers and explores sources of stress that could explain these associations directly through the perceptions of the caregivers themselves. As a mixed methods approach, it leverages the strengths of both qualitative and quantitative methods. While in general, qualitative methods are stronger in their understanding of the context of a phenomenon in comparison to quantitative methods, their weaknesses also can include researcher bias and a lack of generalizability. In contrast, quantitative methods are regarded as less biased and more generalizable; yet, they often lack the depth of understanding gained through qualitative inquiry. This approach is a way to take advantage of the strengths of both qualitative and quantitative research designs while mitigating each of their weaknesses (Creswell, 2014).

For this study, findings from qualitative analysis are used to illuminate results from the quantitative analysis. The research design for the present study is illustrated in Fig. 1. As can be seen in the figure, the study was implemented in two phases. In the first phase, a survey was used to gather data about parental stress as well as demographic, socioeconomic and personal factors. The second phase consisted of focus groups whose purpose was to explore sources of parental stress in caregivers' own words.

3.2. Participant recruitment process

In the demonstration counties, public child welfare and temporary assistance workers as well as community agency workers were asked to use a simple one-page form to ask permission from the kinship caregiver to receive outreach services from kinship navigator service organizations and to be contacted to participate in the study. Once workers received written permission, the form was transmitted to the statewide navigator and to the research team. Kinship navigator service organizations provide comprehensive services (e.g., community outreach, legal resources, policy advocacy) to address the multiple needs of kinship

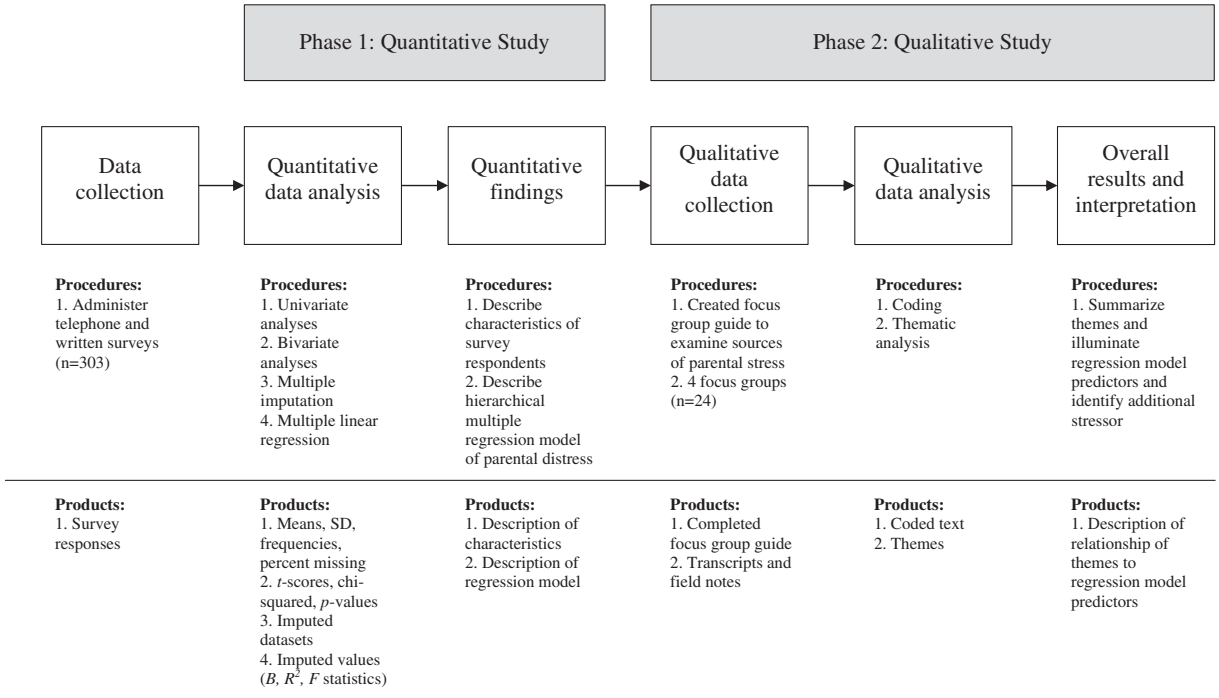

Fig. 1. Description of study design.

caregivers and their families. A research staff contacted prospective participants by telephone and asked for additional oral consent for participation in the study. Due to the nature of rolling study enrollment, data collection for the survey lasted 16 months beginning in May 2013 and ending in September 2014. To be eligible for the study, a primary kinship caregiver and the children in her/his care had to reside in one of the aforementioned counties at the time of study participation, provide full time care to children in their own household without the biological parent(s) present, and not receive foster care payment.

