

Chapter 1 : Engaging Kinship Caregivers With Joseph Crumbley - The Annie E. Casey Foundation

To support systems and caseworkers in this work, the Foundation developed a five-part video training series: "Engaging Kinship Caregivers: Managing Risk Factors in Kinship Care." Led by Joseph Crumbley, the training sessions strengthen the skills of child welfare professionals in supporting families to improve outcomes for children.

References This page was updated on June 19, , to incorporate the corrections in Vol. Research investigating psychosocial challenges associated with asthma is limited. This study examines support resources, support-seeking strategies, support and education needs, and intervention preferences of Aboriginal youth with asthma and their caregivers in an effort to encourage community-wide, health-promoting behaviors. After conducting interviews that explored existing and desired social, educational, and health support in participating communities, we held a 2-day asthma camp to engage participants in asthma education, social support networking, and cultural activities. At the camp, we collected data through participant observation, sharing circles, focus groups, and youth drawings of their experiences living with asthma. Results Our study yielded 4 key findings: Future asthma interventions for marginalized populations must be culturally meaningful and linguistically accessible to those using and providing asthma support. Existing health inequalities facing Aboriginal peoples can be linked to social determinants of health at multiple scales: New chronic conditions that have begun affecting Aboriginal peoples, especially type 2 diabetes, obesity, and cardiovascular disease, have received considerable attention from health researchers and policy makers 3. The lasting effects of colonization that are known to affect asthma are easily evident in observations of the underlying conditions on Aboriginal reserves 9. Aboriginal peoples are more likely to live in overcrowded or substandard housing where respiratory infections resulting from exposure to dust, mold, and mildew can easily pass between family members Smoking rates among Aboriginal peoples are nearly 3 times that of the general Canadian population 5, The use of woodburning stoves often a financial necessity and the practice of curing and tanning in living areas are common in Aboriginal communities, further contributing to degraded indoor air quality Many Aboriginal peoples live in poverty 2 , creating a financial barrier to asthma treatment and medication Moreover, Aboriginal children are more likely to live with a single caregiver than Canadian youth in general, putting them at a greater risk of being exposed to a stressful home environment 5, An understanding of the social determinants of health among Aboriginal peoples is necessary to an understanding of the social etiology of asthma in Aboriginal communities 2. Although most asthma research is centered on physiologic aspects of the disease, less commonly examined are the psychosocial difficulties persistent among youth who have asthma. In addition to having the physiologic symptoms of asthma, youth with asthma are reported to experience low self-esteem, social isolation, family problems, poor relationships with peers, and worry 15, With satisfactory asthma-support programs in place, however, the quality of life for these young people can be greatly improved The research reported here is part of the first phase of a larger 3-phase, multisite national study that seeks to examine the support resources, support-seeking strategies, support and education needs, and intervention preferences of Aboriginal youth with asthma and their caregivers referring to either biological parent or appointed guardian to facilitate community-wide health-promoting behaviors. To ensure that local considerations were prioritized from the inception of the research, each study site employed independent methods for project design, data collection, intervention design, and data analysis to tailor their studies to the common objectives. The CAC informed recruitment strategies, refined the research design, pilot-tested the data collection process, commented on preliminary findings, and communicated protocols to the communities. Generally, a participating family consisted of 1 youth and 1 caregiver. In instances in which a caregiver was responsible for more than 1 youth with asthma, the family was defined as 1 caregiver and 2 or more youths. All data were translated and transcribed in English. The youth and their caregivers individually participated in semistructured interviews with the intent of identifying their asthma-related support needs and intervention preferences. The interviews with caregivers lasted approximately 1 hour each and were conducted by community researchers using an interview guide. Interviews with youth were much briefer because they did not elaborate on their responses. Open-ended questions addressed issues specific to existing community