3.3. Quantitative data collection and measures

3.3.1. Survey

Quantitative data was collected through telephone surveys lasting approximately 35 to 45 min. The survey examined parenting stress, family needs, health and emotional well-being and sociodemographic characteristics. This survey was developed as part of an evaluation of the kinship navigation service demonstration project and was approved by the research team's Institutional Review Board. Out of 354 caregivers initially approached, 303 (86%) agreed to participate in the study and subsequently completed the survey.

3.3.2. Measures

3.3.2.1. Parenting stress. The study used Parent Distress (PD), a subscale of the Parenting Stress Index (Abidin, 1995), as a measure of parenting stress. Research indicates a strong linkage between stress and caregivers' resources and support (Bundy-Fazioli, Fruhauf, & Miller, 2013; Dunne & Kettler, 2008; Lin, 2014; Linsk et al., 2009). The PD subscale has 12 items that assess the extent to which caregivers have difficulties with implementing their parenting roles. Each item is rated on a five-point scale with response options ranging from 1 = strongly disagree to 5 = strongly agree. For our study, the PD demonstrated sufficient internal consistency with an alpha coefficient of 0.87.

3.3.2.2. Family Needs Scale. To measure caregivers' perceived needs for resources and support, the study used the Family Needs Scale (FNS). This 41-item instrument consists of one total scale measuring a range of needs. The areas of need include health care, education and basic resources, such as having heat. The respondent identifies the extent that they feel they need help or assistance in various areas of their family life by rating each item of the instrument. Reponses range from 1 = almost never to 5 = almost always. The total FNS score demonstrated robust internal consistency reliability with an alpha coefficient of 0.94.

3.3.2.3. Health and emotional well-being. Health and emotional well-being were measured using two survey questions. One item asked participants about their perception of their general health while the other item asked more specifically about their perception of their mental and emotional health. Responses range from 1 = poor to 5 = excellent. After adding the two items, we calculated the combined average for use in our analyses.

3.3.2.4. Kinship family characteristics. Research has indicated that the number of children in a household is associated with a caregiver's level of parenting stress (Denby et al., 2014). Larger households tend to have less resources, especially for child-care and time to socialize or to sleep, compared to families with fewer members (Brannan, Manteuffel, Holden, & Heflinger, 2006).

Given this study's focus on parenting stress, we included two separate measures to examine the effects of kinship family composition on stress: (1) the number of kinship caregivers' biological children in the household and (2) the number of kinship children in the household. This allowed us to determine to what extent having their own as well as kinship children predicted parenting stress among caregivers.

3.3.2.5. The reasons for kinship care. The reason(s) the kinship child was not living with their parent (i.e., mother, father, both parents) was asked with multiple items that provided caregivers with a list of various causes, such as a parent(s) with a drug/alcohol problem, a parent(s) with a mental health issue, or CPS involvement with the parent(s). Caregivers gave a yes/no response to each reason presented.

3.3.2.6. Socioeconomic and demographic variables. As an indicator of family resources, we used the family's household income. Caregivers reported their household income by selecting one of several income brackets, and we recoded them into three groups: under $20,000, between $20,000 and $50,000, and over $50,000. In our analysis, household income was included as a categorical variable, with a household income greater than $50,000 as the referent.

Demographic variables included the caregiver's age and the caregiver's race. Ages were calculated by dividing the difference between the survey completion and birth dates into 365-day increments. Race and ethnicity were coded as non-Hispanic White, non-Hispanic Black, Hispanic, and Other (i.e., Asian or Native American). For a few cases with multiple ethnic and race entries, anyone who selected Hispanic, we recoded that individual as Hispanic. For analysis, we used White and Other as the combined referent since only a very few identified as Asians or Native Americans.

3.4. Qualitative data collection: Focus groups

Survey data indicated that while the majority of caregivers were grandparents, the sample also included a sizable number of non-grandparent kin. This significant but less examined subpopulation of kin caregivers included relatives other than grandparents but a few were non relatives. Following the federal definition of kinship (CWIG, 2012), we identified two groups of kin caregivers for further investigation: a group of grandparents and a group of non-grandparent kin caregivers.

We selected a focus group method as the most effective way to gain collective insights into informal kinship caregivers' perspectives of raising children in their care. Focus groups, defined as a "carefully planned series of discussions designed to obtain perceptions on a defined area of interest in a permissive, nonthreatening environment" (Krueger & Casey, 2009), are particularly suited when a group of participants have a shared experience and can bring their unique perspectives to it.

To solicit a broad range of experiences, we recruited a diverse group of participants in terms of age, race and income levels from our survey database. Once they responded to our phone and mail messages and agreed to participate, we held focus groups in different localities that exhibited considerable differences in child welfare practice, as well as court access and geographical distances. Two groups of only grandparent caregivers and two groups of other kin caregivers were organized, yielding four focus groups in total. Since the nature of our inquiry was phenomenological, literature suggests four focus groups are an adequate number to achieve saturation (Creswell, 2014). The identification of grandparent and other kin caregivers was conducted using survey data. Groups were separated to allow participants of each focus group to develop distinct collective perceptions of their experience. To encourage their participation, we provided transportation, food, childcare and a $25 incentive.

3.5. Data analyses

3.5.1. Statistical analysis

Bivariate associations for participant characteristics according to caregiver relationships (grandparents vs. other kin) were evaluated with independent *t*-tests and χ^2 tests. After assessing whether missing data was completely at random (Allison, 2002), hierarchical multiple regression models assessed the associations of the aforementioned predictors and PD. In order to increase the power of analysis in hierarchical multiple regression, we employed multiple imputation, then deletion

(MID), to impute missing values on the dependent variable and covariates and pool estimates from imputed datasets. In this method, all cases are used for imputation, but cases with imputed values of the dependent variable are excluded from the analysis (Von Hippel, 2007). We used SPSS to impute the missing data with the fully conditional specification (FCS) method (Van Buuren, Brand, Groothuis-Oudshoorn, & Rubin, 2006). All analytic variables were used to impute independent variables, and 20 imputed datasets were created (Graham, Olchowski, & Gilreath, 2007). A total run length of 200 iterations was used with imputations made after every 10th imputation. The analytic sample size for hierarchical multiple regression with listwise deletion was 229, indicating that 24.4% of the observations had missing data. After applying the MID procedure, the analytic sample size was increased to 277. Twenty-six cases (8.6%) who did not provide a response for PD were not included in the analysis. Packages "mice" and "miceadds" in R were used for multiple imputed model comparison.

3.5.2. Focus group data analysis

After the completion of a focus group, one researcher who functioned as a note taker immediately created a transcript of the session by integrating their field notes and the session's recording. To increase the credibility of the findings, the second researcher, who facilitated the focus group, reviewed the transcript and added their own observations to it. Topics covered in the focus groups centered on social and economic impacts of providing kinship care. Thematic analysis, nested within a phenomenological perspective, was the approach used to evaluate data (Braun & Clarke, 2006). Once all four focus groups were completed, we reviewed the transcripts and began analysis. Analysis included deductive and inductive features. Deduction was implemented by coding content using preset categories based on the interview guide such as 'financial strain.' Inductive features were evident in emerging categories such as 'conflict with birth parents' (Miles, Huberman, & Saldaña, 2013). After combing through the codes to determine their relevancy to the context of our study's aim and purpose, we developed themes. Initial themes were then classified with a focus on differences and similarities in experience between grandparents and other kin caregivers.

3.5.3. Mixed methods analysis

In an explanatory sequential mixed methods design, qualitative findings are used to elucidate quantitative results (Creswell, 2014). Therefore, mixed methods analysis involved a discussion of how our focus group findings helped explain our survey results. Since the purpose of the explanatory sequential mixed methods design used in this study was to understand the stressors experienced by informal kinship caregivers, both grandparent and other kin, focus group themes were used to explain the findings from hierarchical multiple regression analyses.

4. Results

4.1. Findings from the survey

4.1.1. Characteristics of survey respondents

Table 1 presents the results of descriptive analyses for the study sample as a whole and then by the caregiver relationship to the child. While grandparents were a majority of kinship caregivers (72%), other kin were a significant minority (28%). Other kin caregivers included the child's aunts, uncles, siblings, cousins and family friends (i.e., 'fictive' kin).

Not surprisingly, there was a significant difference in age between grandparents and other kin caregivers. The mean ages were 56 for grandparents and 43 for other kin. However, it should be noted that a sizable number of grandparents were in their 40s. About two-thirds of the participants were non-Hispanic white (67.2%) with the other third (33.8%) were Hispanic or non-Hispanic Black. The two groups were similar in race and ethnicity. The racial composition of the participants was also similar to that of the region from which the participants were recruited. Just over half (53%) of grandparent and other kin caregivers had a spouse.