asthma support, asthma education, and asthma intervention preferences. All participants were then invited to a 2-day asthma camp held in July. The camp agenda included Aboriginal ceremonies smudging, prayer; cultural activities drum-making, drumming, singing, dancing; entertainment games, art, relay races, movie night; social support informal networking opportunities; and education asthma awareness training, guest speakers with expertise in asthma support, education, and outreach. We also held 1 sharing circle and 1 focus group 23 during the camp with the 17 caregivers to help identify their asthma support intervention preferences. Distinct from focus groups, sharing circles emphasize equality among everyone involved in the circle. Sharing circles involve formal turn-taking versus spontaneous dialogue of a focus group; sacred meaning for many Aboriginal peoples in terms of spiritual and emotional growth; more sharing of the whole individual rather than just knowledge-sharing; nonjudgmental, helpful, and supportive discourse; respectful listening among participants; and, often, ceremony eg, smudge, talking stick. Both the focus group and sharing circle lasted approximately 1 hour each and were facilitated by community researchers who used an interview guide. Open-ended questions were used throughout these sessions. The sharing circle focused on both existing asthma support needs and intervention preferences of participants, while the focus group centered solely on intervention preferences. The interviews, sharing circle, and focus group were digitally recorded and transcribed to ensure accuracy. In addition to the participant data collected, the research team engaged in participant observation, recorded field notes, and held 2 debriefing sessions during the gathering, all of which were taken into consideration and applied to our analyses. The research team tried out a sharing circle and focus group activity with participating youth, similar to those used with caregivers; however, these methods proved ineffective because the youth were uncomfortable with sharing personal experiences in a group. The flexible nature of CBPR use in the field enabled the research team to replace large group interactions with opportunities for the youth to make drawings of what it was like to have asthma. Then, in informal, individual, and small-group conversations, the youth talked about what they had drawn without interviewers using recording devices, which were also a source of discomfort for youth. As a result, the research team relied heavily on participant observation and field notes to document youth experiences with asthma. All data obtained from the pre-camp interviews, participant observations, sharing circle, and focus group underwent a thematic analysis 24 to identify diverse factors influencing challenges facing Aboriginal youth with asthma and their families. This analysis offered suggestions for how youth with asthma and their caregivers can cope with the challenges. In addition, youth participants assented to taking part in the research activities. The presence of these themes throughout the data was triangulated across the research team and CAC, increasing our confidence in the findings. Triggers and prevention strategies. Virtually all caregivers were aware of asthma triggers specific to their children and had developed strategies for avoiding them. Triggers were household mold, smoking, pets, season change, strenuous exercise, and extreme cold or humidity. Most caregivers indicated that they had had mold in their homes. Caregivers made extensive efforts to provide mold-free environments for their family. For example, one caregiver said: Although smoking tended to be limited to certain rooms or floors of the residence, secondhand smoke still triggered attacks. Contact with household pets was also identified as an asthma trigger for some youth. You have to do things differently in the house. You have to use certain products. Some products you find after a while are triggers, and one of the big things was floor wax. You have to keep fresh air circulating in the house. But it is the opposite in the summer; when the [gravel] road is graded and the road is dusty, you have to keep the doors and windows closed. So you just always have to be aware of the triggers and of the air quality. During her games she takes her inhalers when she gets sick. But we have learned this year to take the inhaler half an hour before the game and then play. This reduced her chance of getting an attack. They also relied on their caregivers to both supply and administer inhalers appropriately during an asthma attack. Current asthma supports and services. Participating caregivers reported a lack of community-level asthma support resources. When asked if they were aware of any asthma support resources or services in or outside their community, none were identified. I never even heard of anything outside the community. Many caregivers shared their frustration with having to travel well outside of their reserve community to connect with specialized asthma support personnel. Types of support-seeking strategies. Generally, caregivers rely on family members to provide them with the support they need to manage the