One third of the informal kinship caregivers had annual household incomes of under $20,000, indicating serious financial hardship. Another third had incomes between $20,000 and $50,000. The rest reported more than $50,000, reflecting higher median household incomes of the region where the study was conducted, compared to the national median.

A majority of caregivers had only one child in their care, but one third of them reported having two or more children. Grandparent caregivers were significantly more likely to have more than one child in their care. Reflecting their life stage, grandparents were less likely to have their own children living at home than other kin caregivers. Interestingly, almost 19% of grandparent caregivers also had their own children living at home reflecting the fact that some grandparents were in their 40s. Their own children were significantly older (difference of age = 3.58 years, $p < 0.001$) than children living with other kin caregivers.

Caregivers reported various reasons why children were not living with their parents. The most frequent reasons included drug/alcohol problems (68.3%, n = 207), mental health issues (61.7%, n = 187), financial problems (61.1%, n = 185), involvement in CPS (59.1%, n = 179), and housing problems (56.8%, n = 172). Some caregivers provided multiple reasons such as CPS involvement and drug/alcohol problems. There were no significant differences in the reasons between two groups.

Caregivers rated their health and emotional well-being as "good" overall (mean = 3.50; 5 being excellent). But, reflecting their advanced age and lower overall health, grandparents' health and emotional well-being was significantly lower than other kin caregivers. Higher scores in the Family Needs Scale indicated that the caregiver had several areas of needs, including basic resources, financial assistance and social support.

4.1.2. Differences in parenting stress between grandparents and other kin caregivers

As shown in Fig. 2, the caregivers in our sample showed a range of parenting stress measured in PD scores. Grandparents had higher PD scores than the other kin caregivers (mean = 28.41 s.d. = 9.00 vs. mean = 23.87 s.d. = 8.19, $p = 0.001$), indicating they experienced more parenting stress than other kin caregivers.

A PD score higher than the 85th percentile (>35) is considered clinically significant (Abidin, 1995), meaning that interventions should be considered to decrease stress for the respondents. Almost one out of five grandparent caregivers (18.2%) and a smaller yet sizable proportion of other kin caregivers (11.0%) exhibited clinically significant levels of parental stress.

4.1.3. Hierarchical multiple regression of parenting stress

Hierarchical multiple regression with multiple imputation and then deletion was employed to examine predictors of parenting stress. Table 2 displays the pooled unstandardized (B) as well as the standardized (β) coefficients and intercepts, the squared multiple correlation coefficients (R^2), and the F-scores for two models of PD. Both models were significant. The first model (Step 1) included the caregiver's relationship to children in their care, the caregiver's age, their race/ethnicity, their household income, and the number of their own and kinship children in the household ($R = 0.302$, $F(8, \infty) = 3.356$, $p < 0.001$). The second model (Step 2) included two additional variables measuring the caregiver's family needs and their health and emotional well-being in addition to the predictors in the first model ($R = 0.492$, $F(10, \infty) = 8.357$, $p < 0.001$).

In Step 1, grandparents showed higher levels of PD ($B = -2.964$, $p < 0.05$) compared to other kin caregivers while controlling for sociodemographic variables and family composition. In Step 2, when health and emotional well-being and family needs (FNS) were added to the model, it resulted in a significantly larger proportion of explained

Table 1
Characteristics of all kin caregivers and by relationship to children.

Variables	All	All	Grandparent caregivers[a] (n = 214)	Other kin caregivers[a] (n = 86)	*p*-Value[b]
	N	% (n)	% (n)	% (n)	
Caregiver race/ethnicity					
White (Non-Hispanic)	302	67.2% (203)	69.0% (147)	62.8% (54)	n.s.
Black (Non-Hispanic)		22.5% (68)	22.1% (47)	24.4% (21)	
Hispanic		9.3% (28)	8.0% (17)	11.6% (67)	
Other		1.0% (9)	0.9% (2)	1.2% (1)	
Household income					
Under $20,000	290	35.2% (102)	38.0% (78)	28.9% (24)	n.s.
$20,000–50,000		34.8% (101)	31.7% (65)	41.0% (34)	
Over $50,000		30.0% (87)	30.2% (62)	30.1% (25)	
Having a spouse					
Yes	303	53.1% (161)	53.3% (114)	53.5% (46)	n.s.
No		46.9% (142)	46.7% (100)	46.5% (40)	
Number of kin children (under 21)	303				
One		66.3% (201)	63.1% (135)	76.7% (66)	0.011
Two		21.1% (64)	24.8% (53)	9.3% (8)	
Three or more		12.5% (38)	12.1% (26)	14.0% (12)	
Number of own children (under 18)					
None	303	79.2% (240)	87.4% (187)	58.1% (50)	<0.001
One		12.2% (37)	8.4% (18)	22.1% (19)	
Two		5.6% (17)	3.3% (7)	11.6% (67)	
Three or more		3.0% (9)	1.0% (2)	8.2% (7)	
Reason the child/ren not living with parent (mother, father or both)[b]					
Involvement in CPS	303	59.1% (179)	57.5% (123)	61.6% (53)	n.s.
Mental health issues		61.7% (187)	62.1% (133)	59.3% (51)	
Drug/alcohol problems		68.3% (207)	66.8% (143)	72.1% (62)	
Financial problems		61.1% (185)	61.2% (131)	61.6% (53)	
Housing problems		56.8% (172)	55.6% (119)	59.3% (51)	
	N	Mean (SD)	Grandparent	Other kin	*p*-Value[b]
Age (years)	302	52.23 (11.46)	55.77 (9.21)	43.39 (11.9)	<0.001
Kin children age	445	8.73 (4.94)	8.53 (4.85)	9.28 (5.22)	n.s.
Own children age	100	10.94 (4.97)	13.13 (3.68)	9.55 (5.21)	<0.001
Health and emotional well-being	301	3.50 (0.85)	3.40 (0.84)	3.75 (0.82)	<0.001
Family Needs Scale (FNS)	255	58.69 (34.09)	56.17 (34.03)	64.37 (34.03)	0.078

p-Value corresponds to χ^2/independent *t*-tests for categorical/continuous variables.
[a] The relationship to the youngest child at placement.
[b] The caregiver could provide multiple reasons by responding yes and no to each item.

variation in PD ($R^2 = 0.242$, $\Delta R^2 = 0.150$, $p < 0.01$). Grandparents continued to report higher levels of PD compared to other kin caregivers ($B = -2.596$, $p < 0.05$). Changes in R^2 were robust (0.150) indicating the second model was a significant improvement in predicting parenting stress than the first model.

4.2. Findings from focus groups

4.2.1. Characteristics of focus group participants

Table 3 summarizes the composition of the four focus groups conducted in this study, two grandparent and two other kin caregiver groups. The number of participants varied from five to eight per group. Grandparent groups were exclusively female while both of two other caregiver groups included one male participant. Overall, the number of kin children in focus group participants' care was consistent with survey findings. Most had one child in their care, but a few had as many as four children. In three of the focus groups, participants were all or

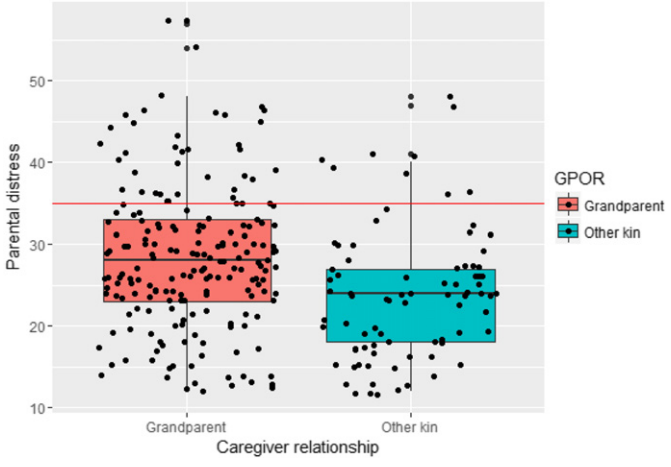

Fig. 2. Box plots of parental distress along with caregiver relationship.

Table 2
Hierarchical Multiple Regression on parental distress (n = 277).

	Step 1 B (β)	Step 2 B (β)
Grandparent vs other relative caregivers	−2.964 (−0.151)*	−2.596 (−0.132)*
Caregiver age	0.051 (0.065)	0.071 (0.091)
Race/ethnicity		
Black	−1.338 (−0.062)	−0.903 (−0.042)
Hispanic	2.418 (0.079)	1.510 (0.049)
Household income		
Under $20,000	0.196 (0.010)	−1.593 (−0.084)
$20,000–$49,999	−0.258 (−0.014)	−1.878 (−0.100)
Have own children (y/n)	−2.026 (−0.092)	−1.140 (−0.052)
Have more than one kin child (y/n)	2.407 (0.127)*	1.906 (0.100)†
Perceived well-being		−3.213 (−0.301)**
Family Need Scale (FNS)		2.619 (0.243)**
ANOVA tests at each step[a]	$F(8, \infty) = 3.356$**	$F(10, \infty) = 8.357$**
R at each step	0.302	0.492
R^2 (adjusted R^2) at each step	0.092 (0.064)	0.242 (0.214)
R^2 change		0.150
Intercept	25.071	32.564

[a] Micombine *F*: degrees of freedom of the numerator are approximated by ∞.
† $p < 0.10$.
* $p < 0.05$.
** $p < 0.01$.