demands of raising a child with asthma. Often these family members have direct experience raising their own child with asthma. When [my children] are having an attack, it is really hard watching them suffering. Talking helps me cope. I have a really good support network with my sisters and my mother, family, and friends. However, caregivers said such support usually involved writing prescriptions and giving basic instructions on administering medication rather than psychosocial support. Participating youth also relied heavily on family, particularly mothers, as their primary asthma support. Teachers and peers also represent a support resource when children are absent from parental care. Desire for future support and education interventions Many caregivers identified the need for increased information and educational resources. My biggest wish is. So then they could pass on the information to the parents. One caregiver describes this scenario: Caregivers considered community education and provision of resources that promote community-wide understanding of asthma a priority. One caregiver described a situation where her daughter was involved in an after-school activity with another family: Although participating youth were reluctant to identify any support or education needs, in several cases caregivers voiced concerns about a lack of asthma-friendly school policies: They thought that she would get addicted to it. Adequate support resources can improve the quality of life for asthma-affected youth; conversely, the absence of these supports can lead to ineffective asthma management, resulting in harmful health consequences. For future intervention strategies to be effective, however, the issue of accessibility must be addressed. Given that many Aboriginal communities embrace a philosophy of a community-raised child²⁸ in which family members, teachers, and peers are all looked upon to provide support for youth with asthma and their caregivers, it is paramount that entire communities and government agencies support asthma management strategies eg, reducing traffic-related dust on gravel roads, eliminating mold from housing, relieving overcrowding in housing. Knowledge holders such as health professionals must be made aware of the lack of asthma-related information available to community members and must be willing to provide it through a medium that is culturally relevant, accessible, and designed for a broad audience. The results of this study indicate the need for expanded awareness of asthma: In addition, greater consistency between school policy and asthma management needs is required. Caregivers expressed strong interest in establishing support groups. Communities fostering socially supportive environments are healthier than their socially unsupportive counterparts. Asthma support groups or support networks are a viable, culturally appropriate way to supplement asthma education strategies. Regular in-community gatherings of asthma-affected families would provide caregivers and youth with a safe space to talk about asthma, share information, voice concerns, and ask questions in an effort to aid each other in their own asthma management. Nevertheless, the study reveals a lack of asthma support resources in these communities. Improved support and educational resources are needed to foster effective asthma support networks that include both people closely involved with youth with asthma and members of the larger community. Asthma support and education specific to Aboriginal peoples are required for effective management of this disease². Future asthma support interventions involving Aboriginal peoples or other marginalized populations must overcome geographic barriers, be culturally relevant, and be linguistically accessible both to those using asthma support and to those providing it.

Top of Page Acknowledgments We thank participants for their contribution to the study.

Chapter 2 : 43 best Multigenerational Living images on Pinterest

Using a national sample of married persons, this study examines how the assumption of multigenerational caregiving responsibilities affects caregivers' well-being. It is found that this change in family responsibilities has little to no effect on caregivers' well-being, even after considering factors including caregivers' gender and weekly.