Table 3
Characteristics of focus groups.

	Number of participants	% White	% Female	Number of kinship children
Grandparent group 1	6	33%	100%	1–3
Grandparent group 2	8	88%	100%	1–4
Other kin group 1	5	80%	80%	1–2
Other kin group 2	5	100%	80%	1–3

predominantly White. However, one grandparent group was predominantly non-White.

4.2.2. Sources of stress

Both grandparents and other kin caregivers reported an array of stress sources ranging from the challenges of "second time" parenting to dealing with family courts. Focus group data analysis resulted in four themes. These themes were financial strain, children's well-being, relationship with birth parents, and dealing with authorities.

4.2.2.1. Financial strain. Whether they were grandparents or other kin, most participants were not financially well off. For example, one grandparent was living in crowded public housing where she was caring for three grandchildren in a two bedroom rent-subsidized apartment. Many grandparent caregivers were retired and, as a result, were living on fixed incomes. Other kin caregivers were generally younger and more likely to hold regular jobs where, depending on the availability of childcare, they were able to work additional hours for extra money.

Lack of financial resources sufficient to cover the additional expenses associated with caring for kinship children added to participant perception of their parenting stress. Some were receiving the Non-Parent Caregiver grant (NPC, popularly known as the Child-Only grant) available through TANF, which offset some costs, but others disclosed they were not receiving it and did not know about this grant.

Across the focus group participants, caregivers were keenly aware of the fact that if the child in their care went into the foster care system, the state would have to pay for the child's care rather than the caregivers themselves. The apparent disparity in the burden of payment for the kinship child's care rankled some caregivers as many of them recognized that their service was taken for granted by the state. One caregiver expressed the following sentiment to the universal agreement and nods among the group:

> "The state should send us a gift certificate every month so we could enjoy a dinner outside once in a while. We are saving a lot of money for the state. That is the least it can do for us."

4.2.2.2. Children's well-being. Concerns over children's well-being included behavioral issues, emotional problems and concerns about their future. Most focus group caregivers were committed to providing a stable home to children living with them. However, they were aware of the challenges that came with raising children who had been abused and neglected, often by their biological parents.

One grandmother of a seven-year-old boy expressed the joys and challenges of raising a child with behavioral issues:

> "My experience is challenging. There is anger sometimes and fun sometimes…He is a very smart kid but also has issues. During the school year, it got worse and worse and worse, and he ended up getting suspended from school. Now he goes to therapy, and I make sure he gets there… It is stressful but with God's help we do all things through…."

One aunt was quite distressed by her niece's recent behavior problems and was contemplating the hard decision of discontinuing her role as a kinship caregiver. Having a young child of her own, she had to make the tough decision between what was best for her own young family and the continued support of her niece.

The subtheme of concerns over the children's future was more pronounced among grandparent caregivers. Perhaps grandparents worried more about what would happen to their grandchildren because they were older and many had their own health issues.

4.2.2.3. Relationships with birth parents. Both groups experienced a great deal of conflict with their children's birth parents without the support of any intervening resources. Except for one family who recently adopted the child, a majority of the caregivers struggled to work with the birth parents. Most of the birth parents still had parental rights and some caregivers put in extra efforts to help parents. For example, a great aunt made a weekly trip of 72 miles so the child could visit with the biological mother. Despite these heroic efforts, she seemed to believe that the mother was not taking a path that would lead to eventual reunification.

Some were openly angry with birth parents for breaking promises to their children and for not remembering important milestones, such as the child's birthday. As a caregiver explained, it was she "…who had to deal with the crying, upset child after the mother forgot to call on his birthday."

4.2.2.4. Stress of dealing with authorities. Taking responsibility for raising kinship children brought caregivers into contact with social services, the legal system and school administration. Study participants found all these systems were unfamiliar and unresponsive to their needs. Grandparent caregivers, in particular, pointed out the irony of the legal assistance afforded to birth parents by the family court system, but denied to them. One grandmother caregiver shared her challenge in navigating social and legal systems:

> "My grandchild was from a different county where I live. So my husband and I had to go through two different court systems and two different social services…. It was like Jupiter and Mars."

Dealing with the school system was another major challenge. Unique was informal kin caregivers' challenge in establishing and maintaining legitimacy as the kinship child's guardian. Depending on placement circumstances, the level of family court involvement, and the quality of the relationship between the kin caregiver and the birth parents, access to necessary documents to register the child (e.g., birth certificate) and availability of documents necessary to establish their legal relationship to her or him (e.g., custody papers, court orders) were or were not available. In addition, dependent on legal circumstances and the interest and involvement of the birth parent(s), schools varied in their responses to caregiver's requests and needs. Many caregivers also found the school system was often unresponsive to children's emotional and behavioral issues.

4.2.3. Additional stress faced by grandparents

Parenting children who were placed after a series of disruptive life events presented challenges to all caregivers, but grandparents seemed to have additional stressors. Feeling guilty for their adult children's failure as parents weighed heavily on most grandparent caregivers. One such grandmother explained why she was raising her grandson:

> "I was a young parent, my daughter was a young parent from my missteps, and she had my grandson…She lived with who we thought was the father at the time; they got in a fight; she came home…She has another little one who's three…He has already been hospitalized once for a fever so we went to family court and filed an emergency to see the judge…we got temporary custody."

Another common stressor was being a "second time parent." Grandparents described coming from "a different generation" and being "out of the loop" with other young parents whom they ran into at school or recreational activities. This disconnectedness extended to the grandparents' social network. Being second time parents seemed to increase the social isolation of grandparent caregivers. As one grandmother stated, "my friends did not understand what I was going through." And, as grandparent caregivers devoted their time to the daily activities of caring for their children, they had less time to socialize with their friends, further isolating them from their peer groups.

4.3. Mixed methods findings

Hierarchical multiple regression analyses of survey data revealed significantly elevated levels of parental stress for grandparent caregivers compared to other kin caregivers while controlling for various demographic differences, perceptions of health and emotional well-being and perceptions of family needs. Focus group findings revealed this difference was due to feelings of guilt grandparents hold for their adult children's failure as parents. Grandparents' advanced age compared to other kin caregivers and the concomitant bio-psychosocial differences experienced by them due to their developmental differences intermingled with their guilt in exacerbating their concern about their grandchild's future. Grandparents recognized and encountered the limits of their own abilities more pervasively than other kin caregivers, which created a sense of urgency to achieve permanency for their grandchildren. In addition, stress because of social isolation due to being a "second time parent" exacerbated caregiver worry.

Financial strain, as a source of stress experienced by both groups of caregivers, explained the significance of family need as a predictor of parental stress. When needs such as adequate housing and enough money to pay for food and clothing were not met, parenting stress increased. Concerns over the children's well-being, including managing difficult behaviors and emotional problems, took their toll on caregivers' health and emotional well-being, which explained its presence as a predictor of parental distress.

5. Discussion

This study brings much needed attention to parenting challenges of grandparent and other kin caregivers providing out of home care to millions of children outside of the formal foster care system. Using a mixed methods design, the study's findings helped not only to identify the characteristics of informal kinship caregivers and predictors of parenting stress, but also to provide insight into the contexts and challenges of raising children with little formal support services and financial assistance.

The survey results indicated that grandparents, indeed, made up a larger share of informal kin caregivers, but other kin such as aunts, uncles, cousins and family friends were a significant minority. Their proportion in our survey (28%) is consistent with an estimate (22%) from a population based national survey (U.S. DHHS, 2014), and suggests a need for more research on this subpopulation.

Not surprisingly, other kin caregivers were younger and reported better health and emotional well-being compared to grandparents. They were more often raising their own children but unlike grandparents were also more likely to have only one child in their care. In other areas such as household income and race, the two groups were remarkably similar.

A large body of literature has documented the economic needs of kinship caregivers, primarily focusing on grandparent caregivers in informal kinship care arrangements (Baker & Mutchler, 2010; Ellis & Simmons, 2014). Our findings indicated that the majority of kinship households lived below their region's median household income, regardless of who the caregiver was. Other relatives and fictive kin faced similar financial strain as grandparents. For both groups, unmet needs were found to be a significant predictor of stress, adding further evidence to the growing literature on service needs and stress among these families (Doley et al., 2015; Kelley et al., 2013; AECF, 2012).