Social Work Today Vol. Social workers can help navigate the rough spots. In one corner, a set of twin toddlers cries in tandem, hungry for food and affection. At the same time, an older woman moves frantically around the kitchen, struggling to put dinner on the table. Against a backdrop of clanging metal pots and pans, she sings sweetly to the twins, hoping to soothe their frustration as well as her own. From a busy office, Carol returns to a bustling home, wanting nothing more than to prop up her feet and rest her head—“if only for a few minutes. But on entering the kitchen, she sees three sets of eyes light up, all waiting to get her attention. Multigenerational households are at the forefront of American society now more than ever before. For many caregivers, coming home to a spouse and children has its challenges yet is nonetheless considered standard in most traditional households. Pair those challenges with the ones that come with having an elder parent in the home or an adult child with special needs, and the dynamic changes entirely. With 90 million caregivers across the country, four in 10 families are experiencing this reality daily. In his research, he has found as many as four generations living under the same roof. On the opposite side of the spectrum, Marianne Nicolosi, LMSW, executive director of the Bay Ridge Center in Brooklyn, NY, has encountered multigenerational households where the caregivers managed their younger disabled adult children within the home. Margaret Platt Jendrek, PhD, a professor of sociology at Miami University in Ohio, has worked extensively with two-generational households where there were only grandparents and grandchildren with no parents present. On one hand, it provided a roof over their heads and some stability in their lives, but on the other hand, it created unanticipated issues around boundaries. When disagreements occurred, the children were confused about who to listen to and thus the loyalty to parent vs. Due to a lack of problem-solving skills, these families faced greater stress and conflicts. For example, how does a grandparent obtain health insurance or school enrollment without having legal custody of a grandchild? How does someone entertain friends who are in their 50s, 60s, and 70s with a young child at the table? Do grandparents need to put off retirement plans because their grandchild needs to go to college? Can they even retire? Should a grandparent pursue custody when doing so implies that his or her own child is an unfit parent? For many families, these are painful and difficult decisions to make. Some grandparents, although thoroughly enjoying the experience of being with their grandchildren, also complain of exhaustion. At this stage in their lives, they were hoping to have time for their personal interests, such as travelling or engaging in volunteer work. Then there are the medical implications that caregivers must consider. In his work with multigenerational families, Schall found that medication safety becomes an important focus. This applies both to unsuspecting youngsters who may rummage through cabinets and teenagers or their friends who want to use the medication recreationally. Young and old still can share experiences and draw from each other, he says. With more hands on deck, the overall caregiver burden no longer trickles down to one or two individuals. Schall has seen grandparents step forward and help take care of the grandchild in order to give their children an opportunity to return to work or take off an hour or two to get some respite. Although the setup may not always be ideal, a working parent with long hours often can rely on the grandparents to provide childcare and supervision when needed. Furthermore, it can be a relief to know that a child is left in the hands of a family member who has been down that road before. According to Langosch, a multigenerational home can provide a family with safety, security, and stability in many ways. A growing body of attitude change concerning men has been recognized within multigenerational households. In addition, they learned how to cook, manage finances, and become educated shoppers, which in the past had been taken on by the female members in the household. These men felt that they reached a higher purpose by giving back, making their relationships truly reciprocal. Although grandparents with this disease experienced memory loss, they could naturally connect with their young grandchildren through memory puzzles and sing-alongs. Due to the cognitive limitations of both, grandparent and grandchild could enjoy activities

together, which especially was beneficial to the middle-aged parent who could not easily bond with an year-old in this manner. According to Nicolosi, another benefit of this group dynamic includes learning about the dignity of growing old with family around to help. Since all generations learn the power of cooperation, love, and problem solving, this creates good feelings among all. It also allows family members to feel strong and empowered while being valued and cared for. How Social Workers Can Help As the number of multigenerational households increases, social workers find themselves taking on clientele who need their help more than ever. As challenges and complexities abound, social workers can offer tremendous relief and assistance to these families in the following ways: A proper and thorough needs assessment will allow the social worker to see the bigger picture of what the family is facing and help them understand what they can anticipate in the future. This especially is crucial when living with a person with medical complications. By knowing the trajectory of the disease they could learn things such as behavioral modifications to help get them through. In most cases, the patient himself will have a one-on-one conversation with his medical provider, but Hunt believes there needs to be a triad involving the primary care physician, the patient, and the caregiver so that all parties can share this responsibility. This particularly is important when the caregiver needs to ensure compliance with medication. Social workers should take the opportunity to validate the hard work that families are doing and outline the strengths that each family member brings. When a caregiver feels supported and recognized, their role within the family becomes more approachable and rewarding. To ease the blow, Schall recommends sharing knowledge within the family. A social worker can put them in touch with much-needed resources that will help ease the burden. Ensuring that everyone in this household has access to health care as well as sufficient economic resources is very important. Social workers can use this occasion to point them in the direction of community resources, such as alternative living situations, adult day centers, long term care options, babysitting services, home health care, and other forms of respite care. Langosch calls social workers the bridge that guides families to entitlements they never knew about. Social workers pick up the slack, he says. With everyone working together, multigenerational families can be feel empowered by their living situation and can approach the future with confidence, self-assurance and, perhaps most importantly, some peace of mind.

Chapter 3 : Caregiving in Multigenerational Homes

Introduction. Multigenerational family ties have long been considered an important source of support, both for older and younger generations (Bengtson,). An example of this is the case of grandparents raising grandchildren, the growing importance of which is reflected in family-policy changes in the United States over the past 30 years.

Chapter 4 : Multigenerational Approach - Rural Services Integration Toolkit

Introduction. Midlife has been defined as the period between ages 40 and 60, although there is wide variation both across research studies and individuals' self-labeling (Lachman,).