Consistent with previous research, we found that a kin caregiver's own health and emotional well-being was adversely associated with parenting stress (Kelley et al., 2000; Leder et al., 2007). Caregivers with low well-being scores were more likely to report parenting stress than those with high scores. One study reported that greater parenting stress at baseline predicted greater depression at one year follow up among caregivers with low or moderate social support (Hayslip et al., 2015). Our results affirm the interrelated nature of well-being and stress.

Our focus group findings provided a rich contextual view of the challenges faced by caregivers that complemented survey outcomes. Kinship caregivers' concerns over children's emotional and behavioral issues were understandable, given that many of these children had been maltreated. Concern over maltreatment can take a toll on caregivers, exacerbating issues with their own health and emotional well-being, leading to increases in parental stress. (Choi et al., 2016). Our findings support prior research demonstrating children's trauma, emotional and behavioral issues are a major source of caregiver stress (Butler & Zakari, 2005; Harnett et al., 2014; Sprang, Choi, Eslinger, & Whitt-Woosley, 2015).

Finally, even after considering differences in sociodemographic characteristics and risk factors, grandparents continued to demonstrate higher levels of parenting stress compared to other kin caregivers. To our knowledge, our study is the first to demonstrate differences in parenting stress by the caregiver's relationship to the child using a multivariate model.

We believe that grandparent caregivers faced additional stressors. They personalized and carried guilt over their adult children's failure as parents and have accepted the role of substitute parents to their grandchildren when needed (Gleeson et al., 2009). At the same time, they faced challenges in 'parenting the second time' where generation gaps remained steep.

5.1. Limitations

The current study has a few limitations. First, participants were recruited from community and social service agencies and thus study findings may not be easily generalized to the broader informal kinship caring community. This sample might be skewed toward those who were more economically disadvantaged and were more likely to be involved in child welfare services. Another limitation is that we were not able to control for all possible relevant variables to parenting stress in our survey, such as children's behavior and emotional issues. We also cannot eliminate the possibility of bias in our interpretation of focus group findings even though we implemented a number of steps to reduce bias, including the presence of a second researcher and recording the focus group sessions. In addition, since focus group participants were self-selected, it is difficult to gauge to what extent this selection influenced our findings.

5.2. Implications for practice

Kinship caregivers would continue to benefit from the provision of support groups by kinship service providers. Not surprisingly, research has indicated that kin caregivers draw emotional support from attending this kind of group (Hammond, Graham, Hernandez, & Hinkson,

2014; Leder et al., 2007). In addition to support groups, kinship service providers should deliver case management services to reduce financial strain and meet their concrete needs, including helping them with applications for assistance and advocating on their behalf in social service interviews.

Aging services at the local level, which may not be familiar with informal kinship care, should also consider providing case management services, including assessing caregivers' parenting stress. Elder informal kin caregivers may come in contact first with aging rather than child welfare service providers if the kinship placement did not involve child welfare services. The focus of the case management services would be linking elderly caregivers to community based providers to improve their own as well as the children's well-being (Blair &Taylor, 2006).

Finally, staff in social service, educational and legal systems first need to be cognizant of informal kinship care and support caregivers' legitimacy as guardians by working with them to resolve barriers (e.g., paperwork) to this role. In addition, service providers from any of these systems should assist in referring kinship children with emotional and behavioral problems to behavioral health services.

5.3. Implications for policy

Informal kinship caregivers and children in their care are often invisible to policy makers and service system administrators as they are either missing or obscured in official databases. As findings on the reasons for kinship care indicate, most of these children experienced trauma and parental neglect. Despite the child welfare system's reliance on informal kin caregivers (Gleeson et al., 2009); Wallace & Lee, 2012), its policies have been inadequate and inconsistent in addressing needs of these families. The child welfare system's identification of this population as well as better assessment of service needs would improve the experience of kin caregivers and their children.

An outreach model such as Kinship Navigator or a kinship support center is effective in identifying and assisting informal kinship families to meet their needs (Feldman & Fertig, 2013). We recommend the extension of such services but emphasize that kinship navigator programs and support centers work closely with child welfare and other social service systems. The collaboration will ensure these families are no longer lost between systems and will allow kinship programs to be at the center of service coordination for informal kinship families.

The imbalanced payment policy that disadvantages informal kinship care as compared to formal foster care is likely to continue (Testa, 2013; Taussig & Clyman, 2011). In light of emerging evidence on prior child welfare involvement of children placed with informal kin caregivers (Stein et al., 2014; Walsh, 2013) and the well-documented needs of these families, policymakers need to develop coherent, comprehensive and equitable payment policies for this underserved and overlooked population.

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